HEALTH COMMITTEE

Cambridgeshire County Council

Date:Thursday, 19 October 2017

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

13:30hr

Shire Hall
Castle Hill
Cambridge
CB3 0AP

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

AGENDA

Open to Public and Press

CONSTITUTIONAL MATTERS

1.	**Apologies for absence and declarations of interest** *Guidance on declaring interests is available at http://tinyurl.com/ccc-conduct-code*	
2.	**Minutes and Action Log of the meeting held 7th September 2017**	**5 - 20**
3.	**Petitions**	

DECISIONS

4.	**Finance and Performance Report - August 2017**	**21 - 40**
5.	**Service Committee Review of draft Revenue Business Planning proposals for 2018-19 to 2022-23**	**41 - 88**
6.	**Pressures in the School Nursing Services**	**89 - 100**

The Health Committee comprises the following members:

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

Councillor Lorna Dupre Councillor Lynda Harford Councillor David Jenkins 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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HEALTH COMMITTEE: MINUTES

Date: Thursday 7th September 2017

Time: 1:30pm to 5:30pm

Present: Councillors C Boden, L Dupré, L Harford, Cllr Hudson (Chairman), D Jenkins, L Jones, T Sanderson, K Reynolds and S van de Ven

District Councillors M Abbott (Cambridge City), S Ellington (South Cambridgeshire) and J Tavener (Huntingdonshire)

Apologies: District Councillor M Cornwell

28. DECLARATIONS OF INTEREST

There were no declarations of interest.

29. MINUTES – 20th JULY AND ACTION LOG:

The minutes of the meeting held on 20TH July 2017 were agreed as a correct record and signed by the Chairman. The action log was noted including the following updates relating to on-going actions

Minute 17a – Cambridgeshire Community Services (CCS) had been asked to investigate the matter and was in progress.

Minute 17b – The information was now presented within the Finance and Performance Report

Minute 17c – Sanctions under the S75 agreement did not exist. Underspends were required to be declared.

Minute 19 – Following further discussion it was agreed that a briefing regarding Delayed Transfers of Care would be circulated outside of the meeting in preparation for a liaison group meeting with Addenbrooke's Hospital

Minute 22 – Confirmation had been received that the delivery groups were operational meetings and if Members were appointed it may affect scrutiny.

30. PETITIONS

No petitions were received.

31. HEALTHY WEIGHT STRATEGY

The Committee received the Healthy Weight Strategy designed to address issues around healthy weight in Cambridgeshire. Following the presentation to the Committee of the draft strategy in July 2016 a period of public consultation took place after which a system wide event took place attended by key stakeholders and representatives from a wide range of organisations that assisted with the development of the implementation plan.

The Healthy Weight Strategy was reliant on a range of organisations in order to be effective in its goals. The implementation plan was formulated to be achievable and be able to demonstrate clear improvements.

During the course of discussion Members:

- Drew attention to obesity as both a local and national issue that required leadership nationally. The Council possessed limited tools with which to tackle the problem.

- Highlighted the role of communications and the role of District Councils and the Cambridgeshire and Peterborough Combined Authority in the strategy.

- Expressed concern regarding the focus of the strategy that would make it unlikely that the strategies targets would be achieved and questioned whether the strategy would slow that rate at which the situation was becoming worse or would actually reduce the rates of obesity. Officers drew attention to the rates of childhood obesity that had stabilised since 2008 and some reduction in the rates had been seen more recently which despite the complex challenges faced, gave encouragement for the success of the strategy.

- Highlighted the goal on page 35 of the strategy that would address health inequalities in Cambridgeshire but could not see that it was permeated throughout the targeting of the strategy. Officers informed Members that targeting was alluded to within the implementation plan and that there were issues where specific targeting was required and others where a broader approach was more suited.

- Questioned how the Council could influence the location of fast food outlets within communities. Members were informed that Public Health could have more involvement in the planning process and there were examples of this in other areas of the country.

- Requested greater leadership from the Clinical Commissioning Group (CCG) and hospitals where fast food outlets were located within hospital premises.

- Emphasised the role of the Health Committee in influencing other Policy and Service Committees in order they consider how their policies impact on people's health.

- Set the strategy within the context of the multi-million pound food industry and the fashion magazine industry that played a significant role in women's relationship with food. There was also contradictory advice received from health professionals where foods once considered to be unhealthy became healthy following further research. Therefore it was important that the strategy focussed on 2 or 3 goals that were achievable. Officers explained that the implementation plan had been designed in order that it was achievable. The strategy was aimed to create an environment where taking the healthy route was the most convenient thing to do.

- Highlighted the need for an over-arching Public Health goal for the county from which the various strategies would work to achieve. There was a danger that there could be many strategies but limited understanding of the Public Health priorities. There was also a need for the Council to become more effective at influencing partners and the wider public.

- Questioned whether the strategy went far enough in terms of influencing partner organisations and drew attention to the need for the Council to demonstrate leadership by reviewing what was stocked in its staff cafeteria. Officers welcomed the support Members could provide in influencing partners and requested that Members of the Addenbrooke's Hospital Liaison Group present the strategy to the hospital. **ACTION**

- Councillor Jones proposed the addition of a third recommendation with the unanimous agreement of the Committee that requested officers supporting other Council Policy and Service Committees to advise the Director of Public Health of any current or planned initiatives within their areas of responsibility which support the Healthy Weight Strategy, and to work with Committees to review whether their areas of responsibility meet the recommendations of the Strategy.

It was resolved unanimously to:

a) Approve the Healthy Weight Strategy and Implementation Plan

b) To endorse partners taking forward the Implementation Plan

c) Ask officers supporting other Council Policy and Service Committees to advise the Director of Public Health of any current or planned initiatives within their areas of responsibility which support the Healthy Weight Strategy, and to work with Committees to review whether their areas of responsibility meet the recommendations of the Strategy.

32. FINANCE AND PERFORMANCE REPORT – JULY 2017

Members received the July iteration of the Finance and Performance Report. Officers reported that the overall position had remained relatively static from the previous month and was following a similar trend to the previous year due to the nature of programmes and cycle of invoicing. It was anticipated that it would be November before a true picture of the financial position emerged.

During discussion of the report Members:

- Noted that the 'number of health checks completed' performance indicator remained red. This was partly due to data recording issues that were being addressed. There had been a lot of work to increase the numbers of checks completed and officers explained that the targets were necessary in order to effectively manage rates of cardio-vascular disease.

- Noted that a meeting had taken place with Fenland District Council's senior management team regarding outreach health checks and information would be provided to Members on engagement. **ACTION**

It was resolved unanimously to review and comment on the report and note the finance and performance position as at the end of July 2017.

33. CAMBRIDGESHIRE ADULT DRUG AND ALCOHOL TREATMENT SERVICES PROCUREMENT

The Committee received a report that described the rationale and benefits of procuring a new Cambridgeshire Adult Drug and Alcohol Treatment Service though a competitive tender. There was a need with an aging population of drug users for a different approach together with the increasing misuse of prescription drugs. There was also a need to transform services and achieve best value from any contract.

- Emphasised the need for an evidence based approach - as from a Public Health perspective there was some return on investment from drugs and alcohol services,l but there was significant return on investment in terms of reduction in crime and suggested that the Police and Crime Commissioner be involved in the process. Officers explained that the office of the Police and Crime Commissioner invested in services every year. The Drugs and Alcohol Delivery Board brought together a wide range of organisations and there was an expectation that organisations would work collaboratively in order to tackle the issue.

- Drew attention to the benefits of an over-arching Public Health strategy that would better inform where money was targeted.

It was resolved unanimously to approve:

a) The initiating a competitive tender for the procurement of a Cambridgeshire integrated drug and alcohol service

b) The scope of service to be included in the tender

c) A transformation approach that reflects the findings of the recent Drugs and Alcohol Joint Strategic Needs Assessment and the National Drugs Strategy, is evidence based and provides value for money.

34. ANNUAL PUBLIC HEALTH REPORT 2017

The Director of Public Health presented the Annual Public Health Report 2017 to the Committee. The report was the statutory duty of the Director of Public Health. In presenting the report attention was drawn to the section regarding trends in mental health that showed an increase in the number of admissions for self-harm however, there had been no overall increase in the suicide rate. The report recommended a consistent and sustainable focus on the north of Fenland and the Wisbech area that suffered particularly from acute health inequalities.

In welcoming the report Members:

- Drew attention to young people's mental health questioning whether the rise in admissions could be attributed to changes in the recording of admissions and therefore would be reflected nationally also. Officers explained that although the national requirements for recording admissions had changed local practices within individual hospital also influenced the data. There was also the potential for a small number of individuals to be admitted but they have several admissions over a period of time. Members noted the wide range of activity and the role of the Health and

Wellbeing Board that retained oversight of developing work in the area. Officers agreed to provide Members with further details of the areas of activity. **ACTION**

- Expressed concern regarding the level of health inequality across the county and requested that further information be provided to Members on what the inequalities were, the action being taken by the Council and the effectiveness of the action taken. **ACTION**

- Noted that GCSE attainment for pupils that received free school meals was significantly worse than other local authorities and was an area being focussed on by the Learning Directorate.

- Clarified that the asterisks contained within the table shown at figure 21 of the report were included in order that the identity of those affected could not be revealed because the numbers were so small.

- Drew attention the resource implications that related to Public Health. Cambridgeshire was one of the fastest growing areas in the United Kingdom and there was currently a situation where expenditure was below the mean.

- Highlighted the cuts in the Children's and Young Peoples budget and the changes to the provision of Children's Ccentres. Officers explained that the report signalled the relationship between achieving positive health outcomes while targeting resources based on analysis of needs and outcomes. Officers agreed to provide an objective briefing to Members regarding research on the contribution of Children's Centres to health outcomes. **ACTION**

- Emphasised the need to focus on the priorities for the Public Health budget and the determination of the relative values of the priorities.

- Requested that more neighbourhood mapping was included within the report as well as that based on electoral divisions.

It was resolved to:

a) Discuss and comment on the information outlined in the Annual Public Health Report

b) Consider any recommendations the Committee may wish to make based on the content of the report.

35. PUBLIC QUESTION

Mrs Jean Simpson had submitted a question by the deadline and the Chairman invited her to address the Committee.

Mrs Jean Simpson had submitted a question by the deadline and the Chairman invited her to address the Committee.

In her introduction she commented on the priorities of the Health Committee regarding its scrutiny function and raised concern regarding how that function was undertaken. With regard to engagement with the public Mrs Simpson questioned with regard to the

Sustainability Transformation Partnership (STP) Board strategy that mentioned a stakeholder group. Mrs Simpson asked what the membership of the Stakeholder Group was, whether service users and members of the public were to have seats on the STP Board, whether the meetings of the Board would be held in public with minutes made available and whether the STP would explain how the Capped Expenditure Process would result in cuts to health service provision.

The Chairman thanked Mrs Simpson for her question and informed her that a written response to her question would be sent within 10 working days from the date of the meeting.

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36. PLANNING FUTURE PRIORITIES FOR HEALTH COMMITTEE

Members received a report that requested the Committee review and agree its priorities for 2017/18. The report built on development session held for the Committee and summarised the issues discussed at that event.

During the course of discussion Members:

- Welcomed the priorities set out in the report following the development session including the scrutiny areas of focus; delayed transfers of care and the Sustainability and Transformation Partnership.

- Emphasised the need to focus on what could achieve the best outcomes based on the resources that were available.

- Requested that health inequalities be reduced to the extent that it could be achieved. Members noted the success that financial incentives provided to pregnant women who were smokers and the evidence base that supported the conclusions, requesting that the same evidence based approach applied to priorities in the future.

- Drew attention to the need for an overarching Public Health Strategy in order for the Committee and officers to assess the priorities effectively.

It was resolved to:

a) Discuss the priorities recommended in paragraphs 2.3 and 2.4 of the officer report following a development session for Committee members held in July

b) Agree Health Committee priorities for 2017/18

c) Consider what reporting mechanisms the Committee would like to see put in place to monitor progress against identified priorities.

37. SUICIDE PREVENTION STRATEGY UPDATE

This report provided the Committee with an update on progress relating to the suicide prevention strategy and presented the draft refresh of the strategy prior to it being presented to other organisations and stakeholders. Officers drew attention to the collaborative approach of a number of organisations that ensured the strategy was effective and some of the initiatives and programmes that had been implemented during the period of the strategy.

During discussion

- Requested that the report focussed more on the positive results of the strategy and that they be circulated to Members and the public. **ACTION**

- Drew attention to the provision of Survivors of Bereavement Due to Suicide (SOBS) branches across the county and questioned how a branch in Cambridgeshire and Peterborough would be achieved. Officers informed Members that there had been interest received from bereaved relatives who were interested in setting a group up but had experienced difficulties in accessing the necessary training. Officers were therefore contacting neighbouring local authorities in order to be able to achieve the numbers of people necessary to make training events viable.

- Highlighted the complex needs of the bereaved that required a broad range of support, noting that Public Health England had provided guidance on post suicide bereavement services and this would be provided to Members **ACTION**.

- Sought greater clarity regarding occupations that were seen as higher risk of suicide such as construction and I.T. and emphasised the importance of the language used to describe suicide noting the legal connotations of the term committing suicide. Officers explained that those professions in particular tended to be isolated and work was being undertaken with MIND that focussed on workers living alongside the construction of the new A14 during the week.

- Noted that assisted suicide was not mentioned in the report as it focussed on mental health rather than end of life care.

It was resolved to:

a) Note and comment on progress to date against the suicide prevention strategy 2014/17
b) Comment on the draft suicide prevention strategy 2017/20

38. SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP

The Committee received a presentation from the Sustainability and Transformation Partnership (STP) including areas of reporting requested by the Health Committee at the July 2017 meeting. The purpose of the presentation was to provide the Committee with information relating to STP operational performance, STP programme delivery and risk management.

Councillor Harford left the meeting at 4:30pm and did not return.

During the course of discussion Members:

- Requested that information on Delayed Transfers of Care (DTOCS) be provided by hospital and by type. It was also requested that it be presented in graphical form with 18 month rolling format that illustrated fluctuations attributable to seasonality. Officers agreed to provide the level of analysis requested.

- Confirmed that a list of subjects for 'deep dives' would be provided to the STP for future scrutiny at the Health Committee.

- Highlighted the importance of transforming how communities related to the health service which entailed a large communications requirement. Members were informed that national communications products did not appear to be working effectively and there was a need to find a new way to approach the issue.

- Drew attention to and welcomed the template contained on page 17 of the presentation as it was clearly presented.

- Emphasised the importance of investing in hospital and community services. Officers acknowledged the pressures and risk associated with funding. Attention was drawn to the STP investment fund and an initiative regarding suicide prevention and the level of funding provided being significantly more than had been requested due to the potential benefits of the initiatives. Each initiative had a clear set of objectives and deliverables that were reviewed continuously and if an initiative was not working then it would be closed.

- Noted that the political risks associated to the STP which recognised that without the support of Councillors then it was likely that the partnership would fail.

- Expressed concern with the level of engagement from primary care providers. Officers confirmed that great efforts were being made to engage with providers including GPs. Communication was highlighted as an issue where there were 30 different mechanisms for contacting GPs but no single way of contacting all 800 in one go.

- Noted the issues faced by the STP regarding engagement with the political process. Service Directors lacked the mandate through which some decisions could be taken and therefore was a risk that the progress was slow as a result.

- Requested that direction of travel indicators be plotted against each risk in order that the trend could be monitored.

It was resolved to note the oral update provided in terms of the Sustainability Transformation Partnership (STP) and to request a series of "deep dives" for the Committee to scrutinise areas of activity of the STP.

