HEALTH COMMITTEE

Cambridgeshire County Council

Date:Thursday, 21 January 2016

Democratic and Members' Services
Quentin Baker
LGSS Director: Law, Property and Governance

13:00hr

Shire Hall
Castle Hill
Cambridge
CB3 0AP

Council Chamber
Shire Hall
Cambridge
CB3 0AP

AGENDA

Open to Public and Press

CONSTITUTIONAL MATTERS

1	**Apologies and Declarations of Interest** *Guidance for Councillors on declaring interests is available at http://tinyurl.com/ccc-dec-of-interests*	
2	**Minutes – 17th December 2015 and Action Log**	**5 - 16**
3	**Petitions**	

KEY DECISIONS

OTHER DECISIONS

4	**Service Committee review of draft business planning proposals for 2016-17 to 2020-21**	**17 - 120**

The Health Committee comprises the following members:

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

Councillor Peter Ashcroft Councillor Barry Chapman Councillor Paul Clapp Councillor Adrian Dent Councillor Peter Hudson 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

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HEALTH COMMITTEE: MINUTES

Date: Thursday 17th December 2015

Time: 2.00pm to 4.25pm

Present: Councillors P Ashcroft, B Chapman (substituting for Cllr van de Kerkhove), P Clapp, P Hudson, D Jenkins (Chairman), Z Moghadas, T Orgee (Vice-Chairman), P Sales, M Smith, P Topping and S van de Ven

District Councillor S Ellington (South Cambridgeshire)

Apologies: County Councillors Dent, Loynes and van de Kerkhove (Cllr Chapman substituting); District Councillors D Brown (Huntingdonshire), M Cornwell (Fenland), R Johnson (Cambridge City) and C Sennitt (East Cambridgeshire)

174. DECLARATIONS OF INTEREST

In relation to agenda item 9 (minute 181), Councillor Hudson declared an interest as a Trustee of Over Day Centre.

The Chairman proposed, and the Committee agreed, that the agenda running order be changed to take item 9 (Prevention work for the Health System Transformation Programme) before item 8 (Service Committee review of additional draft revenue business planning proposals for 2016/17 to 2020/21).

175. MINUTES: 5th NOVEMBER 2015 AND ACTION LOG

The minutes of the meeting held on 5th November 2015 were agreed as a correct record and signed by the Chairman.

The Action Log was noted. The Director of Public Health (DPH) advised that the first of CUHFT's reports had been received and circulated to Members with updates on the three topics identified. It was agreed that a letter be sent to CUHFT thanking them for the report and asking them to continue to provide reports, but to bear in mind when writing them that they would be read by a non-NHS audience. **Action required**

176. CO-OPTION OF DISTRICT COUNCIL REPRESENTATIVE

It was resolved unanimously to co-opt Councillor Daryl Brown of Huntingdonshire District Council as a non-voting member of the Committee.

177. PETITIONS

There were no petitions.

178. CARE QUALITY COMMISSION INSPECTION REPORTS – CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST (CPFT)

The Committee considered the recent Care Quality Commission inspection of Cambridgeshire and Peterborough NHS Foundation Trust. Four of the five CQC inspection areas had been rated as Good, with the fifth inspection area, Safe, being rated as Requires Improvement. The overall rating of the trust had been Good.

In attendance to present information and respond to Members' questions were:

- from Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)
    - John Ellis, Commissioning and Contract Lead
    - Jill Houghton, Director of Quality / Nurse Member
- from Cambridgeshire and Peterborough NHS Foundation Trust
    - Mel Coombes, Director of Nursing
    - Aidan Thomas, Chief Executive.

Members noted that nationally only 20% of mental health trusts received an overall rating of good, and there were no such trusts rated outstanding. An action plan was in place and being monitored internally by CPFT and externally by Monitor and the CCG. Because waiting lists were already due to be considered at its next meeting in January 2016, the Committee decided to focus on other aspects of the CQC report. The Chief Executive said that, with a couple of minor exceptions, CPFT had already been aware of the matters pointed out by the CQC. He recognised the value of inspections for patients and the Trust as improving quality and safety.

In the course of discussion, Members

- requested more information about the rating of Requiring Improvement for community-based mental health services for older people and for specialist community mental health services for children and young people. Members were advised that, for children and young people's services, this rating related largely to waiting lists. Following discussion with the CCG, more resources were being put into dealing with this; the list for Child and Adolescent Mental Health (CAMH) would conform to national guidance on waiting lists later in December, and waiting list for attention deficit hyperactivity disorder (ADHD) had recently been re-opened.

  For Older People's services, issues had been identified around consent to treatment and around management of mixed sex accommodation on one ward in the Peterborough area. The problem with consent to treatment was not that consent was not being obtained, but that the consent was not being recorded. Management of single sex accommodation had been improved by providing a male lounge in addition to the required female lounge

- welcomed the CCG's increase of investment in mental health services by 5.6% in 2015/16 but commented that this represented an input rather than output; in future, it would be helpful to see the outputs that were flowing from the increased input. The Committee was advised that the CCG's report to its January meeting would include information on where the investment had been made. The number of patients accessing treatment had increased, and there were two urgent issues of capacity, in community services and in the capacity of voluntary sector organisations to support patients on discharge. Investment in IAPT (Improving Access to

Psychological Therapies) had also increased, as had CAMH investment. More detail could be made available if required

- noted that the 5.6% increase represented an additional spend of about £2.2m.

The Chairman congratulated the CPFT representatives on the CQC's judgement, describing it as something to be proud of and to defend. The Chief Executive paid tribute to the efforts of CPFT's staff, to whom the praise was due; the staff were determined to achieve an outstanding rating in due course.

It was resolved unanimously:

to note the information provided by the Cambridgeshire and Peterborough Clinical Commissioning Group and CPFT in advance and at the meeting

179. OLDER PEOPLE AND ADULT COMMUNITY SERVICES – ARRANGEMENTS FOR PATIENT CARE FOLLOWING TERMINATION OF UNITINGCARE CONTRACT

The Committee received a report updating it on the actions taken by the CCG since the announcement on 3rd December 2015 that the contractual arrangement between the CCG and UnitingCare was coming to an end.

In attendance from Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) to present the report and respond to Members' questions were

- Jessica Bawden, Director of Corporate Affairs
- Neil Modha, Chief Clinical Officer (Accountable Officer).

Aidan Thomas, Chief Executive of Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) also responded to questions.

The Chairman explained that the Committee would focus in the present meeting on what had happened in the two weeks since the announcement of the end of the contract, and look at what arrangements had been put in place to ensure that no service user had been disadvantaged. There would then be further discussion of other aspects of the termination at the Committee's meeting in January 2016.

The Accountable Officer advised Members that a major incident plan had been put in place to manage the situation following the contract termination. Every provider had been contacted on the same morning and reassured that services would continue, and messages to all staff involved had been consistent, whether they were employed by CPFT or Cambridge University Hospitals NHS Foundation Trust (CUHFT). He accepted the need for an enquiry; Healthwatch had already written helpfully to the CCG at the end of the previous week posing a number of questions, and the CCG would be meeting with Healthwatch in the coming week.

The Chairman read two questions from a member of the public, Jean Simpson of Cambridge. In answer to the question 'Will the Committee take steps to investigate how much public money had been spent on this whole exercise so far, and how the service is going to be securely financed from now on?', he said that yes, the Committee would be examine secure financing of the service at its January meeting. In reply to 'Will the Committee also require the CCG to halt the current procurement exercises ongoing, in particular that for Out of Hours and 111 services, until we can be assured that the CCG is capable of doing this properly?', he said that the answer was no, but

Members had already indicated to health system officers that they did not expect them to ignore the issue.

The Accountable Officer added that the 111 and Out of Hours procurement was based on a national specification, and the CCG had been advised in this work by different advisers from those involved in the UnitingCare contract. The other current procurement exercise concerned the provision of Non-Emergency Patient Transport Services (NEPTS); both these contracts were far smaller in value than that for Older People's and Adult Community Services (OPACS). He assured Members that the CCG was taking Jean Simpson's comments very seriously.

In the course of discussion Members

- raised the possibility of the Committee writing to Monitor and the Department of Health (DH) arguing that community services needed investment to establish them, and suggesting that the DH support the Cambridgeshire and Peterborough project. The Accountable Officer replied that the fundamental principles of the Older People's programme (to keep the elderly in their own homes) had not changed, and that, after the Committee's January meeting, they should work together to see how support to that area of work could be increased

- in relation to the 111 and Out of Hours contract, enquired whether the national 111 contract formula was fit for purpose. Members were advised that 111 and Out of Hours had not been joined up services for historic reasons; to address the problem of many callers to 111 being told to attend hospital unnecessarily, GPs were now available to speak to 111 callers where appropriate, and to see Out of Hours walk-in patients. The CCG was of the view that the contract specification was fit for purpose and would deliver what was required. Pilot work on the integrated service had been undertaken in Cambridgeshire and gone into development; it was not a new model of care, but a new integrated service

- asked what the evidence was to support the assertion that there had been continuity of care for service users. The Chief Executive of CPFT, speaking as one of the sub-contractors, said that CPFT had been telephoned about continuity as already described. He had talked to large groups of CPFT staff to say that existing arrangements for the new model of care would continue, staff had passed that assurance on to patients, and he knew from CPFT's records that care was being delivered; many patients had not noticed the organisational difference.

  The Accountable Officer added that feedback was also being received from the Patient Advice and Liaison Service (PALS), and asked Members to let the CCG know of any evidence they had that services were not being continued. The front-line staff were all still in place, but the bills were now being paid by the CCG rather than by UnitingCare.

- sought assurance that services in community hospitals would not be affected by the contract termination. Members were advised that services previously delivered through the UnitingCare contract would continue, including those in community hospitals. There might in time be some discussion of future community hospital services, but the topic would have arisen even if UnitingCare had continued. Unrelated to the termination of the UnitingCare contract, Cambridgeshire Community Services NHS Trust (CCS) had decided to withdraw its outpatient

service at North Cambridgeshire Hospital, Wisbech; this service would in future be provided by Queen Elizabeth Hospital, Kings Lynn

- commented that an enormous amount of work and resource had gone into the OPACS procurement exercise, and expressed concern about where the resource could be found for the future. The Accountable Officer replied that the first mission was to stabilise without there being any impact at patient level, and the second mission was to learn lessons and get all possible benefit from the procurement experience to help influence future service development

- noted that the CCG had notified the Committee Chairman and Vice-Chairman of the termination of the contract on the day of the announcement, but ahead of the media being informed by press release. The CCG had been working closely with UnitingCare and had hoped until only days beforehand to find a solution

- commented that some Members would have appreciated earlier notification, and recalled that there had been no indication of any concerns when the Committee's Commissioning Older People's Healthcare working party had met with UnitingCare on 5th November 2015. The Chairman asked that the relevant Chief Executives attend working group meetings in future

- noted that Keith Spencer continued in post as Chief Executive of UnitingCare, which was a limited liability partnership and still existed. Most of its staff had been on secondment, and had now returned to their seconding organisations; UnitingCare no longer received any payment from the CCG. The CCG's intention was to take stock of the UnitingCare programme, see what elements were working well and use those findings to inform the development of future services; providers had been told that the CCG aimed to stabilise the situation in the course of the current financial year.

At the Chairman's invitation, and in response to a Member's comment that there was now an opportunity for Healthwatch to take a lead and demonstrate that it was a watchdog, the Chair of Healthwatch Cambridgeshire, Val Moore, spoke. She said that after a week of talking with the organisations involved, Healthwatch too had concluded that it had a part to play, including reassuring the public about the reassurance that it had itself received. There had been promising signs of good services being developed by UnitingCare; Healthwatch's role would be to support the development of the work going forward, bringing it to public attention and sharing information with the groups and networks to which it had access. Healthwatch would assist in any examination of what had happened; it had written and published a letter to the CCG's Accountable Officer which had in part set an agenda for future questions.

Members asked that the Committee in due course receive a full account of what had happened, with no financial information concealed on the grounds of commercial sensitivity. The Accountable Officer undertook to be open with the Committee.

It was resolved unanimously to note the report.

180. HEALTH COMMITTEE WORKING GROUP UPDATE AND MEMBERSHIP

The Committee received a report informing it of the health scrutiny activities undertaken and planned since 5th November 2015. Members noted that the report and its recommendations had been written before the collapse of the UnitingCare contract.

Commenting on recent working groups, Members said that the meeting with UnitingCare had left a positive impression of progress and an opportunity to change the delivery of services for the better. In retrospect, it would have been helpful to have a more senior officer from UnitingCare present, as the group had received a presentation, rather than information. The Chairman pointed out that working groups represented a form of low-level scrutiny, and required good attendance from Members.

It was resolved unanimously:

1) to note and endorse the progress made on health scrutiny by the liaison groups.

2) to defer until the next meeting consideration of whether public consultation on future service configurations in dementia teams in Cambridgeshire and Peterborough NHS Foundation Trust should be tabled into forward plan for future scrutiny.

3) to reconfirm liaison and working groups as a low-level form of scrutiny

4) to establish liaison groups for the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG), Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) and Cambridge University Hospitals NHS Foundation Trust (CUHFT)

5) to hold quarterly meetings of the above liaison groups at the offices of the relevant NHS organisation and require the Chief Executive of the organisation to attend

6) that the Chairman/woman and Vice-Chairman/woman serve on all three liaison group, and all Members of the Committee be invited to attend liaison meetings

7) that Councillors Clapp, Ellington, Hudson and Topping be core Members of the CUHFT liaison group.

181. PREVENTION WORK FOR THE HEALTH SYSTEM TRANSFORMATION PROGRAMME

The Committee received a report introducing the first draft of a health system prevention strategy for Cambridgeshire and Peterborough, noting timescales and that the draft strategy had already been considered by the Health and Wellbeing Board. The strategy was looking at what would quantifiably save money for the local NHS over the next five to ten years; modelling NHS savings was not a precise science, but the strategy was building on the best evidence available, and linked with national and academic work where available. A glossary was being developed to help make the document more manageable for a non-NHS audience.

Members were advised that since publication of the committee papers, Falls Prevention modelling work had been added to the draft strategy. This was focused on people aged over 75, and had been identified as another area where savings could be made from prevention initiatives. Additional modelling had been undertaken around cardio-vascular conditions. Estimated savings would be increased slightly by the addition of these areas.

The Chairman congratulated Emma de Zoete, Consultant in Public Health, and her team on the production of a very professional, large-scale piece of work, which had involved analysts, public health expert officers, and national and academic input.

In answer to their questions and comments, Members noted that

- elements of the strategy would be funded from different sources; some (such as hypertension work largely undertaken by GPs) would come from the mainstream NHS budget, whereas for example falls prevention work involved several agencies; the strategy was more about what could be done than about which body was funding individual elements of prevention work

- the strategy could be summarised at present as a strong evidence base for investment rather than a costed plan at this stage; it needed to be taken through the local health system and the Health and Wellbeing Board

- the Committee's previous views about not disinvesting in long acting reversible contraception (LARC) had been confirmed by the work, which showed a high rate of return to the NHS from LARCs

- funding for day centres was a matter for the Adults Committee; day centres could relate to the public health budget if they for example provided targeted exercise programmes as part of falls prevention work.

Members drew attention to the scale of potential savings in relation to the investment made, and stressed the importance of all parties involved thinking more broadly, not just within their own budget silos. Much prevention work depended on other organisations, but the savings for all involved could be substantial. At the Chairman's suggestion, and with the support of the Committee, two additional recommendations were proposed, that the draft strategy be given to Group Leaders and that Health Spokes make their groups aware of its contents.

It was resolved unanimously

a) to note the first draft of the health system prevention plan

b) that the most recent draft of the health system prevention plan be given to Group Leaders to inform their budget considerations

c) that the Health Spokes for each political group make their groups aware of the contents of the prevention plan.

182. SERVICE COMMITTEE REVIEW OF ADDITIONAL DRAFT REVENUE BUSINESS PLANNING PROPOSALS FOR 2016/17 TO 2020/21

The Committee received a report providing an overview of the draft Business Plan Proposals for Public Health Grant (PHG) funded services, and a summary of the latest available results from the budget consultation.

Members noted that it had only become clear in November 2015 that the ring-fence on the PHG would continue for a further two years, and that there would be an average of 3.9% real-terms cuts each year to 2020/21, in addition to the in-year cut to the PHG in 2015/16. No Community Impact Assessments had yet been completed for the new

savings proposals developed since November. Ring-fencing of the PHG meant that, in accordance with the Council's custom and practice, any savings required would have to come from the services funded by the ring-fenced grant.

The Director of Public Health thanked the Public Health directorate, the Council's other directorates, and contractors for being very understanding of the position in which Public Health had been placed. In terms of forecast cash savings for 2016/17, the revised savings target for PHG-funded expenditure was predicted to be £2.7m. The key factor in determining savings was how to minimise the impact on residents; it was necessary to consider deliverability, and consider the most vulnerable communities. Work was also being undertaken to identify scope for income generation.

Members noted that it was planned to hold a workshop for committee members on the business planning proposals in early January, and consider the findings at its meeting on 21st January to inform the General Purposes Committee's consideration for the Council's overall Business Plan.

In answer to questions, Members were advised that treating the PHG as a ring-fenced grant concentrated the savings into the Public Health budget; the position of the rest of the Council had therefore been improved by the £1.8m anticipated reduction in PHG, which would now be found from within PHG-funded services, rather than from the Council as a whole (which would have been the case had the ring fence been removed). Public Health had been working closely with other directorates on how savings could be made in PHG-funded work carried out in other directorates through the Memorandum of Understanding (MOU); there might be opportunities for services giving Public Health outcomes to be funded in other ways, as they had been before the introduction of the MOU. Members commented that long-term savings in Public Health lead to long-term increases in health costs.

The Chairman distributed additional text for consideration as a possible resolution:

That the Committee

1) notes the Government's decision to continue funding an increasingly expensive NHS
2) notes the evidence-supported positive long term impact that Public Health spending has on NHS costs
3) notes the recent Government decision to
    a. continue the ring fence of the Public Health grant
    b. cut next year's grant by 3.9% on top of the in year cut of 7% this year
4) is concerned because of the impact that this will have on short and longer term total health economy costs and therefore
5) requests that the Chairman writes to local MPs asking them for support in reversing next year's cut
6) requests that Cambridgeshire County Council co-ordinates a broader response via the Local Government Association
7) requests the Director of Public Health to develop alternative approaches to funding Public Health programmes.

Discussing this text, Members suggested adding that there had been a significant increase in population in this area, from both housing development and immigrant populations, which required recognition as part of the funding process. Bearing in mind the report on prevention work, it was also suggested that an effort be made to add some figures to points 2) and 4). However, Members also queried whether this was the

right time to write to MPs, given the forthcoming budget workshop in January and subsequent meeting of the Committee. One Member reported that she had been contacted by her local MP asking for help to secure funding for Centre 33 for residents of South Cambridgeshire; a letter along the lines proposed would make it clear to MPs that there was indeed a funding difficulty in Cambridgeshire.

On being put to the vote, it was resolved by a majority to defer taking the proposed action. Instead, the Committee would consider a motion at its next meeting along the lines already discussed. It was suggested that some informal discussion with the potential recipient MPs could assist in arriving at helpful wording for the letter.

The Committee then considered what its comments to the General Purposes Committee would be on the draft revenue saving proposals for 2016/17.

It was resolved unanimously to:

a) note the overview and context provided for the 2016/17 to 2020/21 Business Plan revenue proposals for Public Health grant funded services, updated since the last report to the Committee in November.

b) relay to the General Purposes Committee as part of consideration for the Council's overall Business Plan the comments that

    a. the Committee would work on a budget incorporating the savings requested in Public Health grant funded services for 2016/17 to 2020/21

    b. the Committee was unable to consider the revenue savings proposals to Public Health grant funded services for 2016/17 to 2020/21 in the absence of Community Impact Assessments

    c. the Committee would consider and comment on the draft revenue savings proposals to Public Health grant funded services for 2016/17 to 2020/21 at a workshop in early January 2016 and at its meeting on 21 January 2016, and then relay its comments to the 2 February 2016 meeting of the General Purposes Committee as part of consideration for the Council's overall Business Plan

c) note the ongoing stakeholder consultation and discussions with partners and service users regarding emerging business planning proposals

183. PUBLIC MENTAL HEALTH STRATEGY UPDATE (INCLUDING WIDER PROGRAMME UPDATES)

The Committee received a report on the County Council's public mental health work; a number of the projects reported on were funded through the public mental health strategy implementation.

In answer to their questions and comments, Members noted that

- the work was proceeding largely as planned, though progress was quicker in some areas and delayed by external factors in other areas, for example, in the case of the

physical health of those with severe mental illness, work by the CCG and CPFT meant that Public Health needed to do less

- cyber bullying was to be a topic for the anti-bullying steering group's meeting in January 2016; Members suggested that cyber-bullying be specifically included in the public mental health strategy

- Public Health was working closely with the Learning Directorate and Personal, Health and Social Education (PHSE) colleagues to develop a toolkit for secondary schools, and to develop consistency of approach to bullying across schools

- the strategy recognised that bullying was a risk factor for poor mental health

- a pilot scheme was being conducted in 12 Cambridge schools. As part of the pilot, training provided by CPFT was being offered to a mental health champion in each school to support champions in working to ensure that schools were meeting their requirements relating to the mental health needs of students

- there was a separate suicide prevention strategy which covered the question of people with severe mental health problems who were not working, not in education, and not involved in day to day community activities, and were bordering on suicidal. Officers offered to supply a copy of the strategy to the questioner. **Action required**

It was resolved unanimously:

to note the progress and work being undertaken in delivery of the Public Mental Health Strategy.

184. TRANSFER OF RESPONSIBILITIES FOR COMMISSIONING HEALTH VISITING AND FAMILY NURSE PARTNERSHIP TO CAMBRIDGESHIRE COUNTY COUNCIL

The Committee received a report updating it on the main issues relating to responsibility for public health commissioning for children aged 0-5. Members noted that Public Health in Cambridgeshire and Peterborough worked closely together, with the Cambridgeshire and Peterborough Children's Health Joint Commissioning Unit (JCU) being led by the Peterborough City Council Director equivalent to Cambridgeshire's Executive Director: Children, Families and Adults. Having taken over contracts with Cambridgeshire Community Services NHS Trust, the JCU was monitoring current performance, outcomes and delivery of services. The basis on which work was commissioned had changed from being based on GP practice to geographical location.

Commenting on the update, the Chairman suggested that, because this area of business was a recent addition to the Council's Public Health responsibilities, it would be helpful to hold a training seminar for Members to give them an overview of how this work was managed and implemented.

It was resolved unanimously:

to receive this briefing on the current commissioning responsibility of health visiting to Cambridgeshire County Council.

185. HEALTH COMMITTEE TRAINING PLAN

The Committee considered its training plan, noting the addition of an invitation to attend a training event being organised by the Centre for Public Scrutiny on 11th February 2016. The Chairman reported that three names had been put forward to reserve the three places offered (Councillors Clapp, Jenkins and Orgee), but other nominations could be made through Spokes. It was suggested that those who attend should feed back their findings after the event.

It was resolved unanimously

a) to note the training plan

b) to add a training seminar, to be held jointly with the Children and Young People Committee, on the commissioning of children's health and the services the Council was required to deliver.

186. HEALTH COMMITTEE AGENDA PLAN AND APPOINTMENTS TO INTERNAL ADVISORY GROUPS AND PANELS, AND PARTNERSHIP LIAISON AND ADVISORY GROUPS

The Committee considered its agenda plan. Members asked that they be given sight of business planning papers as early as possible, even if in draft and in instalments. The Director of Public Health noted this request.

It was suggested that there be a very brief item on hospital car parking charges at the next meeting, to give an opportunity to propose writing to hospital chief executives encouraging them to publicise the various reductions in charges available.

Because of the likely length of the January agenda, it was proposed to start the meeting at 1pm and take a break halfway through.

It was resolved unanimously:

a) to note the agenda plan, with the addition of items on Business Planning and on hospital car park charges to the agenda for 21st January 2016
b) to start the meeting on 21st January at 1pm
c) to note that there were currently no outstanding appointments to be made.

Chairman

SERVICE COMMITTEE REVIEW OF DRAFT BUSINESS PLANNING PROPOSALS FOR 2016/17 TO 2020/21

To:	**Health Committee**
Meeting Date:	**21st January 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 Proposals for Public Health grant funded services that are within the remit of the Health Committee.** **The report provides a summary of the latest available results from the budget consultation.**
Recommendation:	**a) It is requested that the Committee note the overview and context provided for the 2016/17 to 2020/21 Business Plan proposals for the Service, updated since the last report to the Committee in November.** **b) It is requested that the Committee comment on the draft revenue savings proposals that are within the remit of the Health Committee for 2016/17 to 2020/21, and endorse them to the General Purposes Committee as part of consideration for the Council's overall Business Plan, including recommendations for corporate funding headroom outlined in paras 3.6 and 3.7.** **c) Note the ongoing stakeholder consultation and discussions with partners and service users regarding emerging business planning proposals** **d) It requested that the Committee endorse the proposed Key Performance Indicators as part of the Strategic Framework alongside the 2016-21 Business Plan**

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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 is reducing at a time when our costs continue to rise significantly due to inflationary and demographic pressures. This means that despite the way in which we have been able to stimulate local economic growth, and the improving national economy, the financial forecast for the Council continues to present huge challenges.

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 £73m in the last two years and are on course to save a further £30m this year (2015/16). 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. The choices are stark and unpalatable but very difficult decisions will need to be made as the Council has a statutory responsibility to set a balanced budget each year, as well as a duty to provide the best possible services for Cambridgeshire's communities. It is the Chief Finance Officer's statutory role to provide a statement on the robustness of the budget proposals when they are considered by Council in February.

1.3 This year the Council has agreed to move towards an outcome-led approach to business planning. This is defined and described through the draft Strategic Framework that was approved by the General Purposes Committee on 20 October this year (http://www2.cambridgeshire.gov.uk/CommitteeMinutes/Committees/AgendaItem.aspx?agendaItemID=12221).

1.4 The Strategic Framework sets out the outcomes that the Council will work towards achieving, and the ways of working the Council will adopt, in the face of prolonged and extensive budget pressures. It is not a solution to austerity in itself, but instead it is the approach the Council has taken to best tackle the huge challenges it faces.

1.5 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.

1.6 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.

1.7 The main causes of uncertainty are the effects of the Comprehensive Spending Review (CSR) issued on 25 November. Several of the announcements impact on the funding available to, and responsibilities of, local government from 2016/17 onwards, although a consultation document on the grant settlement has been published. Until the detailed Local Government Finance Settlement is issued and can be analyzed we cannot be certain of the impact on the Council. These budget proposals are prepared on the basis of financial modelling that takes into account some announcements from the CSR, but that does not yet take into account the full settlement. It

should be noted that an initial assessment of 2016/17 settlement consultation document suggests that the council is likely to lose an additional £5m of Revenue Support Grant in 2016/17.

A full briefing on the finance settlement is expected to be issued in early January. Once the finance settlement is issued, a full review of our estimates of funding for the five year period will be undertaken, and budget proposals will be reviewed if necessary.

1.8 The Council issues cash limits for the period covered by the Business Plan (rolling five years) in order to provide clear guidance on the level of resources that services are likely to have available to deliver services over that period. To maintain stability for services and committees as they build their budgets we will endeavor to minimise variation in cash limits during the remainder of the process unless there is a material change in the budget gap.

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

1.10 The Committee has previously received reports from the public consultation carried out as part of this year's business planning process. An updated summary report is attached as Annex D.

2. SUMMARY OF THE DRAFT REVENUE BUDGET

2.1 In order to balance the budget in light of the cost and reduced government funding, savings or additional income of £42.9m are required for 2016-17, and a total of £121m across the full five years of the Business Plan. The following table shows the total amount necessary for each of the next five years, split by service block.

Service Block	2016-17 £'000	2017-18 £'000	2018-19 £'000	2019-20 £'000	2020-21 £'000
Children, Families and Adults	-31,299	-22,175	-16,499	-13,112	-8,048
Economy, Transport and Environment	-6,815	-3,663	-2,856	-2,041	-982
Public Health	-1,979	-1,198	-685	-830	-515
Corporate and Managed Services	-1,892	-1,746	-319	-869	-430
LGSS Operational	-971	-571	-803	-708	-351
Total	**-42,956**	**-29,353**	**-21,162**	**-17,560**	**-10,326**

2.2 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.
A list of pressures was reported in October, but since then two further pressures have been factored into financial modelling. These further pressures have not required an increase in the total level of savings, as it is anticipated that corporate funding will be available. The pressures are:

Service Block/Description	2016-17 £'000	2017-18 £'000	2018-19 £'000	2019-20 £'000	2020-21 £'000
CFA: National Living Wage	4,956	4,861	4,765	4,763	4,833
CST: Apprenticeship Levy	0	500	0	0	0

Budget tables to date had assumed government funding to offset the National Living Wage pressure. The 2016/17 settlement consultation contained no funding for this new burden, however. It is likely that the flexibility for upper-tier councils to raise Council Tax by an additional 2% to support adult social care announced in the Autumn Statement is intended to give councils a means to fund this pressure.

2.3 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 plan proposals are still being developed to deliver the following:

Service Block	2016-17 £'000	2017-18 £'000	2018-19 £'000	2019-20 £'000	2020-21 £'000
Children, Families and Adults	0	0	0	0	0
Economy, Transport and Environment	0	-1,135	-2,391	-2,041	-982
Public Health	0	0	-755	-912	-562
Corporate and Managed Services	0	0	-285	-827	0
LGSS Operational	0	0	0	0	0
Total	**0**	**-1,135**	**-3,431**	**-3,780**	**-1,544**

2.4 The level of savings required is predicated on an expected 1.99% increase in council tax each year. This assumption was built into the Medium Term Financial Strategy (MTFS) which was agreed by Full Council. For each 1% more or less that council tax is changed, the level of savings required will change by approximately +/-£2.4m.

2.5 Since the reports that were considered by the December service committees, additional funding headroom has been identified as a result of the change in the treatment of Public Health Grant (PHG) funding required by an announcement in the Comprehensive Spending Review. The PHG was ring-fenced for a further two years, which has resulted in an element of the overall savings allocation moving to PHG-funded services in order to ensure total PHG-funded expenditure matches the actual grant. This headroom will allow the removal of a limited number of savings that were originally planned, described in the paragraphs below.

2.6 The following savings in ETE were recommended to be removed by Highways & Community Infrastructure and Economy & Environment Committees in December:

Directorate	Committee	Proposal	2016/17 Impact £'000	2017/18 Impact £'000
ETE	HCI	Reactive highway maintenance	452	

ETE	HCI	Cyclic highway maintenance	217	
ETE	HCI	Mobile libraries	55	105
ETE	EE	Fenland Learning Centres		90
ETE	EE	Reduction in Passenger Transport Services	694	
Total			1,418	195

2.7 The following savings are also proposed to be removed or reduced subject to the views of the relevant committees:

Directorate	Committee	Proposal	2016/17 Impact £'000	2017/18 Impact £'000
CFA	CYP	Post-16 home to school transport saving for disadvantaged students	250	
CFA	CYP	Assistant Locality Manager posts in highest need areas	80	
CFA	Adults	Voluntary sector adult mental health contracts	134	
CFA	Adults	Community Equipment	100	
CFA	CYP	Personal budgets for children with disabilities	200	
CFA	CYP	NEET post to partly offset planned reductions	40	
PH	Health	Immunisations programme promotion	20	
PH	Health	Joint health intelligence unit with NHS/ reduced JSNA work	50	
PH	Health	Health visiting/family nurse partnership	100	
CST	GPC/Health	Community Engagement (including Time-banking) and contact centre PH activities	35	
CFA	Adults/Health	Older people's day services £150k	150	
ETE	EE/Health	Market town transport strategy – public health impact	40	
ETE	EE/Health	Fenland learning (PH MOU)		90
Total			1,199	90

3. OVERVIEW OF PUBLIC HEALTH GRANT FUNDED SERVICES DRAFT REVENUE PROGRAMME

Public health ring-fenced grant – impact of Comprehensive Spending Review

3.1 As part of the Comprehensive Spending Review issued on 25 November 2015, the Chancellor of the Exchequer announced that the ring-fence on the

public health grant (PHG) would continue for a further two years to the end of 2017/18, and that there would be an average of 3.9% real-terms cuts (including a 1.9% allowance for inflation) each year to 2020/21. Further correspondence received from Public Health England confirmed firstly that these cuts are in addition to the 6.2% in-year 'cash' reduction to the PHG in 2015/16, and secondly that they would be phased in with 'cash' reductions of 2.2% in 16/17, 2.5% in 17/18, 2.6% in 18/19 and 19/20, and flat cash in 2020/21.

This means that the forecast level of PHG over the period is:

£000	2016/17	2017/18	2018/19	2019/20	2020/21
	27,642	26,951	26,250	25,568	25,568

3.2 The treatment of the PHG as a ring-fenced grant means that any pressures caused by inflation, demography or cuts in grant must be met through reducing grant-funded expenditure. This has resulted in a revised savings target for PHG-funded expenditure in 2016/17 of £2.7million. This savings figure is formed by:

	£000
Inflation/Demography/Pressures	468
Income inflation	-3
15/16 grant cut rolled-forward	1613
16/17 additional grant cut	622
	2,700

This is still an estimated savings target, subject to announcement of the exact 2016/17 PHG allocation to each local authority by central government.

Process to date to develop new savings proposals

3.3 Following the comprehensive spending review it was been necessary to rapidly develop further savings proposals for public health grant funded services, due to the additional £2.2M of savings required in 2016/17 over and above the £0.5M of savings already recommended by Health Committee at their November meeting. Indicative proposals for 2017/18 have also been developed. All additional proposals were developed and prioritised on the basis of

- Maximising value for money of public health services in terms of the overall impact of the service on public health outcomes, including reduction in demand for other health and care services due to effective prevention.
- Maximising value for money of public health services through efficiencies and transformation of service delivery .
- Awareness of population need and where service reductions would have greatest negative impact on public health and health inequalities
- The views of the Health Committee, based on discussions of the in-year PHG reduction, that long acting reversible contraception services and Child and Adolescent Mental Health voluntary sector counselling should be protected.

3.4 All services have been considered for savings proposals including external contracts (which make up the majority of public health grant spending), services delivered directly by the public health directorate (about 9% of total public health grant funding) and services delivered by other County Council directorates through a Public Health Memorandum of Understanding.

3.5 These savings proposals were initially brought to the Health Committee in December, but were not discussed in detail as at that point as Community Impact Assessments (CIAs) had not yet been completed. An informal workshop was held early in January to enable Health Committee members to further explore the proposals, and Community Impact Assessments for all proposals have now been completed (Annex C). Discussion with service providers, for externally contracted services, and with other Council directorates for services within the Public Health Memorandum of Understanding (PHMOU), have also been ongoing.

3.6 An overview of savings proposals, which provides the base budgets against which savings have been made, and therefore the 'percentage' impact is provided in Annex A and is further summarised in the table below. Further detail is given in the Financial tables in Annex B.

Service area	**Total base budget 2016/17 £k**	**Total saving 2016/17 £k**	**% saving 2016/17**
Sexual health and contraception	5692	280	5%
Smoking cessation and tobacco control	1253	220	18%
General prevention: including obesity prevention, health checks, falls prevention, workplace health, general project budgets	2465	125	5%
Public mental health	224	60	27%
Health protection/ emergency planning (non-pay)	16	10	63%
Public health directorate staffing Including PH intelligence/specialist advice; PH commissioning; PH directly provided services	2567	584	23%
Drug and alcohol services (CFA directorate)	6269	289	5%
Public Health cross-directorate MOU: PHG funding pooled into preventive services across CCC directorates	1567	431	28%
Children's public health services 0-5 Health visiting and family nurse partnership	7594	290	4%
Demography/inflation/pressures	468	408	87%

Key risks and mitigations

3.6 Given the fast pace of the development of these savings proposals, there remain some general key risks which require mitigation:

- **Inability to deliver a full-year saving:** For many of the proposals there will be a lead-time for implementation, therefore the full-year effect of the saving will not be achievable in 2016/17. This needs to be fully quantified as further work is done on the detailed business case for each saving. In general, where there is unavoidable delay in implementation of savings, it is proposed to meet the shortfall non-recurrently from the ring-fenced public health grant general reserve.

- **Impact on other corporate outcomes - Public health MOU funded services:** There are some services funded in other directorates by the public health grant, which are included in these savings proposals because they provide lower value for money when only public health outcomes are considered, as required under the terms of the public health grant. However some of these services have important outcomes for other aspects of the Council's work – e.g. social outcomes, community engagement, transport planning; and removing the public health funding would have a significant impact on the overall viability and delivery of the service. These services are detailed below and have been recommended by both the Director of Public Health and the Executive Director of the Service concerned, for use of additional funding headroom, as outlined in para 2.4.

Directorate	Committee	Savings Proposal for public health grant funded service	2016/17 Impact £'000	2017/18 Impact £'000
CST	GPC/Health	Community Engagement (including Time-banking) and contact centre public health activities	35	
CFA	Adults/Health	Older people's day services £150k	150	
ETE	EE/Health	Market town transport strategy – public health impact	40	
ETE	EE/Health	Fenland learning (public health MOU funding)		90
Total			225	90

- **Impact on other corporate outcomes and the NHS – general public health services:** Public health services are preventive and therefore in the medium and longer term, they reduce pressures on other public services. This is true particularly of the NHS which treats the majority of lifestyle related on and adult social care, due to development of health conditions and disabilities for which residents require support from these Council services. The evidence for the financial impact of public health services on the local NHS is provided in the Cambridgeshire and Peterborough Health System Transformation Programme 'Prevention Strategy' which was considered by December Health Committee. Examples of impact for the Cambridgeshire population include:

- An annual investment of £157,000 in smoking cessation services generates a net saving to the NHS of £161,000
- £70,000/year invested in in long acting reversible contraception services generates a net saving to the NHS of £770,000
- Investing over 3 years of £1,173,000 in falls prevention generates a net saving to the NHS of £1,244,000

3.7 The risks associated with individual savings proposals services are outlined in the Community Impact Assessments (CIAs) in Annex C. Key risks include:

- **Savings proposal for Family Nurse Partnership (FNP) and Health Visiting:** This £290k savings proposals will require changes in service model, with a move from a highly targeted FNP service for a relatively small number of teenage parents, to a more accessible service for a wider range of vulnerable women. To ensure that this change can be made at an appropriate pace and with sufficient ongoing funding for the wider service to be fully

effective, this savings proposal has been put forward for £100k of additional funding headroom as outlined in para 2.4.

