HEALTH COMMITTEE

Thursday, 19 September 2019

Democratic and Members' Services
Fiona McMillan
Monitoring Officer

13:30

Shire Hall
Castle Hill
Cambridge
CB3 0AP

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

AGENDA

Open to Public and Press

CONSTITUTIONAL MATTERS

1 Apologies for Absence

2 Declarations of Interest

Guidance for Councillors on declaring interests is available at:

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

3 Minutes - 11th July 2019 & Action Log **5 - 16**

4 Petitions and Public Questions

KEY DECISIONS

The Health Committee comprises the following members:

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

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

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

Clerk Name: Daniel Snowdon

Clerk Telephone: 01223 699177

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Agenda Item No: 3

HEALTH COMMITTEE: MINUTES

Date: Thursday, 11 July 2019

Time: 1.35p.m. – 16.02 p.m.

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

District Councillors D Ambrose-Smith, G Harvey and J Taverner.

Apologies: Councillors K Reynolds, T Sanderson and P Topping and District Councillor Massey.

224. DECLARATIONS OF INTEREST

The Director of Public Health advised the Committee that as a co-opted non-voting member of the Clinical Commissioning Group's Governing Body she would take no part in minutes 229 and 230.

The Vice-Chairman advised the Committee that the Co-opted Member representing Fenland District Council had changed to Councillor Alan Bristow following advice of the Monitoring Officer.

225. MINUTES – 23rd MAY 2019

The minutes of the meeting held on 23rd May 2019 were agreed as a correct record and signed by the Chairman.

226. HEALTH COMMITTEE – ACTION LOG

The Action Log was noted. A Member requested that the estimated completion date of actions be updated.

227. CO-OPTION OF DISTRICT MEMBERS

It was resolved to co-opt, Councillor David Ambrose Smith (South Cambridgeshire District Council), and Alan Bristow (Fenland District Council) to the Committee.

228. PETITIONS

There were no petitions.

229. COMMUNICATIONS AND ENGAGEMENT APPROACH TO DELIVERING THE CCG FINANCIAL PLAN

The Chairman invited Jess Bawden (Director of External Affairs and Policy), Dr Gary Howsam (Clinical Chair) and Dr Mark Sanderson (Medical Director) to inform the Committee of the Clinical Commissioning Group's (CCG) engagement plan.

Introducing the item, the Director of External Affairs and Policy informed the Committee that a lot of work had been done regarding communication however, the deadline of the

end of July would not be met due to work taking place relating to the Community Services review. Discussions had yet to take place with Parish Councils and they would be factored into the engagement plan. Members noted that engagement with the public would be undertaken through a variety of means including social media.

During discussion Members:

- Commented that values, priorities and change were not mentioned in the covering report and expressed concern that there was too great a focus on lifestyle which was difficult to influence when focused on in too directive a way.

- Commented that the title, The Big Conversation – Using Our Resources Wisely implied that resources had not been used wisely up to now and therefore suggested that context be included that provided greater understanding of where differences could be made.

- Sought clarity regarding the purpose of the Big Conversation. Officers explained that the 10 week time frame was challenging. A Community Panel was being established with Health Watch that would discuss prioritization and specifics that would feed into the long term plan. Officers emphasised that the purpose of the Big Conversation was to be a catalyst for changing the way in which health and wellbeing was discussed. Medical professionals had limited scope through which to influence health and wellbeing and there was a desire to expand the discussion to include green spaces and planning.

- Drew attention to the concept of the Big Conversation and questioned the extent to which it was two-way. Officers explained it was deliberately not called a consultation because responses had been historically low. Methods of engagement had been developed such as targeting individual questions on social media to younger people. In order for the exercise to be a success it was essential that engagement had to be focused and targeted.

- Questioned whether there would be a change in the CCG's actions based on the feedback received. Although unable to answer the question directly officers drew attention to a campaign undertaken by the CCG relating to the return of over the counter medicines and the cost of prescribing paracetamol that had been successful conversations with the public. A Member questioned whether they were in fact promotional campaigns rather than conversations.

- Questioned whether the CCG was asking the public what they want the CCG as an organisation to do and if so how that would be achieved. Officers explained that Health Watch would undertake testing of priorities with four panels.

- Noted the role of communications leads that would test the Big Conversation with as many groups as possible including patients.

- Noted the different layers of patient representation that included 90 patient groups that filtered into patient fora and then a single patient reference group.

It was resolved to:

a) Note and endorses the process of the draft engagement plan;

b) Require the timescales and the final for the engagement plan as soon as possible; and

c) Require the opportunity to comment and influence the approach to communications and engagement through regular Member briefings

230. CAMBRIDGESHIRE AND PETERBOROUGH CLINICAL COMMISSIONING GROUP ADDITIONAL UPDATE REPORT ON COMMUNITY SERVICES REVIEW

The Chairman informed the Committee that he had exercised his discretion and called in this item despite it not having been available five clear working days in advance of the meeting due to the significant public interest surrounding the financial position of the CCG.

Officers representing the CCG, Jess Bawden (Director of External Affairs and Policy), Dr Gary Howsam (Clinical Chair) and Dr Mark Sanderson (Medical Director), tabled an additional supporting document that would be presented to the CCG Board that evening. The spreadsheet detailed services identified by the CCG that were either to be decommissioned or contracts were not to be renewed, contracts which were to be renegotiated or required further information and finally a group of services that required further learning by the CCG.

The Committee was informed that there were three key components that were contributing to the financial position at the CCG. Firstly the CCG experienced higher activity when benchmarked against other comparable areas, secondly there was significant duplication of services provided through a multiplicity of providers and thirdly, the allocation of funding to the CCG was significantly less than its closest neighbours and was the third lowest funded CCG in the country.

Expanding on the allocation of funding, officers explained that there was a significant difference in the level of funding received per head of population compared to some neighbouring areas, which totaled £150m across the CCG. The shortfall in funding could not be afforded by the NHS and therefore there was a need to review every contract in order that best value and efficiency be ensured.

Members noted that hospitals were equally challenged financially and the Community Services review was about reviewing every service to ensure best value. Officers informed the Committee that although engagement work with providers had been undertaken, the publication of the CCG Board papers had brought forward significantly revised and improved data from providers and therefore the review was paused for two weeks in order for new information to be robustly assessed. Officers assured Members that the pause did not represent a loss of momentum with the review as the CCG was losing £1m per week and therefore momentum could not lost.

During discussion Members:

- Were informed that the Carers Trust supplied different categories of carers support and further work was being undertaken to assess whether funding be provided where the support bordered on a clinical level of support.

- Noted that the Health and Wellbeing Network had identified that the current grant required modification and had provided a revised proposal that required less funding.

- Sought greater clarity regarding the number of users of services. Officers explained the cost versus the number of interventions provided and informed the Committee during the review process some of the figures had been found to be incorrect.

- Questioned how the Dial-a-Ride service would be replaced. Officers explained that the CCG could not afford to maintain the service as it was provided to a small area surrounding Addenbrooke's Hospital and was not provided elsewhere in the county and was therefore inequitable.

- Questioned the level of engagement that had taken place and expressed concern that providers had claimed they had only been provided one week notice that their grant would cease. Officers advised that meetings with providers had taken place in May 2019 and letters had been written in December 2018 and March 2019. Throughout the conversations that had taken place organisations were aware that funding may cease. Providers were informed of the recommendation to the CCG Governing Body a week prior to the meeting and all were subject to further notice periods.

- Noted the ongoing work taking place with the Sustainability and Transformation Partnership (STP) that focussed on how organisations were working together and integrating more closely. Officers advised that the solution to the issues facing the CCG was through health and social care working together through the STP.

- Questioned the level of discussion that had taken place regarding displacement of service users to other providers. Members were informed that local authorities had been contacted where duplication of services existed. While there would be an impact on services officers sought to assure the Committee that the review was clinically led and patient focussed.

- Sought reassurance that transformational work was being undertaken by the CCG as their appeared to be little evidence it was taking place. Officers drew attention to the 'Big Conversation' which sought to empower communities in shaping the services they received which had not been done before.

- Expressed concern regarding the length of time that it had taken to reach this stage of the process. There was a need to change and act on what needed to be done.

- Expressed deep concern regarding the funding formula for the CCG that had resulted in it being severely underfunded for a number of years.

- Noted the comments of officers that the situation was different from the previous year and although the £192m figure was challenging there was an understanding on the part of the regulator that the work being undertaken was in the best interest of the system.

- Drew attention to the Stroke Association that was identified to have funding ceased and highlighted the risk of undermining community groups by doing so. Officers explained that the proposed contract for termination was a very small visiting sign-posting service that was also provided by the hospital. Sign-posting was provided by GPs, NHS England, providers and Cambridgeshire and Peterborough Foundation Trust (CPFT) who were also commissioned to provide the service.

- Noted the majority of stroke patients did not receive the stroke service as it was only provided in the Addenbrooke's area. If the service was required it would be provided by another part of the system.

- Commented that they remained to be satisfied that the impacts of the cuts to services had been thoroughly considered on a system-wide basis. Officers sought to provide assurance to the Committee that the proposed changes would not create gaps in provision.

- Noted that impact assessments had been undertaken on each individual services affected.

- Noted the assurance provided by officers that no changes to funding provided by the CCG would result in an organisation failing as they were funded through a variety of sources.

- Were informed that regarding the Alzheimers Society, further information had been provided by the organisation providing greater clarity on the work they undertook. Therefore, further work was being undertaken prior to any decision being taken.

- Drew attention to dermatology and asserted that the quality of service was being changed. Officers explained that duplication of the service was being removed from 9 GP practices where the service was provided at Addenbrooke's Hospital. The service could not be provided across all the county's GP practices and it was therefore inequitable for the service to remain in a small number.

- Sought greater clarity regarding the level of savings hoped to be achieved from groups 3 and 4 which required re-negotiation or further investigation. Officers informed the Committee that the CCG was hoping to achieve savings of £3m to £6m from the two groups.

- Noted the value of the Joint Emergency Team (JET) that prevented hospital admissions though supporting GPs. There was therefore a need to undertake further work with CPFT in order to re-design the patient pathway and make best use of the resources.

- Drew attention to the legal requirements regarding consultation when services were being altered and how that duty may be discharged.

In summary the Chairman expressed his deep concern regarding the planned focus on short-term financial cuts rather than service transformation. Without transformation the CCG would continue to struggle to find a sustainable financial platform on which to deliver services.

The Chairman with the support of the Committee undertook to write to the Secretary of State for Health and Social care regarding the disparity of funding received by Cambridgeshire which was one of the fastest growing areas of the country when compared to its closest neighbours such as Norfolk and Suffolk. The letter would highlight the ongoing difficulties within the CCG and request all possible support for the current management team. It would also emphasise the critical situation at the CCG and the concerns the Committee shared for the health and wellbeing of Cambridgeshire residents.

It was resolved to:

a) Note with concern the CCG update on the first phase of its Community Services Review

b) Require the CCG to return to the Committee in September 2019 in order to update Members following the meeting of the of the CCG Governing Board

c) |Require regular briefings from the CCG on the Community Services Review.

231. KEY DEVELOPMENTS AT CAMBRIDGE UNIVERSITY HOSPITAL FOLLOWING AN UNANNOUNCED CQC INSPECTION IN OCTOBER 2018 AND WELL-LED USE OF RESOURCES INSPECTIONS IN 2018

The Chief Executive Officer (CEO), Cambridge University Hospital, Roland Sinker, was invited by the Chairman to address the Committee regarding its recent inspection undertaken by the Care Quality Commission (CQC) and Well-Led Use of Resources inspections undertaken by NHS Improvement in November 2018.

The CEO reminded the Committee that the CQC was responsible for assessing the quality of care against four categories; safe, effective, caring, well-led and responsive. In September 2015 the CQC rated the hospital as inadequate.

Members noted the work that had been undertaken over the course of three years to move the hospital into the rated good category. It was unusual that the hospital had not been rated outstanding as all measures apart from responsive were rated as outstanding. A huge amount of work was being undertaken within the system and that was noted by the inspection team however, it was not enough to alter the rating.

During discussion, Members:

- Sought further information regarding waiting times. The CEO informed members that the 95% target for the emergency admissions to be seen within 4 hours was not being met. The target for treating people within18 weeks for planned care was not being met. There remained issues regarding Delayed Transfers of Care (DTOC) where upwards of 10% of the bed base was being held by patients who were fit for discharge.

- Noted that as a health system a control total had been agreed that was deeply challenging and the sustainability of the challenge required testing within a three to five year financial plan. From that the factors driving the current financial difficulties could be established and a position moving forward could be established.

- Questioned whether the areas that required improvement; responsiveness and use of resources, could be improved without moving significant resources from elsewhere and whether they likely to improve because of the planned cuts. The CEO explained that there was significant transformational work that could be undertaken that would improve patient pathways and therefore move forward on the responsiveness measure. Regarding the use of resources, the hospital would struggle to move forward without government support which was backed by the report.

- Emphasised the importance of giving due recognition to the positive elements of the report.

- Drew attention to the failure to improve the position relating to the responsiveness measure and sought further information regarding the reasons why. In response the CEO explained that large numbers of metrics were supplied to the inspection team that demonstrated improvement in the responsiveness measure however it was not enough in order to be moved into the good category. If the hospital was to be reviewed again, in the case of older people fit for discharge it has improved significantly down from 100 to 29 patients classed as DTOCs. The CEO warned that the coming year would be very difficult and transformational work to improve the patient pathway would improve the position however, if the financial position could not be solved then the system would be under severe pressure.

- Welcomed the time taken within the organisation to develop staff and emphasised that the hospital should be enormously proud of its staff.

It was resolved to note the contents of the report, recognise the improvement that has taken place over the last three years and the work being undertaken to address the findings and deliver further improvement.

232. CONTRACT NOVATION IN RESPECT TO THE INTEGRATED DRUG AND ALCOHOL TREATMENT SERVICE CONTRACT

A report was presented that sought to secure the support of the Health Committee to novate Cambridgeshire County Council's Integrated Drug and Alcohol Treatment Service contract from the charity Change Grow Live, to the wholly owned subsidiary of the charity, Change Grow Live Services Limited.

Commenting on the report a Member confirmed their satisfaction with how the arrangement had been organised and drew attention to the Charity Commission who were supportive of this type of novation, providing the purpose was to improve outcomes for service users.

It was resolved to:

a) Review the rationale for the request for contract novation

b) Approve the contract novation of Cambridgeshire County Council's Integrated Drug and Alcohol Treatment Service contract from the charity Change Grow Live, to the wholly owned subsidiary of the charity, Change Grow Live Services Limited

c) Authorise the Director of Public Health, in consultation with the Chairman and Vice Chairman of the Health Committee, to novate the current contract subject to compliance with all required legal processes; and

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

233. FINANCE AND PERFORMANCE REPORT – MAY 2019

Members considered the May 2019 iteration of the Finance and Performance report, the first of the financial year that presented a balanced financial position.

During the course of discussion Members:

- Drew attention to the accruals process and suggested it was an area that required the focus of officers and the Committee in order to ensure that costs were reported in the same financial year.

- Highlighted decreasing activity in primary care and questions the reasons why it was happening. Officers explained that the trend had occurred over several years and was related to workload.

It was resolved to review and comment on the report and to note the finance and performance position as at the end of May 2019

234. NHS QUALITY ACCOUNTS – HEALTH COMMITTEE FINAL RESPONSES TO QUALITY ACCOUNTS 2017/18

Members received a report that provided an update to the Committee on the final responses submitted to NHS provider Trusts in regards to their Quality Accounts 2018/19.

The Committee recognised and thanked Councillor Jones for the work she had undertaken in reviewing the accounts.

It was resolved to note the statements and responses sent to the NHS Provider Trusts.

235. HEALTH COMMITTEE WORKING GROUP AND QUARTERLY LIAISON GROUP Q2 UPDATE REPORT

The Committee received a report that updated it of the activities and progress of the Committee's working groups.

The Vice-Chairman reported to the Committee the work of the Earmarked Reserves Working Group and applauded it as an example of good cross-party working and thanked all that attended.

Members noted that a decision would be brought before the Committee regarding the level of reserves that would be maintained (around £500k). A further report would be provided to the Committee in September 2019 that would seek the Committee's approval for the allocation of reserves for a falls prevention programme and to achieve transformational change. Members were informed that £45k of the reserves had been allocated to support work on a best start in life strategy, which was authorised by the Director of Public Health.

It was resolved to:

a) Note the content of the quarterly liaison groups and consider the recommendations that may need to be included in the forward agenda plan

b) Note the discussions from the Public Health Reserves Working Group.

236. HEALTH COMMITTEE TRAINING PLAN

The Committee received its Training Plan.

It was resolved to note the training plan.

237. HEALTH COMMITTEE AGENDA PLAN,

The Committee examined its agenda plan and noted the additional scrutiny item scheduled for September 2019 relating to the Clinical Commissioning Group.

It was resolved to review the agenda plan

Agenda Item No: 3b

HEALTH COMMITTEE

Minutes-Action Log

Cambridgeshire County Council

Introduction:

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

Minute No.	Item	Action to be taken by	Action	Comments	Status & Estimated Completion Date
Meeting of 17 January 2019					
185.	**Finance & Performance Report – November 2019**	**Liz Robin**	Provide further information relating to the Ambulance Trust within C&CS Research	Research team has been asked for an update.	**Ongoing**
Meeting of 23rd May 2019					
221.	**Public Health System Peer Review**	**Liz Robin**	Members requested a structure chart in which the links between directorates were visible		**Completed**

Agenda Item No: 5

FALLS PREVENTION PROGRAMME INVESTMENT

To: **Cambridgeshire County Council Health Committee**

Meeting Date: **19th September 2019**

From: **Director of Public Health**

Electoral division(s): **All**

Forward Plan ref: **2019/057** *Key decision:* **Yes**

Purpose:

To consider the investment and recommended changes in the Falls Prevention Programme.

Recommendation:

a) To approve a three year investment in the Falls Prevention Programme as detailed in paras 2.11 - 2.27;

b) Consider and approve the geographical area(s) for deployment of an intensive Multi-Factorial Falls Risk Assessment and home adaptations programme, choosing from the two options presented in para 2.32;

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

d) Authorisation of LGSS Law to draft and complete the necessary documentation to enter into the section 75 agreement.

	Officer contact:		***Member contacts:***
Name:	**Helen Tunster**	Names:	Cllr Peter Hudson
Post:	Senior Partnership Manager (Falls Prevention)	Post:	Chair, Health Committee
Email:	Helen.Tunster@cambridgeshire.gov.uk	Email:	Peter.hudson@cambridgeshire.gov.uk
Tel:	01223 699405	Tel:	01223 706398

1. BACKGROUND

1.1 A fall is defined as an unplanned descent to the floor with or without injury to the patient. Falls are the commonest cause of accidental injury in older people and the commonest cause of accidental death in the population aged 75 and over in the UK. The estimated cost of falls and fractures to the health and social care system in Cambridgeshire and Peterborough in 2017 was £85.5M (STP Falls Prevention Business Case, 2017). In addition to the financial costs, the intangible human costs of falling include distress, pain, injury, loss of confidence and loss of independence, as well as the anxiety caused to relatives, carers, and hospital staff.

1.2 The existing Falls Prevention Programme commenced a two year project in October 2017, funded in part by the STP and Public Health. Between October 2017 and September 2018 almost 7000 people over the age of 65 were screened for their risk of falls, of which over 4400 people were identified at risk of a fall, and 2430 had an intervention plan put in place.

1.3 A preliminary analysis was conducted on the impact of the programme on hospital admissions for falls to Cambridge University NHS Foundation Trust (CUHFT). The analysis indicated there were promising, but not conclusive, reductions in the number of admissions. Comparing the eight month period from February-September 2017 with the same period in 2018, there was a reduction of 50 fall related admissions.

1.4 In order to continue to develop these interventions further, an extension and variation to the original programme is required. The amended programme is based on the recommendations from the evaluation of the previous programme and more recent published evidence. The evaluation showed that any future programme should have sufficient scale, power and duration to detect changes in admissions at a population level, and that it should monitor the impact of the programme for each participant. More recent published evidence includes a review of the Occupational Therapy-led Home Hazard Assessment and Improvement Programme with a reported Return on Investment of £3.17 saved for a £1 spend and a reduction in the rate of falls by 31%. The evidence also demonstrates that the Falls Management Exercise (FaME) programme is more effective for all older people, than the existing OTAGO provision which is aimed at people at a high risk of falling. Finally there has been further evidence in support of home and group based strength and balance programmes with each reducing the rate of falls by 29% and 32% respectively.

2. MAIN ISSUES

2.1 Programme Overview

2.11 The aim of the programme is to prevent any increase in the rate of injurious falls and improve the quality of life and health outcomes. The programme will be integrated within the Adults Positive Challenge and will contribute to the savings target of £3.8M in 2020/21. It is proposed to extend the Falls Prevention Programme by a period of three years and reshape the programme in line with the lessons learnt so far and the evidence base. The aim of the

programme is threefold; 1) to initiate the delivery of integrated Multi-Factorial Falls Risk Assessments (MFFRAs) with Occupational Therapy led home hazard assessments and modifications; 2) to refocus the Falls Prevention Health Trainer service to deliver a programme that is effective in a greater cohort of the population, and; 3) to strengthen and pump prime the strength and balance classes run in the community. Subject to evaluation, the evidence collected from the programme will be used in future service specification with the negotiation of a funding contribution from the NHS. The total annual cost of the programme is £257k, with an additional option for a full economic evaluation of £33k.

2.2 Programme Scope

2.21 To extend the number of Multi-Factorial Falls Assessments (MFFRAs) integrated with home hazard assessments and home adaptations/equipment. To expand the team by an additional four Therapy Assistants within the approved area(s). Total cost £148.6k p.a excluding major adaptations which are funded through the Disabled Facilities Grant in agreement with District Councils.

2.22 To expand the Falls Prevention Health Trainer Team by one member of staff, and to deliver the Falls Management Exercise (FaME) programme to target a cohort of people at a lower risk of falls. Total cost £51.3k p.a.

2.23 To commission a community provider(s) to deliver the FaME programme. Quality assurance of provision through Cambridgeshire and Peterborough Foundation Trust exercise specialists. Total cost £13.4k p.a.

2.24 To continue the Forever Active Coordinator post at 3 days per week. The role will support the set up and co-ordination of community based strength and balance classes and new physical activity opportunities for younger older adults (section 2.25). Total cost £20k p.a.

2.25 To join-up with existing providers/projects to promote, develop and implement existing and new physical activity opportunities to prevent the age-related decline in muscle strength, bone health and balance for the 50+. To include pump-priming of quality assured level 4 strength and balance classes and activities such as tai chi, resistance training and ball sports. Total cost £20.4k p.a.

2.26 Implement a falls communications plan. The proposal is to continue the marketing campaign to target those who may or may not have fallen. Total cost £10k p.a.

2.27 Formal evaluation. The proposal details the metrics which will demonstrate the effectiveness of the programme. However, an in-depth and independent evaluation should be commissioned to advise a future programme specification. Estimated total cost £33k.

2.3 Programme targeting

2.31 The evaluation of the previous programme demonstrated the need to increase scale in order to demonstrate an effect on the number of hospital admissions. The proposal is to continue a universal programme but to intensify the Multi-Factorial Falls Risk Assessment and home

adaptations in a specific geographical area(s). It is anticipated that such a concentrated programme will reduce or slow the rate of hospital admissions for falls in those areas.

2.32 An options framework was developed and ratified at the Falls Prevention Strategy Group to recommend the areas for the intensive programme. The framework took into account rates of falls related hospital admissions and the feasibility of implementation. Two options for deployment are presented. Option 1 targets Cambridge City and South Cambridgeshire to align with the CPFT locality of 'Cambridge' thus supporting feasibility of delivery. Option 2 targets Cambridge City and Fenland and more precisely matches the known local need.

2.4 Project management and governance.

2.41 All aspects of the proposal remain the responsibility of the Falls Programme Manager within the Public Health department and will continue to be reviewed on a quarterly basis by the Falls Prevention Strategy Group. The options within the proposal relate to the scale of Home Hazard Assessments, and the recruitment of additional support for the Health Trainer team. The Forever Active Coordinator post and Community Classes would be time extensions of the existing provision, subject to advice from LGSS procurement. Due to the existing partnership arrangements the recommendation is to commission the Multi-factorial falls assessment and home hazard assessment service as a Section 75 agreement with Cambridgeshire and Peterborough NHS Foundation Trust with a full contract specification and monitoring process, and to deliver the additional Health Trainer through a variation to the contract for the current falls health trainer service, subject to advice from LGSS procurement.

2.5 Anticipated savings.

2.51 The implementation of the Falls Prevention Programme and reduction in the rate of falls will reduce demand for health and care resources. The prevention of serious falls will reduce the social care demand for long or short term residential care, whilst the prevention of less serious falls will reduce the cohort of people that may become high risk fallers in the future. The group aspects of the programme will help people to maintain independence and improve their quality of life. The rate of falls for the participants has been assumed to be a 24% reduction in participants receiving an integrated Multi-Factorial Falls Risk Assessment (MFFRA) and home adaptations, and the 6 month Falls Management Exercise (FaME) Strength & Balance programme is assumed as a 26% reduction.

2.52 The proposed service model for Multi-Factorial Falls Risk Assessments and home adaptations suggests 960 assessments per year, which is anticipated to prevent 230 falls of which 23 will be serious falls. The expected cost savings are £114k for social care with a total system saving of £208k. The reduction of 23 injurious falls is expected to prevent 1.5 admissions to long term care a year, a saving of £87k based on an average length of stay of 27 months (of the total social care cost of £114k).

2.53 The proposed service model for delivering the FaME programme is expected to reach 575 participants in total, and anticipated to prevent 104 falls of which 10 will be serious falls. The expected cost savings are as £49.8k for social care with a total system saving of £90k. The reduction of 10 injurious falls is expected to prevent 0.5 admissions to long term care a year,

a saving of £37.8k based on an average length of stay of 27 months (of the total social care cost of £49.8k).

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 A good quality of life for everyone

The report above sets out the implications for this priority in **2.51**

3.2 Thriving places for people to live

The report above sets out the implications for this priority in **2.51**

3.3 The best start for Cambridgeshire's children

There are no significant implications for this priority.

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

The report above sets out details of significant implications in 2.2

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

The report above details the procurement implications in para 2.41

4.3 Statutory, Legal and Risk Implications

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

- Falls resulting in hospital admission have significant health and social care resource implications

4.4 Equality and Diversity Implications

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

- The programme is universal in the interventions it offers, communications and engagement will be tailored to the specific communities identified
- The Community (Equality) Impact Assessment is attached as Appendix 2.

4.5 Engagement and Communications Implications

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

- A specific resource has been identified and the Falls Prevention Strategy Group can oversee the communications and engagement plans.

4.6 Localism and Local Member Involvement

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

- The Falls Prevention Programme will work with individuals and communities across the whole of Cambridgeshire to support their engagement with the programme.
- Any fall can reduce the motivation of an individual to be active members of the local community
- The provision of a community and group based falls programme will help alleviate loneliness

4.7 Public Health Implications

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

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

Source Documents	Location
Appendix 1 Falls Prevention Business Case	Attached
Appendix 2 Community Impact Assessment	Attached
Craig J, Murray A, Mitchell S et al. The high cost to health and social care of managing falls in older adults living in the community in Scotland. Scottish Medical Journal 2013;58(4):198-203.	Room 108, Shire Hall, Cambridge Also available at: http://scm.sagepub.com/content/58/4/198.
Public Health England (2018). A Return on Investment Tool for the Assessment of Falls Prevention Programmes for Older People Living in the Community. London: Public Health England. Available at: [Accessed 14 June 2019]	Room 108, Shire Hall, Cambridge Also available at: https://www.gov.uk/government/publications/falls-prevention-cost-effective-commissioning

Business Case

PROJECT MANAGEMENT TOOLKIT

Business

Cambridgeshire County Council

Project Title: Falls Prevention Programme

Date: 7th June 2019

Strategic Lead: Laurence Gibson

Project Manager: Helen Tunster

Approvals:

1. **Health Committee**

Distribution:

1. Ageing Well Strategy Board
2. Cambridgeshire and Peterborough Falls Prevention Strategy Group
3. Cambridgeshire Adaptations Steering Group
4. See Section 8 for all Key Stakeholders

The Business Case is a description of the reasons for the project and the justification for undertaking it, based on the estimated costs, risks and the expected business benefits and savings.

*It is the **most important** set of information for the project as it drives the decision-making process. It is updated if any changes occur to the project to ensure it is still aligned to the business objectives.*

Before proceeding please consider whether it may be more appropriate to develop the Business Case on Verto.

VERSION HISTORY

Version	Date	Comments/evidence of decision (hyperlink to document)
1.0	**7th June 2019**	Final Version for Sign-off
2.0	**14th June 2019**	Updated version following discussed changes
3.0	**28th June 2019**	Updated version following feedback from Advanced Chair and Lead Members' briefing group, and Cambridgeshire and Peterborough Falls Prevention Strategy Group
4.0	**2nd August 2019**	Updated with feedback from Cambridgeshire and Peterborough Falls Prevention Strategy Group, Adaptations Steering Group, CPFT and individual organisational feedback
5.0	**13th August 2019**	Review and sign-off by Laurence Gibson
6.0	**29th August 2019**	Feedback from the Health Committee Advanced Chair and Lead Members' briefing
7.0	**9th September 2019**	Feedback from significant implications

1) Project Driver

A fall is defined as an unplanned descent to the floor with or without injury to the patient. Falls are the commonest cause of accidental injury in older people and the commonest cause of accidental death in the population aged 75 and over in the UK. The estimated cost of falls and fractures to the health and social care system in Cambridgeshire and Peterborough in 2017 was £85.5M (STP Falls Prevention Business Case, 2017). In addition to these financial costs, there are additional costs that are more difficult to quantify. The intangible human costs of falling includes distress, pain, injury, loss of confidence and loss of independence, as well as the anxiety caused to patients, relatives, carers, and hospital staff.

Demography

Table 1 shows population forecasts for the Cambridgeshire population aged 65 and over. The number of older people aged 65 and over is expected to increase by 23,000 people by 2028, an increase of 18%.

Table 1 Cambridgeshire population forecasts, and % change, people aged 65 years and over

Age	2020	2024	2028	% Change 2020-2028
65+	127,900	138,500	151,300	21%

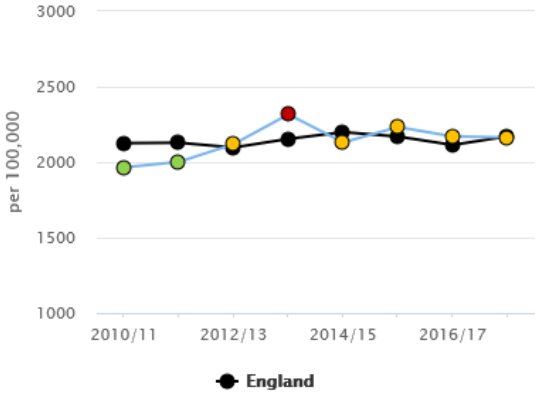
Source: ONS 2016-based subnational population projections

Incidence and outcome of falls

Hip fractures remain the most serious consequence of a fall and the most common cause of accident related death in older people. In 2017/18 in Cambridgeshire there were 2,659 people aged 65 and over who were admitted to hospital as an emergency with injuries due to falls and 654 people aged 65 and over admitted with a fracture of the hip. The rate in Cambridgeshire for falls

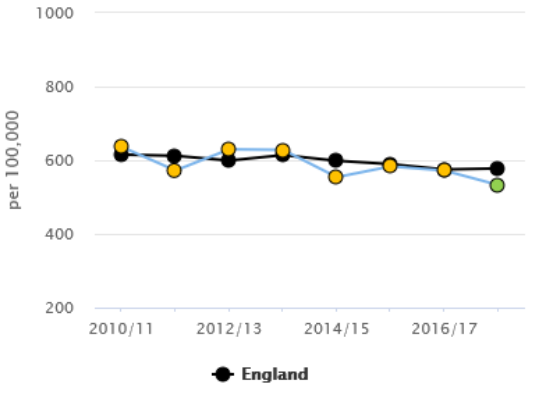
causing an admission to hospital in 2017/18 was 2,164 per 100,000, higher than the East of England region (2,026 per 100,000) but similar to the rate in England (2,170 per 100,000). In contrast, the rate of more serious falls (fractured neck of femur) in 2017/18 in Cambridgeshire was 533 per 100,000, lower than both the East of England region (577 per 100,000) and England (578 per 100,000).