39. AIR QUALITY IN CAMBRIDGESHIRE UPDATE

The Committee received an update regarding the measures to address current concerns regarding air quality in Cambridgeshire following the Health Committee recommendations agreed at the 16th March 2017 meeting. Officers introduced Stuart Keeble, Public Heath Consultant who was newly appointed at Peterborough City Council who would be working across Cambridgeshire and Peterborough as part of the joint Public Health team.

Members noted that only 2 annual reports from Cambridge City Council and South Cambridgeshire District Council had been received and officers requested that Members influence their respective District Councils to ensure that the reports were sent as soon as possible.

In discussion, issues raised included:

- Expressed disappointment with the level of progress made and requested that other organisations and local authorities attributed the issue a higher priority.

- Expressed that the significant implications paragraphs of the officer report suggested there were no implications when in fact there were and requested that greater encouragement be given to partner organisations and District Councils regarding air quality.

- Noted that Public Health retained the responsibility for air quality but no authority through which to address it.

- Noted the work of officers that had offered to provide air quality training to officers who worked in transport.

- Drew attention to the complexities of air quality where it was not absolutely clear whether nitrogen dioxide or particulate emissions were the issue and that by tacking one problem can often lead to another as was seen when the Government encouraged people to switch to diesel cars from petrol.

- Noted that the primary source of air pollution in Cambridgeshire was from traffic.

- Requested that a further report be presented in 2 months that provided an outline air quality partnership strategy and included an analysis of the responsibilities regarding air quality and which organisations were responsible.

It was resolved to note and comment on progress since the meeting on 16th March.

40. PUBLIC HEALTH RISK REGISTER UPDATE

Members were presented the Public Health Risk Register and were informed that since its last presentation to the Committee there had been no new risks added though some residual risk had changed.

It was resolved to:

a) Note the position in respect of Public Health Directorate Risk
b) Comment on the Public Health Risk Register and endorse the amendments since the previous update.

41. EMERGING ISSUES IN THE NHS

This item was removed from the agenda following its publication.

42. HEALTH COMMITTEE WORKING GROUPS UPDATE

An update was provided to Members on the various Working Groups of the Health Committee. Officers would confirm whether a further meeting of Healthwatch had been scheduled.

43. HEALTH COMMITTEE TRAINING PLAN

Members noted that the training scheduled to take place in November be retained in order that a session for Business Planning be provided. The Sustainability Transformation Partnership (STP) would also provide a development session regarding workforce recruitment and retention to be scheduled.

44. HEALTH COMMITTEE AGENDA PLAN

It was resolved to note the agenda plan and addition of the following items:

Delayed Transfers of Care from Hospital - November

Integrated Commissioning of Children's Health and Wellbeing Services'. - November

Air Quality in Cambridgeshire – November

Chairman

HEALTH COMMITTEE

Minutes-Action Log

Cambridgeshire County Council

Introduction:

This log captures the actions arising from the Health Committee on **11th October 2017** and updates Members on progress in delivering the necessary actions.

Minute No.	Item	Action to be taken by	Action	Comments	Status
17.	**Public Health Finance and Performance Report** **a) Health visiting mandated checks whether geographical / social reasons for lack of take-up**	**L Robin**	Health visiting mandated checks - the percentage of children who received 12 month review by 15 months – with reference to the decline in performance, a question was raised regarding whether there was a geographical / social pattern to them not being wanted or not attended? **Action: Dr Robin to find out and report back with more detail.**	Under investigation.	**On-going**
19.	**Update from Cambridge University Hospitals NHS Foundation Trust (CUHFT)**	**Kate Parker**	**b)** To request consideration that one of the quarterly liaison meetings with CUHFT being held at the Granta medical centre / practice.	Looking at scheduling new liaison meetings with CUHFT for 2018 and first meeting to be held at Granta Medical practice.	**Completed**
		Scott Haldane / Aidan Fallon	It was suggested that each of the delivery groups should include a representative from the Health Committee. The report	This suggestion by the Health Committee has been taken back by the report leads and is currently being considered. A further	**Completed**

Minute No.	Item	Action to be taken by	Action	Comments	Status
			leads agreed to take this suggestion away.	update will be available for the Health Committee meeting on 7th September 2017.	
25.	**Appointment of a Member Champion for Mental Health**	**Democratic Services**	.		**On-going**
31.	**Healthy Weight Strategy**	**K Parker**	The Healthy Weight Strategy be presented to Addenbrooke's hospital at the next meeting of the Liaison Group	Discussed at the Liaison meeting on 29th September and a further meeting with relevant officers is to be set up to take this work forward.	**Completed**
32.	**Finance & Performance Report – July 2017**	**V Thomas**	Information would be provided to Members regarding engagement with outreach health checks following a meeting with Fenland District Council's senior management team.		**Ongoing**
34.	**Annual Public Health Report 2017**	**L Robin**	Details of areas of activity regarding younger people's mental health to be circulated to Members	Briefing circulated to heath committee members on 2nd October 2017	**Completed**
34.	**Annual Public Health Report 2017**	**L Robin**	Information on health inequalities to be circulated to Members along with the action being taken and the effectiveness of the action.	Email with relevant links sent to Health Committee members on 2nd October 2017.	**Completed**
34.	**Annual Public Health Report 2017**	**L Robin**	Officers agreed to provide an objective briefing to Members regarding research on the contribution of Children's Centres to health outcomes.		**Completed**
37.	**Suicide Prevention Strategy Update**	**K Hartley**	Members requested that the report focussed more on the positive results of the strategy and that they be circulated to Members and the public.	Strategy will be presented to Health Scrutiny Committee in Peterborough before it is finalised and ready for circulation	**Ongoing**

Minute No.	Item	Action to be taken by	Action	Comments	Status
37.	**Suicide Prevention Strategy Update**	**L Robin**	Public Health England had provided guidance on post suicide bereavement services and this would be provided to Members	Email with relevant links to guidance sent to Health Committee Members on 2nd October 2017.	**Completed**

Agenda Item No: 4

FINANCE AND PERFORMANCE REPORT – AUGUST 2017

To:	**Health Committee**
Meeting Date:	**19th October 2017**
From:	**Director of Public Health** **Chief Finance Officer**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable** *Key decision:* **No**
Purpose:	**To provide the Committee with the August 2017 Finance and Performance report for Public Health.** **The report is presented to provide the Committee with the opportunity to comment on the financial and performance position as at the end of August 2017.**
Recommendation:	**The Committee is asked to review and comment on the report and to note the finance and performance position as at the end of August 2017.**

Officer contact:	
Name:	Martin Wade
Post:	Strategic Finance Business Partner
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Tel:	01223 699733

1.0 BACKGROUND

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

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

2.0 MAIN ISSUES IN THE AUGUST 2017 FINANCE & PERFORMANCE REPORT

2.1 The August 2017 Finance and Performance report is attached at Annex A.

2.2 A balanced position is forecast for the Public Health Directorate for 2017/18.

A balanced budget was set for the Public Health Directorate for 2017/18, incorporating savings as a result of the reduction in Public Health grant.

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

The August 2017 Finance and Performance report (F&PR) is attached at Annex A and shows the forecast outturn for the Public Health Directorate is a balanced position.

Further detail on the outturn position can be found in Annex A.

2.3 The Public Health Service Performance Management Framework for July 2017 is contained within the report. Of the twenty nine Health Committee performance indicators, three are red, seven are amber, seventeen are green and two have no status.

3.0 ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

3.1.1 There are no significant implications for this priority.

3.2 Helping people live healthy and independent lives

3.2.1 There are no significant implications for this priority

3.3 Supporting and protecting vulnerable people

3.3.1 There are no significant implications for this priority

4.0 SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

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

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

4.2.1 There are no significant implications for this priority

4.3 Statutory, Legal and Risk Implications

4.3.1 There are no significant implications within this category.

4.4 Equality and Diversity Implications

4.4.1 There are no significant implications within this category.

4.5 Engagement and Communications Implications

4.5.1 There are no significant implications within this category.

4.6 Localism and Local Member Involvement

4.6.1 There are no significant implications within this category.

4.7 Public Health Implications

4.7.1 There are no significant implications within this category.

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

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

From: Martin Wade

Tel.: 01223 699733

Date: 07 Sep 2017

Public Health Directorate

Finance and Performance Report – Aug 2017

1 SUMMARY

1.1 Finance

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

1.2 Performance Indicators

Monthly Indicators	Red	Amber	Green	No Status	Total
Jul (No. of indicators)	3	7	17	2	29

2. INCOME AND EXPENDITURE

2.1 Overall Position

Forecast Variance - Outturn (Jul) £000	Service	Current Budget for 2017/18 £000	Current Variance £000	Forecast Variance - Outturn (Aug) £000	Forecast Variance - Outturn (Aug) %
0	Children Health	9,200	-3	0	0%
0	Drug & Alcohol Misuse	5,845	-25	0	0%
0	Sexual Health & Contraception	5,297	-21	0	0%
0	Behaviour Change / Preventing Long Term Conditions	3,638	-3	0	0%
0	General Prevention Activities	56	1	0	0%
0	Adult Mental Health & Community Safety	263	-0	0	0%
0	Public Health Directorate	2,421	-196	0	0%
0	**Total Expenditure**	**26,720**	**-248**	**0**	**0%**
0	Public Health Grant	-26,041	-92	0	0%
0	s75 Agreement NHSE-HIV	-144	216	0	0%
0	Other Income	-149	63	0	0%
0	Drawdown From Reserves	0	0	0	0%
0	**Total Income**	**-26,334**	**187**	**0**	**0%**
0	**Net Total**	**386**	**-61**	**0**	**0%**

The service level budgetary control report for August 2017 can be found in appendix 1.

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

2.2 Significant Issues

There are currently no over or underspends expected within the Public Health Directorate. A balanced budget was been set for the financial year 2017/18. Savings totalling £606k have been budgeted for and the achievement of savings will be monitored through the monthly savings tracker, with exceptions being reported to Heath Committee and any resulting overspends reported through the monthly Finance and Performance 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 2017/18 is £26.9m, of which £26.041m is allocated directly to the Public Health Directorate.

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

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

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

3. BALANCE SHEET

3.1 Reserves

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

4. PERFORMANCE SUMMARY

4.1 Performance overview (Appendix 6)

Sexual Health

- Performance of sexual heath and contraception services remains good with all indicators green.

Smoking Cessation

- The service is now being delivered by Everyone Health as part of the wider Lifestyle Service. Performance indicators for people setting a four week quit remains good.

National Child Measurement Programme

- The measurement programme for 2017/18 will commence in September 2017, measurements are undertaken during school term.

NHS Health Checks

- NHS Health Checks completed performance indicator remains red but the number of outreach health checks carried out is amber. Please see commentary for further details.

Lifestyle Services

- From the 14 Integrated Lifestyle Service indicators reported the overall performance shows nine green, four amber and one red indicator.

Health Visitor and School Nurse Data

- The overall performance indicators for Health Visiting and School Nursing show three green, two amber and one red indicator.
- Health Visiting data is reported on quarterly and this data provided reflects the quarter 1 period for 2017/18 (April-June).

4.2 Health Committee Priorities (Appendix 7)

Reports due bi-monthly and will next be reported in the September report at November's Health Committee.

4.3 Health Scrutiny Indicators (Appendix 8)

Reports due bi-monthly and will next be reported in the September report at November's Health Committee.

4.4 Public Health Services provided through a Memorandum of Understanding with other Directorates

The next update will be provided after the end of Quarter 2.

APPENDIX 1 – Public Health Directorate Budgetary Control Report

Forecast Variance Outturn (Jul) £'000	Service	Current Budget for 2017/18 £'000	Expected to end of Aug £'000	Actual to end of Aug £'000	Current Variance £'000	Current Variance %	Forecast Variance Outturn (Aug) £'000	Forecast Variance Outturn (Aug) %
	Children Health							
0	Children 0-5 PH Programme	7,253	2,491	2,491	0	0.00%	0	0.00%
0	Children 5-19 PH Programme - Non Prescribed	1,947	527	524	-3	-0.65%	0	0.00%
0	Children Mental Health	0	0	0	0	0.00%	0	0.00%
0	**Children Health Total**	**9,200**	**3,019**	**3,015**	**-3**	**-0.11%**	**0**	**0.00%**
	Drugs & Alcohol							
0	Drug & Alcohol Misuse	5,845	1,419	1,394	-25	-1.75%	0	0.00%
0	**Drugs & Alcohol Total**	**5,845**	**1,419**	**1,394**	**-25**	**-1.75%**	**0**	**0.00%**
	Sexual Health & Contraception							
0	SH STI testing & treatment – Prescribed	3,975	1,359	1,343	-16	-1.19%	0	0.00%
0	SH Contraception - Prescribed	1,170	33	28	-5	-14.68%	0	0.00%
0	SH Services Advice Prevn Promtn - Non-Presribed	152	34	34	1	1.57%	0	0.00%
0	**Sexual Health & Contraception Total**	**5,297**	**1,426**	**1,406**	**-21**	**-1.44%**	**0**	**0.00%**
	Behaviour Change / Preventing Long Term Conditions							
0	Integrated Lifestyle Services	1,732	301	291	-10	-3.34%	0	0.00%
0	Other Health Improvement	281	139	133	-6	-4.00%	0	0.00%
0	Smoking Cessation GP & Pharmacy	828	-37	-28	9	25.00%	0	0.00%
0	Falls Prevention	80	34	40	6	18.21%	0	0.00%
0	NHS Health Checks Prog – Prescribed	716	209	207	-3	-1.25%	0	0.00%
0	**Behaviour Change / Preventing Long Term Conditions Total**	**3,638**	**645**	**643**	**-3**	**-0.42%**	**0**	**0.00%**
	General Prevention Activities							
0	General Prevention, Traveller Health	56	44	45	1	1.82%	0	0.00%
0	**General Prevention Activities Total**	**56**	**44**	**45**	**1**	**1.82%**	**0**	**0.00%**
	Adult Mental Health & Community Safety							
0	Adult Mental Health & Community Safety	263	11	11	-0	-3.97%	0	0.00%
0	**Adult Mental Health & Community Safety Total**	**263**	**11**	**11**	**-0**	**-3.97%**	**0**	**0.00%**

Forecast Variance Outturn (Jul) £'000	Service	Current Budget for 2017/18 £'000	Expected to end of Aug £'000	Actual to end of Aug £'000	Current Variance £'000	Current Variance %	Forecast Variance Outturn (Aug) *£'000*	Forecast Variance Outturn (Aug)
	Public Health Directorate							
0	*Public Health - Admin & Salaries*							
0	Health Improvement	463	193	202	9	4.71%	0	0.00%
0	Public Health Advice	714	298	263	-35	-11.60%	0	0.00%
0	Health Protection	221	92	100	8	8.60%	0	0.00%
0	Childrens Health	57	24	26	2	9.47%	0	0.00%
0	Comm Safety, Violence Prevention	22	9	4	-5	-56.36%	0	0.00%
0	Public Mental Health	127	53	36	-17	-31.97%	0	0.00%
0	Drug & Alcohol Misuse	150	63	22	-41	-64.80%	0	0.00%
	Cross Directorate Costs	667	278	159	-119	-42.79%	0	0.00%
0		**2,421**	**1,009**	**812**	**-196**	**-19.47%**	**0**	**0.00%**
0	**Total Expenditure before Carry forward**	**26,720**	**7,573**	**7,325**	**-248**	**-3.27%**	**0**	**0.00%**
0	**Anticipated contribution to Public Health grant reserve**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0.00%**
	Funded By							
0	Public Health Grant	-26,041	-13,155	-13,247	-92	-0.70%	0	0.00%
0	S75 Agreement NHSE HIV	-144	0	216	216	0.00%	0	0.00%
0	Other Income	-149	-63	0	63	100.00%	0	0.00%
	Drawdown From Reserves	0	0	0	0	0.00%	**0**	0.00%
0	**Income Total**	**-26,334**	**-13,218**	**-13,031**	**187**	**1.41%**	**0**	**0.00%**
0	**Net Total**	**386**	**-5,645**	**-5,706**	**-61**	**-1.07%**	**0**	**0.00%**