- **Savings proposal for public health intelligence service:** The £111k savings proposal for the public health intelligence/JSNA service is a 40% reduction on the total staffing budget for the service. This service provides key infrastructure for a range of public health work, analyses, and reports, including work which generates income for CCC from local authority, NHS and university partners. Discussions are under way to develop a joint health intelligence unit with the Cambs & Peterborough Clinical Commissioning Group, which would be a potentially positive service transformation and would generate part of this saving in the short term. However there is a significant risk that the savings proposal is over ambitious and that full implementation would permanently reduce the public health service's ability to deliver income generation alongside core work – with a longer term negative effect on the finances of the public health service. This savings proposal has therefore been put forward for £50k of additional funding headroom as outlined in in para 2.4.
- **Savings proposal for public health specialist nursing and immunisation function:** This savings proposal of £73k against the specialist nursing and immunisation function requires a number of functions to be reallocated within the public health directorate. There are also functions relating to immunisation which these posts have been delivering on a 'historic' basis, but which are the core responsibility of NHS England and GP practices. Negotiation and joint planning with NHS England and GP practices will be required to ensure smooth transition to services which do not involve input from Council staff. This is of particular concern because uptake of childhood immunisations in Cambridgeshire is relatively poor – below the England average, and this may relate to health inequalities and communication with mobile migrant populations. Communication and promotion of immunisation programmes to local residents is a local authority public health responsibility, and a proposal has been put forward for £20k of additional funding headroom as outlined in para 2.4, in order to mitigate the staffing reduction by putting some additional resource into promotion of immunisations to higher risk communities.
- **Savings proposal for Tobacco Control: Engagement with at-risk groups:** This savings proposal of £50k reduction in the budget for tobacco control: engagement with at risk groups was initially put forward by the director of public health for additional funding headroom. However alternative ways of mitigating this saving within existing budgets have been identified and therefore this proposal has been withdrawn.

The following table summarises proposals for additional funding headroom from the public health directorate:

Directorate	Committee	Proposal	2016/17 Impact £'000	2017/18 Impact £'000
PH	Health	Saving on specialist public health nurse and immunisation functions – promotion of immunisations	20	
PH	Health	Joint health intelligence unit with NHS/ reduced JSNA work	50	
PH	Health	Health visiting/family nurse partnership	100	

PH	**Health**	**TOTAL**	**170**	

3.8 Other service specific risks have been identified for mitigation in-year from ring-fenced public health reserves

- **Road safety projects and campaigns (ETE):** Before April 2013 and the transfer of public health to the Council, road safety projects and campaigns were funded by core Council budgets as a preventive service. Since then the public health grant has taken on the majority of funding for this area and currently provides funding of £225k, with ongoing ETE funding of £100k. It is proposed to reduce public health grant funding to £100k, which will enable the core road safety team to remain in place, but will require development of income generation and obtaining more external grants to fund project and campaign work. The road safety team is developing an income generation model, and it is proposed that a non-recurrent amount of £84k will be allocated from the PH grant reserve in 2016/17 to allow time for transition to this model, giving a net saving for 2016/17 of £36k.
- **Youth offending service (YOS) specialist drug and alcohol component:** This savings proposal proposed that the public health funded specialist drug and alcohol component of the YOS service is withdrawn, with potential redundancies. The Children and Young People's Substance Misuse Service, CASUS would be provided with some additional funding to assume a bigger role in the YOS through providing support to young people, training for YOS staff to increase their skills in screening and responding to substance misuse issues, and with ongoing supervision. This model does require further exploration of demand and capacity of the CASUS Service to ensure the business case is robust. It is proposed that public health reserves will be used as necessary to ensure that the service continues without adverse impact on outcomes, depending on the result of more detailed exploration of the business case.

Next steps

3.9 Savings proposals are currently in draft and the final public health grant allocation to local authorities has not yet been announced. The recommendations of the Health Committee regarding savings proposals for public health grant funded services will be considered at General Purposes Committee in February. The draft 2016/17 Business Plan will then be discussed by full Council.

4. KEY PEFORMANCE INDICATORS

4.1 The Council uses a set of Key Performance Indicators (KPIs) to monitor progress against its key priorities. These KPIs form part of the Strategic Framework which outlines how the Council intends to deliver these priorities. To reflect the Operating Model being adopted in the Strategic Framework this year, directorates have worked together to propose a set of KPIs which are aligned to outcomes.

4.2 For this Committee, the proposed KPIs in Annex E will have two main purposes. Firstly they will form part of the full list that will be regularly presented to this Committee in Finance and Performance Reports. Secondly, they will be the KPIs that flow from this Committee into the set of indicators

that accompany the Council-wide Strategic Framework which is monitored by General Purposes Committee.

4.3 Some of the KPIs relate to more than one outcome and where this is the case, the indicator has been allocated a 'primary' outcome and one or more 'secondary' outcomes. Where KPIs for outcomes are also KPIs intended to monitor the "narrowing the gap" Council motion, this is indicated in the Annex. For Health Committee, inequalities in strategic KPIs relevant to narrowing the gap will be reported in detail in the 'health inequalities' section of the Finance and Performance Report.

5. NEXT STEPS

January	General Purposes Committee meets to consider the impacts of the Local Government Finance Settlement
February	General Purposes Committee meets to consider the full Business Plan and recommend it to Full Council
February	Draft Business Plan for 2016/17 discussed by Full Council.
March	Publication of final CCC Business Plan for 2016/17. Ongoing work to deliver savings proposals.

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 in Annex A and Annex B.

7.2 Statutory, Risk and Legal Implications

Due to continuation of the public health ring-fence until 2018/19, public health grant spend must continue to meet the grant conditions. Key risks and mitigations are outlined in paragraphs 3.6, 3.7 and 3.8.

7.3 Equality and Diversity Implications

Equality and diversity implications are considered in the Community Impact Assessments provided in Annex C.

7.4 Engagement and Consultation Implications

Engagement and consultation on the County Council's business plan is outlined in para 1.10 and Annex D. Ongoing engagement with service providers, stakeholder organisations, and across Council directorates is taking place during development of these proposals.

7.5 Localism and Local Member Involvement

There are no significant implications.

7.6 Public Health Implications

The impact of each proposal on public health outcomes has been considered as part of the prioritisation process, with the aim of minimising negative impacts.

Source Documents	Location
Paper to December Health Committee: Service Committee Review of Draft Business Planning Proposals for 2016/17 to 2020/21	***http://www2.cambridgeshire.gov.uk/CommitteeMinutes/Committees/AgendaItem.aspx?agendaItemID=12533***

ANNEX A: OVERVIEW OF PUBLIC HEALTH SAVINGS PROPOSALS FOR 2016/17

Savings against public health grant managed by public health directorate (excluding Children's 0-5 services)

Service Category	Ref no	Title of savings proposal	Description
Sexual health and contracep-tion	E/R 6.002 E/R 6.002	PREVIOUSLY AGREED SAVING: Reduced spend on out-of-county sexual health clinics Saving £141k Total budget £216k %saving 65%	Cambridgeshire County Council is cross-charged for Cambridgeshire patients attendingsexual health clinics in other areas. A contingency has been held to cover unpredictedpressures on out-of-area sexual health. The contingency funding has not been used tothe level expected and so will be removed from budgets, and any futureunpredictedpressures met from alternative sources. Local residents now have access to the newlocal Cambridgeshire Community Services sexual health clinics.
	E/R 6.003	CCS contract for integrated contraception and sexual health services (mandated service). Saving £50k Total contract budget: £3,581 % saving 1.4%	Reductions in contract value for 2016/17 and 2017/18. Detail to be determined in discussion with Cambridgeshire Community Services. May involve efficiencies, changes in skill mix (increase in nurse led clinics) or changes in clinic opening times (reducing clinics with lower attendance, including out of hours clinics)
	E/R.6.005	Retendering of contract for sexual health advice prevention and promotion for at risk groups Saving £40k Total contract budget £147k % saving 27%	The charity DHIVERSE is currently commissioned to provide a range of sexual health prevention and promotion interventions including campaigns, advice and promotion with targeted high risk groups with a focus on early diagnosis and treatment of HIV, school based information and advice programme. There is a procurement requirement to re-tender the service, the saving would be made by removing the school based service, while maintaining services to high risk groups.
	E/R.6.004	Chlamydia screening/MICCOM Saving £49k Total Chlam lab budget £142k Total MICCOM budget £9k % saving 32%	Efficiencies already made on laboratory testing costs (Chlamydia) and transformation of booking system for clinic appointments
Total sexual health and contraception		**Total budget: £5692k** **Total saving: £280k** **% saving: 4.9%**	

Service Category	Ref no	Title of savings proposal	Description
Smoking cessation and tobacco control	E/R 6.007 E/R 6.008	EXISTING SAVING: Smoking cessation medication and payments to GPs and pharmacies Total budget £1099k Total saving £170k % saving 15.5%	This level of underspend is likely to occur due to recent reduction in take up of smokingcessation services – thought to be due to the reduced prevalence of smoking recordedin Cambridgeshire and to the use of e-cigarettes. A saving at this level still allows forsome proactivetargetted work to increase uptake of smoking cessation services, and piloting of amore modern 'harm reduction' approach for longer term smokers as recommended byNICE public health guidance
	E/R.6.009	Tobacco control -engagement with at risk groups Saving £50k Total budget £92k % saving 54%	Reduce 2015/16 business plan recurrent investment in engagement and communications work with groups at high risk of smoking behaviour – pregnant women, young people, manual workers (rural deprivation), migrant workers. Mitigate through ongoing tobacco control work through smoking cessation services and/or external grants. .
Total smoking cessation and tobacco control		**Total budget £1253k** **Total saving £220** **% saving 17.6%**	
General prevention workplace health, obesity prevention , health checks, project budgets, falls prevention	E/R.6.010	General prevention projects and workplace health Savings: £50k general prevention projects. £45k workplace health Total budget £112k workplace health and general prevention projects (note: may also involve sexual health general project budgets) % saving 85%	Remove project budgets for small scale public health prevention work, which is often one off projects with more marginalised or high risk groups such as people with disabilities or LGBT groups. Fund a workplace health contract with Business in the Community non-recurrently for two years (already in place), on condition that BITC obtains funding directly from businesses/employers after this period.
	E/R.6.011	Falls prevention contract Saving £20k Total budget £100 % saving 20%	Saving on recurrent investment of £100k allocated to falls prevention in 2015/16 business plan. Falls prevention services have been contracted from Everyone Health for £80k. Ear-marked non-recurrent PH reserve for falls prevention remains in place
	E/R.6.017	Review non-pay budget general Traveller health team Saving £10k From general prevention budget £112k as per E/R.6.010	Saving on non-pay/project budgets held by the Traveller health team. These are underspent due to availability of grants from the Community Adult Learning Fund for the same purpose (literacy training).

Service area	Ref no	Title of savings proposal	Description
Total general prevention, obesity prevention, health checks , falls prevention		**Total budget £2465k** **Total saving £125k** **% saving 5%**	
Public Mental Health strategy	E/R.6.015 -	Public mental health strategy implementation (recurrent revenue not yetcommitted) Saving £60k Total budget £120k % saving 50%	Saving on recurrent investment of £120k allocated to public mental health strategy. This reflects objectives of the strategy delivered in other ways – through BITC contract to achieve the workplace mental health objective, and through joint work with the NHS to achieve the objective of improving physical health for people with severe mental health problems.
Total public mental health		**Total budget £224k** **Saving £60k** **% saving 27%**	**Note: Public mental health has received investment of X in 2014/15 and 2015/16 – a total of y% of all new investment over these two years.**
Health protection and emergency planning non-pay budgets	E/R.6.016	Health protection and Emergency planning non-pay budgets **Total budget £16k** **Saving £10k** **% saving 63%**	Savings on health protection and emergency planning budgets which are held as contingency for emergency situations. Contingency to be sought when necessary from generic budgets or reserves
Public health director-ate staffing budgets	E/R6.018	Vacancy management in the public health directorate including removal of a vacant physical activity post Total budget £2567k Saving £115k % saving 4.5%	There have been underspends against the public health staff budget in previous yearsdue to vacancies. This saving is a reduction in the staff budget based on predicted levelof staff turnover and vacancies, associated with active vacancy management.
	E/R6.019	Public health programmes team restructure/vacancy management – changes to staffing structure of CAMQUIT and deletion of vacant part-time mental health promotion post. Saving £59k CAMQUIT Total budget:: £474k %saving 12% Saving £26k MH promotion post Total budget £52k %Saving 50%	Changes to the staffing structure of CAMQUIT smoking cessation services: Making redundant two senior smoking cessation specialist posts which deliver training and lead other support and project work. Freeing up smoking cessation advisor time, by employing a health trainer to deliver project work. Vacant mental health promotion post to be deleted, with key work covered by other staff and contracts .

	Ref no	Title of savings proposal	Description
Public health director-ate staffing budget	E/R.6.019	Public health programmes team restructure/vacancy Management – redundancy of public health specialist nurse and immunisation healthcare assistant posts. Saving £73k Total budget PH specialist nurse and immunisation functions £73k % saving 100% **RECOMMENDED BY DPH FOR £20k CORPORATE HEADROOM FUNDING FOR PROMOTION OF IMMUNISATIONS**	Restructure of public health front line delivery services, reducing input to immunisation services, for which commissioning responsibility and funding now sits with NHS England. CCC public health have been supporting administration of GP practice led BCG clinics for children and neonates, GP practice immunisation reporting, immunisation training for GP practice nurses, some follow up of non-attenders for immunisation. Points (a)-(c) are the responsibility of NHS England and GP practices rather than LAPH. (d) could be within the remit of health visitors. The post-holders also manage the 'Healthy Start' scheme, and the specialist PH nurse line manages the Traveller Health Team and smoking in pregnancy midwife..
	E/R.6.021	Public health commissioning - explore joint work with other organisations Saving £50k Total budget PH commissioning staff £94k (+ £322k health improvement/PH manager posts). % saving 53%, or 12% including wider posts	Explore partnership work for public health commissioning across other local organisations and CCC directorates to deliver efficiencies. This will form part of a wider corporate review of commissioning.
	E/R.6.020	Public health intelligence/JSNA - explore jointintelligence unit with NHS and restructure; Redundancy of part-time JSNA programme manager post. Saving £111k (propose reduce to £61k) Total PHI/JSNA staffing budget £259k % saving 43% **RECOMMENDED BY DPH FOR £50k CORPORATE HEADROOM FUNDING TO RETAIN ANALYST CAPACITY FOR INCOME GENERATION**	The public health intelligence service provides analytical, statistical and epidemiological leadership, expert input and support to the Public Health Directorate, to the Cambridgeshire and Peterborough Clinical Commissioning Group ('the CCG'), to the wider Council, to Peterborough City Council and to other partners. The service also provides analytical input and programme management to the Joint Strategic Needs Assessment (JSNA) programme. The savings proposal is to explore a joint Health Intelligence Unit with Cambridgeshire and Peterborough CCG and an associated restructure. Also to reduce JSNA work to the statutory minimum required and make the JSNA programme manager post redundant.
	E/R.6.022	Public health consultant - remove 0.4 wtepost supporting ETEfromEstablishment (currently short term postholder) Saving £30k Total PH consultant staffing budget £472k (already reduced from £657k at transfer to CCC) % saving 6%	Remove 0.4wte PH consultant post from establishment. Public health consultants are medical consultants (or staff with equivalent specialist training), directly employed by the County Council as part of the public health team. This will affect public health consultant capacity, including support to ETE directorate. Mitigate through joint health improvement specialist post with SCDC focussing on transport and environment.

Service area	Ref no	Title of savings proposal	Description
Public health director-ate staffing budget	E/R 7.101	Income generation shared DPH and PH team with Peterborough Saving (through income generation) £80k	The Director of Public Health and some staff members in the Public Health Team haveentered into a shared service arrangement with Peterborough City Council whichgenerates this level of income for Cambridgeshire County Council
	E/R.7.104	Income generation Saving (through income generation) £40k	Further income generation reflecting extension of the shared public health team across Cambridgeshire and Peterborough, and potential further opportunities with the Cambs & Peterborough Clinical Commissioning Group
Total public health directorate staffing budget including income generation		**Total budget: £2567k** **Total saving: £584k** **% saving23%**	

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

Director-ate	Title of savings proposal	Description
CFA drug & alcohol services	Drug and Alcohol Action Team – vacancy management/comms and training budgets Saving £51k Total Budget DAAT commissioning system £338k % saving 15%	The DAAT team includes commissioners and strategic leads who also deliver training and promotional activities. Ongoing vacant post in the DAAT team deleted and responsibilities shared among other team members. Saving on generic communications and training budgets. Mitigation – work closely with PH directorate to access free comms materials and training from Public Health England and other sources.
CFA drug & alcohol services	Reduction in contract value drug misuse services contract Saving £170k Total value £4271k adult drug misuse treatment contract and £961k alcohol treatment contract. % saving 3.2%	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

Director-ate	Title of savings proposal	Description
CFA drug & alcohol services	GP shared care contract efficiencies Saving £10k Total budget £20k % saving 50%	GPs are offered a shared care contract for alcohol misuse to support prescribing for community detoxification. . However take up of the contract has been low and the saving reflects recurrent underspend against the budget.
CFA drug & alcohol services	Cease drug and alcohol component of Youth Offending (YOS) service and replace with Children and Young People's Substance Misuse (CASUS) input Saving £58k Total YOS budget for specialist substance misuse £95k Total CASUS budget £315k % saving as % of YOS budget for specialist substance misuse 61% % saving as % of both services 14%	It is proposed that this public health funded component of the YOS service is withdrawn, with potential redundancies..The Children and Young People's Substance Misuse Service, CASUS would be provided with some additional funding to assume a bigger role in the YOS through providing support to young people, training for YOS staff to increase their skills in screening and responding to substance misuse issues and with ongoing supervision. This model does require further exploration of demand and capacity of the CASUS Service to ensure the business case is robust. Public health reserves will be used as necessary to ensure that the service continues without adverse impact on outcomes, depending on the result of more detailed exploration of the business case.
Total drug and alcohol services	**Total budget £6269k** **Total savings £289** **% saving 4.6%**	
CFA – PHMOU Services	Physical activity promotion - older people's day centres Saving £150k Total older people's day centre budget not known. **RECOMMENDED FOR £150k CORPORATE HEADROOM FUNDING BY DPH AND EXEC DIRECTOR CFA**	£150k public health grant funding has been substituted into the core funding for Tier 1 and 2 Older People's Day Centres run by Age Concern, with the aim of promoting physical activity to improve health outcomes for older people. Under the PH grant terms and conditions, interventions must not be charged for. Meetings with the Day Centres have found that physical activity interventions are limited, and this is unlikely to be demonstrably effective use of PH grant funding.
CFA – PHMOU Services	PHSE service (non-traded) review of public health activities Saving £41k Total PSHE budget not known	There are funding streams into the CCC Personal Health and Social Education Service (PHSE) through the PHMOU and directly from PH directorate budgets. This saving would reduce but not cease public health funding into PHSE services, and together with changes already planned by CFA would enable targeting of PHSE activity to maximise positive health outcomes.

Director-ate	Title of savings proposal	Description
CFA – PHMOU Services	Chronically excluded adults team efficiencies Saving £25k Total CEA team budget £93k % saving 27%	The PH grant funded chronically excluded adults team works with very chaotic individuals, usually street homeless and with multiple drug/alcohol/mental health issues. There is a recurrent underspend of £25k.
CFA – PHMOU Services	Housing related support Saving £6k Total spend £3833k in 2014/15 % saving 0.2%	The public health grant is pooled into the wider CCC housing related support funding and makes up a very small proportion of overall spend. This saving can be managed within the service without major impact.
ETE PHMOU Services	Market town transport strategy - public health impact Saving £40k Total budget not known **RECOMMENDED FOR £40k CORPORATE HEADROOM FUNDING BY DPH AND EXEC DIRECTOR ETE**	The public health grant is substituted into core ETE funding for the Market Town transport strategy,to support joint work with the public health team to promote active travel within the strategy. This saving would significantly reduce ETE capacity to deliver the Market Town Transport strategies.
ETE PHMOU Services	Road safety projects and campaigns Saving £120k mitigated by £84k non-recurrent transition funding from PH reserve in 2016/17. Total budget (PH + ETE) approx. £325k % saving 37% without in year mitigation from reserves % saving 11% with in year mitigation from reserves.	The public health grant was substituted into core ETE funding for road safety staff, projects and campaigns – and now funds the majority of the service. £100k funding is still provided directly by ETE. It is proposed to reduce public health grant funding to £100k, which will enable the core road safety team to stay in place, but will require income generation and finding more external grants to fund project and campaign work. The road safety team is developing income generation, and it is proposed that a non-recurrent amount of £84k will be allocated from the PH grant reserve in 2016/17 to support transition to an income generating model, giving a net saving for 2016.17 of £36k.
ETE PHMOU Services	Review trading standards public health activities Saving £15k Total budget not known	Trading standards (part of Supporting Businesses and Communities) received public health grant funding to support test purchasing of cigarettes (Kick Ash project) and alcohol, to prevent underage sales. This reduction in funding is the amount allocated against alcohol test purchasing. The reduction can be managed within current planned changes to the service.

Director-ate	Title of savings proposal	Description
ETE PHMOU Services	Fenland Learning service **(2017/18 only)** Saving £90k **in 2017/18** Total budget approx. £180k **RECOMMENDED FOR £90k CORPORATE HEADROOM FUNDING BY ECONOMY AND ENVIROMENT COMMITTEE (ETE COMPONENT) AND BY DPH and EXEC DIRECTOR ETE**	2017/18 only. The Fenland Learning Service enables residents of Fenland to access adult learning which increases their employability, such as literacy and computer skills. Historically it was funded by ETE, but more recently £90k of the funding has been substituted by public health grant, alongside £90k of funding from ETE.
CS&T PHMOU Services	Review community engagement and timebanking public health activities Saving £28k Total budget not known, but limited **RECOMMENDED FOR £28k CORPORATE HEADROOM FUNDING BY DPH AND DIRECTOR CS&T.**	Public health grant funding was substituted into funding for existing staff in CS&T who support community engagement and timebanking. They helped promote community engagement to set up the Healthy Fenland Fund which is now being run through a voluntary sector contract with Care Network.
CS&T PHMOU Services	Review contact centre public health activities Saving £6.5k Total budget not known **RECOMMENDED FOR £6.5k CORPORATE HEADROOM FUNDING BY DPH AND DIRECTOR CS&T**	The Contact Centre was used as a contact number for members of the public in public health 'winter warmth' campaign' and to support this ,public health grant was substituted into existing contact centre funding. Monitoring showed only 4-6 calls a month were received in the winter period. The voluntary sector also provides contact numbers and these provide an alternative.
Total PHMOU services (except drug and alcohol)	**Total budget for PHMOU services in other directorates (preventive services previously funded by core Council budgets) £1567k** **Total saving £431k** **% saving 28%** **% saving with mitigation of road safety savings 22%**	

Savings against Children's 0-5 Public Health Services (transferred to local authorities in October 2015)

Ref no	Title of savings proposal	Description
E/R.6.012	Health visiting and family nurse partnership Saving £290k Total budget for contract £7594k % saving 3.8% **RECOMMENDED BY DPH FOR £100k CORPORATE HEADROOM FUNDING**	Reduction in the contract value for age 0-5 public health services with Cambridgeshire Community Services. Details to be established in partnership with CCS, but likely to include review of Family Nurse Partnership and development of other more inclusive services for vulnerable women and teenagers, review of staffing skill mix, and potentially reduction in 2-3 month check, which is not nationally mandated.

Savings against no inflation/demography/pressures uplift to external contracts

Ref no	Title of savings proposal	Description	Impact on public health outcomes	Impact on other corporate outcomes	Impact on inequalities groups (CIA)	Deliverability	Political acceptability
E/R.6.023	No uplift for demography/inflation/pressures **Saving £408k** **Total demography/inflation/ pressures £468k** **% saving 87%**	Do not resource uplifts for demography /inflation/ pressures for externally provided public health contracts, requiring providers to make cost improvement programmes to cover the activity required. Absorb demography pressures for internal services, within existing resource envelope.	Difficult to assess as contractors will need to find efficiency savings.	Limited in the short term.	CIA not yet completed. Difficult to assess as contracts will need to find efficiency savings.	Deliverable as contractors are not expecting uplifts.	Likely to be acceptable.

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 2016-17 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 2016-17 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: 2016-17 to 2020-21

Net Revised Opening Budget 2016-17 £000	Policy Line	Gross Budget 2016-17 £000	Fees, Charges & Ring-fenced Grants 2015-16 £000	Net Budget 2016-17 £000	Net Budget 2017-18 £000	Net Budget 2018-19 £000	Net Budget 2019-20 £000	Net Budget 2020-21 £000
	Health Improvement							
4,364	Sexual Health STI testing & treatment	4,134	-	4,134	4,190	4,282	4,357	4,431
1,170	Sexual Health Contraception	1,170	-	1,170	1,170	1,170	1,170	1,170
-	National Child Measurement Programme	-	-	-	-	-	-	-
223	Sexual Health Services Advice Prevention and Promotion	173	-	173	173	173	173	173
-	HI - Obesity Adults	-	-	-	-	-	-	-
82	Obesity Children	82	-	82	82	82	82	82
100	Physical Activity Adults	100	-	100	70	70	70	70
1,605	Healthy Lifestyles	1,605	-	1,605	1,650	1,692	1,733	1,771
-	Physical Activity Children	-	-	-	-	-	-	-
1,099	Stop Smoking Service & Intervention	929	-	929	959	987	1,011	1,032
63	Wider Tobacco Control	13	-	13	13	13	13	13
265	General Prevention Activities	155	-	155	155	155	155	155
100	Falls Prevention	80	-	80	80	80	80	80
2	Dental Health	2	-	2	2	2	2	2
9,073	**Subtotal Health Improvement**	**8,443**	**-**	**8,443**	**8,544**	**8,706**	**8,846**	**8,979**
	Children Health							
7,722	Children 0-5 PH Programme	7,431	-	7,431	7,235	7,362	7,513	7,643
1,745	Children 5-19 PH Programme	1,745	-	1,745	1,695	1,695	1,695	1,695
9,467	**Subtotal Children Health**	**9,176**	**-**	**9,176**	**8,930**	**9,057**	**9,208**	**9,338**
	Adult Health & Wellbeing							
712	NHS Health Checks Programme	712	-	712	712	712	712	712
224	Public Mental Health	164	-	164	164	164	164	164
37	Comm Safety, Violence Prevention	37	-	37	37	37	37	37
973	**Subtotal Adult Health & Wellbeing**	**913**	**-**	**913**	**913**	**913**	**913**	**913**
	Intelligence Team							
16	Public Health Advice	16	-	16	16	16	16	16
10	Info & Intelligence Misc	10	-	10	10	10	10	10
26	**Subtotal Intelligence Team**	**26**	**-**	**26**	**26**	**26**	**26**	**26**
	Health Protection							
11	LA Role in Health Protection	1	-	1	1	1	1	1

Section 4 - E: Public Health

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

Budget Period: 2016-17 to 2020-21

Net Revised Opening Budget 2016-17 £000	Policy Line	Gross Budget 2016-17 £000	Fees, Charges & Ring-fenced Grants 2015-16 £000	Net Budget 2016-17 £000	Net Budget 2017-18 £000	Net Budget 2018-19 £000	Net Budget 2019-20 £000	Net Budget 2020-21 £000
5	Health Protection Emergency Planning	5	-	5	5	5	5	5
16	**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
125	General Prevention, Traveller, Lifestyle	125	-	125	75	75	75	75
156	**Subtotal Programme Team**	**156**	**-**	**156**	**106**	**106**	**106**	**106**
	Public Health Directorate							
-18,197	Public Health - Admin & Salaries	2,058	-20,781	-18,723	-18,272	1,783	1,783	1,783
-18,197	**Subtotal Public Health Directorate**	**2,058**	**-20,781**	**-18,723**	**-18,272**	**1,783**	**1,783**	**1,783**
-	**UNIDENTIFIED SAVINGS TO BALANCE BUDGET**	**3**	**-**	**3**	**35**	**-650**	**-1,480**	**-1,995**
	Future Years							
-	Inflation	-	-	-	372	777	1,193	1,623
-	Savings	-	-	-	-660	-660	-660	-660
1,514	**PUBLIC HEALTH TOTAL**	**20,781**	**-20,781**	**-**	**-**	**20,064**	**19,941**	**20,119**

Section 4 - E: Public Health

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

Budget Period: 2016-17 to 2020-21

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.

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	6,422	-6,422	-
-	**Subtotal Children, Families and Adults Services**	**6,422**	**-6,422**	**-**
-	**Economy, Transport and Environment Services** Public Health expenditure delivered by ETE	243	-243	-
-	**Subtotal Economy, Transport and Environment Services**	**243**	**-243**	**-**
-	**Corporate Services** Public Health expenditure delivered by CS	202	-202	-
-	**Subtotal Corporate Services**	**202**	**-202**	**-**
-	**LGSS - Cambridge Office** Overheads associated with Public Health function	220	-220	-
-	**Subtotal LGSS - Cambridge Office**	**220**	**-220**	**-**
-	**PUBLIC HEALTH MANAGED IN OTHER SERVICE AREAS TOTAL**	**7,087**	**-7,087**	**-**

-42	Less Fees & Charges / Contributions	-42	42	-
1,472	**EXPENDITURE FUNDED BY PUBLIC HEALTH GRANT TOTAL**	**27,826**	**-27,826**	**-**

Section 4 - E: Public Health

Table 2: Revenue - Net Budget Changes by Operational Division

Budget Period: 2016-17

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	4,364	53	27	-	-	-310	4,134
Sexual Health Contraception	1,170	14	-	-	-	-14	1,170
National Child Measurement Programme	-	-	-	-	-	-	-
Sexual Health Services Advice Prevention and Promotion	223	3	1	-	-	-54	173
HI - Obesity Adults	-	-	-	-	-	-	-
Obesity Children	82	1	2	-	-	-3	82
Physical Activity Adults	100	1	-	-	-	-1	100
Healthy Lifestyles	1,605	19	29	-	-	-48	1,605
Physical Activity Children	-	-	-	-	-	-	-
Stop Smoking Service & Intervention	1,099	13	12	-	-	-195	929
Wider Tobacco Control	63	1	1	-	-	-52	13
General Prevention Activities	265	4	18	-	-	-132	155
Falls Prevention	100	1	-	-	-	-21	80
Dental Health	2	-	-	-	-	-	2
Subtotal Health Improvement	**9,073**	**110**	**90**	**-**	**-**	**-830**	**8,443**
Children Health							
Children 0-5 PH Programme	7,722	45	69	-	-	-405	7,431
Children 5-19 PH Programme	1,745	22	-	-	-	-22	1,745
Subtotal Children Health	**9,467**	**67**	**69**	**-**	**-**	**-427**	**9,176**
Adult Health & Wellbeing							
NHS Health Checks Programme	712	9	-	-	-	-9	712
Public Mental Health	224	3	-	-	-	-63	164
Comm Safety, Violence Prevention	37	1	-	-	-	-1	37
Subtotal Adult Health & Wellbeing	**973**	**13**	**-**	**-**	**-**	**-73**	**913**
Intelligence Team							
Public Health Advice	16	-	-	-	-	-	16
Info & Intelligence Misc	10	-	-	-	-	-	10
Subtotal Intelligence Team	**26**	**-**	**-**	**-**	**-**	**-**	**26**
Health Protection							
LA Role in Health Protection	11	-	-	-	-	-10	1

Section 4 - E: Public Health

Table 2: Revenue - Net Budget Changes by Operational Division

Budget Period: 2016-17

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	5	-	-	-	-	-	5
Subtotal Health Protection	**16**	**-**	**-**	**-**	**-**	**-10**	**6**
Programme Team							
PT - Obesity Adults	-	-	-	-	-	-	-
Stop Smoking no pay staff costs	31	1	-	-	-	-1	31
General Prevention, Traveller, Lifestyle	125	2	-	-	-	-2	125
Subtotal Programme Team	**156**	**3**	**-**	**-**	**-**	**-3**	**156**
Public Health Directorate							
Public Health - Admin & Salaries	2,461	82	-	34	-	-519	2,058
Subtotal Public Health Directorate	**2,461**	**82**	**-**	**34**	**-**	**-519**	**2,058**
Public Health Ring-fenced Grant and Fees & Charges	-20,658	-3	-	-	-	-120	-20,781
UNIDENTIFIED SAVINGS TO BALANCE BUDGET	**-**	**-**	**-**	**-**	**-**	**-**	**-**
PUBLIC HEALTH TOTAL	**1,514**	**272**	**159**	**34**	**-**	**-1,982**	**-3**

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: 2016-17 to 2020-21

		Detailed Plans	Outline Plans						
Ref	**Title**	**2016-17 £000**	**2017-18 £000**	**2018-19 £000**	**2019-20 £000**	**2020-21 £000**	**Type**	**Description**	**Committee**
1	**OPENING GROSS EXPENDITURE**	**18,222**	**20,781**	**20,365**	**20,375**	**20,253**			
E/R.1.001	Transfer of Function - Public Health Researcher	29	-	-	-	-	Existing	Public Health reasearcher post transfer from CS&T to Public Health	**Health**
E/R.1.002	Transfer of Function - HIV Commissioning	144	-	-	-	-	Existing	Funding for HIV services provided by Cambridgeshire Community Services transferred to NHS England	**Health**
E/R.1.003	Transfer of Function - Healthy Child Programme	3,861	-	-	-	-	Existing	Transfer of the healthy child programme for 0-5 year olds from NHS England in October 2015.	**Health**
E/R.1.004	One-off use of Public Health reserve funding	-84	84	-	-	-	New	A one-off use of PH reserve funding will be used in 2016/17 to allow a transitional period for the reduction of PH grant funding to ETE.	**Health**
1.999	**REVISED OPENING GROSS EXPENDITURE**	**22,172**	**20,865**	**20,365**	**20,375**	**20,253**			
2	**INFLATION**								
E/R.2.001	Inflation	275	373	406	417	431	Existing	Forecast pressure from inflation, based on detailed analysis incorporating national economic forecasts, specific contract inflation and other forecast inflationary pressures.	**Health**
2.999	**Subtotal Inflation**	**275**	**373**	**406**	**417**	**431**			
3	**DEMOGRAPHY AND DEMAND**								
E/R.3.001	Sexual Health Services	28	106	92	75	74	Existing	Funding to support increased demand for sexual health and contraception services, based on population growth in the age groups which use these services.	**Health**
E/R.3.002	Adult Health Improvement	15	30	28	24	21	Existing	Funding to support increased demand for adult health improvement services, based on population growth in the age groups which use these services.	**Health**
E/R.3.003	Integrated Lifestyle Service	29	45	42	41	38	New	Increased demand for integrated lifestyle services, in particular the weight management services etc.	**Health**
E/R.3.004	Children's Health Improvement	87	144	127	151	130	Existing	Funding to support increased demand for obesity prevention and treatment services, based on population growth in the age groups which use these services.	**Health**
3.999	**Subtotal Demography and Demand**	**159**	**325**	**289**	**291**	**263**			
4	**PRESSURES**								
E/R.4.001	Single-tier State Pension	34	-	-	-	-	New	The Government plans to abolish the State Second Pension on 1st April 2015. The Council currently receives a rebate on the amount of National Insurance contributions it pays as an employer because it has "contracted out" of the State Second Pension. This rebate will cease when the State Second Pension is abolished, resulting in an increase in the cost of National Insurance contributions which the Council is required to pay.	**Health**
4.999	**Subtotal Pressures**	**34**	**-**	**-**	**-**	**-**			
5	**INVESTMENTS**								
5.999	**Subtotal Investments**	**-**	**-**	**-**	**-**	**-**			

Section 4 - E: Public Health

Table 3: Revenue - Overview

Budget Period: 2016-17 to 2020-21

		Detailed Plans	Outline Plans						
Ref	**Title**	**2016-17 £000**	**2017-18 £000**	**2018-19 £000**	**2019-20 £000**	**2020-21 £000**	**Type**	**Description**	**Committee**
6	**SAVINGS**								
	Health Improvement								
E/R.6.001	Sexual Health - Peterborough Services	-26	-	-	-	-	New	Predicted underspend on use of Peterborough sexual health services by Cambridgeshire residents (for which Cambs is cross charged). Local residents now have access to Cambridgeshire Community Services sexual health clinics in Fenland and Huntingdon.	**Health**
E/R.6.002	Sexual Health – Out of Area Treatments	-115	-	-	-	-	New	Cambridgeshire County Council is cross-charged for Cambridgeshire patients attending sexual health clinics in other areas. A contingency has been held to cover unpredicted pressures on out-of-area sexual health. The contingency funding has not been used to the level expected and so will be removed from budgets, and any future unpredicted pressures met from alternative sources. Local residents now have access to the new local Cambridgeshire Community Services sexual health clinics.	**Health**
E/R.6.003	CCS contract for integrated contraception and sexual health services	-50	-50	-	-	-	New	Reductions in contract value for 2016/17 and 2017/18. Detail to be determined in discussion with Cambridgeshire Community Services. May involve efficiencies or some changes in clinic opening times.	**Health**
E/R.6.004	Chlamydia screening/MICCOM	-49	-	-	-	-	New	Efficiencies already made on laboratory testing costs (Chlamydia) and transformation of booking system for sexual health clinic appointments.	**Health**
E/R.6.005	Retendering of contract for sexual health advice prevention and promotion for at risk groups	-40	-	-	-	-	New	The service currently provided by voluntary organisation DHIVERSE for sexual health advice, prevention and promotion for at risk groups is due to be re-tendered. A proposed reduction in the financial envelope for the retendered service of £40k, with the specification focussing specifically on the most vulnerable groups less likely to engage with statutory services.	**Health**
E/R.6.006	Review exercise referral schemes and potential to joint fund with NHS	-	-30	-	-	-	New	Exercise referral schemes are recommended for individuals with long term conditions as part of disease management, but not for public health promotion of physical activity in the general population. Explore potential to co-fund existing exercise referral schemes with the local NHS. .	**Health**
E/R.6.007	Smoking Cessation - Medication and Payments to GPs	-145	-	-	-	-	New	This level of underspend is likely to occur due to recent reduction in take up of smoking cessation services – thought to be due to the reduced prevalence of smoking recorded in Cambridgeshire and to the use of e-cigarettes. A saving at this level still allows for some proactive work to increase uptake of smoking cessation services, and piloting of a more modern 'harm reduction' approach for longer term smokers as recommended by NICE public health guidance.	**Health**
E/R.6.008	Smoking Cessation - Pharmacy Programme	-25	-	-	-	-	New	Due to the significant fall in uptake of smoking cessation services through pharmacies, this aspect of the service has reduced in activity and therefore in the payments required.	**Health**
E/R.6.009	Tobacco control -engagement with at risk groups	-50	-	-	-	-	New	Cease 2015/16 business plan recurrent investment in engagement and communications work with groups at high risk of smoking behaviour – pregnant women, young people, manual workers (rural deprivation), migrant workers. Deliver some on-going tobacco control work through smoking cessation services and/or external grants.	**Health**
E/R.6.010	General prevention projects and workplace health	-95	-	-	-	-	New	Saving on project budgets for small scale public health prevention work. Fund workplace health contract with Business in the Community non-recurrently for two years, on condition that BITC obtains funding directly from businesses/employers after this period.	**Health**