Table 2 Emergency hospital admissions due to falls in people aged 65 and over. Cambridgeshire. Directly standardised rate - per 100,000



	Number	Rates per 100,000 DSR		
		Cambridgeshire	East of England	England
2010/11	1,973	1,965	1,886	2,126
2011/12	2,080	2,002	1,917	2,128
2012/13	2,291	2,119	1,973	2,097
2013/14	2,577	2,316	2,025	2,154
2014/15	2,448	2,130	2,026	2,199
2015/16	2,613	2,232	1,989	2,169
2016/17	2,600	2,170	1,974	2,114
2017/18	2,659	2,164	2,026	2,170

Table 3. Hip fractures in people aged 65 and over. Cambridgeshire Directly standardised rate - per 100,000



	Number	Rates per 100,000 DSR		
		Cambridgeshire	East of England	England
2010/11	639	636	607	615
2011/12	600	572	597	612
2012/13	683	630	601	599
2013/14	698	628	616	614
2014/15	635	554	582	599
2015/16	681	583	583	589
2016/17	684	572	579	575
2017/18	654	533	577	578

Source: PH Outcomes: accessed June 2019

Estimated costs of falls and hip fractures in Cambridgeshire

In 2013, results were published from a Scottish study which aimed to estimate the costs for health and social care services in managing older people in the community who fall.[1] The study used predominantly national databases and cost of illness methodologies and the authors noted that costs, while specific to Scotland, were anticipated to generalise to other parts of the UK. The study found that 34% of people aged 65 years and over living in the community fall at least once a year and 20% of these people contacted a medical service for assistance. Applying the results from the Scottish study to local population figures for Cambridgeshire, we can estimate several associated costs of falls across health and social care. It is suggested that 55% of costs are incurred by social

[1] Craig J, Murray A, Mitchell S et al. The high cost to health and social care of managing falls in older adults living in the community in Scotland. Scottish Medical Journal 2013;58(4):198-203. Available at: http://scm.sagepub.com/content/58/4/198.

care, mainly providing long term care following hospital discharge. The costs associated with social care after discharge are estimated at £36m[2], of which £27m are subsequent discharges to long term residential care.

Progress to date

Reducing the risk of a fall requires the active engagement of many individuals, disciplines and teams involved in caring for older people. Targeted evidence based interventions have shown to reduce falls by up to 30%, with specific programmes for improving strength and balance demonstrating reductions in risk of 55% in high-risk groups[3]. To ensure co-ordination, high-quality prevention requires an organisational culture and operational practices that promote teamwork and communication, as well as individual expertise. Therefore to reduce the level of hospital admissions due to falling, a multi-faceted falls prevention approach is considered fundamental.

The STP Falls Prevention Programme commenced a two year pilot in October 2017, and in order to continue to address the number of falls across Cambridgeshire, an extension to the original programme is required. The STP Falls Prevention Programme was designed around the published evidence base, and findings from the Better Care Fund St Ives Falls Prevention pilot. The Programme specifically focussed on 1) Standardising provision and reducing the known local variation in quality and equitable accessibility of falls prevention services in the local community 2) Increasing the scale of delivery to reach higher numbers of older people known to be at risk of falls and 3) Building and strengthening co-ordination of the health and care system.

The STP falls prevention programme was implemented across Cambridgeshire & Peterborough with a fundamental goal to embed the most effective interventions - multi-factorial falls risk assessments and strength and balance exercise programmes - into the processes and practices of the 14 Neighbourhood Teams, Everyone Health and the new Peterborough provider, Solutions4health. The implementation was enabled by a new IT falls pathway in CPFT (driven by the STP programme/falls working group), and comprehensive training and supervision of staff as part of the STP programme. A multi-media 'Stronger for Longer' social marketing campaign was launched on 1st October 2018 to raise awareness and encourage the uptake of strength and balance programmes. Furthermore, work to strengthen system level coordination was initiated to embed the links between community pathways and pathways in acute, primary care, care home, adult social care, and ambulance/emergency services. This system integration continues to be led by the Cambridgeshire and Peterborough Falls Prevention Strategy Group reporting to the Ageing Well Strategy Board.

The evaluation of the Falls Prevention Programme showed that the programme had substantially improved the identification of people at risk of falls compared to before the programme. Almost 7000 of the projected 119,070 over 65 population (approximately 6%) in Cambridgeshire were screened for falls risk between October 2017 and September 2018, leading to the pro-active identification of over 4400 people at risk of falls (approx. 10.8% of the 40,484 at risk). Over 2430 of these had received a high quality multi-factorial falls risk assessment completed by CPFT or Everyone Health (approx. 6% of the population at risk) by September 2018, and, as a result, had an intervention plan in place to reduce their risk of falling by addressing risk factors such as underlying medical causes of falls, high risk falls medications or 4+ medications, balance and gait issues, and vision impairments. Following the assessment, nearly 750 older people had a home strength and balance exercise programme set up and were working to improve their strength and

[2] At discharge all patients were assumed to have a shared assessment by a social care worker and community. For those going directly home, a care package comprising a GP visit and eight weeks of 'low cost' care including home care and healthcare was assumed. For those discharged into a care setting two costs were assumed – those able to return home by 120 days, and costs for those remaining in residential care for average length of stay of 27 months.

[3] P. A. Logan et al (2010). Community Falls Prevention for People Who Call an Emergency Ambulance after a Fall: Randomised Controlled Trial. BMJ; 340: c2102.

balance motivated by CPFT, Everyone Health and Solutions4Health. The evaluation of the 'Stronger for Longer' campaign demonstrated an additional 101 people attending community strength and balance exercise classes in the first three months after the launch (October 2018 – December 2018). In this time, the campaign received good coverage including: Interviews on radio (BBC Radio Cambridgeshire x3 with a reach of 40K-60K adults per show) and TV (Look East News and ITV News with a reach of 250K-300K adults per show); Local Newspapers (x3); 11 community newsletters; 44 council social media posts with 10.5K older adults clicking on posts; 400 posters; and approx. 36,000 'super six' exercise leaflets distributed. This resulted in 5,000 unique visits to the Be-Well website 2,300 downloads of exercise leaflets, and 29,000 views of videos and the animation challenge.

A preliminary analysis was conducted of the impact of the programme on falls admissions to Cambridge University NHS Foundation Trust (CUHFT). The analysis indicated there were promising, but not conclusive, reductions in the number of admissions. Comparing the eight month February-September period 2017 with the same period in 2018, there was a reduction of 50 admissions due to injurious falls (assuming falls would have increased at a rate of 2% per annum). This would equate to a saving of £302,000 to the commissioner in terms of secondary care activity savings and a saving of £305,000 to social care, £174,000 of which would be realised in the first year after the prevented falls. Based on the total spend on the programme of £307,720 from the STP, Public Health and Better Care Fund and the total savings of £612,000 (including future years), the programme can be shown to demonstrate an ROI of £1.98 for every £1 spent.

Lessons learned from the evaluation report

- The programme showed a reduction in admissions due to injurious falls but the programme was not at a sufficient scale to detect a statistically significant reduction in falls admissions. Any future programme should have sufficient scale, power and duration to detect changes in admissions at a population level.
- The additional falls work for CPFT Neighbourhood Teams generated by the falls programme were not fully understood and adequately resourced at the outset of the programme. This lead to increased workloads for Neighbourhood Teams, longer waiting lists and a lower threshold of activity reached than planned. Any future programme should ensure the delivery model is adequately resourced and financially sustainable to meet the demand and increase in future demand from an ageing population.
- The level of strength and balance exercise activity of the CPFT band 4 Therapy Assistants was lower than expected in comparison to the activity of the Everyone Health Falls Prevention Health Trainers. This was due to operational issues, a broadening of roles to support Neighbourhood Teams, and the client group having a higher level of need requiring more intensive follow up.
- The use of dedicated staff for falls prevention work should be considered in future and also, opportunities should be explored to integrate and cross populate assessments with falls risk assessment questions to streamline and improve efficiency
- There is a need to utilise more robust ways to monitor the impact and outcomes of the programme, including the wider impact on other services in the system in addition to hospital admissions.

New evidence since the programme was implemented:

Further evidence has now been published;

- Home-based and group based strength and balance programmes have strong evidence of effectiveness reducing the rate of falls by 29% and 32% respectively with both demonstrating a £1:£1 financial Return on Investment (ROI) and a societal ROI of around £2.20:1 (Public Health England, 2017[4]; Public Health England 2018[5]).
- Delivery of an Occupational Therapy-led Home Hazard Assessment and Improvement Programme reduces the rate of falls by 31% and shows a good ROI (Financial ROI is £3.17:£1 spent and a societal ROI of £7.34:£1)(Public Health England, 2017[4]; Public Health England 2018[5]). The effectiveness is greatest by delivery by OTs and targeting those at highest risk of falls (People aged 65+, with a history of falls, and also possess more than one other risk factor for falls)[6&7.]
- The Falls Management Exercise (FaME) programme is effective for all older people (no previous history of falling, higher and lower functioning adult) whereas OTAGO is only effective in frailer/lower functioning older adults and high risk fallers (>3 falls in previous year and frail).

[4] Public Health England (2017). Falls and Fragility Fracture Consensus Statement. London: Public Health England. Available at: https://www.gov.uk/government/publications/falls-and-fractures-consensus-statement [Accessed 14 June 2019]

[5] Public Health England (2018). A Return on Investment Tool for the Assessment of Falls Prevention Programmes for Older People Living in the Community. London: Public Health England. Available at: https://www.gov.uk/government/publications/falls-prevention-cost-effective-commissioning [Accessed 14 June 2019]

[6] Other risk factors includes use of mobility device, requiring assistance for activities of daily living (ADLs), use of psychoactive medicines and history of falls.

[7] Pighills et al (2019). What type of environmental assessment and modification prevents falls in community dwelling older people? BMJ: 264.

The lessons learned and the new evidence suggest a number of points to address in any programme extension:

- A falls specific home hazard assessment has been integrated into the existing high quality multi-factorial falls risk assessments, and capacity would be increased with four Therapy Assistants recruited in addition to extending the contracts of the two existing Therapy Assistants.
- Delivery of the FaME strength and balance exercise programme would be scaled up and a resource has been put in to manage a number of community strength and balance classes.
- Project outputs and outcomes will be specified to monitor uptake and compliance to interventions, and appropriate IT systems will be implemented as necessary.

2) Project Overview

The aim of the programme is to prevent any increase in the rate of injurious falls and improve the quality of life and health outcomes. This will be achieved by scaling up and targeting the delivery of the existing integrated Falls Prevention programme across Cambridgeshire. The proposal includes deploying the programme in areas of greatest need to demonstrate that an intensive local programme could reduce falls. This will provide a local evidence base to support a future funding requirement from the wider NHS and local government health and care systems.

It is proposed to extend the Falls Prevention Programme by a period of three years and reshape the programme in line with the lessons learnt so far and the emerging evidence base. The aim of the programme is threefold; 1) to deliver integrated Multi-Factorial Falls Risk Assessments (MFFRAs) with OT-led home hazard assessments and modifications in areas of greatest need; 2) to refocus the Falls Prevention Health Trainer service to deliver a programme that is effective in a greater cohort of the population, and; 3) to strengthen and pump prime the strength and balance classes run in the community.

1. To extend the number of MFFRAs incorporating a comprehensive, validated, functional home hazard assessment tool (Westmead Home Safety Assessment tool) with accompanying modifications proven to reduce falls. This will be through deployment of an additional four Band 4 CPFT Therapy Assistants in a particular geographical area(s) and through the activity of the two current Band 4 Therapy Assistants.

   1.1 The current programme is delivered by two Therapy Assistants and core Neighbourhood team staff across Cambridgeshire. While the take up of the existing programme has been successful, it is noted that it is not of sufficient scale to demonstrate an impact on admissions across Cambridgeshire[8]. Across Cambridgeshire there is a potential demand for 6000 MFFRAs per year (CPFT data, 2018/19), which would require an additional 13.6 Therapy Assistant staff[9] at an individual salary cost of £33k, and anticipated equipment and adaptations costs of between £2.8k and £27.8k per Therapy Assistant (Appendix 1). The proposal therefore seeks to implement the same level of programme intensity but to deliver it in a smaller geography within Cambridgeshire. The combined cost is £132k for the four additional salaries (two salaries are planned to be mainstreamed to support sustainability) and £10.6k housing equipment / adaptations. Wet room adaptations are funded through the DFG and are excluded from these predicted costs, but at this scale could equate to £100k.

[8] To demonstrate a statistically significant reduction, it is estimated that 134 admissions per year would need to be prevented in people aged 75+ or 163 admissions per year in people aged 65+ (based on 2018/19 SUS admissions data). To prevent this number of injurious falls, it is estimated that 6000 people who have fallen would need to receive a MFFRA/year.

[9] 13.6 staff would be expected to complete 3843 MFFRAs. This is in addition to the 2321 non-integrated MFFRAs conducted by core Therapy Assistant staff in all 14 neighbourhood teams in 2018/19 which are expected to continue as core business.

1.2 In order to identify which area(s) to deploy the integrated assessments, an options framework was developed (Appendix 3). The framework took into account the areas with the highest rate of falls related hospital admissions and the feasibility of implementation (Appendix 4 & 5). Two options are presented.

Option 1: Deployment at a locality level: 'Cambridge' locality.

Option 1 proposes to target older people in Cambridge City and South Cambridgeshire in full alignment with the CPFT locality of 'Cambridge' thus facilitating feasibility of operational delivery and maximum intensity in a concentrated area.

The option is proposed for the reasons outlined (Appendix 4):

- Rates of hospital admissions. Compared to the other two locality areas, Cambridge CPFT locality has the highest rate and number of hospital admissions due to falls; the highest number of admissions due to fractured neck of femur; the largest 65+ population; and highest population at risk of falls. Analysing the admissions data on a smaller geographical level shows that the Cambridge CPFT Locality has two of the top three Primary Care Network (PCNs) with the highest rates of admissions due to falls (Appendix 6). The area has also demonstrated the highest level of demand for MFFRAs between 1 January and 31 June 2019.
- Feasibility of implementation. CPFT have indicated that Cambridge locality would be the preferred option due to: availability / recruitment of staff; strong leadership skills of the Neighbourhood Team Leads; enthusiasm and engagement of Occupational Therapy and Physiotherapy staff; and the opportunity to link with the development of a joint CPFT, CUH and PCN frailty pathway/programme. The urban nature of Cambridge City will also facilitate easier access to the programme in terms of transport and venue provision.

Option 2: Deployment at district level: Cambridge City and Fenland

Option 2 proposes to target those areas with the highest rates of falls at a District level, which are Cambridge City and Fenland.

The option is proposed for the reasons outlined (Appendix 5):

- Rates of hospital admissions.
  - In Cambridgeshire, Cambridge City has the highest rate of any admission relating to a fall and Fenland has the highest rate of falls resulting in a hip fracture. However care should be taken in the interpretation of the Appendix 5, in terms of statistical significance only the rates of any admission relating to a fall in Cambridge is significantly worse than the rates in the whole East of England region. There is no statistically significant difference for falls with a hip fracture between the district areas and the East of England.
  - Analysing the admissions data at Primary Care Network (PCN) level shows that the PCN for the Wisbech Neighbourhood Team, has the highest rate of falls in the 75+ age group in Cambridgeshire and Peterborough, and is the only PCN with a statistically significantly higher rate of admissions compared to the CCG average[10] (Appendix 6). Cambridge City has two of the top three PCNs with the highest rates.
  - Fenland is ranked as the most deprived district for older people and Cambridge is the next most deprived.

[10] It should be noted that the PCN with the highest admissions (statistically significant compared to the CCG average) is PCN 15 which corresponds with the Wisbech NT in Fenland (worse off).

1.3 The home modifications required as a result of the assessment includes necessary equipment, minor adaptations and major adaptations which are delivered by different providers, some of which require grants (Appendix 1). It is proposed that funding (£10.6k) for equipment and minor adaptations for CPFT be administered via the Integrated Community Equipment Service (ICES) budget overseen by Cambridgeshire County Council. This is in line with current arrangements with CPFT as part of the existing Section 75 Community Occupational Therapy for Adults (Integrated Service) contract.

1.4 The Disability Facilities Grant (DFG) is used to fund major adaptations. The use of the grant is for negotiation with each District Council. Those areas with a fully utilised grant may incur further demand of up to £100k. (Appendix 1).

1.5 In terms of activity, it is anticipated that the four Therapy Assistants will be able to complete 960 MFFRAs/year which is expected to prevent 230 total falls per year (non-injurious and injurious)[11] of which 23 would be injurious and require medical attention. The need for people requiring evidence based falls prevention interventions exceeds the reach per year and thus a diminishing effect is not expected in the first three years of programme delivery.

2. To expand the Everyone Health Falls Prevention Health Trainer service by one member of staff, and to deliver the FaME (Falls Management Exercise) programme to target a population at a lower risk of falls, and prevent falls from first occurring. The FaME programme consists of 24 weekly classes per cohort with motivational support provided. A time for socialising after each class is planned to facilitate social connectedness.

2.1 Each Falls Prevention Health Trainer will be able to deliver approximately 12 FaME programmes per year consisting of cohorts of up to a maximum of 15 people per programme, with an anticipated attendance of 100 people per trainer. It is expected that this would prevent 90 falls per year of which 9 could be injurious and result in a hospital admission.

3. To commission a community provider(s) to deliver up to five cohorts of the FaME programme to support the Falls Prevention Health Trainer service in areas of high demand. This will enable up to 75 people to access the programme at the earliest opportunity when motivation is high. It is expected that this would prevent 14 total falls of which one hospital admission may be prevented.

4. To continue a 0.6WTE co-ordinator post based within the charity, Forever Active (Forum Ltd). The Development Officer post, originally funded for 3 years by CCC Adult Social Care, has been instrumental in increasing the availability and accessibility of strength and balance classes (and other physical activities for the 50+) across Cambridge City, South Cambridgeshire, East Cambridgeshire and Fenland. The role will support co-ordination and sustained delivery of more than 45 open access community strength and balance classes offering up to 640 weekly places[12] across the aforementioned districts. In addition, it will set up new physical activity opportunities to prevent the age-related decline in muscle strength, bone health and balance for the 50+, including strength and balance classes, tai chi, ball sports etc.

5. To pump-prime community level 4 strength and balance classes, especially focussing on areas of low provision (Fenland and East Cambridgeshire). This will enable people to exit the FaME

[11] Injurious falls are defined as falls that result in injuries requiring medical attention
[12] Based on a maximum strength and balance community class size of 14.

programme and continue with equivalent level strength and balance exercise in the community (at a charge). In addition, it will enable higher functioning adults in the community to access a class directly thereby supporting a lifecourse approach to strength and balance and early intervention. The classes will be quality assured by CPFT employed exercise specialists.

6. To raise awareness of falls prevention messages through the Stronger for Longer campaign working group. The proposal is to continue the 'Stronger for Longer' marketing campaign, which may include the following: 1) the printing of more of the successful super six leaflets 2) a primary prevention falls leaflet designed to help people identify their risk factors for falling as the risk emerges and take appropriate action to reduce their risk 3) Promotion of evidence based activities to slow the natural decline and preserve strength, balance and bone health, in younger older adults 60+ years.

3) Project Objectives

- Implement an integrated multi-factorial falls risk assessment containing an evidence-based home-hazard assessment tool
- Target at risk older people that are most likely to benefit
- Ensure 960 people receive the integrated multi-factorial falls risk assessment with home-hazard assessment and necessary home improvements
- Ensure the people requiring equipment and adaptations receive it
- Ensure programmes are specified with explicit criteria and process KPIs
- Initiate delivery of the FaME programme to ensure a more effective strength and balance exercise programme is in place to reduce the risk of falls in a wider spectrum of older people with both high and low functional abilities
- Increase the number of people taking up and completing the FaME programme
- Increase the number of people maintaining their increased level of strength and balance following a FaME programme through attendance at community classes and/or continuing the exercises at home
- Strengthen the onward referral pathway to signpost people completing the FaME programme to a range of existing local physical activity pathways and activities to maintain their level of strength and balance, specifically focussing on activities proven to contribute to strength, balance and bone health (see [13,14])
- Improve and maintain system-level integration and join-up of partners across the system
- Increase awareness of falls prevention messages to the public.

[13] Public Health England (2018). Muscle and bone strengthening and balance activities for general health benefits in adults and older people: Summary of a rapid evidence review for the UK Chief Medical Officers' update of the physical activity guidelines. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721874/MBSBA_evidence_review.pdf [Accessed 28 June 2019]

[14] Activities include: Resistance training, Circuit training, Ball games, Racquet sports, Nordic Walking, Tai Chi, Yoga, Dance, Running, and Cycling

4) Key Benefits

Key Benefit	*Measure*	*Baseline*	*Target & Timescale*
To prevent any increase in hospital admission rates due to injurious falls	Observed **number** of emergency hospital admissions for injuries due to falls in persons aged 65+ Age standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65+	There were 2,164 admissions per 100,000 over 65s in 2017/18 (Public Health Outcomes Framework, 2019) A baseline will be specified to represent the chosen area(s)	No more than 2164 over 65s admissions per 100,000 from 2020 - 2023
A reduction in the rate of self-reported falls post intervention	The number of falls per person per year Numerator: No. of falls reported in the completers Denominator: Total no. of completers	Baseline to be obtained from individuals pre-intervention	Target: 20% of completers. 960 people expected to receive an integrated MFFRA and interventions per year from the four CPFT Therapy Assistants (excludes non-integrated assessments of core staff across Cambs). 500 people are expected to receive a FaME programme from the Everyone Health Falls Prevention Health Trainers (FPHT). Up to 75 people are expected to receive a FaME programme from additional provider(s). **109 people will also receive a non-integrated MFFRA by the FPHT but this has been omitted to avoid potential double counting.*
Delivery of an effective, high quality, integrated assessment to improve an individuals' proxy falls risk functional outcomes	No. of integrated multi-factorial risk assessments completed by staff No. and % of patients completing at least 75% of their intervention plan	New assessment and therefore no baseline.	960 integrated assessments completed per year by 4x CPFT staff* **dependent on contract negotiations*
An improvement in an individuals' proxy falls risk functional outcomes following completion of a FaME exercise programme	Number and % improving: 1) static balance and the mean improvement 2) timed up and go score and mean improvement 3) sit to stand score and mean improvement 4) level of concern for falling and mean improvement	Baseline to be obtained from individuals pre-intervention	Target: 30% of completers* Approx. 575 people attending the FaME exercise programme per year, Falls Prevention Health Trainers (n=500) and 5 community programmes (n=75). **excludes those starting at the highest level and therefore not able to make an improvement*

Key Benefit	*Measure*	*Baseline*	*Target & Timescale*
People progressing to a community class to maintain strength and balance post intervention or self-reporting exercising at home	% who have carried on exercising post intervention	Placeholder - Data not currently collected	25% of completers
Positive patient experience of the falls prevention pathway	Qualitative feedback	Placeholder – No robust data collected currently	70% reporting a positive experience

5) Project Interdependencies

1) The programme is awaiting the outcome of contract negotiations with the STP to continue to fund the Locality Falls Leads which are required to supervise the six 'falls prevention' specific Therapy Assistants
2) The programme has some dependency on the provision of housing improvements, funding streams and funding eligibility requirements of:
    a. Home Improvement Agencies (HIAs) – the HIAs provide major adaptations, such as wet rooms, ramps, and stair lifts, which are means tested and funded through the Disability Facilities Grants (DFGs) (the grants are provided from central government via the BCF and are administered locally via CCC),
    b. Council Adaptation Services – responsible for providing adaptations for tenants of local authority housing stock using the Housing Revenue Account. Only Cambridge City and South Cambridgeshire District Councils have a housing stock. The housing stock of East Cambridgeshire, Huntingdonshire and Fenland moved over to social landlords (registered providers) predominantly Sanctuary Housing Association, Chorus Group (formerly Luminus) and Clarion, respectively.
    c. Age UK Handyperson Service – A chargeable service for the provision of repairs and maintenance services such as small plumbing jobs and grab rails; hospital discharge service; checks around the home (such as energy, fire and security), first-contact and referral services and other housing maintenance related services to older individuals at a very low cost to mainly owner occupiers or private sector tenants. Funded by all five Cambridgeshire District Councils until March 2021.
    d. Specialist Housing Advisors – the Advisors support clients to consider relocating homes as a different option to expensive major adaptations. Funded by CCC.
3) The completion of a high quality, comprehensive MFFRA requires primary care to assess underlying medical causes of falls and onward referrals to specialist services if required, and conduct medication reviews (including osteoporosis medication and management)
4) The continued delivery of quality assured strength and balance exercise specifically to prevent falls is dependent on the CPFT Clinical Specialists to continue to provide quality assurance and providers of classes - our key delivery Cambridgeshire partners are Forever Active, One Leisure (Huntingdonshire District Council), and Oak Activities Limited.
5) The delivery and promotion of appropriate physical activities to prevent the age-related decline in muscle strength, bone health and balance for the 50+ is dependent on linking with those activities being offered by existing providers/projects and developing opportunities to fill in any identified gaps. Providers include the aforementioned providers, existing services such as Everyone Health lifestyle service, Living Sport, and Let's Get Moving Co-ordinators, and others yet to be identified.
6) The identification and referral of those at highest risk of falling to CPFT from key partners such as at CPFT triage, hospital discharge, CCC through Reablement and the Enhanced

Response Service, and community providers such as Cambridgeshire Fire and Rescue Service through Safe and Well Visits and Age UK.

7) This programme will be integrated within the Adults Positive Challenge Programme and will contribute to the existing Adults Positive Challenge recurrent savings target of £3.8M in 2020/21.

6) In Scope

- To extend the number of Multi-factorial Falls Assessments (MFFRAs) integrated with home hazard assessments and home adaptations/equipment. To expand the team by an additional four Therapy Assistants. **Total cost £142k p.a. (Appendix 2)**
- To expand the Falls Prevention Health Trainer Team by one member of staff, and to deliver the FaME (Falls Management Exercise) programme to target a cohort of people at a lower risk of falls. **Total cost £51.3k p.a.**
- To continue the 0.6WTE Forever Active Coordinator post. The role will support co-ordination, set up and maintenance of open access community strength and balance classes. **Total cost £20k p.a.**
- To commission a community provider(s) to deliver the FaME programme. Quality assurance of provision through CPFT employed exercise specialists. **Total cost £13.4k p.a.**
- To join-up with existing providers/projects to promote, develop and implement existing and new physical activity opportunities to prevent the age-related decline in muscle strength, bone health and balance for the 50+. To include pump-priming of quality assured level 4 strength and balance classes and activities such as tai chi, resistance training and ball sports. **Total cost £20.4k p.a**
- Implement a falls communications strategy. The proposal is to continue the marketing campaign to target those who may or may not have fallen. **Total cost £10k p.a.**
- Formal evaluation this programme. The proposal details the number of metrics which we believe will demonstrate the effectiveness of the programme. However, an in-depth and independent evaluation should be commissioned to advise further specification. Subject to negotiation. **Total cost £33k p.a.**

7) Out of Scope

The proposal described does not include;

- The existing Everyone Health Falls Prevention Health Trainer service. This service has four staff, and is funded from within existing Public Health revenue. The service delivers the MFFRAs and strength and balance programmes, and through an existing contract variation will deliver the FAME programme to target people at a less advanced stage of functional decline
- The Falls Clinical Lead, Falls Clinical Exercise Specialist and Falls Locality Leads currently funded by the STP
- OTAGO strength and balance exercise programme delivered by the six Therapy Assistants – OTAGO exercise programmes will be delivered by other staff as part of core CPFT business
- In-depth work with Care Homes
- Cambridgeshire County Council Enhanced Response Service (provides a lifting service for Lifeline users) for management of people who have fallen and are unable to get off the floor and referral for an MFFRA
- Cambridge University Hospital NHS Foundation Trust (CUHFT) Fracture Liaison Service
- Cambridgeshire Fire and Rescue Service Safe and Well Visits
- Cambridgeshire Home Improvement Agency Occupational Therapy Bathing pilot
- Early Intervention Vehicle Business Case proposal of East of England Ambulance Service

8) Key Stakeholders

Stakeholder	Involvement	Best way to communicate with them
CCG (Dr Catherine Bennett, Alecsandra Mecan, Ellie Addison)	Contact sought from the CCG lead for falls, to ensure partnership fit of the proposals	Email
CPFT (Annami Palmer, Karen Hurst, Elaine Young, Poonam Hyland, Annemie Waaning, Carol Claxton, Simon Hanna)	To discuss proposals for operational feasibility, and specification	Email or telephone
Adult Social Care CCC (Diana McKay, Lisa Sparks, Jane Crawford-White, Rebecca Bartram)	To raise awareness and opportunities for programme integration with ASC and the Community Occupational Therapy Integrated service with CPFT	Email or telephone
Cambridgeshire Home Improvement Agency (Frances Swann)	To ensure operational and strategic fit	Email or telephone
Age UK (Andrew Morris, Sarah Thomson)	Interdependency with Handyperson Service	Meeting
Everyone Health (Brigitte McCormack, Ryan Chillingworth)	To discuss proposals for operational feasibility, and specification	Meeting
Forever Active (Jane Jones)	To discuss proposals for operational feasibility, and specification	Meeting
Huntingdonshire District Council (Jo Peadon and Angie Skipper)	To discuss and develop proposals around the exercise and housing components	Email or Strategy/Steering Groups
East Cambridgeshire District Council (Liz Knox and Sophie Edwards)	To discuss and develop proposals around the exercise and housing components	Email or Strategy/Steering Groups
South Cambridgeshire District Council (Lesley McFarlane, Ellen Bridges, and Julie Fletcher)	To discuss and develop proposals around the exercise and housing components	Email or Strategy/Steering Groups
Cambridge City District Council (Carrie Holbrook and Helen Reed)	To discuss and develop proposals around the exercise and housing components	Email or Strategy/Steering Groups
Fenland District Council (Dan Horn and Kate Squires)	To discuss and develop proposals around the exercise and housing components	Email or Strategy/Steering Groups
Living Sport (Michael Firek, Rebecca Evans	To discuss and develop proposals around the exercise component	Email or telephone
Cambridgeshire Fire and Rescue service (Paul Clarke)	Join up with Safe and Well visits and member of Strategy Group	Email or telephone
Ageing Well Strategy Board	To consult and gain feedback on proposals	Meeting or email
Falls Prevention Strategy Group	To consult and gain feedback on proposals	Meeting or email
Adaptations Steering Group	To consult and gain feedback on proposals	Meeting or email

1) Delivering the Programme

Project management and governance

The options within the proposal relate to the scale of Home Hazard Assessments, and the recruitment of additional support for the Health Trainer team. The Forever Active Coordinator post and Community Classes in Fenland and East Cambridgeshire are time extensions of the existing provision. All aspects of the proposal remain the responsibility of the Falls Programme Manager within the Public Health department and will continue to be reviewed by the Falls Prevention Working Group.

All projects within the Programme will be managed by the Falls Programme manager, quarterly monitoring reports will be prepared and shared at the Falls Prevention Working Group. In addition the housing adaptations or aids to mobility will be managed, within a capped budget over the course of each year. The potential demand is a recognised risk to the project, detailed adaptation and aid costings will be specified and agreed before the project commences.

Commissioning and procurement

Option 1 (Section 75) : Under Section 75 of the NHS Act 2006 (as amended), the Secretary of State can make provision for local authorities and National Health Service (NHS) bodies to enter into partnership arrangements in relation to certain functions, where these arrangements are likely to lead to an improvement in the way in which those functions are exercised. The specific provision for these arrangements is set out in the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000. The regulations sets out how partners can enter into arrangements whereby a NHS body may exercise the prescribed health-related functions of local authorities.

There are also a number of contracts that are excluded from the scope of the Public Contracts Directive. Articles 12 of the Directive outline situations whereby Public contracts between entities within the public sector are excluded. The establishment of a section 75 whereby delegation of duties are assigned to the Health Authority are not required to be procured.

The risks of pursuing this option may be mitigated by issuing a Voluntary Ex-Ante Transparency Notice (VEAT) outlining the proposed arrangement. A VEAT notice is a means of advertising the intention to let a contract without opening it up to formal competition evidencing that under the “Duty of Best Value” the arrangements being proposed secure continuous improvement in the way in which its functions are exercised, having regard to a combination of economy, efficiency and effectiveness.

Timescales: VEAT Notice published, following a 10 day standstill.