APPENDIX 2 – Commentary on Expenditure Position

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

Service	Current Budget for 2017/18 £'000	Current Variance		Forecast Variance - Outturn	
		£'000	%	£'000	%

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

Awarding Body : DofH

Grant	Business Plan £'000	Adjusted Amount £'000	Notes
Public Health Grant as per Business Plan	**26,946**		Ring-fenced grant
Grant allocated as follows;			
Public Health Directorate	20,050	26,041	Including full year effect increase due to the transfer of the drug and alcohol treatment budget (£5,880k) from CFA to the PH Joint Commissioning Unit. Also the transfer of the MH Youth Counselling budget (£111k) from CFA to PH mental health budget.
CFA Directorate	6,322	331	£5,880k drug and alcohol treatment budget and £111k mental health youth counselling budgets transferred from CFA to PH as per above.
ETE Directorate	153	153	
CS&T Directorate	201	201	
LGSS Cambridge Office	220	220	
Total	**26,946**	**26,946**	

APPENDIX 4 – Virements and Budget Reconciliation

	£'000	Notes
Budget as per Business Plan	20,560	
Virements		
Non-material virements (+/- £160k)	-8	
Budget Reconciliation		
Drug and Alcohol budget from CFA to PH	6,058	
Youth Counselling budget from CFA to PH	111	
Current Budget 2016/17	**26,721**	

APPENDIX 5 – Reserve Schedule

Fund Description	Balance at 31 March 2017	2017/18		Forecast Closing Balance	Notes
		Movements in 2017/18	Balance at 31 Aug 2017		
	£'000	£'000	£'000	£'000	
General Reserve					
Public Health carry-forward	**1,040**	0	1,040	**1,040**	
subtotal	**1,040**	**0**	**1,040**	**1,040**	
Other Earmarked Funds					
Healthy Fenland Fund	400	0	400	300	Anticipated spend £100k per year over 5 years.
Falls Prevention Fund	400	0	400	200	Planned for use on joint work with the NHS in 2017/18 and 2018/19.
NHS Healthchecks programme	270	0	270	170	This funding will be used to install new software into GP practices which will identify patients for inclusion in Health Checks. The installation work will commence in June 2017. Funding will also be used for a comprehensive campaign to boost participation in NHS Health Checks.
Implementation of Cambridgeshire Public Health Integration Strategy	850	0	850	592	£517k Committed to the countywide 'Let's Get Moving' physical activity programme which runs for two years 2017/18 and 2018/19.
Other Reserves (<£50k)	0	0	0	0	
subtotal	**1,920**	**0**	**1,920**	**1,262**	
TOTAL	**2,960**	**0**	**2,960**	**2,302**	

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

Fund Description	Balance at 31 March 2017	2017/18		Forecast Closing Balance	Notes
		Movements in 2017/18	Balance at 31 Aug 2017		
	£'000	£'000	£'000	£'000	
General Reserve					
Joint Improvement Programme (JIP)	59	0	59	59	
Improving Screening & Immunisation uptake	9	0	9	9	£9k from NHS ~England for expenditure in Cambridgeshire and Peterborough
TOTAL	**68**		**0**	**68**	

APPENDIX 6 PERFORMANCE

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

The Public Health Service Performance Management Framework (PMF) for July 2017 can be seen within the tables below:

Measures										
Measure	Y/E Target 2017/18	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
GUM Access - offered appointments within 2 working days	98%	98%	98%	98%	G	99%	98%	98%	↔	
GUM ACCESS - % seen within 48 hours (% of those offered an appointment)	80%	80%	92%	92%	G	91%	80%	92%	↔	
Number of Health Checks completed	18,000	4,000	3,810	85%	R	N/A	4500	85%	↔	The comprehensive Improvement Programme is continuing this year with an extensive promotional campaign in high risk areas and the introduction of the new software into practices has commenced which will increase the accuracy of the of the number of invitations that are sent for NHS Health Check. There is also ongoing training of practice staff.
Number of outreach health checks carried out	2,000	340	315	93%	A	85%	95	84%	↓	The Lifestyle Service is commissioned to provide outreach Health Checks for hard to reach groups in the community and in workplaces. Workplaces in the South of the county are performing well. However it has not been possible to secure access to the factories in Fenland where there are high risk workforces. This has affected overall performance. Engaging workplaces in Fenland is challenging with in excess of 100 workplaces and community centres contacted with very little uptake. There is a need to secure high level support that could be from an economic development perspective, if employers are to be effectively engaged. This would reflect the evidence that supporting employee health and well being brings cost benefits to businesses.
Smoking Cessation - four week quitters	2278	396	401	101%	G	121%	396	101%	↓	• The most recent Public Health Outcomes Framework figures (June 2017 data for 2016) suggest the prevalence of smoking in Cambridgeshire remains at a level statistically similar to the England average (15.2% v. 15.5%). Rates remain higher in Fenland (21.6%) than the Cambridgeshire and England figure • There is an ongoing programme to improve performance that includes targeting routine and manual workers (rates are known to be higher in these groups) and the Fenland area.

Measure	Y/E Target 2017/18	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
Percentage of infants being breastfed (fully or partially) at 6 - 8 weeks	58%	56%	56%	56%	G	57%	56%	56%	↓	A stretch target for the percentage of infants being breastfed was set at 58% for 2016/17, - above the national average for England. The number of infants recorded as breastfed (fully or partially) at 6 weeks for Q4 has increased to 57%, and has decreased slightly to 56% for this quarter, meeting the revised target. This figure is one of the highest statistics in the Eastern region in published Public Health England data (2015/16) and Cambridgeshire continues to exceed the 45% national target.
Health visiting mandated check - Percentage of first face-to-face antenatal contact with a HV at >28 weeks	50%	50%	28%	28%	R	33%	50%	28%	↓	All of the health visiting data is reported quarterly. The data presented relates to the Q1 period (April to July 2017). The proportion of antenatal contacts continues to fall well below the 50% target and a strategy is in place to improve the notification process between maternity services and health visiting to remedy this. If we take into account exceptions the figure for Q1 increases to 31%. Priority is being given to those parents who are assessed as being most vulnerable. Since the same period last year, staffing levels are down by 16%. There has been recruitment days, and posts have been recruited to as a result. New staff are expected to start in the next 3 months.
Health visiting mandated check - Percentage of births that receive a face to face New Birth Visit (NBV) within 14 days, by a health visitor	90%	90%	96%	96%	G	95%	90%	96%	↑	The number of New Birth Visits completed within 14 days of birth continues exceed the 90% target.
Health visiting mandated check - Percentage of children who received a 6 - 8 week review	90%	90%	92%	92%	G	95%	90%	92%	↓	The proportion of 6-8 week development checks completed within 8 weeks has declined slightly this quarter but continues to be above the 90% target.
Health visiting mandated check - Percentage of children who received a 12 month review by 15 months	100%	100%	87%	87%	A	91%	100%	87%	↓	This figure is below the set target. However if we take into account exception (which included visits not wanted or "did not attend") reporting the figure for Q1 increases to 91%, although this is still below target and need to be monitored.
Health visiting mandated check - Percentage of children who received a 2 -2.5 year review	90%	90%	78%	78%	A	82%	90%	78%	↓	The number of 2-2.5 year reviews being completed is below the set target. However if exception reporting (which included visits not wanted or "did not attend") is accounted for, the figure for Q1 increases to 92% which is above target.
School nursing - Number of young people seen for behavioural interventions - smoking, sexual health advice, weight management or substance misuse	N/A	N/A	100	100	N/A	59	N/A	100	↑	The School Nursing service has introduced a duty desk this quarter to offer a more efficient service. The figures reported are for those that have been seen in clinics in relation to a specific intervention.
School nursing - number of young people seen for mental health & wellbeing concerns	N/A	N/A	733	733	N/A	305	N/A	733	↑	The School Nursing service has introduced a duty desk this quarter to offer a more efficient service. The figures reported are for those that have been seen in clinics in relation to a specific intervention. There has been a sharp increase in the number of children being seen for issues relating to their emotional health and wellbeing.

Measure	Y/E Target 2017/18	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
Childhood Obesity (School year) - 90% coverage of children in year 6 by final submission (EOY)	90%	90.0%	91.6%		G	91%	90.0%	92%	↑	The National Child Measurement Programme (NCMP) has been completed for the 2016/17 academic year. The coverage target was met and the measurement data has been submitted to the PHE on 21/07/2017 for in line required timeline. The cleaned measurement data will be available at the end of the year. The new measurement programme for 2017/18 will start in September.
Childhood Obesity (School year) - 90% coverage of children in reception by final submission (EOY)	90%	90.0%	95.0%		G	95%	90.0%	95.0%	↔	
Overall referrals to the service	5100	1480	1488	101%	G	107%	390	101%	↓	
Personal Health Trainer Service - number of Personal Health Plans produced (PHPs) **(Pre-existing GP based service)**	1517	415	417	100%	G	112%	100	97%	↓	
Personal Health Trainer Service - Personal Health Plans completed **(Pre-existing GP based service)**	1138	257	221	86%	R	65%	87	53%	↓	A larger number than usual of patients were referred to Tier 2 weight management which has increased the length of intervention (on average normally 6 months). Consequently there were fewer completions.
Number of physical activity groups held **(Pre-existing GP based service)**	664	190	214	113%	G	116%	60	87%	↓	
Number of healthy eating groups held **(Pre-existing GP based service)**	450	160	201	126%	G	115%	30	187%	↑	
Personal Health Trainer Service - number of PHPs produced (Extended Service)	723	217	231	106%	G	88%	54	150%	↑	
Personal Health Trainer Service - Personal Health Plans completed (Extended Service)	542	150	148	99%	A	93%	50	80%	↓	
Number of physical activity groups held (Extended Service)	830	175	155	89%	A	68%	35	94%	↑	
Number of healthy eating groups held (Extended Service)	830	270	310	115%	G	133%	55	80%	↓	
Proportion of Tier 2 clients completing the intervention who have achieved 5% weight loss.	30%	30%	25%		A	115%	30%	79%	↓	The percentage of participants who achieve the recommended weight loss is affected by the severity of the obesity. As part of demand management for the Tier 3 service patients are directed to Tier 2, these patients are more complex and have higher levels of obesity.

Measure	Y/E Target 2017/18	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
Proportion of Tier 3 clients completing the course who have achieved 10% weight loss	60%	60%	61%		G	0%	60%	75%	↑	
% of children recruited who complete the weight management programme and maintain or reduce their BMI Z score by agreed amounts	80%	80%	100%		G	n/a	80%	100%	↑	No courses completed during this period
Falls prevention - number of referrals	386	90	92	101%	G	150%	20	105%	↓	
Falls prevention - number of personal health plans written	279	59	58	98%	A	143%	14	107%	↓	This reflects the number of referrals that occurred in the preceding months. Referrals originate from the wider Falls Prevention Service which was being re-organised and consequently the referral number fell.

* All figures received in August 2017 relate to July 2017 actuals with exception of Smoking Services, which are a month behind and Health Checks, some elements of the Lifestyle Service, School Nursing and Health Visitors which are reported quarterly.

** Direction of travel against previous month actuals

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

APPENDIX 7

Health Committee Priorities

Reports due bi-monthly and will next be reported on in the September report at November Health Committee.

APPENDIX 8

Reports due bi-monthly and will next be reported on in the September report at November Health Committee.

Agenda Item No: 5

SERVICE COMMITTEE REVIEW OF DRAFT REVENUE BUSINESS PLANNING PROPOSALS FOR 2018-19 TO 2022-23

To:

Meeting Date: **Health Committee**

From: **Dr. Liz Robin, Director of Public Health**

Chris Malyon, Chief Finance Officer
Tom Kelly, Head of Finance

Electoral division(s): **All**

Forward Plan ref: **Not applicable** *Key decision:* **No**

Purpose: **This report provides the Committee with an overview of the draft Business Plan Revenue Proposals for Public Health that are within the remit of the Health Committee.**

Recommendation:

a) It is requested that the Committee note the overview and context provided for the 2018-19 to 2022-23 Business Plan revenue proposals for the Service.

b) It is requested that the Committee comment on the draft revenue savings proposals that are within the remit of the Health Committee for 2018-19 to 2022-23.

Officer contact:	Member contact:
Name: Dr. Liz Robin Post: Director of Public Health Email: Liz.Robin@cambridgeshire.gov.uk Tel: 01223 703259	Name: Cllr Peter Hudson Post: Chair of Health Committee Email: Peter.Hudson@cambridgeshire.gov.uk

1. OVERVIEW

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

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

1.3 Like all Councils across the country, we are facing a major challenge. Demand is increasing and funding is reducing at a time when the cost of providing services continues to rise significantly due to inflationary and demographic pressures. Through our FairDeal4Cambs campaign we are currently linking with the 39 Shire County areas who make up membership of the County Council's Network and who are raising the issue of historic underfunding of Shire Counties with our MPs and through them with Government. As the fastest growing County in the country this financial challenge is greater in Cambridgeshire than elsewhere. We have already delivered £186m of savings over the last 5 years and have a strong track record of value for money improvements which protect front line services to the greatest possible extent. However we know that there will be diminishing returns from existing improvement schemes and that the substantial pressure on public finances remains. It is therefore clear that we need to work more closely with local communities to help them help themselves as well as going further and faster in redesigning the way we commission and deliver services.

1.4 As such our Business Plan recognises the scale of change needed and proposes a significant programme of change across our services, with our partners and, crucially, with our communities. To support this we have a dedicated transformation fund, providing the resource needed in the short term to drive the change we need for the future.