Section 4 - E: Public Health

Table 3: Revenue - Overview

Budget Period: 2016-17 to 2020-21

	Detailed Plans	Outline Plans			

Ref	Title	2016-17 £000	2017-18 £000	2018-19 £000	2019-20 £000	2020-21 £000	Type	Description	Committee
E/R.6.011	Falls prevention contract	-20	-	-	-	-	New	Saving on recurrent investment of £100k allocated to falls prevention in 2015/16 business plan. Falls prevention services have been contracted from Everyone Health for	Health
	Children Health								
E/R.6.012	Health visiting and family nurse partnership	-290	-90	-	-	-	New	Reduction in the contract value for age 0-5 public health services with Cambridgeshire Community Services. Details to be established in partnership with CCS, but likely to include review of family nurse partnership and of staffing skill mix.	Health
E/R.6.013	0-15 public health services as part of wider children's health 0-19 proposals	-	-250	-	-	-	New	Savings on age 0-5 public health services as part of proposed wider transformation of public health and other health and preventive services for 0-19 year olds, to be developed for 2017/18.	Health
E/R.6.014	Review CAMH voluntary sector funding as part of wider children's health 0-19 proposals	-	-50	-	-	-	New	Savings on child and adolescent mental health voluntary sector counselling services as part of wider transformation of public health and other health and preventive services for 0-19 years olds, to be developed for 2017/18.	Health
	Adult Health & Wellbeing								
E/R.6.015	Public mental health strategy (recurrent revenue not yet committed)	-60	-	-	-	-	New	Saving on recurrent investment of £120k allocated to public mental health strategy. This reflects objectives of the strategy delivered in other ways – through BITC contract to achieve the workplace mental health objective, and through joint work with the NHS to achieve the objective of improving physical health for people with severe mental health problems.	Health
	Intelligence Team								
E/R.6.016	Health protection and Emergency planning non-pay budgets	-10	-	-	-	-	New	Savings on health protection and emergency planning budgets which are held as contingency for emergency situations. Contingency to be sought when necessary from generic budgets.	Health
	Programme Team								
E/R.6.017	Review non-pay budget general prevention/Traveller/Lifestyle	-10	-	-	-	-	New	Saving on non-pay/project budgets held by the public health programmes team, including Traveller health team.	Health
	Public Health Directorate								
E/R.6.018	Public Health Directorate Staffing	-115	-	-	-	-	Modified	There have been underspends against the public health staff budget in previous years due to vacancies. This saving is a reduction in the staff budget based on predicted level of staff turnover and vacancies, associated with active vacancy management.	Health
E/R.6.019	Public health programmes team restructure/vacancy management	-158	-50	-	-	-	New	Restructure of public health front line delivery services, reducing input to immunisation services, for which commissioning responsibility and funding now sits with NHS England; and making some changes to the staffing structure of CAMQUIT smoking cessation services.	Health
E/R.6.020	Public health intelligence/JSNA - explore joint intelligence unit with NHS and restructure	-111	-	-	-	-	New	Public health intelligence services already work across Cambridgeshire County Council and Peterborough City Council. Explore a joint Health Intelligence Unit with Cambridgeshire and Peterborough CCG and an associated restructure. This would include a reduction in focus on Joint Strategic Needs Assessment work, to the statutory minimum required.	Health
E/R.6.021	Public health commissioning - explore joint work with other organisations	-50	-50	-	-	-	New	Explore partnership work for public health commissioning across other local organisations and CCC directorates to deliver efficiencies.	Health

Section 4 - E: Public Health

Table 3: Revenue - Overview

Budget Period: 2016-17 to 2020-21

		Detailed Plans	Outline Plans						
Ref	**Title**	**2016-17 £000**	**2017-18 £000**	**2018-19 £000**	**2019-20 £000**	**2020-21 £000**	**Type**	**Description**	**Committee**
E/R.6.022	Public health consultant - remove short term post from establishment	-30	-	-	-	-	New	Cease cover of part time public health consultant vacancy by short term post, and remove post from the establishment. This will affect public health consultant input available for ETE directorate.	**Health**
	Public Health Cross-Directorate and External Contracts								
E/R.6.023	No uplift for demography/inflation/pressures	-408	-660	-	-	-	New	Do not resource uplifts for demography /inflation/ pressures for externally provided public health contracts, requiring providers to make cost improvement programmes to cover the activity required. Absorb demography pressures for internal services, within existing resource envelope.	**Health**
	Health Improvement								
E/R.6.024	Resource Library	-5	-	-	-	-	New	This funding was held as contingency if the health promotion resource library required additional materials. In future any pressures can be met from general project budgets.	**Health**
6.999	**Subtotal Savings**	**-1,862**	**-1,230**	**-**	**-**	**-**			
	UNIDENTIFIED SAVINGS TO BALANCE BUDGET	**3**	**32**	**-685**	**-830**	**-515**			
	TOTAL GROSS EXPENDITURE	**20,781**	**20,365**	**20,375**	**20,253**	**20,432**			
7	**FEES, CHARGES & RING-FENCED GRANTS**								
E/R.7.001	Previous year's fees, charges & ring-fenced grants	-18,222	-20,781	-20,365	-311	-312	Existing	Previous year's fees and charges for the provision of services and ring-fenced grant funding rolled forward.	**Health**
	Changes to fees & charges								
E/R.7.101	Fess and Charges Inflation	-3	-1	-1	-1	-1	Existing	Income from teaching medical students.	**Health**
E/R.7.102	Increase in fees & charges from system	-173	-	-	-	-	New	Income for provision of HIV services	**Health**
E/R.7.103	Increase in fees and charges	-80	-	-	-	-	New	The Director of Public Health and some staff members in the Public Health Team have entered into a shared service arrangement with Peterborough City Council which generates this level of income for Cambridgeshire County Council	**Health**
E/R.7.104	Income generation	-40	-	-	-	-	New	Further income generation reflecting extension of the shared public health team across Cambridgeshire and Peterborough, and potential further opportunities with the Cambs & Peterborough Clinical Commissioning Group.	**Health**

Section 4 - E: Public Health

Table 3: Revenue - Overview

Budget Period: 2016-17 to 2020-21

		Detailed Plans	Outline Plans						
Ref	**Title**	**2016-17 £000**	**2017-18 £000**	**2018-19 £000**	**2019-20 £000**	**2020-21 £000**	**Type**	**Description**	**Committee**
	Changes to ring-fenced grants								
E/R.7.201	Change in Public Health Grant	-2,263	417	20,055	-	-	Existing	Change in ring-fenced Public Health grant to reflect change in Public Health functions (FYE transfer of 0-5 public health commissioning in 2016/17),grant reductions announced in the comprehensive spending review, and removal of the ring-fence in 2018/19.	**Health**
7.999	**Subtotal Fees, Charges & Ring-fenced Grants**	**-20,781**	**-20,365**	**-311**	**-312**	**-313**			
	TOTAL NET EXPENDITURE	**-**	**-**	**20,064**	**19,941**	**20,119**			
FUNDING SOURCES									
8	**FUNDING OF GROSS EXPENDITURE**								
E/R.8.001	Cash Limit Funding	-	-	-20,064	-19,941	-20,119	Existing	Net spend funded from general grants, business rates and Council Tax.	**Health**
E/R.8.101	Public Health Grant	-20,472	-20,055	-	-	-	Existing	Direct expenditure funded from Public Health grant.	**Health**
E/R.8.102	Fees & Charges	-309	-310	-311	-312	-313	Existing	Income from teaching medical students.	**Health**
8.999	**TOTAL FUNDING OF GROSS EXPENDITURE**	**-20,781**	**-20,365**	**-20,375**	**-20,253**	**-20,432**			

MEMORANDUM: SAVINGS / INCREASED INCOME					
Savings	-1,862	-1,230	-	-	-
Unidentified savings to balance budget	3	32	-685	-830	-515
Changes to fees & charges	-296	-1	-1	-1	-1
TOTAL SAVINGS / INCREASED INCOME	**-2,155**	**-1,199**	**-686**	**-831**	**-516**

MEMORANDUM: NET REVISED OPENING BUDGET					
Revised Opening Gross Expenditure	22,172	20,865	20,365	20,375	20,253
Previous year's fees, charges & ring-fenced grants	-18,222	-20,781	-20,365	-311	-312
Changes to fees, charges & ring-fenced grants in revised opening budget	-2,436	416	20,054	-1	-1
NET REVISED OPENING BUDGET	**1,514**	**500**	**20,054**	**20,063**	**19,940**

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ANNEX C

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: 21/12/15 .....
Business Plan Proposal Number (if relevant)	E/R.6.003	Date approved: .....

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 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.
- A key element of the modernisation of services is the increase in nurse led clinics. CCS has been training staff to ensure that there will be more nurse led clinics which are associated with cost efficiencies. These should be in place in 16/17.

Specific proposals that reflect these options will be drawn up by CCS in January.

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 has been considered with Drug and Alcohol Services identifies as most suitable service 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)
1	21/12/15		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: December 22 2015 ..... Date approved: .....
Service / Document / Function being assessed		
Chlamydia Screening and MICCOM Online Booking for Sexual Health Services		
Business Plan Proposal Number (if relevant)	**E/R. 6.004**	

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 by the Cambridgeshire Community Services through its countywide Integrated Sexual Health and GP practices. Those screens undertaken in GP practices are sent to the Public Health England laboratories at Cambridge University Hospitals Foundation Trust for analysis.

MICCOM

Miccom is the name of the company that provided an online booking service for the sexual health services prior to the commissioning of the Integrated Sexual health Service.

It enabled patients to book an appointment online anywhere in Cambridgeshire

What is changing?

Chlamydia Screening Programme

There has been a decrease in the number of screens analysed at the PHE 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.

- In addition 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. This is popular and more cost-effective than using the local 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 in Fenland where there are 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.

MICCOM

As indicated above this system operated prior to the start of the Integrated Sexual Health Service when the MICCOM system was decommissioned. It was replaced with centralised booking system which enables patients to be triaged and they can choose to be seen at any of the appropriate services in 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			
Sex			
Sexual orientation			
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

The positive impact of the changes to the Chlamydia Screening is that it is focusing on using internet approaches that evidence indicates that young people prefer and it targets those groups most at risk either through deprivation, disability or rural isolation.

Negative Impact

None identified.

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	24/12/15		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 01223 703264 ..... Date completed: 24/12/15 ..... Date approved: .....
Service / Document / Function being assessed	
Tendering of contract for sexual health advice prevention and promotion for at risk groups	
Business Plan Proposal Number (if relevant) E/R.6.005	

Aims and Objectives of Service / Document / Function

The charity DHIVERSE is currently commissioned to provide a range of prevention and promotion interventions that includes a focus upon at risk groups.
The areas it covers include population level and targeted campaigns, advice and promotion with targeted high risk groups with a focus on early diagnosis and treatment of HIV, school based information and advice programme.

What is changing?

Procurement regulations require that this service is taken out to tender. It is proposed to change the existing service specification and decrease the contract value.
The new specification would exclude the school based work which is often undertaken in lower risk areas.
The new service would continue to focus upon high risk groups.
The PSHE service includes a sexual health component that addresses prevention in school settings.

In addition the Cambridgeshire Community Service countywide integrated Sexual Health Service subcontracts with the Terence Higgins Trust to work in Fenland with high risk groups which includes working in schools in the area.

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
Neutral Impact
The sexual health of Cambridgeshire compares well to other areas although there are population groups where there is a higher prevalence of sexual ill health. This change acknowledges the relatively good level of sexual health in the Cambridgeshire population but calls for a more targeted approach. The change will not affect work with the high risk groups and there are other interventions that will support wider population approaches e.g. school based work, youth service work, campaigns. The new specification will be based on a needs assessment which will ensure that the service specification reflects the targeted approach for high risk groups and addresses any equality issues Age: there is potential for the proposal to impact most upon young people as the schools work currently carried out by DHIVERSE will not be included in the new service specification. This will be mitigated by: • The PSHE service includes a sexual health component that addresses prevention in school settings. In addition the Cambridgeshire Community Service countywide integrated Sexual Health Service subcontracts with the Terence Higgins Trust to work in Fenland with high risk groups, which includes working in schools with higher rates of teenage pregnancy.
Issues or Opportunities that may need to be addressed
It will be necessary to monitor the impact of these changes upon the sexual health of Cambridgeshire residents.

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	24/12/15		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 01223 703264 Date completed: 29 December 2015 ..... Date approved: .....
Service / Document / Function being assessed	
Review exercise referral schemes and potential to joint fund with the NHS	
Business Plan Proposal Number (if relevant) E/R.6.006	

Aims and Objectives of Service / Document / Function

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 and to South Cambridgeshire District Councils 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

What is changing?

During 16/17 the current funding arrangement will be reviewed and the potential to co-fund existing schemes with the local NHS will be explored. The saving is proposed for 17/18

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.

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

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
NHS funding of exercise referral schemes which would increase the focus upon people with long term conditions who would benefit from increased physical activity. This would include those who have a disease related disability and could increase the number of referrals for those with a disability.
Negative Impact
None identified
Neutral Impact
There should not be any impact upon equalities as there is no proposed change in the service (other than those with disabilities) delivery. The change is the proposed transfer of funding to the NHS.
Issues or Opportunities that may need to be addressed
There is the issue that the NHS could decline to assume responsibility for funding the exercise referral schemes. However the NHS has a current concerted focus upon prevention and has produced an NHS System Prevention Strategy which will provide opportunities for the NHS to commission more prevention interventions.

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)
V.1	29/12/15		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 Heath .....
Tobacco Control – engagement with at risk groups		Contact details: val.thomas@cambridgeshire.gov.uk 01223 703264 .....
Business Plan Proposal Number (if relevant)	E/R. 6.009	Date completed: 29 December 2015 .....
		Date approved: .....

Aims and Objectives of Service / Document / Function

Tobacco Control interventions aim to reduce the overall prevalence of smoking through the prevention of uptake of smoking and supporting smokers to quit. There are a number of interventions that are associated with an effective Tobacco Control Programme. http://www.nice.org.uk/advice/LGB24/
This includes targeted engagement and communications work with groups that have a high risk of smoking – pregnant women, young people, manual workers (rural deprivation), and migrant workers.

In 2015/16 a rolling programme of tobacco control with recurrent investment was launched. Funding was allocated to an engagement communications campaign in collaboration with Norfolk and Suffolk Local Authorities that is targeting migrant communities.

What is changing?

During 15/16 the tobacco control funding is being used to fund market research into migrant communities and their relationship with smoking along with an engagement and communications campaign.
This will provide the information about the communities and identify the most effective means of engaging and communicating with them in relation to tobacco control. The effect of the reduction of recurrent investment will be mitigated through the following projects.

- The Stop Smoking Services, CAMQUIT will build on its existing tobacco control work using the intelligence garnered from the commissioned research and engagement campaign.
- CAMQUIT has existing specific programmes targeting pregnant women working with midwives and children's centres.
- The Service runs a number of initiatives to engage and target migrant and other high risk groups with a focus on Fenland that includes a mobile service that visits communities and workplaces.
- There is a midwife at Addenbrooke's Hospital who Public Health commissions to work with pregnant smokers.
- The Integrated Lifestyle Service provided by Everyone Health has a Migrant Worker Health Trainer post that has a role in promoting the tobacco control messages.
- There is external funding that is being used to implement an Illicit Tobacco Campaign working collaboratively with Norfolk and Suffolk Local Authorities.

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

This CIA has been 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

Negative Impact

Neutral Impact

The work undertaken in 15/16 will provide a good basis in terms of information and initial engagement of migrant communities and this will support further development through the Stop Smoking and the other services. Budget has been identified for core work to continue. In addition, potential impacts on equalities groups will be mitigated as follows:

Pregnancy

- CAMQUIT has existing specific programmes targeting pregnant women working with midwives and children's centres.
- There is a midwife at Addenbrooke's Hospital who Public Health commissions to work with pregnant smokers.

Race

- The Integrated Lifestyle Service provided by Everyone Health has a Migrant Worker Health Trainer post that has a role in promoting the tobacco control messages.

Rural isolation and deprivation

- The Service runs a number of initiatives to engage and target migrant and other high risk groups with a focus on Fenland that includes a mobile service that visits communities and workplaces.

Issues or Opportunities that may need to be addressed

The impact of these alternative projects will require monitoring to ensure that the high risk groups are being accessed and engaged. There is the potential for a positive impact due to the initial work undertaken in 15/16 which will provide intelligence for the ongoing work.

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	29/12/15		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 01223 703264 ..... Date completed: 29/12/15 ..... Date approved: .....
Service / Document / Function being assessed		
General prevention projects and workplace health		
Business Plan Proposal Number (if relevant)	E/R.6.010	

Aims and Objectives of Service / Document / Function

Workplace Programme
Workplace Health Programmes improve the health and well being of employers and employees and are associated with decreased absenteeism costs. It is considered to an effective means of accessing the working age population with prevention information and opportunities to improve their health. The working age group accesses services to a lesser degree than other population groups

Public Health currently runs a Workplace Health Programme across Cambridgeshire which offers employers policy development support and a range of programmes that includes Workplace Health Champion training, Mental Health First Aid Training, Stop Smoking Services, NHS Health Checks (Health MOTs for the those not eligible) . Public Health provides the co-ordination and some of the services provided to workplaces.

Business in the Community (BITC) is a social enterprise that has a long experience of successfully engaging and securing the support of employers for developing and implementing workplace programmes, which is often the most challenging part of a Workplace Health Programme. It has been commissioned to support the Cambridgeshire Workplace Health Programme primarily with employer engagement, both initial and ongoing, and also with the wider programme providing skills and additional capacity. Some employers require support for longer periods to ensure that they are fully engaged.

Prevention Projects
Public Health funds small scale public health projects such as a specific campaign where resources are not available nationally or a short term specific intervention with a targeted group e.g. training about prevention and health promotion for people with disabilities and their carers.

What is changing?

Workplace Programme
Funding for the BITC contract will become non-recurring and its contract will end after 2 years. BITC will be asked to secure funding from employers for it to continue to provide them with support if required and from employers who would be new to the Programme. It will be important during the two years BITC is contracted for more members of the Public Health Team to increase their skills in engaging and supporting employers.

Prevention Projects
Small scale public health projects will not be funded. These have been identified on an ongoing basis. So there will not be any change in service delivery as currently no projects have been identified for future delivery

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

This CIA was prepared 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.

BITC Contract

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**

General Prevention Projects

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.
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Positive Impact
None
Negative Impact
Workplace Programme If the BITC Workplace Programme is not funded to provide support to employers then there is high risk of that it will discontinue as the Programme takes a several years to become sustainable without ongoing support. The Workplace Health Programme has and continues to focus on workplaces in areas of rural isolation and deprivation. These workplaces are often the hardest to engage and require additional support. Those of working age run the risk of not being able to access public health information and services especially in the more isolated deprived areas. In mitigation employers are being asked to fund BITC to continue to provide ongoing support. However if this not secured from employers it will be important that Public Health staff further develop the skills to work effectively with employers.
Neutral Impact

Workplace Programme
The change to the workplace programme will have a neutral impact on equalities as indicated above (except those of working age, deprivation and rural isolation) as the programmes are open to everyone and will not be targeted. If BITC support is not funded all employees in any particular workplace will be affected in the same way.

Prevention Projects
As indicated above these have been funded on an ongoing basis as a need is identified. No new projects have been identified so there will not be any change in existing service delivery.

Issues or Opportunities that may need to be addressed

Workplace Programme
It is possible that BITC will not be able secure funding from employers after 2 years and there is the risk that the relationships and new Programmes will falter without the expertise of BITC. The opportunity for more Public Health staff is to increase their skills in working and engaging employers.

Prevention Projects
It is possible that going forward funding will be required for small scale time limited projects to address specific needs of particular groups as they are identified.

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)
V 1	29/12/15		Val Thomas

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area		**Officer undertaking the assessment**
Public Health		Name: Helen Johnston & Angelique Mavrodaris .....
Service / Document / Function being assessed		Job Title: Senior Public Health Manager & Consultant in Public Health .....
2016/17 Public Health Savings: Falls Prevention		Contact details: angelique.mavrodaris@cambridgeshire.gov.uk.....
Business Plan Proposal Number (if relevant)	Falls prevention E/R 6.011	Date completed: 31 December 2015 .....
		Date approved: .....

Aims and Objectives of Service / Document / Function

The Falls prevention project delivered since April 2015, has used investment strategically to complement the existing work of health professionals, District Councils, voluntary and community sector organisations, and other stakeholders in evidence-based approaches to reduce injurious falls among older people in Cambridgeshire.

What is changing?

Savings have been identified in the falls prevention project, due to some identified overlap of activities with work delivered across the system by CPFT falls prevention specialists. The project will continue to commission the provision of falls prevention health trainers and coaches from Everyone Health, ensure coordination of activities, and support the quality assurance of falls prevention interventions in Cambridgeshire.

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

The 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
This saving is based on an alternative approach for falls prevention awareness raising among professionals and wider health and social care workforce reducing the CCC funding requirement for the activity.
Issues or Opportunities that may need to be addressed

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)

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area		Officer undertaking the assessment
Public Health		Name: Kirsteen Watson/Janet Dullaghan .....
Service / Document / Function being assessed		Job Title: Consultant in Public Health .....
Family Nurse Partnership (FNP)		Contact details: Kirsteen.watson@cambridgeshire.gov.uk
		Date completed: 4 January 2016 .....
Business Plan Proposal Number (if relevant)	E/R 6.012	Date approved: .....

Aims and Objectives of Service / Document / Function

Summary:
The Family Nurse Partnership (FNP) is a national preventive program for vulnerable, young first-time mothers under 19 years of age. It offers intensive and structured home visiting, delivered by specially trained family nurses, from early pregnancy until the child is two. 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 family nurse and the young parent(s) commit to an average of 64 planned home visits over two and a half years. Building this relationship over a long period allows the family and nurse to establish a trusting, therapeutic relationship. Weekly and fortnightly visits take place from early pregnancy.

Background:
The FNP programme was developed in the USA for vulnerable women of all ages. The University of Colorado, who developed FNP, licensed it to ensure that it is delivered in accordance with the original programme model to ensure the intervention has fidelity to the evidence and research from which it was developed. In 2007, the Department of Health funded the introduction of the licensed programme in England for pregnant teenagers under 19. This was a change from the original evidenced based program and over the past 6 years the NHS and Local Authorities have tried to collect evidence to demonstrate local outcomes.

Evidence:
A study conducted by *Cardiff University* and published in *The Lancet* in November provides important new evidence on the effectiveness of the Family Nurse Partnership (FNP) in England. The *Building Blocks* randomised control trial followed over 1,600 young mothers-to-be until their baby reached two years old. It provides an independent assessment of the effectiveness of FNP between early pregnancy and the child's second birthday, focusing on four primary outcomes and a range of secondary outcomes.

The trial showed that there were some positive effects on early child development and that FNP may prevent children 'slipping through the net' by identifying safeguarding risks early. It also found that young mothers engaged well with FNP and especially valued the close and trusting relationship that they had with their family nurses. The trial found that the intervention may promote cognitive and language development more effectively than normally provided care alone up to a child's second birthday but it is unclear whether this is due to the intensive support until 2 years of age or specific elements of FNP activities.

However, the trial found that FNP alone is no more effective than routinely available health care alone in reducing smoking in pregnancy, improving birth weight, reducing rates of second pregnancies by two years postpartum or reducing rates of emergency attendance or hospital admissions for any reason by the child's second birthday, when delivered in an English healthcare setting. (Building Blocks Executive summary. Available at: http://medicine.cardiff.ac.uk/media/filer_public/f5/db/f5db1bcc-a280-4f08-a34e-14a54d861c14/bb_exec_summary.pdf). The paper concluded that FNP was not cost-effective when assessed against minimal gains in maternal health and that the difference in results from the US original trials and the setting in England may be that health and other supportive services for young first time mothers are more numerous and available in England than in the US.

Limitations of the local model:
Challenges or weaknesses of the FNP programme locally are that the license requires fidelity to the specific FNP model, with limited flexibility to assess the specific needs of the parents enrolled in the programme over time. The current FNP programme in Cambridgeshire only funds places for 20% of the vulnerable teenage population and once caseloads are full there are no places for others, 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 widow of opportunity' for help and support from this intervention.

What is changing?

The proposal is to review and redesign the service as an enhanced service for all vulnerable teenagers as a core part of the Health visiting service, closely attached to midwifery and linking with social care colleagues when appropriate. This would be a dedicated health visiting support service for all teenage parents across the county (instead of just 20%), needs-based and with a focus also on reducing inequalities. It would include regular needs assessment and evaluation of the needs of the parents and a flexible approach.

The new service would aim to build on the effective elements of FNP and experience of local staff which do not require the FNP license. The RCT trial showed that there were some positive effects on early child development from intensive support to teenage parents and that young mothers especially valued the close and trusting relationship that they had with their family nurses. FNP was also useful to ensure continuity and identify safeguarding risks early. However, it is not clear that fidelity to the FNP model is required to achieve this. The new service would aim to provide: intensive support when needed, regular visits that focus on building resilience, a named and skilled key worker to support teenage parents and ensure that vulnerable children are monitored and followed up to ensure safeguarding. Indeed, these are features of the 'Universal progressive' element of Health visiting, for parents and families most in need.

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

Cambridgeshire County Council
Joint Commissioning Unit
CCG
Cambridge Community Services

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

It is expected that this service designed for teenage parents will improve pregnancy and child health outcomes and provide a dedicated support service tailored to the needs of young parents. The service is primarily focussed on teenage mothers but includes support and interventions for both parents where they wish to participate and activities and involvement of fathers is encouraged. This will continue in the new service in line with Health Visiting focus on families.

It is also anticipated that this may provide an improved service for those experiencing rural isolation or deprivation, as the service will move from 6 dedicated nurses working with limited caseload capacity across the county, to a service model which ensured that support was available in all locality teams as part of an integrated offer. This aims to be more efficient and effective in terms of reducing staff travel time and ensuring greater coverage for those in more deprived areas.

Negative Impact

No negative impact is anticipated from this change in service.

Neutral Impact

It is not expected that the change in this service would adversely impact on other particular protected characteristics.

Issues or Opportunities that may need to be addressed

All those currently enrolled on the FNP scheme (which lasts 2 years) will be assessed and a needs-based action plan developed to ensure they continue to receive intensive support.
There will need to be attention paid to what elements of the FNP scheme locally can be utilised to improve a county-wide service without breaching the terms of the license and to harnessing the considerable expertise and experience of current Family Nurse Practitioners within the wider Health Visiting team.

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	4 Jan 2016	First draft	Janet Dullaghan (JD)
2	4 Jan 2016	Revised and completed	Kirsteen Watson (KW)

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area		Officer undertaking the assessment
Public mental health strategy (recurrent revenue not yet committed)		Name: Emma de Zoete .....
Service / Document / Function being assessed		Job Title: Public Health Consultant .....
		Contact details: 01223 699117 emma.dezoete@cambridgeshire.gov.uk .....
Business Plan Proposal Number (if relevant)	E/R 6.015	Date completed: 06.01.15 .....
		Date approved: .....

Aims and Objectives of Service / Document / Function

The Public Mental Health Strategy for Cambridgeshire was approved by Health Committee in May 2015, it focuses on promoting mental health and preventing mental illness.

This funding has supported implementation of specific areas of the action plan, which include:

- Mental health in schools - additional funding for secondary schools consultancy support (a half day for each school) to plan their curriculum to address mental health needs. In addition an anti-bullying toolkit for secondary schools is being produced as well as delivery of mental health resources for primary schools not subscribing to the PSHE service.
- A one-off pilot of ACAS training for employers to enable them to better support employees with mental illness(es). This pilot took place in Wisbech.
- Funding of a campaigns officer post that is based within MIND (jointly funded with Peterborough City Council) – the post focuses on building campaign work (particularly in children and young people) and targeting of the suicide prevention campaign and training to higher risk groups.
- Improving the physical health of those with severe mental illness, in part this will be by ensuring health improvement services are linked to physical health assessments.

What is changing?

There was £120k a year funding for the implementation of the Public Mental Health Strategy. This funding has been available from 2015/16. It is proposed that this is cut from £120k to £60k a year for 2016/17. A proportion of the £120k remains unallocated for 2016/17 currently for variety of reasons.

Physical health of those with serious mental illness

- Since the public mental health strategy was approved the Clinical Commissioning Group (CCG) and Cambridgeshire and Peterborough Foundation Trust (CPFT) have both begun work streams focusing on improving the physical health of those with serious mental illness, and have both made investments in this area. CPFT have appointed a nurse to focus on physical health improvements within the trust and the CCG are planning the introduction of an enhanced primary care service from 2016/17, initially in Fenland and Huntingdonshire.
- We want to ensure that any investments made by CCC complement this programme of work, and build on the available evidence. We are proposing to invest in improving the knowledge and skills of health trainers in relation to mental health, and to fund increased health trainer capacity aligned with the enhanced primary care service being developed. The funding available for work focusing on the physical health of those with SMI is not as large as first envisaged , however the model proposed is sustainable and will provide additional lifestyle support to these new teams.

Workplace health

- Workplace health is now being taken forward through a two year contract with Business in the Community (BITC). Additional work is also taking place through the Public Health Reference Group (PHRG) with local authorities, and through the Health System Prevention Plan with the NHS as an employer. All of these initiatives include mental health as a core part of their work improving workplace health.

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

Council officers and partners such as the CCG.

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
Negative Impact
Neutral Impact
There is no impact from this change in funding as there is no reduction in current services. Additionally service improvements being undertaken by CPFT and the CCG, and other public health contracts mitigate some of the possible impact of reduced investment levels.
Issues or Opportunities that may need to be addressed

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)

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area		**Officer undertaking the assessment**
Public Health		Name: Linda Sheridan/Tiya Balaji..... Job Title: Consultant in Public Health ..... Contact details: linda.sheridan@cambridgeshire.gov.uk Date completed: 8 January 2016 ..... Date approved: .....
Service / Document / Function being assessed		
Health Protection and Emergency Planning non pay budgets		
Business Plan Proposal Number (if relevant)	E/R 6.016	

Aims and Objectives of Service / Document / Function

Health and Social Care Act 2012: Provide leadership, advice and information in order to protect the health of the population. Ensure ability to scrutinise and be assured of plans and protocols between key partners on responding to health emergencies in the community.

CCA: As Cat 1 organisation responsibility to protect health of the local population, in particular provide advice and information to promote health protection, recognising that PHE provides the specialist health protection function.

What is changing?

Savings on health protection and emergency planning budgets which are held as contingency for emergency situations. Contingency to be sought when necessary from generic budgets or reserves.

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

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
Negative Impact
Neutral Impact
Urgent contingencies will be funded from PH reserves if required.
Issues or Opportunities that may need to be addressed

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)

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area		**Officer undertaking the assessment**
Public Health		Name: Kate Parker Job Title: Head of Public Health Programmes Contact details: 01480 379561 kate.parker@cambridgeshire.gov.uk
Service / Document / Function being assessed		
2016/17 Public Health Savings: Review of non-pay budget general prevention/ traveller/ lifestyle		
Business Plan Proposal Number (if relevant)	E/R 6.017	

Aims and Objectives of Service / Document / Function
Additional saving made from reducing the non pay budget for the Gypsy & Traveller Health Team by 10k. Budget sits seperatly within the public health programmes team.
What is changing?
The Gypsy & Traveller health team have a proportion of the budget set aside as non-pay to support the team in providing small scale project support work particularly around literacy training It is proposed to reduce the budget by 10k, this will have a minimum inpact on the team as the current literacy tutoring work is being provided through the access to grants from the Community Adult learning fund.
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 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

None
Negative Impact
None
Neutral Impact
Some minimal impact on effectiveness of programmes team in delivering community facing projects specifically for the Gypsy & traveller community.
Issues or Opportunities that may need to be addressed
Increased importance on accessing grants available to support the community development work delieverd by the Gypsy & Traveller Health Team.

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: Kate Parker Job Title: Head of Public Health Programmes Contact details: 01480 379561 Kate.parker@cambridgeshire.gov.uk liz.robin@cambridgeshire.gov.uk
Service / Document / Function being assessed		
2016/17 Public Health Savings: Public Health Programmes Team restructure / Vacancy management		
Business Plan Proposal Number (if relevant)	**E/R6.019**	

Aims and Objectives of Service / Document / Function

Smoking Cessation Service

The County Council directly provides a smoking Cessation Service for Cambridgeshire residents (CAMQUIT). This service supports people who wish to stop smoking through the provision of evidence based one to one or group support for behavior change along with a combination of medication e.g. nicotine replacement therapy (NRT) on prescription.(A Level 2 service) 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 it 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. Further savings can be achieved in the wider economy by reducing absenteeism through smoking related illnesses. It is important that smoking cessation services are easily accessible for people to use, so in Cambridgeshire. Contracts have been in place for many years with GP practices and community pharmacies for them to offer a smoking cessation service provided by their own staff. County Council CAMQUIT staff also provide clinics in some of the GP practices. The CAMQUIT service in addition provides specialist support to both pharmacies and GP's through the provision of specialist smoking cessation training programmes and regular advisor contact for pharmacies.

Immunisation Programme

The Public Health Programmes team has historically delivered functions which support the delivery and uptake of immunisation programmes in Cambridgeshire.

The Public Health Nurse specialist manages a number of defined programmes, including the coordination of immunisations across Cambridgeshire representing and addressing target issues involving data capture by Primary Care and Child Health Departments. This has included leading on the delivery of update Immunisation training for primary care staff. The Immunisation Healthcare assistant provides support in the delivery of effective targeted immunisation and public health screening programmes across Cambridgeshire. The posts aim is to assist with administration, promotion and supporting the implementation of various vaccination programmes including targeted childhood immunisations including BCG, Healthy Start and other related activities.

What is changing?

Smoking Cessation Service

The demand for smoking cessation services in GP practices and pharmacies has reduced over the past few years. This has been attributed to a fall in the overall percentage of adults who smoke in the county and increased usage of electronic cigarettes. As a result of reduced demand it is proposed that the Camquit service is restructured, removing the two Senior Smoking Cessation posts and creating an additional health trainer post. These posts provide limited service delivery and currently this could be absorbed by more junior members – the smoking cessation advisors- of the Service as they will acquire additional capacity through their prpject work being taken by the new Health Trainer post.

The pharmacy contribution to overall people setting a quit date has reduced from 15% in 2011-12 to 7% (mid-year point 2015-16). The numbers of pharmacies actively delivering smoking cessation at Level 2 has decreased from 57 to 30 over a 5 year period. The GP contribution to overall smokers setting a quit date was 74% in 2011-12 which had dropped to 57% (mid-year point 2015-16). In addition the number of GP practices who deliver their own smoking cessation service has decreased from 74 to 48 over the same 5 year period. The core Camquit service

now delivers 28 clinics in GP practices which have increased from 15 in 2011-12.

Both GP practices and pharmacies receive Level 2 and update training provided by the core service through the Senior Smoking Cessation Specialists. The Service found that in 13/14 & 14/15 the demand for the full day Level 2 course reduced and sessions had to be cancelled, therefore for 15/16 the number of timetabled sessions was reduced which has given us greater flexibility to offer in-house sessions. The demand for update training has been unchanged but for both types of training the preference of GP practices is for in house training due to problems related to work pressures when releasing staff. The Service now focuses on providing training as part of the routine visits to practices which can involve a wider range of practice staff and more junior CAMQUIT staff – the smoking cessation advisors- are able to assume some of the teaching responsibilities. The CAMQUIT Co-ordinator also contributes to the teaching programme.

It is anticipated that the demand by practices for CAMQUIT to undertake more clinics for their patients will continue to increase along with a fall in community pharmacy activity will consequently continue to decrease demand for training.
If additional training is required this could be commissioned on an ad hoc basis as it easily available through various organisations.

Marketing the Camquit Service is still a key function to ensure that promotion of the service generates increased referrals into Camquit but also identifies opportunities to generate new referral pathways. Project development work was previously within the Senior Smoking Cessation Specialist roles and this will be transferred to the Business Manager and Camquit Co-coordinator. Project delivery work will be removed from smoking cessation advisors as their clinical work increases and it is proposed the project delivery work will be part of a new Health Advisor / Trainer post that will report to the Business Manager.

Immunisation Programme
Responsibility for the commissioning of immunisation programmes sits with NHS England. NHS England has reduced the requirements for aspects of the roles carried out by the public health programmes team. This proposal is to remove two posts with a focus on support to immunisation programmes - the Public Health Specialist Nurse and Immunisation Healthcare Assistant.

The Public Health Nurse specialist functions associated with immunisation programme are described above the post holder carries out some other functions i.e. management of the Gypsy and Traveller Health Team, management of smoking in pregnancy/ breastfeeding specialist and co-ordination of the Healthy Start programme. These functions will need to be reallocated within the directorate. The post holder supported NHS England in providing and co-ordinating immunisation update training to practice nurses in Cambridgeshire in 2015/16. This training provision will need to be picked up by NHS England in the future.

The Immunisation Healthcare Assistant co-ordinates community clinics and the risks associated with removing this post and resulting closure of these clinics are addressed in the issues section below.

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 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

None

Negative Impact

Race: There is a transition issue as outlined below for access to BCG immunisations for eligible children, who are usually children born abroad or with close relatives born abroad. This will be mitigated by collaborative working with NHS England to ensure appropriate services are in place.
Deprivation: The Healthy Start programme is used by low income families who are more likely to live in areas of deprivation. There will be careful planning to minimise any disruption to the Healthy Start programme during transition.

Neutral Impact

It is unlikely that there would be any direct impacts on particular groups from the proposed restructure however the issues section notes some service implications.

Smoking Cessation

This saving is based on reduced demand for training due to lower activity particularly within the pharmacy setting but also within GPs. Local residents are still able to attend smoking cessation services it should not impact on access to support services across the county. 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 through project work, pilot models which meet the needs of the smokers in particular communities e.g. long term conditions, pregnant smokers.

Some training provision delivered by Camquit will be reduced on the basis of a reduction in demand however it is anticipated that the reduced training programme can be picked up within the service through the Camquit Co-coordinator and advisor support for update training. Follow up training mentor sessions will be divided across specific advisors. Contracted pharmacy face to face support sessions will be reduced to one annual visit at end year data collection point. Contracted GP provider support sessions will continue and each advisor will be allocated a minimum of 6 practices to support on 4-6 weekly bases.

Immunisation Programme

This saving is based on the commissioning and providing immunisation co-ordination for the population is the responsibility of NHS England. The Immunisation programme will still continue for residents of Cambridgeshire but the commissioning responsibility sits with NHS England and not Cambridgeshire County Council.

Issues or Opportunities that may need to be addressed

Smoking Cessation

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.