Option 2 (Tender)

A procurement could be undertaken for the service under the EU Light Tough Regime. This would open the opportunity to any supplier that were able to demonstrate the ability to provide the service as outlined in the service specification. The benefits of a tender is that it could create efficiency or savings, however if the market is small the tender may not be able to deliver the required number of suppliers to make the competition viable.

Timescales:

- Pre-procurement (specification/ terms and conditions/ evaluation criteria/scoring/pricing will all need to be done prior to going to the market) 2 Months
- Procurement- once live the suppliers would be given 30 days to respond

- Evaluation- evaluation of the bids can be time consuming and a moderation will also need to be undertaken 1 month
- Award- 10 day Alcatel period
- Contract Award
- Mobilisation- 2 – 3 months (if new supplier)

Recommendation

Due to the successful programme so far and extension of existing streams of work, the recommendation is to commission this proposal as a Section 75 agreement with a full contract specification and monitoring process.

Is a Community Impact Assessment Required for this Project?

YES ☐ *<insert hyperlink here>*
~~NO~~ ☐ *<give the reason this is not required>*

Costs of what will be delivered?

Summary of estimated project costs (see separate template (http://camweb/Projects/tools/)	Next financial year (2019/20)	Year 2/3
Project running costs	£257.1k	£257.1k
Project Implementation costs	Met as part of existing staff roles	Met as part of existing staff roles
Procurement costs (Revenue costs - i.e. on-going costs such as contact maintenance)	-	-
Equipment / Property (Capital - one off costs i.e. new Library Management System)		£33k (Independent evaluation)
Total	£257.1k	£290.1k

2) Benefits

Cashable benefits (savings)	Current financial year	Next financial year
No cashable savings		
Total		

Non-cashable benefits	Current financial year	Next financial year
Evidenced based programmes demonstrate a reduction in falls, additionally research estimates the costs incurred to the health and care system as a result of falls[15] 24% of those completing a MFFRA or 26% completing a 6 month FaME S&B programme[16] will have a reduced rate of falls. Assuming the above, the expected reduction in falls are calculated as: **1) <u>For 960 people receiving an MFFRA/year</u>** 230 total falls prevented per year and 23 injurious falls (See Appendix 7, Table 1) *Assumptions: 100% uptake and implementation of the MFFRA and modifications, 24% effect size.* **2) <u>For 575 people attending the FaME programme/year</u>** 104 total falls prevented per year and 10 injurious falls (see Appendix 8, Table 1) *Assumptions: 100% uptake, 70% completion rate, 26% effect size in completers.* **N.B. There may be some degree of double counting with some clients having a MFFRA and a Strength and Balance programme. However, there may be an additive/synergistic effect in preventing falls with multiple interventions having a greater effect on reducing falls as the individual risk factors are likely to act independently of one another.**	£243k (adjusted for long term residential placements avoided over 27 months.) **1) <u>MFFRAs</u>** Total health and social care system savings anticipated as £208k The cost saved for Social Care is estimated as £114k relating to those clients discharged to home, residential care (short-term), and residential care (long-term, based on an average 27 month residency). (Appendix 7, Table 2.) **2) <u>S&B programmes</u>** The total health and social care system savings anticipated as £90.4k The cost saved for Social Care is estimated as £49.8k (Appendix 6, Table 2) relating to those clients discharged to home, residential care (short-term), and residential care (long-term, based on an average 27 month residency). (Appendix 8, Table 2). Further savings can be expected for other aspects of the programme, but predicting these savings is less robust.	£298k

[15] Craig J, Murray A, Mitchell S et al. The high cost to health and social care of managing falls in older adults living in the community in Scotland. Scottish Medical Journal 2013;58(4):198-203. Available at: http://scm.sagepub.com/content/58/4/198.

[16] Iliffe S, Kendrick D, Morris R, et al. Multicentre cluster randomised trial comparing a community group exercise programme and home-based exercise with usual care for people aged 65 years and over in primary care. Health Technology Assessment 2014;**18**(49):vii-xxvii, 1-105

3) Key Risks

- Project ownership and management. Current project and specification rests with two CCC employees. Mitigation is for a detailed contract and correspondence log to be stored on shared folders. Team members' roles and responsibilities stated on project implementation plan.
- Provider compliance to specification. Mitigation is that compliance will be sought during procurement, and monitored / sanctioned at subsequent quarterly monitoring meetings.
- Continuation of existing community provider (CPFT). Mitigation is to issue the specification through Section 75, and publish a VEAT notice to ensure legal compliance.
- Conflict resolution and incident management. Mitigation is that the team procedures will be written and stored centrally to detail the procedure to resolve conflicts, report clinical and information governance incidents and when to escalate to Senior Management specified within the project implementation plan.
- Recruitment to key staff is unsuccessful (Therapy Assistants, Falls Prevention Health Trainer, Forever Active Coordinator). Mitigation is to ask stakeholders of the risk before project implementation, and to monitor initial recruitment and retention of staff in quarterly monitoring meetings.
- The STP currently fund the Falls Clinical Lead, Falls Clinical Exercise Specialist and three Locality Falls Leads. The programme is dependent on supervision provided through the STP funded work stream to the six additional staff. If the STP funded work stream expires, additional managerial costs will need to be considered (Approx. £55k per Locality Lead) and/or alternative mechanisms of providing line management via the existing Neighbourhood Team Leads.
- Clinical supervision (Occupational Therapy) for the Therapy Assistants becomes compromised and ineffective. Mitigation is to specify clinical supervision within the contract specification and monitor compliance in quarterly meetings.
- Inability to provide high quality and routine process and outcome monitoring. Mitigation is to clearly specify requirements within contract specifications and seek assurance IT capabilities are scrutinised during contract agreement.
- Agreement of validated outcome measures. Mitigation is for clinical specialists to be involved in the contract specification.
- Future funding of Disability Facilities Grant (DFG). There is currently an underspend on the DFG in Cambridge City, South Cambridgeshire and East Cambridgeshire, however, this may change as is dependent on future funding allocation.
- Demand for housing adaptations and equipment. The budget for housing adaptations and equipment will be capped, demand will be carefully monitored in the first quarter of the programme to predict what level of adaptations can reasonably be supplied within the programme budget.
- There is a risk that the programme will create unexpected impact on capacity and financial pressure on other services. Mitigation is to gain agreement of providers to provide relevant data that would allow the monitoring of the impact and further management. In addition, to consider ways the Therapy Assistants can manage impact on service capacity by increasing their knowledge and skills to have productive conversations about relocation or Technology Enabled Care (TEC).
- Agreement of the target geographies for the programme. Mitigation is to highlight rationale of why a particular locality is chosen in terms of feasibility of project implementation and the relative rate of falls in the locality (Appendix 4 &5).
- Patient consent to identifying their record on a GP register for follow up and linkage to hospital data to determine subsequent falls admissions. Mitigation is for staff to seek

consent at earliest opportunity on the patient pathway, and to assure client that only a qualified health care professional will provide the follow up call, any that patient identifiable data used for data linkage will be done so in line with the GDPR and local LA and NHS policy.

4) Key Milestones - High Level Plan

Milestone Point/ Task/Phase	Date	Dependency/ Interface	Overall Responsibility	Resources agreed? Yes/No
Decision to proceed	19 September 2019		Health Committee	
Procurement process approved	30 September 2019	Section 75 decision, if full tender required project timescale will extend	Laurence Gibson	
Contract signature	31 October 2019	Provider compliance with specification	Laurence Gibson	
Job description and recruitment processes	1 November 2019 – 31 March 2020	Specification of roles Job evaluation and HR approval	Laurence Gibson	
IG assurance	31 December 2019	IG approval process across LA and any NHS requirement	Laurence Gibson	
Media and publicity materials, drafted and printed	28 February 2020	CCC Communications	Laurence Gibson	
Monitoring report technical compilation	31 March 2020	CPFT IT infrastructure	Laurence Gibson	
Project Start	1 April 2020	Provider contract	Laurence Gibson	
Quarterly monitoring meetings	1 April 2020 – 31 March 2023		Laurence Gibson	
Routine quality inspection of community based classes	1 April 2020	CPFT role description	Laurence Gibson	
Annual evaluation and client satisfaction report	1 April 2021		Laurence Gibson	
Project Closure	**31 March 2023**		Laurence Gibson	

10.6 Resources needed to deliver the project (please show days per month (full time equivalent)), if not known at this stage please show as to be confirmed)
(Note - this section maybe replaced by a reference to a full MS Project Plan if required)

Resource	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Sponsoring Service (Public Health)	1 WTE	1 WTE	1 WTE	1 WTE	1 WTE	1 WTE	1 WTE	1 WTE	1 WTE	1 WTE	1 WTE	1 WTE
CCC Service Transformation Team												
Internal CCC Public Health Intelligence	2 days per month	2 days per month	2 days per month	2 days per month	2 days per month	2 days per month	2 days per month	2 days per month	2 days per month	2 days per month	2 days per month	2 days per month
Internal CCC Supervision (Consultant in PH)	0.1 WTE	0.1 WTE	0.1 WTE	0.1 WTE	0.1 WTE	0.1 WTE	0.1 WTE	0.1 WTE	0.1 WTE	0.1 WTE	0.1 WTE	0.1 WTE
Internal CCC Other 3												
LGSS HR												
LGSS IT												
LGSS Finance	1 day per month	1 day per month	1 day per month	1 day per month	1 day per month	1 day per month	1 day per month	1 day per month	1 day per month	1 day per month	1 day per month	1 day per month
LGSS Audit												
LGSS Property												
LGSS Legal												
LGSS Other 1												
LGSS Other 2												
External Resources 1 (program staff)	7.2 WTE	7.2 WTE	7.2 WTE	7.2 WTE	7.2 WTE	7.2 WTE	7.2 WTE	7.2 WTE	7.2 WTE	7.2 WTE	7.2 WTE	7.2 WTE

Appendix 1

Table: Local quantification of the cost of home modifications recommended (A return on investment tool for falls prevention, PHE, 2018)

	Offered to	Take-up rate	Local cost per modification	Notes	No. of modifications expected based on 960 MFFRAs/yr	Total cost of modifications based on of 960 MFFRAs (£)	Recipient of funding
Use non-slip bathmat	24%	54%	n/a	These would be self-funded	0	£0	n/a - self-funded
Add rail to stairs (bannister rail)	12%	19%	£49.53	Based on a 3m rail, £16.51/m via NRS contract. Includes materials and labour	33	£1,084	ICES - Community Equipment Service
Move electrical cord	12%	67%	£10	Assumes 1 hour of labour time	116	£772	ICES
Add grab rails	15%	78%	£12	Could be done by either Age UK or NRS contract. NRS contract is average £3 per rail + delivery & fit of £9.17	168	£1,348	ICES or Age UK Handyperson Scheme
Use a raised toilet seat	24%	54%	£16.16	£6.99 for RTS + £9.17 delivery	187	£2,011	ICES
Add shower seat	13%	83%	£29.17	Approx. £20 + delivery of £9.17	155	£3,022	ICES
Use of a rollator walking frame	20%	58%	£21	£12 + delivery of £9.17	167	£2,339	ICES
Wet room conversion	10%	20%	£5,800	£5800. Mandatory through the DFG. Means tested. Assumed 90% were eligible for DFG and 10% self-funded	26	£100,224	Home Improvement Agency
Total equipment and minor adaptations (excludes wet rooms) ALL FOUR THERAPY						**£10,574**	
Total equipment and minor adaptations (excludes wet rooms) PER THERAPY						**£2,644**	
Total equipment and minor adaptations (includes wet rooms) (£) ALL FOUR THERAPY						**£110,798**	
Total equipment and minor adaptations (includes wet rooms) (£) PER THERAPY						**£27,700**	

Appendix 2

Table 1: Summary of delivery costs

	Project costs per annum*
Four Therapy Assistants (salary)(£33k each)	£132,000
Equipment and adaptations	£10,578
Additional Falls Prevention Health Trainer (salary & associated costs)	£39,488
Additional room hire and equipment for FaME delivery by 4x existing Falls Prevention Health Trainers	£11,798
Forever Active Co-ordinator (salary) and classes	£20,000
Deliver 5x FaME programmes	£13,419
Physical activity opportunities for muscle strengthening, bone health and balance	£20,361
Communications	£10,000
Independent evaluation	£33,000
TOTAL	**£290,644**

*Assumes no funding is required from Public Health for major adaptations

Appendix 3

Defining the criteria for choosing a Cambridgeshire locality in which to deliver an intensive falls prevention programme.

The Falls Prevention programme is an evidence based programme operating across different levels of at-risk individuals in different settings. It has been proposed that the programme is not of sufficient scale across Cambridgeshire and Peterborough to demonstrate an observed reduction in the rate of falls requiring hospitalisation. In order to demonstrate the effectiveness of the programme a single locality will be targeted with an intense programme. The targeting will be monitored and evaluated with the intention of demonstrating impact and therefore rolling out a highly specific programme across Cambridgeshire. This paper sets out how the Cambridgeshire and Peterborough Falls Prevention Strategy Group will assess and recommend the locality to be targeted.

The framework chosen consists of a Corporate view, a Comparative Analysis and an Epidemiological assessment.

The Corporate view will be provided through the C&P Falls Prevention Strategy Group. The group **will/have** agreed the criteria and associated weightings with each locality being scored against a number of criteria. The criteria are;

- Alignment with District objectives
- Availability and recruitment of staff
- Positive culture and attitude of staff towards falls prevention and new initiatives
- Transport availability
- Acceptability of Community organisations, Charities, and Voluntary groups
- Room availability
- Availability of Disability Facilities Grant

The **comparative and epidemiological views** concern the number of people at risk, now and in the future, and the number of injurious falls requiring hospitalisation, and the number of fractured neck of femurs. The criteria are;

- Assessed local demand for the service
- Current population size 75+
- Future population size 75+ in 2025
- Present size of high risk groups
- Rate and number of injurious falls
- Rate and number of fractured neck of femurs
- Number of Care homes

Appendix 4

Table 1: Comparison of comparative and epidemiological views by CPFT localities

	'Cambridge' CPFT Locality area (approx. covers Cambridge City and South Cambridgeshire districts)	**'Ely and Fenland' CPFT Locality area (approx. covers East Cambridgeshire and Fenland districts)**	**'Huntingdonshire' CPFT Locality area**
Assessed local demand for the service – *No. of MFFRAs completed 1 Jan – 30 June 19*	451	266	335
Current population size 65+ (2018/19)	48,699	34,795	31,715
Estimated high risk group population	16,558	11,830	10,783
Rate of admissions due to injurious falls in 65+ in 2017/18	2,156 per 100,000	2,121 per 100,000	1,908 per 100,000
Number of admissions due to injurious falls in 65+ in 2017/18	1050	738	605
Rate of fractured neck of femurs in 65+ in 2017/18	513.35 per 100,000	514.44 per 100,000	567.55 per 100,000
Number of fractured neck of femurs in 65+ 2017/18	250	179	180
Number of Care homes	Cambridge = 17 South Cambs = 31	East Cambs = 31 Fenland = 28	Huntingdonshire = 35

Appendix 5

Table: Comparison of comparative and epidemiological views by district

		East of England	Cambridge	East Cambridgeshire	Fenland	Huntingdonshire	South Cambridgeshire
Current population size 65+ (2018/19)		122,764	16122	17842	23008	35209	30583
Estimated high risk group population		41,740	5481	6066	7823	11971	10398
Hip fractures 65 and over	Rate*	577.0	527.4	462.4	592.9	558.4	514.7
	Count	7,151	94	82	137	184	157
Hip fractures 65 - 79	Rate*	243.8	269.6	158.6	267.8	244.6	215.8
	Count	2,049	28	20	43	61	45
Hip fractures 80 and over	Rate*	1543.3	1275.0	1343.2	1535.9	1468.3	1381.3
	Count	5,102	66	62	94	123	112
Emergency hospital admissions due to falls 65 and over	Rate*	2026.3	2590.7	2013.6	2176.6	2055.9	2123.2
	Count	25,066	467	356	506	678	652
Emergency hospital admissions due to falls 65 -79	Rate*	916.1	1263.2	751.8	951.2	955.8	875.8
	Count	7,728	133	95	152	238	185
Emergency hospital admissions due to falls in people 80+	Rate*	5245.8	6440.5	5672.7	5730.5	5246.0	5740.5
	Count	17338	334	261	354	440	467
Income Deprived Older People - 2015 Index			12.7	11.7	16.4	9.6	8.4
Care Homes	142		17	31	28	35	31

*Directly age standardised rate per 100,000

Table 1 illustrates the size of the populations at risk and the observed level of hospital admissions for all falls, and for falls resulting in a hip fracture (fractured neck of femur). The table highlights the districts with the highest and lowest level of hospital related falls, in particular Cambridge has the highest rate of all falls admissions and Fenland the highest rate of falls resulting in a hip fracture. However care should be taken in the interpretation of the table, in terms of statistical significance only the rates of all falls in Cambridge are significantly worse than the rates in the whole East of England region. There is no statistically significant difference for falls with a hip fracture between the district areas and the East of England. Based on the analysis within the table the areas that could be prioritised are Fenland and Cambridgeshire.

Appendix 6: Table showing the rate of emergency falls admissions in the 75+ population, by Primary Care Network

Primary Care Network (PCN)	17/18 Falls Emergency Admission Number - 75+	17/18 Falls Emergency Admission (DASR per 100,000 - 75+)	Rank (highest to lowest falls admissions (DASR 75+)	CPFT Locality (approximate - not all PCNs are co-terminous with a locality)	Neighbourhood Team (approximate)
PCN15	218	4,860.3	1	CPFT Ely and Fenland locality	Wisbech
PCN03	73	4,467.4	2	CPFT 'Cambridge' locality	City South (S) & North (N)
PCN05	169	4,449.3	3	CPFT 'Cambridge' locality	City North
PCN21	122	4,342.3	4	CPFT 'Huntingdonshire' locality	St Neots
PCN04	149	4,281.3	5	CPFT 'Cambridge' locality	City S & N
PCN14	119	4,178.7	6	CPFT 'Huntingdonshire' locality	Huntingdon Centr.
PCN06	153	3,916.9	7	CPFT 'Cambridge' locality	North Villages
PCN13	250	3,890.6	8	CPFT Peterborough locality	Mix of P'boro
PCN09	122	3,842.1	9	CPFT Ely and Fenland locality	Isle of Ely
PCN12	163	3,836.9	10	CPFT 'Cambridge' locality	Cambridge East
PCN16	62	3,828.9	11	CPFT Peterborough locality	P'boro City 1
PCN11	159	3,762.4	12	CPFT 'Cambridge' locality	Cambridge East
PCN10	105	3,681.5	13	CPFT Ely and Fenland locality	Isle of Ely
PCN01	118	3,668.6	14	CPFT 'Huntingdonshire' locality	St Neots/Hunts
PCN07	79	3,573.9	15	CPFT 'Cambridge' locality	City North
PCN20	140	3,514.6	16	CPFT 'Huntingdonshire' locality	St Ives
PCN17	117	3,491.8	17	CPFT Ely and Fenland locality	Fenland
PCN19	184	3,478.1	18	CPFT Peterborough locality	Borderline/Central
PCN02	119	3,462.3	19	CPFT Peterborough locality	Pboro City 1&2
PCN08	19	3,140.8	20	CPFT Peterborough locality	Pboro City 1
PCN18	79	3,083.5	21	CPFT Ely and Fenland locality	Isle of Ely/ Fen
CCG Total	**2,719**	**3,869.1**			

Source: Hospital Episode Statistics

Key
Statistically significantly better than CCG average
Statistically significantly worse than CCG average

Appendix 7

Table 1: Table showing the expected reductions in the number of injurious falls as a result of the integrated MFFRA

	Receiving a new integrated MFFRA/month per Therapy Assistant	Receiving a new MFFRA/year per Therapy Assistant	Receiving a new MFFRA/year per 4x Therapy Assistants	Taking up and completing the modifications per year (100%)	In whom a fall has been prevented per year (Injurious or non-injurious) (24%)	In whom an injurious fall has been prevented per year (10%)
Number of people	20	240	960	960	230	23

Table 2: Table showing the cost savings of the 34 injurious falls prevented as a result of the integrated MFFRA

Clinical Event	-	Number	Cost per event (2018/19)	Total cost
No. of falls prevented by MFFRA		230	-	-
Of whom serious	10% of falls	23	-	-
GP attendances	51% of serious falls	12	£45.36	£532.07
Ambulance callouts	61% of serious falls	14	£323.82	£4,543.19
A&E attendances	80% of serious falls	18	£127.26	£2,341.58
Inpatient admissions	35% of A&E attendances	6	-	-
Falls (non hip fractures)	69% of admissions	4	£9,331.56	£41,465.72
Hip fracture	31% of admissions	2	£18,305.28	£36,544.66
Discharge falls - home	64%	3	£2,237.76	£6,363.97
Discharge falls - residential short term	21%	1	£10,591.56	£9,883.58
Discharge falls - long term	15%	1	£83,086.92	£55,380.76
Discharge fractures - home	34%	1	£2,237.76	£1,518.94
Discharge fractures - residential short term	47%	1	£10,591.56	£9,938.15
Discharge fractures - long term	19%	0	£83,086.92	£31,516.20
Re-admissions	7% of admissions	0	£9,331.56	£4,206.67
Mortality at one year	12% of admissions	1	£4,665.78	£3,605.71
Total savings to health and social care	-	-	-	£207,841.20
Total savings community health and social care (discharge of falls and fractures)				£114,601.59

Appendix 8

Table 1: Table showing the expected reductions in the number of injurious falls as a result of the FaME strength and balance exercise programme

	No. of people attending FaME prog/yr	No. of people taking up and completing the FaME prog/yr (70%)	No. of people in whom a fall has been prevented (Injurious or non-injurious) (26%)	No. of people in whom an injurious fall has been prevented (10%)
5 FPHT (based on current target)	500	350	90	9
5x FaME progs/year by another provider(s)	75	53	14	1
TOTAL	**575**	**403**	**104**	**10**

Table 2: Table showing the cost savings of the 10 injurious falls prevented as a result of the FaME programme

Clinical Event	-	Number	Cost per event (2018/19)	Total cost
No. of falls prevented by FaME		104	-	-
Of whom serious	10% of falls	10	-	-
GP attendances	51% of serious falls	5	£45.36	£231.34
Ambulance callouts	61% of serious falls	6	£323.82	£1,975.30
A&E attendances	80% of serious falls	8	£127.26	£1,018.08
Inpatient admissions	35% of A&E attends	3	-	-
Falls (non hip fractures)	69% of admissions	2	£9,331.56	£18,028.57
Hip fracture	31% of admissions	1	£18,305.28	£15,888.98
Discharge falls - home	64%	1	£2,237.76	£2,766.95
Discharge falls - residential short term	21%	0	£10,591.56	£4,297.21
Discharge falls - long term	15%	0	£83,086.92	£24,078.59
Discharge fractures - home	34%	0	£2,237.76	£660.41
Discharge fractures - residential short term	47%	0	£10,591.56	£4,320.93
Discharge fractures - long term	19%	0	£83,086.92	£13,702.69
Re-admissions	7% of admissions	0	£9,331.56	£1,828.99
Mortality at one year	12% of admissions	0	£4,665.78	£1,567.70
Total savings to health and social care	-	-	-	**£90,365.74**
Total savings community health and social care (discharge falls & fractures)	-	-	-	**£49,826.78**

Appendix 2: COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area		**Officer undertaking the assessment**
Public Health		Name: Laurence Gibson Job Title: Consultant in Public Health Contact details: laurence.gibson@cambridgeshire.gov.uk Date completed: 14th June 2019 ..... Date approved: 14th July 2019 .....
Service / Document / Function being assessed		
Falls Prevention Programme Business Case		
Business Plan Proposal Number (if relevant)		

Aims and Objectives of Service / Document / Function
The Falls Prevention Programme aims to ensure that older people have been appropriately risk assessed for falling and offered an intervention which will improve their strength and balance to reduce the level of risk. The programme has been running as a pilot for 2 years. The extended programme builds on initial success and intensifies programme provision in areas of particular need
What is changing? Where relevant, consider including: how the service/document/function will be implemented; what factors could contribute to or detract from this; how many people with protected characteristics are potentially impacted upon; who the main stakeholders are; and, details of any previous or planned consultation/engagement to inform the CIA.
The programme is being extended and provision is being strengthened. Demographic characteristics of fallers have been assessed in the approach and offer of community interventions to ensure equitable access and provision of services.
Who is involved in this impact assessment? e.g. Council officers, partners, service users and community representatives.
Council Officers **Cambridge and Peterborough Foundation Trust falls prevention project representatives**

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

Age: Falls resulting in hospital admission are more likely in populations over 65 than younger age groups. The individual initiatives within the falls prevention programme will therefore particularly target older age groups.
Deprivation: Falls have been correlated with areas of deprivation. Therefore a particular aspect of the extended programme is to strengthen provision in a particular locality of need, this will be chosen according to rates of falls, project feasibility and level of deprivation.

Negative Impact

Rurality: Assessing the risk of falls and providing advice will not be affected by rurality. The programme will continue to encourage community groups and charities to run quality assessed classes across the County. However the full programme incorporating the Risk Assessment and Housing Adaptations is only being run in a particular locality in order to demonstrate effectiveness. The lessons learnt will be used in formulating an appropriate County wide service design should the evaluation prove successful and future resources are available. Rurality and geographical distribution of the programme will continued to be monitored.

Neutral Impact

The Falls Programme proposal has been formulated to promote equalities whilst taking into account patient's needs and preferences. The new proposals cover all people identified by a clinician as being at risk of falling irrespective of gender, ethnicity, disability, religion or beliefs, sexual orientation and gender identity or socio-economic status. The body of evidence for falls programmes and protected characteristics does not give conclusive proof of the need for specific programmes. However the implementation and follow up of the programme will capture these characteristics and ensure appropriate representation.

Issues or Opportunities that may need to be addressed

To ensure rural areas are adequately covered in the continuation of the programme
To ensure areas of deprivation (and high incidence of falls) are adequately covered in the continuation of the programme

Community Cohesion

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

The programme recognises the capability and opportunity for community groups to adequately provide falls prevention activities. The programme specifically resources a coordinator to facilitate such provision. The community provision will integrate alongside the development of the Think Communities programme across Cambridgeshire and Peterborough, and the development of the integrated workstreams behind the newly forming Primary Care Networks.

Version Control

Version no.	Date	Updates / amendments	Author(s)
1	14/06/2019	Initiation	Laurence Gibson
2	14/08/2019	Update	Laurence Gibson

Agenda Item No: 6

FINANCE MONITORING REPORT – JULY 2019

To:	**Health Committee**
Meeting Date:	**19 September 2019**
From:	**Director of Public Health** **Chief Finance Officer**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable** ***Key decision:*** **No**
Purpose:	**To provide the Committee with the July 2019 Finance Monitoring Report for Public Health.** **The report is presented to provide the Committee with the opportunity to comment on the financial position as at the end of July 2019.**
Recommendation:	**The Committee is asked to review and comment on the report and to note the finance position as at the end of July 2019.**

	Officer contact:		***Member contacts:***
Name:	Stephen Howarth	Names:	Councillor Peter Hudson
Post:	Strategic Finance Business Partner	Post:	Chairman Health Committee
Email:	stephen.howarth@cambridgeshire.gov.uk	Email:	peter.hudson@cambridgeshire.gov.uk
Tel:	01223 714770	Tel:	01223 706398

1.0 BACKGROUND

1.1 Previously the Finance & Performance Report for Public Health (PH) was produced monthly and the most recent available report presented to the Committee when it met, in common with the approach for other services and committees. At the General Purposes Committee meeting on 16 July 2019 it was agreed to revise the reporting of financial information to committees:

a) Finance Reports – to be produced monthly and published online (May - Year End)
b) Reported to Committees – to be presented at all scheduled substantive Committee meetings (but not reserve dates)
c) Savings Tracker – to be presented 3 times per annum

1.2 In respect of Performance data, Service Committees will receive a separate quarterly performance report, based on a set of KPIs determined by the Committee which relate to the areas the Committee is responsible for, and organised by outcome area. The Finance aspects of what was the F&PR will now be titled the Finance Monitoring Report (FMR).

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

2.0 MAIN ISSUES IN THE JULY 2019 FINANCE MONITORING REPORT

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

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

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

2.4 The July 2019 FMR shows the forecast outturn for the Public Health Directorate is currently a balanced position, and contains further information about the forecast outturn and current spend.

3.0 ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

3.1.1 There are no significant implications for this priority.

3.2 Helping people live healthy and independent lives

3.2.1 There are no significant implications for this priority

3.3 Supporting and protecting vulnerable people

3.3.1 There are no significant implications for this priority

4.0 SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

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

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

4.2.1 There are no significant implications for this priority

4.3 Statutory, Legal and Risk Implications

4.3.1 There are no significant implications within this category.

4.4 Equality and Diversity Implications

4.4.1 There are no significant implications within this category.

4.5 Engagement and Communications Implications

4.5.1 There are no significant implications within this category.

4.6 Localism and Local Member Involvement

4.6.1 There are no significant implications within this category.

4.7 Public Health Implications

4.7.1 There are no significant implications within this category.

Implications	**Officer Clearance**
Have the resource implications been cleared by Finance?	Yes
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	N/A

Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	N/A
Have the equality and diversity implications been cleared by your Service Contact?	N/A
Have any engagement and communication implications been cleared by Communications?	N/A
Have any localism and Local Member involvement issues been cleared by your Service Contact?	N/A
Have any Public Health implications been cleared by Public Health?	N/A

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

From: Stephen Howarth
Tel.: 01223 714770
Date: 15/08/2019

Public Health Directorate

Finance Monitoring Report – July 2019

1 SUMMARY

1.1 Finance

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

2. INCOME AND EXPENDITURE

2.1 Overall Position

Forecast Outturn Variance (June) £000	Service	Budget for 2019/20 £000	Actual to end of July 19 £000	Forecast Outturn Variance £000	Forecast Outturn Variance %
0	Children Health	8,799	2,119	0	0%
0	Drug & Alcohol Misuse	5,463	15	0	0%
0	Sexual Health & Contraception	5,097	953	0	0%
0	Behaviour Change / Preventing Long Term Conditions	3,720	625	0	0%
0	Falls Prevention	80	3	0	0%
0	General Prevention Activities	13	1	0	0%
0	Adult Mental Health & Community Safety	256	50	0	0%
0	Public Health Directorate	1,926	575	0	0%
0	**Total Expenditure**	**25,355**	**4,340**	**0**	**0%**
0	Public Health Grant	-24,726	-12,780	0	0%
0	s75 Agreement NHSE-HIV	-144	0	0	0%
0	Other Income	-38	-10	0	0%
0	Drawdown From Reserves	-57	0	0	0%
0	**Total Income**	**-24,965**	**-12,790**	**0**	**0%**
0	**Net Total**	**390**	**-8,450**	**0**	**0%**

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

2.2 Significant Issues

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

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

The total Public Health ring-fenced grant allocation for 2019/20 is £25.560m, of which £24.726m is allocated directly to the Public Health Directorate.