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

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

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

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

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

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

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

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

1.8 Equally as our proposals become more ambitious and innovative, in many instances they become less certain. Some proposals will deliver more or less than anticipated, equally some may encounter issues and delays and others

might be accelerated if early results are promising. To manage this we need to incorporate some changes to our business planning approach, specifically;

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

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

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

2. BUILDING THE REVENUE BUDGET

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

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

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

Inflation Range	2018-19	2019-20	2020-21	2021-22	2022-23
Standard non-pay inflation (CPI)	2.2%	2.0%	2.0%	2.0%	2.0%
Other non-pay inflation (average of multiple rates)	3.5%	2.3%	1.7%	1.7%	1.7%
Pay (admin band)	1.0%	1.0%	1.0%	1.0%	1.0%
Pay (management band)	1.0%	1.0%	1.0%	1.0%	1.0%

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

Service Block	2018-19	2019-20	2020-21	2021-22	2022-23
People and Communities (P&C)	2,197	2,659	2,673	2,673	2,673
Economy, Transport and Environment (ETE)	1,086	1,267	849	874	853
ETE (Waste Private Finance Initiative)	856	918	971	953	945
Public Health	16	19	24	24	24
Corporate and Managed Services	279	128	138	138	138
LGSS Operational	72	88	114	114	114
Total	4,506	5,079	4,769	4,776	4,747

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

Service Block	2018-19 £'000	2019-20 £'000	2020-21 £'000	2021-22 £'000	2022-23 £'000
People and Communities (P&C)	6,693	7,115	7,583	7,626	8,415
Economy, Transport and Environment (ETE)	269	265	267	265	271
Total	**6,962**	**7,380**	**7,850**	**7,891**	**8,686**

2.6 The Council is facing some cost pressures that cannot be absorbed within the base funding of services. Some of the pressures relate to costs that are associated with the introduction of new legislation and others as a direct result

of contractual commitments. These costs are included within the revenue tables considered by service committees alongside other savings proposals and priorities:

Service Block / Description	2018-19 £'000	2019-20 £'000	2020-21 £'000	2021-22 £'000	2022-23 £'000
New Pressures Arising in 18-19					
P&C: Children's Change Programme	886	0	0	0	0
P&C: Legal	400	0	0	0	0
P&C: Adoption	367	0	0	0	0
P&C: DSG Contribution to Combined Budgets	3,612	0	0	0	0
ETE: Cambridgeshire and Peterborough Minerals and Waste Local Plan	108	0	-54	-54	0
ETE: Waste PFI	1,175	0	0	0	0
ETE: Removal of P&R charges	1,200	0	0	0	0
ETE: Ely Archives Centre	0	78	0	0	0
ETE: Norwich Tech Partnership Contribution	25	0	0	0	0
ETE: Guided Busway Defects	1,100	200	-1,300	0	0
ETE: Coroner Service	95	0	0	0	0
CS: Commercial approach to contract management	340	0	0	0	0
Existing Pressures Brought Forward					
P&C: Fair Cost of Care and Placement Costs	0	1,500	2,500	1,000	0
P&C: Impact of National Living Wage on Contracts	3,770	3,761	3,277	0	0
P&C: Local Housing Allowance limits - impact on supported	0	412	595	199	0

accommodation					
P&C: Children Innovation and Development Service	50	0	0	0	0
P&C: Multi Systemic Therapy (MST)	63		0	0	0
ETE: Libraries to serve new developments	0	0	49	0	0
CS: Contract mitigation	0	2,000	0	0	0
A&I: Renewable energy - Soham	4	5	4	5	0
Professional and Management Pay Structure - combined	84	0	0	0	0
Impact of National Living Wage on CCC employee costs (combined)	18	74	174	174	174
Total	**-**	**-**	**-**	**-**	**-**

3. SUMMARY OF THE DRAFT REVENUE BUDGET

3.1 In order to balance the budget in light of the cost increases set out in the previous section and reduced Government funding, savings or additional income of £37.2m are required for 2018-19, and a total of £85m across the full five years of the Business Plan. The following table shows the total level of savings necessary for each of the next five years, the amount of savings attributed from identified savings and the residual gap for which saving or income has still to be found.:

Service Block	2018-19 £'000	2019-20 £'000	2020-21 £'000	2021-22 £'000	2022-23 £'000
Total Saving Requirement	37,169	23,614	14,221	3,862	5,951
Identified Savings	-25,433	-3,961	-2,304	-581	-278
Identified additional Income Generation	-6,196	-1,712	542	-201	-13
Residual Savings to be identified	5,540	17,941	12,459	3,080	5,660

3.2 As the table above shows there is still a significant level of savings or income to be found in order to produce a balanced budget for 2018-19. While actions are being taken to close the funding gap, as detailed below, it must be acknowledged that the proposals already identified are those with the lower risk and impact profiles and the further options being considered are those considered less certain, or with greater impact.

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

- Reviewing all the existing proposals to identify any which could be pushed further – in particular where additional investment could unlock additional savings

- Identifying whether any longer-term savings can be brought forward

- Reviewing the full list of in-year and 2018-19 pressures – developing mitigation plans wherever possible to reduce the impact of pressures on the savings requirement

- Bringing more ideas into the pipeline – this work will continue to be led across service areas - recognising that it is the responsibility of all areas of the Council to keep generating new proposals which help meet this challenge. This ongoing focus on finding new ways of working includes the new programme of 'outcomes focused reviews' which have been commissioned in priority areas; this means looking in-depth at services where it is considered further savings or opportunities for creating additional income may be possible

3.4 There are also a number of risks or assumptions which are not included in the numbers above, or accompanying tables. These will be incorporated (as required) as the Business Plan is developed and the figures can be confirmed:

- While the Business Plan includes a pressure relating to the increase in the National Living Wage, the phasing of this increase has not been confirmed. Once this is known the pressure will be updated to reflect this.

- The result of schools funding reforms, in particular the control of the Dedicated Schools Grant shifting further toward individual schools, is still under discussion and the significant current pressure will be updated as the outcome of this discussion becomes clear.

- Movement in current year pressures – Work is ongoing to manage our in-year pressures downwards however any change to the out-turn position of the Council will impact the savings requirement in 2018-19. This is particularly relevant to demand led budgets such as children in care or adult social care provision.

- Due to the level of reduction in Government grants in later years the Council did not take the multi-year settlement offered as part of the 2015 Spending Review. As such there is some uncertainty around the accuracy of our funding assumptions which will become clearer after the Government's Autumn Budget is announced on November 22nd and the Local Government Finance settlement due in mid-December.

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

3.6 This report forms part of the process set out in the Medium Term Financial Strategy whereby the Council updates, alters and refines its revenue and

capital proposals in line with new savings targets. New proposals are developed across Council to meet any additional savings requirement and all existing schemes are reviewed and updated before being presented to service committees for further review during December.

3.7 The level of savings required is based on a 2% increase in Council Tax, through levying the Adults Social Care precept in, but a 0% general Council Tax increase. It should be noted that the Government has only confirmed that ASC precept will be available up to and including 2019-20. For each 1% more or less that Council Tax is changed, the level of savings required will change by approximately +/-£2.5m.

3.8 There is currently a limit on the increase of Council Tax to 1.99%, above which approval must be sought from residents through a positive vote in a local referendum. It is estimated that the cost of holding such a referendum would be around £100k, rising to as much as £500k should the public reject the proposed tax increase (as new bills would need to be issued).

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

4. OVERVIEW OF PUBLIC HEALTH'S DRAFT REVENUE PROGRAMME

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

4.2 The transformation programme for Public Health Services over the next five years focuses on the following key themes:

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

4.3 Public Health services are funded by a ring-fenced grant from the Department of Health which currently totals £26,946K. Following a period where the level of public health grant was increased in 2013/14 and 2014/15, central government made the decision to reduce the public health grant over a five year period from 2016/17. In 2016/17 the grant to CCC was reduced by £2.3M and from 2017/18 to 2019/20 the grant is expected to reduce by approximately £0.7M per year. These are cash reductions to the grant, which do not take account of local inflation, pressures or demography.

4.4 It is important to note that public health 'inflation' as outlined under para 2.4 appears very low. The reason for this is that public health contracts with

external providers have been agreed with no inbuilt year on year uplifts for inflation or demography - therefore providers are expected to absorb wage inflation (e.g. NHS pay settlements) and other inflationary or demographic pressures through their own cost improvement programmes, and there is no direct inflationary pressure on the Council's commissioning budgets.

4.5 As noted above, transformation of the services we commission has been the main focus in developing new savings proposals for 2018/19 to meet the reduction in the national public health grant received by the Council. Therefore service transformations which support the required savings are negotiated collaboratively within existing contracts, or when the opportunity for new procurements arises. As a result of reductions to the public health grant, all areas of service have made 'cash savings' over previous years (in addition to internal cost improvement programmes to cover inflationary or demographic pressures) as outlined in Figure 1 below:

Service Category	Original Funding April 2015	Cash Saving 2016/17	Cash Saving 2017/18	% Cash Saving
Drug and alcohol services	£6269k	£289k	£100k	6.2%
Sexual Health & Contraception	£5692k	£280k	£100k	6.7%
Smoking Cessation & Tobacco Control	£1253k	£220k	£110k	26.3%
General Prevention: Obesity, Health Checks, Falls Prevention	£2465k	£125k	£101k	9.3%
Health Protection & Emergency Planning	£16k	£10k	No saving	63%
Public Mental Health	£224k	£60k	£60k reinvested	0%
Children's 0-19 Public Health Services	£9527k (indicative)	£190k	£188k	4%
Public Health Directorate staffing & Income generation	£2567k	£524k	£75k	23.2%

4.6 The public health savings proposals for 2018/19 can be summarised as follows. The full table of proposals can be found in Appendix 1 and the associated Business Cases and Community Impact Assessments are contained in Appendix 2 in draft form and these will be updated as the savings proposals develop

Drug and alcohol misuse services: Current budget £5,845k; Proposed saving £154k. *[Please note that, due to technical issues, the drug and alcohol misuse service budgets have not yet been incorporated into the Public Health opening position for 2018/19 in the attached financial tables. This will be corrected before the tables are finalised.]* Preparations are being made to take the adult Drug and Alcohol Services out to tender. Savings are proposed firstly through integration of drug and alcohol services, which are currently commissioned as separate services from the same provider. Secondly from transforming the service model to one more in line with the needs identified in the recent Drug and Alcohol misuse JSNA. Notably an aging long-term drug using population require ongoing support for physical and mental health and a focus on recovery, using cost-effective peer support models to avoid readmission to the acute drug and alcohol treatment services.

Sexual health and contraception services: Current budget £5,297k; Proposed saving £140k. There are proposals to transform aspects of the model of delivery for sexual health services, firstly through moving to online screening and postal samples for low risk patients who do not have symptoms of infection. Secondly through reviewing the 'hub and spoke' model for sexual health clinics, as many patients prefer to use the 'hubs' and there is low attendance at some 'spoke' clinics. Thirdly through providing oral contraception to low risk patients who are registered with a GP for one year only and then referring back to their GP.

Behaviour change/preventing long term conditions: Current budget £3,638k; Proposed saving: £84k It is proposed that these savings would be made within the commissioned Integrated Lifestyle and Behaviour Change Services, through efficiencies and transformation following the transfer of the CAMQUIT Stop Smoking Service to Everyone Health earlier this year, which would not affect front line services.

Children's public health services age 0-19 services: Current budget £9,200k; Proposed saving £238k Savings are proposed for the Cambridgeshire Community Services NHS Trust (CCS) Section 75 contract for Health Visiting and School Nursing - through a combination of modernisation and efficiency, including a reduction in management costs, and a move to a more targeted offer. The use of technology will enable efficiency savings - for example online training for schools, introduction of a duty desk to manage and coordinate all referrals and a text messaging service for children and young people. The proposals also include some changes to delivery approaches - and reduction in school nursing services in low risk schools where there is low take up of services. A change to skill mix for some mandated checks for low risk families receiving the universal health visiting service is also proposed. Across the service resources will be target to areas of greatest need and delivery will be needs-led and evidence based, with evaluation of the changes made.

Public health directorate staffing and non-pay budgets: Current budget £2,421k Proposed saving: £49k This will be achieved through rationalisation of posts within the Directorate.

Public Mental Health Budget efficiencies: £7k. Reduction in public mental health budget of £7k, resulting from removal of non-recurrent set up costs, spent in 2017/18. This will not result in any reductions to services.

Unidentified savings: £28k Further savings of £28k will be required to meet the savings requirement from public health grant reductions in 2018/19 and alternatives are being explored.

4.7 A financial risk associated with the savings outlined above is that the Drug and Alcohol Services procurement is scheduled for implementation in October 2018. This means that savings will only have a part year effect and some use of public health reserves is likely to be needed to cover the first half of the year. Savings would be further reduced by any delay to the procurement process. A more general risk is that a number of the proposals developed with commissioned services are transformational and innovative – therefore while they may have been trialled elsewhere with promising results, they will need ongoing local monitoring and evaluation

4.8 It is important to note that these are draft proposal at this stage, and subject to further development. The point at which proposals become the Council's Business Plan is at Full Council in February 2018.

5. NEXT STEPS

December	Service Committees will review draft proposals again, for recommendation to General Purposes Committee
December	General Purposes Committee will consider the whole draft Business Plan for the first time
January	General Purposes Committee will review the whole draft Business Plan for recommendation to Full Council
February	Full Council will consider the draft Business Plan

6. ALIGNMENT WITH CORPORATE PRIORITIES

6.1 Developing the local economy for the benefit of all

Public health services provide support to the local economy through their role in maintaining a healthy and productive workforce.

6.2 Helping people live healthy and independent lives

The purpose of public health services is to help people live healthy and independent lives at all ages.

6.3 Supporting and protecting vulnerable people

The majority of public health services include a focus on identifying and supporting children or adults who are more vulnerable to ill health and poor outcomes, as well as providing more universal preventive services.

7. SIGNIFICANT IMPLICATIONS

7.1 Resource implications

Resource implications are outlined in paras 4.3-4.6

7.2 Statutory, Legal and Risk Implications

Details of the ring-fenced public health grant are given in para 4.3. Significant risks are outlined in para 4.7.

7.3 Equality and Diversity Implications

Equality and diversity implications are considered in the Community Impact Assessments in Appendix 2.

7.4 Engagement and Communications

There has been strong engagement with provider organisations in developing these proposals, and they will be considered as part of the Council's consultation on the Business Plan.

7.5 Localism and Local Member Involvement

There are no significant implications at this stage.

7.6 Public Health Implications

The savings proposals made aim to achieve best value through public health services while minimising the risk of impact on public health outcomes.

Implications	Officer Clearance
Have the resource implications been cleared by Finance?	Yes 4 October 2017 Name of Financial Officer: Clare Andrews
Have Procurement implications been cleared?	Yes 4 October 2017 Name of Procurement Officer: Paul White
Has the impact on Statutory, Legal and Risk implications been cleared by LGSS Law?	Yes 2 October 2017 Name of Legal Officer: Fiona McMillan
Are there any Equality and Diversity implications?	Outlined in draft community impact assessments 9 October 2017 Liz Robin :
Have any engagement and communication implications been cleared by Communications?	Yes 5 October 2017 Name of Officer: Matthew Hall
Are there any Localism and Local Member involvement issues?	No 9 October 2017 Liz Robin
Have any Public Health implications been cleared by Public Health	Yes 9 October 2017 Liz Robin

Source Documents	Location
Strategic Framework	***https://cmis.cambridgeshire.gov.uk/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/182/Committee/2/Default.aspx***

Section 4 - E: Public Health

Table 3: Revenue - Overview

Budget Period: 2018-19 to 2022-23

		Detailed Plans	Outline Plans				
Ref	**Title**	**2018-19 £000**	**2019-20 £000**	**2020-21 £000**	**2021-22 £000**	**2022-23 £000**	**Description**
1	**OPENING GROSS EXPENDITURE**	**20,560**	**19,876**	**19,895**	**19,919**	**19,943**	
1.999	**REVISED OPENING GROSS EXPENDITURE**	**20,560**	**19,876**	**19,895**	**19,919**	**19,943**	
2	**INFLATION**						
E/R.2.001	Inflation	16	19	24	24	24	Forecast pressure from inflation in the Public Health Directorate, excluding inflation on any costs linked to the standard rate of inflation where the inflation rate is assumed to be 0%.
2.999	**Subtotal Inflation**	**16**	**19**	**24**	**24**	**24**	
3	**DEMOGRAPHY AND DEMAND**						
3.999	**Subtotal Demography and Demand**	**-**	**-**	**-**	**-**	**-**	
4	**PRESSURES**						
4.999	**Subtotal Pressures**	**-**	**-**	**-**	**-**	**-**	
5	**INVESTMENTS**						
5.999	**Subtotal Investments**	**-**	**-**	**-**	**-**	**-**	
6	**SAVINGS**						
	Health						
E/R.6.032	Miscellaneous Public Health Efficiencies	-7	-	-	-	-	Reduction in public mental health budget of £7k, resulting from removal of non-recurrent set up costs spent in 2017/18 for the adult 'Keep Your Head' website and the post suicide bereavement service. This saving will not result in any reductions to services.
E/R.6.033	Recommissioning Drug & Alcohol Treatment Services	-154	-	-	-	-	Savings will be secured through the re-commissioning of the Cambridgeshire Adult Drug and Alcohol Treatment Services, which will enable transformational changes. The Drug and Alcohol Treatment Services are currently commissioned as separate services but from the same provider, and the integration of drug and alcohol services through a planned formal contractual arrangement will afford efficiency savings.
E/R.6.034	Sexual Health Services - Changes to Delivery Model	-140	-	-	-	-	There are proposals to transform aspects of the model of delivery for sexual health services, firstly through moving to online screening and postal samples for low risk patients who do not have symptoms of infection. Secondly through reviewing the 'hub and spoke' model for sexual health clinics, as many patients prefer to use the 'hubs' and there is low attendance at some 'spoke' clinics. Thirdly through providing oral contraception to low risk patients who are registered with a GP for one year only and then referring back to their GP.