Immunisation Programme

There is a risk that moving from a coordinated local programme may impact on the immunisation figures for Cambridgeshire. Neonatal BCG vaccinations should be given via hospital maternity units but there is a reliance on the BCG community clinics that are coordinated by the Immunisation Healthcare assistant to pick up missed children (18% of referrals to community clinic in Q3 Oct-Dec 2015 were from hospital maternity units). The remaining 82% of referrals were from GPs, practice nurses & health visitors and included children of ages up to 6 previously not receiving the vaccine. NHS England would need to address the current referral practice of hospitals in regards to the provision of neonatal BCG vaccinations. As the Director of Public Health has a duty to ensure plans are in place to immunise their population, consideration should be given by NHS England around how non-immunised older children are being picked up if the community clinics close.

Both post holders are responsible for the co-ordination, administration and implementation of the Healthy Start programme (national government scheme that aims to improve the health of pregnant women and children living on low income by the provision of free vitamin supplements). This programme requires Cambridgeshire County Council to hold a license to operate. If the Healthy Start programme is reallocated within the directorate as proposed, the current licensing agreement will require Cambridgeshire County Council to reapply as the license was granted subject to the current post holders remaining involved in the programme. This will result in a temporary cessation of the programme while a new license and assessment process is undertaken.

Community Cohesion

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

Not relevant to savings proposed

COMMUNITY IMPACT ASSESSMENT

<table>
<tr><th colspan="2">Directorate / Service Area</th><th>Officer undertaking the assessment</th></tr>
<tr><td colspan="2">Public Health / Public Health Intelligence</td><td rowspan="4">Name: David Lea

Job Title: Assistant Director, Public Health Intelligence

Contact details: 01480 379494 or david.lea@cambridgeshire.gov.uk

Date completed: 29/12/2015

Date approved:</td></tr>
<tr><th colspan="2">Service / Document / Function being assessed</th></tr>
<tr><td colspan="2">2016/17 Public Health Savings: joint intelligence unit with Cambridgeshire and Peterborough Clinical Commissioning Group, including restructure of public health intelligence service.</td></tr>
<tr><td>Business Plan Proposal Number (if relevant)</td><td>E/R.6.020</td></tr>
</table>

Aims and Objectives of Service / Document / Function

The public health intelligence service provides analytical, statistical and epidemiological leadership, expert input and support to the Public Health Directorate, to the Cambridgeshire and Peterborough Clinical Commissioning Group ('the CCG'), to the wider Council, to Peterborough City Council and to other partners. The service also provides analytical input and programme management to the Joint Strategic Needs Assessment (JSNA) programme.

Public health intelligence underpins the core roles of the Public Health Directorate by providing the analytical support that enables population health improvement via needs analysis and measuring the immediate and longer term impacts of health improvement activities, the population level surveillance data to monitor and protect the public's health and the epidemiological and quantitative analytical input to NHS commissioning to support healthcare public health.

Through the provision of public health data and the application of the appropriate quantitative, statistical and epidemiological tools and techniques, public health intelligence enables and supports the following statutory public health duties and functions of local authorities:

- *The duty on the local authority to improve public health*: public health intelligence provides the quantitative evidence to identify opportunities to improve public health, to assess their potential impacts and to monitor the effectiveness of public health interventions.

- *Regulations on the exercise of local authority public health functions*: public health intelligence provides the analytical assessment related to the weighing and measuring of children under the National Childhood Measurement Programme and the vascular assessment of adults under the health checks programme, the needs analysis to support the provision of open access sexual health services, the epidemiological and analytical input to the healthcare public health advice service to the local NHS Clinical Commissioning Group and the epidemiological and analytical input to health protection planning and emergencies.

- *Duty to have regard to guidance – the Public Health Outcomes Framework*: public health intelligence provides the local analysis and reporting covering the Public Health Outcomes Framework, including making the Public Health Outcomes Framework locally accessible and well understood and reporting on the latest position and tracking trends with regard to public health outcomes in Cambridgeshire and local districts.

- *Responsibility for sexual health services*: as stated in the regulations section above, public health intelligence provides the needs analysis to support the provision of local authority sexual health services and to assess their effectiveness.

- *Joint strategic needs assessment (JSNA)*: the local Health and Wellbeing Board has a statutory duty to provide a local joint health and wellbeing strategy. This strategy must have regard to population needs and the JSNA provides the needs analysis input to the joint health and wellbeing strategy. Local areas are free to undertake JSNAs in a way best suited to their local circumstances – there is no template or format that must be used and no mandatory data set to be included. Health and wellbeing boards are also required to undertake Pharmaceutical Needs Assessments (PNAs) and the public health intelligence teams provides the analytical input to the local PNA.

What is changing?

There are two primary proposed changes:

- **A reduction in the extent and scope of work undertaken under the Council's Joint Strategic Needs Assessment (JSNA) programme.** Cambridgeshire has historically taken an extremely comprehensive and thorough approach to JSNA, providing extensive client based, population based and subject area based reports on a range of topics. This approach has had some success in providing a body of evidence to support commissioning, public health and health improvement and other related activities, but there is the recognition that the programme consumes significant resources within the Public Health Directorate and beyond and that this needs to be balanced against the impact the JSNA is having beyond its statutory duty to provide input to the local joint health and wellbeing strategy. There is no doubt that the strategy could be formulated from a sparser base of targeted needs analysis and, more recently, it has seemed that the public sector system is not in the optimum state to be able to take forward the wider set of recommendations from a broad and extensive local JSNA programme. As such, it is felt that the primary input to JSNA can be provided by the analytical team within the public health intelligence service and the reduced extent and scope of the work will not require the dedicated programme and project management input that is currently provided from within the public health intelligence service by the JSNA Programme Manager.

- **The formation of a joint intelligence unit with Cambridgeshire and Peterborough Clinical Commissioning Group and Peterborough City Council's Public Health Department.** Public health and NHS healthcare commissioning have significant areas of overlap in terms of functions and, consequently, the information requirements of these functions. This overlap covers he analytical and information support needed to commission, provide and assess the impact of services and also the client groups and geographical areas they serve. Added to this, the JSNA process is a joint responsibility of the local Clinical Commissioning Group ('the CCG') and the local authority. As a Cambridgeshire and Peterborough wide organisation the CCG requires input from public health intelligence services in Cambridgeshire and Peterborough local authorities and in practice, since the pilot appointment of a joint Director of Public Health for Cambridgeshire and Peterborough, the public health intelligence service has worked jointly. Public health intelligence provides significant input to the statutory healthcare public health advice service to the CCG and it is felt that a joint service with the CCG would enable the provision of this service to the CCG by enabling access to information and human resources across the three organisations, as well as further enhancing the delivery of public health analysis to the local authority public health, other Council services and NHS commissioning for the same reasons. It is felt that this unit would be able to provide a more strategic, coherent, cogent, efficient and effective health intelligence service to the local authorities and to the local CCG.

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

Negative Impact

Neutral Impact

It is unlikely that there would be any DIRECT impacts on particular groups from either the creation of the joint intelligence unit and the consequent restructure and this is the definition of impacts that has been assumed here.

However, the following issues should be stated:

- A more strategic and targeted joint service operating across the NHS and local government should be able to provide an improved intelligence service, operating more efficiently and effectively, and this could provide the underpinning focussed evidence to commission and provide better services to key client groups, including those with protected characteristics related to age, disability, pregnancy and maternity, race, sex, rural isolation and deprivation. This would be achieved by the reduction in JSNA workload, along with the more effective and efficient use of data and information assets and analytical staff resources.

- A reduced JSNA programme may no longer be able to provide the current levels of in-depth analysis and evidence to enable optimal needs analysis input into the formulation of the local health and wellbeing strategy and into wider commissioning support, including that for the specific protected groups listed above. This needs to be balanced against the less than optimal impacts the JSNA is currently having across the health and social care system compared with the resources it is consuming and with the gains that could be made in the provision of a more targeted and jointly operating intelligence unit.

Issues or Opportunities that may need to be addressed

Joint intelligence unit and reduced public health intelligence analytical capacity.

The joint intelligence unit with the CCG, as well as continued joint working with public health analysts in Peterborough City Council, has two primary benefits:

- The potential to immediately provide local income generation for the local authorities and the longer term

potential to income generate beyond the local area for both the local authorities and the CCG.
- The potential to provide a more cohesive, coherent, effective and efficient service working across public health and the NHS, providing improved access and utilisation of information assets and human resources for the benefit of local public heath, wider local authority commissioners, the CCG and some providers of services.

Cambridgeshire County Council's public health intelligence analysts have a strong, established and current record of delivering high quality information analysis to both the Council and the local NHS and the success of the proposed joint intelligence unit would be in a large part attributable to the use of their high level skills, along with extensive local knowledge, established relationships and organisational memory, and the integration with the information professionals in the CCG and the improved access to CCG information assets.

The reduction in JSNA workload would free these analysts up and would enable them to focus on the key information and intelligence that will need to underpin the commissioning and delivery of services in a significantly challenged health and social care system. While the reduction in the JSNA programme means that dedicated JSNA programme and project management would no longer be absolutely necessary, the loss of one of the public health analysts at this time would severely compromise the stated benefits of the proposed joint intelligence unit as follows:

- The potential for local and more immediate income generation and possibly longer term income generation would be reduced.
- Loss of a highly skilled analyst, a relatively rare commodity, would have significant impacts on the analytical capability within the proposed joint intelligence unit and would seriously inhibit realisation of the stated analytical benefits commissioning support and the public health analysis that underpins core and statutory public health functions and wider local authority commissioning and services.

As a result of these potential issues and opportunities, a better option may be to:

- Go ahead with the saving related to the JSNA Programme Manager, predicated on the basis of a reduction in specific JSNA work and the fact that this post is a general project management role, rather than a specialist analytical role
- Consider the public health intelligence analyst saving at a later date, once the joint intelligence unit is established, and has been operational for a time. It may be a better option to consider the analytical capacity and capability across the entire joint unit later, at that time, rather than reduce the skill set of the unit from the outset, with consequent risks to the success of the unit, as well as reducing short term and longer term income generation opportunities due to losing a highly skilled analyst.

Community Cohesion

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

No direct impacts.

Version Control

Version no.	Date	Updates / amendments	Author(s)
1	29/12/2015	Initial draft	DL

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area	**Officer undertaking the assessment**
Public health	Name: Dr Liz Robin .....
Service / Document / Function being assessed	Job Title: Director of public health .....
Public Health Consultant – removed 0.4 wte post from establishment, currently covered by short term post holder	Contact details: liz.robin@cambridgeshire.gov.uk .....
	Date completed: 11/1/16 .....
	Date approved: 11/1/16.....
Business Plan Proposal Number (if relevant) E/R 6.022	

Aims and Objectives of Service / Document / Function

Public health consultants are specialist public health doctors or other staff with equivalent training directly employed by the Council. This 0.4 wte post is focussed on specialist input to the wider determinants of health including planning, transport and housing, support on these issues to the ETE directorate and district councils, and a focus on some specific inequalities groups such as migrant workers. The current short term post-holder is leading the new communities (land use planning and housing developments) JSNA and the migrant workers JSNA.

What is changing?

This post will be deleted in order to deliver savings against the public health directorate staffing budget. This will not require a redundancy payment as the current post-holder's contract finishes at the end of January 2016. Some mitigation will be put in place through making permanent a joint health improvement specialist post with South Cambs District Council with a focus on land use and transport planning which has previously been managed as a secondment, and through ongoing links with academic colleagues in this field.

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

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
Negative Impact
The post included a focus on the health and wellbeing needs of migrant workers. This is not being mitigated through the joint health improvement specialist post, so mitigation will be sought through allocating a lead role to another member of the public health consultant team. However capacity to deliver this role will be very limited.
Neutral Impact
Issues or Opportunities that may need to be addressed

Community Cohesion

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

Public health leadership and analysis of the health and wellbeing of migrant workers has a potential impact on community cohesion.

Version Control

Version no.	Date	Updates / amendments	Author(s)

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area		**Officer undertaking the assessment**
Public Health		Name: Dr Liz Robin .....
Service / Document / Function being assessed		Job Title: Director of Public Health .....
No uplift for demography/inflation/pressures		Contact details: liz.robin:cambridgeshire.gov.uk.....
		Date completed: 11/116 .....
Business Plan Proposal Number (if relevant)	6.023	Date approved: 11/1/16.....

Aims and Objectives of Service / Document / Function
The majority of contracted public health services involve delivery of support to individuals to change behaviour, address addictions, and be screened for treatable health conditions. Demographic increases in population therefore result in an increased demand for service. Because the services relay on front line staff, any increases in staff salaries, such as 1% cost of living increase, or pension contributions results in inflationary pressures. Medication costs may also result in inflation requirements.
What is changing?
Uplifts for demography, inflation and pressures will not be offered to externally contracted service providers, which account for around 85% of public health budgets. Providers will be expected to deliver cost improvement programmes to deliver against this savings requirement.
Who is involved in this impact assessment? e.g. Council officers, partners, service users and community representatives.
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

Negative Impact
Neutral Impact
This is a generic requirement for service providers which should not impact disproportionately on any particular equalities group.
Issues or Opportunities that may need to be addressed

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)

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area		**Officer undertaking the assessment**
Public health		Name: Dr Liz Robin .....
Service / Document / Function being assessed		Job Title: Director of Public Health .....
Additional income generation		Contact details: liz.robin@cambrideshire.gov.uk .....
		Date completed:11/1/16 .....
Business Plan Proposal Number (if relevant)	7.104	Date approved: 11/1/16.....

Aims and Objectives of Service / Document / Function
This income generation proposal for £40k proposed ongoing development of existing income generation streams from the Cambridgeshire ,University Medical School, Peterborough City Council (shared team) and Cambridgeshire and Peterborough Clinical Commissioning Group (a combination of secondments and specific consultancy projects)
What is changing?
In 2015/16 this level of additional income was generated but on an ad hoc basis and not factored into budgets. The income generation will be mainstreamed and incorporated into annual service plans.
Who is involved in this impact assessment? e.g. Council officers, partners, service users and community representatives.
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

Negative Impact
Neutral Impact
The income generation proposals should not impact disproportionately on any specific inequalities group.
Issues or Opportunities that may need to be addressed
Given the reductions in staffing of the public health directorate, care will be needed to avoid undue pressure on remaining staff from additional income generation requirements, and work will need to be prioritised appropriately

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)

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area	**Officer undertaking the assessment**
Public Health Grant – DAAT Enhanced and Preventative Services Cambridgeshire Safer Communities Partnership Team	Name: Susie Talbot & Val Thomas Job Title: Cambridgeshire Safer Communities Partnership Team Lead Contact details: 01223 699838 susie.talbot@cambridgeshire.gov.uk Consultant in Public Health Contact details: 01223 703264 Val.thomas@cambridgeshire.gov.uk
Service / Document / Function being assessed	
Substance misuse services in the County of Cambridgeshire	
Business Plan Proposal Number (if relevant)	

Aims and Objectives of Service / Document / Function

Cambridgeshire Safer Communities Partnership Team (CSCPT) commission drug and alcohol services for adults and children and undertakes a number of wider preventative and promotional activities through Public Health funding.

DAAT Team
The DAAT team includes commissioners and strategic leads who also deliver training and promotional activities.

GP Shared Care Contract
The current Alcohol Treatment Service was commissioned without a prescribing function. Consequently community alcohol detoxifications need to be undertaken jointly by GPs and the Inclusion Service with GPs assuming the prescribing function through a contractual arrangement.

Specialist Drug and Alcohol Support to the Youth Offending Service (YOS)
Specialist drug and alcohol support is commissioned to provide input into the YOS for young people who have substance misuse issues.

Commissioned Drug and Alcohol Services
The CSCPT commissions countywide specialist drug & alcohol treatment services and associated support provision. Currently there are separate adult treatment contracts for alcohol and drugs however both are provided by the Inclusion Service which is part of the South Staffordshire & Shropshire NHS Foundation Trust (SSSFT). The Services are aimed at tackling and preventing adult substance misuse under a recovery focused model. providing the following functions across the county namely; brief advice, information and drugs education, structured treatment programmes (including community medically assisted detoxification), countywide Needle and Syringe Programme (including community pharmacies), Blood Borne Virus testing, support groups.

What is changing?

DAAT Team
Savings are proposed (£51k)through not recruiting to vacant posts with their responsibilities being shared amongst other Team members. Campaigns will only use free resources and the team will work closely with the Public Health Team to benefit from any efficiencies. Staff will only access training that is free through such organisations as Public Health England.

GP Shared Care
There has been limited uptake by GPs for assuming shared care responsibilities despite very active promotion of the opportunity. Consequently there has been an underspend (£10k) since the establishment of the shared care model of service delivery.

Specialist Drug and Alcohol Support to the YOS
It is proposed that this public health funded specialist support is withdrawn (£58k). The Children and Young People's Substance Misuse Service, CASUS would assume a bigger role in the YOS through providing support to young people, training for YOS staff to increase their skills in screening and responding to substance misuse

issues and with ongoing supervision.

This model does require further exploration of demand and capacity of the CASUS Service. Alternative non public health funding that could replace some of the savings has been identified for use if the proposed model is not feasible**.**

Inclusion Community Drug & Alcohol Treatment Services
SSSFT currently operate separate drug and alcohol treatment services within the county as these services were commissioned under separate tenders, the alcohol contract having only been awarded in 2014 after the responsibility for the alcohol commissioning came across to the local authority in the Public Health transfer. Both contracts run until 2019 with aligned break clauses in place. It has been the ambition of CSCPT, as commissioners of the service, to encourage greater integration between drug and alcohol service provision with clear benefits in terms of cost savings and efficiencies. SSSFT and CSCPT have already undertaken provisional consultation in respect of advancing an integrated service agenda which will be underpinned by a formal contract variation. The ambition from the commissioner perspective will be to identify cost savings from non frontline resource and management overheads without impacting on the overall service delivery and, where possible, to improve the treatment journey/experience for service users with drug and alcohol comorbidity through better service integration.(£170k)

In order to deliver the necessary savings, SSSFT 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 levied by the Trust as part of the existing contract agreement.

In addition efficiencies are to be sought through the reduction of weekend working arrangements. Currently 4 service bases are open 4 hours each Saturday across the county staffed by 11 paid workers. By removing weekend working or moving to a volunteer/service user weekend arrangement the saving would be equivalent to 2.5 full time equivalent worker posts. Currently, Saturday opening attracts limited numbers footfall through the door. Volunteers and Recovery Champions that work for Inclusion undertake both intensive training and vigorous safeguarding checks and have robust supervisory structures in place. Volunteers and recovery champions already play a key role in running parts of the countywide service and this will be a small extension to current activity.

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
None
Negative Impact
There is potential for the service changes in regard to the YOS service to have a negative impact on young people with substance misuse issues. This will be mitigated by a fuller exploration of the feasibility and impact of the business case, and funding for services from public health reserves until we are confident that a proposed change in service model will not have a negative impact on outcomes.
Neutral Impact
The impacts will be neutral as the new service models will not impact on any frontline service delivery
Issues or Opportunities that may need to be addressed
The potential issue is with regard to the specialist input into the YOS described above. This will require further exploration and ongoing monitoring of the changes. The key opportunity to be addressed will be the advancement of the integration agenda for drug and alcohol service provision under one provider. The spin off benefits will be to ensure all frontline staff become substance misuse recovery focussed enabling those service users with dual drug and alcohol issues to remain within one service under one appointed recovery worker. There will be a reduction in management costs as there will no longer be a requirement for separate drug and alcohol leads across the county and this will reduce the management overheads proportionally levied by SSSFT on the overall contract value.

Community Cohesion

There is no immediate direct effect upon community cohesion

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area	**Officer undertaking the assessment**
CFA public health grant: Older People's Day Centres,	Name: Liz Robin (Public Health)/Louise Tranham (CFA) Job Title: Director of Public Health/ ..... Contact details: liz.robin@cambridgeshire.gov.uk ..... Date completed:11 January 2016 Date approved: .....
Service / Document / Function being assessed	
Older People's Day Centres – physical activity promotion	
Business Plan Proposal Number (if relevant)	

Aims and Objectives of Service / Document / Function

£150k public health grant was allocated to replace core funding for Older People's Day Centres to promote physical activity for older people. There is a reasonably strong evidence base for the impact of physical activity on health outcomes for older people.

What is changing?

Due to a £2.7M savings requirement on public health grant funded services, it is proposed to cease public health grant funding to promote physical activity through Older People's Day Centres. Following a review of current work to promote physical activity in each day centre, it is unlikely that ceasing this funding would have a significant impact on population levels of physical activity among older people. However the £150k funding for day centres is part of the core contract budget (i.e. not additional funding for physical activity interventions) and the day centres enable a wide range of outcomes for older people to be achieved. Therefore the overall impact of a reduction of £150k on Older People's day centre budget needs to be considered.

Background:
The Council conducted a review of older people's day care provision in 2011/12 with the aim of rationalising its support to this broad range of services. One of the key findings is that there is a wide range of services providing for very different needs and offering a wide range of social benefits. Some are very much community services that focus on socialising (e.g. lunch clubs, and activity based centres). While others- such as those provided directly by the Council- meet high end personal care needs, providing much needed respite for family carers. As a result of the review, the Council agreed to contribute funding to 25 day services across the County. Of this number 15 are voluntary sector organisations, 4 Registered Social Landlords, 2 Residential care homes. In addition, there are 3 older people day services provided directly by the Council in partnership with Learning Disability services.

Impact of the Public Health Cut:
The 150K, contributed by Public Health is focussed on the day services that are not directly provided by the Council and does form a significant part of the total annual spend on community day services of £766K.The impact of removing 150k from this budget would mean that services would have to be reduced. The best way to mitigate the effect would be to have a targeted approach- working with the locality teams- to ensure that the service funding reduction had the minimum effect on the smallest number and least vulnerable service users. This would best managed through a phased approach. This would enable engagement with the services effected and provide an opportunity for them to consider how to address the funding gap. However, such a process might adversely impact on the savings plan as it would be unlikely to be completed by the start of the next financial year.

In terms of Adult Social Care plans for day services:

- We are in the process of specifying the role of day centres to ensure that they are operating in a way that will enable us to implement Transforming Lives (i.e. by providing information, advice and a range of preventative services to targeted groups of older people)
- In line with this we are planning to use existing funding for day centres in a way that reduces demand on more expensive institutional care- as day centres can be critical to enabling someone to stay in their home and avoid residential care and more expensive specialist services. E.g. through the use of targeted programmes. This work can have particular benefits in terms of social isolation and falls prevention.
- As part of the business planning process CFA did consider taking funding out of day centres but decided not to for the reasons stated above

Conclusion: While the reasons for the Public Health recommendation are understood, there is a real concern that this decision could have unintended consequences. It is recognised that day services for older people provide an important opportunity to promote independence and to reduce social isolation. If this recommendation proceeds, it is likely that some services will close. Great care will, therefore need to be taken to ensure that these are not high quality services that reduce long term dependency on statutory health and social care services.
Who is involved in this impact assessment? e.g. Council officers, partners, service users and community representatives.
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
N/A
Negative Impact
It is recognised that day services for older people provide an important opportunity to promote independence and to reduce social isolation. Therefore a reduction in the funding of day services that has not been managed in way to minimise risk to those services users that by removing this service could greatly increase their need for more costly social care and health services. Those most at risk would be older people, people with disabilities and those living in isolated communities with limited or no opportunities to spend time with other people.
Neutral Impact
Issues or Opportunities that may need to be addressed

Community Cohesion

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

Reducing the level of funding in a time limited manor could potentially impact on communities were the day service in that community is key in providing a service that enables older people living in their own home . A reduction or closure of a day service could not only remove a service that provides a current community resilient function but would remove that asset at a time when we know Cambridgeshire has a growth in older people. Therefore we expect the demands on these services to increase. From the community impact point of view family and informal carers use day services as a respite service to enable them to continue their caring roles. In some communities that have limited paid care staff available, day services can provide a key part of an older person support plan both for a short time and on a move permanent basis.

Version Control

Version no.	Date	Updates / amendments	Author(s)

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area	**Officer undertaking the assessment**
Public Health Grant into CFA - PSHE	Name: Val Thomas..... Job Title: Consultant in Public Health ..... Contact details: val.thomas@cambridgeshire.gov.uk 01223 703264 ..... Date completed: 29/12/15 ..... Date approved: .....
Service / Document / Function being assessed	
Children, Families and Adults (CFA) - Public Health Expenditure delivered by CFA – PSHE review of public health activities.	
Business Plan Proposal Number (if relevant) Public Health MOU	

Aims and Objectives of Service / Document / Function

Personal and Social Health Education (PSHE) can be defined as a planned programme of learning through which children and young people acquire the knowledge, understanding and skills they need to manage their lives, now and in the future. The Council has had long standing PSHE Service providing support to schools for developing and implementing PSHE Services. Some elements of this Programme have been funded by Public Health

What is changing?

It is proposed that some of the Public Health funding to PSHE is withdrawn.

Public Health funded programmes are informally reviewed annually jointly by PSHE and Public Health with an emphasis on clearly demonstrable impact and outcomes. It has been agreed that some projects, where impact has been harder to demonstrate, should be changed or stopped and that programmes where there are clear outputs should be prioritised.

The reduction in Public Health funding will lead to a reduction in the PSHE Service's capacity to support Public Health priorities through schools as funding pays directly for staff delivery hours. The remaining Public Health funding will be allocated to supporting high priority and high impact programmes to minimise the impact of this capacity reduction.

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
Negative Impact
None
Neutral Impact
There would not be any impact on equalities as the most effective elements of the Programme would be maintained and any parts discontinued would be those that have limited impact.
Issues or Opportunities that may need to be addressed
There is the opportunity to re-design support for Public Health priorities delivered through the PSHE Programme in the longer term to ensure positive impact for young people is maximised.

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)
V.1	29/12/15		Val Thomas
V.2	07/01/16		Amanda Askham

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area		**Officer undertaking the assessment**
Public Health Grant - Chronically Excluded Adults		Name: Emma de Zoete/Ivan Molyneux Job Title: Public Health Consultant ..... Contact details: 01223 699117 emmadezoete@cambridgeshire.gov.uk..... Date completed: 06.01.2016 ..... Date approved: .....
Service / Document / Function being assessed		
Business Plan Proposal Number (if relevant)		

Aims and Objectives of Service / Document / Function

The CEA service works with the most chaotic and excluded adults in Cambridgeshire to improve outcomes for individuals and for society as a whole. It targets clients who have fallen between services in the past and employs a Coordinator who uses a person centred approach to tailor a support package around each client's needs. The service currently operates in Cambridge City and between Since the start of the project pilot in 2011, up to January 2015, the project received 130 referrals. Key outcomes that the service seeks to deliver are:

- Reduced arrests, contact with the criminal justice system and anti-social behaviour
- Reduced admission to prison within 12 months post entry to the project
- Increased numbers in self-contained accommodation
- Increased numbers consistently attending or completing treatment for problematic alcohol and/or drug use
- Increased numbers engaging positively with services (drug, alcohol, mental health, housing) or managing independently of service support.

What is changing?

The public health contribution to the Chronically Excluded Adults service will reduce from £91,000 to £66,000 for 2016/17. This will not impact on service provision in 2016/17. There are a number of reasons why this change will not impact on current services.

- The programme has not cost as much as originally predicted, as costs have been lower than expected, with the ability to carry forward any underspends being a benefit to the success of the service.
- Expansion of the service to the other parts of the county has been slow with the districts only taking up relatively few places within the service. The expansion into Peterborough has been funded by the Department for Communities and Local Government (DCLG).
- The economic evaluations of the service over two subsequent years has clearly demonstrated the substantial cost saving to the constabulary. A paper will be presented to the constabulary outlining these savings, and asking that the police make a contribution to the service.

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

Council officers and partners such as the Police.

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	

Sexual orientation		X	
The following additional characteristics can be significant in areas of Cambridgeshire.			
Rural isolation		X	
Deprivation		X	

Impact	**Positive**	**Neutral**	**Negative**
Religion or belief		X	
Sex		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
Negative Impact
Neutral Impact
The impact of this reduction in 2016/17 is neutral. Current services will not be affected, and will be maintained at the same level as in previous years.
Issues or Opportunities that may need to be addressed

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)**

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area	**Officer undertaking the assessment**
Public Health Grant - Supported housing **Service / Document / Function being assessed**	Name: Emma de Zoete ..... Job Title: Public Health Consultant ..... Contact details: 01223 699117 emma.dezoete@cambridgeshire.gov.uk ..... Date completed: 06.01.15 ..... Date approved: .....
Business Plan Proposal Number (if relevant)	

Aims and Objectives of Service / Document / Function

Supported housing and floating support services are designed to provide support to vulnerable families and single people in order to help them avoid homelessness across the county. These services are successful in keeping people living independently in accommodation, preventing them from falling into more costly statutory services. A number of supported housing services are funded by Cambridgeshire County Council. Public Health has in previous years contributed a small amount towards these services in recognition of the impact in secure housing and homelessness has on health.

What is changing?

Public Health provide £6k towards the overall costs of these services. This is 0.16% of the total budget which is £3,833,156.75. It is proposed that this £6k a year contribution is removed from 2016/17.

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

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

Negative Impact
Neutral Impact
There will be an impact but given the size of the reduction to total budget this will be minimal and work is being undertaken to ensure the service prioritizes those in most need
Issues or Opportunities that may need to be addressed

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)

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area	**Officer undertaking the assessment**
Public health grant into ETE: Market Town Transport Strategy	Name: Liz Robin (Public Health) Jack Eagle (ETE) .....
Service / Document / Function being assessed	Job Title: Director of Public Health/ .....
Savings proposal to withdraw £40k public health grant funding into ETE for the Market Town Transport Strategy team.	Contact details: liz.robin@cambridgeshire.gov.uk .....
	Date completed: 8 Jan 2016
Business Plan Proposal Number (if relevant)	Date approved: .....

Aims and Objectives of Service / Document / Function

Public health grant funding was allocated to replace £40k of core ETE funding for the Market Town Transport Strategy Team, (a) to recognise the role played by the team in supporting Active Travel, which has positive health benefits through increased physical activity and (b) to promote interaction between the team and public health specialists.

The transport strategies are developed to reflect new information regarding the current funding environment and the aspiration set out in the Local Plans. This involves the development of Policies and Objectives and action plan of schemes.

The broad aims of the strategies and plans are to improve transport, to support economic growth, mitigate the transport impacts of the growth agenda and help protect the area's distinctive character and environment.

What is changing?

Due to a £2.7M savings requirement on public health grant funded services, it is proposed to cease the £40k funding to the Market Town Transport Strategy team. The impact of ceasing this funding on public health outcomes is difficult to quantify, as there are a number of intermediate steps between a commitments to prepare a market town transport strategy, and achieving demonstrably higher rates of physical activity amongst sedentary populations in market towns whose health is most likely to benefit. The opportunities for interaction between the market town transport strategy team and public health staff are also reducing due to other savings in Public Health directorate staffing, which impact on public health specialist input to ETE.

However there are significant impacts on the overall commitment from ETE to prepare Market Town Strategies – The major effects of reducing or removing the £40k are detailed below:

- There would be less money available to carry out detailed and focused consultation on the market town/ district wide transport strategies; reducing the input from harder to reach groups who would be the target of these consultation
- A reduction in the funding would also reduce the ability of the team producing the transport strategies to gain input from other professionals in the fields of public health and transport to help produce and review the strategies as they are being developed

The overall effect of this would be that whilst staff in ETE will always consider public health and the benefits of active travel when producing transport strategies the detailed focus and knowledge would not be as complete as when the grant was in place. It is also possible that barriers to active travel that harder to reach groups have may not be identified and thus remain in place as they are not addressed by transport strategies.

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

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
Negative Impact
The groups highlighted above will be negatively impacted on as these are generally the hard to reach when consulting and developing transport strategies. It may be possible that there groups encounter transport related issues that are not currently known and without detailed consultation that this funding would allow could remain unidentified and thus unaddressed by transport strategies.
Neutral Impact
Due to a reduction in funding the groups identified above will not be impacted on in anyway.
Issues or Opportunities that may need to be addressed

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)

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area		Officer undertaking the assessment
Public Health Grant into ETE: Road safety interventions		Name: Liz Robin (Public Health) / Matt Staton (ETE) Job Title: Director of Public Health / Road Safety Education Team Leader Contact details: liz.robin@cambridgeshire.gov.uk / matt.staton@cambridgeshire.gov.uk Date completed: 8/1/16 ..... Date approved: .....
Business Plan Proposal Number (if relevant)		

Aims and Objectives of Service / Document / Function

The work of the team contributes to the shared vision across the Cambridgeshire and Peterborough Road Safety Partnership to "prevent all road deaths across Cambridgeshire and Peterborough and to significantly reduce the severity of injuries and subsequent costs and social impacts from road traffic collisions." The work of the partnership takes a holistic view of road safety and involves approaching and engaging voluntary and community groups in decision making and delivery with the partnership officer's expert advice. The cross-boundary working extends not only to Peterborough, but also to collaborative work across Bedfordshire, Hertfordshire and Cambridgeshire and the wider East Region.

Specifically, the team aims to prevent road users from being killed or seriously injured (KSI) through enabling behaviour change and delivering education to road users. This work involves delivering evidence-based interventions that develop safe road user behaviour from a young age and identifying high risk road users and delivering targeted initiatives to prevent collisions and influence attitudes and behaviour.

Public health grant funding was allocated to replace £220k ETE core funding for ETE road safety team staffing, project work and campaigns, recognising the impact of road traffic injuries and deaths and safety barriers to active travel on public health outcomes in Cambridgeshire. This has risen to £225k in 2015/16 and ETE continues to provide £100k funding, so the overall budget for the team is £325k.

What is changing?

Due to a £2.7M savings requirement on public health grant funded services, it is proposed to reduce public health grant funding for the ETE road safety team from £225k to £105k in 2016/17. This is in line with savings on project and campaign budgets in other areas of public health activity. There is evidence that campaigns and projects change attitudes to road safety, but the public health evidence for direct and quantifiable impact on outcomes is less robust, although the ETE road safety team always aims to work with the best evidence available.

The Road Safety team are exploring the potential to source grants for road safety projects and campaigns from a wider range of sources, and are also developing an income generation model. Recognising that the scale of cuts proposed pose significant risks to this transformation, it is proposed to provide non-recurrent transformation funding during 2016/17 of £84k, to allow the income generation model to be fully developed. The net saving in 2016/17 would therefore be £36k.

In order to scale the project delivery based on this budget reduction it is most likely that the reach of individual projects will be rationalised rather than completely removed, with any additional funding sourced externally used to supplement the reduced programme. In some cases where reductions would take delivery below a "critical mass", e.g. Children's Traffic Club, it may be necessary to cease the project entirely. While every effort will be made to mitigate the risks to frontline staff from these reductions, as their knowledge and experience to provide communities with information, advice and support is a core element of the programme, without sourcing additional funding it is likely a reduction to staffing will be necessary.

An evidence-based approach will be used to rationalise the programme to try to keep resources directed towards the greatest need/risk, however, as these groups are generally more resource intensive to reach it is likely high risk groups will see some reduction in resource allocation and this is reflected in the impact statements, below.

Who is involved in this impact assessment? e.g. Council officers, partners, service users and community representatives.
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
No positive impacts are expected as a result of reduced funding in this area
Negative Impact
Age – *Young people* (age 17-25) are significantly overrepresented in road traffic collisions as drivers of vehicles (inc bicycles) and as passengers, and young drivers are also overrepresented in road traffic offence statistics. A significant proportion of the programme targets these users and the reduced resources will likely mean less young people will receive direct road safety education input (e.g. Drive2Arrive workshops) and targeted information campaigns such as drink/drug driving messages. A large proportion of the programme also targets *school children* with the aim of developing safe road user behaviour at appropriate ages and developmental stages (e.g. pedestrian training), support for schools to address parking issues and work to increase sustainable travel to school (and in turn improve the health of those children). Reductions to resources will likely mean fewer educational establishments can access direct road safety education input and support in these areas. While *older road users* in Cambridgeshire are not currently overrepresented in road traffic collisions, nationally there is an increasing concern related to the ageing population and increases in the number of older drivers on the road. The reduction in resources means it is unlikely the Road Safety Team will be able to implement interventions where the need arises in Cambridgeshire. **Pregnancy and maternity** – The road safety education team provide advice to parents, in particular those of very young children, relating to the use of child car seats and arrange events to check child car seat fitting. This will reduce as part of the proposals. **Sex** – Males are significantly overrepresented in road traffic collisions and in road traffic offence statistics. Campaign work to target these behaviours will be significantly reduced as a result of these proposals and will likely mean less male road users will receive targeted information campaigns.

Rural isolation – Research[1] has shown that people, particularly young people, who live in rural areas of Cambridgeshire, in particular in Fenland, are at greater risk of being involved in a serious road traffic collision due to the type of roads they drive on and their increased exposure due to reliance on driving to access services. Reduced resources for targeted interventions will likely mean fewer people in these areas will receive these interventions. Car user casualties in NE Cambridgeshire (parliamentary constituency) are 55% higher than the national rate, the 7th worst district in the country, and in NW Cambridgeshire are 36% higher than the national rate[2].

Deprivation – Cambridgeshire residents in more deprived IMD quintiles are overrepresented in road traffic collisions while those in less deprived IMD quintiles are underrepresented. Reduced resources for targeted interventions will likely mean fewer people in these areas will receive these interventions.

Neutral Impact

Disability, gender reassignment, marriage and civil partnership, religion or belief and sexual orientation are not characteristics associated with increased risk of road traffic collision involvement or access to the programmes affected; therefore a neutral impact on these groups is expected.

Issues or Opportunities that may need to be addressed

Public Health indicator 1.10 the "number of people reported killed or seriously injured on the roads" is currently worse than the national average in Cambridgeshire overall, worse than the national average in East Cambs, Fenland and South Cambs (showing red on the public health profiles 2015) and similar to the national average in Cambridge and Hunts (amber on the public health profiles 2015)[3].

The team have identified opportunities to source other grant funding and/or income generation to mitigate this reduction, and other proposed reductions in funding during the current period of CCC Business Planning. The provision of non-recurrent transformation funding recognises the need for resources to transform the team's delivery in order to realise these opportunities and potentially mitigate some or all of the negative impacts identified above.

Past reductions in staff across all partner organisations have had a critical impact on the effectiveness of partnership working. It is important to address the effect these proposals will have on the Cambridgeshire and Peterborough Road Safety Partnership as a whole as this has been identified as a key mechanism to continue casualty prevention and reduction work in this area going forward.

Community Cohesion

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

The Road Safety Officers often provide a link between school and parish concerns relating to road user behaviour, particularly in village locations, and work alongside the Local Highways Officers to resolve issues and support communities in bidding for Local Highways Improvement schemes. The resource for Road Safety Officers to do this is likely to reduce as part of these proposals if other sources of funding cannot be secured and this will have a knock-on effect on the work of other staff such as the Local Highway Officers.