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

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

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

3. BALANCE SHEET

3.1 Reserves

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

4. MEMORANDUM OF UNDERSTANDING (MOU)

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

APPENDIX 1 – Public Health Directorate Budgetary Control Report

Forecast Outturn Variance (June) £000's	Service	Budget 2019/20 £000's	Actual July 2019 £000's	Forecast Outturn Variance £000's	%
	Children Health				
0	Children 0-5 PH Programme	6,907	2,132	0	0%
0	Children 5-19 PH Programme - Non Prescribed	1,622	-14	0	0%
0	Children Mental Health	271	0	0	0%
0	**Children Health Total**	**8,799**	**2,119**	**0**	**0%**
	Drugs & Alcohol				
0	Drug & Alcohol Misuse	5,463	15	0	0%
0	**Drugs & Alcohol Total**	**5,463**	**15**	**0**	**0%**
	Sexual Health & Contraception				
0	SH STI testing & treatment - Prescribed	3,829	942	0	0%
0	SH Contraception - Prescribed	1,116	-55	0	0%
0	SH Services Advice Prevention/Promotion - Non-Prescribed	152	66	0	0%
0	**Sexual Health & Contraception Total**	**5,097**	**953**	**0**	**0%**
	Behaviour Change / Preventing Long Term Conditions				
0	Integrated Lifestyle Services	1,984	537	-5	0%
0	Other Health Improvement	408	154	5	1%
0	Smoking Cessation GP & Pharmacy	703	-154	0	0%
0	NHS Health Checks Programme - Prescribed	625	88	0	0%
0	**Behaviour Change / Preventing Long Term Conditions Total**	**3,720**	**625**	**0**	**0%**
	Falls Prevention				
0	Falls Prevention	80	3	0	0%
0	**Falls Prevention Total**	**80**	**3**	**0**	**0%**
	General Prevention Activities				
0	General Prevention, Traveller Health	13	1	0	0%
0	**General Prevention Activities Total**	**13**	**1**	**0**	**0%**
	Adult Mental Health & Community Safety				
0	Adult Mental Health & Community Safety	256	50	0	0%
0	**Adult Mental Health & Community Safety Total**	**256**	**50**	**0**	**0%**
	Public Health Directorate				
0	Children's Health	290	92	0	0%
0	Drugs & Alcohol	220	78	0	0%
0	Sexual Health & Contraception	158	30	0	0%
0	Prevention Long Term Conditions (Behaviour Change)	568	153	0	0%
0	General Prevention (Travellers)	209	75	0	0%
0	Adult Mental Health	22	9	0	0%
0	Health Protection	136	51	0	0%
0	Analysts	323	87	0	0%
0	**Public Health Directorate Total**	**1,926**	**575**	**0**	**0%**
0	**Total Expenditure before Carry-forward**	**25,355**	**4,340**	**0**	**0%**
0	**Anticipated Carry-forward of Public Health Grant**	**0**	**0**	**0**	**0%**

Forecast Outturn Variance (June)	Service	Budget 2019/20	Actual July 2019	Forecast Outturn Variance	
£000's		£000's	£000's	£000's	%
	Funded By				
0	Public Health Grant	-24,726	-12,780		0%
0	s75 Agreement NHSE-HIV	-144	0		0%
0	Other Income	-38	-10		0%
0	Drawdown From Reserves	-57	0		0%
0	**Grant Funding Total**	**-24,965**	**-12,790**	**0**	**0%**
0	**Overall Total**	**390**	**-8,450**	**0**	**0%**

APPENDIX 2 – Commentary on Expenditure Position

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

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

Awarding Body: Department of Health

Grant	Business Plan £'000	Adjusted Amount £'000	Notes
Public Health Grant as per Business Plan	**25,560**	**25,560**	Ring-fenced grant
Grant allocated as follows:			
Public Health Directorate	24,726	24,726	
P&C Directorate	293	283	
P&E Directorate	120	130	
CS&T Directorate	201	201	
LGSS Cambridge Office	220	220	
Total	**25,560**	**25,560**	

APPENDIX 4 – Virements and Budget Reconciliation

No budget virements have been performed in year.

APPENDIX 5 – Reserve Schedule

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

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

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

Agenda Item No: 7

PERFORMANCE REPORT QUARTER 1 2019/20

To:	**Health Committee**
Meeting Date:	**19 September 2019**
From:	**Liz Robin, Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**N/A** *Key decision:* **No**
Purpose:	**To provide performance monitoring information**
Recommendation:	**To note and comment on performance information and take remedial action as necessary**

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

1 BACKGROUND

1.1 This performance report provides information on the status of performance indicators the Committee has selected to monitor to understand performance of services the Committee oversees.

1.2 The report covers the period of Q1 2019/20, up to the end of June 2019.

1.3 The full report is in the appendix. It contains information on

- Current and previous performance and projected linear trend
- Current and previous targets (not all indicators have targets, this may be because they are being developed or because the indicator is being monitored for context)
- Red / Amber / Green (RAG) status
- Direction for improvement (this shows whether an increase or decrease is good)
- Change in performance (this shows whether performance is improving (up) or deteriorating (down)
- Statistical neighbour performance (only available where a standard national definition of indicator is being used)
- Indicator description
- Commentary on the indicator

1.4 The following RAG statuses are being used:

- Red – current performance is 10% or more from target
- Amber – current performance is off target by less than 10%
- Green – current performance is on target or better
- Very Green – current performance is better than target by 5% or more

1.5 Information about all performance indicators monitored by the Council Committees will be published on the internet at https://www.cambridgeshire.gov.uk/council/finance-and-budget/finance-&-performance-reports/ following the General Purposes Committee meeting in each quarterly cycle.

2 CURRENT PERFORMANCE

2.1 Current performance of indicators monitored by the Committee is as follows:

Status	Number of indicators	Percentage of total indicators with target
Red	3	20%
Amber	2	13%
Green	4	27%
Very Green	6	40%

2.2 The new format of performance report changes the way that indicators were previously reported. The indicators are under review and the Health Committee is meeting with

officers to update them. At the same time, the way in which they are reported will be reviewed to ensure they are presented in a clear and informative way.

Source Documents	Location
None	N/A

Target	Current Month	Previous Month	Direction for Improvement	Change in Performance
98.0%	100.0%	100.0%	↑	↔

Statistical Neighbours Mean	England Mean	RAG rating
N/A	N/A	G

Indicator Description

Key quality statement for access to Sexual health Services. Prompt access to sexual health services will promote good sexual health and reduce sexual health inequalities. Quick and easy access to support can help to reduce the likelihood of onward transmission of sexually transmitted infections (STIs).

This measure is the percentage of people who contact the service about a sexually transmitted infection who are offered an appointment within 2 working days, with a 98% target threshold.

NICE guidance suggests that people contacting a Sexual Health Service about a sexually transmitted infection should be offered an appointment within 2 working days. The outcome measure is set to reflect this.

Calculation:
(X/Y)*100

Where:
X: Number of people contacting a sexual health service offered an appointment in 2 working days in a month.

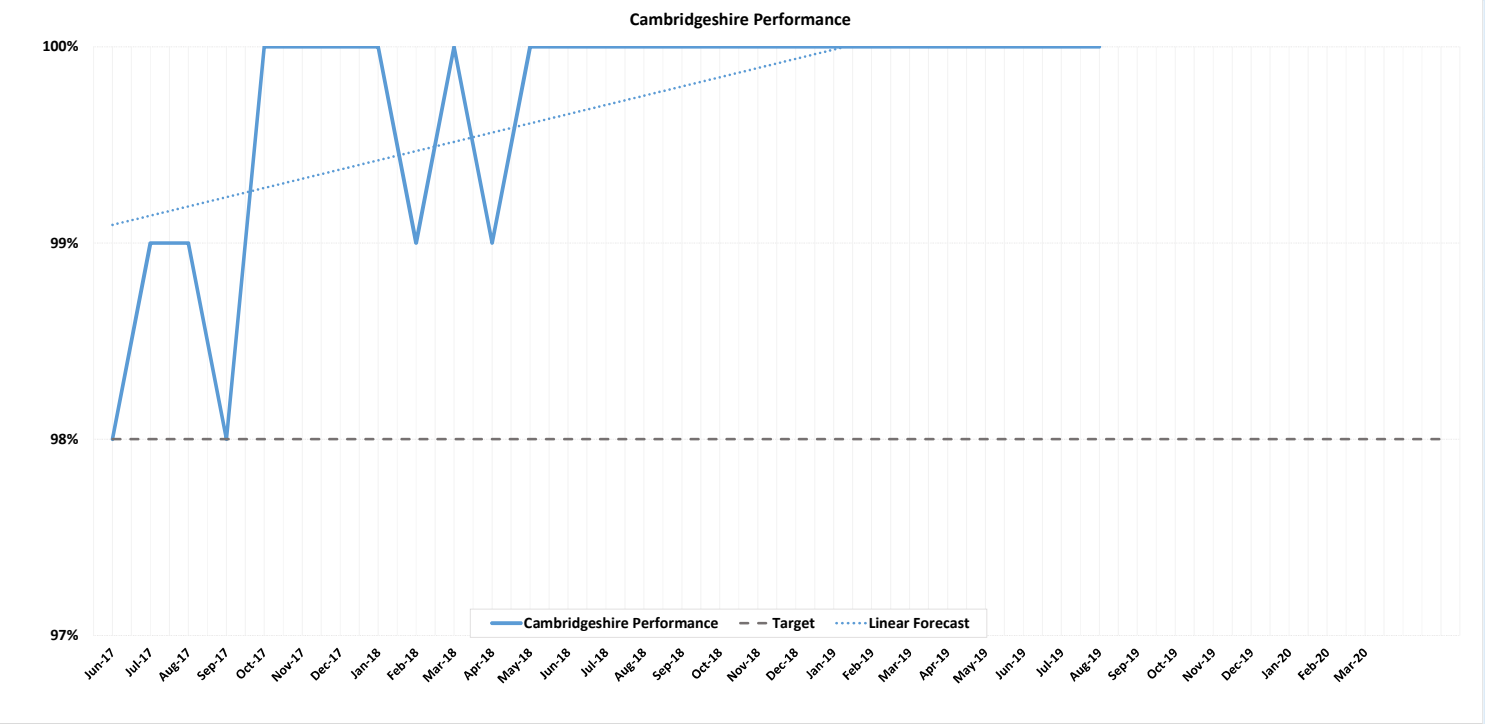
Y: Number of people contacting a sexual health service in a month.

Source: NICE

Useful Links

LG Inform:
https://lginform.local.gov.uk/

Nice Guidance Quality Statement 4
https://www.nice.org.uk/guidance/qs178/chapter/Quality-statement-4-Access-to-sexual-health-services



Commentary

Target	Current Month	Previous Month	Direction for Improvement	Change in Performance
80.0%	92.0%	86.0%	↑	↑

Statistical Neighbours Mean	England Mean	RAG rating
N/A	N/A	VG

Indicator Description

Key quality statement for access to Sexual health Services. Prompt access to sexual health services will promote good sexual health and reduce sexual health inequalities. Quick and easy access to support can help to reduce the likelihood of onward transmission of sexually transmitted infections (STIs).

This measure is the percentage of those offerd an appointment (as per above) who then go on to be seen within 48 hours of contacting the service.

This is a BASHH standard and is a recommended outcome within the Integrated Sexual Health Service National Specification template.

Calculation:
(X/Y)*100

Where:
X: The number of people offered a appointment with a sexual health service seen within 48 hours.

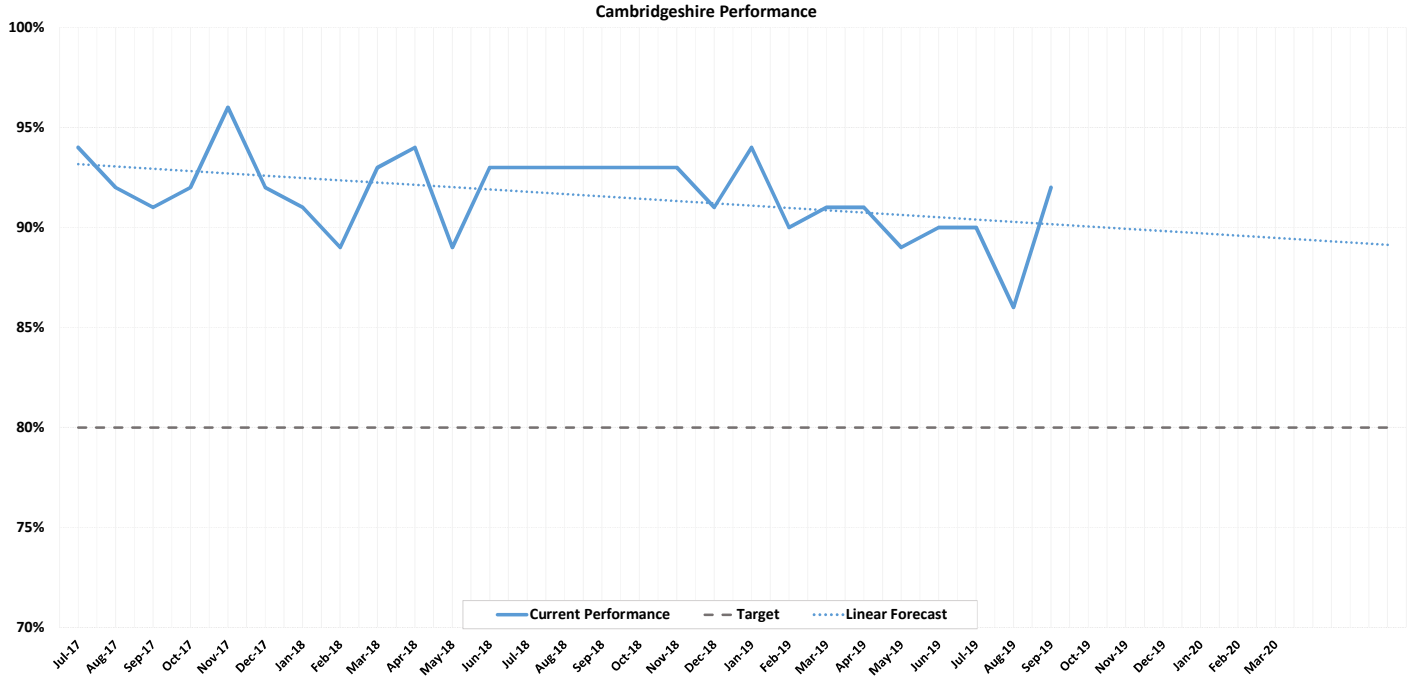
Y: The number of people offered an appointment with a sexual health service.

Source: Integrated Sexual Health National Specification

Useful Links

LG Inform:
https://lginform.local.gov.uk/

Integrated Sexual Health National Specification
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/731140/integrated-sexual-health-services-specification.pdf



Commentary

Target	Current Quarter	Previous Quarter	Direction for Improvement	Change in Performance
4500	2964	4512	↑	↓

Statistical Neighbours Mean	England Mean	RAG Rating
N/A	N/A	R

Indicator Description

This measure is the number of people within the eligible population who receive an NHS health check via their GP Practice.

Targets are set based on the eligible population for an NHS health check, as outlined in the NHS Health Check programme guidance. The Local Authority's Public Health Intelligence Team support with the target setting distribution across all GP practices.

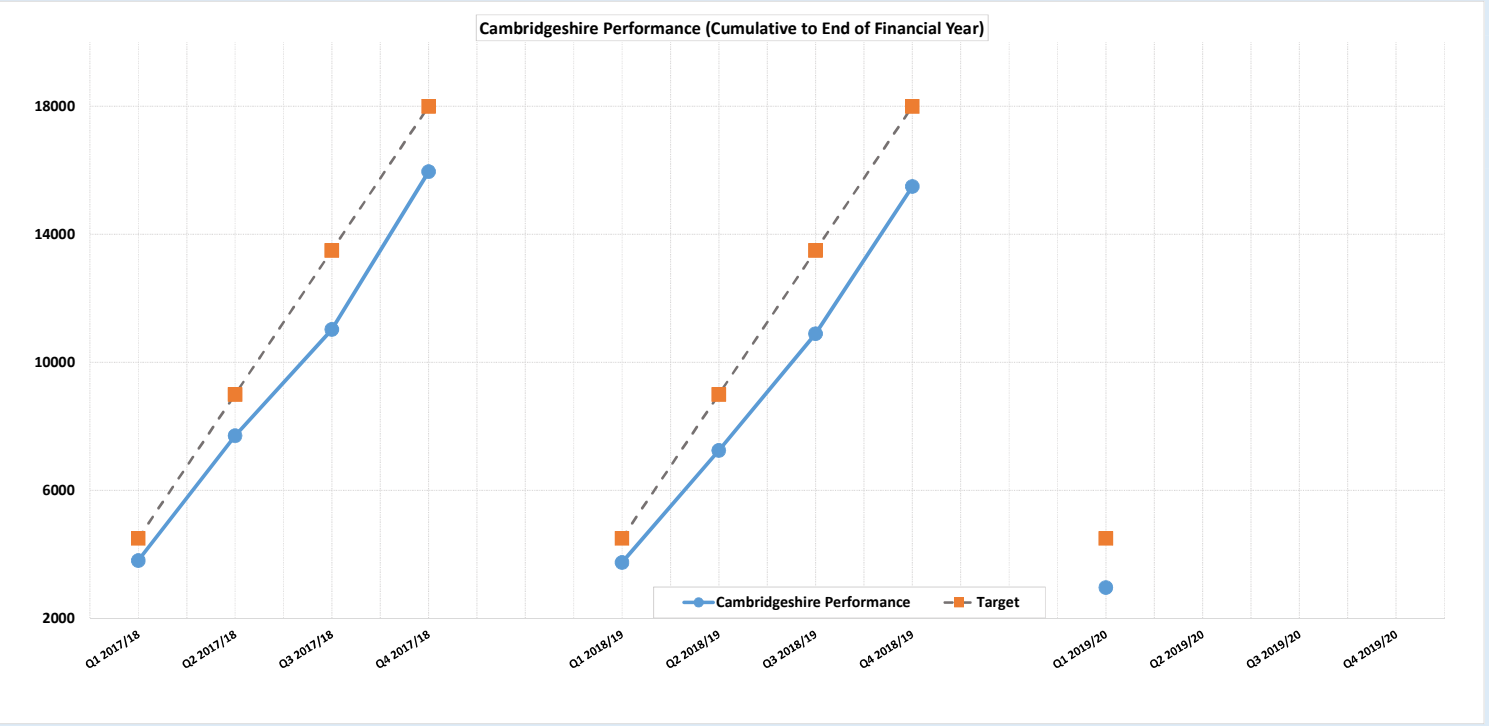
Calculation:
Number of health checks completed within a financial quarter.

Source: NHS Health Check National Guidance

Useful Links

LG Inform:
https://lginform.local.gov.uk/

NHS Health Check National Guidance
https://www.healthcheck.nhs.uk/commissioners-and-providers/national-guidance/



Commentary

Perfomance this quarter is lower (at 66% of target for the period) than for 2018/19 (86% of the target achieved). This reflects the efforts made to support GP practices to trawl their data systems to ensure that all data is reported. NHS Health Checks is a core programme for Public Health as it provides a way of engaging people in an early conversation about their health, risks and lifestyle changes. It also includes potential early detection of risk factors relating to Diabetes, Hypertension, CVD and provides an opportunity to discuss Dementia Awareness.

Target	Current Month	Previous Month	Direction for Improvement	Change in Performance
360	384	142	↑	↑

Statistical Neighbours Mean (2017/18)	England Mean (2017/18)	RAG rating
N/A	N/A	VG

Indicator Description

Smoking remains a Public Health Priority area, it remains the main cause of preventable illness in England.

This measure uses the number of indiviudals receiving stop smoking support via a set programme, who are confirmed as smokefree at 4 weeks post set quit date.

4 week quitters are counted based on the number of indiviudals accessing a stop smoking programme (via GP, Pharmacy or integrated lifestyle provider), who are confirmed as being smokefree 4 weeks after setting a quit date. Targets are calculated by the Public Health Intelligence team based on the national guidance, considering the estimated number of smokers.

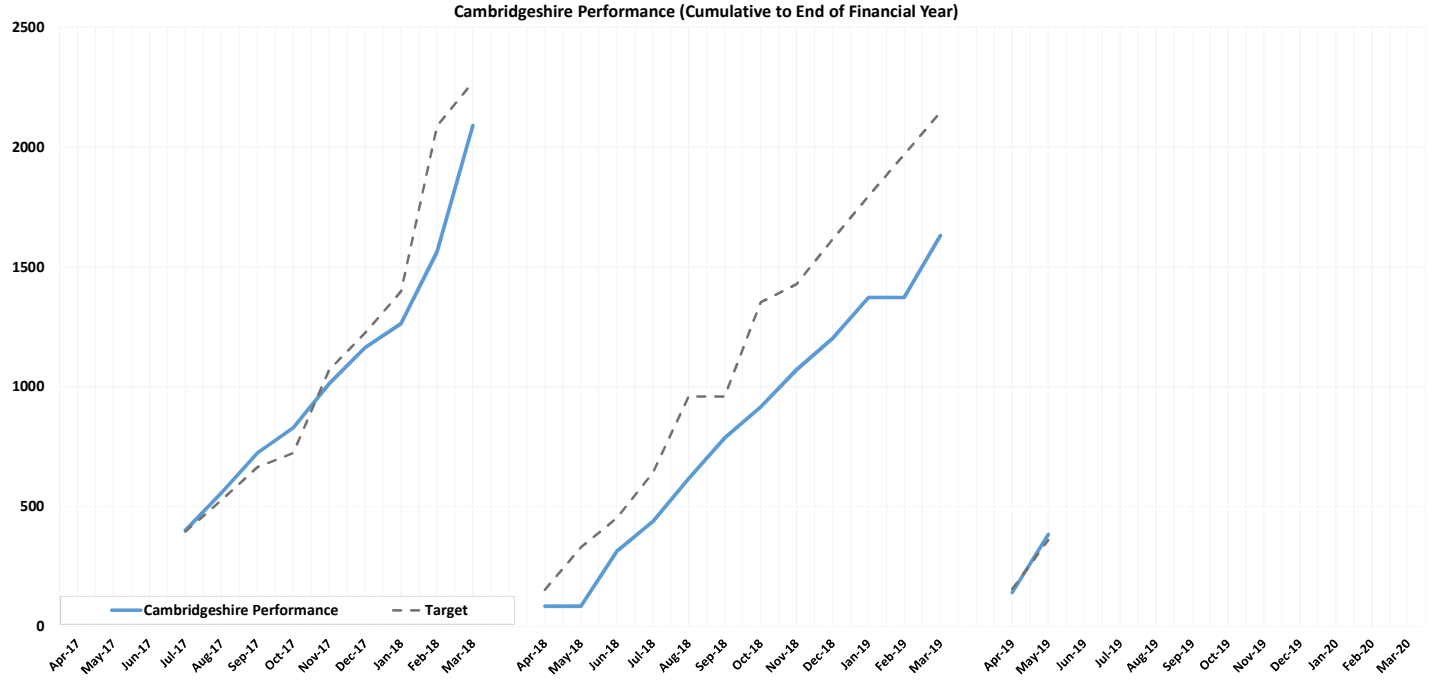
Calculation:
Number of 4 week quitters.

Source: NSCST Stop Smoking Guidance

Useful Links

LG Inform:
https://lginform.local.gov.uk/

NSCST Stop Smoking Guidance
https://www.ncsct.co.uk/usr/pub/Guidance_on_stop-smoking-interventions-and-services.pdf



Commentary

Target	Current Quarter	Previous Quarter	Direction for Improvement	Change in Performance
56.0%	56.0%	57.0%	↑	↓

Statistical Neighbours Mean (2017/18)	England Mean (2017/18)	RAG Rating
N/A	N/A	G

Indicator Description

TBC

Useful Links

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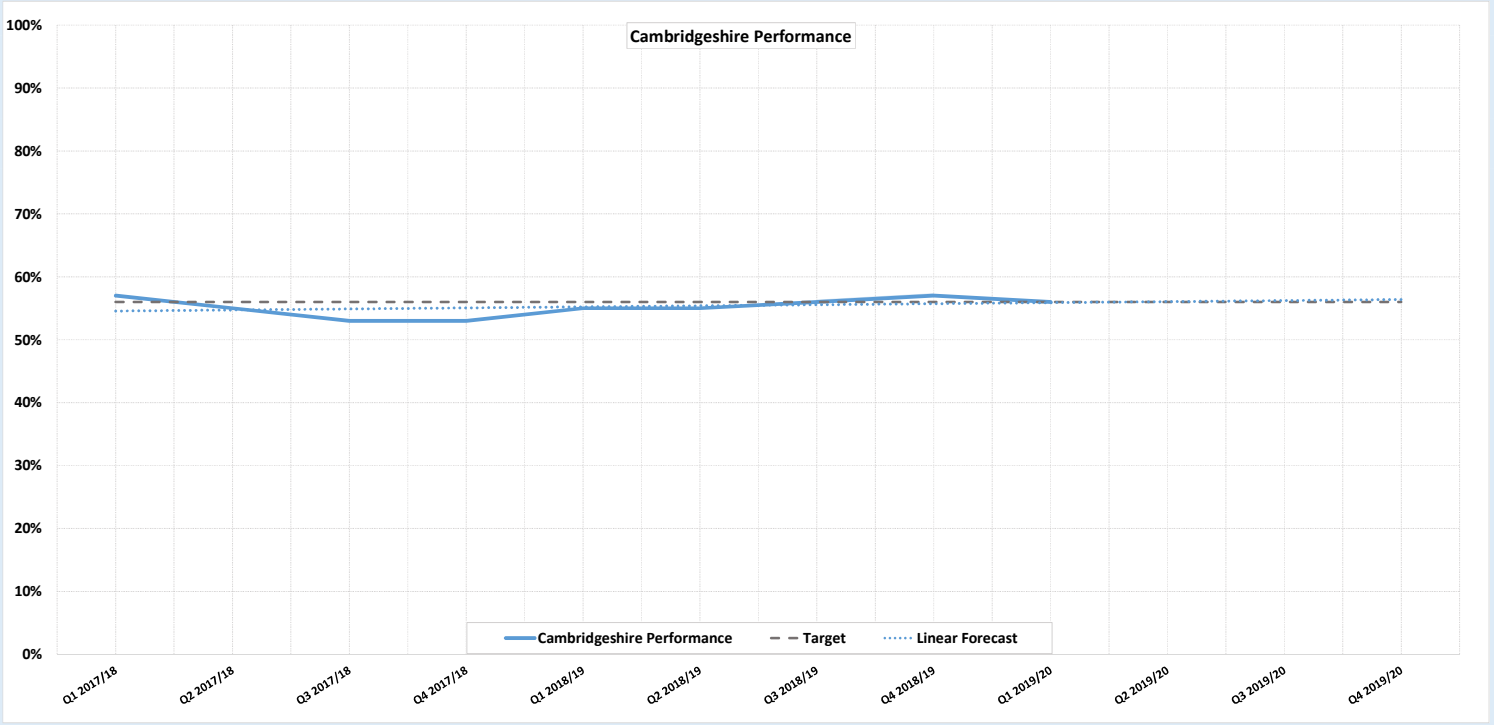

Commentary

Despite being a challenging target and experiencing a 1 percentile decrease this quarter, county breastfeeding statistics remain on target at 56% target, which significantly exceeding the national average of 45%. Breastfeeding prevalence rates, which comprise of both exclusive breastfeeding and mixed feeding vary greatly across the county. Broken down by districts, prevalence for Q1 stand at 66% in South Cambridgeshire, 65% in Cambridge City, 55% in both Huntingdonshire and East Cambridgeshire, and 39% in Fenland. The Health Visiting service remains Stage 3 UNICEF Baby Friendly accredited, which demonstrates quality of care in terms of support, advice and guidance offered to parents/carers and the excellent knowledge that staff have in respect of responsive feeding.

Target	Current Quarter	Previous Quarter	Direction for Improvement	Change in Performance
50.0%	27.0%	23.0%	↑	↑

Statistical Neighbours Mean (2017/18)	England Mean (2017/18)	RAG Rating
N/A	N/A	R

Indicator Description

TBC

Useful Links

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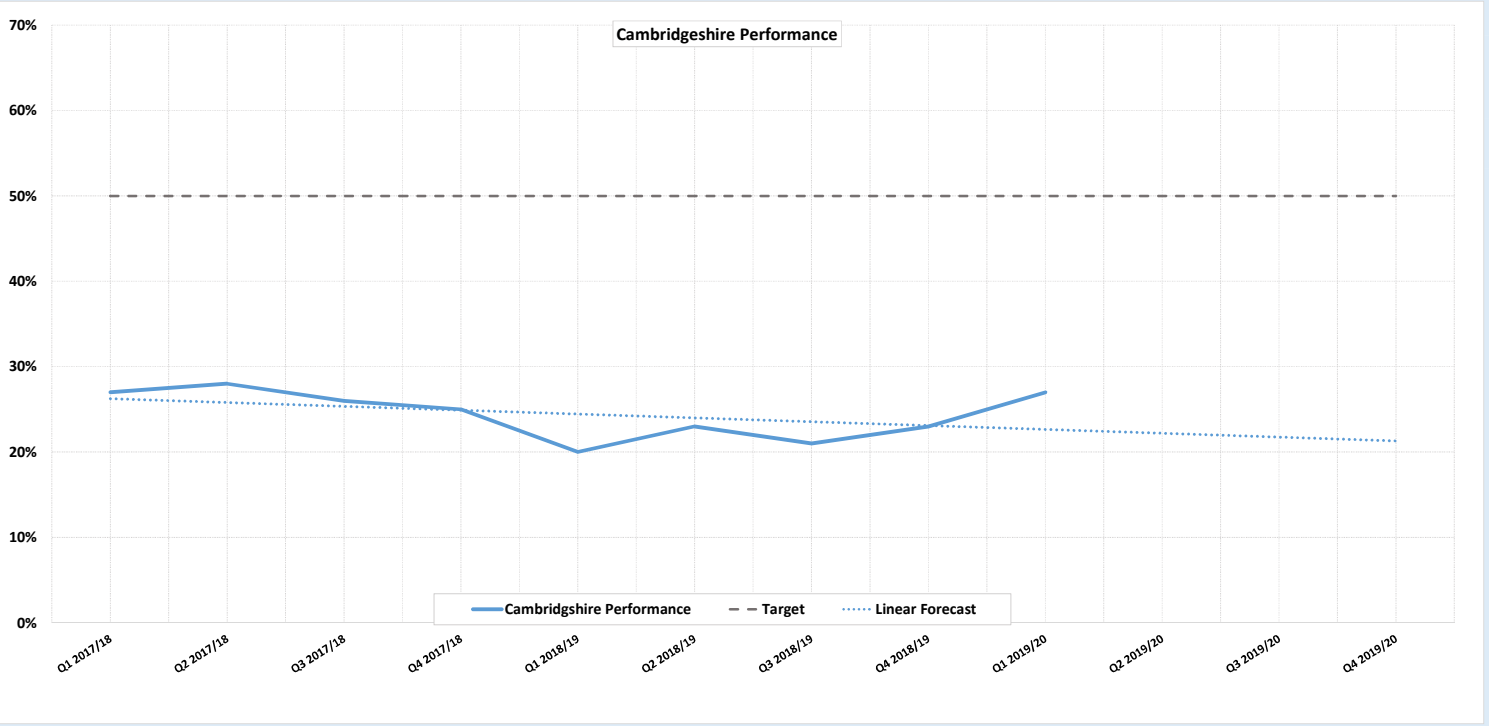

Commentary

In Cambridgeshire a local target has been set for 50%, with the longer term goal of achieving a target of 90% by 2020. Service transformation, which has included use of the Benson Modelling tool to determine workforce required to deliver the service, has accounted for Health Visitors to be completing all antenatal contacts and will start to be worked against from April 2019. Quarter 1 shows an increase of 5% of antenatal contacts achieved across the service in comparison to quarter 4 performance and month on month improvements - reaching 30% in June. If exception reporting is accounted for, consisting of those booked but not attended, this increases to a quarterly average of 35%. Disaggregated into distracts, there continues to be significant variance: Fenland completed 52% of contacts (70% including exception reporting) therefore reaching the target and is a recognisable achievement; Huntingdonshire achieved 47% of contacts (58% including exception reporting); Cambridge City achieved 10% of contacts (12% including exception reporting); East Camb and South Cambs both achieved 8% (11% including exception reporting). Reasoning cited for this disparity continues to be staffing pressures in the South Locality team, which covers East Cambs, Cambs City and South Cambs. These are being addressed and work is underway to streamline the waiting list to aid assessment and contact planning as well as improving communication with Maternity services. Monthly face to face HV/Midwifery meetings are being established to discuss identified vulnerable pregnant women and there is ongoing development to embed an electronic notification process. The provider reports that the locality is committed to improving the volume of antenatal contacts completed and to address the situation in the immediacy, the student nursing cohort have recently started their consolidation of learning, with specific concentration on delivery of antenatal contacts in the area.