Section 4 - E: Public Health

Table 3: Revenue - Overview

Budget Period: 2018-19 to 2022-23

		Detailed Plans	Outline Plans				
Ref	**Title**	**2018-19 £000**	**2019-20 £000**	**2020-21 £000**	**2021-22 £000**	**2022-23 £000**	**Description**
E/R.6.035	Integrated behaviour change services - efficiencies	-84	-	-	-	-	It is proposed that these savings would be made within the commissioned Integrated Lifestyle and Behaviour Change Services, through efficiencies and transformation following the transfer of the CAMQUIT Stop Smoking Service to Everyone Health earlier this year, which would not affect front line services.
E/R.6.036	Children's 0-19 Services - School Nursing and Health Visiting	-238	-	-	-	-	Savings are proposed for the Cambridgeshire Community Services Section 75 (contract) for Health Visiting and School Nursing - through a combination of modernisation and efficiency, including a reduction in management costs and a move to a more targeted offer. The use of technology will enable efficiency savings - for example online training for schools, introduction of a duty desk to manage and coordinate all referrals and a text messaging service for children and young people. The proposals also include some changes to delivery approaches and a reduction in school nursing services in low risk schools where there is little take up of services. A change to skill mix for some mandated checks for low risk families receiving the universal health visiting service is also proposed. Across the service resources will be targeted to areas of greatest need and delivery will be needs-led and evidenced based. The reduction in spend proposed of £238k is from a total annual contract value of £8,760k, which is a 2.7% reduction.
E/R.6.037	Public Health Directorate - In house staff rationalisation	-49	-	-	-	-	This will be achieved through rationalisation of posts within the directorate.
E/R.6.038	Unidentified Public Health Savings	-28	-	-	-	-	Work is ongoing to identify a further £28k of savings from public health grant funded services, to deliver against the 2018/19 reduction in the national ring-fenced public health grant.
6.999	**Subtotal Savings**	**-700**	**-**	**-**	**-**	**-**	
	TOTAL GROSS EXPENDITURE	**19,876**	**19,895**	**19,919**	**19,943**	**19,967**	
7	**FEES, CHARGES & RING-FENCED GRANTS**						
E/R.7.001	Previous year's fees, charges & ring-fenced grants	-20,360	-19,665	-312	-313	-314	Fees and charges expected to be received for services provided and Public Health ring-fenced grant from Government.
	Changes to fees & charges						
E/R.7.101	Fess and Charges Inflation	-1	-1	-1	-1	-1	Inflation on external income.
	Changes to ring-fenced grants						
E/R.7.201	Change in Public Health Grant	696	19,354	-	-	-	Grant reductions announced in the comprehensive spending review, and removal of the ring-fence in 2019-20
7.999	**Subtotal Fees, Charges & Ring-fenced Grants**	**-19,665**	**-312**	**-313**	**-314**	**-315**	

Section 4 - E: Public Health

Table 3: Revenue - Overview

Budget Period: 2018-19 to 2022-23

		Detailed Plans	Outline Plans				
Ref	**Title**	**2018-19 £000**	**2019-20 £000**	**2020-21 £000**	**2021-22 £000**	**2022-23 £000**	**Description**
	TOTAL NET EXPENDITURE	**211**	**19,583**	**19,606**	**19,629**	**19,652**	
FUNDING SOURCES							
8	**FUNDING OF GROSS EXPENDITURE**						
E/R.8.001	Budget Allocation	-211	-19,583	-19,606	-19,629	-19,652	Net spend funded from general grants, business rates and Council Tax.
E/R.8.101	Public Health Grant	-19,354	-	-	-	-	Direct expenditure funded from Public Health grant.
E/R.8.102	Fees & Charges	-311	-312	-313	-314	-315	Income generation (various sources).
8.999	**TOTAL FUNDING OF GROSS EXPENDITURE**	**-19,876**	**-19,895**	**-19,919**	**-19,943**	**-19,967**	

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area		Officer undertaking the assessment
Public Health		Name: Val Thomas..... Job Title: Consultant in Public Health ..... Contact details: val.thomas@cambridgshire.gov.uk ..... Date completed: 26th September 2017 ..... Date approved: .....
Service / Document / Function being assessed		
Cambridgeshire Community Services contract for Integrated Sexual Health Services		
Business Plan Proposal Number (if relevant)	E/R 6.034	

Aims and Objectives of Service / Document / Function

Integrated Sexual Health Services

The Local Authority commissions an Integrated Sexual Health and Contraception Service from Cambridgeshire Community Services. Sexual health clinics offer testing, treatment and contact tracing for people at risk of sexually transmitted infections Services are 'open access' – i.e. people can refer themselves and are entitled to be seen. They also offer the full range of contraception services. They are a mandated local authority public health service under the Health and Social Care Act (2013). The Integrated Service was commissioned in 2014 and brought together sexual health and contraception into the integrated service. The Service is delivered through a Hub and Spoke model whereby there are three hubs that offer the full range of clinical services and are Consultant led (Wisbech, Cambridge City and Huntingdon). In addition there are nurse led spoke clinics that provide less complex sexual health and contraception services.

It was commissioned to meet the following main objectives.

- Integrate sexual health and contraception services so that patients are able to address all their sexual health and contraception needs in one service and location.

- Address the health inequalities and inequities of service provision between the north and south of the county.

- Modernise the service to ensure that it is efficient and cost effective.

What is changing?

Proposed Savings

Online Asymptomatic Testing. A number of people who attend sexual health clinics do not have any symptoms i.e. they are asymptomatic and on testing are found not to have any infections. Different service models have been introduced that decrease the number of clinic attendances of people who are asymptomatic. Asymptomatic pathways can reduce long clinic waits. A number of asymptomatic pathways have been developed and introduced. This started with asymptomatic service users being asked to fill in a questionnaire and then being seen by a healthcare support worker. However now some areas are offering online screening to asymptomatic patients. For example Guys and St Thomas's clinics in London no longer accept walk-ins for asymptomatic check-ups with patients being referred for online testing. Cambridgeshire Community Services have recently started the same asymptomatic service in Norfolk. Online testing means that those who do not have any symptoms access an online home testing kit. (There has been online testing for Chlamydia for many several years in Cambridgeshire which has been accessed by many people. They only proceed to a clinic appointment if they test positive and require treatment. The online tests are free but for those who test negative the unit cost of the test is cheaper as clinic costs are not incurred. Overall clinic activity will not fall but there will be a reduction in clinic opening times and the savings will be through the associated lower staffing costs.

Reviewing the existing Spokes Clinics: The Hub and Spoke service model was established in 2015. The clinic locations were based on the tender consultation, however it became apparent that a large proportion of people prefer to access the Hubs. Often service users prefer the anonymity of accessing services out of their home area. The spokes are being continuously reviewed as in some locations numbers attending are very small and the clinics become very expensive to operate and not cost-effective. Currently activity in clinics varies and is low in some areas. The activity levels, opening hours and access to alternative provision is being reviewed. Any change in access to spoke clinics must be in areas where the GP clinics in the areas offer a full contraceptive service that may be accessed by the local community.

Transferring Ongoing Oral Contraception Follow Up Management to General Practice: Community sexual health and contraception clinics provide all types of contraception. This includes the most effective (especially for high risk groups) and cost saving form, Long Acting Reversible Contraception (LARCs) as well as oral contraception. All GP practices provide oral contraception as part of their main GMS contraception. LARCS are also commissioned from GP practices by Cambridgeshire County Council. It is proposed that the Integrated Sexual Health and Contraception Service provide women who are registered with a GP practice and are not high risk with oral contraception for one year but then they ask them to access any further oral contraception from their GPs. Women from vulnerable high risk groups would not be affected and they would be able to continue to receive all their contraception from community clinics.

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

This CIA was completed by Council Officers

What will the impact be?

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

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

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

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

Positive Impact
Those living in more rural isolated or deprived areas would benefit from having access to testing from the internet, avoiding the need to travel which may be difficult and expensive. Travel would only be necessary if treatment is required.
Negative Impact
None
Neutral Impact
Although services will be delivered in a different way the aim will be to ensure that services remain acceptable and accessible to all patients.
Issues or Opportunities that may need to be addressed
The key issues are whether clients are happy to access testing on the Internet. Although it should be noted that there has been an online chlamydia testing service that has been accessed by many people for several years in Cambridgeshire. Changes in access to clinics must be in areas where there are robust GP clinics that high risk groups would be comfortable accessing. Any change must have support from a comprehensive local consultation.

Community Cohesion

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

N/A

Version Control

Version no.	Date	Updates / amendments	Author(s)
1	11/09/17		Val Thomas

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area	Officer undertaking the assessment
Public Health	Name: Dr Raj Lakshman Job Title: Consultant in Public Health Medicine Contact details: raj.lakshman@cambridgeshire.gov.uk Date completed: 22nd September 2017 Date approved:
Service / Document / Function being assessed	
Healthy Child Programme 0-19: Health Visiting (HV), Family Nurse Partnership (FNP), School Nursing (SN)	
Business Plan Proposal Number (if relevant) E/R.6.036	

Aims and Objectives of Service / Document / Function

Public Health is responsible through the Children's Health Joint Commissioning Unit (CHJCU) for commissioning the 0-19 Healthy Child Programme (HCP) which consists of Health Visiting (0-5yrs), Family Nurse Partnership (for vulnerable teenage parents), and School Nursing (5-19yrs). Commissioning arrangements of Health Visiting and FNP transferred to the Local Authority in October 2015. School Nursing continues to be commissioned by the Local Authority since April 2013 when Public Health responsibilities transferred from the NHS to Local Authorities. Currently a Section 75 agreement is in place for Cambridgeshire Community Services NHS Trust (CCS) to deliver the service.

The Healthy Child Programme (0-19yrs) provides a framework to support collaborative work and more integrated delivery and aims to:

- help parents develop and sustain a strong bond with children
- encourage care that keeps children healthy and safe
- protect children from serious disease, through screening and immunisation
- reduce childhood obesity by promoting healthy eating and physical activity
- identify health issues early, so support can be provided in a timely manner
- make sure children are prepared for and supported in all child care, early years and education settings and especially are supported to be 'ready for to learn at two and ready for school by five.
- Identify and help children, young people and families with problems that might affect their chances later in life.

The Healthy Child programme is a universal-progressive, needs-based service delivered at 4 levels: Community, Universal, Universal Plus (single agency involvement) and Universal Partnership Plus (multi-agency involvement). All children, young people and families are offered a core programme of evidence based, early intervention and preventative health care with additional care and support for those who need it.

Health Visiting Service

Health Visitors (HV) are a workforce of specialist community public health nurses who provide evidence-based advice, support and interventions to families with children under the age of 5. Health visitors lead the delivery of the 0-5 Healthy Child Programme, the evidence-based, preventive, universal-progressive service for children in the early years of life. The work with families is needs-led to help empower parents to make decisions that affect their families' future health and wellbeing. Health visitors manage and supervise skill mix teams whilst working in partnership with other partner agencies.

The six high impact areas for the 0-5 Healthy Child Programme are

- transition to parenthood and the early years (0-5)
- maternal mental health
- breastfeeding (initiation and duration)
- healthy weight, healthy nutrition and physical activity
- managing minor illness and reducing hospital attendance and admission
- health, wellbeing and development of the child age 2– 2.5 year old review (integrated review) and support to be 'ready for school'.

The HV service uses a national service specification whereby specific elements of universal service provision are mandated for the first 5 years to ensure that there is universal coverage to a national standard format.

The five mandated universal checks are: antenatal, new birth, 6-8 wks, 1 year and 2-2.5 yrs.
Health visitors assess families' needs at the universal contacts and then work in partnership with the family to

provide a package of care and improve outcomes for the child and family.

Family Nurse Partnership
The Family Nurse Partnership (FNP) is a national preventive programme for vulnerable, young first-time mothers under 19 years of age.

It is a structured home visiting parenting programme, delivered by specially trained family nurses, from early pregnancy until the child is two years old. The family nurse and the young parent(s) commit to an average of 64 planned home visits over two and a half years. The team work in partnership with other health professionals, social care professionals and other agencies to ensure the best possible outcomes for young people, their children and families.

In 2016/17 a modelling exercise was carried out by a multi- agency team to look at the impact of reducing/stopping FNP or revising the eligibility criteria to provide FNP to the most vulnerable teenagers. The outcome and recommendation of the group was to make this a targeted provision for the most vulnerable young parents – i.e. the service is no longer available to all teenage parents but targeted to need. Those not meeting criteria would receive the universal HCP programme delivered through the health visiting service. In addition to making savings, sharing good practice including training has enhanced the interface between FNP and HCP and the offer to families. The National FNP knowledge exchange is also available to the wider HCP.

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

Further details about the 0-19 HCP can be found here:
Healthy Child Programme: Pregnancy and the first five years of life
Healthy Child Programme: From 5-19 years old
http://www.nhs.uk/conditions/pregnancy-and-baby/pages/baby-reviews.aspx

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.

Budget changes to date
When the commissioning responsibility for HV and FNP transferred over to the Local Authority in October 2015, the 2015/16 budget was **£7,593,199**. With the cut in the Public Health ring-fenced grant, £340K (4.5% reduction) savings were made over 2 years (£190K in 16/17 and £150K in 17/18), and the contract value in 2017/18 is **£7,253,199**.

The SN budget has been protected and in 2015/16 and 2016/17, the budget for school nursing was **£1,446,540**. In 2017/18 and an additional 60K investment was put into school nursing for the extension of coverage to special schools, taking the annual contract value to (4.1% increase).

Total 0-19 HCP budget for 2017/18 is **£8,759,739**. A saving proposal of £238K (2.7% reduction) would take the budget for 18/19 to **£8,521,739**.

In order to make these savings and mindful of the fact that 232Ksavings are required for 19/20 the following changes are proposed.

Health Visiting
- **Universal mandated checks at 1 year and 2-2.5 years:** It is proposed to change the way these are delivered to clinic based rather than home visits and use of lower skilled staff (e.g. nursery nurses). Home visits will only be offered for high need (Universal Partnership Plus) families.
- **Efficiency savings** by integration with Children's Centres- Child and Family hubs. Identify what can be delivered by Children's centre staff trained by CCS- e.g. school readiness. Other efficiency savings will be explored with the provider CCS.