Version Control

Version no.	Date	Updates / amendments	Author(s)

[1] Fosdick, T. (2012) Young Drivers' Road Risk and Rurality. Road Safety Analysis.
[2] PACTS Constituency Dashboard http://www.pacts.org.uk/dashboard/
[3] Local PHOF summary for Cambridgeshire – November 2015 http://www.cambridgeshireinsight.org.uk/file/2381/download

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area		**Officer(s) undertaking the assessment**
Public Health Grant into ETE – Trading Standards (Supporting Business and Communities)		Name: Liz Robin (Public Health) ; Aileen Andrews (SBC, ETE) Job Title: LR - Director of Public Health/ AA - Acting Head of Supporting Businesses and Communities Contact details: liz.robin@cambridgeshire.gov.uk / aileen.andrews@cambridgeshire.gov.uk Date completed: 8 Jan 2016 Date approved: .....
Service / Document / Function being assessed		
Review trading standards public health activities		
Business Plan Proposal Number (if relevant)		

Aims and Objectives of Service / Document / Function

Trading Standards (part of Supporting Business and Communities) receives public health grant funding to support test purchasing of cigarette sales and age related smoking prevention (through the Kick Ash programme), prevention of underage sales of alcohol and a small amount of funding for investigating sales of illicit tobacco.

What is changing?

Due to a £2.7M savings requirement on public health grant funded services, it is proposed to reduce public health grant funding into ETE trading standards from £53k to £38k. This is equivalent to the sum currently allocated for test purchasing of alcohol to prevent underage sales.

The three funded areas (illicit tobacco, Kick Ash and underage alcohol sales) continue to be priority areas for Trading Standards.

Taking an intelligence based approach to re-prioritising resource and activity in these three areas, if agreed by Public Health, would allow for the £15k reduction in public health grant funding in 2016/17 having a low impact on the outcomes and responsibilities.

This proposed reallocation of resource has been carefully considered as a direct result of the work carried out by Supporting Businesses and Communities during 2015/16 to improve the effectiveness and efficiency of resources and processes in these funded priority areas and use available intelligence to prioritise areas of most concern.

In particular for 2016/17, to minimise the impact of the reduced funding, less resource will be used to deliver Kick Ash and underage alcohol sales and more resource to focus on removal of illicit tobacco.

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

Council officers (Trading Standards)
Public Health (PH Consultants; Kick Ash Programme Manager)

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
The changes are not expected to have any positive impact on the protected characteristics.
Negative Impact
The changes are not expected to have any negative impact on the protected characteristics.
Neutral Impact
The changes are expected to have a neutral impact on the protected characteristics.
Issues or Opportunities that may need to be addressed
The findings of 2015/16 work to improve the efficiency and effectiveness of delivery, review resource requirements and gather intelligence to assist prioritisation of resource has been used to propose best use of reduced funding for 2016/17.

Community Cohesion

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

There is a possibility of a negative impact on community cohesion if enforcement and business advice on illicit tobacco is perceived to be targeting only those businesses owned or run by particular population groups.

To mitigate this risk, all enforcement activity will be intelligence led. Activity to identify problem premises and ensure compliance across all businesses will be based on random selection of other similar businesses in that local area. All activity regarding business compliance will be carried out in line with the Service's Enforcement Policy.

Version Control

Version no.	Date	Updates / amendments	Author(s)
V0.1	8 Jan 2016		Elaine Matthews
V0.2	11 Jan 2016	Community cohesion mitigation confirmed	Aileen Andrews/Elaine Matthews

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area		Officer undertaking the assessment
Public health grant to ETE: Fenland Learning Service		Name: Liz Robin (Public Health) Lynsi Hayward-Smith (ETE) Job Title: Director of Public Health/ Contact details: liz.robin@cambridgeshire.gov.uk Date completed: 8 January 2016 Date approved:
Business Plan Proposal Number (if relevant)		

Aims and Objectives of Service / Document / Function

The Focus for the Learning and Skills Services is to help individuals, communities and businesses fulfill their potential and grow, by giving them access to learning and skills development. The services work to offer a consistent and high quality experience for people wherever they engage with us and to work with partners to ensure we reach those furthest from learning. The teams within the service can offer careers advice and guidance, assessment, initial and advanced skills learning and a range of support for skills development and routes into employment.

The work is focused on closing the gap for the targeted learners who are out of learning and unemployed or lacking in skills to gain sustainable employment.
It supports intergenerational learning to break the cycle of deprivation within families.

The wider outcomes of learning are well documented and the impact of this work will facilitate reduction in other budgets by reducing dependency on mental health and other care and health services. (*Fujiwara D. Valuing The Impact of Adult Learning 2012*).

Public health grant was used to replace £90k ETE funding for Fenland learning service, recognising the overall benefits to people's health of being in employment, and the wider picture of health inequalities in Fenland.

What is changing?

If the revenue grant is no longer provided there would be a significantly reduced offer in Fenland and one centre would no longer be sustainable and would have to close.
This would mean reduced opportunities for people to undertake training related to employment or volunteering and reduced opportunities for people to come out of isolation and join a programme at a learning centre. *AL&S outcome data

- 1000 individuals supported through Learn My Way in the two learning centre and outreach location across Fenland;
  -488 of these were supported at Wisbech and March Learning Centre by tutors.
- 288 individuals have used the free Work Club provision we have set up at March Learning Centre
- 200 learners undertook and gained Qualifications at Wisbech and March Learning Centre.

23% of those who gained specific work related qualifications gained sustainable employment as a direct consequence of completing the course (Learn Direct data 2014/15 against a target of 20%

It is difficult to quantify the exact impact and value for money of the Fenland Learning Service on public health outcomes, as there are a number of steps between provision of this service, users of the service gaining employment, and any resulting health gains or reduction in health inequalities as the result of being in employment or improved health literacy. However the impact data gathered as feedback from learners demonstrate that learning and gaining employment are closely linked .

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

What will the impact be?

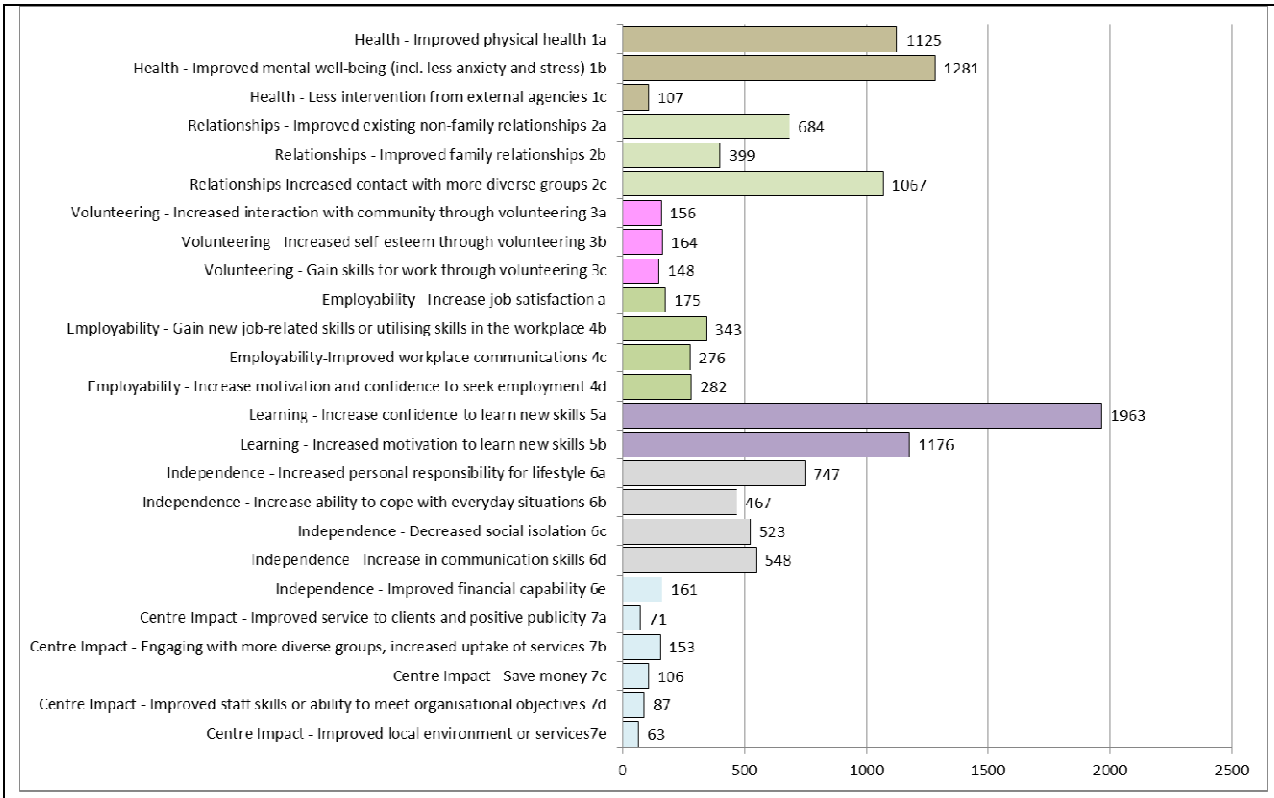
Tick to indicate if the expected impact on each of the following protected characteristics is positive, neutral or negative.

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
Negative Impact
The most noticeable negative impact will be on learners who cannot travel to other centres for their learning. As the number of disabled people in the population is higher than other areas of Cambridgeshire it may impact disproportionately on that group. The service may not have the data to support this as people frequently do not declare a disability when they sign up for a programme of learning The learning centres are located in areas of significant deprivation and rural isolation The closure or reduced availability of a learning centre would impact negatively on those communities. *Adult Learning and Skills Wider Outcome data for info. See table below



Neutral Impact
Issues or Opportunities that may need to be addressed

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)

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area	**Officer undertaking the assessment**
Public Health grant: CS&T community engagement/timebanking	Name: Val Thomas & Sue Grace..... Job Title: Consultant in Public Health Director of Customer Service and Transformation..... Contact details: val.thomas@cambridgeshire.gov.uk 01223 703264 ..... sue.grace@cambridgeshire.gov.uk 01223 715680 Date completed: 06/01/16 ..... Date approved: .....
Service / Document / Function being assessed	
CS&T – Public Health Expenditure – Community Engagement and Timebanking	
Business Plan Proposal Number (if relevant) Public Health MOU	

Aims and Objectives of Service / Document / Function

Public Health Funding was allocated to CS&T Customer Services and Community Engagement Team to enable them to provide Contact Centre and community engagement activities, which includes support for Public Health projects and timebanking. These activities support the public health objective of engaging individuals and communities with taking responsibility for their health and the wider Council priorities of supporting healthy lifestyles and the development of community resilience.

The CS&T Community Engagement team have strong links into communities across Cambridgeshire which contribute to achieving the Public Health objective of engaging communities in their own health. The links have provided opportunities to link with communities especially in Fenland. Staff from the CS&T Team have provided support to the development of the Healthy Fenland Fund initiative and were involved in the procurement process to award the contract for running the Initiative to Care Network.

The Contact Centre has assisted with the winter Warm Homes Healthy People campaign that targets vulnerable groups which includes older people and children under the age of 5. It provides a dedicated telephone number in the winter months that people can call to find out about the services that are available to help them mitigate the impact of winter upon their health and wellbeing.

What is changing?

It is proposed to decrease public health grant funding to CS&T by £34.5k which will impact upon community engagement activities (£28k) and the Contact Centre (£6.5k).

The wider budget pressures within CS & T, including the significant reduction of the community engagement team in 2014/15 alongside the closure of Shape Your Place, has meant that the public health grant funding has been critical in enabling us to maintain a small core community engagement team of three people to support community engagement / community resilience across the council. This has included the support to Public Health outlined above. This team has supported time-banking county wide, is working closely with Cllr Criswell, the Localism Champion, on the Connecting Councillors programme, is providing leadership in our developing work with Parish Councils and supports the transformation of other council services to reflect the principles and practice outlined in the Community Resilience Strategy Stronger Together. The loss of this investment would mean we could not retain this staffing resource at the current level this would impact on our ability to deliver our Community Resilience Strategy.

The Contact Centre is already under significant pressure where the resourcing has not kept pace with the increased volume of work flowing through the centre. These increased volumes have been seen particularly in our support for vulnerable people both young and old. This has regrettably led to an inability for us to meet the performance standards that we would and should be meeting for our customers. This further reduction of support for the Contact Centre would add to this already pressured situation and would impact directly on our ability to respond in a timely and effective way to our customers and to deliver critical support to the most vulnerable through initiatives such as the Winter Warmth campaign.

The main focus of the CS&T Community Engagement work in support of Public Health has been in Fenland with

the Healthy Fenland Fund. The initial engagement work for the Programme has been completed and this will now be taken forward as planned by the community workers employed by Care Network. In addition the Integrated Lifestyle Service provided by Everyone Health employs Health Trainers and engages volunteers who have a remit to develop links with communities and support them to become engaged in health promoting activities. Therefore this tranche of public health developmental work involving CS&T staff has largely finished and been handed on to an external provider. However it is anticipated that as the Programme develops further, Public Health and Care Network would benefit from the support of the CS&T Team. More generally the strategic leadership and support of this small team needs to continue to be available for Public Health colleagues as well as the rest of the council.

Timebanking was started in Cambridgeshire in 2006. It is a way for people to come together and help each other by exchanging knowledge, help and skills on an hourly basis. They may be set up by community organisations or individuals. Timebank coordinators, who are often employed by a community organisations match people's skills, arrange time exchanges and keep a record of all the members 'banked' hours. Cambridgeshire currently has community Timebanks in five different areas, each having its own coordinator. It has almost 500 individual members and 65 organisational members with ages ranging from 3 to 96 years old. The total numbers of hours exchanged to date have been 12,033. The continued development and rollout of this and other initiatives as a means of strengthening community resilience is a key aspect of our implementation of our Community Resilience Strategy Stronger Together which supports many aspects of the public health agenda

The Contact Centre has provided for two years a dedicated number for providing information to the public about the risks to health during the winter months and where support can be secured. For example grants for heating improvements. It is proposed that this bespoke number is discontinued. The Contact Centre has received fewer calls than anticipated since its inception, despite widespread publicity. (Between 4-6calls per month)
Since the number has been established the voluntary sector has expanded its helplines and these provide similar information. In addition as part of the Older People' s Service development a bespoke helpline has been established to provide information which includes avoiding the risks to health associated with winter conditions. Nevertheless the Contact Centre needs to retain its ability to respond to the health needs of our customers, through providing information and signposting people to a range of health services including public health in house and commissioned services. In addition it has an important role in supporting Public Health colleagues in conveying key messages and supporting future campaigns.

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

This CIA was prepared 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
Community engagement seeks to engage all members of the community especially those at risk of inequalities. The lack of an overall coordinator to facilitate new projects and provide strategic direction could limit the expansion of the Programme in these high risk groups. It can be more difficult to engage people from high risk groups in community activities and additional external support is required to develop projects and new and innovative ways of engagement.
Neutral Impact
None
Issues or Opportunities that may need to be addressed
It takes time to build relationships with communities; change can compromise these relationships and any ongoing engagement work. If community engagement activity becomes more limited and there is a perception that support is being withdrawn before communities are ready to take responsibility for any projects it will need to be addressed.

Community Cohesion

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

The withdrawal of external support for community engagement work can as described above undermine the building of communities and community cohesion.

Version Control

Version no.	Date	Updates / amendments	Author(s)
V1	29/12/15		Val Thomas
V2	06/01/16		Val Thomas & Sue Grace

Agenda Item No: 5

FINANCE AND PERFORMANCE REPORT – November 2015

To:	**Health Committee**
Meeting Date:	**21st January 2016**
From:	**Director of Public Health** **Chief Finance Officer**
Electoral division(s):	**All**
Forward Plan ref:	**N/A** ***Key decision:*** **No**
Purpose:	**To provide the Committee with the November 2015 Finance and Performance report for Public Health. The report is presented to provide the Health Committee with the opportunity to comment on the financial and performance forecast outturn position as at the end of November 2015.**
Recommendation:	**The Committee is asked to review and comment on the report.**

	Officer contact:
Name:	Chris Malyon
Post:	Chief Finance Officer
Email:	Chris.malyon@cambridgeshire.gov.uk
Tel:	01223 699796

1. BACKGROUND

1.1 The Finance & Performance Report for the Public Health Directorate is produced monthly and the most recent available report is presented to Health 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. MAIN ISSUES

2.1 The November 2015 Finance and Performance report is attached at Appendix A.

2.2 The Department of Health has now published its response to the consultation on the in-year reduction to the Public Health Grant, which confirms an in year reduction of £1,6m for Cambridgeshire County Council. This reduction in funding will be met through the one-off application of reserves and in-year savings.

2.3 The service is forecasting a £930K underspend, which normally would transfer to reserves given the grant is ring-fenced, but given the grant funding will reduce, the underspend will be held and be used to partly offset the reduction in grant as outlined in 2.2 The remainder (£610k) will be drawn down from Public Health Grant reserves.

2.4 The Public Health Service Performance Management Framework for October 2015 is contained within the report. Of the thirty Health Committee performance indicators, six are red, three are amber, thirteen are green, and eight currently have no status.

3.0 ALIGNMENT WITH CORPORATE PRIORITIES

3.1 **Developing the local economy for the benefit of all**
There are no significant implications for this priority.

3.2 **Helping people live healthy and independent lives**
There are no significant implications for this priority.

3.3 **Supporting and protecting vulnerable people**
There are no significant implications for this priority.

4.0 SIGNIFICANT IMPLICATIONS

4.1 **Resource Implications**
This report sets out details of the overall financial position of the Public Health Service.

4.2 **Statutory, Risk and Legal Implications**
There are no significant implications within this category.

4.3 **Equality and Diversity Implications**
There are no significant implications within this category.

4.4 **Engagement and Consultation Implications**
No public engagement or consultation is required for the purpose of this report.

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

4.6 **Public Health Implications**
This report provides an overview of the finance and performance position of the Public Health service.

Source Documents	Location
None	

From: Martin Wade **Annex A**

Tel.: 01223 699733

Date: 14 December 2015

Public Health Directorate

Finance and Performance Report – November 2015

1. SUMMARY

1.1 Finance

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

1.2 Performance Indicators

Monthly Indicators	Red	Amber	Green	No Status	Total
October (No. of indicators)	6	3	13	8	30

2. INCOME AND EXPENDITURE

2.1 Overall Position

Forecast Variance - Outturn (Oct) £000	Directorate	Current Budget for 2015/16 £000	Current Variance £000	Current Variance %	Forecast Variance - Outturn (Nov) £000	Forecast Variance - Outturn (Nov) %
-745	Health Improvement	9,048	-2,423	-41.4%	-745	-8.2%
0	Children Health	5,606	-212	-8.7%	0	0%
-20	Adult Health & Well Being	979	-362	-57.7%	-20	-2.0%
0	Intelligence Team	26	-11	-71.9%	0	0%
-5	Health Protection	16	5	44.5%	-5	-32.3%
-10	Programme Team	153	-37	-36.2%	-10	-6.55%
-150	Public Health Directorate	2,567	-209	-12.2%	-150	54.2%
-930	**Total Expenditure**	**18,395**	**-3,249**	**-30.2%**	**-930**	3.3%
-610	Anticipated use of carry-forward of Public Health grant				-610	
1,540	Public Health Grant	-18,395	49	0%	1,540	-8.4%
930	**Total Income**	**-18,395**	**49**	**0%**	**930**	**-8.4%**
0	**Net Total**	**0**	**-3,200**		**0**	

The service level budgetary control report for November 15 can be found in appendix 1.
Further analysis of the results can be found in appendix 2.

2.2 Significant Issues

The Department of Health has now published its response to the consultation on in-year savings to the public health grant in 2015-16. The response confirms the Government's initial proposal to reduce each local authority's overall public health allocation for 2015-16 by 6.2%, achieving a total £200m saving nationally. The 6.2% saving is based on each authority's share of the overall allocation of public health funding which for Cambridgeshire equates to a reduction of £1,610k.

Furthermore, in the Comprehensive Spending Review in November 2015, the Chancellor announced further reductions to the Public Health grant for 2016-17 to 2019-20 and additionally confirmed that the grant would remain a ring-fenced grant for two more years, to the end of March 2018. As a result of the grant remaining ring-fenced, the usual treatment would be for services funded by the public health grant to absorb pressures arising from the grant reduction, demography and inflation; however at the time of this report being produced the treatment has yet to be confirmed.

Details of variances from budget at this point in the year are explained at appendix 2.

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

The Public Health ring-fenced grant allocation is £22.2m, but an in-year cut has been announced. The grant will increase from September 2015 by £3.9m (full year £7.7m) in respect of the transfer from NHS England of 0 – 5 funding.

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

4.1 The Public Health Service Performance Management Framework (PMF) for October 2015 can be found in Appendix 6.

The following commentary should be read in conjunction with the PMF.

4.2 Stop Smoking Programme:

Measure	Y/E Target 2015/16	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)
Smoking Cessation - four week quitters	2237	829	755	91%	A	105%	161	96%	↓

- Since 2013/14 there has been an ongoing drop in the percentage of the target number of smoking quitters achieved. In 2012/13 92% was achieved, in 2013/14 this fell to 76%. This fall continued in 2014/15 when 64% of the target was met. The drop locally mirrors the national picture for the past three years. A number of factors have been associated with the fall in quitters in recent years but e cigarettes are generally seen as being the key factor across the country. During these years performance in GP practices and community pharmacies was especially poor and they report there is a consistent problem with recruiting smokers to make quit attempts
- The most recent update to the Public Health Outcomes Framework has shown that the positive movement in smoking prevalence in the percentage of adults smoking across the County between 2012 and 2013 had generally been sustained between 2013 and 2014. However inequalities in smoking rates remain, with the prevalence in Fenland, Cambridge City and amongst manual workers being higher than the Cambridgeshire average.
- The target number of quitters has been revised for 2015/16 to reflect the fall in smoking prevalence in Cambridgeshire. The old target was based on the previous higher prevalence. Performance against the revised target is continuing to improve.
- 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. During 2014/15 social marketing research was undertaken which is informing activities to promote Stop Smoking Services. Other activities introduced recently include a mobile workplace service, a migrant worker Health Trainer post that will target these communities where smoking rates are high, a wide ranging promotional campaign and the recruitment of an additional Stop Smoking Advisor to focus upon Fenland.

NHS Health Checks

Measure	Y/E Target 2015/16	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)
Number of Health Checks completed	18,000	9,000	6996	78%	R	78%	4500	77%	↓
Percentage of people who received a health check of those offered	45%	45%	36%	36%	R	38%	45%	36%	↓

- Reporting of Health Checks is quarterly. In 2014/15 83% of the target was achieved compared to 93% in the previous year. The % of health checks offered and converted into completed was comparable to 2014/15 at 38%.

- In Q1 2015/16 78% of the monthly target was achieved with a conversion rate of 38%. In Q2 there has not been any improvement with the conversion at 36% Although there continues to be a considerable improvement in the quality of data returned and numbers referred onwards to services following a health check; which has been attributed to the ongoing training programme.

- 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 favourably to other areas but the issue is the conversion rate which is attributed to the poor public understanding of the Programme. There is a concerted drive to launch a promotion campaign as soon as possible.
  Other activities include staff training from a commissioned Coronary Heart Disease specialist nurse, new data collection software for practices, and additional staff support for practices. In addition in Fenland a mobile service has been established and is visiting factories to offer health checks especially to those more hard to reach groups. The new Lifestyle Service is commissioned to provide outreach health checks for hard to reach groups.

Background Information

- Health Checks is cardio vascular risk assessment offered to people between the ages of 40 to 74. There is a 5 year rolling programme and each year up to 20% of the eligible population should be invited to a health check. The important indicators are the number of health checks completed and the number of those invited who actually complete a health checks. The Health Checks Programme has been primarily provided by GP practices that are responsible for sending out invitations to the eligible population.

Integrated Lifestyle Service

The new Countywide Integrated Lifestyle Service provided by Everyone Health commenced on June 1 2015. It includes the Health Trainer and Weight Management Services. The trajectories for many of the indicators for the initial months of the contract reflect the fact that the Service was still recruiting and developing the Service. Also some of outputs are not available in the timeframe as the interventions take place over several months.

School Nursing:

Measure	Y/E Target 2015/16	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)
School Nursing : Contacts made	9000	4154	4616	111%	G	119%	923	102%	↓
School Nursing : Group activities	4784	2208	1947	88%	G	112%	490	4%	↓

- Currently individual contacts continue to be above target while group contacts are below. The low figure for September can be accounted for by some degree by school holidays. However this data doesn't tell us anything about the value on these contacts or the outcomes for those involved.

- A new service specification and Key Performance Indicators for School nursing have been agreed. A new performance template has been developed and this will be used to understand baseline activity from October. Over the next year we will be able to agree targets in areas which contribute towards public health outcomes and reflect this in our reporting. This will also reflect the activity across different parts of the county.

4.2 The detailed Service performance data can be found in appendix 6.

4.3 Health Committee Priorities

Health Inequalities

Smoking Cessation

- The following describes the progress against the ambition to reduce the gap in the smoking rates between patients of the most socio-economically deprived 20% of GP practices and the remaining 80% of GP practices in Cambridgeshire (monitored monthly). The GP practices in the 20% most deprived areas of Cambridgeshire are given more challenging smoking cessation targets and more support than other practices, to help reduce this gap.
  - The percentage of the smoking quit target achieved in September was higher among the least deprived 80% of practices in Cambridgeshire compared with the most deprived 20%
  - In the least deprived 80%, 100 four-week quits were achieved, 88% of the monthly target of 114; in the most deprived 20% of practices, 47 four-week quits were achieved, 64% of the monthly target of 73.
  - Looking at performance data for the year to date, the percentage of the quit target achieved in the least deprived 80% of practices stands at 83% and in the most deprived 20%, at 71%.
  - The gap in performance in quits achieved between the two groups increased in September compared to the gap seen in August due to both a fall in quits achieved in the most deprived practices and an increase in quits achieved for the least deprived practices.

Percentage of smoking quit target achieved by deprivation category of general practices in Cambridgeshire, September 2015/16

Practice deprivation category	Year end target	Year-to-date					September			Previous month	
		Target	Completed	Percentage	Difference from target	RAG status	Target	Completed	Percentage	Percentage	Direction of travel
Least deprived 80%	1,366	683	570	83%	17%		114	100	88%	80%	↑
Most deprived 20%	871	436	309	71%	29%		73	47	64%	81%	↓
All practices	2,237	1,119	879	79%	21%		186	147	79%	81%	↓

RAG status:

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

Direction of travel:

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

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

	Year-to-date	September	Previous month	Direction of travel
Percentage point gap	12%	23%	1%	↓

Direction of travel:

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

-

Sources:

General practice returns to Cambridgeshire County Council Smoking Cessation Service
Public Health England 2011 Indices of Multiple Deprivation for general practices, based on the Index of Multiple Deprivation, Department for Communities and Local Government, 2011

Health and Social Care Information Centre Organisation Data Service

Office for National Statistics Postcode Directory

Prepared by:

Cambridgeshire County Council Public Health Intelligence, 01/12/15

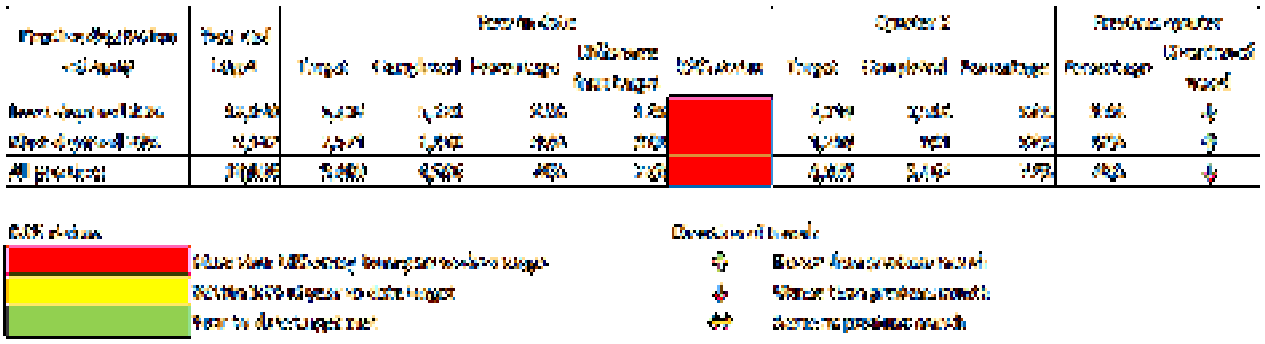
Actions:
There is an ongoing programme that targets the more deprived areas. The biggest focus is in Fenland where there is an active promotion programme in the community which includes visits to shops and a mobile service. Staff have been trained at the Migrant Community Centre in Wisbech to support people to quit or refer to the local Stop Smoking Services. Smoking rates amongst the migrant communities are high. Promotional campaigns that reflect commissioned social marketing research are being implemented in the more deprived areas across the county. The Workplace Health Programme is expanding and it targeting workplaces where there is high rate of smoking amongst employees.

NHS Health Checks

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

Quarterly:
- The percentage of the health check target achieved in Quarter 2 was higher in the least deprived 80% of practices than in the most deprived 20%.
- In the least deprived 80%, 2586 health checks were delivered, 80% of the quarterly target of 3214; in the most deprived 20% of practices, 881 health checks were delivered, 69% of the quarterly target of 1286.
- The gap in performance in health checks delivery between the two groups was 11 percentage points in Quarter 2.
- The gap in performance in health checks achieved between the two groups decreased in Q2 compared to the gap seen in Q1 due to both an increase in health checks in the most deprived practices and a decrease in health checks for the least deprived practices.

Year to date:
- Looking at performance data for the year to date, the percentage of the health check target achieved in the least deprived 80% of practices stands at 83% and in the most deprived 20%, at 65%.
- The percentage of the health check target achieved in the year to date is more than 10% away from the target in both groups.
- Performance for the most deprived 20% of practices is 18 percentage points behind performance in the least deprived practices.



Sources:

Practice returns to Cambridgeshire County Council Public Health Team
Public Health England 2011 Indices of Multiple Deprivation for general practices, based on the Index of Multiple Deprivation, Department for Communities and Local Government, 2011

Health and Social Care Information Centre Organisation Data Service

Office for National Statistics Postcode Directory

Prepared by:

Cambridgeshire County Council Public Health Intelligence, 01/12/2015

Actions:

Improving the number of completed NHS Health Checks is requiring considerable effort in deprived areas but also across the whole area. Each Health Check demands that invitations are only sent to those eligible, the Health Check itself is complicated and time consuming in terms of the risk assessment and subsequent actions. All of these make the assessment, recording and capture of Health Checks challenging for busy GP practices. Although there are new commissioned interventions across the county to improve the clinical aspects and to make data management much more robust, efforts to work with individual practices have been concentrated in the more deprived areas to ensure that they maximise the benefits of these improvements.
In addition although historically the NHS Health Checks Programme has been provided in GP practices, the new Integrated Lifestyle Service has been commissioned to provide outreach Health Checks to more at risk populations in the community and workplaces.

Life expectancy and healthy life expectancy

There is no update to the data provided in the September report and so the material provided previously is replicated below. There will be an update to the life expectancy data in the next report. The delay is attributable to the publication

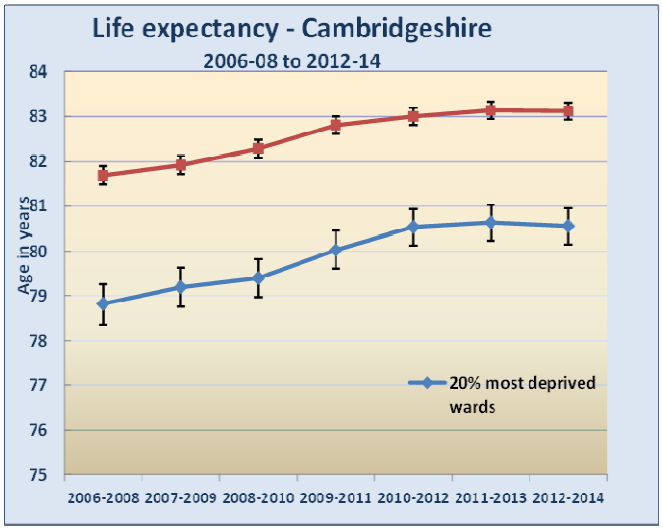
and analysis of mortality data for the life expectancy data and in national reporting in the case of healthy life expectancy.

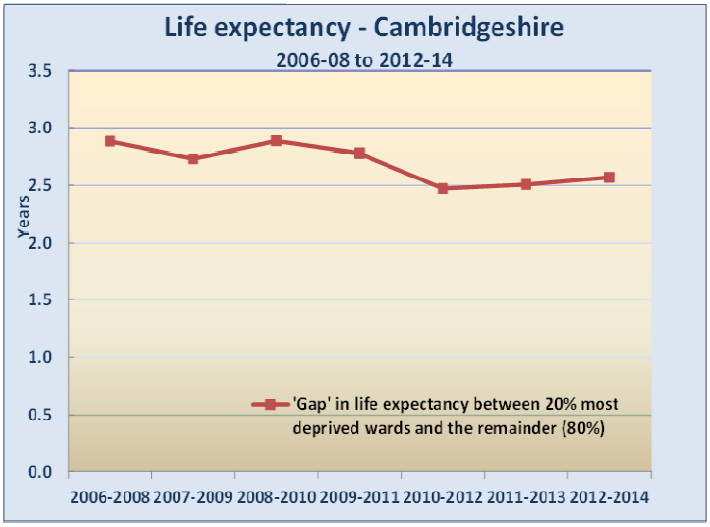
- Inequalities in life expectancy in the most deprived quintile of Cambridgeshire (monitored quarterly subject to data availability)
  - The indicator statistic is the gap in years of life expectancy between the best-off and worst-off within the local authority, based on a robust statistical model of the life expectancy and deprivation scores across the whole area.
  - The absolute gap in life expectancy at birth for all persons between the 20% most deprived electoral wards in Cambridgeshire and the 80% remainder of areas was 2.6 years for the period 2012-2014.
  - For the years 2013-2015 (provisional data to Q1 of 2015) the absolute gap was 2.5 years.
  - There are significant inequalities nationally and locally in life expectancy at birth by socio-economic group. Certain sub-groups such as people with mental health problems, people who are homeless also have lower life expectancy than the general population. Key interventions to reduce this gap are in tackling lifestyle factors and ensuring early intervention and prevention of key diseases.

- An annual indicator covering healthy life expectancy.
  - Healthy life expectancy for men for the period 2011-2013 in Cambridgeshire was 66.4 years. For females the figure was 65.5 years. The 'actual' figure for men (66.4 years) is higher than for females (65.5 years). No target has been set for this indicator. The local value reported is to be assessed in comparison with the England figure at year end. For the period 2011-2013 in England HLE for men was 63.3 years and for women 63.9 years. The Cambridgeshire figure is higher than that of England in both men and women.
  - Healthy Life Expectancy (HLE) measures what proportion of years of life men and women spend in 'good health' or without 'limiting illness'. This information is obtained from national surveys and is self-reported (General Lifestyle Survey for example). Nationally the figures suggest that men spend 80% of their life in 'good health' with women spending a slightly lower proportion. Women experience a greater proportion of their lives lived at older ages and with a higher prevalence of disabling conditions. So although women live longer, they spend more time with disability. The fact that this information is "self-reported" may influence these figures as well. In many countries with lower life expectancies this difference between male and females is not so apparent.

Calendar years	Average Life Expectancy (95% confidence interval)				Gap (in years)	Relative gap (%)
	20% most deprived wards		80% remainder of wards			
2006-2008	78.8	(78.4 - 79.3)	81.7	(81.5 - 81.9)	-2.9	3.5%
2007-2009	79.2	(78.8 - 79.6)	81.9	(81.7 - 82.1)	-2.7	3.3%
2008-2010	79.4	(79.0 - 79.8)	82.3	(82.1 - 82.5)	-2.9	3.5%
2009-2011	80.0	(79.6 - 80.4)	82.8	(82.6 - 83.0)	-2.8	3.4%
2010-2012	80.5	(80.1 - 80.9)	83.0	(82.8 - 83.2)	-2.5	3.0%
2011-2013	80.6	(80.2 - 81.0)	83.1	(82.9 - 83.3)	-2.5	3.0%
2012-2014	80.6	(80.2 - 81.0)	83.1	(82.9 - 83.3)	-2.6	3.1%
2013-2015 to Q1	80.4	(79.9 - 80.8)	82.9	(82.7 - 83.1)	-2.5	3.1%

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





Child obesity

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

Children aged 4-5 years classified as overweight or obese

The target for Reception children in Fenland is to reduce the proportion of children with excess weight (overweight and obese) by 1% a year, whilst at the same time reducing the proportion for Cambridgeshire by 0.5%. In 2014/15 Fenland did not meet this target (22.1% actual against 21.4% target), but there was a reduction from the previous year (22.4%). There was a noticeable decrease in Cambridgeshire, which meant the target was met (19.4% actual, 20.4% target) but that the gap between Fenland and Cambridgeshire had widened.

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

Area		Actual			2014/15		2015/16	
		2011/12	2012/13	2013/14	Actual	Target	Actual	Target
Fenland	Number	261	249	232	230	-		-
	%	26.7%	24.9%	22.4%	22.1%	21.4%		20.4%
Cambridgeshire	Number	1,394	1,327	1,399	1,317	-		-
	%	22.4%	20.2%	20.9%	19.4%	20.4%		19.9%
Gap		4.3%	4.7%	1.5%	2.7%	1.0%		0.5%

Source: NCMP, HSCIC

Children aged 4-5 years classified as obese

There was a noticeable decrease in the recorded obesity prevalence in Reception children in Cambridgeshire between 2013/14 and 2014/15 (8.0% to 7.3%). The target (described below) to improve recorded child obesity prevalence in Reception children in the 20% most deprived areas in Cambridgeshire was met in 2014/15 (9.6% actual, 10.1% target). The target for the remaining 80% of areas was also met (6.6% actual, 7.1% target).

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

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

Source: NCMP cleaned dataset, HSCIC

Children aged 10-11 years classified as obese

There was a noticeable decrease in the recorded obesity prevalence in Year 6 pupils in Cambridgeshire between 2013/14 and 2014/15 (16.2% to 15.0%). The target to improve recorded child obesity prevalence in Year 6 children in the 20% most deprived areas in Cambridgeshire was off target in 2014/15 (19.6% actual, 19.4% target), but there had been a decrease from the previous year (19.9%). The target for the remaining 80% of areas was met (13.7% actual, 15.0% target).

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

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

Source: NCMP cleaned dataset, HSCIC

Excess weight in adults

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

Physically active and inactive adults

This target needs to be re-calculated as there was an error in the original data released in the PHOF. An incorrect weighting error had been used by Sport England.