Target	Current Quarter	Previous Quarter	Direction for Improvement	Change in Performance
90.0%	89.0%	93.0%	↑	↓

Statistical Neighbours Mean (2017/18)	England Mean (2017/18)	RAG Rating
N/A	N/A	A

Indicator Description

TBC

Useful Links

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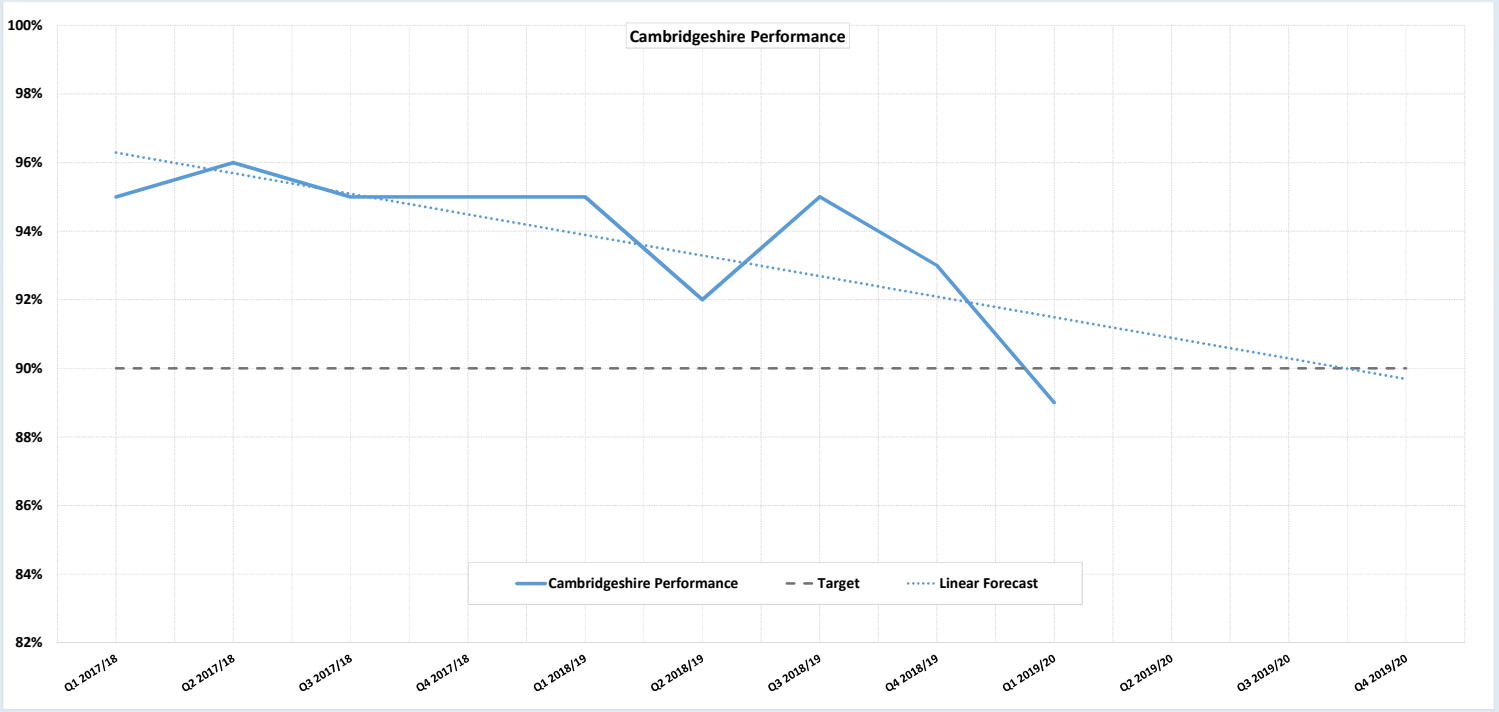

Commentary

The proportion of 10 - 14 day new birth visits completed within 14 days of birth has decreased this quarter by 4% and is now standing at 1% below target. If those completed after 14 days are accounted for, the quarterly average increases to 96%, which whilst being 2% below the overall target for completed visits (98%) indicates a majority of families are receiving this contact.

Target	Current Quarter	Previous Quarter	Direction for Improvement	Change in Performance
90.0%	92.0%	93.0%	↑	↓

Statistical Neighbours Mean (2017/18)	England Mean (2017/18)	RAG Rating
N/A	N/A	G

Indicator Description

TBC

Useful Links

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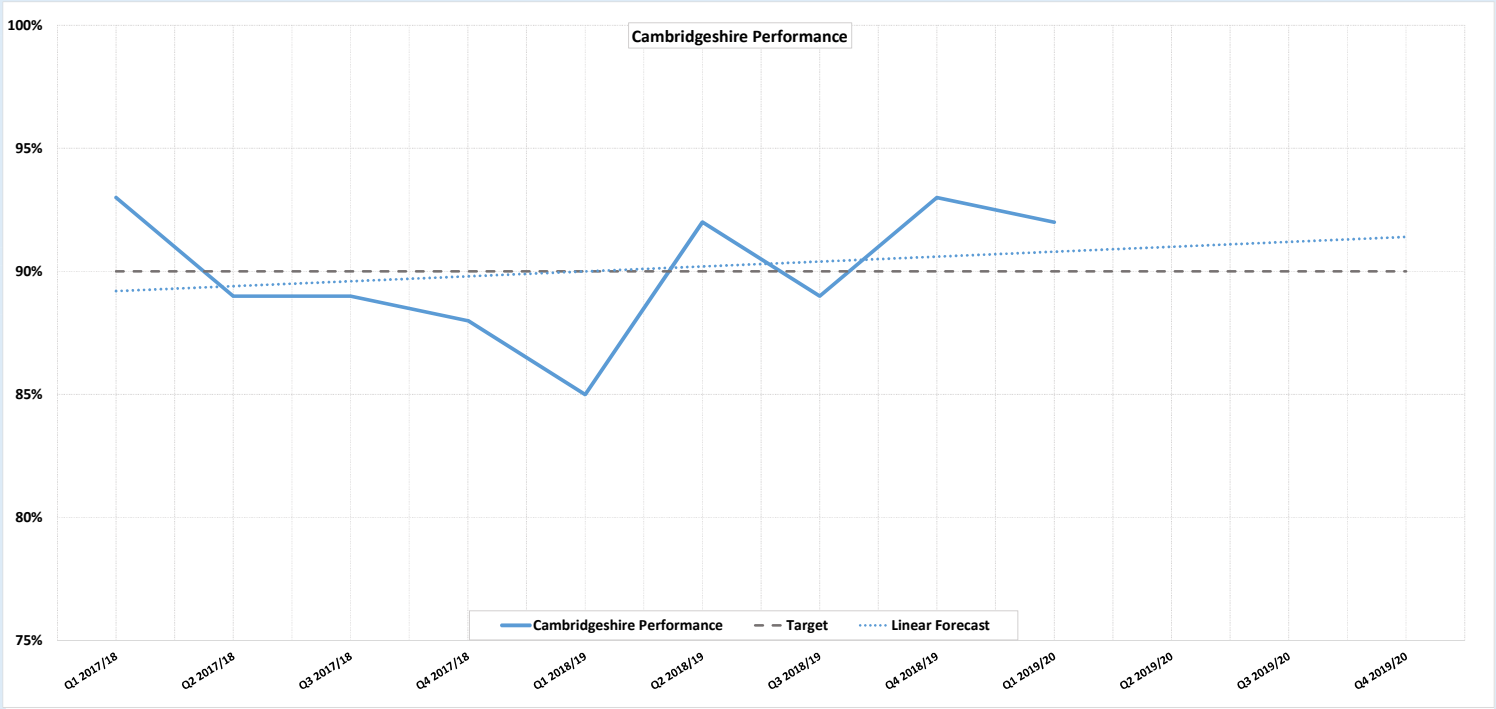

Commentary

Performance for the 6 - 8 week review has remained steady and above target, despite a 1% decease in performance against the Q4 2018/19 position.

Target	Current Quarter	Previous Quarter	Direction for Improvement	Change in Performance
95.0%	86.0%	84.0%	↑	↑

Statistical Neighbours Mean (2017/18)	England Mean (2017/18)	RAG Rating
N/A	N/A	A

Indicator Description

TBC

Useful Links

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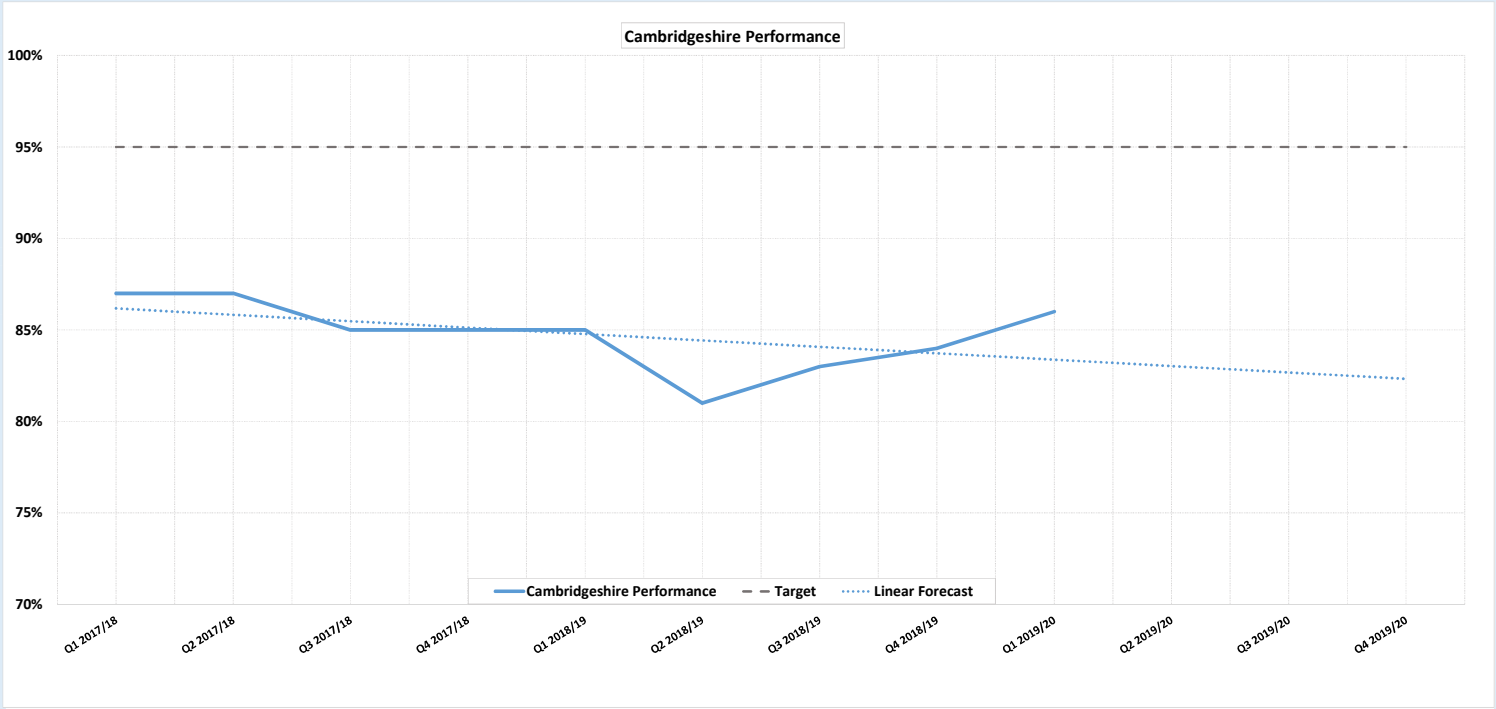

Commentary

Performance has increased by 2% this quarter, standing at 86%; by comparison 76% of families received this visit by the time the child turned 12 months old. The inclusion of exception reporting would increase the quarterly performance to 94% of families having this review by the time the child turns 15 months. Of all appointments offered this quarter, 78 were not wanted by the family and 77 were not attended. Assurances are in place to ensure vulnerable families (those on Universal Plus or Universal Partnership Plus pathways) are receiving this contact and an escalation plan is in place if these mandated visits are missed. A further 107 contacts were 'not recorded'. When district varience is considered, 95% of contacts were completed in Fenland, 79% were completed in Cambs City, 86% completed in East Cambs, 85% completed in Huntingdonshire, and 87% in South Cambridgeshire

Target	Current Quarter	Previous Quarter	Direction for Improvement	Change in Performance
90.0%	59.0%	73.0%	↑	↓

Statistical Neighbours Mean (2017/18)	England Mean (2017/18)	RAG Rating
N/A	N/A	R

Indicator Description

TBC

Useful Links

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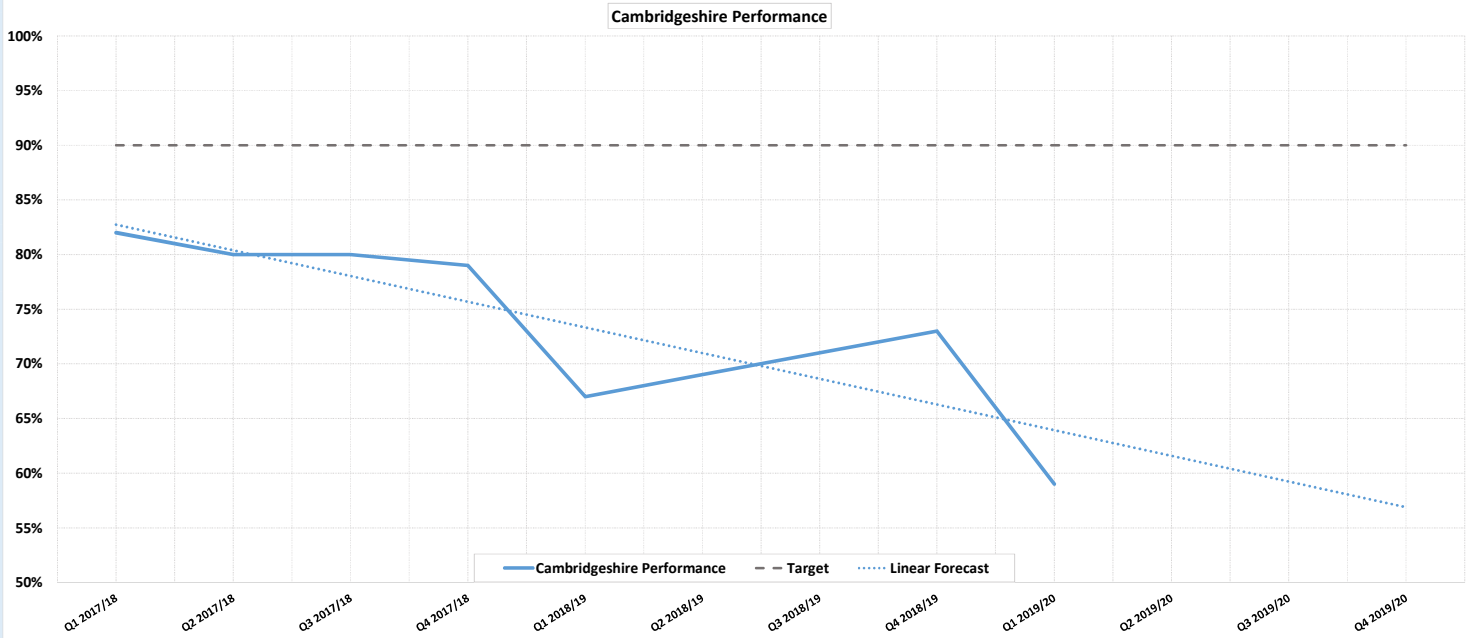

Commentary

Performance has declined significantly this quarter from 73% to 59% of contacts being completed. The main cause of performance issues against this target is staffing and capacity challenges in the South Locality which has resulted CCS needing to implement stage 4 of the Business Continuity Plan across this team based on their staffing prediction tool generating a result of 61% staffing availability for May/June.This has meant the implementation of a number of short term mitigation measures, including 2 year development checks for those who have only universal needs recorded on their records will also be suspended for the summer in the south locality area with parents sent a self-assessment ASQ and asked to contact the Duty Desk with any concerns. Consequently the number of contacts/assessments being completed by the HCP team has reduced substantially and is impacting on overall figures. It is anticipated that BCP measures will cease by September and business as usual will recommence. This quarter however, broken down at district level, 32% of contacts were completed in Cambs City; 39% of contacts completed in South Cambs; 54% of contacts completed in Huntingdonshire. More positively, 95% of contacts were achieved in Fenland. If exception reporting is accounted for, this quarter it was reported that 64 reviews were not wanted and 75 were not attended. 405 contacts were listed as 'not recorded' and 208 were not offered.

Target	Current Month	Previous Month	Direction for Improvement	Change in Performance
300	305	63	↑	↑

Statistical Neighbours Mean (2017/18)	England Mean (2017/18)	RAG rating
N/A	N/A	G

Indicator Description

TBC

Useful Links

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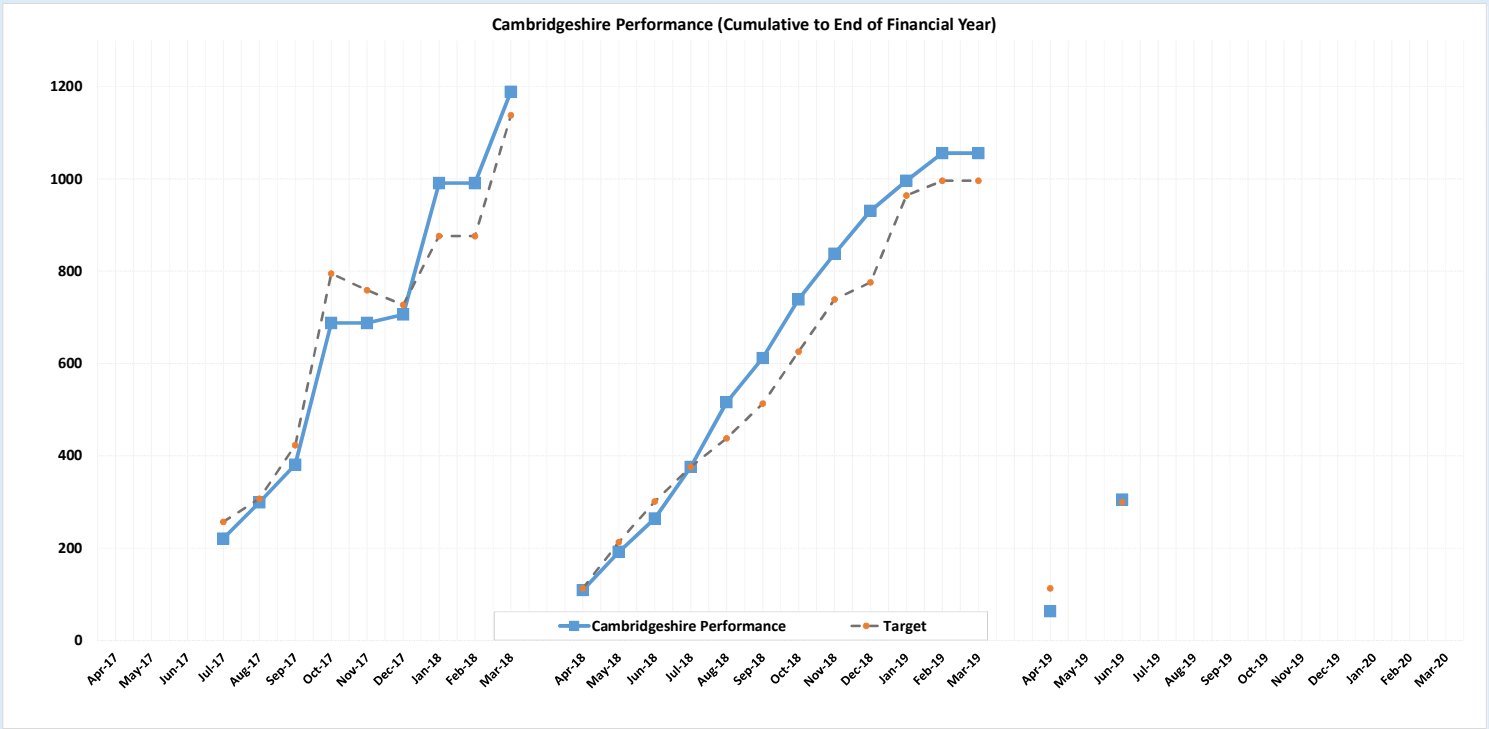

Commentary

Target	Current Month	Previous Month	Direction for Improvement	Change in Performance
163	182	17	↑	↑

Statistical Neighbours Mean (2017/18)	England Mean (2017/18)	RAG rating
N/A	N/A	VG

Indicator Description

TBC

Useful Links

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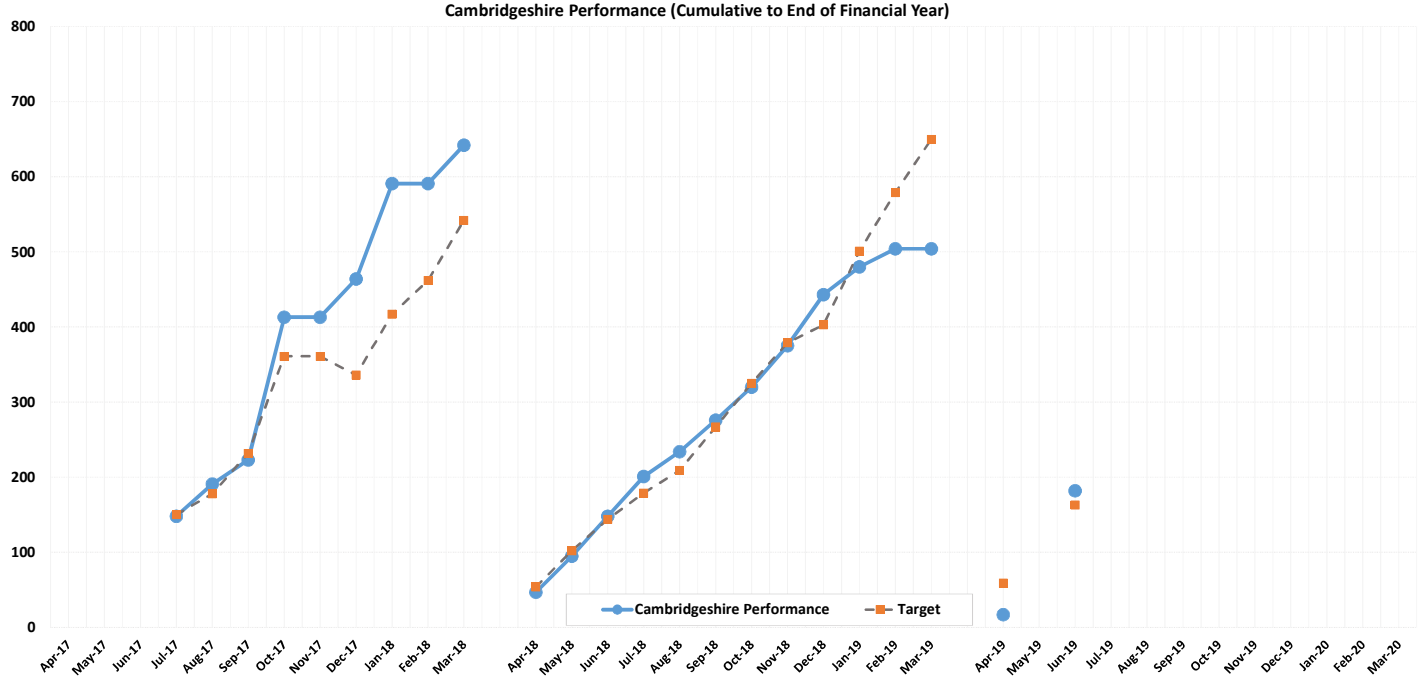


Commentary

Target	Current Month	Previous Month	Direction for Improvement	Change in Performance
30.0%	35.0%	43.0%	↑	↓

Statistical Neighbours Mean (2017/18)	England Mean (2017/18)	RAG rating
N/A	N/A	VG

Indicator Description

Obesity is a chronic condition with multiple risk factors associated such as type 2 diabetes, heart disease etc. The Tier 2 weight management services offers individuals a structured programme to make continued lifestyle changes. This is a significant area of Public health Priority.

% of individuals completing a Tier 2 weight management intervention who have a weight loss of 5%.

PHE KPI recommendations for Tier 2 Adult Weight Management suggests that 30% of all participants will lose a minimum of 5% of their (baseline) initial body weight, at the end of the active intervention.

Calculation:
(X/Y)*100

Where:
X: The number of Tier 2 clients recruited who complete the couirse and achieve 5% weight loss.

Y: the number of Tier 2 clients recruited.

Source: NHS Key Performance Indicators Tier 2

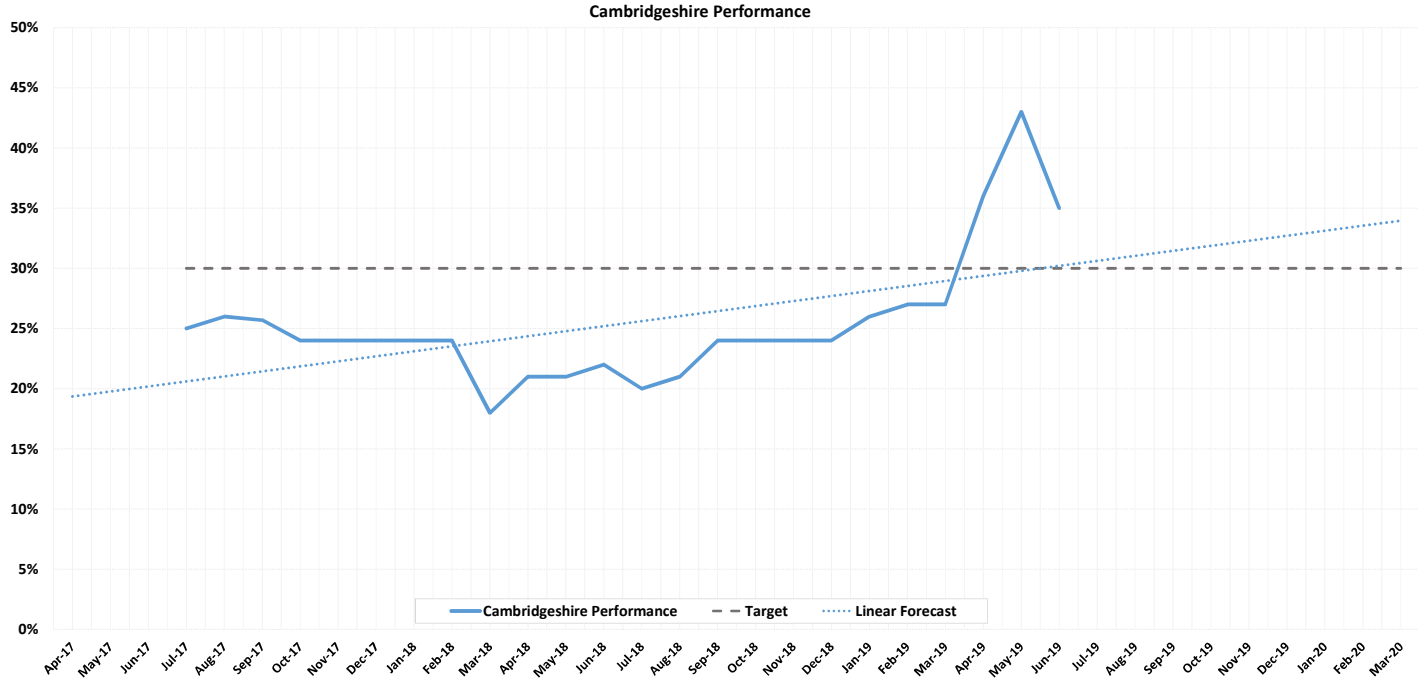
Useful Links

LG Inform:

https://lginform.local.gov.uk/

Public Health Key Performance Indicators Tier 2:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/656531/adult_weight_management_key_performance_indicators.pdf



Commentary

Target	Current Month	Previous Month	Direction for Improvement	Change in Performance
60.0%	64.0%	45.0%	↑	↑

Statistical Neighbours Mean (2017/18)	England Mean (2017/18)	RAG rating
N/A	N/A	VG

Indicator Description

Obesity is a chronic condition with multiple risk factors associated such as type 2 diabetes, heart disease etc. The Tier 3 weight management services offers individuals a structured programme to make continued lifestyle changes. This is a significant area of Public health Priority.

% of individuals completing a Tier 3 weight management intervention who have a weight loss of 10%.

PHE KPI recommendations for Tier 3 Adult Weight Management suggests that 30% of all participants will lose a minimum of 10% of their (baseline) initial body weight, at the end of the active intervention.

Calculation:
(X/Y)*100

Where:
X: The number of Tier 3 clients recruited who complete the couirse and achieve 10% weight loss.

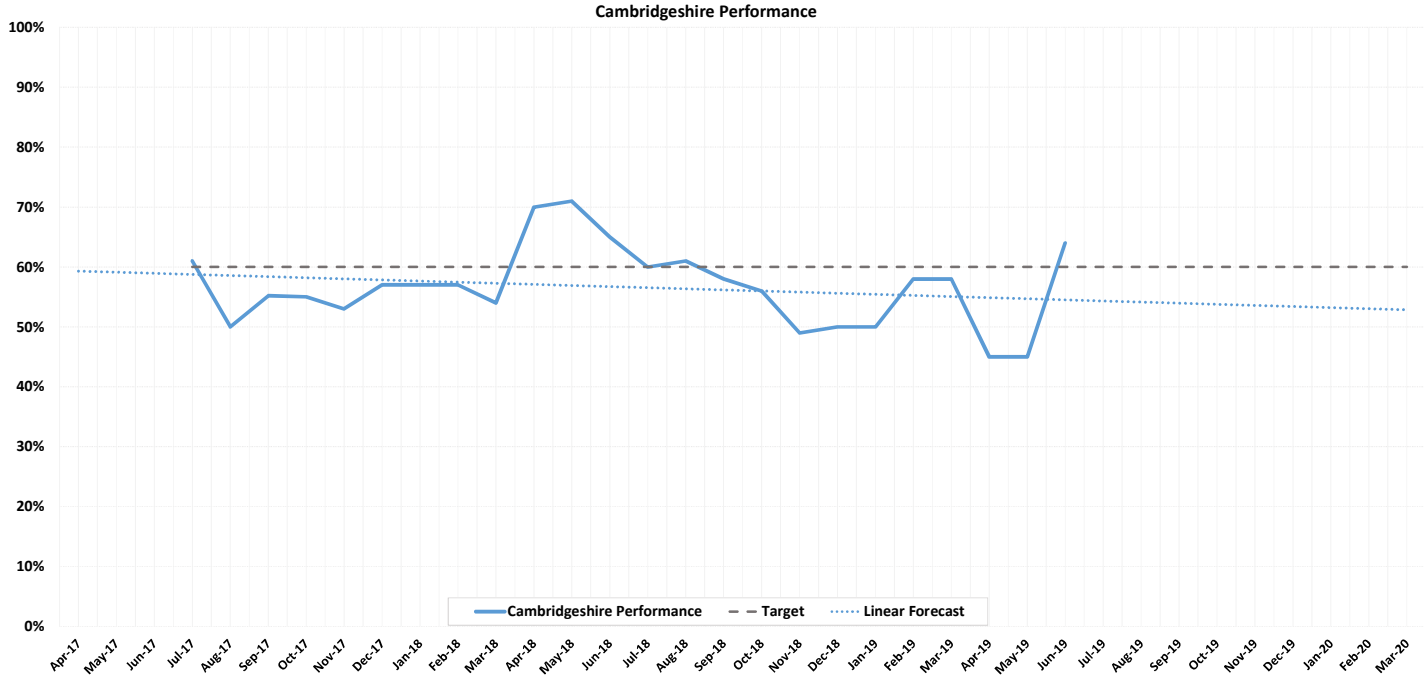
Y: the number of Tier 3 clients recruited.