School Nursing

- **Duty desk**: A duty desk and help line has been launched to manage and coordinate all referrals and queries into the SN service, provide one to one support and where necessary, signpost callers to appropriate services. All telephone calls are now redirected from nine locations across Cambridgeshire plus from the School Nurses' mobile phones. The duty desk is staffed by a school nurse and an administrator and is open Monday to Friday, 9.30am to 4pm term time. During the recent summer holidays, only emails were responded to, and not telephone calls. It is planned to keep the duty desk open for phone calls on reduced hours during school holidays in the future.
- **Chat Health**: Chat Health is a confidential texting service for young people aged 11-19 years. It guarantees swift access to a school nurse, during normal working hours, for signposting, advice and / or booking into an appointment clinic, as appropriate. Out of working hours, signposting advice is given particularly in relation to safeguarding. This scheme has been successfully implemented in different areas of the UK and a pilot in East Cambs and Fenland has been completed. The aim is to continue to build on the service in East Cambs and Fenland and to introduce this service to the whole of Cambridgeshire.
- **Emotional Health and Wellbeing**: Contract monitoring information suggests that schools nurses spend a high proportion of their time supporting children with emotional health and wellbeing issues. There has been significant investment into the provision of emotional health and wellbeing services, particularly as a result of the transformation of Child and Adolescent Mental Health Services (CAMHS). Self-help is promoted through a website developed by the public health team (www.keep-your-head.com) and is intended to be used as the local 'go to' site for all matters regarding emotional health and wellbeing for children and young people. Six new Emotional Health and Wellbeing posts have been created to work with local services, such as schools and primary care services, to provide advice, consultation, training, and support in order to build skills and confidence in those working with children and young people with mental health problems. They will work closely with the Local Authority Early Help teams and be based in the districts. A drop-in service has been set up in Huntingdon and on-line counselling services have been commissioned (www.kooth.com). In addition, there has also been a recent invitation to tender for counselling services across Peterborough and Cambridgeshire, which will commence delivery from January 2018. These new services will reduce the pressure on the school nurse provision, and provide a more integrated offer for schools across the county.
- **On-line medicines management** guidance for primary and secondary schools: Traditionally, Medicines Management was carried out by school nurses at each school regarding management of 4 chronic/acute conditions (epilepsy, anaphylaxis, asthma, diabetes). The new on-line service offers a consistent, evidence-based model, which is convenient for schools since teachers can complete it at their convenience and reduces demand on school nurse time.
- **Nocturnal Enuresis**: As part of the Children and Maternity Sustainability Transformation Partnership (STP), pathways are being developed for the management of children with incontinence in the community. A clear pathway has been now been put in place for management of nocturnal enuresis so that children who do not need any dietary, behaviour or alarm support and only need medication are no longer seen by the school nursing service.
- **Safeguarding:** School nurses used to spend a lot of their time attending child protection conferences where there were no health concerns and the child/family were not known to the service. Working with the CCG designated nurse and CCS safeguarding lead, clear and consistent guidance has been agreed ensuring that the needs of children and young people are placed at the centre and that the school nurses comply with safeguarding requirement.
- **Targeted support for areas of greater need**: Rather than having a named school nurse for every secondary school and its feeder primary schools, the service will be targeted to areas of most need based on the Child Poverty Index (Income Deprivation Affecting Children Index (IDACI)). These schools have been identified by the County Council Business Intelligence and Public health teams and a discussion with CCS will be had on which of the 31 secondary schools and feeder primary schools will be prioritised. CCS plan to introduce an allocated time for each school to identify local health needs so that they are able to plan individual PSHE sessions and / or offer themed drop in sessions where young people can drop in to get a range of health support - including advice and guidance on sexual health and contraception, drug and alcohol issues, emotional health and wellbeing and weight management.

Integrated 0-19 service: In order to maintain a high quality service, with a shrinking resource and increasing demand, the long term plan is for an integrated 0-19 service including a range of provision- healthy child programme, children's centers, specialist therapy services, such as speech and language therapy, occupational therapy, physiotherapy, and CAMH. Transformation work with Cambridge shire and Peterborough Foundation Trust (CPFT) and Children's Centers to develop an integrated service offer is currently underway**.**

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

Janet Dullaghan (Head of Commissioning CHJCU), Pam Setterfield (Commissioner CHJCU), Nicola Maclean (Children and Young People's Service Lead CCS), John Peberdy (Service Director - Children and Young People's Health Services CCS), Fleur Seekins (Clinical Lead Healthy Child Programme- CCS)

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

We are still following the principles of Proportionate (or progressive) Universalism but targeting more resources to areas of high need. We are following the iTHRIVE principles which promote a needs-led approach, shared decision making, and evidence based interventions that are outcome focused.

Duty Desk: School nurses are positive about the duty desk, as they are able to contain their workload, and concentrate on planned work. This should boost morale and help with recruitment and retention of a sparse workfoce. Schools are reporting that in some cases the service is much more accessible.

A new Universal Offer to 6 Special Schools in Cambridgeshire

Introduction of digital technology i.e. Chat Health texting service will improve accessibility of the service for a greater number of young people including those who are home-schooled.

There will be a consistent offer to all schools with an enhanced offer to schools in areas of greatest need.

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

Negative Impact

There will be a reduction in the Healthy Child Programme (HCP) workforce as a result of the reduced budget. The existing funded workforce is a skill mix of 142 WTE. In order to deliver the reduction of £238k the workforce will have to reduce by the equivalent of 5.5 WTE Health visitors or 18 WTE band 6's (health visitors) skilled mixed to band 4's (nursery nurses).

Working in partnership with our provider CCS, we will evaluate the impact of these changes using qualitative and quantitative data.

Neutral Impact

The status quo will be maintained across some of the service for example FNP (which has already been reorganised), antenatal, new-birth and 6-8 week health visitor checks.

Issues or Opportunities that may need to be addressed

Detailed modelling has not yet been undertaken to validate the changes to the 1 year review and 2-2.5 year check (as described above) and whether this will make the financial savings necessary. Other measures may therefore still be required.

Sharing good practice including training will enhance the interface between FNP and HCP and the offer to families. Service improvement / redesign opportunities will be taken.

Community Cohesion

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

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

Version Control

Version no.	Date	Updates / amendments	Author(s)
1	01.09.17	First Draft	Raj Lakshman
2	04.09.17	Second Draft	Added comments from Pam & Janet
3	06.09.17	Third Draft	Added comments from John Peberdy
4	22.09.17	Fourth Draft	Added comments from PHE, Fleur Seekins and Health Committee workshop

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area	**Officer undertaking the assessment**
Public Health	Name: Val Thomas.....
Service / Document / Function being assessed	Job Title: Consultant in Public Health .....
The proposal to commission a new Adult Drugs and Alcohol Treatment Service in 2018/19 that will make efficiency and transformational changes.	Contact details: val.thomas@cambridgeshire.gov.uk Date completed: 11 September 2017 ..... Date approved:.....
Business Plan Proposal Number (if relevant) **E/R 6.033**	

Aims and Objectives of Service / Document / Function

The overall aim of the service is to provide an effective, recovery focused drug and alcohol misuse treatment service to enable clients to access appropriate and timely treatment resulting in a planned exit from treatment following cessation of drug and alcohol misuse.

The current Services offer a complete pathway through treatment to recovery. It includes

A Single Point of Contact/Advice and information/Assessment
Structured psychosocial interventions
Detoxification
Structured Day Programmes
Family Support
Supervised consumption
GP Shared Care
Support to Criminal Justice System through its Drug Interventions Programme
Harm Reduction i.e. Needle Exchange Schemes, Vaccination for Blood Bourne Viruses
Support fro recovery

The Service works with wide range of partners which includes the Constabulary, the Office of the Police and Crime Commissioner, the Probation Service, the Cambridgeshire and Peterborough Clinical Commissioning Group, Primary Care, Cambridgeshire and Peterborough NHS Foundation Trust and various housing and homelessness services. This liaison work is essential and a key objective for the Service as it reflects the diverse and complex needs of the clients.

What is changing?

The commissioning of services for drugs and alcohol will be through one contract. The Drug and Alcohol Services are currently commissioned as separate services but from the same provider. However, they have become increasingly integrated and secured savings through efficiencies created by the integration. This will become formalised through one contract and this will enable more efficiencies will secured through for example management structures, multi-skilled staff.

The Drugs and Alcohol Joint Strategic Needs Assessment that was completed in 2016 demonstrated a number of changes in the landscape of drug and alcohol misuse.

- An aging long-term drug using population that enter and re-enter the Service may have complex health and social problems, are now seen as having a long-term condition. These clients do not require intensive acute drug treatment services but more cost effective support services to ensure that they have good mental and physical health care along with their addressing their social care needs.
- Patterns of alcohol misuse have changed with it becoming less prevalent amongst young people but increasing amongst some older age groups.
- Mental health remains a key challenge in terms of ensuing that there are responsive and appropriate pathways to ensure that those with both substance misuse and mental health issues (dual diagnosis) receive the most effective treatment.
- Housing is a key challenge and very much influences prevention along with the success of treatment and recovery interventions.
- The increase in the use of prescribed drugs and other new popular recreational drugs that have implications of how the Service works and the organisations with which it is engaged.
- Drug and alcohol misuse was identified as a particular issue for vulnerable groups especially those with mental health problems, vulnerable children and young people , in particular those with parents who misuse substances and the homeless

The new Service will need to be re-focused to address these needs if the best outcomes are to be achieved. Long-term users of the services will need a less intensive acute service and their other health and social care needs will need to be addressed through working with other agencies. Similarly for vulnerable groups, those with mental and physical health and social care needs a similar approach will need to be developed building from the current arrangements. More support to recovery with further development of the peer support workers will be needed to avoid repeat admissions.

The consequence of these changes will be less activity in more costly intensive programmes, more pathways to other appropriate services, a targeted approach for vulnerable groups and strengthening recovery support service though, cost–effective interventions such as peer support workers.

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

This CIA was compiled by Council officers

What will the impact be?

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

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

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

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

Positive Impact
Older age groups who are long- term misusers of drugs or have started to increase their alcohol consumption will experience a positive impact. These groups usually require wide ranging types of health and social care support that reflect their age and health status. A key deliverable for the new Service will be to ensure that all these wider needs are part of client's treatment and recovery pathway. Those who misuse drug and alcohol very often deprived and experience unemployment, are homeless and other social issues. The new Service will be required to work effectively with commissioners and partners to ensure that these wider issues are addressed to ensure that successful treatment and recovery outcomes are achieved.
Negative Impact
None identified
Neutral Impact
The new Service will have a neutral impact of the groups identified as the services are open to all members of the community and there is no difference in the care of these groups as treatment is according to need.
Issues or Opportunities that may need to be addressed
The level and patterns of demand will be closely monitored to identify changes in prevalence and needs amongst any particular group. The main opportunity is to develop effective treatment and recovery pathways that will ensure that the entire needs essential to person's effective treatment and recovery are addressed.

Community Cohesion

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

The further development of peer recovery workers that provide community support to those recovering from drug and alcohol misuse will have a positive impact on cohesion. In addition, by working more closely with all the organisations working in communities with clients supports closer working across communities.

Version Control

Version no.	Date	Updates / amendments	Author(s)
V.1	11/09/17		Val Thomas

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area	**Officer undertaking the assessment**
Public Health	Name: Val Thomas..... Job Title: Consultant in Public Health ..... Contact details: val.thomas@cambridgeshire.gov.uk Date completed: 11 September 2017 ..... Date approved: .....
Service / Document / Function being assessed	
The proposal to make efficiency and transformational changes to the Integrated Lifestyle Service.	
Business Plan Proposal Number (if relevant) **E/R 6.035**	

Aims and Objectives of Service / Document / Function

The Integrated Lifestyle Service is provided by Sport and Leisure Limited through its Public Health Division, Everyone Health. Its overall aim is to increase the number of people who have healthy lifestyle. It is an integrated service and brings together the following services.

- Health trainers – support people for up to one year to make healthy lifestyle changes
- Three tiers of adult weight management: Tier 1 whole community interventions e.g. physical activity sessions. Tier 2 community weight management group sessions. Tier 3 Intensive weight management programme for the morbidly obese often with complex health issues
- Child Weight Management: Lifestyle programme for children and their families that provides opportunities for improving their diet and levels of physical activity.
- National Child Measurement Programme: Annual weighing and measuring of all children in reception and year 6
- Outreach NHS Health Checks: Focuses upon employers that have a large routine and manual workforce
- Behavioural Change Training for staff across the statutory and voluntary sectors to enable them to motivate their patients/clients to make healthy lifestyle changes
- Community healthy eating and physical activity interventions
- In 2017/18 the Stop Smoking Service(CAMQUIT) transferred into the Integrated Lifestyle Service.

Each service has a number of outcome deliverables for them to deliver. The service deliverables focus upon lifestyle changes that will help prevent ill health and improve the health of those already affected by an unhealthy lifestyle. The business case proposal will not affect these outcome deliverables.

The savings proposals are based on the Service developing an increased skill set amongst its staff and reflect an improved understanding of need and demand that will enable the service primarily through its management structure to produce efficiencies and transformational changes.

What is changing?

The following elements of the integrated Lifestyle Service will secure efficiencies and some transformational change. There will not be any change to the commissioned outcomes.

Consolidation of Management Tiers: The Everyone Health team operates across the whole LA area. It has a management structure that includes area managers who each have a locality co-ordinator working as their deputies. As the Service is now well established the two co-ordination posts will be removed from the structure and their functions combined with those of the locality contractors.

Stop Smoking Services (SSS)/Camquit: Currently the Service is functioning without one post through natural wastage. This has not created any capacity pressures and it is planned not to appoint to this post. At high demand periods the Health Trainers will provide Stop Smoking interventions as they are trained in behavioural change interventions.

Communications/Promotion Post: When CAMQUIT was transferred to Everyone Health the communications project officer post was vacant, but the budget was transferred with the Service. The transfer of CAMQUIT created two communications posts as Everyone Health already had a communications lead. These two posts will be consolidated and the funding that was transferred for the CAMQUIT post will contribute to the savings.

Health Coaches: The Everyone Health Coaches work in the less deprived areas undertaking a health trainer role. The different term is used to differentiate between health trainers working on the 20% most deprived areas where they are attached to GP practices. As the service has developed need and demand has become clearer. In lower need areas it is possible to consolidate two health coach posts into one.

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

What will the impact be?

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

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

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

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

Positive Impact
None identified
Negative Impact

None identified

Neutral Impact

There should not be any impact in equalities as there is no planned change in service delivery. Services are open to all members of the community. The current service has a focus upon communities where there are high rates of smoking, low levels of physical activity, high levels of unhealthy eating and high rates of obesity and consequent health inequalities. Services are weighted to ensure that they have the capacity and skills to address the challenges in these areas
.

Issues or Opportunities that may need to be addressed

The changes to the Service will need to be closely monitored to ensure that the changes do not affect performance especially if there are changes in demand.

The transfer of the Stop Smoking Services to the Integrated Lifestyle Services supports the proposals as the health trainers can provide stop smoking services in periods of high demand. Going forward increased integration between the stop smoking specialists and health trainers will provide the opportunity to develop a robust team of behavioural change specialists that could provide further efficiencies.

Community Cohesion

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

Everyone Health provides the majority of its services in community venues and sometimes peer support groups form amongst clients who have accessed the services. These groups support each other to maintain their lifestyle changes.

Version Control

Version no.	Date	Updates / amendments	Author(s)
V.1	11/09/17		Val Thomas

Business Case

Adult Integrated Drug and Alcohol Treatment Services (E/R.6.033)

Project Overview

Project Title	Adult Integrated Drug and Alcohol Treatment Services (E/R.6.033)		
Saving	£154,000	**Business Planning Reference**	E/R.6.033
Business Planning Brief Description	For savings to be secured through the re-commissioning of the Cambridgeshire Adult Drug and Alcohol Treatment services.		
Senior Responsible Officer	Val Thomas		

Project Approach

Background

Why do we need to undertake this project?

The service redesign which is currently being discussed is based on evidence from other areas which have successfully introduced new cost-effective delivery models and evidence based studies.

What would happen if we did not complete this project?