Actions
Interventions to address both childhood and adult obesity include prevention and treatment though weight management programmes. Examples for promoting healthy eating include the commissioning of the Food for Life Partnership to work in schools to set policy, provide information and skills about healthy eating and growing healthy food, similar approaches are being used in children's centres and with community groups. The Workplace Health programme is another avenue for promoting health eating workplace policy.
There is a range of physical activity programmes provided in different settings across the county targeting all ages that are provided by CCC and district councils along with the voluntary and community sector.

CCC recently commissioned a new integrated lifestyle service which includes a Health Trainer Service which supports individuals to make healthy lifestyle changes, children and adult weight management service and community based programmes that focus up on engaging groups in healthy lifestyle activities.

Mental health
Proposed indicators:

- **Number of schools attending funded mental health training:**
  Training is provided via Cambridgeshire and Peterborough Foundation Trust and consists of a range of courses covering broad areas of mental health to more specific issues, such as self-harm. http://www.trainingcamh.net/

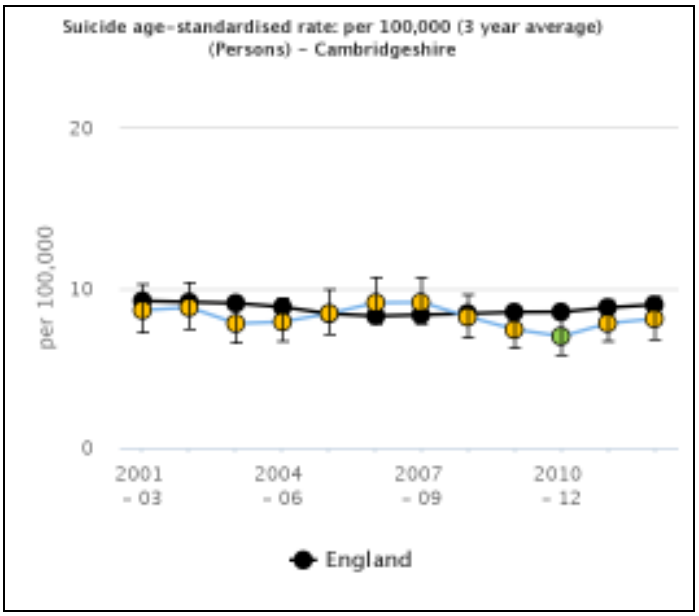
  As of July, 119 schools (out of 256 schools) had engaged with at least one element of the training package (which includes online training, face to face courses and staff briefings). The monitoring of this work is currently being reviewed and more up-to-date data will be available shortly. Anecdotally, the recent additional promotion to schools via new the new prospectus and the Ordinary Magic Conference has seen an increase in enquiries, particularly from primary schools.

- **Number of secondary schools taken up offer of consultancy support around mental and emotional wellbeing of young people** (annual) – *data not yet available as this is newly funded work as part of the public mental health strategy.*

- **Number of front line staff that have taken part in MHFA and MHFA Lite commissioned training** (quarterly):
  Mental Health First Aid and Mental Health First Aid Lite are offered free of charge to front line staff within Cambridgeshire County Council and partner organisations. Up until September 2014:
  MHFA (2 day course) attendance: 157
  MHFA Lite (1/2 day) attendance: 53.

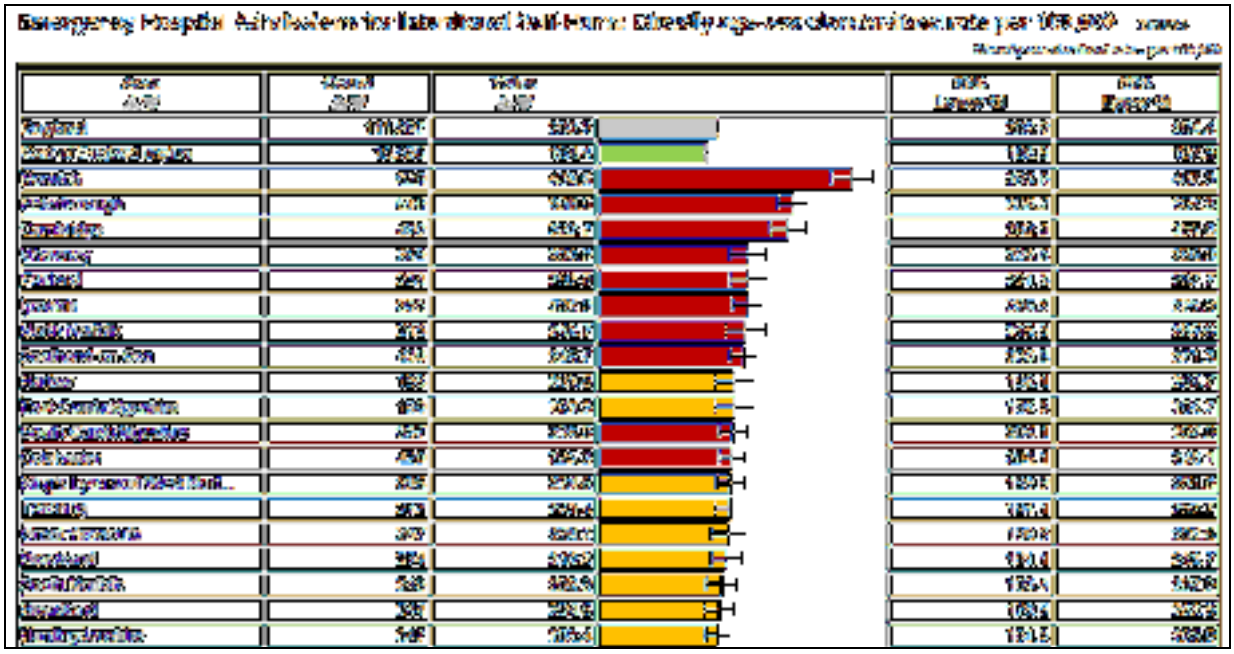
  The contract is for a two year period from October 2014-October 2016. The annual target is to train 255 front line staff in full Mental Health First Aid and 126 staff from other groups in Mental Health First Aid Lite

- **PHOF Indicator: Mortality rate from suicide and injury of undetermined intent** (annual):
  In Cambridgeshire, the rate of suicide and injury of undetermined intent is 8.1 per 100,000 (3 year average, 2012-14), this is not significantly different to the England rate or the East of England rate. The chart below shows the trend in recent years; the rate has remained fairly stable in Cambridgeshire.



Source: Public Health Outcomes Framework

- **Emergency hospital admissions for intentional self-harm** (annual): In 2013/14 the Cambridgeshire rate for emergency hospital admissions for intentional self-harm was 244.1 per 100,000 population. This was significantly higher than the England and East of England rate. Within Cambridgeshire, the following districts have significantly higher rates of emergency hospital admissions than England: Cambridge, Fenland and South Cambridgeshire (see chart below).



Source: Public Health Outcomes Framework

TRANSPORT AND HEALTH

Air pollution – Monitoring indicators

Air pollution PHOF: Fraction of all-cause adult mortality attributable to anthropogenic particulate air pollution

- Mortality attributable to particulate air pollution has remained relatively stable in Cambridgeshire between 2010 and 2013.

Fraction of mortality attributable to particulate air pollution	In JSNA			Update from PHOF (as at 01/12/2015
District	**2010**	**2011**	**2012**	**2013**
Cambridge City	-	5.7%	5.4%	5.6%
East Cambrigeshire	-	5.1%	5.1%	5.5%
Fenland	-	5.2%	5.2%	5.7%
Huntingdonshire	-	5.4%	5.3%	5.5%
South Cambridgeshire	-	5.4%	5.3%	5.5%
Cambridgeshire	5.5%	5.4%	5.2%	5.5%
England	5.6%	5.4%	5.1%	5.3%

Data taken from PHOF, Fingertips, PHE

Air pollution – Action plan indicators

Communication of public health impact of air pollution to organisational partners including LA and CCG.

- Air pollution section of JSNA communicated to:
  - Health and Wellbeing Board
  - Cambridgeshire County Council SMT
  - East Cambridgeshire District Council Joint Planning and Transport Steering group
  - Cambridgeshire and Peterborough CCG Clinical and Management Executive Team; highlighting health impact of air pollution, hot spots near Addenbrooke's and impact of indoor air quality

Public Health impacts of air pollution are incorporated within each Local Transport Strategy through strengthened collaboration between the Economy, Transport and the Environment Department and the Public Health Department

- Public Health has provided input into Transport Strategy for East Cambridgeshire (TSEC). Involving meetings with colleagues in ETE and presentations to East Cambridgeshire District Council Joint Planning and Transport Steering group, reviewing draft TSEC and involvement in planning consultation
- Public Health has provided support to the Stagecoach Low Emission Bus bid through a letter of support and data on the health impacts of air pollution

Active Travel – Monitoring Indicators

1% reduction per year in pupils travelling to school by car

To be added

PHOF physical inactivity indicator: Proportion physically inactive adults (less than 30 minute moderate activity a week, in bouts of 10 minutes or more). Annual – based on Active People Survey. Awaiting revised data see above

Proportion of residents who cycle for utility purposes by District. Annual – based on Active People Survey

- Numbers should be treated with caution as sample size is small for each district and there is only two years of data presented
- Regular utility cycling (3 or 5 times per week) for utility purposes has generally increased across all Cambridgeshire districts
- Rates of utility cycling in districts other than Cambridge City are better than the national rate, but still low

District	Sample size	Cycle at least							
		1 x per month		1 x per week		3 x per week		5 x per week	
		2012/13	2013/14	2012/13	2013/14	2012/13	2013/14	2012/13	2013/14
Cambridge	498	52.6	51.7	36.8	44.2	24.5	31.6	10.9	24.1
East Cambridgeshire	492	7.6	7.8	3.4	6.0	0.9	2.7	0.2	1.9
Fenland	498	12.0	11.4	6.9	6.2	3.9	4.4	2.1	3.8
Huntingdonshire	500	9.7	6.5	7.0	5.3	3.0	3.7	1.2	2.2
South Cambridgeshire	501	15.6	17.6	9.1	13.4	5.4	6.8	2.1	4.7
Cambridgeshire	2,489	20.1	19.4	15.5	15.5	10.2	10.2	5.8	7.6
England	163,750	6.5	6.5	4.5	4.5	2.6	2.6	1.5	1.6

Proportion of residents who walk for utility purposes by District. : Annual - based on APS

- Numbers should be treated with caution as sample size is small for each district and there is only two years of data presented.
- Regular utility walking (3 or 5 times per week) for utility purposes has generally increased across all Cambridgeshire districts
- Rates of utility walking in districts other than Cambridge City are lower than the national rates

District	Sample size	Walk at least							
		1 x per month		1 x per week		3 x per week		5 x per week	
		2012/13	2013/14	2012/13	2013/14	2012/13	2013/14	2012/13	2013/14
Cambridge	483	75.4	75.2	62.7	68.7	39.7	48.6	27.9	35.5
East Cambridgeshire	477	49.1	50.8	37.8	42.9	25.0	29.5	17.0	22.0
Fenland	482	51.6	47.4	43.2	37.7	26.1	22.5	17.6	17.6
Huntingdonshire	481	55.0	50.8	43.4	43.4	28.2	26.7	17.6	18.9
South Cambridgeshire	485	57.2	59.3	48.7	49.5	28.1	32.0	18.5	20.0
Cambridgeshire	2,408	58.4	57.5	47.8	49.2	29.8	32.2	19.8	22.9
England	159,058	57.2	58.7	47.4	50.1	30.2	33.0	20.2	22.3

Active Travel - Action plan indicators

The Local Transport Strategies are designed to improve PH outcomes through strengthened collaboration with ETE and input into the local strategies to improve active travel opportunities in Fenland, East Cambridgeshire and Huntingdonshire

- Public Health has provided input into Transport Strategy for East Cambridgeshire (TSEC). Involving meetings with colleagues in ETE and presentations to East Cambridgeshire District Council Joint Planning and Transport Steering group, reviewing draft TSEC and involvement in planning consultation

Maximise opportunities for active travel in each of the Districts

- Active Travel is an element of the Public Health Reference Group's Implementation Planning and projects are being taken forward with District Councils as part of a wider Workplace programme. It will also be addressed in the developing Obesity Strategy (Physical Activity and Healthy Diet)

- Provision of Fenland data and maps regarding areas of low active travel to Belinda Pedler, Fenland District Council

Engage with local communities to develop local solutions to active travel
- Engaged with Transport for Work Partnership

Access to transport – Monitoring indicators
Proportion of Wards with average travel time to hospital< 1 hour on public transport, by District. Annual - based on DfT accessibility data.

- No new data since Transport and Health JSNA (33 out of 123 wards, 26.8%, 2013)

Proportion of LSOAs with average travel time to GP< 20 minutes on public transport, by District. Annual - based on DfT accessibility data.

- No new data since Transport and Health JSNA (6 out of 123 wards, 4.9%, 2013)

Access to transport - Action plan indicators
Engage with local authority and CCG teams around patient transport

- Attendance at Cambridgeshire Future Transport Meetings
- Presentation to Cambridgeshire and Peterborough CCG Clinical and Management Executive Team
- Involvement with Total Transport Initiative
- Engagement and agreement with CCG around Non-Emergency Patient Transport (NePTS) to ensure that JSNA findings and Total Transport pilot impact procurement process
    - Meetings with CCG commissioners for NePTS
    - Total Transport pilot and opportunities highlighted to potential providers at NePTS Market Event (November 2015)
    - Agreement that Total Transport Pilot results and evaluations will be reviewed and incorporated into NePTS/Patient Transport as appropriate

Communication of Transport and Health access data and "flags" with Districts and Economy, Transport and Environment Department and incorporation into relevant strategies

- Presentation to Cambridgeshire and Peterborough CCG Clinical and Management Executive Team
- Presentation to East Cambridgeshire District Council Joint Planning and Transport Steering group
- Data provided to Fenland District Council for evaluation by Transport Access Group

4.4 Health Scrutiny Indicators

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

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

The Health Committee received an update from CPCCG on 28 May 2015 on the position regarding Delayed Transfers of Care (DTOC) in Cambridgeshire and Peterborough and requested regular updates on the current status of Delayed Transfer of Care.

The reasons for DTOC are multi-factorial and need to be addressed by the whole system. Whilst it is not unusual to have delayed transfers of care, the numbers of DTOC across the CCG are higher than the system can manage. A concerted effort continues to be made by all providers in partnership with Commissioning and Local Authority leads to reduce the impact of DTOC.

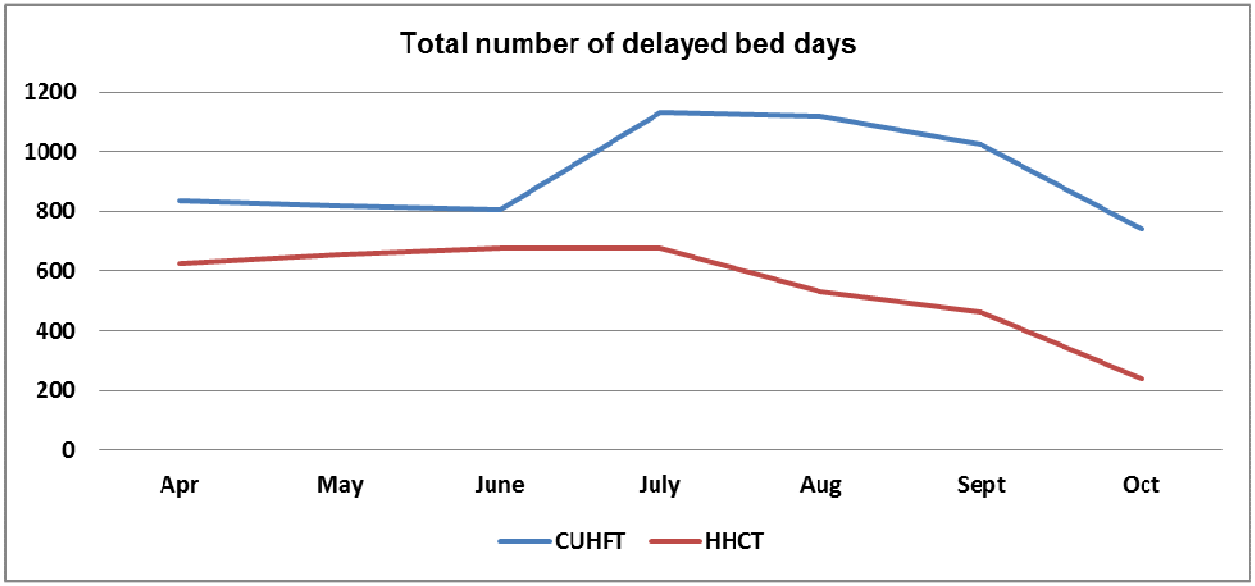
For the Health Committee meeting scheduled 5th November updates were provided using monthly data from NHS England. It was noted that the data provided on 5th November was retrieved from the monthly situation report which collects data on the number of patients delayed on the last Thursday of each month and the total delayed days during the month for all patients delayed throughout the month.

However Cambridgeshire & Peterborough Clinical Commissioning Group (CCG) CG are able to provide reports on DToC bed days, which gives a more robust picture of what's going on. NHS England's data using patient count is just a snapshot on the last Thursday of each month, whereas delayed bed days are counted for the whole month

Please note the new CCG reporting data will be used for future updates.

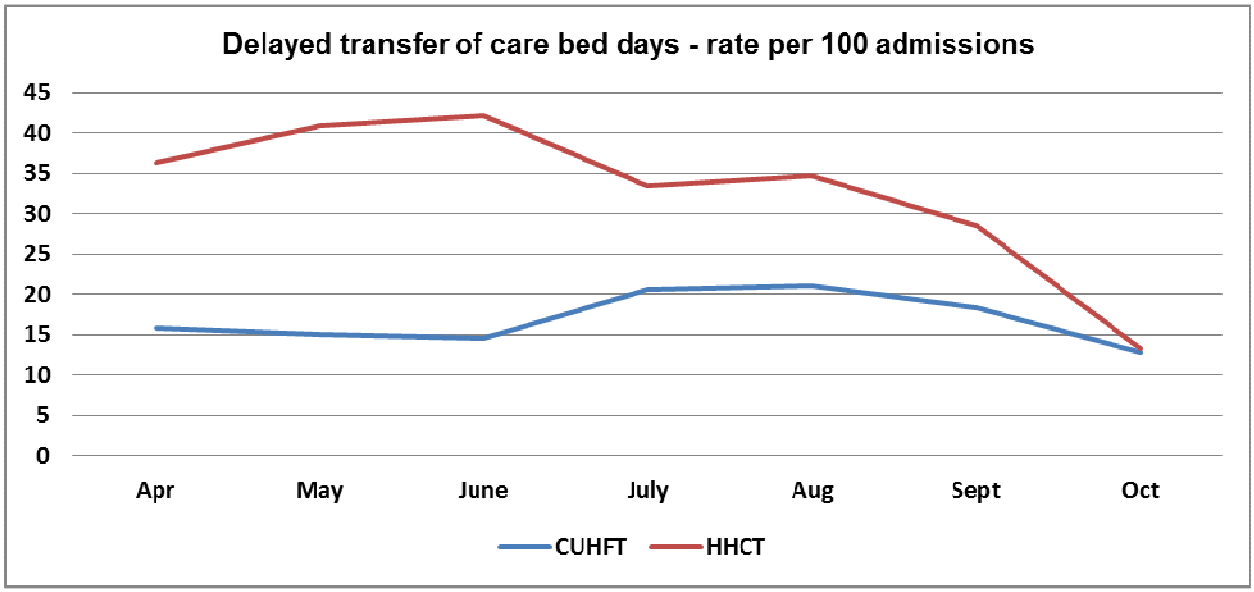
Total Number of delayed bed days:

Name	Apr 15	May	June	July	Aug	Sept	Oct
CUHFT	836	819	804	1132	1121	1023	741
HHCT	625	656	678	586	531	462	241
TOTAL	**1461**	**1475**	**1482**	**1718**	**1652**	**1485**	**982**



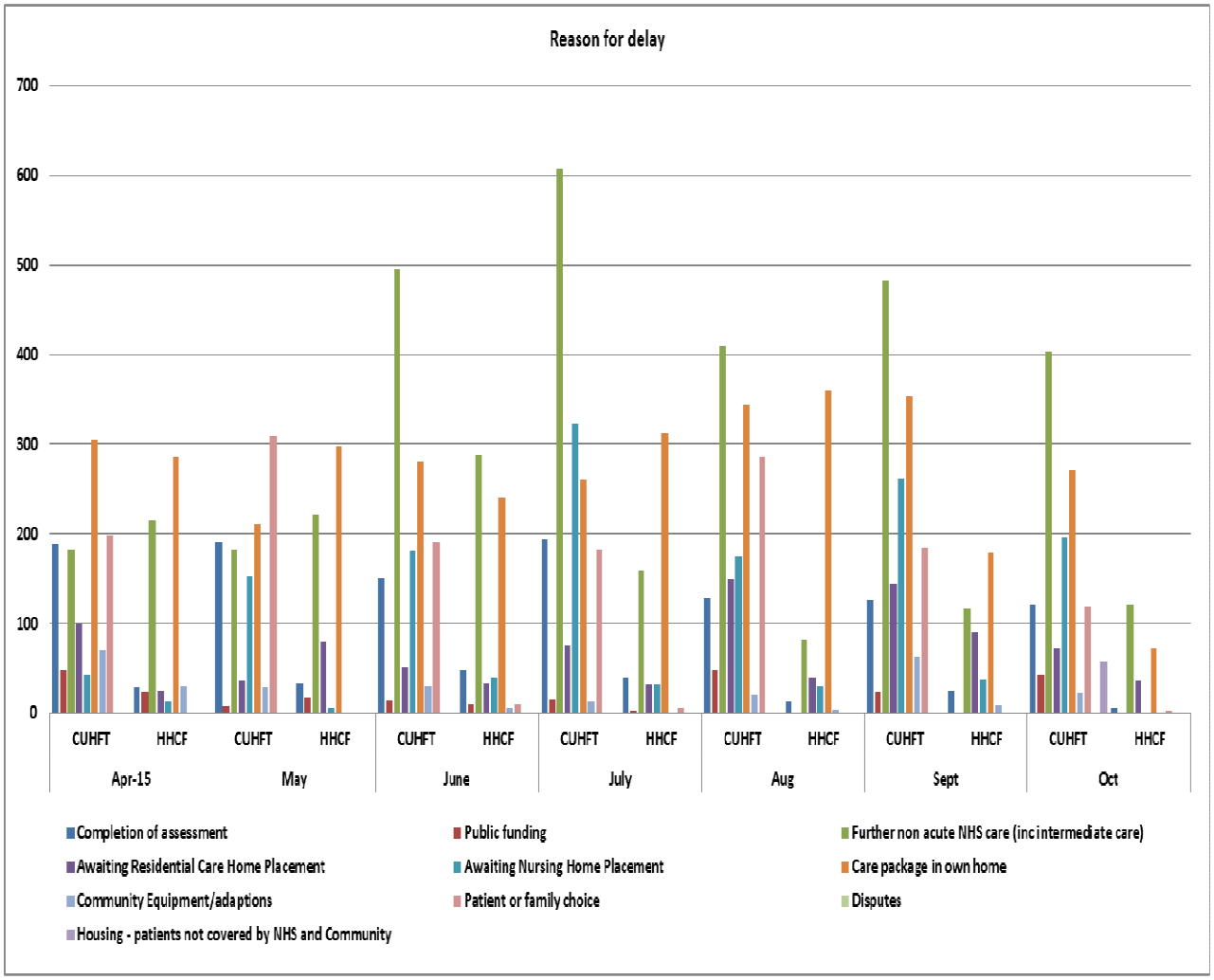
Delayed transfer of care bed days – rate per 100 admissions:

Name	Apr 15	May	June	July	Aug	Sept	Oct
CUHFT	15.8	15.0	14.5	20.5	21.0	18.3	12.8
HHCT	36.3	40.9	42.1	33.5	34.7	28.5	13.3
TOTAL	**52.1**	**55.9**	**56.6**	**54.0**	**55.7**	**46.8**	**26.1**



Total number of delayed bed days by reason:

Reason for delay	Apr-15		May		June		July		Aug		Sept		Oct	
	CUHFT	HHCF	CUHFT	HHCF	CUHFT	HHCF	CUHFT	HHCF	CUHFT	HHCF	CUHFT	HHCF	CUHFT	HHCF
Completion of assessment	189	30	191	34	151	49	194	41	128	13	127	25	122	7
Public funding	48	24	8	17	15	11	16	3	48	0	24	0	43	0
Further non acute NHS care (inc intermediate care)	182	215	182	222	494	288	607	159	410	83	483	118	403	122
Awaiting Residential Care Home Placement	100	26	37	80	51	33	75	32	150	40	144	91	73	36
Awaiting Nursing Home Placement	43	13	153	6	181	40	323	32	175	31	262	38	196	0
Care package in own home	305	286	211	297	281	240	261	312	345	360	354	180	272	73
Community Equipment/adaptions	70	31	29	0	31	6	13	1	22	4	63	10	23	0
Patient or family choice	199	0	309	0	190	11	182	6	287	0	185	0	119	3
Disputes	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Housing - patients not covered by NHS and Community	0	0	0	0	0	0	0	0	0	0	0	0	58	0
Total	1136	625	1120	656	1394	678	1671	586	1565	531	1642	462	1309	241
Grand total	**1761**		**1776**		**2072**		**2257**		**2096**		**2104**		**1550**	
Patients delayed	45	17	58	22	45	21	53	19	74	16	40	8	49	5
TOTAL	**62**		**80**		**66**		**72**		**90**		**48**		**54**	



- **E-Hospital Programme**

  As part of their E-Hospital Programme, Cambridge University Hospitals NHS Foundation Trust (CUHFT) implemented a new clinical information system EPIC on 26th October 2014. The Health Committee considered an item on the E-Hospital system on 28th May 2015 following reports of substantial problems in the system. Members requested regular updates on the E-Hospital performance

  Cambridge University Hospital Foundation Trust (CUHFT) have provided the committee with a copy of the e-hospital progress report (November 2015). See appendix 7.

  The Executive summary notes the following key issues.

  - There remain significant challenges to resolve, in particular relating to high cost drugs, which impact the return to Payment by Results (PbR).
  - The Inpatient and Outpatient Designs Authorities continue to prioritise workload and deliver improvements in Epic based on key operational stakeholder input. The Speciality reviews are ongoing, and the training team are expanding the courses on offer to staff. The PAS and Information Management teams focus on key build and resolving data quality and set issues.
  - Significant progress has been made in response to the CQC Inspection Report recommendations.

- The e-Hospital Benefits Realisation plan has been reviewed by the Recovery Team, restructuring such that it has been taken on by Operations linked to the recovery programme.

The full report is provided as Appendix 7. The committee is reminded that a CUHFT will be providing further e-hospital updates at a workshop scheduled for Feb/ March 2016. Monthly updates are also being provided directly to the Health Committee, as part of a wider update on key priorities following the CQC inspection of CUHFT.

- **CAMH Waiting Lists**

The Health Committee received a report on the service pressures in Children & Adult Mental Health Services on 16th July 2015. The CCG & CPFT were present at the committee to discuss the service pressures in particular relating to the Child and Adolescent Mental Health Services (CAMH).

Following receipt of a report to the Children's Health Joint Commissioning Board (CHJCB) due 7th September, the committee requested updates on the progress around rectifying the waiting list. An up to date position on the CAM waiting lists will be provided by representatives from CCG and CPFT as part of a formal Health Scrutiny report scheduled for discussion on 21st January 2016.

APPENDIX 1 – Public Health Directorate Budgetary Control Report

Forecast Variance Outturn (Oct) £'000		Service	Current Budget for 2015/16 £'000	Expected to end of Nov £'000	Actual to end of Nov £'000	Current Variance £'000	Current Variance %	Forecast Variance Outturn (Nov) £'000	Forecast Variance Outturn (Nov) %
		Health Improvement							
-170	**1**	Sexual Health STI testing & treatment	4,299	2,825	2,021	-805	-28.48%	-170	-3.96%
-100	**2**	Sexual Health Contraception	1,170	725	325	-400	-55.15%	-100	-8.55%
0		National Child Measurement Programme	0	0	19	19	0.00%	0	0.00%
-30		Sexual Health Services Advice Prevention and Promotion	223	166	107	-60	-35.91%	-30	-13.43%
0		Obesity Adults	0	0	47	47	0.00%	0	0.00%
0		Obesity Children	82	55	72	17	31.88%	0	0.00%
-15		Physical Activity Adults	100	100	63	-36	-36.37%	-15	-15.07%
-40		Healthy Lifestyles	1,464	923	649	-274	-29.65%	-40	-2.73%
0		Physical Activity Children	0	0	0	0	0.00%	0	0.00%
-295	**3**	Stop Smoking Service & Intervention	1,099	590	15	-575	-97.42%	-295	-26.85%
-40		Wider Tobacco Control	123	101	0	-101	-100.00%	-40	-32.50%
-5		General Prevention Activities	386	309	119	-190	-61.58%	-5	-1.29%
-50		Falls Prevention	100	67	0	-67	-100.00%	-50	-50.00%
0		Dental Health	2	0	0	0	0.00%	0	0.00%
-745		**Health Improvement Total**	**9,048**	**5,860**	**3,437**	**-2,423**	**-41.35%**	**-745**	**-8.24%**
		Children Health							
-		Children 0-5 PH Programme	3,861	1,250	1,250	0	0.02%	0	0.00%
		Children 5-19 PH Programme	1,745	1,179	967	-212	-17.99%	0	0.00%
-		**Children Health Total**	**5,606**	**2,429**	**2,217**	**-212**	**-8.72%**	**0**	**0.00%**
		Adult Health & Wellbeing							
0		NHS Health Checks Programme	719	422	222	-200	-47.43%	0	0.00%
-20		Public Mental Health	224	168	43	-125	-74.23%	-20	-8.94%
0		Comm Safety, Violence Prevention	37	37	0	-37	-100.00%	0	0.00%
-20		**Adult Health & Wellbeing Total**	**979**	**627**	**265**	**-362**	**-57.69%**	**-20**	**-2.04%**
		Intelligence Team							
-		Public Health Advice	16	9	6	-3	-38.24%	0	0.00%
-		Info & Intelligence Misc	10	6	-1	-7	-122.27%	0	0.00%
-		**Intelligence Team Total**	**26**	**15**	**4**	**-11**	**-71.86%**	**0**	**0.00%**
		Health Protection							
0		LA Role in Health Protection	11	7	15	8	110.32%	0	0.00%
-5		Health Protection Emergency Planning	5	3	0	-3	-93.87%	-5	-100.00%
-5		**Health Protection Total**	**16**	**11**	**15**	**5**	**44.48%**	**-5**	**-32.26%**

	Programme Team							
0	Obesity Adults	0	0	-0	-0	0.00%	0	0.00%
0	Stop Smoking no pay staff costs	31	21	18	-3	-12.83%	0	0.00%
-10	General Prev, Traveller, Lifestyle	121	81	47	-34	-41.66%	-10	-8.24%
-10	**Programme Team Total**	**153**	**102**	**65**	**-37**	**-36.22%**	**-10**	**-6.55%**

Forecast Variance Outturn (Oct) £'000		Service	Current Budget for 2015/16 £'000	Expected to end of Nov £'000	Actual to end of Nov £'000	Current Variance £'000	Current Variance %	Forecast Variance Outturn (Nov) £'000	Forecast Variance Outturn (Nov) %
		Public Health Directorate							
		Health Improvement	448	300	240	60	19.91%		0.00%
		Public Health Advice	750	502	490	12	2.39%		0.00%
		Health Protection	150	101	99	2	1.98%		0.00%
-150	**4**	Programme Team	1,080	722	696	26	3.60%	-150	0.00%
		Childrens Health	23	15	16	-1	-4.35%		0.00%
		Comm Safety, Violence Prevention	52	35	34	1	1.92%		0.00%
		Public Mental Health	64	44	33	11	24.43%		0.00%
-150		**Public Health Directorate total**	**2,567**	**1,719**	**1,608**	**-209**	**-12.15%**	**-150**	**-5.84%**
-930		**Total Expenditure before Carry forward**	**18,395**	**10,762**	**7,611**	**-3,249**	**-30.19%**	**-930**	**-5.06%**
-610		**Anticipated Carry forward of Public Health grant**	**0**	**0**	**0**	**0**	**0.00%**	**-610**	**0.00%**
		Funded By							
1,610		Public Health Grant	**-18,209**	**-12,692**	**-12,692**	0	0.00%	**1,610**	-8.84%
		S75 Agreement NHSE - HIV	**-144**	**0**		0	0.00%		0.00%
-70		Other Income	**-42**	**-21**	**-70**	49	-233.33%	**-70**	166.67%
1,540		**Income Total**	**-18,395**	**-12,713**	**-12,762**	**49**	**-0.39%**	**1,540**	**-8.37%**
0		**Net Total**	**0**	**-1,951**	**-5,151**	**-3,200**	**-**	**610**	**0.00%**

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 2015/16 £'000	Current Variance		Forecast Variance - Outturn	
		£'000	%	£'000	%
1 Sexual Health STI testing & treatment	**4,299**	**-172**	**-9.2%**	**-170**	**-3.96%**
NHS England re HIV (£72k) and QEH (£10k) relating to 2014/15 still not paid, and some 2015/16 invoices from out of area providers may not yet have been received. Part of 2015/16 savings plan. £170k savings to be achieved through predicted underspend through reduced use of the Peterborough Service, reduction in the contingency for unpredicted pressures and lower than expected uptake of the Chlamydia programme.					
2 Sexual Health Contraception	**1,170**	**-29**	**-8.33%**	**-100**	**-8.55%**
Part of 2015/16 savings plan. £100k non-recurrent in-year savings to be achieved due to reduced activity in delivering Long acting reversible contraception (LARCs) in GP practices.					
3 Stop Smoking Service & Intervention	**1,099**	**-212**	**-93.7%**	**-295**	**-26.85%**
There is a variance due to the timing of payments reference reserved creditors from 2014/15, in particular prescribing costs and miscellaneous Interventions. Part of 2015/16 savings plan. £295k savings to be achieved due to reduced activity from smoking cessation services.					
4 Public Health Directorate	**2567**	**-144**	**-9.53%**	**-150**	**-5.84%**
Part of 2015/16 savings plan. £150k savings to be achieved through vacancy management strategy.					