Source: NHS Key Performance Indicators Tier 2; Qualitative insights into user experiences of tier 2 and tier 3 weight management services

Useful Links

LG Inform:
https://lginform.local.gov.uk/

Qualitative insights into user experiences of tier 2 and tier 3 weight management services:
https://www.innovationunit.org/wp-content/uploads/PHE-Report_with-discussion.pdf



Commentary

Target	Current Month	Previous Month	Direction for Improvement	Change in Performance
79	88	67	↑	↑

Statistical Neighbours Mean (2017/18)	England Mean (2017/18)	RAG rating
N/A	N/A	VG

Indicator Description

TBC

Useful Links

LG Inform:

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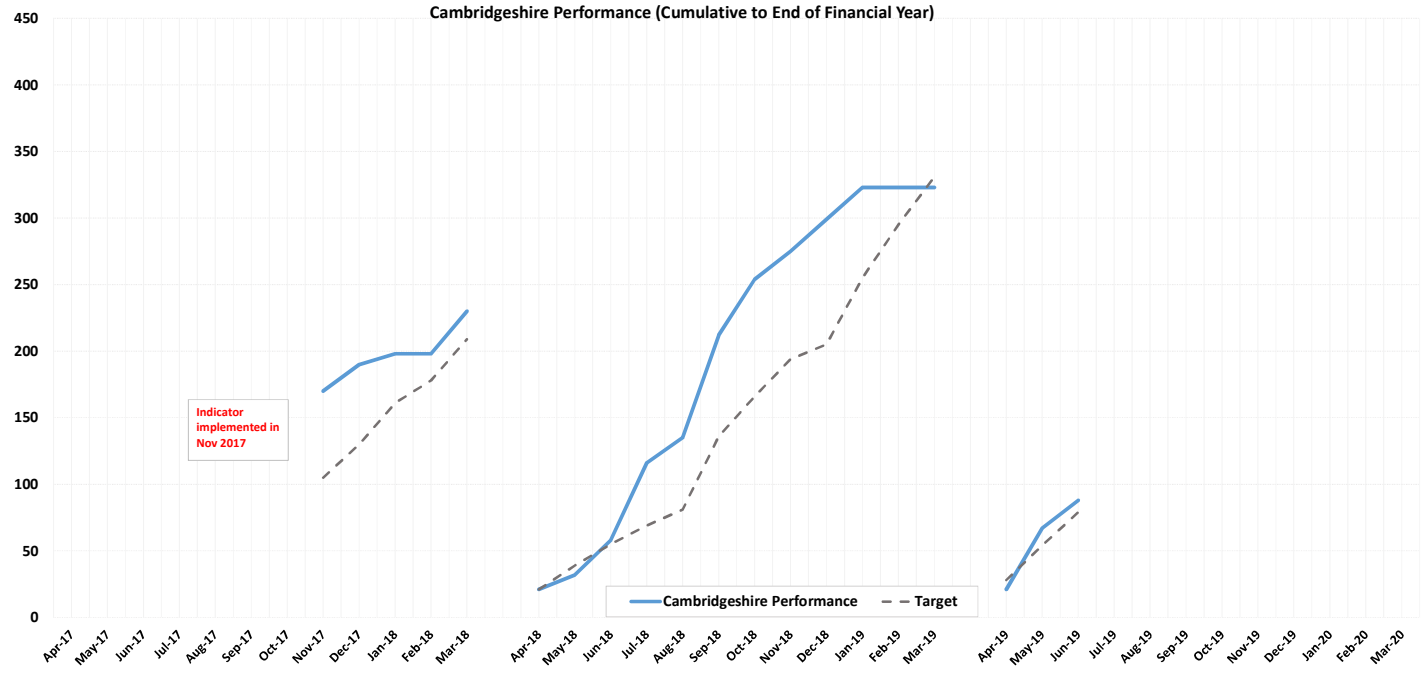


Commentary

Agenda Item No: 8

DRAFT JOINT BEST START IN LIFE (BSiL) STRATEGY

To:	**Health Committee**
Meeting Date:	**19th September 2019**
From:	**Liz Robin, Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**N/A**
Key decision:	**No**
Purpose:	**The key purpose of this paper is to ensure that there is co-ordinated and integrated multi-agency agreement on the delivery of pre-birth to 5 services, including public health services, that is tailored appropriately to local need.**
Recommendation:	**Endorse the Draft Joint Best Start in Life Strategy 2019 – 2024 attached at Appendix 1 and approve the full engagement of children's public health services in delivering the Strategy**

	Officer contact:		***Member contacts:***
Name:	Helen Freeman	Names:	Cllr Peter Hudson
Post:	Children's public health commissioning team leader	Post:	Chair Health Committee
Email:	Helen.Freeman@cambridgeshire.gov.uk	Email:	Peter.hudson@cambridgeshire.gov.uk
Tel:	01223 728177	Tel:	01223 706398

1. BACKGROUND

1.1 Best Start in Life is a 5 year strategy which aims to improve the life chances of children (pre-birth to 5 years) in Cambridgeshire and Peterborough by addressing inequalities, narrowing the gap in attainment and improving outcomes for all children, including disadvantaged children and families.

The strategy development was led jointly by Cambridgeshire and Peterborough local authorities, co-chaired by the Executive Director People and Communities and the Director of Public Health, and working with a wide range of stakeholders. It is built on knowledge of local need and what the evidence says works in improving outcomes during the early years. Local user research also informed the process.

The strategy reflects the national and local policy context, including: Better Births, The Government's Prevention Vision, NHS Long Term Plan and the Government's plan for improving social mobility through education, Think Communities, Cambridgeshire and Peterborough's child poverty strategies and healthy weight strategies, SEND Strategy

Cambridgeshire and Peterborough have worked together over the past seven months to develop 'Best Start in Life' – an ambitious high-level strategy to improve the outcomes of children in the early years. The vision is that "Every child will be given the best start in life supported by families, communities and high quality integrated services". We recognise that children and families face many challenges, not all of which can be resolved by the strategy's proposals. The aim is to ensure that available resources are used to best effect and with a focus on key outcomes, through integrated working across the organisations involved and with communities.

An intensive discovery phase was undertaken during November 2018 to March 2019 resulting in the production of a draft Joint BSiL Strategy. This phase involved extensive engagement with both existing research, data and evidence, alongside local parents and communities.

2. MAIN ISSUES

2.1 The Best Start in Life strategy focusses on three key outcomes which represent our ambition for children in Cambridgeshire and Peterborough:

- Children live healthy lives
- Children are safe from harm
- Children are confident and resilient with an aptitude and enthusiasm for learning

The core of the Best Start in Life Start strategy consists of five themes of integrated delivery – these describe how we intend to improve outcomes, by focussing on:

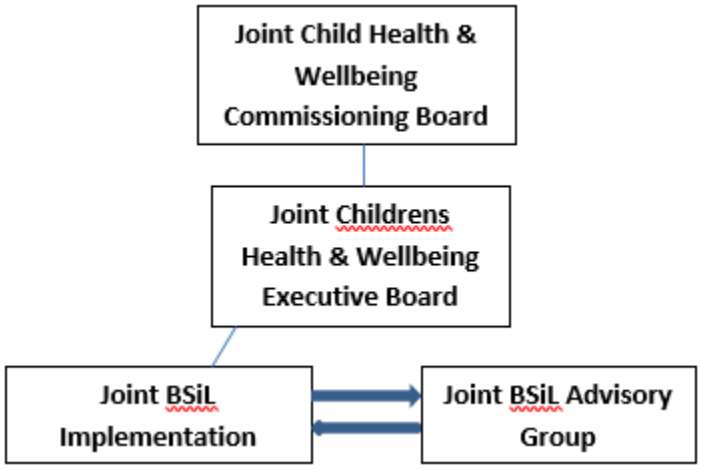
1. Healthy pregnancy, parents and children

2. Vulnerable parents - identified early and supported
3. Well prepared parents
4. Good attachment and bonding
5. Supporting child development

The five themes are underpinned by nine building blocks, which will ensure that the aims of the strategy are met and sustained over time:

Governance

A new governance structure has been established, as shown in the image below. There is strong public health representation at all levels of governance:



A co-produced implementation plan is being developed to monitor the progress and impact of the strategy. A 'strategy on a page' approach to engage families further will also be included within this implementation plan. A communications sub-group is being established to support the work of the BSiL implementation and advisory groups.

The Joint Childrens Health & Wellbeing Executive Board will monitor the progress of the implementation plan and direct activities through the joint implementation and

advisory groups to ensure key measures and deliverables are achieved and at the right pace.

The BSiL strategy and implementation plan are being developed at a time of reducing resources and we will be seeking to deliver these in the most efficient and effective way possible.

The current, second phase of the BSiL programme runs until September. The aim of the second phase is to identify options for an integrated delivery of early years provision. The third phase will work towards commencing the new model in April 2020. This will include further work to ensure that evaluation is built in from the start, using appropriate methodologies.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 A good quality of life for everyone

Please see wording under point 3.3.

3.2 Thriving places for people to live

There are no significant implications for this priority.

3.3 The best start for Cambridgeshire's Children

Best Start in Life is a 5 year strategy which aims to improve life chances of children in Cambridgeshire and Peterborough by; addressing inequalities, narrowing the gap in attainment, and improving outcomes for all children including disadvantaged children and families.

Evidence is clear that the early years (pre-birth to 5 years) are a crucial period of change. The experiences of babies and children during this time lay the foundations for their future, and shape their development, educational attainment and life chances.

It is therefore a period of great opportunity, where the combined efforts of parents, communities and services can make a real and lasting difference. The Best Start in Life strategy aims to take this opportunity to ensure that its vision and outcomes are a shared responsibility and ambition across all partners who provide a service to children and their parents.

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

There are no significant implications within this category.

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

There are no significant implications within this category.

4.3 **Statutory, Legal and Risk Implications**

There are no significant implications within this category.

4.4 **Equality and Diversity Implications**

There are no significant implications within this category.

4.5 **Engagement and Communications Implications**

Engagement with the public and communities is central to the BSiL strategy development and implementation. The approach adopted to date is ethnographic user research. This is an example of human centred design and allows us to understand and empathise with our users in order to design services to meet their needs.

As part of the Best Start in Life strategy development, a multi-disciplinary team of service specialists and designers went out over 2 weeks to settings, services, public places, health centres and homes to learn about people's lives. We wanted to find out what motivates and drives them, what is important to them, what the hardest aspects of parenting are and how they source help and support.

Below are some insights from the user research programme along with some representative quotes:

- Parents value social connection and networks with others and they offer each other advice and support in parenthood. Parents also seek personalised, professional advice and support and seek this during touchpoints with health visitors and also community groups. "I trust the advice from a professional. Families and friends have their own opinions and ways of doing things that is right for them." They also value seeing the same professional again, with whom they build up a relationship and trust. "It was really nice when the Health Visitor recognised me and my baby at the weighing clinic and asked how we were - it made me feel special"

- It can be hard to ask for help if you are struggling with a new baby and there was a feeling that you have to know what the right questions to ask are. One mum with post-natal depression said "you have to ask for help, which is the hardest thing because when the health visitor comes you are trying to impress them. No-one says "I'm really struggling" because they are scared of having their baby taken away so you put the brave face on and hide it"

- Parents like groups led by volunteers and parents because they feel less watched and judged. "The groups I attend are parent led rather than run by trained professionals, where it can feel like there is a social worker around."
- There are many community groups that aim to cater for parent's needs and are highly attended and successful. The most successful ones focus and succeed in giving parents a warm welcome, creating a non-judgemental environment,

making activities available for children, giving parents a chance to relax and socialise with other parents and offering support from professionals. The groups that provide high quality refreshments help make parents feel valued. “Bumps & Babies had a really welcoming atmosphere, it felt safe, friendly, chilled out and calm. They had AMAZING coffee too! Great for bonding time.”

- There is a lack of community provision specifically for fathers. [When you’re the only Dad at a parenting group] “It’s quite isolating, you don’t feel included and you do feel vulnerable.”
- Most people know what it takes to be healthy (eating well and moving more) but most people know that they don’t do the ‘right’ things all the time. Getting children out and about walking and playing at the park is seen as important for their wellbeing. “My son is awful with eating the right things - he thinks we are trying to trick him"
- Pre-schools are very good at helping to prepare children for school, especially those that are linked to a school where the transition is more seamless. “Pre-school Piglets really helped with the transition - they talked to the children about what a typical school day looked like, told them about uniform, how the desks would be set up and that they could get used to the environment. They also arranged for the pre-schoolers to join in a lunchtime at the school from Easter time.”
- Parents of children with disabilities or undiagnosed problems find navigating services, entitlement and regular form filling to be a significant ‘pain point’. Parents find the process of explaining their situation and accessing the help and support they need very challenging. “I love being Molly’s mummy but I don’t like the managerial/administrative side of it. It could be simpler. Molly will need an EHCP and SEND support and I find it so overwhelming I push it away...I don’t know where to start with it all.”
- There is a perceived lack of support for children aged 2 to 5 and sometimes parents are not clear about what development milestones they should be helping their children to achieve and by when. “There is a real lack of advice available from 2-5 years old and that it's assumed you've got it now - it's there if you need it, but you really have to seek it out yourself. It's a shock from the first two years when you have health visitors and regular appointments to just having nothing”

A further programme of user research and engagement is planned for two weeks in July 2019 which will be used to inform the co-produced strategy implementation plan, which will be supported by a communications strategy. The intention is to reach more of the public and professionals who represent the wide diversity across Cambridgeshire and Peterborough.

4.6 **Localism and Local Member Involvement**

There are no significant implications within this category.

4.7 **Public Health Implications**

The Strategy includes a focus on improving health outcomes for young children

Implications	Officer Clearance
Have the resource implications been cleared by Finance?	Yes Martin Wade
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	Yes Name of Officer: Gus da Silva (for the same paper going to Children & Young People's Committee)
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	Yes Name of Legal Officer: Fiona McMillan (for the same paper going to Children and Young People's Committee)
Have the equality and diversity implications been cleared by your Service Contact?	Yes Name of Officer: Liz Robin
Have any engagement and communication implications been cleared by Communications?	Yes Name of Officer: Jo Dickson
Have any localism and Local Member involvement issues been cleared by your Service Contact?	Yes Name of Officer: Liz Robin
Have any Public Health implications been cleared by Public Health	Yes Name of Officer: Liz Robin

Source Documents	Location
Draft Best Start in Life Strategy 2019-2024	Appendix 1 to this report.

Best Start in Life Strategy 2019-2024

Contents

Authors and Acknowledgments

Principle author	Ben Brown, Speciality Registrar Public Health, Public Health Directorate
Contributing authors	Gwendolyn Casazza, Transformation Manager, Cambridgeshire County Council Kat Sexton, Digital Services Architect, LGSS

Acknowledgements

The creation of the Best Start in Life strategy would not have been possible without the dedication and expertise of the strategy group members. As well as playing a key part in shaping the strategy they have helped to refine the document itself.

The input of wider multi-agency stakeholder group members has also been essential and we thank them for their commitment and guidance.

The executive leads, Wendi Ogle-Welbourn (Executive Director: People and Communities for Cambridgeshire & Peterborough Councils) and Dr Liz Robin (Director of Public Health) have provided the leadership and guidance necessary to ensure the success of the strategy development.

The 'Five Themes' which provide a focus for the strategy have been adapted from the Leeds 'Best Start' Plan 2015-19.

Executive Summary

Our Vision

Every child will be given the best start in life supported by families, communities and high quality integrated services.

Best Start in Life is a 5 year strategy which aims to improve life chances of children (pre-birth to 5 years) in Cambridgeshire and Peterborough by addressing inequalities, narrowing the gap in attainment and improving outcomes for all children, including disadvantaged children and families.

Why We Need Strategy

All children have the right to grow up with the best health possible, to be protected from harm and to have access to an education that enables them to fulfil their potential[1].

Whilst on many measures, the health and wellbeing of young children in Cambridgeshire and Peterborough compares well to other similar areas, this is not the case for all children. This creates unacceptable and avoidable inequalities which impacts on their future health and life chances.

For example, whilst the level of 'school readiness' in Cambridgeshire is similar to England as a whole, in Peterborough it is worse and they reside in lowest 10% of all local authorities. However, for children taking free school meals, Cambridgeshire is worse than Peterborough and England and has declined since 2015/16[2].

Many children also face a number of other challenges growing up, including; the effects of smoking in pregnancy, poor oral health, low vaccine uptake, parental mental health problems, domestic abuse and parental substance misuse.

Poor outcomes for children also have a significant social and economic cost. For example, high levels of accident and emergency department attendance and increasing pressures on Children's Social Care create unsustainable levels of demand for services. Public services are part of a wider local system which includes families, communities, local organisations and institutions, the voluntary sector and businesses. We believe it is only through taking a preventative approach and involving this wider system that our vision can be achieved[3].

Cambridgeshire and Peterborough has a huge range of services and innovative programmes available for children and families. However, evidence suggests that the best practice is not always available to all and that services are not always provided in a joined up way which is helpful to families[4]. There is much to be gained by creating a more integrated approach which maximises the benefits of services working together better and involving the public and communities at every stage.

[1] United Nations Convention on the Rights of the Child (UNCRC) 1989
[2] https://fingertips.phe.org.uk/profile/public-health-outcomes-framework
[3] Prevention is better than cure: Our vision to help you live well for longer. Department of Health and Social Care. November 2018
[4] Early Years Social Mobility Pilot Peer Review of Peterborough and Cambridgeshire. Local Government Association. 2018.

What We Are Trying To Achieve

We have an opportunity improve outcomes for children by bringing all the strands of early years provision together, into an integrated strategy and model of delivery.

The Best Start in Life strategy focusses on three key outcomes which represent our ambition for children in Cambridgeshire and Peterborough.

- Children live healthy lives
- Children are safe from harm
- Children are confident and resilient with an aptitude and enthusiasm for learning

The strategy will measure its success through a shared outcomes framework and developing a process for evaluation at an 'intervention' and 'system' level.

How We Will Achieve Our Goals

The core of the Best Start in Life Start strategy consists of;

Five themes[5] for integrated delivery – these describe how we intend to improve outcomes, by focussing on;

1. Healthy pregnancy for parents and children
2. Vulnerable parents - identified early and supported
3. Well prepared parents
4. Good attachment and bonding
5. Supporting child development

See page 32.

Nine building blocks – these form the foundations for creating a long term system wide collaboration which we believe will be required to improve outcomes for children. See page 33.

For example, central to the strategy is an acknowledgement that in order to create the change we want to see, it will require a change in culture and a co-ordinated approach across the whole workforce. This means everyone should know what it means to give children the Best Start in Life and how they can contribute to this vision.

How The Strategy Was Developed

The strategy development was led jointly by Cambridgeshire and Peterborough local authorities, working with a wide range of stakeholders. It is built on knowledge of local need and what the evidence says works in improving outcomes during the early years. Local user research also informed the process.

The strategy reflects the national and local policy context, including: Maternity Transformation - Better Births, The Government's Prevention Vision, the NHS Long Term Plan and the Government's plan for improving social mobility through education, Think Communities and Cambridgeshire and Peterborough's child poverty, healthy weight and SEND strategies.

[5] The 'Five Themes' have been adapted from the Leeds 'Best Start' Plan 2015-19.

Programme Plan

Phases 2 and 3 of the strategy run from May 2019 to March 2020.

Phase 2 (May to September 2019) will further develop the strategy and identify options for the future integrated delivery model.

Phase 3 (October to March 2020) will focus on arrangements for implementing the new model in April 2020, including development of the 'building blocks' which underpin the strategy.

Best Start in Life

Our vision

Every child will be given the best start in life supported by families, communities and high quality integrated services.

3 Key impacts

Children live healthy lives
Children are safe from harm
Children are confident and resilient with an aptitude and enthusiasm for learning

Outcome measures

Smoking and obesity during pregnancy Low birth weight ✗ Infant mortality ✗ Breastfeeding ✗ A&E attendances ✗ Unintentional and deliberate injuries ✗ Dental decay ✗ Excess weight ✗ Immunisations ✗ Rates of looked after children ✗ Children in need plans ✗ Child protection plans ✗ Appropriate referrals to social care ✗ School readiness (good level of development and phonics) ✗ 2-2 ½yr HCP review (ASQ3) ✗ 2 year early education progress check ✗ Uptake of funded education

Integrated Delivery

5 Themes

Healthy pregnancy, parents and children
Vulnerable parents identified early and supported
Well prepared parents
Good attachment and bonding
Supporting child development

9 Building Blocks

A collaborative leadership and governance structure	Place-Based Strategies & Plans	Outcomes & Accountability
Funding & Commissioning	Culture Change & People Development	Integrated Service Delivery
Data, Evidence & Evaluation	Collaborative Physical and Digital Platforms	Communications & Engagement

Introduction

Best Start in Life is a 5-year strategy which aims to improve life chances of children in Cambridgeshire and Peterborough by; addressing inequalities, narrowing the gap in attainment, and improving outcomes for all children including disadvantaged children and families.

Evidence is clear that the early years (pre-birth to 5 years) are a crucial period of change. The experiences of parents, babies and children during this time lay the foundations for their future, and shape their development, educational attainment and life chances.

It is therefore a period of great opportunity, where the combined efforts of parents, communities and services can make a real and lasting difference. The Best Start in Life strategy aims to take this opportunity by being bold and acting to ensure that its vision and outcomes are a shared responsibility and ambition across all partners who provide a service to children and their parents. It sets out new arrangements for providing an integrated early years provision across Cambridgeshire and Peterborough.

A cultural shift is needed in the understanding of the 3 prime areas of development (personal, social and emotional; communication and language; and physical) and how to foster and promote secure and positive parent-child relationships. This means recognising that everyone can play a role, and ensuring that all professionals coming into contact with children or their parents feel a shared purpose and understanding of how they can contribute to giving children the Best Start in Life.

Finally, it is only by engaging and empowering parents and communities that we can ensure that they feel supported, in a positive way when they need it. The strategy will ensure that they know where to go for safe and consistent information, advice and support. Whilst for many, universal preventative approaches will be the right approach, some children and families will need more targeted and specialist support and this should be available close to where they live.

Background

Following a recent Early Years Social Mobility Pilot Peer Review of Peterborough and Cambridgeshire, undertaken by the Local Government Association (LGA), a recommendation was made that the local authorities develop a holistic early years strategy that brings together all the strands of the early years offer,[6] so that children across the county have the best start in life and are 'school ready'.

The review found a number of areas of innovative and impactful practice. This included the START[7] programme in Peterborough and the Wisbech Literacy Project. It reported that where services work together, there is a positive impact on children and their families. Examples included; co-ordination between Special Educational Needs Co-ordinators (SENCOs) and Portage Home Visitors[8]; working relationships around school clusters.

The review also identified a number of strategic issues and challenges, including;

- a lack of universal understanding about how early years, early help and early support join together to ensure that services are provided to families in a way that is right for them

[6] Including Better Births, Healthy Child Programme, Children's Centres and Early Years Education Settings
[7] A practical guide for parents and professionals on how to prepare children for school. https://www.peterborough.gov.uk/residents/schools-and-education/school-readiness/
[8] Portage is a home visiting educational service for pre-school children with additional support needs and their families.

- recruitment and retention of professional staff and budget reductions
- a lack of clarity around strategic leadership in health which creates issues for accountability and responsibility
- a need to align with the new SEND strategy – in particular early identification and joined up response to needs

The creation of a multi-agency early years strategy is an opportunity to address these issues and bring all the strands of early years provision together to ensure that the children in Peterborough and Cambridgeshire have the Best Start in Life.

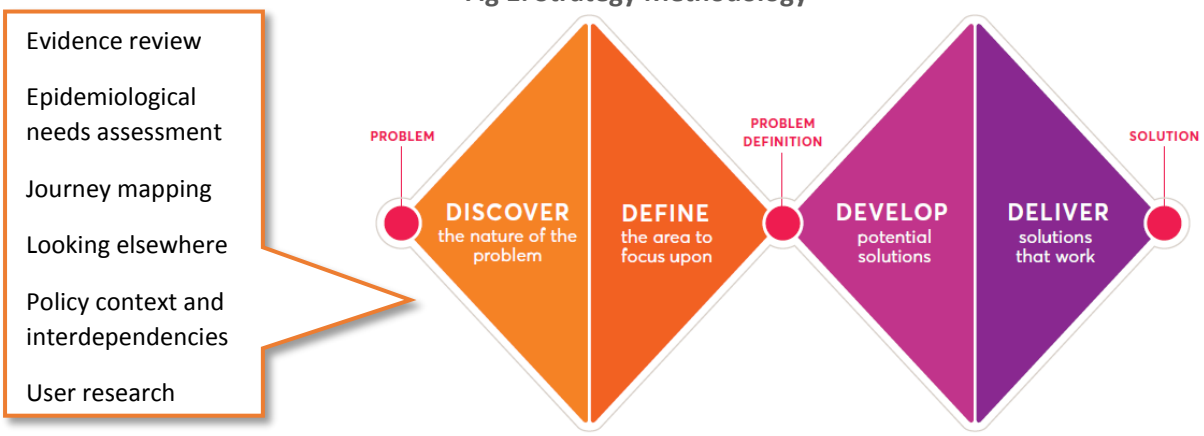
The Child Health Joint Commissioning Unit has worked with the providers of health visiting, school nursing, children's centres, early years education and early help services to review the delivery of early years provision. This work has taken into account national policy and guidance including 'Better Births'[9] and 'Best start in life and beyond'[10] and is set in the context of continuing financial constraints. In November 2018 it established a process for developing a Best Start in Life Strategy bringing together a wide range of stakeholders.

Strategy Development

The process to develop a Best Start in Life Start Strategy began in November 2018. A core strategy group met every two weeks to progress the work. Another, larger stakeholder group has met every 6 weeks. This has served as a reference group and also a forum for exploring or generating ideas, through a workshop format. See Appendix 1 for the groups membership.

The methodology used the four stages of design outlined in Fig 1. Initial phase of the project involved bringing together and synthesising the data, evidence, user research and journey mapping. It also included a look for integrated strategies elsewhere in the country. The elements of the draft strategy were then presented to the stakeholder group for agreement.

Fig 1. Strategy Methodology



[9] Better Births: Improving outcomes of maternity services in England. A Five Year Forward View for maternity care. National Maternity Review.

[10] Best start in life and beyond: Improving public health outcomes for children, young people and families
Guidance to support the commissioning of the Healthy Child Programme 0-19: Health visiting and school nursing services
Commissioning guide 2: Model specification for 0-19 Healthy Child Programme: Health visiting and school nursing services.
Revised March 2018. Public Health England

Best Start in Life Vision

Every child will be given the best start in life supported by families, communities and high quality integrated services.

Key Impact Statements

The Best Start in Life strategy focusses on three key outcomes which represent our ambition for children in Cambridgeshire and Peterborough;

- Children live healthy lives
- Children are safe from harm
- Children are confident and resilient with an aptitude and enthusiasm for learning

Guiding Principles

The strategy aims to give children the best start in life. We will achieve this by;

- Ensuring the opportunity to thrive is available to all children - leaving no one behind
- Recognising the diversity of our population
- Addressing inequalities in outcomes and access to advice and help
- Placing children and families at the centre of all that we do
- Empowering and supporting parents, families and communities to play a role
- Ensuring services work together well and overcome barriers to doing so
- Recognising that every professional has a role to play
- Ensuring the workforce are trained and supported to provide high quality and consistent advice and support
- Using the best available evidence and examples of good practice
- Achieving best value for money and effective use of the resources available
- Being bold in our vision and creative in our approach

Discover and Define

User Research

Best Start in Life Research

Engagement with the public and communities is central to the Best Start in Life strategy development and implementation. The approach adopted to date is ethnographic user research. This is an example of human centred design and allows us to understand and empathise with our users in order to design services to meet their needs.

As part of the Best Start in Life strategy development, a multi-disciplinary team of service specialists and designers went out over 2 weeks to settings, services, public places, health centres and homes to learn about people's lives. We wanted to find out what motivates and drives them, what is important to them, what the hardest aspects of parenting are and how they source help and support.

Below are some insights from the user research programme along with some representative quotes:

- **Parents value social connection and networks with others and they offer each other advice and support in parenthood.** Parents also seek personalised, professional advice and support and seek this during touchpoints with health visitors and also community groups. "I trust the advice from a professional. Families and friends have their own opinions and ways of doing things that is right for them." They also value seeing the same professional again, with whom they build up a relationship and trust. "It was really nice when the Health Visitor recognised me and my baby at the weighing clinic and asked how we were – it made me feel special"
- **It can be hard to ask for help if you are struggling with a new baby and there was a feeling that you have to know what the right questions to ask are**. One mum with post-natal depression said "you have to ask for help, which is the hardest thing because when the health visitor comes you are trying to impress them. No-one says "I'm really struggling" because they are scared of having their baby taken away so you put the brave face on and hide it"
- **Parents like groups led by volunteers and parents because they feel less watched and judged**. "The groups I attend are parent led rather than run by trained professionals, where it can feel like there is a social worker around."
- **There are many community groups that aim to cater for parent's needs and are highly attended and successful**. The most successful focus and succeed in giving parents a warm welcome, creating a non-judgemental environment, making activities available for children, giving parents a chance to relax and socialise with other parents and offering support from professionals. The groups that provide high quality refreshments help make parents feel valued. "Bumps and Babies had a really welcoming atmosphere, it felt safe, friendly, chilled out and calm. They had AMAZING coffee too! Great for bonding time."
- **There is a lack of community provision specifically for fathers**. [When you're the only Dad at a parenting group] "It's quite isolating, you don't feel included and you do feel vulnerable."
- **Most people know what it takes to be healthy (eating well and moving more) but most people know that they don't do the 'right' things all the time**. Getting children out and about walking and playing at the park is seen as important for their wellbeing. "My son is awful with eating the right things - he thinks we are trying to trick him"
- **Pre-schools are very good at helping to prepare children for school**, especially those that are linked to a school where the transition is more seamless. "Pre-school Piglets really helped with

the transition - they talked to the children about what a typical school day looked like, told them about uniform, how the desks would be set up and that they could get used to the environment. They also arranged for the pre-schoolers to join in a lunchtime at the school from Easter time."

- **Parents of children with disabilities or undiagnosed problems find navigating services, entitlement and regular form filling to be a significant 'pain point'**. Parents find the process of explaining their situation and accessing the help and support they need very challenging. "I love being Molly's mummy but I don't like the managerial/administrative side of it. It could be simpler. Molly will need an EHCP and SEND support and I find it so overwhelming I push it away...I don't know where to start with it all."
- **There is a perceived lack of support for children aged 2 to 5 and sometimes parents are not clear about what development milestones they should be** helping their children to achieve and by when. "There is a real lack of advice available from 2-5 years old and that it is assumed you've got it now – it's there if you need it, but you really have to seek it out yourself. It's a shock from the first two years when you have health visitors and regular appointments to just having nothing"

A further programme of user research and engagement is planned for two weeks in July 2019 which will be used to inform the co-produced strategy implementation plan, which will be supported by a communications strategy. The intention is to reach more of the public and professionals who represent the wide diversity across Cambridgeshire and Peterborough.

Cambridgeshire Children's Centre Consultation – July-September 2017.

The Best Start in Life Strategy is concerned with all aspects of early years provision and so public views on the use of children's centres is an important consideration. Questions 1-4 below related to children's centres across the local authority. Questions 5-9 related to specific district related plans and are not included below.

Question 1. Do you support our Children's Centres meeting the needs of a wider age range, from expectant parents to young adults?

You said:

You support us offering services across a broader age range.

There were concerns this would cost more money, and would require staff with different skills.

Question 2. To what degree do you support the proposal to focus services on those families that need them most?

You said:

Many of you agree we should focus our services on those who need us most.

Early Intervention is important to our residents.

We need to ensure our access routes to services is clear

Question 3. To what degree do you support the proposal to focus services on those families that need them most?

You said:

Having health services based with Children's Centre services could make it easier for people to access.

There were concerns this could create a space that was too clinical, and not welcoming.

Question 4. Our Child and Family Services will include the following:

- Maintaining some of our existing Children's Centres
- Delivering services in shared community spaces
- Providing outreach programmes at a local level
- A greater online offer. To what degree do you support this?

You said:

Many of you are attached to the building you currently use, even if they are underutilised.

Some people feel positively about services being delivered in other spaces, and feel it makes sense.

Many respondents have accessed outreach provision already.

Key Challenges

Impact 1: Children live healthy lives[11]

Smoking in pregnancy *has well known detrimental effects for the growth and development of the baby and health of the mother.* On average, smokers also have more complications during pregnancy and labour. Rates are particularly high for mothers attending Queen Elizabeth Hospital and Peterborough City Hospital where 22% and 14% of mothers report smoking respectively at time of delivery. This compares to 11% nationally.

Breastfeeding *has benefits for both child and the mother.* Exclusive breastfeeding is recommended for the first 6 months of life. Breastfeeding prevalence at 6-8 weeks is higher in Cambridgeshire than nationally and slightly higher in Peterborough. Trends are relatively static. However, breastfeeding prevalence increases as levels of relative deprivation decrease.

Low birth weight *is strongly associated with increased risk of infant death and poorer outcomes for the health and development of the child.* It is influenced by a range of factors including the mother's age and general well-being, ethnicity, smoking, nutrition, socio-economic position. Rates are statistically significantly high in most deprived quintile in Peterborough however there are hotspots across the county.

Vaccination *coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases.* This varies across the county and by vaccination type, with potential areas of concern in Cambridge City, where uptake is below 90% for 5 out of the 8 vaccinations reported. Two doses of MMR by 5 years olds are low in Cambridgeshire and Peterborough, but uptake is increasing. There are concerning downward trends in the uptake of most of the vaccinations in Peterborough.