Approach

Aims / Objectives

This proposal is for savings to be secured through the re-commissioning of the Cambridgeshire Adult Drug and Alcohol Treatment Services. The Drug and Alcohol Treatment Services are currently commissioned as separate services but from the same provider. However, they have become increasingly integrated and secured savings through efficiencies created by the integration.

Investing in Drug and Alcohol Services provides cost savings to different organisations across the system including Local Authorities, Health Services and the Criminal Justice System.

Project Overview - What are we doing

The procurement affords the opportunity to deliver savings through the following areas.

- The integration of drug and alcohol services through a planned formal contractual arrangement will afford increased integration that will produce further efficiency savings.
- Adult drug and alcohol treatment services provide cost savings for different organisations providing the opportunity for joint commissioning.
- The Drugs and Alcohol Joint Strategic Needs Assessment that was completed in 2016 demonstrated a number of changes in the landscape of drug and alcohol misuse.
- An aging long-term drug using population that enter and re-enter the Service may have complex health and social problems, are now seen as having a long-term condition. These clients do not require intensive acute drug treatment services but more cost effective support services to ensure that they have good mental and physical health care along with their addressing their social care needs.
- Patterns of alcohol misuse have changed with it becoming less prevalent amongst young people but increasing amongst some older age groups.
- Mental health remains a key challenge in terms of ensuing that there are responsive and appropriate pathways to ensure that those with both substance misuse and mental health issues (dual diagnosis) receive the most effective treatment.
- Housing is a key challenge and very much influences prevention along with the success of treatment and recovery interventions.
- The increase in the use of prescribed drugs and other new popular recreational drugs that have implications for how the Service works and the organisations with which it is engaged.
- Drug and alcohol misuse was identified as a particular issue for vulnerable groups especially those with mental health

problems, vulnerable children and young people , in particular those with parents who misuse substances and the homeless

The new Service will need to be re-focused to address these needs if the best outcomes are to be achieved. Long- term users of the services will need a less intensive acute service and their other health and social care needs will need to be addressed through working with other agencies. Similarly for vulnerable groups, those with mental and physical health and social care needs a similar approach will need to be developed building from the current arrangements. More support to recovery with further development of the peer support workers will be needed to avoid repeat admissions.

The consequence of these changes will be less activity in more costly intensive programmes, more pathways to other appropriate services, a targeted approach for vulnerable groups and strengthening recovery support service though cost–effective interventions such as peer support workers.

The commissioning model will promote the delivery of improved outcomes through payments being linked to outcomes. In addition the new contract will not come into effect until the third quarter. Therefore there will be only half year savings, (required full year savings - £154k) the shortfall can either be from Public Health reserves or through ongoing contractual arrangements with the new provider.

What assumptions have you made?

The assumptions that have been made are:

- That a new model of service delivery, including increased integration, will be effective and deliver the required savings.
- That although there is a changing landscape for drug and alcohol misuse, the prevalence will remain stable.
- New drugs have come into circulation that are harmful and popular. It is assumed that any increase in demand for these would be temporary and manageable.

What constraints does the project face?

That the new service model will not be flexible enough to meet the ever changing landscape of drug and alcohol misuse. It will have to meet a range of many new types of need e.g. the misuse of prescription drugs or new popular recreational drugs.

Delivery Options

Has an options and feasibility study been undertaken?

Both the drug and alcohol contracts will end and the new tender will afford the opportunity to develop a new service model that will provide efficiencies and more effectively address the newly emerging needs.
The option of asking the current provider to find savings for the last six months of the contract was considered but not developed as it would require considerable support from the outgoing provider. Therefore no other options were considered.

Scope / Interdependencies

Scope

What is within scope?

Adult Drug and Alcohol Treatment Services

What is outside of scope?

Children and Young Peoples Drug and Alcohol Treatment Services. There is evidence that the integration of drug and alcohol services with other services is most effective when it joins with sexual health services. This will be considered when the sexual health services are re-commissioned.

Project Dependencies

Title
Internal Dependencies
External Dependencies

Cost and Savings

See accompanying financial report

Non Financial Benefits

Non Financial Benefits Summary

Title

Risks

Title

The new service model will not be flexible enough to meet the ever changing landscape of drug and alcohol misuse. It will have to meet a range of many new types of need e.g. the misuse of prescription drugs or new popular recreational drugs.

Project Impact

Community Impact Assessment

Who will be affected by this proposal?

Service users and family networks

The Service works with wide range of partners which includes the Constabulary, the Office of the Police and Crime Commissioner, the Probation Service, the Cambridgeshire and Peterborough Clinical Commissioning Group, Primary Care, Cambridgeshire and Peterborough NHS Foundation Trust and various housing and homelessness services. This liaison work is essential and a key objective for the Service as it reflects the diverse and complex needs of the clients.

What positive impacts are anticipated from this proposal?

Older age groups who are long- term misusers of drugs or have started to increase their alcohol consumption will experience a positive impact. These groups usually require wide ranging types of health and social care support that reflect their age and health status. A key deliverable for the new Service will be to ensure that all these wider needs are part of client's treatment and recovery pathway.

Those who misuse drug and alcohol are very often deprived and experience unemployment, are homeless and other social issues. The new Service will be required to work effectively with commissioners and partners to ensure that these wider issues are addressed to ensure that successful treatment and recovery outcomes are achieved.

The further development of peer recovery workers that provide community support to those recovering from drug and alcohol misuse will have a positive impact on cohesion.

In addition, working more closely with all the organisations working in communities with clients will support closer working across communities.

What negative impacts are anticipated from this proposal?

None identified

Are there other impacts which are more neutral?

The new Service will have a neutral impact of the groups identified as the services are open to all members of the community and there is no difference in the care of these groups as treatment is according to need.

Disproportionate impacts on specific groups with protected characteristics

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

Business Case

BP - Lifestyle Services (E/R.6.035)

Project Overview

Project Title	BP - Lifestyle Services (E/R.6.035)		
Saving	£84,000	**Business Planning Reference**	E/R.6.035
Business Planning Brief Description	Work with Everyone Health the current service provider to make savings within the contract. This would include rationalisation of management tiers and some consolidation of posts following transfer of the CAMQUIT service into Everyone Health.		
Senior Responsible Officer	Val Thomas		

Project Approach

Background

Why do we need to undertake this project?

The transfer of the Stop Smoking Service, CAMQUIT has created savings through consolidation and increased efficiencies. For example during periods of high demand the Health Trainers can support the service Stop Smoking interventions. In addition, the vacant CAMQUIT communications post will not be recruited to as this would create two similar posts within the Everyone Health Service.

This supports the following outcomes:

- Healthy Lifestyle Outcome Priority. The Lifestyle Services play a key role in supporting people to improve their lifestyles The Cambridgeshire economy prospers to the benefit of all Cambridgeshire residents. Stopping Smoking, Weight Management and community physical activity programmes contribute to workforce health. Smoking and obesity are amongst the biggest causes of long term health conditions that affect productivity

What would happen if we did not complete this project?

We would not be able to deliver these savings.

Approach

Aims / Objectives

The savings will focus upon efficiencies and some transformational change with no change in commissioned outcomes.

The Integrated Lifestyle Service is provided by Sport and Leisure Limited through its Public Health Division, Everyone Health. The overall aim of the service is to increase the number of people who lead a healthy lifestyle. It is in an integrated service that includes health trainers, the three tiers of adult weight management, children's weight management, community based lifestyle programmes, the National Child Measurement Programme, outreach NHS Health Checks, Behavioral Change training and in 2017/18 the Stop Smoking Service(CAMQUIT) transferred to Service. The areas that have been proposed for contributing to the savings target are as follows and reflect improved understanding of need and demand that enables the service to produce efficiencies and transformational changes.

Project Overview - What are we doing

The Integrated Lifestyle Service is provided by Sport and Leisure Limited through its Public Health Division, Everyone Health. Its overall aim is to increase the number of people who have healthy lifestyle. It is an integrated service and brings together the following services.

- Health trainers – support people for up to one year to make healthy lifestyle changes
- Three tiers of adult weight management: Tier 1 whole community interventions e.g. physical activity sessions. Tier 2 community weight management group sessions. Tier 3 Intensive weight management programme for the morbidly obese

often with complex health issues
- Child Weight Management: Lifestyle programme for children and their families that provides opportunities for improving their diet and levels of physical activity.
- National Child Measurement Programme: Annual weighing and measuring of all children in reception and year 6
- Outreach NHS Health Checks: Focuses upon employers that have a large routine and manual workforce
- Behavioral Change Training for staff across the statutory and voluntary sectors to enable them to motivate their patients/clients to make healthy lifestyle changes
- Community healthy eating and physical activity interventions
- In 2017/18 the Stop Smoking Service (CAMQUIT) transferred into the Integrated Lifestyle Service.

Each service has a number of outcome deliverables for them to deliver. The service deliverables focus upon lifestyle changes that will help prevent ill health and improve the health of those already affected by an unhealthy lifestyle. The business case proposal will not affect these outcome deliverables.

The savings proposals are based on the Service developing an increased skill set amongst its staff and reflect an improved understanding of need and demand that will enable the service primarily through its management structure to produce efficiencies and transformational changes.

Consolidation of Management Tiers: The Everyone Health team operates across the whole LA area. It has a management structure that includes area managers who each have a locality co-ordinator working as their deputies. As the Service is now well established the two co-ordination posts will be removed from the structure and their functions combined with those of the locality managers.

Stop Smoking Services (SSS)/Camquit: Currently the Service is functioning without one post through natural wastage. This has not created any capacity pressures and it is planned not to appoint to this post. At high demand periods the Health Trainers can provide Stop Smoking interventions as they are trained in behavioral change interventions.

Communications/Promotion Post: When CAMQUIT was transferred to Everyone Health the communications project officer post was vacant, but the budget was transferred with the Service. The transfer of CAMQUIT created two communication posts as Everyone Health already has a communications lead. These two posts will be consolidated and the funding that was transferred for the CAMQUIT post will contribute to the savings.

Health Coaches: The Everyone Health Coaches work in the less deprived areas undertaking a health trainer role. The different term is used to differentiate between health trainers working on the 20% most deprived areas where they are attached to GP practices. As the service has developed and need and demand has become clearer, it is possible in lower need areas to consolidate two health coach posts in to one.

What assumptions have you made?

Managers in the Lifestyle Service have developed the Service to a point where tiers of management can be consolidated without undermining delivery of the Service.

Health Trainers who are trained to deliver lifestyle interventions will be able to deliver the same quality of service as the experienced CAMQUIT team.

One communications post can support the whole Service.

Service users will be able to access the same service as the savings will not affect service delivery to clients in anyway. Therefore a consultation will not be undertaken.

What constraints does the project face?

Delivery Options

Has an options and feasibility study been undertaken?

The Integrated Lifestyle Service has been commissioned from June 2015. During this period a greater understanding of needs and demand has led to the ongoing development of the Service. Part of this development has enabled efficiencies to be identified. The efficiencies that were identified for this business case are those that most support ongoing development of the service. Therefore no other options were considered.

Scope / Interdependencies

Scope

What is within scope?

Particular services included in the Integrated Lifestyle Service i.e. Stop Smoking and health Coaches services along with management staffing efficiencies.

What is outside of scope?

The proposal does not affect health trainers, adult and children's weight management services, National Child Measurement Programme, outreach NHS Health Checks, behavioral change training and community lifestyle services. Although indirectly they will affected by the general management changes.

Project Dependencies

Title

Cost and Savings

See accompanying financial report

Non Financial Benefits

Non Financial Benefits Summary

Title

Risks

Title

Increased demand

Project Impact

Community Impact Assessment

Who will be affected by this proposal?

No planned change in Service Delivery

What positive impacts are anticipated from this proposal?

None identified

What negative impacts are anticipated from this proposal?

None identified

Are there other impacts which are more neutral?

There should not be any impact in equalities as there is no planned change in service delivery. Services are open to all members of the community. The current service has a focus upon communities where there are high rates of smoking, low levels of physical activity, high levels of unhealthy eating and high rates of obesity and consequent health inequalities. Services are weighted to ensure that they have the capacity and skills to address the challenges in these areas

Disproportionate impacts on specific groups with protected characteristics

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

Business Case

BP - Public Health - Children's 0-19 Service (E/R.6.036)

Project Overview

Project Title	BP - Public Health - Children's 0-19 Service (E/R.6.036)		
Saving	£238,000	**Business Planning Reference**	E/R.6.036
Business Planning Brief Description	Saving will be delivered through a reduction to the CCS Section 75 (contract) value for Health Visiting and School Nursing.		
Senior Responsible Officer	Val Thomas and Raj Lakshman		

Project Approach

Background

Why do we need to undertake this project?

Budget changes to date

When the commissioning responsibility for Health Visiting (HV) and Family Nurse Partnership (FNP) transferred over to the Local Authority in October 2015, the 2015/16 budget was £7,593,199. With the cut in the Public Health ring-fenced grant, £340K (4.5% reduction) savings were made over 2 years (£190K in 16/17 and £150K in 17/18), and the contract value in 2017/18 is £7,253,199.

The School Nursing (SN) budget has been protected and in 2015/16 and 2016/17, the budget for school nursing was £1,446,540. In 2017/18 and an additional 60K investment was put into school nursing for the extension of coverage to special schools, taking the annual contract value to £1,506,540 (4.1% increase).

Total 0-19 Healthy Child Programme (HCP) budget for 2017/18 is £8,759,739. A saving proposal of £238K (2.7% reduction) would take the budget for 18/19 to £8,529,739.

In order to make these savings and mindful of the fact that 232Ksavings are required for 19/20 the following changes are proposed to School Nursing and Health Visitors.

What would happen if we did not complete this project?

Approach

Aims / Objectives

Saving will be delivered through a reduction to the Cambridgeshire Community Services (CCS) Section 75 (contract) value for Health Visiting and School Nursing.

Project Overview - What are we doing

Health Visiting

- **Universal mandated checks at 1 year and 2-2.5 years:** It is proposed to change the way these are delivered to clinic based rather than home visits and use of lower skilled staff (e.g. nursery nurses). Home visits will only be offered for high need (Universal Partnership Plus) families.
- **Efficiency savings** by integration with Children's Centres- Child and Family hubs. Identify what can be delivered by Children's Centre staff trained by CCS- e.g. school readiness.

School Nursing

- **Duty desk**: A duty desk and help line has been launched to manage and coordinate all referrals and queries into the SN service, provide one to one support and where necessary, signpost callers to appropriate services. All telephone calls are now redirected from nine locations across Cambridgeshire plus from the School Nurses' mobile phones. The duty desk is staffed by a school nurse and an administrator and is open Monday to Friday,

9.30am to 4pm term time. During the recent summer holidays, only emails were responded to, and not telephone calls. It is planned to keep the duty desk open for phone calls on reduced hours during school holidays in the future.