APPENDIX 3 – Grant Income Analysis
The tables below outline the allocation of the full Public Health grant, and includes an update for Quarter 1of spend by other directorates
Awarding Body : DofH

Grant	Business Plan £'000	Adjusted Amount £'000	Forecast Outturn Expenditure £'000	Expected / Actual Transfer to PH Reserves	Notes
Public Health Grant as per Business Plan	22,155	22,155	22,155		Ringfenced grant (excluding 0 – 5 funding) - Income
Children's 0 – 5 grant (Oct – March)	3,861	3,861			In Public Health directorate
Grant allocated as follows;					
Public Health Directorate	**14,319**	**14,348**			As detailed in report. £29k increase ref the transfer of a post from CS&T
Public Health Directorate, Children 0-5	**3,861**	**3,861**			
CFA Directorate	**6,933**	**6,933**			See following tables for Q2 update
ETE Directorate	**418**	**418**			See following tables for Q2 update
CS&T Directorate	**265**	**236**			£29k decrease ref the transfer of a post from CS&T to PH. See following tables for Q2 updates
LGSS Cambridge Office	**220**	**220**			

Directorate	Service	Total	Contact	Cost Centre/ Finance Contact	Q2 Info requested	Q2 Update	Q2 expected spend	Q2 Actual Spend	Variance	Predicted spend Y/E	YTD Expected spend	YTD Actual spend	Variance YTD
CFA	DAAT	£6,269k	Susie Talbot	NB31001-NB31010 Jo D'Arcy/Ali Wilson	19/10/2015	At the end of Q2 there had not been any current spend for the allocated budget for GP Shared Care, Nalmefene, Recovery Hub Coordinator and BBV as this is work in progress. We were also awaiting Q2 invoices for CASUS YP Contract which we received early October along with Q3 so this will now show Q1, 2 & 3 at the end of Q3. We are also awaiting Q1 20% performance element of both Inclusion Drug & Alcohol contracts and these will be agreed once the performance meeting has taken place and agreed at the DACG. The predicted Q2 spend is based solely on a half of the overall allocated budget so the predicted and actual spend will vary during the year depending on when invoices are received but we anticipate that all contracted payments will be made by then end of Q4. 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 by the DACG members for payment. At the end of Q2 a prediction was made that there will be a possibility of an underspend in the PHG of around £70K. This is estimated from vacant posts which have not been filled and also from the Nalmefene & GP Shared care budget which to date has no current spend.	£ 3,134,500	£ 2,460,260	£ 674,240	£ 6,199,000	**£4,701,750**	**£3,883,438**	**£818,312**
CFA	**Reduction in Self Harm**	£189K			16/10/2015	**Training provision and support :** Workshop has been held with CCC and CPFT reps to identify what is being offered to schools and to ensure there is consistency and clarity in CCC offer **CPFT engagement data :** Data collated into a single spreadsheet and analysis undertaken **Training via Senco :** Ongoing, continues to be promoted, and once offer has been put into diagramatic form will be publicised further. Newsletter contributions ongoing (monthly) **Implementing additional support :** this work is now being implemented **School newsletters :** regular contributions have included case studies provided by CPFT and a regular item being added on the CPFT training. The 'Ordinary Magin' mental health conferences for schools was also promoted in September **Quality Assurance framwork :** it has since been discovered that there is a similar piece of work being undertaken in the council. We will be working to see if there is a need for this work or if it is covered elsewhere	£47,250	£45,249	£2,001	£189,000	**£94,500**	**£90,496**	**£4,004**

Directorate	Service	Total	Contact	Cost Centre/ Finance Contact	Q2 Info requested	Q2 Update	Q2 expected spend	Q2 Actual Spend	Variance	Predicted spend Y/E	YTD Expected spend	YTD Actual spend	Variance YTD
CFA	**Physical Activity in Older People**	£150k			16/10/2015	Workshop held in August, with 14 attendees. Discussion highlighted current levels of PA in day centres may be low. To follow this up and understand current provision in detail, a questionnaire to gather baseline data was developed, and meetings have been held with managers to gain insight on delivery, opportunities and challenges to inform project roll out. By the end of September information from 8 day centres had been collated.							
CFA	**Childrens Centres**	£170k	Sarah Ferguson/Jo Sollars	CE10001 : Rob Stephens	19/10/2015	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 In Q2 Children's Centres have continued to promote Public Health summer exercise programmes and the summer water safety campaign, and representatives are working with Public Health to develop a cross-service breast feeding strategy for Cambridgeshire. Children's Centres have also been involved in the planning, preparation work and as a delivery outlet for the winter 2015 Warm Homes programme 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 has been initiated to ensure arrangements with Health partners are consistent and functionally effective at a community level for families as service structural change is brought in across the system	£42,500	£42,500	£0	£170,000	£85,000	£85,000	£0
CFA	**Education Well-Being Team : KickAsh, Life Education (LEC) and other tbc**	£56k	Amanda Askham	CB40401 : Adam Cook	19/10/2015	Kick Ash £25,000 confirmed spend (two additional schools) - on track. Life Education £15,000 confirmed spend - on track Training days for school nurses £2,500 - currently being negotiated Research and development of resources on Health Relationships £1,500 - on track HBT/SRE resources and training £3,000 - on track SRE Theme-set for secondary schools £9,100 - on track	£28,050	£25,550	£2,500	£56,100	**£35,050**	**Q1 actual awaited**	

Directorate	Service	Total	Contact	Cost Centre/ Finance Contact	Q2 Info requested	Q2 Update	Q2 expected spend	Q2 Actual Spend	Variance	Predicted spend Y/E	YTD Expected spend	YTD Actual spend	Variance YTD
CFA	**Chronically Excluded Adults (MEAM)**	£93k	Ivan Molyneux	MN92145 : Matt Moore	19/10/2015	The CEA Team continues to work hard to continue to ensure that the co-ordinated approach is supported by relevant services The service expansion into Peterborough has been successful with the service embedding the CEA approach to address the issues facing their complex needs population. The CEA team continue to work with colleagues in Peterborugh on what promises to be an exciting partnership We are currently working to put together a three year strategy so as to be able to take forward the CEA work across Cambridgeshire and its expansion into Peterborough Training has been provided to staff from Colchester, Norwich and Lowestoft Work with faith based services will be developed in the coming year, which will include presenting the CEA work and advising how services can be involved Service users and staff have met with a local MP to highlight the CEA work in Cambridgeshire Work continues with voices from the frontline in partnership with MEAM	£28,052	£28,997.54	-£945.54	£110,000	**£56,102**	**£54,034**	**£2,068**
CFA	**Housing related support**	£6k	Alison Bourne		19/10/2015	**Huntingdonshire Floating Support Services:** Continuing to provide support to avoid homelessness, and continues to meet targets set **East Cambs Floating Support Service:** From Apr-June 2015 this service supported 58 households and individuals to prevent homelessness, and continues to meet targets set **Ferry Project:** Contract provides for support to single homeless people in Fenland. Contract 1 saw 42 clients supported in Q1. Contract 2 saw 19 clients supported in Q1. Q2 data not yet available **Cambridge Cyrenians:** Saw 22 referrals in to service in Q1. 20 individuals moving into longer term accommodation. Q2 information not yet available. **Jimmy's:** Continues to support homelessness with 22 beds. 100 guests to date. **Metropolitan Cambridge Mental Health Cluster - Supported Housing/Visiting Support:** Continues to provide 148 supported accommodation units	Total budget is £3,833,156.75, the Public Health element equates to 0.16% of the total, and as such it is impossible to split this out			£6,000	**£3,000**	**£3,000**	**£0**

Directorate	Service	Total	Contact	Cost Centre/ Finance Contact	Q2 Info requested	Q2 Update	Q2 expected spend	Q2 Actual Spend	Variance	Predicted spend Y/E	YTD Expected spend	YTD Actual spend
ETE	Reducing Road Traffic Injuries	170k			16/10/2015	**Child Road Safety** **Childrens Traffic Club :** 1567 registrations to end September 2015 **Advice & information to schools :** Work limited as includes 6 weeks holidays. In the new school term (September), we have responded to requests for advice/support from the following schools/school communities about specific issues: Barton, Ely St Mary's, Fen Ditton, Long Road 6th Form, St Paul's Spring Meadow Infants and Waterbeach **Intensive work with 15-20 schools for age appropriate interventions :** 8 schools signed up to Junior Travel Ambassador Scheme Walk Smart delivered to 67 pupils (2 schools) Scoot Smart delivered to 155 pupils (3 schools) **Young Drivers/Riders and their passengers** **Drive to arrive :** at college of West Anglia (two days) Princes Trust even in Wisbech **Work with locality teams :** delayed to Q3 - booked to start 11 November in Chatteris. **Explore additional interventions :** Data and intelligence group producing profile for targetting young drivers Research being undertaken to review Norfolk's provision for Young Drivers will be utilised to inform our own provision Review of provision across Eastern Region currently underway will also inform our future provision **Vulnerable Road Users** Explore better interventions for motor cyclists : campaign ran during August. **Road User Behaviour Change Campaigns** **Anit-Drink/Drug Driving Campaigns :** Planning for national drink driving campaign in November/ December 2015 and drug driving campaign in February 16 **Distraction (mobile phone) campaigns :** campaign ran in July **Speed (rural roads) :** no additional work **Seatbelt wearing** : Campaign ran in September **Explore partnerships:** Larger scale research project with University proposed via Cambridgeshire and Peterborough Road Safety Partnership, but unlikely to be started this financial year. Interim project assessing current programme against Behaviour Change techniques to be undertaken internally	£60,000	£39,152	£20,848	£140,000	**£83,500**	**£62,692**

Directorate	Service	Total	Contact	Cost Centre/ Finance Contact	Q2 Info requested	Q2 Update	Q2 expected spend	Q2 Actual Spend	Variance	Predicted spend Y/E	YTD Expected spend	YTD Actual spend	Variance YTD
ETE	Active Travel	£125			16/10/2015	**Overcoming Safety Barriers** **Interventions:** 23 Awards for academic year 2014/15 including 1 school achieving Silver and Gold and going on to be awarded School of the Region for the East of Egland and the award for Cycling initiatives Currently 48 schools actively using STARS **Explore better interventions:** Report compiled for steering group with recommendations. Fresher's Fair activity with Skanska and supply chain raising awareness of cycle/large vehicle conflicts and providing new students with advice and information **Pedestrian safety :** CPRSP data and delivery groups exploring areas with higher pedestrian casualties **Market Town Strategies:** Ensure that PH are fully involved in the consultationa nd development of TSEC Ensure that the evidence from the Transport and Health JSNA is used in the development of TSEC	£41,550	£35,440	£6,110	£125,000	**£51,600**	**£35,440**	**£16,160**
ETE	Community Engagement in Fenland	£100			16/10/2015	Procurement complete and contract awarded. Engagement of communities and organisations in Fenland to identify an approach. Formation of a reference group to monitor the work of the healthy Fenland fund. Chatteris confirmed as a priority area. Measures to be put in service spec. Help to develope a wider implementation plan to take forward work in the New Year.							

Directorate	Service	Total	Contact	Cost Centre/ Finance Contact	Q2 Info requested	Q2 Update	Q2 expected spend	Q2 Actual Spend	Variance	Predicted spend Y/E	YTD Expected spend	YTD Actual spend	Variance YTD
ETE	**Kick Ash**	£31k	Elaine Matthews or Aileen Andrews	JM12800 : John Steel	19/10/2015	10 schools are involved in this school year with the project and 2 further schools are involved with an eduction day only, St Bedes and St Ivo Swavesey Village college: Completed 3 sessions with 36 mentors to discuss the role of Trading Standards and its purpose within KickAsh and how they can support local businesses in the campaign to prevent underage smoking and sales. Worked with them to prepare their own preventative messages and design their own delivery approach to businesses. Discussing the new laws around the E-Cigarettes, Nicotine inhaling products, smoking in cars with children present and plain packaging. Ways in which we can use an awareness display in school for peers to also benefit from increased knowledge into the effects and dangers of smoking. S Peters School: Completed 3 sessions with 16 mentors again to discuss the purpose of KickAsh and how they can support local businesses in the campaign to prevent underage smoking Bottisham Village College: Completed 2 sessions with 20 mentors, when we discussed the many aspects of SBC in delivery effective business advice education for the prevention of underage sales Currently anticipating that 8 out of the 10 schools will have a programme of business visits and up to 3 schools will have 5 half termly lunchtime visits to discuss actions for the various activities throughout the year Other activity by SBC officers which supports the Kick Ash programme includes: Advice to businesses, developing business practices to prevent underage tobacco sales Counterfeit and illicit tobacco communications work, reducing availability of illicit tobacco to all age groups in the County Safety Zones includes age related tobacco sales and preventative messaging. Consumer Challenge with 6 special schools in Cambridgeshire includes age related tobacco sales and preventative messaging Other activity by SBC officers which supports the KickAsh programme includes: C25 advice to businesses, developing business practices to prevent underage tobacco sales Counterfeit and illicit tobacco work, reducing availability of illicit tobacco to all age groups in the County 35 x Safety Zones includes age related tobacco sales and preventative messaging to Year 5 children Consumer Challenge to 6 special schools includes age related tobacco sales and preventative messaging	£3,750 based on 0.25 of anticipated spend of £15k pa	£1,721.65 (Q2 covers school summer holiday period	£2,028.35	£15,000	**£7,500**	**£5,051.65**	**£2,448.35**

Directorate	Service	Total	Contact	Cost Centre/ Finance Contact	Q2 Info requested	Q2 Update	Q2 expected spend	Q2 Actual Spend	Variance	Predicted spend Y/E	YTD Expected spend	YTD Actual spend	Variance YTD
ETE	**Alcohol Underage Sales**	£15k	Elaine Matthews or Aileen Andrews	JM12800 : John Steel	19/10/2015	Review of all new licence applications Challenge 25' underage sales business advice and guidance issued to 15 new alcohol licenced businesses Preparation of Licencing Act representation paperwork as applicant Advice to new police licencing officer for Cambridge Safety Zone activity includes underage sales information Worked with Police on Railway Public House (Whittlesey) licence review. Police evidence included alleged underage sales as well as ASB. Licence revoked.	£3,750 (estimated on 0.25 of allocation)	£2,000	£1,750	£10,000	**£7,500**	**£5,989**	**£1,511**
ETE	**Illicit Tobacco - joint working**	£7k	Elaine Matthews or Aileen Andrews	JM12800 : John Steel	19/10/2015	• 3 test purchases of illicit tobacco were made. 2 from shops previously sold and visited and the third from a new premises whose owner has previously had illicit tobacco seized from premises outside the county. • Post seizure work to secure successful enforcement continuing. PACE interview preparation and interviewing of suspects. • Training session on illicit tobacco delivered to Fenland District Council staff and South Cambs District Council staff. • Preparation of Licencing Act representation paperwork as applicant has links to illicit tobacco. · Tobacco display ban visits as part of national project.	£1,750 (based on estimated 0.25 of total allocation	£3,898	-£2,148	Exceeding allocated £7k	**£3,500**	**£8,018**	**-£4,518**
CS&T	**Community Engagement in Fenland**	£28.5k			16/10/2015	Procurement complete and contract awarded. Engagement of communities and organisations in Fenland to identify an approach. Formation of a reference group to monitor the work of the healthy Fenland fund. Chatteris confirmed as a priority area. Measures to be put in service spec. Help to develope a wider implementation plan to take forward work in the New Year.							

Directorate	Service	Total	Contact	Cost Centre/ Finance Contact	Q2 Info requested	Q2 Update	Q2 expected spend	Q2 Actual Spend	Variance	Predicted spend Y/E	YTD Expected spend	YTD Actual spend	Variance YTD
CS&T	**Research**	£22k	Mike Soper	KH5000 : Maureen Wright	19/10/2015	The majority of the funding is used to maintain / develop the http://www.cambridgeshireinsight.org.uk/ website include maintaining the content for Health Joint Strategic Needs Assessment (http://www.cambridgeshireinsight.org.uk/jsna). The contribution is also used to partly support the Research Team's work on population forecasting and estimating that is used heavily by Cambridgeshire Health Services. The main development with the Cambridgeshire Insight has been to move the site to a responsive design so that it can be accessed with ease by a wide variety of mobiles / tablets and other devices. We've also continued to develop Cambridgeshire Insight Open Data. Encouraging the sharing of Open Data by developing the tools with which to share data to a high standard as well as encouraging more data sharing amongst our partners. This data rich environment will benefit the JSNA in the medium to long term. The 2013 based population forecasts have been published to schedule and the team continues to provide detailed forecasts for new settlements / developments in order to support the future planning of services.	£5,500	£5,500	£0	£22,000	**£11,000**	**£11,000**	**£0**
CS&T	**Health & Wellbeing Board support**	£27k	Dan Thorpe	KA2000 : Maureen Wright	19/10/2015	With supervision from Director of Public Health, approximately 2.5 days per week of the Policy and Projects Officer's time, who sits within Policy and Business Support Team of Customer Service and Transformation Support during Q2 has included: Planning and inputting to the delivery of a development day for the Health & Wellbeing Board in October Following up on actions and work arising from the development day Supporting the effective functioning of the Health & Wellbeing Board Supporting the effective functioning of the Health & Wellbeing Board Support Group Researching and preparing reports for the Health & Wellbeing Board, including on key policy/ strategy changes Presenting relevant reports at the Health & Wellbeing Board, and Support Group meetings Developing and maintaining a forward plan for the Board's shift to themed meetings Agenda Planning Supporting induction of new Board members Co-ordinating and preparing the quarterly stakeholder newsletter - most recently issued in October Dealing with queries in relation to HWB business Staying up to date with policy, legislation and guidance regarding HWBs and briefing the Director of Public Health and members appropriately This is in addition to ongoing, reactive support as required.	£6,750	£6,750	£0	£27,000	**£13,500**	**£13,500**	**£0**

Directorate	Service	Total	Contact	Cost Centre/ Finance Contact	Q2 Info requested	Q2 Update	Q2 expected spend	Q2 Actual Spend	Variance	Predicted spend Y/E	YTD Expected spend	YTD Actual spend	Variance YTD
CS&T	**Communications support**	£25k	Matthew Hall	KH60000 : Maureen Wright	19/10/2015	Supporting Public Health on campaigns such as Healthier Options, Stoptober, Mental Health Week, Keep Warm Keep Well etc. These include planning, developing material, working with the media, social media etc Supporting Public Health on the budget announcements, including the media briefing, news release, staff briefing etc Working closely with Val Thomas and other consultants on reactive media enquiries on subjects such as smoking, sexual health, obesity, physical activity etc Working with the media to maximise opportunities for Public Health Briefing the Director of Public Health on the applications of social media Attending Health Committee	£6,250	£6,250	0	£25,000	**£12,500**	**£12,500**	**£0**
CS&T	**Strategic advice, strategy dev etc**	£22k	Sue Grace	KA20000 : Maureen Wright	19/10/2015	This year the Council has undertaken a fundamental strategic review through the development of the new operating model. This has been led by CS&T, and has focussed on finding ways in which the Council's breadth of directorates (including Public Health) can better convene around shared outcomes and common core activities. Most recently this has been demonstrated through the General Purposes Committee's endorsement in October 2015 of a new Strategic Framework for the council, based upon the new operating model Public Health colleagues have been involved and engaged in this work from the beginning, through the Director of Public Health and other senior Public Health representatives Alongside the above, CS&T manages the business planning process and other cross-council policy groups, all of which have benefited from the strong engagement of Public Health colleagues	£5,500	£5,500	0	£22,000	**£11,000**	**£11,000**	**£0**
CS&T	**Use of Contact Centre**	£6.5k	Joanne Tompkins	KD23500 : Maureen Wright	19/10/2015	Winter Warmth training has been delivered to a group of 12 call handlers, with materials prepared in advance Delivery of the service is now underway from 1 October to the end of March 2016 The Digital Strategy Team have built a new script within CRM (customer relationship management system) which collates customer data as requested by the service and which enables call handers to hand off complex enquiries to the service Telephon messages have been recorded in agreement with the service re content and an 0345 number is being provided	£1,625	£1,625	0	£6,500	**£3,250**	**£3,250**	**£0**

Directorate	Service	Total	Contact	Cost Centre/ Finance Contact	Q2 Info requested	Q2 Update	Q2 expected spend	Q2 Actual Spend	Variance	Predicted spend Y/E	YTD Expected spend	YTD Actual spend	Variance YTD
CS&T	**Emergency Planning Support**	£5k	Stewart Thomas	KA40000 : Maureen Wright	19/10/2015	Ongoing close working with the Health Emergency Planning and Resilience Officer (HEPRO) on a number of Emergency Planning tasks: Close collaboration and contribution to the preparation for Exercise Numbus to take place 6/7 November 2015 Contribution to HEPRO for Cambridgeshire and Peterborough Local Resilience Forum (CPLRF) Influenza planning and participation in Exercise Corvus 9/10/2015 Contribution and support for the work for the Local Health Resilience Partnership (LHRP) including backgroun work following the incident at the waste wood facility at Benwick Road, Whittlesey Provision of out of hours support for the Director of Public Health (DPH), ensureing that the DPH is kept up to date on relevent incidents that occur, or are responded to, outside normal working hours as part of the 25/7 provision	£1,250	£1,250	0	£5,000	**£2,500**	**£2,500**	**£0**
CS&T	**LGSS Managed overheads**	£100k	Sue Grace	UQ10000 : Maureen Wright	19/10/2015	This continues to be supported on an ongoing basis, including provision of IT equipment, office accommodation, telephony and Members' allowances	£25,000	£25,000	0	£100,000	**£50,000**	**£50,000**	**£0**
LGSS	**Overheads associated with public health function**	£220k	Maureen Wright	QL30000, RL65200, TA76000 : Maureen Wright	19/10/2010	This covers the Public Health contribution twoards 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	£55,000	£55,000	£0	£220,000	**£110,000**	**£110,000**	**£0**

APPENDIX 4 – Virements and Budget Reconciliation

	£'000	Notes
Budget as per Business Plan	18,222	
Virements		
Non-material virements (+/- £160k)	0	
Budget Reconciliation		
Transfer of post from CS&T to PH	29	Contra CS&T Research grant income
S75 agreement with NHS(England) for £144,000 income to fund HIV commissioning which we have undertaken on their behalf	144	
Current Budget 2015/16	**18,395**	

APPENDIX 5 – Reserve Schedule

Fund Description	Balance at 31 March 2015	2015/16		Forecast Balance at 31 March 2016	Notes
		Movements in 2015/16	Balance at 30 Nov 2015		
	£'000	£'000	£'000	£'000	
General Reserve					
Public Health carry-forward	952	0	952	**342**	**To be part used to meet in-year PH grant reduction**
subtotal	**952**	**0**	**952**	**0**	
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 over 5 years**
Falls Prevention Fund	400	0	400	200	**Anticipated spend over 2 years**
NHS Healthchecks programme	270	0	270	**0**	**Delayed 14/15 spend**
Implementation of Cambridgeshire Public Health Integration Strategy	850	0	850	700	**2-3 years funding commence mid-year 15/16.**
Other Reserves (<£50k)	61	-61	0	0	**Service earmarked reserves**
subtotal	**2,081**	**0**	**2,020**	**1,642**	
TOTAL	**3,033**	**-61**	**2,972**	**1,642**	

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

Fund Description	Balance at 31 March 2015	2015/16		Forecast Balance at 31 March 2016	Notes
		Movements in 2015/16	Balance at 30Nov 2015		
	£'000	£'000	£'000	£'000	
General Reserve					
Joint Improvement Programme (JIP)	164	17	181	90	Expenditure anticipated over 2 years.
Improving Screening & Immunisation uptake	0	9	9	0	£9k from NHS ~England for expenditure in Cambridgeshire and Peterborough
TOTAL	**164**	**26**	**190**	**90**	

APPENDIX 6 Performance

HEALTH IMPROVEMENT												
Service		Measures										
	Overall RAG status	Measure	Y/E Target 2015/16	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%	99%	99%	G	97%	98%	99%	↑	
		GUM ACCESS - % seen within 48 hours (% of those offered an appointment)	80%	80%	89%	89%	G	87%	80%	89%	↑	
		Dhiverse : % of people newly diagnosed offered and accepted appointments	100%	100%	100%	100%	G	100%	100%	100%	↔	
		Access to contraception and family planning (CCS)	7200	4200	6700	160%	G	155%	600	161%	↑	
Health Improvement: Caring for people and assisting in improving all aspects of their general wellbeing	G	Number of Health Checks completed	18,000	9,000	6996	78%	R	78%	4500	77%	↓	HCs reported quarterly (this is Q2 / end of September 15 data)
		Percentage of people who received a health check of those offered	45%	45%	36%	36%	R	38%	45%	36%	↓	HCs reported quarterly (this is Q2 / end of September 15 data)
		Number of outreach health checks carried out	1,050	0%	0%	0%	N/A	N/A	0	0%	N/A	This is part of the new Lifestyle Service contract that began on June 1 . Training commenced 18th Aug 2015. HC targets been revised to take into account mobilisation period.
		Smoking Cessation - four week quitters	2237	829	755	91%	A	105%	161	96%	↓	August 2015 figures based on timelinesss trajectory
		School Nursing : Contacts made	9000	4154	4616	111%	G	119%	923	102%	↓	No submission received for October hence it is Sept figures
		School Nursing : Group activities	4784	2208	1947	88%	G	112%	490	4%	↓	
		Childhood Obesity (School year) - 90% coverage of children in year 6 by final submission (EOY)	90%	90%	92%	102%	G	N/A	90%	92%	N/A	This is reported on Annually. From June 2015 this service isprovided by SLM/Everyone Health. Measurements to commence in November 2015
		Childhood Obesity (School year) - 90% coverage of children in reception by final submission (EOY)	90%	90%	95%	106%	G	N/A	90%	95%	N/A	
		Personal Health Trainer Service - number of referrals received **(Pre-existing GP based service)**	1675	725	695	96%	A	62%	175	53%	↓	The new Lifestyles contract started June 1 2015. Many of the indicators are not populated for July as the Service was recruiting and establishing itself or the outputs were not available in the timeframe as the interventions take place over several months. Recruited staff focused upon the referrals to the one to one service and the groups will be developed as more post are filled
		Personal Health Trainer Service - number of initial assessments completed **(Pre-existing GP based service)**	1424	616	543	88%	R	74%	149	62%	↓	

Health Improvement: Caring for people and assisting in improving all aspects of their general wellbeing	G	Personal Health Trainer Service - Personal Health Plans completed **(Pre-existing GP based service)**	908	393	369	94%	A	72%	95	75%	↑	
		Number of referrals from Vulnerable Groups **(Pre-existing GP based service)**	335	145	539	372%	G	151%	35	149%	↓	Definition of VG and target under review with CCC
		Number of physical activity groups held **(Pre-existing GP based service)**	555	150	156	104%	G	78%	60	60%	↓	Service was still recruiting to posts where staff had left before the start of the new contract.
		Number of healthy eating groups held **(Pre-existing GP based service)**	555	150	6	4%	R	0	60	0	← →	Service was still recruiting to posts where staff had left before the start of the new contract.
		Recruitment of volunteer health champions **(Pre-existing GP based service)**	20	10	0	0%	R	0	2	0	← →	Service was still recruiting to posts where staff had left before the start of the new contract.
		Personal Health Trainer Service - number of referrals received (Extended Service)	625	75	97	129%	G	132%	50	30%	↓	
		Personal Health Trainer Service - number of initial assessments completed (Extended Service)	531	64	82	128%	G	148%	43	63%	↓	
		Personal Health Trainer Service - Personal Health Plans completed (Extended Service)	188	0	0			0	0	0	N/A	An individual may take up to year to complete a Personal Health Plan
		Number of referrals from Vulnerable Groups (Extended Service)	125	15	55	367%	G	320%	10	50%	↓	
		Number of physical activity groups held (Extended Service)	600	90	0			0	60	0	N/A	Service was still recruiting to posts and establishing itself and was not rag rated
		Number of healthy eating groups held (Extended Service)	600	90	0			0	60	0	N/A	Service was still recruiting to posts and establishing itself and was not rag rated
		Recruitment of volunteer health champions (Extended Service)	21	6	0			0	3	0	N/A	Service was still recruiting to posts and establishing itself and was not rag rated
		Number of behaviour change courses held	30	3	0			N/A	2	0%	N/A	Programme scheduled to start in the autumn
		%r of Tier 2 clients recruited who complete the course and achieve 5% weight loss	300	45	3	7%	R	7%	30	7%	← →	Please note that the minimum time for both children and adult weight management course is 3 months with Tier 3 courses lasting 6 months;Unable to report weight loss on those patients who transfer from Weigh2Go as no baseline data was provided
		% of Tier 3 clients recruited completing the course and achieve 10% weight loss	11	0	0			N/A	0	0%	N/A	Each patienst goes through a 6 months course
		% of children recruited who completie the weight management programe and maintain or reduce their BMI Z score by agreed amounts	TBD	0	0			N/A	0	0%	N/A	The first course commences in January

* All figures received in November 2015 relate to October 2015 actuals with exception of Smoking Services which are month behind and Health Checks 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.

Agenda Item No: 6

PUBLIC HEALTH RISK REGISTER UPDATE

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

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

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

	Officer contact:
Name:	Tess Campbell
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1. BACKGROUND

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

1.2 The Council's approach to the management of risks is encapsulated in 2 key documents:

- Risk Management Policy (Appendix 1)

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

- Risk Management Procedures

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

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

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

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

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

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

1.5 Risk Identification

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

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

- Risk management should be embedded in everyday business processes;

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

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

1.6 There are 2 distinct elements to risk scoring:

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

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

1.7 This report is supported by:

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

2. PUBLIC HEALTH DIRECTORATE RISK REGISTER

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

2.2 The Directorate's Corporate Risk Group member co-ordinates risk

management across the Directorate liaising with representatives from services and teams to ensure this approach functions effectively.

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

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

2.4 Following the review of Public Health Directorate risks by the Directorate Management Team (DMT) on 21 October 2015, DMT is confident that the Public Health Risk Register is a comprehensive expression of the main risks faced by the Directorate and that mitigation is either in place, or in the process of being developed, to ensure that each risk is appropriately managed.

2.5 The Public Health Directorate Risk Register to October 2015 is presented at Appendix 3 and illustrates that there are 24 current Directorate risks. There are two new Public Health Risks. The Residual Risk Scores for these risks are: 22 amber and 2 green. There are a total of 62 individual actions associated with the overarching risks. Of the individual actions 0 are red, 38 are amber, 20 are green and 2 are under review with no current action status.

- ***Risk 1 (amber risk): Failure to address health inequalities, particularly in the north of the county***. This risk was discussed at the Corporate Risk Group in October, as proposed by the Director of Public Health, and was taken for discussion at SMT in November. It is proposed that this risk incorporate the wider determinates of inequalities across directorates, and as such a decision on this will be forthcoming shortly.

- ***Risk 25 (amber risk) : Public Health Grant Assurance.*** This is a new risk aligning both the Peterborough and Cambridgeshire risk registers,
- ***Risk 26 (amber risk) : Public Health Services will not meet quality safety and risk standards.*** This is a new risk aligning both the Peterborough and Cambridgeshire risk registers.

3. ADDITIONAL RISKS AND ISSUES

3.1 Because the Public Health Risk Register is reviewed and amended on a quarterly basis, there are some new risks and issues which are currently being addressed but will not be formally included in the directorate risk register until the next meeting of the Public Health quality, safety and risk Group. The main issue identified since October, which is a subset of Risk 10 'Inability to manage the budget effectively and utilise resources available', is the risk associated with an additional savings requirement of £2.2M for public health grant funded services in 2016/17, following the announcement of reductions to the local authority public health grant in the Comprehensive Spending Review. This has been mitigated by a proactive approach to business planning within and across directorates, described in the Committee Agenda Item 'Service Committee Review of draft business planning proposals from 2016/17 to 2020/21.

3.2 In addition, Internal Audit have advised that a process should be developed for reporting progress on joint working across Cambridgeshire Public Health Directorate and Peterborough Public Health Office to Health Committee, including associated staffing and financial agreements. This is covered under Risk 7 'Impact of Joint working with Peterborough on Public Health Services for Cambridgeshire', and it is planned to provide a more detailed report of progress as an appendix to the next Public Health Risk Register update.

4. ALIGNMENT WITH PRIORITIES AND WAYS OF WORKING

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

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

5. SIGNIFICANT IMPLICATIONS

5.1 Resource and Performance Implications

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

5.2 Statutory, Risk and Legal Implications

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

5.3 Equality and Diversity Implications

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

5.4 Engagement and Consultation

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

5.5 Public Health

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

Source Documents	Location
Corporate Risk Register	Internal Audit and Risk Management Shire Hall, Cambridge CB3 0AP

APPENDIX 1

CAMBRIDGESHIRE COUNTY COUNCIL

RISK MANAGEMENT POLICY

1. INTRODUCTION

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

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

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

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

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

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

The Accounts and Audit Regulations, 2003 state:

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

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

2. WHAT IS RISK?

The Council's definition of risk is:

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

3. RISK MANAGEMENT OBJECTIVE

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

4. RISK MANAGEMENT PRINCIPLES

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

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

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

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

- Risk management should be embedded in everyday business processes;

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

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

5. APPETITE FOR RISK

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

6. BENEFITS OF RISK MANAGEMENT

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

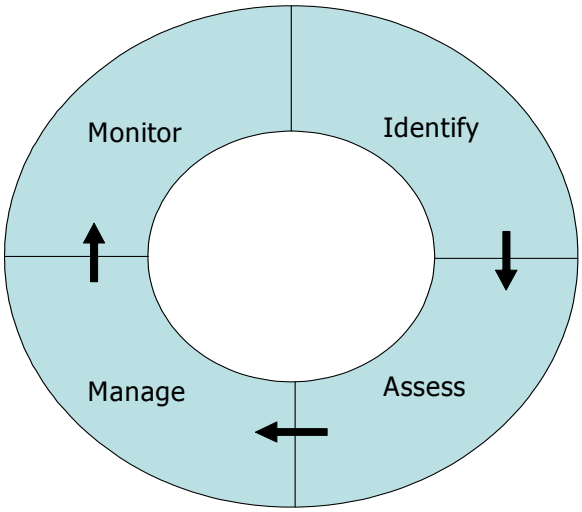
- Risk management at the point of decision making should ensure that councillors and officers are fully aware of any key risk issues associated with proposals being considered.

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

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

7. RISK MANAGEMENT APPROACH

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



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

The Risk Management Procedures document can be located on Camweb at

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

8. AWARENESS AND DEVELOPMENT

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

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

9. CONCLUSION

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

APPENDIX 2

RISK SCORING MATRIX

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

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

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

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

IMPACT DESCRIPTORS

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

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

APPENDIX 3

CORPORATE RISK REGISTER

Public Health

Version Date: October 2015

Details of Risk		Key Controls	Residual Risk			Actions				
Risk No.	Risk Description		Probability	Impact	Residual Score	Actions	Action Owner	Target Date	Revised Target Date	Action Status
1	Failure to address health inequalities, particularly in the north of the county	1. Joint Strategic Needs Assessment (JSNA) 2. Health & Wellbeing Strategy and Action Plan (HWB) 3. Local Health Partnership Action Plans/Public Services Board in Fenland 4. Targetted Public Health programmes 5. Annual Public Health Report 6. Shared priorities work 7. Business Plan Targets and Inequalities Indicators	3	4	**12**	1. Ensure 'improving the healfh of the poorest fastest' principle in Health & Wellbeing Board (HWB) Strategy and Action Plan continues to receive high level of focus 3. Ensure monitoring and reporting of inqualities including through routine performance monitoring in F&PR and annual DPH report 4. Monitoring - eg of benefits changes impact (CFA) and of PH outcomes framework 5. Ensure ongoing inequalities are addressed within Children's Outcomes Framework (COF) 8. Implementation of new investments such as Fenland Fund, Tobacco Control and Workplace Health 9. Lifestyle Service procurement will target areas with greatest health inequalities and provide services in areas where residents have previously been unable to access any support for improving high risk health behaviours	LR KW VT VT	Mar-15 ~~Aug-14~~ ~~Jul-14~~ Jun-15	Mar-15 Feb-15	A G A A G G
2	Childhood Immunisation Targets - Rates of immunisations, below national average with potential risk to public health of children	1. Commissioning of immunisations now sits with NHS England 2. Assurance role through Health Protection Steering Group 3. Annual Health Protection Report to HWB Board	5	3	**15**	2. Support to local initiatives - eg through LA Public Health team and LA childrens centres 3. Ongoing close monitoring and public communication of local imms rates through appropriate channels 4. Task & Finish group to be established, Summer 2015 to analyse detailed data, consult stakeholders, and develop recommendation to improve uptake *Note: Current mitigation of risks to neonatal BCG through delivery in community clinics has been at risk due to intention to transfer back to maternity units - Neonatal BCG included in tarriff from maternity care. Work with NHS England to develop reporting by maternity units to provide assurance that need is being met.*	LS	Mar-16		A A A A
3	Public Health does not have staff with the right skills and experience to deliver the priorities at a time of significant demand pressures	1. HR polices and processes 2. SMT	2	4	**8**	1. Development of progressional scheme for all medical consultants (note: scheme developed but requirement to implement currently under review)	LR	Sep-15		A
4	All Antenatal and Newborn Screening programmes. Ante-natal includes screening for anomalies and infectious diseases. Newborn screening includes hearing and general physical health.	2. Assurance role through Health Protection Steering Group 3. Annual Health Protection Report 4. Screening programme boards (and Immunisation Steering group for newborn immunisation)	1	3	**3**	1. Much improved data but need some wider understanding of the programme. Meet with screening leads to discuss further *Note: CCC has accountability without managerial responsibility and require data from NHSE to provide assurance*	LS	Mar-16		A
6	Health Protection Systems to control communicable diseases and environmental hazards continue to function in the new Health Care system architecture	1. Written report to the Health Protection Steering Group 2. Engagement of Local Authority Public Health leads in Instant Management Teams (IMT) for health protection incidents 3. TB : Assurance role through Health Protection Steering Group 4. Continuation of TB Network (led by PHE) and TB cohort reviews to learn from cases and better understand the challenges.	2	4	**8**	4. Ensure sign off from 1 district council that has yet to be received. 5. Re-issue of the MOU 6. TB network reviewed, revised ToRs, membership updated and attendance improved for network meetings and cohort reviews. However need to ensure current enthusiasm is sustained 7. Launch of collaborative TB strategy in Jan 2015. Clarity about role fo TB network and relationship to new TB Control Board (East of England). Workshop held to discuss local priorities to inform implementation.	LS	Dec-15 ~~Sep-13~~ Mar-16	Mar-16	A A A A

Details of Risk		Key Controls	Residual Risk			Actions				
Risk No.	Risk Description		Probability	Impact	Residual Score	Actions	Action Owner	Target Date	Revised Target Date	Action Status
		5. Implementation of 2015 National TB Strategy with establishment of East of England TB Control Board				8. Development of commissioning plan for TB		Sep-15		A
7	Impact of joint working with Peterborough on Public Health Services for Cambridgeshire	1. Joint DPH post 2. Internal Audit (Cambridgeshire) on arrangements 3. Cambridgeshire SMT 4. Peterborough CMT and Public Health Board	3	4	12	1. Merge meetings where appropriate 2. Appoint support post for KW Public Health Consultant 3. Embed internal audit recoomendations	LR	Jan-16 Nov-15 Mar-16		G A A
8	Uncertainty about Cambridge Community Services (CCS), leading to reduced delivery of their Public Health Services	2. Commissioning and contracting structures	2	4	8	*Comment: CCS has been successful in securing the Sexual Health procurement* 2. Ongoing input to commissioning through internal commissioning structures and Childrens Joint Cmmissioning Board	LR	Mar-15		A
9	Impact of removal of On-Call Rota	1. Health Protection Steering Group 2. LHRP 3. ADsPH	3	4	12	1. Transition period during October. New on-call arrangements in place but Cambridgeshire PH cover continues as standby on rota 2. Make arrangements for emergency capacity in a major incident	LR	Oct-15 Nov-15		A
10	Inability to manage the budget effectively, and utilise resources available	1. Health Committee oversight 2. Business Planning Process 3. Monthly Finance Meetings 4. Shared Priorities Steering Group 5. SMT	3	4	12	1. Plan for in year reductions 2. Plan for probable recurrant reduction in PH grant through 2016/17 Business Plannning process 3. Ensure agreed split across directorates through Shared Priorities Steering Group and SMT 4. Maintain close relationships with finance post restructure of the function	LR	Oct-15 Oct-15 Oct-15 Mar-16		A A G A
11	Awareness of legislation and training requirements		2	4	8	4. Public Health session on the law	LR			A
12	A lack of Information Management and Data Accuracy and the risk of non-compliance with the Data Protection Act and inability to access to business critical data	1. Departmental governance, training and awareness raising: compliance of staff with NHS IG and CCC IG training. 2. CCC and Public Health have the necessary policies and procedures in place to ensure compliance with NHS IG Toolkit at level 2 or with an inmprovement plan working towards level 2. 3. Information sharing protocols embedded with partners, espeically the NHS. 4. Supporting corporate controls for "24. A lack of Information Management and Data Accuracy and the risk of non compliance with the Data Protection Act" 5. National and local agreements and legislatiive defintions are in place to allow data flows to be established and to ensure appropriate data access.	2	4	8	1. Complete Local Authority Toolkit - new working on 2015/16 toolkit and work is underway on broadly on track. Most learning points from internal audit report addressed or flagged again for action. 2. Review audit aspects of 2014/15 toolkit work. Has been reviewed. 3. Act on findings of 2014/15 audit work. Initial urgent actions taken and complete. Some actions still in train. Mop-up of incomplete network areas almost complete. Gudiance to be issued to PH Directorate along with key findings. 4. Toolkit improvement plan work & 16/17 Toolkit submission - as per Ian - working with Matthew Smiith - see item 1 5. Submit Local Authority Toolkit for 16/17	LR / DL	Mar-16 Jul-15 Oct-15 Mar-16 Mar-16		A G A A A