Obesity *remains one of the biggest public health challenges facing the UK and other developed countries. The risk of obesity in adulthood and risk of future obesity-related ill health are greater as children get older.* Whilst levels of excess weight in reception year are similar to or better than the national averages, the picture across the county is variable. A fifth of children in Peterborough and Fenland enter reception with excess weight and overall the proportion of obese pupils doubles during primary school. Prevalence of overweight in reception is higher in some ethnic groups including, Black African and Bangladeshi children compared to the county as a whole.

Tooth decay *is one of the most common preventable childhood diseases and can often be arrested and reversed in its early stages.* Dental health is generally good in Cambridgeshire and the districts, with the proportion of decay in 3 and 5 year olds being significantly better than England. However, dental decay in 5 year olds is significantly worse in Peterborough, with a 32% of children experiencing decay (England = 23%).

A & E attendances *in children aged under five years are often preventable, and commonly caused by accidental injury or by minor illnesses which could have been treated in primary care***.** For children aged 0-4 years, attendance are high in Peterborough compared to England, and lower in Cambridgeshire. There is a strong correlation to deprivation with A&E attendances being significantly high from the most deprived areas of Cambridgeshire and Peterborough.

[11] Data Source: Best Start in Life Start in Life Data Pack Feb 2019. Helen Whyman, Public Health Directorate

Hospital admission rates for unintentional and deliberate injuries in children aged under 5 years are similar to England in Peterborough and better than England in Cambridgeshire, with both areas experiencing downward trends in such admissions. However, within the areas there is a correlation to deprivation, with admission rates higher from the more deprived areas

Impact 2: Children are safe from harm[12]

Nationally, Children's Social Care are experiencing unprecedented levels of demand. Research shows that between 2010-11 and 2017-18, referrals increased by 7% (broadly in line with population growth of 5.2%), while child protection assessments increased by 77%. The most expensive cases, where children are taken into care, have risen by almost triple the rate of population growth (15%) over the same period.

There are also significant local pressures. The number of child protection plans per 10,000 children aged under 18 years, between 2012/13 and 2017/18 have decreased in Peterborough (60 to 51) and *increased significantly in Cambridgeshire* (16 to 35). In Cambridgeshire, this represents an increase from 202 plans to 476 (at March 2018).

The rate of children in care (0-17) has increased in Cambridgeshire between 2011 and 2018, and has the 10th highest rate compared to its 16 statistical neighbours. Whilst the rate remains significantly lower than the national average there has been an increase from 470 to 705 children in care over that time period.

The rate of children in care (0-17) has decreased slightly in Peterborough, between 2011 and 2018, and has the 5th lowest rate compared to its 16 statistical neighbours. ***This remains significantly higher than the national average*** and there has been an increase from 310 to 370 children in care over that time period.

In December 2018,

- 901 children (aged 0-5) in Cambridgeshire were known to Children's Social Care. Of which; 60% were subject to child in need plans (CIN), 23% were subject to child protection plans and 17% were in care.
- 541 children (aged 0-5) in Peterborough were known to Children's Social Care. Of which; 70% were subject to child in need plans (CIN), 19% were subject to child protection plans (CP) and 11% were in care.

There is good evidence that the key causes of child maltreatment relate to the individual or combined effects of parental substance misuse, parental mental health problems and domestic abuse[13].

Local analysis suggests that for children aged 0-5 years there are,

- 4,700 living with an adult who has experienced domestic violence and abuse in the last year
- 2,900 living with an adult dependent on alcohol or drugs
- 7,500 living with an adult who has with severe symptoms of mental or psychiatric disorders

[12] Data Source: Best Start in Life Start in Life Data Pack Feb 2019. Helen Whyman, Public Health Directorate
[13] Early Intervention Foundation What Works To Enhance The Effectiveness Of The Healthy Child Programme: An Evidence Update Summary. 2018

- 21,000 living in household where an adult has a moderate or severe mental health problem. This represents a third of children aged 0-5.

Impact 3: Children are confident and resilient with an aptitude and enthusiasm for learning[14]

School readiness is a measure of how prepared a child is to succeed in school cognitively, socially and emotionally. Children are considered 'school ready' if they have reached a good level of development (GLD) at the end of the Early Years Foundation Stage (last term of Reception year, aged 5yrs).

Children are defined as having a good level of development (GLD) if they achieved at least the expected level in the early learning goals in the prime areas of learning (personal, social and emotional development, physical development and communication and language) and in the specific areas of mathematics and literacy.

In Peterborough school readiness is worse than England and despite improving slowly is in the lowest 10% of local authorities in England. In 2017/18, 67% of children were school ready.

In Cambridgeshire school readiness is the same as England but improving slowly. In 2017/18, 71% of children were school ready.

For children eligible for free school meals Cambridgeshire is worse than Peterborough and England and on the decline since 2015/16. In 2017/18, only 47% of these children were school ready.

Funded Pre-School Entitlement. Research shows that attending any pre-school, compared to none, is predictive of higher total GCSE scores, higher grades in GCSE English and maths, and the likelihood of achieving 5 or more GCSEs at grade A*-C.

Funded education uptake in January 2018 is shown in table 1 below. Cambridgeshire and Peterborough have lower proportions of funded early education children recorded as having a special education need compared to England, most notably in Cambridgeshire.

Table 1. Funded Early Education Uptake, Jan 2018[15]

	2 year olds	3 year olds	4 year olds	3 and 4 year olds
Cambridgeshire	68%	95%	95%	95%
Peterborough	69%	88%	95%	91%
England	72%	92%	95%	94%

[14] Data Source: Best Start in Life Start in Life Data Pack Feb 2019. Helen Whyman, Public Health Directorate
[15] Source: Provision for children aged under 5 years of age, January 2018, Department of Education. Children benefitting from funded early education in private, voluntary and independent providers, and in maintained nursery, primary, secondary and special schools.

Evidence Base

The Case for Investment

Producing robust estimates of how the costs of intervening compare with the long-term benefits to society is difficult. However, there is a compelling argument that the costs of intervening early are often likely to pay off to society in overall economic terms and that investing earlier rather than later will lead to cumulative benefits i.e. the skills acquired earlier in childhood will lead to greater additional gains as children get older.[16]

For example, it is estimated that failing to deal adequately with peri-natal health problems comes at a cost of £8.1 billion each year. Social Return on Investment Studies showed a returns of between £1.37 and £9.20 for every £1 invested. [17]

EIF has previously estimated that the costs of late intervention for children and young people add up to £17 billion a year across England and Wales (in 2016/17 prices)[18]. See Fig 2.

Fig 2. EIF estimate of the cost of late intervention

Source: EIF (2016) *The cost of late intervention: EIF analysis 2016.* 2016/17 prices.

Early Years Risk Factors

Studies show that early intervention works best when it is made available to children experiencing particular risks.[19] Risk factors exist at different levels and interact in complex ways, which are not fully understood. Some, such as antenatal development, occur at the level of the individual child whilst others work at the family level, community or societal level. Some risk factors are particularly pervasive, such as childhood poverty. See Appendix 2.

These risk factors are not predictive at an individual level but they can help to identify children who are vulnerable and who may need extra support.

Protective factors also operate at each level and can mitigate these risks. In many cases, risk and protective factors are two sides of the same coin. For example, good parental mental health can

[16] Realising the Potential of Early Interventions. EIF 2018.
[17] https://www.gov.uk/government/publications/health-matters-giving-every-child-the-best-start-in-life/health-matters-giving-every-child-the-best-start-in-life
[18] EIF (2016) The cost of late intervention: EIF analysis 2016. 2016/17 prices.
[19] EIF 2018. Realising the Potential of Early Intervention

underpin consistent and responsive parenting, but where there are problems it can have a wide-ranging impact on family life and child development.

Adverse Childhood Experiences (ACE)

ACE are stressful events occurring during childhood that directly affect a child (e.g. child maltreatment) or affect the environment in which they live (e.g. growing up in a house where there is domestic violence)

Research suggests that a high number of ACEs are associated with poorer outcomes in later life.

According to one study[20], those with 4 or more ACES are:

- 4 times more likely to have had sex while under 16 years old or to have smoked cannabis
- 4 times more likely to have had or caused an unintended pregnancy
- 8 times more likely to have been a victim of violence (12 months) or incarcerated (lifetime)
- 10 times more likely to have been a perpetrator of violence (12 months)

ACE theory is helpful for understanding importance of early years experiences on child development and providing a common language for early years practitioners, however the evidence is not yet advanced enough to be used for identify those at risk at an individual level or setting thresholds for help.

Reducing the Risk of Child Maltreatment

Over half of child protection cases involving an unborn child or infant are based on concerns related to child neglect. For a third of children, the initial concern is emotional abuse[21].

Studies consistently show that children are at a greater risk of maltreatment when[22];

- one or both parents have a mental health problem
- there is ongoing interparental violence in the home
- one or both parents misuse drugs or alcohol

Other factors known to increase the likelihood of child maltreatment include;

- high levels of economic disadvantage
- a low birthweight or premature birth
- higher numbers of children per household
- low levels of social support or single parenthood
- a history of parental maltreatment in childhood.
- children with special educational needs

[20]PHE and Liverpool John Moores University (2016): Adverse childhood experiences (ACE) study in Hertfordshire, Luton and Northamptonshire. http://www.cph.org.uk/publication/adverse-childhood-experiences-aces-in-hertfordshire-luton-and-northamptonshire/

[21] Office for National Statistics. https://www.gov.uk/government/statistics/characteristics-of-children-in-need-2017-to-2018

[22] Early Intervention Foundation What Works To Enhance The Effectiveness Of The Healthy Child Programme: An Evidence Update Summary. 2018

Reducing Child Obesity

Obesity is a complex problem with many drivers, including: behaviour, environment, genetics and culture. Public Health England recommend a number of ways to reduce obesity in children. These include,

- Decreasing pre-schoolers' screen time
- Decreasing consumption of high fat/calorie drinks/foods
- Increasing physical exercise
- Increasing sleep
- Modifying parental attitudes to feeding
- Promoting authoritative parenting
- Involving whole families (parents and children) in interventions that promote both healthier diet and more exercise

The Change for Life promotional campaign includes advice regarding diet and exercise, aimed at children. This includes, 'Sugar Swaps', 'Me Size Meals', '5 a Day' and 'Up & About'[23]. The Chief Medical Officer recommends that mobile under 5s should be physically active for at least 3 hours per day, spread throughout the day[24].

There are also a range of approaches that can be used to change the 'food environment' to promote healthier food and drink choices for parents and children. This includes using planning law to restrict the location and concentration of hot food takeaway outlets. Many local authorities are now working with outlets to encourage and incentivise the provision of healthier ingredients, menus and cooking practices[25].

Schools and early years settings can also play a part in encouraging healthier eating and physical activity.[26]

Improving School Readiness

In terms of what works to improve school readiness, the Department for Education has identified the following[27],

- Good maternal mental health
- Learning activities, including speaking to your baby and reading with your child
- Enhancing physical activity
- Parenting support programmes
- High-quality early education

Through its plan for improving social mobility, and closing the 'word gap', the Government has set a number of challenges which include; ensuring more disadvantaged children are able to experience a language rich early environment; improving the availability and take-up of high quality early years

[23] https://www.nhs.uk/change4life

[24]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213737/dh_128142.pdf

[25] Healthier Catering Guidance for Different Types of Businesses Tips on providing and promoting healthier food and drink for children and families. Public health England. March 2017

[26] Strategies for Encouraging Healthier 'Out of Home' Food Provision. A toolkit for local councils working with small food businesses. Public Health England and Local Government Association. March 2017.

[27] Department of Education, Department of Health (2011) Families in the foundation years evidence pack

provision by disadvantaged children and in challenging areas; improving the quality of early years provision in challenging areas by spreading best practice[28].

Evidence Based Interventions

Given the finite financial resources and the vast array of interventions available, it is more important than ever to be clear about which approaches have been shown to improve child outcomes and which ones have not.

Our evidence review considered 3 main sources of information;

- Early Intervention Foundation (EIF) – part of the What Works Network. The EIF Guidebook contains information on over 100 early intervention programmes that have been shown to improve outcomes for children and young people.
- Public Health England (PHE)
- National Institute for Health and Care Excellence (NICE)

The EIF adopt a widely used framework for categorising interventions according to need[29]. See table 2 below. Appendix 3 provides a summary of the evidence using this framework.

Table 2. Levels of Intervention

Universal	Targeted – selective	Targeted – indicated
Services/interventions which can be made available to all families, including immunisations, developmental reviews and antenatal care	These are offered to children or families based on demographic risks, such as low family income, single parenthood or adolescent parenthood.	Services/interventions for families with a child or parent with a pre-identified issue or diagnosed problem requiring more intensive support.

The evidence base should be considered alongside other factors like cost and existing local resources. Table 3 below shows the 3 interventions for which the EIF have given their highest evidence rating[30]. It clearly show the range of costs involved (5=highest[31]) and the extent to which this is likely to be an important local consideration.

Table 3. Interventions (0-5yrs) with evidence rating > 4. Source: EIF[32]

Programme	Age	Targeting	Evidence Rating	Cost Rating
Family Foundations	Peri-natal	Universal	4	1
Family Nurse Partnership (FNP)	Peri-natal	Targeted Selective	4+	5
The Incredible Years (IY) Preschool	Pre-school	Targeted Indicated	4+	2

[32] https://guidebook.eif.org.uk/

Evaluation and Monitoring

It is important to know whether the services or interventions provided are beneficial for the children and families who most need them and evidence about 'what works' is available to help guide commissioners and planners.

However, this evidence is usually at an intervention rather 'system' level, where a number of agencies, services and interventions are at work. As BSiL has an ambition to create an integrated model for early years it is important to consider how we can generate evidence of impact across the system. This is important for a number of reasons,

1) It is helpful to know which approaches are most promising or which features of the integrated system make the most difference
2) The BSiL strategy extends beyond traditional service delivery, and includes elements such as community engagement and culture change
3) The strategy is committed to building a shared accountability for outcomes across the system

The strategy therefore embeds the principles of evaluation and monitoring at two main levels; System and Service Delivery.

System Level

A draft BSiL Outcomes Framework is detailed in Table 4.

The 'building blocks' of the BSiL strategy includes a commitment to build local accountability through shared outcomes and metrics. As stated previously the strategy aims to explore how measures of impact at system level can be developed.

We aim to measure what is important to citizens and communities. This means thinking beyond traditional measures of user experience for specific services (e.g. children's centres, parenting groups) and working in collaboration with the public to understand what is important to them during the early years.

Service Delivery

It is essential to undertake regular service evaluation. Whilst many interventions may be 'evidence based', it is important to know whether they are producing the expected outcomes locally. For novel or adapted interventions, it provides an additional assurance that the resources are well used and creates an opportunity to share and extend promising new approaches.

The BSiL strategy is an opportunity to explore new evaluation methodologies such as the 'Rapid Cycle Adaptation and Testing[33] or the 10 step framework advocated by the EIF[34]. It is also an opportunity to

[29] Hardiker, P., Exton, K., & Barker, M. (1991). The social policy contexts of prevention in child care. British Journal of Social Work, 341–359

[30] Level 4 evidence rating = long-term positive impact through multiple rigorous evaluations. At least one of these studies must have evidence of improving a child outcome lasting a year or longer

[31] Level 5 cost rating = indicates that a programme has a high cost to set up and deliver, compared with other interventions reviewed by EIF. This is equivalent to an estimated unit cost of more than £2,000.

[32] https://guidebook.eif.org.uk/

[33] https://dartington.org.uk/responding-to-change-by-changing/

[34] 10 steps for evaluation success. Early Intervention Foundation. March 2019

consider how involvement in evaluation and research can be extended to parents and professionals who might not normally get involved.

Table 4. Best Start in Life Start in Life Outcomes Framework - Draft

Key Impact 1: Children Live Healthy Lives
Smoking at time of delivery
Low birth weight of term babies
Infant mortality
Breastfeeding initiation
Breastfeeding at 6-8 wks
A&E attendances - 0-4 years
Hospital admissions caused by unintentional and deliberate injuries in children - 0-4 yrs
Three and five year old children free from dental decay
Excess weight (overweight and obese) at Reception
Obesity at Reception
Immunisation targets met - 1 year olds (3 immunisations)
Immunisation targets met - 2 year olds (4 immunisations)
Immunisation targets met - 5 year olds (3 immunisations)

Key Impact 2: Children Are Safe From Harm
Rates of looked after children
Rates of child protection plans
Rates of child in need plans
Inappropriate referrals to Children's Social Care
Hospital admissions caused by unintentional and deliberate injuries in children - 0-4 yrs

Key Impact 3:Children are confident and resilient with an aptitude and enthusiasm for learning
Two year progress check (early education)
2 – 2 ½ year HCP review (ASQ3)
School Readiness: The percentage of children achieving a good level of development at the end of reception
School Readiness: The percentage of children with free school meal status achieving a good level of development at the end of reception
School Readiness: The percentage of Year 1 pupils achieving the expected level in the phonics screening check
School Readiness: The percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check
Uptake of funded 2,3,4 year old education entitlement

National Policy Context

Sir Michael Marmot's review of health inequalities in 2010[35] stressed,

"what happens in these early years, starting in the womb, has lifelong effects" on a person's health, wellbeing and life chances"

The importance of focusing on the early years of child's life is reflected in a number of recent Government policy documents and parliamentary publications.

The Government's Prevention Vision[36] includes within it an aspiration to give every child the best start in life, including.

- Encouraging healthier pregnancies (reducing smoking before or during pregnancy)
- Working to improve language acquisition and reading skills in the early years, including by supporting parents to help their children's language development at home
- Helping families by taking a whole family approach. This involves coordinating support for those that need it across a range of important areas, including: mental and physical health, housing, debt and employment, reducing parental conflict
- Improving dental health in children
- Protecting and improving children's mental health
- Encouraging healthier food and drink choices

This will be supported by the work of a **new Early Years and Family Support Ministerial Group** announced in July 2018[37]. This was preceded some years previously by the launch of **The 1001 Critical Days Manifesto**[38], a cross party manifesto setting out a vision for the provision of services in the UK for the early years period.

The NHS Long Term Plan includes a focus on providing children with a 'strong start in life', including

- implementing recommendations from the **National Maternity Review: Better Births,** implemented through Local Maternity Systems
- improving access to and quality of perinatal mental health care (up to 24mths)
- prioritising improvements in childhood immunisation
- reducing unnecessary A&E attendance
- new clinical networks for long-term conditions

The National Maternity Review (2016) in its report - **Better Births**[39] – set out the vision to improve the outcomes of maternity services in England so that they are personal and safe. It included a recommendation to create 'Community Hubs' where maternity services, particularly ante- and postnatally, are provided alongside other family-orientated health and social services

[35] Professor Sir Michael Marmot, Fair Society, Healthy Lives. The Marmot Review. 2010.
[36] Prevention is better than cure: Our vision to help you live well for longer. Department of Health and Social Care. November 2018
[37] Office of the Leader of the House of Commons, Cabinet Office and Rt Hon. Andrea Leadsom MP, Leader of the commons to chair ministerial group on family support from conception to the age of two, 27 July 2018
[38] The 1001 Critical Days. The Importance of the Conception to Age Two Period. A cross-party manifesto. Andrea Leadsom, Frank Field, Paul Burstow, Caroline Lucas. 2013.
[39] Better Births. Improving outcomes of maternity services in England. A Five Year Forward View for maternity care. National Maternity Review. NHS England. 2016

provided by statutory and voluntary agencies. They may be located in children's centres, GP surgeries, or midwife-led units.

They have two key purposes:

- To act as "one stop shops" for many services. This means different teams operating out of the same facility
- To provide a fast and effective referral service to the right expert if a woman and her baby need more specialised services.

The recently published **Health and Social Care Committee report, 'First 1000 days of life'** sets out the case for investment in the early years and strong national leadership. It suggests the need for a compelling, long-term strategic vision for giving every child the best start in life nationally as well as locally. In terms of local delivery it advocates 'proportionate universalism' [40], underpinned by,

- focus on prevention and early intervention
- co-design of services with the local community
- engaging with and supporting marginalised communities
- multi-agency working
- delivering evidence-based interventions

It also makes some recommendations regarding the Healthy Child Programme (including an additional mandated visit at 3-3 ½ years), workforce, funding and information sharing.

The Governments report '**Unlocking Talent, Fulfilling Potential. A plan for improving social mobility through education**' [41] sets out a number of ambitions for children and young people in order to "*level up opportunity across the country*" and "*leave no community behind*". This includes,

- Closing the 'word gap' in the early years
- Closing the attainment gap in school while continuing to raise standards for all

The Healthy Child Programme[42] for the early life stages focuses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting. Since 2015 local authorities have been mandated to provide five 'health visitor reviews' to all families within their area, during set periods in a child's development.

Troubled Families is a programme of targeted intervention for families with multiple problems, including crime, anti-social behaviour, truancy, unemployment, mental health problems and domestic abuse. It began in 2012 and is known locally as the 'Think Family Approach' in Cambridgeshire and 'Connecting Families' in Peterborough.

[40] An approach to reducing health inequalities with a balance of universal and targeted services, whereby those services are delivered in proportion to the level of need (Marmot Review 2010)
[41] Unlocking Talent, Fulfilling Potential. A plan for improving social mobility through education. Department for Education. December 2017.
[42] Healthy Child Programme Pregnancy and the first five years of life. Department of Health. 2009

Local Policy Context

Think Communities is Cambridgeshire and Peterborough's approach for creating a shared vision, approach and priorities for building community resilience across the county and reducing demand for statutory services. It is a 'place based' approach which has a strong emphasis on community involvement and creating the right conditions for long term system change i.e. one in which people, communities and services can work together effectively.

The **LGA Early Years Social Mobility Peer Review for Cambridgeshire and Peterborough** last year recommended that the local authorities develop a holistic early years strategy that brings together all the strands of the early years offer so that children across the county have the best start in life and are 'school ready'.

The new **Special Educational Needs and Disabilities (SEND) Strategy 2019-24** sets out the vision, principles and priorities to ensure that we are working together effectively to identify and meet the needs of Cambridgeshire and Peterborough's children and young people with Special Educational Needs and / or Disabilities (SEND) from birth to the age of 25. It has identified 3 priority areas for action.

1) **SEND is everybody's business** - embedding the vision of the SEND Strategy into the practice of everyone who works with children and families in ways that strengthen families
2) **Identify and respond to needs early** - a holistic and joined up early identification of and graduated response to needs
3) **Deliver in the right place at the right time** - improving outcomes for children and young people through making best use of resources, ensuring a graduated response and high quality local support and provision

The Fenland and East Cambridgeshire Opportunity Area (OA) was launched by the Government in January 2017 as one of 12 OAs across England. The aim is to raise education standards locally, providing every child and young person in the area with the chance to reach their full potential.

The first of it 4 priorities is to "Accelerate the progress of disadvantaged children and young people in the acquisition and development of communication, language and reading". Activity includes the launch of an Early Years Improvement Fund and a phonics project to upskill school staff.

Cambridgeshire County Council's Communities and Partnership Programme have developed a **strategy for tackling poverty and improving social mobility.** Amongst its 4 priorities are,

- Priority Two: Improving early literacy, education standards and raising skills
- Priority Three: Strengthening families and communities

Peterborough City Council's **Child Poverty Strategy (2016-21)**. It acknowledges the pervasive effect of poverty on children's life chances, the need to close the attainment gap and develop greater resilience within families. Amongst its 5 priorities, it acknowledges the need to address barriers to work through supporting families with complex needs, improving school attainment and aspirations, supporting children with special educational needs and disabilities (SEND).

Early Help Strategies for both Cambridgeshire and Peterborough set out how 'early help' services are organised across the county. They describe a number of themes, which emerge for the data and provide a focus for how services and interventions are delivered. These include,

- Reducing parental conflict
- Domestic abuse
- Emotional health and well being
- Exploitation
- Challenging / concerning behaviours and parenting support
- Neglect

The current **Healthy Weight Strategies** for Cambridgeshire (2016-19) and Peterborough (2019-2022, draft) emphasise the importance of a joined up 'whole system approach', formed of three main components across the life course, namely;

- the physical environment (e.g. minimise local promotion of unhealthy foods)
- work and educational settings (e.g. policies that support healthy eating and physical activity in pre-school settings)
- information and skills (e.g. equipping professionals to help others)

This is tied to the ambitions of the Government's Childhood Obesity Plan[43].

[43] https://www.gov.uk/government/publications/childhood-obesity-a-plan-for-action

Current Service Delivery

The Healthy Child Programme (0-5)

The Healthy Child programme (HCP) follows a 'progressive universalism' approach, with all families receiving basic elements of the programme and additional services being provided to those with specific needs and risks. Elements of the service include, screening tests, developmental reviews, and information and guidance to support parenting and healthy choices.

The HCP uses the 4-5-6 model. See Appendix 4. This means,

- **4** – levels: Community, Universal, Universal Plus (single service response) and Universal Partnership Plus (multi-agency response for children with complex needs)
- **5** – universal, mandated checks (after 28 weeks into pregnancy; 1 day to 2 weeks after birth; 6 to 8 weeks after birth; 9 to 15 months after birth; and 2 to 2.5 years after birth)
- **6** – high impact areas (parenthood and early weeks; maternal mental health; breastfeeding; healthy weight; minor illness and accidents; healthy 2 year olds getting ready for school.

The service is primarily delivered by health visitors and nursery nurses employed by Cambridgeshire Community Services (CCS) and Cambridgeshire and Peterborough Foundation Trust (CPFT).

The Family Nurse Partnership (FNP)

The FNP is delivered as part of the HCP. It is an in-depth, structured, home visiting programme which aims to improve pregnancy outcomes by supporting mothers-to-be to make informed choices about healthy pregnancy behaviours. This was originally offered to first time parents under the age of 19 at time of conception. However, in 2016, the National FNP Unit introduced the option to modify the eligibility criteria according to local circumstances.

Currently, in Cambridgeshire and Peterborough first time mothers[44] aged 19 years or under who meet the 'fixed' or 'high risk' criteria[45] are eligible for FNP and assigned a Family Nurse as the core offer, with the aim of enrolling women as early as possible in pregnancy, ideally before 16 weeks and by the 28th week of pregnancy. See Appendix 4 for more detail.

For those teenagers not meeting the criteria for FNP, the local commissioned HCP now includes an Enhanced Teenage Parent Pathway, led by FNP, working with the wider locality teams. This includes additional antenatal visits and at least monthly contact for the baby's first year of life. One hundred place are available.

Early Help

Ofsted consider early help to be required for;

"Those children and young people at risk of harm (but who have not yet reached the "significant harm" threshold and for whom a preventative service would reduce the likelihood of that risk or harm escalating) identified by local authorities youth offending teams, probation trusts, police, adult social

[44] Also available to other mothers who did not receive FNP with their first child.
[45] Fixed criteria include very young women (<16yrs) and children in need. High risk criteria include – mental health problems, ever a child in care, no or low educational qualifications (GCSEs)

care, schools, primary, mental and acute health services, children's centres and all local safeguarding Children Board partners including the voluntary sector where services are provided or commissioned"

Cambridgeshire Early Help Delivery Model

Requests for Early Help are received by the Early Help Hub which forms part of the Integrated Front Door, working alongside Multi-Agency Safeguarding Hub (MASH).

Requests will either be sent direct to the Early Help Hub through an Early Help Assessment[46], from the MASH or assessment teams if the threshold of Children's Social Care has not been met. The Early Help Assessment is shared when appropriate [and where there is consent] with other professionals who are working in a co-ordinated way to support the family.

Cambridgeshire Early Help Teams

Early Help teams are multidisciplinary[47] and integrated with Children's Social Care. They support children, young people and families across the 0-19 age range.

They are aligned with District & City Council boundaries. Each team is managed by a District Manager who reports to either the Head of Service North, or Head of Service South.

The 7 teams are:

- East Cambridgeshire
- South Cambridgeshire
- Cambridge City
- March, Chatteris & Whittlesey
- Wisbech
- Huntingdon & St Ives
- Ramsey, Sawtry, Yaxley and St Neots

Peterborough Early Help Delivery Model

Early Help in Peterborough is based on a commissioning model. The Local Authority Early Help Service supports practitioners and professionals in the field to take on the role of Lead Professional, complete Early Help Assessments and co-ordinate services around the family.

Interventions and services to support families are, in the main, commissioned and delivered by external partners, many of whom are third sector organisations. Examples include, supporting young people not in employment, education or training (NEET), youth workers, Healthy Child Programme, Mind, YMCA, NSPCC, Little Miracles (supporting children with additional needs, disabilities and life limiting conditions), CHUMS (emotional health and well-being), Project for Schools (mental health nurses working in primary schools) and Carers Trust.

[46] Early Help Assessment (EHA) as a holistic assessment that captures the family's strengths and unmet needs. They are completed by any professional or partner agency who comes into direct contact with families, and who has identified more than one unmet need that would benefit from a multi-agency support approach.
[47] Early Help Teams - Family workers, Young People's Services, Child and Family Centre delivery, Educational Inclusion Officers, Senior Transition Advisors, transition advisors and Youth Offending Service.

For those children requiring additional, more targeted support, this is accessed through an 'Early Help Panel'. Three outcomes are then available,

- Early Support Pathway (for children with complex health, education, or care needs)
- Multi-Agency Support Group (families requiring more targeted and co-ordinated support)
- Primary Behaviour Panel (for children whose behaviour is putting their school placement at risk)

The Early Help Service maintains a role in monitoring the progress of children through the pathway, at 1 and 6 months.

Children's Centres

Children's centres form part of the Government's agenda to improve outcomes for children, providing a place where families with children under 5 years can access a range of services. Their function and the responsibilities of local authorities are covered by statutory guidance[48].

The purpose of children's centre services is to improve outcomes for young children and their families, with a particular focus on the most disadvantaged families, in order to reduce inequalities in child development and school readiness. This is supported by improving,

- parenting aspirations, self-esteem and parenting skill
- child and family health and life chances

Child and Family Centres - Cambridgeshire

The provision of children's centres was redesigned in April 2018 following a public and staff consultation in 2017. There are 10 Child and Family Centres (some split over 2 sites) across the five districts, plus additional 'Child and Family Zones' (facilities where there is a shared building use). See Table 5 below.

All are managed 'in house' with the exception of South Fenland (March, Chatteris & Whittlesey) where services are delivered by Ormiston. A memorandum of agreement is in place with two nurseries, at Huntingdon Town and the Fields.

Child and Family Centres offer a range of groups, activities and one to one support delivered by Child and Family Centre Workers and Family Workers. The latter provide specific support to children and families known to Children's Social Care.

Centre activity varies across the area, and is provided based on local needs and available resources. However examples include,

- Parent/carer drop-ins
- 'Stay and play' groups
- Targeted parenting groups, school transitions
- Baby Rhyme Time, Messy Play
- Voluntary led toddler groups
- Creative families – talking together project
- Multi-agency early years conferences and safeguarding meetings

[48]Sure Start children's centres statutory guidance. For local authorities, commissioners of local health services and Jobcentre Plus April 2013

The Centres also provide a base for Healthy Child Programme activity (e.g. breastfeeding support, weigh-ins, drop-in clinics, peri-natal mental health support) and midwifery (e.g. antenatal clinics and antenatal classes).

Table 5. Cambridgeshire - Child and Family Centre Offer		
	Child and Family Centres	Child and Family Zones
Fenland	Wisbech (Wisbech Town and Wisbech South)	
	March, Chatteris	Whittlesey
East Cambridgeshire	Ely, Littleport	Soham
Cambridge City	Chesterton/North Cambridge (split Site), Abbey Child and Family Centre (The Fields)	Trumpington, Peacock Centre
South Cambridgeshire	Cambourne	Waterbeach, Sawston, Melbourn, Northstow
Huntingdon	Eaton Socon/Eynesbury (split Site), Huntingdon Nursery/ Huntingdon Youth Centre (split site)	Sawtry, Ramsey, St Ives

Children's Centres – Peterborough

There are four children's centre 'hubs' in Peterborough, with a further three linked sites. They are commissioned externally and provided by Barnardos and Spurgeons. See Table 6. The centres provide a range of services and activity, similar to that provided in Cambridgeshire.