Details of Risk		Key Controls	Residual Risk			Actions				
Risk No.	Risk Description		Probability	Impact	Residual Score	Actions	Action Owner	Target Date	Revised Target Date	Action Status
		6. Internal audit review of Public Health Information Governance and impact of the toolkit								
13	Multi Agency Emergency plans require updating - plans for emergencies need to clarify organisational changes for health sectorsince April 2013	1. Plans to be reviewed through LHRP and LRF health and social care working group 2. Health Protection Steering Group (HPSG) to have oversight of plan development especially plans for Public Health incidents	2	3	6	3. Pandemic flu plan to be taken to Health & Social Care Emergency Planning Group (H&SCEPG) and the LHRP 4. Exercise Corvus to test pandemic flu plan 5. Learning from Exercise Corvus to be included in plan	LS	Jan-15 Oct-15 Mar-16		G G A
14	Failure to progress implementation of Health & Wellbeing Strategy	1. HWB Strategy Stakeholder events 2. HWB Board Newsletter 3. HWB Strategy Action Plan 4. HWB Board formal meetings and development days	2	4	8	1. Arrange future stakeholder events and meetings with key organisations 2. Regular production of newsletter 3. Regular review of action plan and of commissioning intentions of organisations involved 4. Ensure good links with new Corporate Services post 5. Review and update strategy	LR	~~Oct-13~~ Jan-15	Mar-14	G
15	Disruption to business of Public Health Directorate	1. Public Health Business Continuity Plan	2	4	8	1. Write BCP to link with Corporate Business Continuity Plan 2. Test BCP 3. Update and test BCP	LR	~~Nov-13~~ ~~Mar-14~~	May-14 Mar-16 Mar-16	G A A
16	Inequitable school entry hearing screening programme	1. Health Questionnaire on entry to school 2. Health visitors obtain information early on in the life of a child	4	3	12	1. Initial hearing screenings in 2014 work plan ***NB: Awaiting National Guidance which should be published in December 2015***	KW	~~Mar-15~~	Mar-16	A
18	Failure to achieve performance targets as set out in the 2015/16 Business Plan	1. Robust Service Planning in place, established and functioning 2. Performance monitoring, established and functioning and feedback incorporated into the F&PR process 3. Routine monitoring of delivery to identify any required interventions	4	3	12	1. Poor performers are visited and remedial action plans agreed or additional support offered, ie staff training 2. Additional providers commissioned to access hard to reach groups 3. Review of targets for 2016/17	VT	Mar-15		G G G
19	Risk to successful transfer of Healthy Child 0-5 commissioning from NHS England to CCC in October 2015	1. Steering group established across NHS England and CCC 2. Memorandum of understanding between NHS England and CCC 3. Finance and legal advice established 4. Boundary meetings - jointly with NHSE	2	3	6	1. Review draft allocation for healthy child 0-5 programme and feed back to DoH 2 Agree form of contract transfer in October 2015 3. Jointly agree service specification for 2015/16 4. Agree project plan for transfer 5. Develop risk register for transfer Transition of 0-5 Commissioning\Transfer of commissioning 0-5 services - Associated Risk Register V5.xls	LR/FH	Oct-15		G G G G G
20	Directorate support to Health Committee (Scrutiny Function) and CCG: risk of conflict of interest or breaching information barriers	1. Healthcare Public Health advice service MOU includes confidentiality requirements. 2. Honorary contracts for staff handling very sensitive issues 3. Confidentiality agreements on specific sensitive issues (ie major procurements) 4. Committee scrutiny support (ie attendance at meetings, preparation of briefings) carried out by staff not involved in HPHAS 5. Discussion of issues with Chair and Spokes at regular Chair's meetings/Spokes meetings	3	2	6	1. Further discussion with legal team 2. Review after 9 months of operation	KP/DL/LR	Jan-15		A A
21	Cancer Screening inc Bowel Cancer	1. Regular writing reporting to Health Protection Steeting Group by NHS England 2. Task and finish group 3. Key Stakeholder working	3	4	12	1. Taks and finish group to review data and work with key stakeholders to identify issues leading to low uptake, with a view to making recommendations for improvement *Note: Bowel Cancer screening is not being looked at by the Task and Finish group, this is being picked up by the Health Protection Steering Group*	LS	Oct-15		
22	Vision Screening Service not implemented	1. Hand over group to provide support and early identification of issues 2. Communication between commissioners and providers	2	3	6	1. Set up transitional meeting of providers for handover Vision Screening - Risk Register.xls	KW	Oct-15		A
23	Failing to effectively deliver Public Health Outcomes thorugh the	1. Public Health MOU has been developed 2. Comprehensive Governance Framework in Place	1	4	4	1. Put in place comprehensive Governance Framework 2. Put in place reporting mechanism to Health Committee	LR	Oct-15		G G

Details of Risk		Key Controls	Residual Risk			Actions				
Risk No.	Risk Description		Probability	Impact	Residual Score	Actions	Action Owner	Target Date	Revised Target Date	Action Status
23	cross directorate Public Health MOU	3. Professional Assurance of the Grant 4. Finance Director sign off of grant 5. Future reporting to Health Committee as part of Finance and Performance report 6. Reporting to Department of Health	1	4	4	3. On-going-monitoring throughout the year 4. Internal adit 2014/15 spent	LR	Oct-15		G G
24	School nursing contract	1. Signed section 75 2. Performance management	2	3	6	1. Negotiation with Lead School Nurse 2. Performance management of new KPIs within 0-19 healthy child programme by JCU	FH KW	Aug-15 Oct-15		 A
25	Public Health Grant Assurance	1. Public health Board 2. DPH and Finance Director signature on assurance statement to PHE 3. Clear Accounting	2	4	8	1. Meetings to determine 2015/16 final budget allocations and spend	LR	Apr-16		A
26	Public Health Services will not meet Quality Safety and Risk standards	1. Quarterly meetings of QS&R Group	3	4	12					

HEALTH COMMITTEE TRAINING PLAN	Updated from 17th December Health Committee Meeting	

Ref	Subject	Desired Learning Outcome/Success Measures	Priority	Date	Responsibility	Nature of training	Attendance by:	Cllrs Attending	Percentage of total
1.	System Transformation (Raised at Health Committee)	Provide members with an overview of the current System Transformation Programme led by CPCCG.	1	13th Aug 2015	Public Health	Training Seminar	Health Committee members & Subs		53% health committee members
2.	Business planning 2016/17	Provide members with an overview of the business planning decisions for the council	1	1st Oct 2015	Public Health	Training Seminar	Health Committee members & Subs		92% Health committee members (including substitutes)
2.	New legislation on the Care Act (Raised at spokes)	Members develop a clearer understanding of the Care Act and its implications in relation to Health.		TBC	Democratic Services	Information to be circulated to spokes	Health Committee members & Subs		
3.	Equality & Diversity Issues (Raised at spokes)	Members are provided with an overview of equality and diversity issues.		TBC	Democratic Services	Full members seminar	Health Committee members & Subs		
4.	County Council Directorate structures & Officer responsibility (Raised at Health Committee)	Members to understand variety of Council responsibilities		TBC	Democratic Services	Information available on Camweb	Health Committee members & Subs		

Ref	Subject	Desired Learning Outcome/Success Measures	Priority	Date	Responsibility	Nature of training	Attendance by:	Cllrs Attending	Percentage of total
5.	Primary Care &NHS funding & Commissioning responsibilities (Raised at Health Committee)	Members understand the relationships with Primary care &various commissioning accountabilities within the NHS e.g. role of NHS England, CCG and Department of Health. To also now include the role of Community Pharmacists in the seminar	1	3rd March	Public Health	Training seminar	Health Committee members & Subs		
6.	Mental Health Promotion and prevention activity (Raised at Health Committee)	Members to have an overview of the current Mental Health Promotion prevention work particularly partnership arrangements. Update on Public Mental Health Strategy – Action Plan scheduled for December Health Committee	2	17th Dec 2015	Public Health	Update scheduled for November Health Committee	Health Committee Members		
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	3	14th April TBC	Public Health	Training Seminar	Health Committee members & Subs		

Ref	Subject	Desired Learning Outcome/Success Measures	Priority	Date	Responsibility	Nature of training	Attendance by:	Cllrs Attending	Percentage of total
9.	Health Scrutiny Skills Part 2	To understand Health Scrutiny in the context of Health inequalities and the transformation agenda.	2	11th Feb 2016	Public Health & Centre for Public Scrutiny	Training seminar	Places for 3 committee members only	TBC	
10.	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.	1	TBC	Public Health	Training seminar (potentially joint with CYP Committee)	Health Committee Members and subs		

- 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.

Agenda Item No: 8a

CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST – ADULT MENTAL HEALTH SERVICE PRESSURES – UPDATE

To:	**HEALTH COMMITTEE**
Meeting Date:	**21 January 2016**
From:	**Dr Emma Tiffin, CCG GP Clinical Lead – Adult Mental Health**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable**
Purpose:	**The Committee has requested an update on current service pressures in adult mental health services.**
Recommendation:	**The Committee is asked to note the current pressures and the measures put in place locally to mitigate these.**

	Officer contact:		***Member contact:***
Name:	Dr Emma Tiffin	Name:	Councillor David Jenkins
Post:	CCG GP Clinical Lead – Adult Mental Health	Chairman:	Health Committee
Email:	emma.tiffin@nhs.net	Email:	ccc@davidjenkins.org.uk
Tel:	01223 725336	Tel:	01223 699170

1. BACKGROUND

1.1 The Committee has asked for a six-monthly update at its January meeting on current service pressures in local adult mental health services.

1.2 All NHS services typically face two particular pressures on an ongoing basis:

- Population Growth – both the total population locally and the numbers of older people. Cambridgeshire has one of the fastest growing rates of population growth in the UK. This increases the demand for all services including mental health. Some, but not all, of this population growth may be mitigated in some years by increases in the CCG's total resource allocation.

- Efficiency Savings – all NHS service providers have, for some years, been required to make annual cost-improvements, typically 3-4% annually. At the time of writing we do not know the efficiency savings requirement for 2016/17.

1.3 Both of the pressures above have a considerable impact on local adult mental health services. The local bed capacity is more or less fixed, and the numbers of patients being admitted to out-of-area facilities are exceptionally low; the consequence is pressure both on local wards and our community services, to reduce lengths of stay and increase caseloads respectively (as set out below).

1.4 Demand for local adult mental health services is illustrated by the large number of referrals to the single-point-of-access Advice and Referral Centre (ARC) - 14,778 were received in the first seven months of 2015/16 (equivalent to over 25,000 referrals annually). Most referrals are from GPs but they are also received from other agencies including the police, social workers, local voluntary organisations, and other healthcare professionals. The function of the ARC is currently under review and, amongst other innovations, is conducting a pilot on accepting self-referral by the service user in Cambridge.

1.5 The CCG also commissions significant volumes of activity from local "third sector" providers including voluntary organisations, independent providers, and counsellors. In 2015/16 the CCG invested additional "parity of esteem" monies (se Appendix 1) to increase third-sector capacity in order to provide a more resilient overall mental health service model locally. There is also greater partnership working between NHS services and these third-sector providers, which facilitates a more seamless patient journey and enables better management of current service pressures.

1.6 The CCG was required by the national "parity of esteem" initiative to increase its investment in mental health services in 2015/16 by 5.6% - the same as the overall increase in the CCG's financial allocation for this year. Our local annual spend on adult mental health is £51m so this additional investment equated to approximately £2.8m.The breakdown of how these funds have been deployed is set out in the slides attached as Appendix A at the end of this paper.

1.7 CPFT also received an overall rating of Good from the CQC on 13 October, with all points classed as Good except for 'Are Services Safe?' which Requires Improvement, mostly with regard to Children and Adolescent Mental Health Services (CAMHS).

However the report stated the trust had "met its targets required under the Department of Health's 'Positive and Proactive Care: reducing the need for restrictive interventions'

agenda. There had also been a decreasing level of restraint and seclusion over the previous 12 months. […and] The trust demonstrated an improving picture of satisfaction during the 12 months before our inspection."

(From p6 and p12 of the CQC report, dated 13/10/15 and available at: http://www.cqc.org.uk/sites/default/files/new_reports/AAAE1951.pdf)

2. MAIN ISSUES

2.1 The CCG has standard NHS contracts with all its service providers – both statutory and third-sector. All these contracts include Key Performance Indicators which include activity targets. Contracts are monitored on a monthly or quarterly basis as appropriate to the size of the contract.

2.2 In recent months the performance information we receive has highlighted the following services as facing the greatest pressures. All figures quoted relate to the seven month period between April to end of October 2015 and are compared to the same period of 2014:

- Crisis Resolution and Home Treatment Team
  Referrals to the team were 12% above the planned level – which itself is an increase from the previous year's outturn using "parity of esteem" monies. A consequence of this significant increase in referrals is that the team has very limited capacity to undertake home treatment following initial assessment.

  The Health Committee will be aware of the "Crisis Care Concordat" and the local multi-agency Crisis Concordat Delivery Board. Its Action Plan contains a range of initiatives to reduce the pressure on local crisis services, including diversion to alternative sources of advice and support where appropriate for individual patients.

  The CCG is a "Vanguard" site for urgent care and mental health services are playing a prominent role in this. There is anecdotal feedback that the recently-introduced liaison psychiatry service at Peterborough hospital has already reduced pressures on the crisis resolution team that serves the north of the county.

  Improved access to care in a crisis situation has been identified as the CCG's priority for any additional available investment in mental health in 2016.

- Assessment Beds:
  Patients who cannot be cared for safely in their own home are admitted to two local assessment wards, where the planned length of stay is three days. Admissions to the end of October were 13% above the planned level. Because the bed capacity is fixed, this pressure has to be managed by shorter lengths of stay where possible, but inevitably there are knock-on effects for the other local treatment and rehabilitation wards.

- Personality Disorders:
  This service was re-modelled in 2014 towards a more recovery-oriented, community-based service. At present we are still establishing a realistic activity baseline for the new service model. However, waiting-times are again increasing.

The CCG has invested additional resources in four local third-sector organisations with expertise in helping people with personality disorder. The Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) service is engaged in several initiatives to help people to access these and other local services for support once discharged.

Additionally, people with personality disorder are expected to be one of the main groups accessing the new Recovery Coaches and Enhanced Primary Care Mental Health services also being established locally using "parity of esteem" funds.

- Adult Attention Deficit Hyperactivity Disorder (ADHD): This service was established in 2012 in response to feedback received during a public consultation at that time. The service provides diagnosis and subsequent medication support. The numbers being referred (260-300 annually) are now almost three times those originally anticipated.

  There are ongoing discussions between the CCG and CPFT on a revised service model (including post-diagnosis support) that makes the best use of the available resources and local expertise in this field to support people in a range of other local service settings.

- Increased Access to Psychological Therapies (IAPT): Access to psychological therapies has been, and continues to be, a long-standing national priority. The CCG invested an additional £2.2m in 2014/15 to more than double local capacity. During 2015/16 further "parity of esteem" funds have been invested in local third sector providers of these services in order to provide a wider range of treatment options.

  There is now sufficient local capacity to enable over 15,000 people annually to access these services. All our local contracted providers have introduced self-referral and there has been a significant advertising campaign in the local media. The service continues to target patient groups most likely to benefit from psychological therapy – e.g. those with long-term conditions.

- Voluntary Organisations: We have this year conducted a review of all the services that we commission from the local third sector – this includes both voluntary organisations and some "not-for-profit" providers. The objectives were to equalise access CCG-wide, strengthen links between CPFT services and our third-sector providers, and introduce a standard set of Key Performance Indicators (including outcome measures) for all providers. This makes comparisons of the outcomes being achieved by each more straightforward.

  Alongside the additional investment in these organisations already described, these measures have increased the overall capacity of local services. Voluntary organisations typically work under financial constraints and face almost continuous capacity pressures. However, we believe the investments and innovations we have made will enable the local system to offer help to more people and better face the challenges anticipated in the future.

3. SIGNIFICANT IMPLICATIONS

3.1 Resource Implications

There are no significant implications within this category.

3.2 Statutory, Risk and Legal Implications

There are no significant implications within this category.

3.3 Equality and Diversity Implications

There are no significant implications within this category. The measures taken this year are designed to equalise access to services throughout the CCG area.

3.4 Engagement and Consultation Implications

There are no significant implications within this category.

3.5 Localism and Local Member Involvement

There are no significant implications within this category. The Mental Health Commissioning Team meets regularly with, and briefs, all Local Commissioning Groups.

3.6 Public Health Implications

There are no significant implications within this category.

Source Documents	Location
CCG Governing Body papers and presentations made by members of the mental health commissioning team to local and regional stakeholders.	These are available from the CCG Mental Health Commissioning Team on request: **Tel: 01223 725381** **Email: CAPCCG.MHLDCommissioning@nhs.net**
CQC October 2015 report on CPFT	http://www.cqc.org.uk/sites/default/files/new_reports/AAAE1951.pdf)

Cambridgeshire County Council
Health Committee – 21st January, 2016
Pressures in Adult Mental Health Services

Appendix A –
"Parity of Esteem"

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Parity of Esteem – The Principle

- the principle by which mental health must be given equal priority to physical health
- mental health problems account for 28% of the burden of disease but only 13% of NHS spending
- mental ill health is also associated with increased chances of physical illness and significantly reduced life expectancy
- poor physical health increases the risk of mental illness
- the risk of depression is doubled for people with diabetes, hypertension, coronary artery disease and heart failure, and tripled in those with stroke, end-stage renal failure and chronic obstructive pulmonary disease
- medically unexplained symptoms cost the NHS some £3 billion per year

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Parity of Esteem – The Guidance

- the government requires NHS England to work for parity of esteem to mental and physical health through the NHS Mandate
- the "Five-Year Forward View:-
  - "breaking down barriers"
  - waiting-time standards
  - "genuine parity of esteem by 2020"
- Planning Guidance 2015/16 - a real-terms increase in mental health spend, to be at least as great as the overall increase in the CCG's funding allocation for this year
- for Cambridgeshire and Peterborough CCG, this equated to a 5.6 per cent increase
- for local adult mental health annual spend of £51M this equated to additional investment of approx. £2.8M

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Parity of Esteem – Local Implications

- an opportunity to address priority gaps identified from stakeholder feedback and by LCG GP leads in local NHS (CPFT) pathways:-
  - 24/7 staffing of the S136 suite at Fulbourn hospital (£380k)
  - expansion of the capacity of community teams (£499k)
  - some additional out-of-hours capacity in the crisis team (£201k)
  - additional staff on in-patient wards (£496k)
  - additional capacity to meet early intervention access targets (£159k)
- an opportunity to make the overall local mental health system more "resilient" by not simply buying more of the same
  - Re-Commissioning of Third-Sector Services (£550k)
  - Recovery Coaches (£277k)
  - Enhanced Primary Care (£320k)

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Agenda Item No: 8b-i

CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST – CHILD AND ADOLESCENT MENTAL HEALTH SERVICE PRESSURES – UPDATE

To:	**HEALTH COMMITTEE**
Meeting Date:	**21 January 2015**
From:	**Lee Miller**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable**
Purpose:	The purpose of this report is to:- • Outline the current services and issues in Child and Adolescent Mental Health Services (CAMHS) • Identify what has already taken place to address the issues • Highlight future plans • To inform the Board on the above and gain the Board's views on the future plans
Recommendation:	The Committee is asked to note the report and comment on future plans outlined for CAMHS.

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

Key Pressures

- Waiting times in specialist CAMHS have been up to one year.
- Waiting lists were closed temporarily for Autistic Spectrum Disorders (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) referrals where there were no associated urgent Mental Health needs.
- CAMHS emergency assessments in Emergency Department settings have increased significantly in recent years.

CQC report

CPFT also received an overall rating of Good from the CQC on 13 October, with all points classed as Good except for 'Are Services Safe?' which Requires Improvement, in part with regard to staffing for children's mental health services, which had knock on effects for waiting lists and observation.

However the report stated the trust had "met its targets required under the Department of Health's 'Positive and Proactive Care: reducing the need for restrictive interventions' agenda. There had also been a decreasing level of restraint and seclusion over the previous 12 months. […and] The trust demonstrated an improving picture of satisfaction during the 12 months before our inspection."

(From p6 and p12 of the CQC report, dated 13/10/15 and available at: http://www.cqc.org.uk/sites/default/files/new_reports/AAAE1951.pdf)

2. MAIN ISSUES

2.1 There are significant demand and capacity issues within CAMHS:-

- Emergency assessments in Emergency Department settings have increased significantly in recent years; this is causing significant additional demand for specialist CAMHS and puts pressure on acute settings (Addenbrooke's and Hinchingbrooke Hospitals).
- There are not enough inpatient CAMHS beds (commissioned by NHS England) to meet demand. Young people have to often stay in acute settings for a number of days, whilst waiting for a bed to become available. When a bed does become available, this could be anywhere in the country.
- General referrals to specialist CAMHS have also significantly increased in recent years (18% in 2014/15).
- The result of this increase in referrals is that waiting times for non-emergency cases are at unacceptable levels, for Attention Deficit Hyperactive Disorder (ADHD) and Autistic Spectrum Disorder (ASD) cases in particular, but also for 'Core CAMHS'.
- Patient journeys and pathways are often unclear to referrers and to families.

2. 2 What we have done so far

- **Strategic Group** – an Emotional Health and Strategy Group has been set up to have a strategic overview of all local Emotional Health and Wellbeing work, and to be the responsible strategic group for work across Cambridgeshire and Peterborough. This group is chaired by The Corporate Director: People and Communities, Peterborough City Council.

- **Transformation Plan** – A Cambridgeshire and Peterborough CAMHS Transformation Plan has been developed to detail our proposed work on emotional health and wellbeing. The development of such a plan has also been a requirement of each CCG area and needed to be assured by NHS England before additional national resources for CAMHS were released; as such our plan was assured in November 2015.

- **Additional resources** have been invested into specialist CAMHS for 2015/16. £600k recurrent funding and £150k non recurrent funding was invested by the CCG in April 2015 to increase capacity in local specialist services and address long waiting lists. In addition, a national uplift in CAMHS funding has become available to the CCG, since the Transformation Plan was assured (as above). For 2015/16 and subsequent years the additional funding for Cambridgeshire and Peterborough is £1.503m. In total, this represents a 30% increase in available CCG funding for Emotional Health and Wellbeing services.

Specific Short Term measures

- **Waiting lists** were temporarily closed for ASD and ADHD referrals where there were no associated urgent mental health needs. Work has been undertaken to reduce waiting lists and develop a more integrated pathway, so that Local Authority, Community Paediatric and CAMH Services work more effectively together to support children and families. However waiting lists were reopened in December 2015 and additional resources have been invested (£340k), with the intention of reducing the ASD and ADHD waiting times to below 18 weeks by the end of March 2016.
- **Combined single point of access for CAMHS and Local Authority services** – work with both LAs is ongoing to ensure that those with additional needs are assessed for a range of services, not just specialist CAMHS. To support this, a Commissioning for Quality and Improvement (CQUIN) Payment with Cambridgeshire and Peterborough Foundation Trust (CPFT) has been agreed for 2015/16 which focuses on the development of a single point of access for CAMHS and Local Authority Services.
- **Emergency Assessments and support** – A 'task and finish' group was set up in July 2015 and developed proposals for providing emergency assessment services for children and young people. An enhanced CAMHS crisis service was recommended and an additional £360k per annum identified to provide additional capacity. The detailed model is currently being agreed with providers to ensure coverage of times of peak demand and additional crisis support.
- **Eating Disorders** - £429k per annum of the CAMHS Transformation Fund was ringfenced to address those under 18 years old with eating disorders. A new model of care, based on strong evidence, will be implemented to provide intensive support in the community, with the aim of reducing the numbers of young people requiring inpatient admission.
- **Early Intervention –** for 2015/16, CAMHS Transformation Funds have been invested in a range of programmes including: Training on early intervention for Health Visitors and School Nurses; Parent Training programme development; support for Centre 33 to open additional facilities in Fenland; and developing parent support groups through Family Voice and PinPoint.

2. 3 Emotional Health and Wellbeing redesign

It is widely agreed that the work above will not fully address the systemic problems, and urgent redesign work is required across the whole pathway for Emotional Health and Wellbeing, which we have begun.

This redesign includes services currently commissioned by the CCG as well as Local Authority commissioned services. The principles behind this include:

- Integration of services – including multi-agency teams and a single entry point for CCG and Local Authority commissioned services
- A single seamless pathway experienced by children and their families
- Over time, shifting resources from specialist to early intervention and prevention
- Appropriate emergency assessment and support services
- Improving communications and information systems.

The work is being overseen by a Children and Maternity Transformation Programme lead, employed by Cambridgeshire and Peterborough CCG until the end of March 2016.

To support this work, Cambridgeshire and Peterborough have successfully applied to be an ITHRIVE NHS Accelerator site (one of 10 nationally). ITHRIVE provides a framework for emotional health and wellbeing services and we are locally receiving support from the ITHRIVE team to develop our new model for Emotional Health and Wellbeing services. The latest version of the ITHRIVE programme framework can be found here: http://www.annafreud.org/media/3048/thrive-elaborated-2nd-edition25112015.pdf (as detailed in the Source Documents).

A design group is in place involving a wide range of stakeholders, including specialist CAMHS, the voluntary sector, education, local authority staff, parent representatives, YOS, GPs and Early Years professionals.

A Young Person's Reference Group has also been put in place to input into the process and is being led through Healthwatch Cambridgeshire and Peterborough

2.4 Conclusion

Our additional investment has been focused initially on addressing waiting lists and gaps in our current service provision (such as ASD/ADHD, emergency and crisis support, eating disorders and early intervention). However, partners are taking this opportunity to redesign Emotional Health and Wellbeing services, so that they more effectively meet the needs of the population, are effective and efficient.

Source Documents	Location
THRIVE Elaborated; a second version revised framework and summary of the ITHRIVE programme (November 2015)	***http://www.annafreud.org/media/3048/thrive-elaborated-2nd-edition25112015.pdf***
CPFT CQC report, October 2015	***http://www.cqc.org.uk/sites/default/files/new_reports/AAAE1951.pdf***

Cambridgeshire and Peterborough NHS
NHS Foundation Trust

Child Mental Health Service Pressures – update

Report for Cambridgeshire County Council's Health Committee – 21 January 2016

Introduction

Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) are working to address the long waiting times for children and young people within CAMHS pathways both for Core (e.g anxiety, depression/low mood, etc.) and Neurodevelopmental (Attention Deficit Hyperactivity Disorder/Autistic Spectrum Disorder/Learning Disabilities).

There are two main areas of focus:

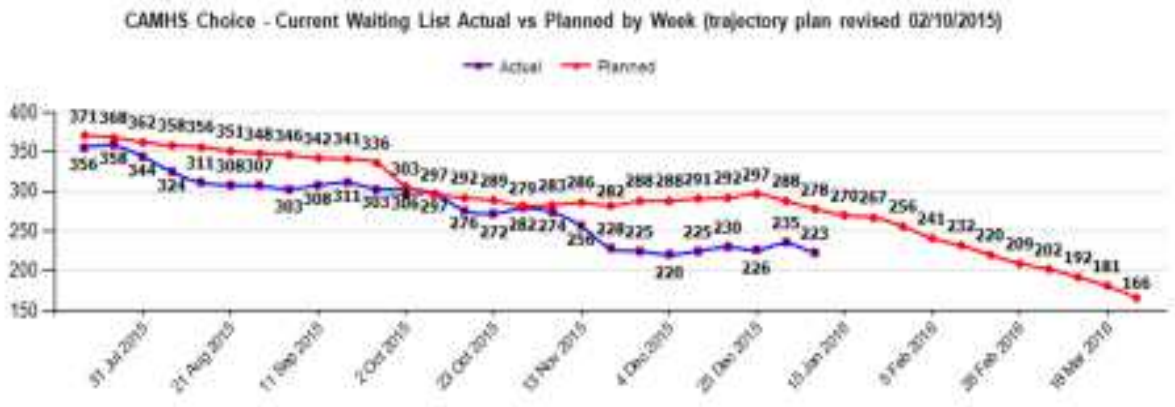
1. To reduce the waiting times for children and young people for assessment and treatment in CAMH for both the core and neurodevelopmenal pathways.
2. Service transformation - for the neurodevelopmental redesigned pathway work is being carried out in partnership between local authority, CCS, CCG and CPFT to ensure that there is a long term sustainable pathway with adequate capacity available to meet the needs of children and young people.

1. Reducing the Waiting Times

1.1 Core CAMHS waiting list

The assessment waiting list within core CAMHS has reduced from 356 to 223 since July 2015. This is a reduction of 133 cases. The waiting list has been targeted at those waiting the longest resulting in a reduction in the number of children and young people waiting more than 27 weeks. We continue to prioritise those requiring urgent assessment. The overall reduction is across all the geographical areas (Peterborough, Huntingdon, Cambridge and Fenland). Those waiting more than 27 weeks have been booked into appointments in January.

Work is ongoing to target those waiting in the 19 – 26 week bracket.
Of those children still waiting there are 175 in total in Cambridgeshire which can be broken down further into 76 waiting in Huntingdon and Fenland and 99 in Cambridge.
There are 2 waiting list blitz's starting in Cambridge week commencing 11 January and Huntingdon and Fenland week commencing 19 January to focus on the longest low risk waiters (note the high risk patients are being seen urgently according to need).
We are on track to reduce the waiting list so that no child waits more than 18 weeks for a first assessment by the end March 2016.



In order to maintain the waiting lists below 18 weeks from 1 April we are introducing Choice and Partnership Approach (CAPA) which is an evidence based approach to managing demand and capacity whilst ensuring active involvement of young people and their families in their care.

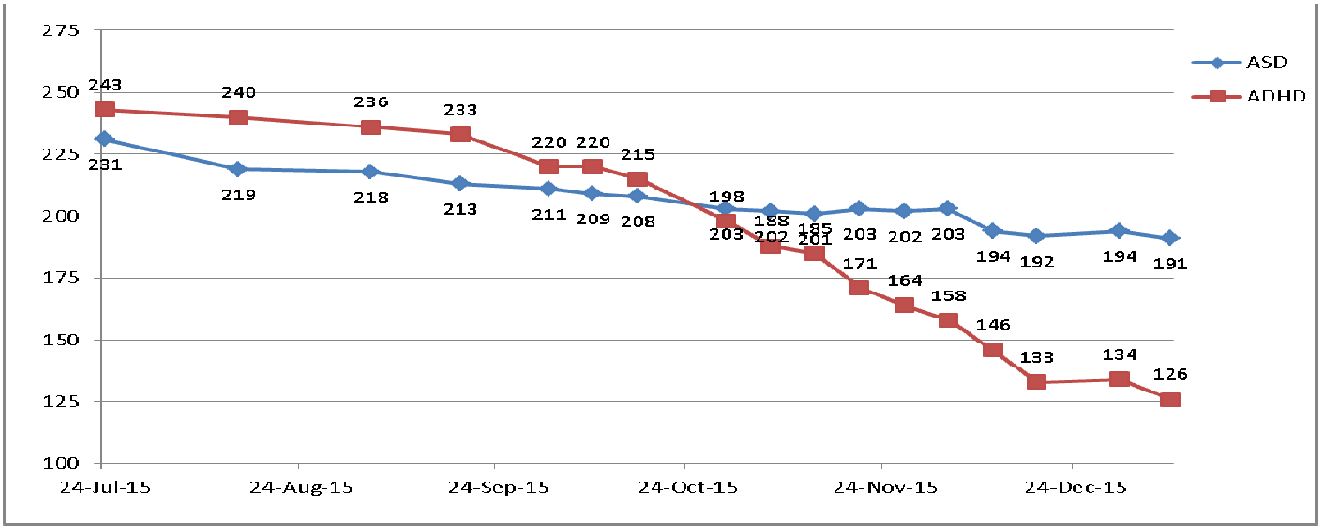
1.2 School age Neurodevelopmental services waiting list

There has been an increasing number of referrals to CPFT for assessment and management of Children and Young People (CYP) with possible Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder (ASD). This has resulted in a mismatch between demand and capacity. We had to temporarily close our service to new referrals due to lack of capacity. There are also gaps in the service for certain groups (17 to 18 years old young people for ADHD and ASD, 12 to 17 years old young people with ASD in Cambridgeshire - unless the young person also has other mental health conditions).

Since the closure of the service to referrals the CCG, Local Authorities and CPFT have been working hard to find a solution to the very real problem of rising numbers of children and families needing support. From 15th December 2015 the waiting list opened to new referrals. In order to ensure a full assessment and to gain access to a wide range of support services including parenting programmes the preferred route is through Family Common Assessment (CAF) in Cambridgeshire.

Following this route will prevent children and families sitting on a waiting list for assessment, with no support and provide the specialist services with further information if a referral is still needed after this initial support.

The graph below shows the current waiting list.



Of those children still waiting there are 104 in total in Cambridgeshire which can be broken down further into 63 waiting in Huntingdon and Fenland for ADHD and 9 for ASD and 27 waiting in Cambridge for ADHD and 5 for ASD.

2. Service Transformation

We are currently working with CCS on a pilot integrated multi-disciplinary team with additional clinics being provided in Fenland to focus on the existing long waiters.

There is now a plan to develop a single integrated multi-disciplinary team with services provided by CCS and CPFT working together in partnership. By enhancing the current provision, we will be able to improve the access to assessment and management for this vulnerable group of CYP. An enhanced service be delivered by CPFT as one part of a well co-ordinated pathway with a number of components delivered by other providers including Early Help Service and CCS Child Health Services. The CPFT neurodevelopmental pathway will be provided in a number of localities across Peterborough, Fenland, Huntingdon and Cambridge with sharing of clinic space between CPFT and CCS. The service would provide assessment, formulation and diagnosis, care planning, a range of evidenced-based psychological therapies and medication where needed.

This will also include working in partnership with Pinpoint and Family Voice on Parent to Parent Support & Training Pilot.

Sarah Spall, General Manager, Children's Directorate
Venkat Reddy, Associate Clinical Director, Children's Directorate

11 January 2016

Agenda Item No: 10

HOSPITAL CAR PARK CHARGES – BRIEFING NOTE

To:	**HEALTH COMMITTEE**
Meeting Date:	**21ST January 2016**
From:	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable**
Purpose:	**The Committee is being asked to consider the briefing report on Hospital Car Park charge.**
Recommendation:	**The committee is asked to**

a) **note the report and comparative charges**

b) **note the Healthcare Travel cost scheme (Appendix A)**

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

1.1 Concerns were raised by members of the Health Committee around excessive hospital car park charges at Cambridge University Hospital foundation Trust.

1.2 Particular issues were raised for visitors on low incomes needing to access the hospital but accessibility was restricted due to car parking charges. Concern was also raised for patients on low income or with no transport and ability to access outpatient appointments.

1.3 It was agreed that Health Committee spokes would review comparative information from hospitals providing services for residents in Cambridgeshire. On review of this information spokes recommended the following paper was brought to the attention of the Health Committee members.

1.4 The information provided below has been taken from each Hospital website on 3rd December 2015 and further patient information can be downloaded from the websites.

2. MAIN ISSUES

2.1 Comparison of Car park Charges

Visitor Car Parking Hospital Charges				
	CUHfT	**Hinchingbrooke Hospital**	**Peterborough & Stanford**	**Queen Elizabeth – Kings Lynn**
Up to 20 Minutes	N/A	No Charge	No Charge	N/A
Up to 30 minutes	N/A	No charge	No Charge	N/A
Up to 1 hour	£2.70	N/A		
Up to 2 hours	£3.90	N/A		
Up to 3 Hours	N/A	N/A	£2.60	£2.60
Up to 4 hours	£7.20	£2.90	£4.20	
Up to 5 hours	N/A	N/A	£5.20	£5.20
Up to 6 hours	£11.00		£6.30	
Up to 8 hours	£14.20	£4.00		£7.20
Over 8 hours	£17.80			
Up to 24 hours	N/A	£6.00	£10.40	£10.50
Frequent Visitors				
Up to 7 days	£18.30			£15.50
Up to 14 days	£31.00			
Outpatients, day surgery and emergency patients				
	CUHfT	No published details		
Up to 24 hrs	£3.40			
Patients receiving treatment for two or more consecutive days				
Seven day ticket £3.40				

2.2 Discounts & Concessions

2.2.1 Each hospital had different arrangements for discounts, all of these were published on the hospital websites. A summary is provided below.

2.2.2 Cambridge University Foundation Hospital Trust

http://www.cuh.org.uk/finding-us/parking

Disabled parking:
Standard and discounted parking fees for patients and visitors apply as above.

If you receive benefits:
On proof of certain benefits you may be able to claim back your travel expenses and car parking fee (where applicable) from the outpatients reception desk.
Patient and other concessionary tickets are available from the customer service desk.
Proof of appointment/s or treatment will be required.

The hospital requests that If you are claiming a concession, you do so at the time of your visit. They do not offer refunds for parking, once the fee has been paid.

CUHfT also operate a Patient Courtesy bus which operates Monday – Friday 07.30-16.00. http://www.cuh.org.uk/corporate-information/finding-us/patient-courtesy-bus

The hospital website also provides information on how funds from car parking charges are spent.
http://www.cuh.org.uk/corporate-information/finding-us/parking/car-parking-charges-how-your-money-spent

2.2.3 Peterborough & Stamford Hospitals

Peterborough City Hospital does offer a concessionary parking facility. This facility is available to those meeting the criteria.

Application forms are available on their website.

Parking at Stamford Hospital is currently free of charge.
http://www.peterboroughandstamford.nhs.uk/page/?title=Travelling+by+car+%26+parking&pid=12915#

2.2.4 Hinchingbrooke Health Care NHS Trust

Concession rates are offered for intensive care, children's ward patients and for all in-patients and visitors whose stay is expected to be over seven days, are these charges are as follows

Hinchingbrooke Hospital website provides information on the Healthcare travel cost scheme on its website this may be available for all hospitals. (See Appendix A)

2.2.5 Queen Elizabeth Hospital – Kings Lynn

Disabled parking
There are 70 disabled parking spaces at the Trust. Drivers displaying a valid Blue Badge can use any space on site free of charge and can stay as long as necessary.

3. SIGNIFICANT IMPLICATIONS

3.1 Resource Implications

There are no significant implications within this category.

3.2 Statutory, Risk and Legal Implications

There are no significant implications within this category.

3.3 Equality and Diversity Implications

There are some equality issues in regards to varying charges across the county.

3.4 Engagement and Consultation Implications

There are some engagement issues in regards to how the different hospitals promote their associated concessions and the use of the Healthcare Travel Cost Scheme.

3.5 Localism and Local Member Involvement

Local members have raised the initial concerns and there are some local differences in regards to charging see also 3.3

3.6 Public Health Implications

The information provided may have implications for the transport and health JSNA.

SOURCE DOCUMENTS GUIDANCE

Source Documents	Location
Cambridge University Foundation Hospital Trust *http://www.cuh.org.uk/corporate-information/finding-us/parking/car-parking-charges-how-your-money-spent*	Trust website
Peterborough & Stamford Hospitals *http://www.peterboroughandstamford.nhs.uk/page/?title=Travelling+by+car+%26+parking&pid=12915#*	Trust website
Hinchingbrooke Hospital *http://www.hinchingbrooke.nhs.uk/patients-and-visitors/parking/*	Hospital Website
Queen Elizabeth Hospital *http://www.qehkl.nhs.uk/car-parking.asp?s=information&ss=getting.to.us&p=parking*	Hospital Website

APPENDIX A

HealthCare Travel Cost Scheme (HTCS)

http://www.nhs.uk/NHSEngland/Healthcosts/Pages/Travelcosts.aspx

Patients and visitors may be able to claim a refund under the 'Healthcare Travel Costs Scheme' (HTCS) of the cost of travelling to hospital or other NHS premises for NHS-funded treatment or diagnostic test arranged by a doctor or dentist. To qualify for help with travel costs under the HTCS, you must meet three conditions:

1. At the time of your appointment, you or your partner (including civil partners) must be receiving one of the qualifying benefits or allowances, or meet the eligibility criteria of the NHS Low Income Scheme.
2. Your journey must be made to receive NHS-funded non-primary medical or non-primary dental care services, to which you have been referred to by a GP, dentist or hospital consultant.
3. For referrals made by a primary practitioner such a GP or dentist, the service must be provided on a different day and in premises other than those occupied by the practitioner who made the referral.