Table 6. Peterborough – Children Centres	
Central (Barnardos)	East Children's Centre – Dogsthorpe
	The Acorn Centre – Welland
	linked sites at Fulbridge School and Gladstone Primary School
North (Spurgeons)	Honeyhill Centre – Paston
	linked site at Watergall School
South (Spurgeons)	Orton Children's Centre - based at Orton Malbourne, Herlington

Early Years Services - Education

Local authorities are required to secure sufficient early years education and childcare provision[49]. This includes an entitlement of 570 hours of free early education entitlement per year for eligible 2 year olds to be taken over no fewer than 38 weeks, equating on average to 15 hours/week [50]. This is also available universally to working parents of 3 and 4 year olds. If both parents are working, most[51] are also entitled to an additional 570 hours per year.

The majority of early education and childcare provision is operated by private, voluntary or independent (PVI) groups. The maintained (council run) sector accounts for a small proportion of

[49] Childcare Act 2006

[50] Eligibility criteria include parental receipt of benefits, children with a statement of special educational needs, children with an education, health and care plan, children in receipt of disability living allowance, children looked after by a local authority.

[51] Where both parents earn a weekly minimum equivalent to 16hrs at national minimum wage or national living wage and less than £100,000.

groups based settings in Peterborough and Cambridgeshire. Childminders are also a vital element within the overall childcare mix in the county.

Delivering services to meet the needs of families requires a partnership approach between the Councils and the PVI sector. Direct delivery by the council is only considered where there is no alternative, an approach encouraged by the Government.

The Early Years Services in Cambridgeshire and Peterborough have a role in supporting early years settings and monitoring the quality of their provision. This is achieved through a range of activity, including training and site visits.

The Early Years Services also co-ordinate or contribute to a range of projects and programme across the county which support early education. This includes,

- Speech, language and communication needs (SLCN). 1 year PHE/DfE led training for health visitors in SLCN
- I CAN and EasyPeasy – home learning environment. 1 year programme starting March 2019
- Talking Together in Cambridgeshire –language and literacy project in deprived communities
- East Cambs and Fenland Opportunity Area Phonics Project
- Cambridgeshire Early Years Service on behalf of the East Cambs and Fenland Opportunity Area. Targeted - 60 practitioners developing phonics skills and confidence through champions and cascade training to others. (October 2018 –June 2019)
- Early Talk Boost - targeted intervention for practitioners in Cambridgeshire settings to work with children with language delay.

Maternity Provision and Better Births

The Better Births agenda is being taken forward locally by Local Maternity System, which brings together the user voice (including Maternity Voice Partnerships and Healthwatch), the voluntary sector, commissioners and providers of statutory maternity services.

Within Cambridgeshire and Peterborough CCG this is overseen by the Senior Responsible Officer and the Maternity Transformation - Better Births Programme Manager.

Through partnership with local authority children's commissioners, three community hub launches have taken plan these are based in children's centres. This work stream also includes the development of 'Pathways to Parenting', a universal antenatal parenting programme which is in pilot form and due to roll out geographically across Cambridgeshire and Peterborough.

Best Start in Life Strategy Proposal

Five Key Themes

The Best Start in Life Start strategy proposes that 5 key themes provide the framework for a new integrated model for early years. Within each theme, detail is provided regarding the areas of focus. This will be delivered through a mix of universal and targeted approaches, and use a variety of methods (face to face, digital, telephone). Wherever possible, a standardised approach will be used, however it may need to be modified locally to be effective.

Healthy pregnancy, parents and children

- Healthy weight – diet and physical activity (incl. mother and baby nutrition)
- High quality maternity services – Better Births & maternity community hubs
- Reduce unplanned teenage pregnancies and support teenage parents
- Improve breast feeding rates
- Increase smoking cessation in pregnancy
- Improve oral health and immunisation uptake
- Reduce childhood accidents

Vulnerable parents will be identified early and supported

- Perinatal mental health support – extended to mild/emerging problems, including infant mental health pathway (identify attachment difficulties early offer support)
- Support parents to reduce use of alcohol, drugs and tobacco
- Support parents to reduce levels of domestic violence/parental conflict

Well prepared parents

- High quality education on sex and relationships
- Antenatal education programmes and postnatal programmes – universal and targeted (e.g. Pathway to Parenting, Baby Steps, FNP)
- Evidence based parenting programmes – universal and targeted
- Promote awareness of specific risks - safe sleeping and accidents
- Parents with an understanding of; their role in child development and learning; how to access services

Postive attachment and bonding

- Perinatal mental health support – extended to mild/emerging problems, including infant mental health pathway (identify attachment difficulties early and offer support)
- Promote positive parent- child interaction (e.g. Five to Thrive - Respond · Cuddle · Relax · Play · Talk, Big Little Moments)

Supporting child development

- Raise awareness of parents about 3 prime areas of development - personal, social and emotional; communication and language; and physical
- Promote early play and communication opportunities
- Promote positive ways to help of help children thrive – through interaction, social contact, first hand experiences e.g. 50 Things to do before you're 5
- Early identification and assessment of need (ASQ, integrated review) - including children with SEND

Building Blocks

As outlined in *Building Collaborative Places: Infrastructure for System* Change, the move to an integrated approach to supporting children pre-birth to five requires the deliberate creation of shared infrastructure as well as the right conditions to 'connect people and organisations and help align the incentives driving individual organisations, creating a gravitational pull that is towards collaboration for shared outcomes.[52] This view places public services (including local authorities, health bodies, and police) within a wider local system which includes people, families, communities, local organisations and institutions, the voluntary sector and businesses – clearly indicating that the public sector alone cannot solve complex social problems.

Drawing from systems change research and more mature early years integration efforts, we propose that our work to implement the Best Start in Life Strategy also include the establishment of key 'building blocks' to support system wide collaboration, as articulated by Collaborate CIC and Lankelly Chase in their 2017 report:

- **Place Based Plans:** These plans set out the social and economic vision for place as a shared challenge among local partners and citizens, and core operating principles for local public services. These plans will be co-produced with families and young children, with particular care and attention to reflecting the cultural and linguistic diversity of our communities. In Cambridgeshire and Peterborough, this work should consider and wherever possible, align with other local programmes of place-based change, including Think Communities and the new primary care networks.[53]
- **Leadership and Governance:** In order to deliver the Best Start in Life strategy, a collaborative system leadership forum which includes community representatives as well as public and voluntary sector representatives and share a commitment to create the necessary conditions to enable collaborative problem solving and embed new shared operating principles.
- **Outcomes and accountability:** Identifying shared outcomes to support children's health, safety and school readiness. Outcomes which reflect the social and economic challenges and aspirations of our places and hold the entire system to account. In this context, organisational outcomes are aligned with place-based outcomes, measuring what is important to citizens and communities and avoiding targets which 'miss the point.'
- **Funding and commissioning:** Considering opportunities for collaborative funding arrangements which support achievement of shared outcome and help reduce duplication and waste, developed in collaboration with service users and flexible to accommodate ongoing learning.
- **Culture change and people development:** Culture change and organisational development programmes designed to develop the capacity of our workforce to work across organisational boundaries. The purposeful creation of a shared culture across our early years workforce where individuals can clearly see their role in giving our youngest children a best start in life. The development of shared knowledge and practice tied to the key areas of focus of the Best Start in Life strategy and its underpinning principles.

[52] Building Collaborative Places: Infrastructure for System Change. Collaborate and Lankelly Chase February 2017
[53] Primary care networks will be based on GP registered lists, typically serving natural communities of around 30,000 to 50,000.

- **Integrated delivery:** Collaborative service models bringing education, early help and community health together in meaningful ways where it makes sense to do so, supporting working relationships built on trust. This will include the iterative design and delivery of interventions, developed with input frontline staff and families and a focus on effective prevention and targeted early intervention. Staff work across organisational boundaries to provide a more coherent approach.
- **Data, evidence and evaluation:** Shared data, both quantitative and qualitative (reflecting the lived experience of children, parents and professionals) used effectively to understand and address root causes of issues and demand. A collaborative 'test and learn' approach that allows for a flexible response to early years interventions.
- **Collaborative digital and physical platforms**: Physical and virtual spaces that bring together people and organisations, enabling them to connect, develop networks and share information. This could include a dedicated website which provides or signposts parents and service providers to trusted information and delivers digital interventions. Enhancing existing public sector co-location, supporting collaboration and the design of joint solutions by cross-sector teams.
- **Communications and engagement:** Clear and consistent information and insight shared fluidly throughout the system: vertically (top-down and bottom-up) and horizontally (across sectors), enabling real-time collaboration and adaptive delivery. Providing families with easy access to reliable, consistent and up-to-date ideas, advice and services. A fundamental commitment to partnership with parents (volunteering, local delivery, service design).

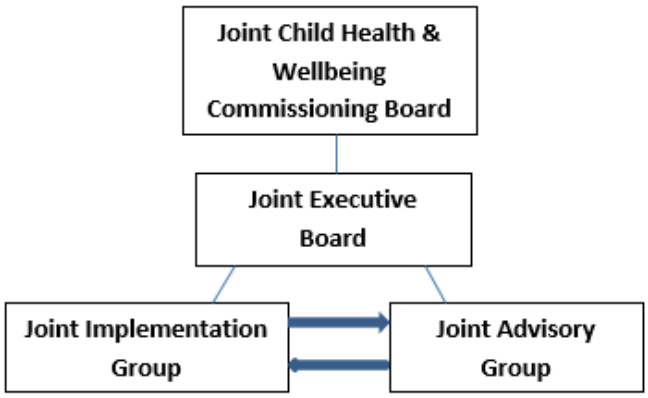
Next Steps

Phases 2 and 3 of the strategy run from May 2019 to March 2020.

Phase 2 (May to September 2019) will further develop the strategy and identify options for the future integrated delivery model.

Phase 3 (October to March 2020) will focus on arrangements for implementing the new model in April 2020, including development of the 'building blocks' which underpin the strategy.

A new governance structure will be used, with a direct reporting line through to the Joint Child Health and Wellbeing Commissioning Board. The indicative schedule until September 2019 is outlined below.



(Formerly, the 'Strategy Group')

(Formerly, the 'Stakeholder Group)

Timeline – May – September 2019

May		**June**		**July**
w/c 6th	w/c 27th	w/c 10th	w/c 24th	w/c 8th
Understanding system conditions	Evidence about what matters/local priorities Consolidating insights from families and communities	System/service and asset mapping	System, service and asset mapping 1-day Summit	Opportunities for evidence informed practice, improvement and innovation
July	**August**		**September**	
w/c 22th	w/c 5th	w/c 19th	w/c 2nd	w/c 16th
Workforce and System Leadership	Theory of change for Integrated Delivery Model	Local theory of change to reflect geographical prioritisation	1-day summit	Refine integrated delivery model and finalise work plan for Oct 19 – March 20

Appendix 1 – Best Start in Life Group Membership

Strategy/Implementation Group

Chair	John Peberdy, Director of Children's Services, Cambridgeshire Community Services
Public Health Lead/Co-ordinator	Ben Brown, Specialty Registrar Public Health (PCC and CCC)
Transformation Team Lead/Co-ordinator	Gwendolyn Casazza (CCC) Rebecca Pentelow (CCC) Emily Sanderson (CCC)
Early Years leads	Karen Hingston (PCC) Annette Brooker (CCC)
Early Help leads	Lisa Riddle/Sarah Tabbitt (CCC) Karen Moody (PCC)
Health Visiting leads	Andrea Graves/ Verity Trynka-Watson (CCS)
Children's Commissioning Lead	Pam Setterfield (PCC and CCC)
Commissioning Team Manager- Healthy Child Programme	Helen Freeman, Public Health (PCC and CCC)
Speech and Language Therapy, Nutrition and Dietetics.	Alison Hanson, Cambridgeshire Community Services
Children and Family Centre Providers	Kat Band, Assistant Director of Children Services at Barnardos
LGSS Digital	Kat Sexton
Communications	Jo Dickson (CCC)
Project planning and management	Tess Campbell, Public Health (PCC and CCC) Helen Gregg, Partnership Manager, People & Communities Directorate

Stakeholder Group

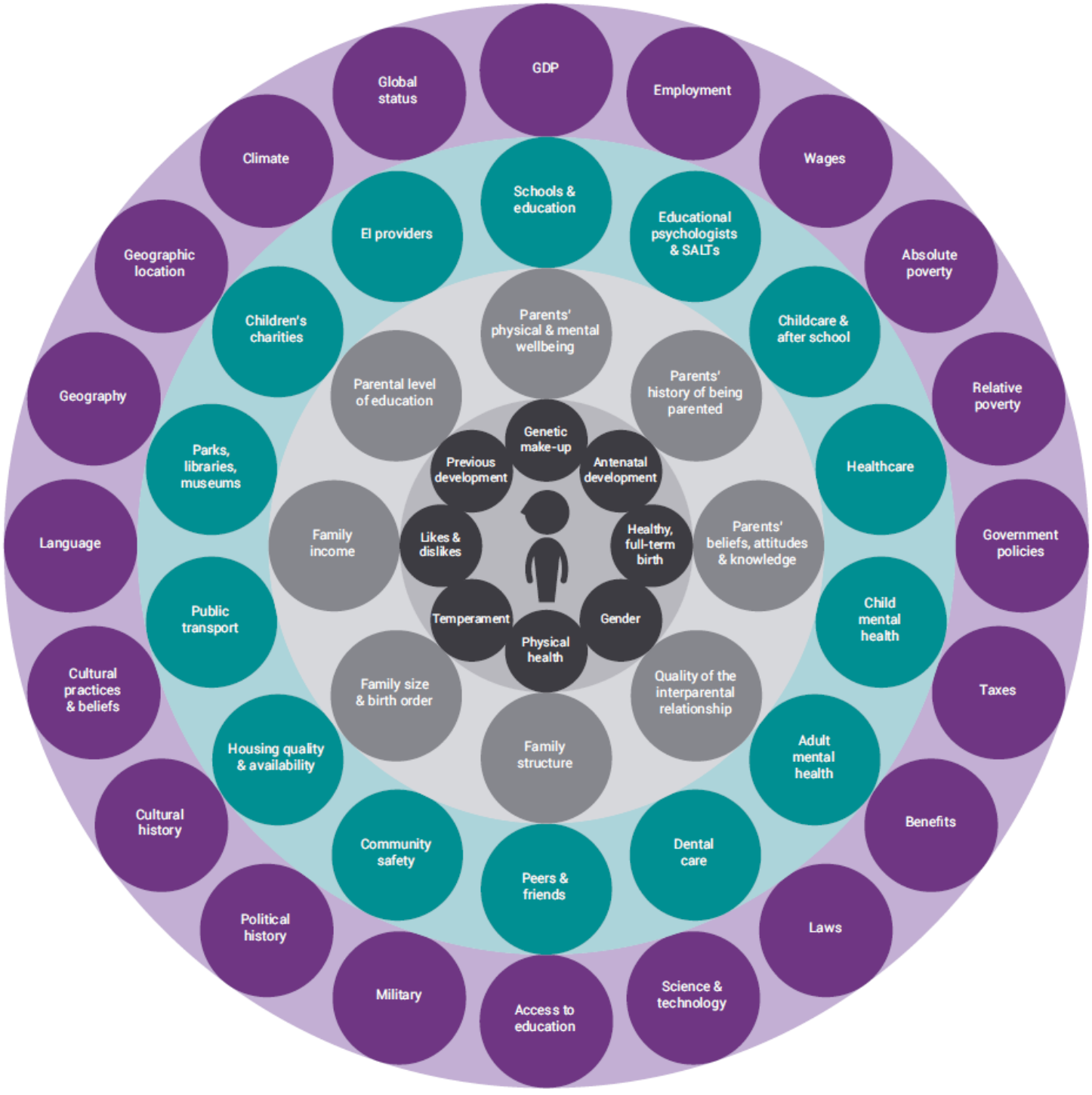
Co-Chairs	Dr Liz Robin, Director of Public Health (PCC and CCC) Wendi Ogle-Welbourn, Executive Director People and Communities (PCC and CCC)
Public Health Consultant	Dr Raj Lakshman, (PCC and CCC)
Public Health Lead/co-ordinator	Ben Brown, Specialty Registrar Public Health (PCC and CCC)
Transformation Team lead/co-ordinator	Gwendolyn Casazza (CCC)
Early Years leads	Karen Hingston (PCC) Annette Brooker (CCC)

Early Years Providers	Jayne Chapman (Harlequin Childcare) Caroline Maryon (PACEY Project Manager)
SEND leads	Marian Cullen and Jo Middleditch (CCC) Sheelagh Sullivan (PCC)
Children's Commissioning Lead	Pam Setterfield (PCC)
Commissioning Team Manager- Healthy Child Programme	Helen Freeman, Public Health (PCC and CCC)
Children's Social Care Assistant Directors	Sarah-Jane Smedmor (CCC) Nicola Curley (PCC)
Education leads	Clare Hawking (Early Years Lead, Virtual School, CCC)
Early Help leads	Lisa Riddle/Sarah Tabbitt (CCC) Karen Moody (PCC)
Children Centre Providers	Kat Band, Barnardos Lynn McNish, Barnardos Amanda Newman, Ormiston Jason Wilson, Spurgeons
Healthy Child Programme	John Peberdy (CCS) Andrea Graves (CCS) Verity Trynka-Watson (CCS)
Speech and Language Therapy, Nutrition and Dietetics	Alison Hanson (CCS)
Primary Care Leads	Dr Becky Jones
Clinical Commissioning Group	Liz Phillips, Better Births Programme Manager (CCG) Ruth Kern - Perinatal Mental Health – (CCG) Sarah Hamilton, Designated Nurse Safeguarding Children (CCG) Karlene Allen, Children's Commissioner(CCG)
Support Cambridgeshire	Julie Farrow
Stakeholder group planning	Helen Gregg, Partnership Manager, CCC/PCC

Corresponding Stakeholder Group Members

Communications lead	Joanne Dickson, Communications & Marketing Manager, CCC
Finance leads	Martin Wade (CCC) Fiona Chapman (PCC)
Information and intelligence lead	Helen Whyman

Appendix 2 – Childhood Risk Factors



Appendix 3 – Summary of Evidence

Universal

Family support via children's centres, key workers, outreach to families **(Marmot Review)**

Teenage pregnancy prevention– (prevention, choice, support)

Transition to parenthood – Family Foundations -reduces parental stress & attachment related behaviours when offered to couples expecting their first child **(EIF)**

Universal screening for mental health problems during pregnancy **(EIF,NICE)** and for mothers if combined with treatment **(EIF)**

Healthy Child Programme 0-5 (4-5-6 model) **(PHE)**

Identifying risks @ 5 key HCP contacts **(NICE)**

SIDS advice re sleeping position **(EIF)**

Individual breastfeeding advice – pre/post natal **(EIF)**
UNICEF Baby Friendly Initiative **(PHE)**
PHE's Start4Life campaign **(PHE)**

Home safety equipment schemes – increase parental knowledge **(EIF)**
Oral health promotion -best evidence and fluoridation of public water supplies **(PHE)**

Obesity – multi-component and holistic approach **(PHE)**

Early cognitive and language development (e.g. Let's play in tandem, Raising early achievement in literacy) **(EIF)**

Speech and language skill assessed @ 2-2 ½ year review **(NICE)**

Pre-school attendance **(DfE)**

Targeted – selective

Attachment programmes (e.g. FNP, Family Foundations, Infant–Parent Psychotherapy, Child First) **(EIF)**

Pre and post-natal care programmes (e.g. Nurse – Family Partnerships) **(GLA)**

FNP for reducing IPV among first time teenage mothers **(EIF)**

Home safety equipment schemes - increase parents' knowledge of home safety **(EIF)**

Preventing unintentional injuries in the home – targeting, working in partnership, co-ordinated delivery, assessments and follow-up **(NICE)**

Providing and fitting free or low-cost home safety equipment (incl. thermostatic mixing valves) **(PHE)**

Healthy Start – UK Gov't voucher scheme **(PHE)**

Oral health – targeted provision of toothbrushes/ toothpaste, supervised tooth brushing in targeted childhood settings, tooth varnishing and healthy food and drink policies in childhood settings **(PHE)**

Take up of funded education/universal entitlement 15hrs @ 2 yrs

Pre-school programmes (e.g. Perry Preschool Programme) **(GLA)**

Home visiting interventions - children's language development in the early years (FNP, Child First, Parents as First Teachers) **(EIF)**

Transition programmes (home/nursery to school) – (targeted, flexible) **(PHE)**

Targeted – indicated

Behaviour programmes (e.g. Incredible Years, Triple P) **(EIF)**

Incentive-based programmes to encourage smoking abstinence during pregnancy **(EIF)**

CO monitoring and opt out systems –smoking in pregnancy **(PHE)**

Post-natal treatment for mental health problems **(NICE)**

Methadone treatment for mothers (buprenorphine during pregnancy) **(EIF)**

LBW – (Kangaroo Mother Care, Infant Massage, H-Hope, MITP) **(EIF)**

Sleep advice – infants ≥4mths **(EIF)**

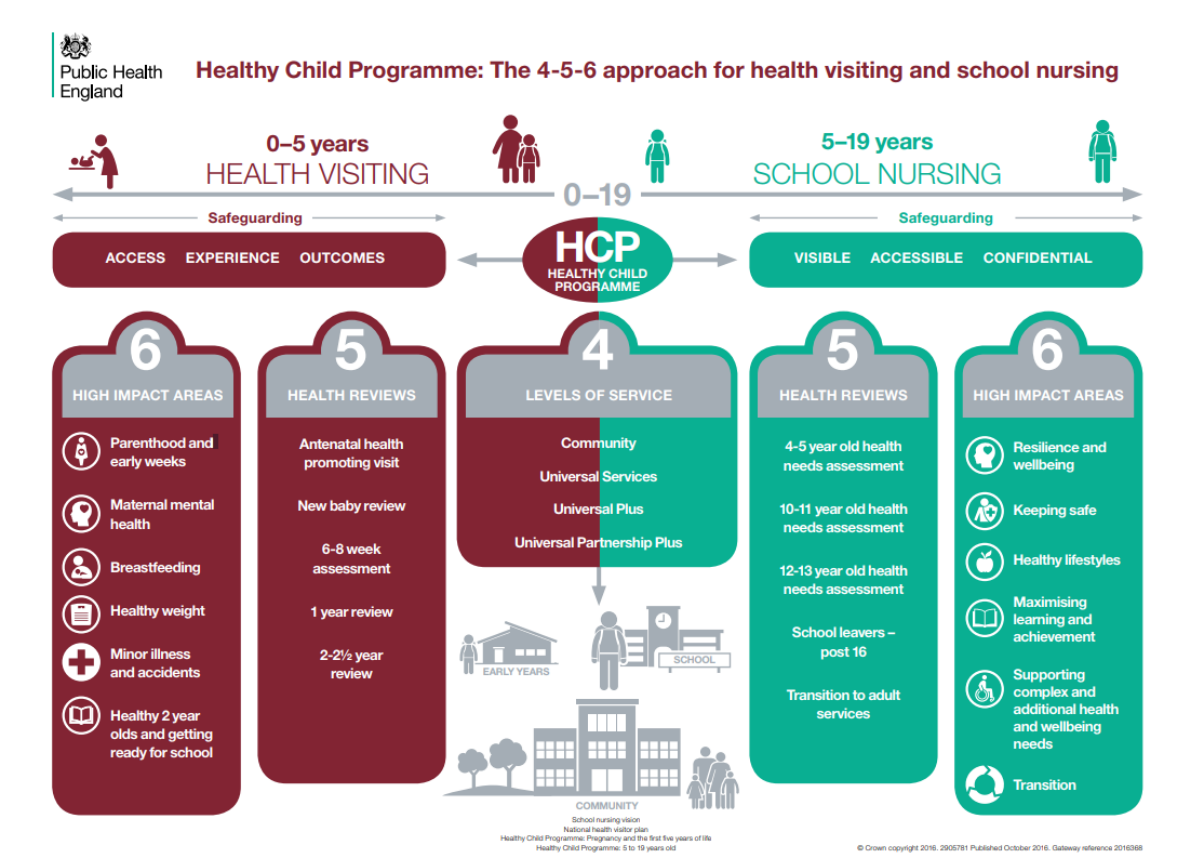
Psychosocial support integrated into routine antenatal care – for reducing revictimisation rates among women reporting IPV Home visiting in highly vulnerable families has the best evidence of reducing child maltreatment during infancy (FNP, Child First, Infant-Parent Psychotherapy) **(EIF)**

Identification, assessment and treatment of attachment difficulties (edge of care, LAC, adopted) **(NICE)**

Joint protocols for parental drug/alcohol use
HIPPY for 3-5yr olds (home instruction or pre-schoolers) **(PHE)**

Families and Schools Together (FAST) for ages 3-11 **(PHE)**

Appendix 4 – Healthy Child Programme



Family Nurse Partnership (FNP) and Enhanced Teenage Parents Pathway

Fixed criteria (all to receive FNP):

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

'High-risk' criteria (any 4 or more of the following risk factors in first-time teenage mothers)

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

Agenda Item No: 9

CCG COMMUNITY SERVICES REVIEW UPDATE AND DELIVERY OF CCG FINANCIAL PLAN

To:	**Health Committee**
Meeting Date:	**19 September 2019**
From:	**Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)**
Purpose:	**This paper provides an update on the Clinical Commissioning Group's community services review and delivery of the CCG financial plan**
Recommendation:	**The Committee is asked to note the contents of this report**

	Report Author
Name:	**Jessica Bawden**
Post:	**Director of External Affairs & Policy**
Email:	**jessica.bawden@nhs.net**
Tel:	**01223 725317**

1. BACKGROUND

1.1 The CCG's 2019/20 Financial Plan is a deficit of -£75m, as agreed with its regulators. To deliver this the CCG needs to make £32.7m of savings on out of hospital services.

1.2 This is part of a plan to deliver a system deficit of -£192.5m across the Cambridgeshire and Peterborough Sustainability and Transformation Partnership (STP). In order to meet the system control total, all system partners need to meet their savings targets with a system focus on demand management and activity growth. Because the CCG has taken on a significant part of the deficit, this reduces the interest payments that the Trusts need to make on debt repayments. If the system succeeds in meeting the deficit target of -£192m the Trusts will receive additional investment from NHS England of £80 million.

1.3 On 2 July 2019 the CCG presented a paper to its Governing Body outlining proposals for reviewing the first cohort of community services contracts. After publishing its review of services, the CCG received a large number of submissions from a number of organisations and so the CCG Governing Body took a 2 week pause in decision making to consider the new information. The CCG refined its proposals further and the Governing Body met again on 16 July to review revised recommendations which were approved. The Governing Body met with the Health Committee beforehand to explain the next steps and the rationale around the process.

2. MAIN ISSUES

2.1 Community Services Review

2.1.1 For the contracts reviewed on 16 July 2019, impact assessments were completed and decisions were made in line with the CCG Decommissioning and Disinvestment Policy. The anticipated savings from this first cohort review is £172,000 in year and £480,000 in 2020/21.

2.1.2 Phase 2 of the CCG Community Services Review Decommissioning and Recommissioning programme is now taking place, with the CCG working with its providers to develop proposals. This includes clinically led "idea generation" for services that can be reduced, transformed or decommissioned to support the system deficit. Engagement with the public will be undertaken as plans develop, and where formal consultation is required, this will be commenced as soon as possible.

2.1.3 The high-level framework for the Phase 2 Decommissioning and Decommissioning Engagement Programme is set out below:

Week	Action
1	Meeting of the Chief Nurses and Medical Directors to set the scene of the financial challenge and seek their commitment to work as clinical leaders in the system to seek solutions.
2	Chief Nurse meeting to flesh out areas to be considered and approach to engage wider clinical workforce.
3	Idea Generating with Frontline Staff – facilitated working sessions for a range of provider staff groups to share their ideas and explore how to reductions.

4	Idea Public and Voluntary Sector with Frontline staff – facilitated working sessions for a range of provider staff groups to share their ideas and explore how to reductions.
5	Joint working sessions with Frontline Staff and Voluntary Sector agreement of recommendations.
6	Chief Nurse and Medical Director validation and agreement of the list to commence Impact Assessment process in collaboration with providers.
7	Impact Assessments drafted. Complementary support from Contracting and Finance Teams as required to inform detail.
8	Cambridgeshire and Peterborough Joint Clinical Group to sign off Impact Assessments. Outcomes will be subject to the CCG's Decommissioning and Disinvestment Policy.

2.1.4 The CCG anticipates that this process will be completed to allow the recommendations identified through this process to be agreed in September 2019.

2.2 CCG Financial Plan

2.2.1 The CCG is already under significant financial pressure at month 3. The year to date position is a £663k adverse variance at Month 3. Whilst the forecast is still to achieve the £75m deficit plan, the CCG's contingency fund has already had to be factored into the year-end position.

2.2.2 There are two issues driving the financial pressure:

- The outcome of the arbitration relating to the ambulance service contract was not in the CCG's favour which has resulted in a £2m full year cost pressure.
- The NHS Continuing Healthcare (CHC) budget is £1.6m overspent at month 3 and is forecasting a £5.0m overspend, this forecast assumes delivery of the QIPP programme. This is currently the biggest financial risk to the CCG and a deep dive into the increase in CHC costs has been completed. The actions from the deep dive are now being taken forward by the CCG's Chief Nurse who is the Senior Responsible Owner for this programme of work.

2.2.3 The CCG has weekly Financial Recovery Planning, Delivery and Monitoring meetings, which are continuing to identify options to increase the forecasts of existing schemes, alongside identifying and scoping new schemes that could provide additional savings in 2019/20.

2.2.4 The CCG is planning to launch its Big Conversation with the public in September. The Big Conversation will be an engagement exercise (rather than a formal consultation). It will be the start an open conversation with the public about commissioning priorities and about how NHS resources are used wisely in relation to self-care and lifestyle.

HEALTH COMMITTEE TRAINING PLAN 2019/20

Updated Sept 2019

Agenda Item No: 12

Proposals

Ref	Subject	Desired Learning Outcome/Success Measures	Priority	Date	Responsibility	Nature of training	Attendance by:	Cllrs Attending	Percentage of total
	Public Health Performance reporting	To provide committee members with an increased understanding of the key performance indicators used in the F&PR To review current reporting and an opportunity to discuss what information members receive in future Performance reports.	2	Sept 16th 2019	Public Health	Development session			
	Mental Health Interventions	To provide committee members with an overview of public mental health focusing on local interventions and services.	4	Nov provisional	Public Health	Development Session			
	School Nursing Service Overview	To provide a development session that specifically focusing on the provisions within the school nursing service and associated trend data around access.	3	TBC	Public Health	Development Session			

		To agree specific objectives for the session and outline to service providers							
	Business Planning 2020	To provide a development session on the Public Health Business Planning processes 2020	2	16th September	Public Health	Development Session			

HEALTH POLICY AND SERVICE COMMITTEE AGENDA PLAN

Published on 2nd September 2019

Cambridgeshire County Council

Agenda Item No: 13

Notes

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

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

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

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
17/10/19	Finance & Performance Report	Liz Robin	Not applicable		
	Business Planning	Liz Robin	Not applicable		
	Quarterly Liaison Meeting Update Report	Kate Parker	Not applicable		
	Approval of Relevant Delegations to Award the Sexual Health Services Contract	Val Thomas	2019/066		
	CUSPE Challenges – Healthy Fenland Fund Evaluation	Val Thomas	Not applicable		
	Approval of Relevant Delegations to Award the Integrated Lifestyle Services Contract	Val Thomas	2019/067		
	Health Committee Training Plan	Kate Parker	Not applicable		
	Agenda Plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
14/11/19	Finance & Performance Report	Liz Robin	Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
	Joint Strategic Needs Assessment and Joint Health and Wellbeing Board Strategy	Liz Robin	Not applicable		
	Business Planning (Reserve item)	Liz Robin	Not applicable		
	Health Committee Training Plan	Kate Parker	Not applicable		
	Agenda Plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
05/12/19	Finance & Performance Report	Liz Robin	Not applicable		
	Business Planning	Liz Robin	Not applicable		
	Health Committee Training Plan	Kate Parker	Not applicable		
	Agenda Plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
23/01/20	Finance & Performance Report	Liz Robin	Not applicable		
	Health Committee Training Plan	Kate Parker	Not applicable		
	Agenda Plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
[06/02/20] Provisional Meeting					
19/03/20	Finance & Performance Report	Liz Robin	Not applicable		
	Health Committee Training Plan	Kate Parker	Not applicable		
	Agenda Plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
[16/04/20] Provisional Meeting					
28/05/20	Finance & Performance Report	Liz Robin	Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
	Health Committee Training Plan	Daniel Snowdon	Not applicable		
	Agenda Plan and appointments to outside bodies	Daniel Snowdon	Not applicable		