- **Chat Health**: Chat Health is a confidential texting service for young people aged 11-19 years. It guarantees swift access to a school nurse, during normal working hours, for signposting, advice and / or booking into an appointment clinic, as appropriate. Out of working hours, signposting advice is given particularly in relation to safeguarding. This scheme has been successfully implemented in different areas of the UK and a pilot in East Cambs and Fenland has been completed. The aim is to continue to build on the service in East Cambs and Fenland and to introduce this service to the whole of Cambridgeshire.
- **Emotional Health and Wellbeing**: Contract monitoring information suggests that schools nurses spend a high proportion of their time supporting children with emotional health and wellbeing issues. There has been significant investment into the provision of emotional health and wellbeing services, particularly as a result of the transformation of Child and Adolescent Mental Health Services (CAMHS). Self-help is promoted through a website developed by the public health team (www.keep-your-head.com) and is intended to be used as the local 'go to' site for all matters regarding emotional health and wellbeing for children and young people. Six new Emotional Health and Wellbeing posts have been created to work with local services, such as schools and primary care services, to provide advice, consultation, training, and support in order to build skills and confidence in those working with children and young people with mental health problems. They will work closely with the Local Authority Early Help teams and be based in the districts. A drop-in service has been set up in Huntingdon and on-line counselling services have been commissioned (www.kooth.com). In addition, there has also been a recent invitation to tender for counselling services across Peterborough and Cambridgeshire, which will commence delivery from January 2018. These new services will reduce the pressure on the school nurse provision, and provide a more integrated offer for schools across the county.
- **On-line medicines management** guidance for primary and secondary schools: Traditionally, Medicines Management was carried out by school nurses at each school regarding management of 4 chronic/acute conditions (epilepsy, anaphylaxis, asthma, diabetes). The new on-line service offers a consistent, evidence-based model, which is convenient for schools since teachers can complete it at their convenience and reduces demand on school nurse time.
- **Nocturnal Enuresis**: As part of the Children and Maternity Sustainability Transformation Partnership (STP), pathways are being developed for the management of children with incontinence in the community. A clear pathway has been now been put in place for management of nocturnal enuresis so that children who do not need any dietary, behavior or alarm support and only need medication are no longer seen by the school nursing service.
- **Safeguarding:** School nurses used to spend a lot of their time attending child protection conferences where there were no health concerns and the child/family were not known to the service. Working with the CCG designated nurse and CCS safeguarding lead, clear and consistent guidance has been agreed ensuring that the needs of children and young people are placed at the centre and that the school nurses comply with safeguarding requirement.

What assumptions have you made?

What constraints does the project face?

Delivery Options

Has an options and feasibility study been undertaken?

No other options considered as the major portion of the rest of the 0-19 budget goes towards the counselling service which has recently been retendered and via a Memorandum of Understanding to Children's Centres.

The most cost-effective way of making the savings have been explored with the provider Cambridgeshire Community Services (CCS) and changing the way the mandated 2-2.5 year checks are done is the is likely to have the least impact on outcomes for children.

Scope / Interdependencies

Scope

What is within scope?

Health Visiting and School Nursing

What is outside of scope?

Family Nurse Partnership as savings have already been made in previous years.

Project Dependencies

Title

Cost and Savings

See accompanying financial report

Non Financial Benefits

Non Financial Benefits Summary

Title

Risks

Title

Possible emerging problems not identified

Lack of detailed modelling means may not reach saving target

Project Impact

Community Impact Assessment

Who will be affected by this proposal?

Users of the School Nursing service and Health Visitors.

What positive impacts are anticipated from this proposal?

We are still following the principles of Proportionate (or progressive) Universalism but targeting more resources to areas of high need. We are following the iTHRIVE principles which promote a needs-led approach, shared decision making, and evidence based interventions that are outcome focused.

Duty Desk: School nurses are positive about the duty desk, as they are able to contain their workload, and concentrate on planned work. This should boost morale and help with recruitment and retention of a sparse workforce. Schools are reporting that in some cases the service is much more accessible.

A new Universal Offer to 6 Special Schools in Cambridgeshire

Introduction of digital technology i.e. Chat Health texting service will improve accessibility of the service for a greater number of young people including those who are home-schooled.

There will be a consistent offer to all schools with an increased offer to schools in areas of greatest need.

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

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

What negative impacts are anticipated from this proposal?

If the proposal to change the 2-21/2 yr review to a questionnaire based review goes ahead, the holistic assessment of the child, family and child-parent interaction will be lost. Currently this review includes an assessment of the child's growth, promotion of healthy nutrition, oral health, physical activity, immunisations, school-readiness, accident avoidance, take up of early years education, and responding to other parental concerns. If the HV service is considered a type of screening programme to identify problems early, then some of the emerging problems in the family may be missed (e.g. domestic abuse, child overweight, subtle developmental delays).

There will be a reduction in the Healthy Child Programme (HCP) workforce as a result of the reduced budget. The existing funded

workforce is a skill mix of 142 WTE. In order to deliver the reduction of £238k the workforce will have to reduce by the equivalent of 5.5 WTE Health visitors or 18 WTE band 6's skilled mixed to band 4's.

Are there other impacts which are more neutral?

The status quo will be maintained across some of the service for example FNP (which has already been reorganised), antenatal, new-birth and 6-8 week checks.

Disproportionate impacts on specific groups with protected characteristics

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

Business Case

Sexual Health Services (E/R.6.034)

Project Overview

Project Title	Sexual Health Services (E/R.6.034)		
Saving	£140,000	**Business Planning Reference**	E/R.6.034
Business Planning Brief Description	The Local Authority commissions an Integrated Sexual Health and Contraception Service from Cambridgeshire Community Services. Sexual health clinics offer testing, treatment and contact tracing for people at risk of sexually transmitted infections. Services are 'open access' – i.e. people can refer themselves and are entitled to be seen.		
Senior Responsible Officer	Val Thomas		

Project Approach

Background

Why do we need to undertake this project?

- Integrate sexual health and contraception services so that patients are able to address all their sexual health and contraception needs in one service and location.
- Address the health inequalities and inequities of service provision between the north and south of the county.
- Modernise the service to ensure that it is efficient and cost effective.

What would happen if we did not complete this project?

Approach

Aims / Objectives

The contracts with both organisations for 2018/19 will reflect this change in activity and the savings will be available from April 2018. Please note it is planned to take the services out to joint tender in 2018/19 with Peterborough City Council. More efficiencies will be sort through the re-commissioned service.

Project Overview - What are we doing

What assumptions have you made?

Asymptomatic testing: There is an assumption that people will be willing to take a free online screen before they attend a clinic. As Cambridgeshire has in general good sexual health there could be a high level of people concerned they might have an STI but who do not test positive. There is an increasing use of the internet and technology to improve services and make them more accessible. For several years for example online chlamydia screening has been available to Cambridgeshire residents and it is increasingly a part of health care services and everyday life.
Risks: That insufficient number people access the online service. This will be mitigated through a comprehensive promotional campaign.

Decreasing the number of spoke clinics: That patients are willing to travel out of their local areas including high risk groups
Risks That high risk groups will not be able to access a service as they do not want to access their GPs or are not registered with a GP. Mitigation will be through promoting the online service and working closely with the GP practices to promote their services.

Oral Contraception: That low risk women will attend their GP practices. That GPs will be able to meet any increase in demand for oral contraception.
Risks: That women will not attend their GP practices and therefore do not access contraception. Mitigation will be through careful monitoring of request for contraception and promotion of Gap services.

What constraints does the project face?

Delivery Options

Has an options and feasibility study been undertaken?

Scope / Interdependencies

Scope

What is within scope?

Scope - Asymptomatic Testing: This proposal involves people requesting a sexually transmitted testing kit online if they do not have any symptoms of sexual transmitted infection. If the test is positive they will be treated at their local clinic
Scope - Rationalisation of Clinics: This proposal involves reviewing the demand for the spoke clinics in areas where there is low demand, access to services at local GP clinics or clients have a willingness to travel to other clinics.
Scope - Provision of oral contraception to low risk women: Provision of oral contraception to low risk women for one year with all follow up being provided by their GPs.

What is outside of scope?

Project Dependencies

Title

Internal Dependencies

External Dependencies

Cost and Savings

See accompanying financial report

Non Financial Benefits

Non Financial Benefits Summary

Title

Risks

Title

Risks

Project Impact

Community Impact Assessment

Who will be affected by this proposal?

Sexual Health and Contraception Service provide women who are registered with a GP practice and are not high risk with oral contraception for one year but then they ask them to access any further oral contraception from their GPs. Women from vulnerable high risk groups would not be affected and they would be able to continue to receive all their contraception from community clinics.

What positive impacts are anticipated from this proposal?

Those living in more rural isolated or deprived areas would benefit from having access to testing from the internet, avoiding the need to travel which may be difficult and expensive. Travel would only be necessary if treatment is required.

What negative impacts are anticipated from this proposal?

None

Are there other impacts which are more neutral?

Although services will be delivered in a different way the aim will be to ensure that services remain acceptable and accessible to all patients.

Disproportionate impacts on specific groups with protected characteristics

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

Agenda Item No: 6

PRESSURES IN THE SCHOOL NURSING SERVICES

To:	**Health Committee**
Meeting Date:	**19 October 2017**
From:	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable** *Key decision:* **No**
Purpose:	**To provide the Committee with information about the school nursing service** **The report is presented to provide Health Committee with an opportunity to comment on the school nursing services and changes to the service delivery**
Recommendation:	**The Health Committee are recommended to:** **b) Note the content of the report** **b) Support the action outlined in the report, which outlines the changes to the school nursing provision moving forward**

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

1.1 The school nursing service works across education and health, providing a link between school, home and the community. The school nursing service delivers part of the Healthy Child Programme (5 - 19), which is a universal progressive, needs based service delivered at four levels: Community; Universal; Universal Plus (single agency involvement); Universal Partnership Plus (multi agency involvement). The school nursing service is responsible for delivering a cost effective public health programme or intervention to improve health outcomes for school aged children.
This includes contributing to reducing childhood obesity, under 18 conceptions, prevalence of chlamydia, substance misuse and supporting good emotional health and wellbeing for children and young people.

1.2 School nurses are qualified and registered nurses or midwives, who may have undertaken further training to become a Specialist Community Public Health Nurse (SCPHN) and work in teams with a range of skill mix. School nurses are skilled in identifying issues and risks early and providing early intervention. The school nurses will support children and young people to enable them make healthy lifestyle choices, reach their full potential and enjoy life.

1.3 In April 2013, local authorities took on the statutory responsibility of delivering and commissioning public health services, including the school nursing services. Cambridgeshire currently commissions the service from Cambridgeshire Community Services NHS Trust (CCS), a local health provider.

2. MAIN ISSUES

2.1 In March 2017, CCS reported staffing issues, with school nursing service operating with only 60% of staff on establishment, due to staff leaving and long term sickness. Despite an ongoing recruitment drive, recruiting suitably qualified staff is a challenge. The Royal College of Nursing's publication: The Best Start: The Future of Children's Health (2017), identified workforce as a national issue. This report identified a fall in the number of full time school nurses of 16% between 2010 and 2017, whilst also identifying a rise in pupil numbers over this same period by 5%.

2.2 As a result of the staff shortages, CCS requested that some school nursing activity be reduced and commissioners consider changing the way the school nursing service is delivered to help capacity. This was agreed as a temporary measure to support the challenges in the services, with a view of continuing to review the way the school nursing service is delivered.

2.3 There were concerns at this time that some of the safeguarding responsibilities would not be able to be met, in particular, timely reports for initial case conferences and attendance at child protection conferences. Working with the CCG designated nurse and CCS safeguarding lead immediate action was taken. Guidance was agreed that ensured the school nurse input to safeguarding was consistent and clear. This offer concentrated on ensuring that the needs of children and young people are placed at the centre and that school nurses comply with safeguarding. This guidance will continue to be reviewed to ensure that needs continue to be met. A copy of this guidance is attached at Annex 1. This

prompt action has helped ensure that CCS has complied with its safeguarding responsibilities throughout this period of diminished staff numbers.

2.4 CCS also developed a detailed remedial action plan to address safeguarding issues and provide reassurance on how the challenges and risks within the school nursing service would be addressed over the next 18 months.

2.5 Current staffing:

- 15.2 Whole Time Equivalent (WTE) qualified school nurses including 2 WTE on the duty desk & 1 WTE Project Lead
- 6 WTE qualified nurses (not SCPHN trained), including 0.5 in MASH (Multi-Agency Safeguarding hub) ,
- 2.3 WTE Health Care Assistants

The total establishment numbers for the service is 35 WTE. A number of posts are filled within the school nursing service, but are not directly delivering front facing services:

- 0.5 WTE Long Term Sick
- 4.6 WTE SCPHN students in training
- 1.9 WTE Community Practice Teacher (CPT) (to support SCPHN 's in practice)

In terms of vacancies there are 4.9 WTE vacancies plus 2.5 WTE staff working but with impending retirement resulting in 7 WTE vacancies from September. One new staff member will be starting in September 2017. This means that front line delivery is at 70% of capacity.

2.6 Whilst staff vacancies are high there are also a high number of staff completing school nurse training. The training is on a part time basis, 50% of a full time equivalent post over 2 years. In order to deliver a high quality school nursing service, the team must maintain sufficient qualified Specialist Community Public Health Nurses (SCPHNs). In 2018/19 the commissioning of staff training will change, with Health Trusts themselves being responsible for the commissioning of training. Currently the training is commissioned through Public Health England. Due to the uncertainty around 2018/19 staff training, additional staff have been identified to complete training starting 2017/18. This decision was made at a time when there were a greater number of staff in the team. However, whilst the situation has now changed, reducing the number of staff on the training programme will result in the training not being viable. High numbers of staff in training will put further pressure on an already depleted team and the action plan developed takes this issue into account.

3. FUTURE PLANNING

3.1 The long term plan for the school nursing service is to be part of an integrated Cambridgeshire and Peterborough 0 - 19 service, including a range of provision; health visiting; family nurse partnership; children's centres; specialist therapy services, such as speech and language therapy, occupational therapy, physiotherapy; Child and Adolescent Mental Health Services. However, this integrated service will not be in place until April 2019. In the meantime a plan for school nursing needs to be in place.

3.2 An action plan has been developed to manage the service with the reduced workforce and CCS has introduced a number of new ways of working, including a greater use of technology to ensure the ongoing delivery of the school nursing service. Initiatives introduced include:

3.3 **Duty Desk**

The duty desk and help line was launched on 5th June 2017. The duty desk manages and coordinates all referrals and queries into the service, provides one to one support and where necessary, signposts callers to appropriate services. The school nurse referral form has been updated to reflect the presence of the duty desk and widely disseminated. Staff use specially developed algorithms based on the presenting concern, backed up by their clinical experience, to deal most effectively with queries / concerns.

The duty desk is staffed by a school nurse and administrator. It is open Monday to Friday, 9.30am to 4pm term time. During the summer holidays, emails not phone calls were responded to. It is planned to keep the duty desk open for phone calls, on reduced hours, during school holidays in the future.

All telephone calls are now redirected from nine locations across Cambridgeshire plus from the School Nurses' mobile phones.

- 467 telephone calls were received in the first three weeks of opening (Average 31 calls per day, peaking at 47)
- Over 200 emails are being received per week (40 per day)

Telephone calls are being received from parents, schools, GPs, other NHS Trusts and other professionals. This trend has continued until the start of the school holidays.

School nurses are positive about the duty desk, as they are able to contain their workload, and concentrate on planned work. Schools are reporting that in some cases the service is much more accessible.

3.4 **Medicines Management**

Traditionally, Medicines Management was carried out by school nurses at each school. The Universal Medicines Management for schools is now on line. This on line service offers a consistent, evidence based model, which is convenient for schools. Primary schools have already transitioned, and secondary schools are due to make this transition in September 2017. This has in turn reduced the demand on school nurse time in this area of work.

3.5 **Enuresis (Night time bed wetting)**

The school nursing service is commissioned to deliver nocturnal enuresis support for children aged 7 years or over requiring dietary, behaviour or enuresis alarm support. The school nursing service does not support children who are receiving medication support alone. A review of the enuresis support provided has been undertaken and cases where there is no requirement for dietary, behaviour and alarm support have been discharged back to the care of the GP. A clear pathway has been now been put in place for the management of nocturnal enuresis.

3.6 **Moving Forward**

The above initiatives have now been initiated and the action plan identifies a further range of measures that will be rolled out in the coming months to both address capacity issues, as well as ensure a consistent and transparent school offer across the county:

3.7 **Management of Duty Desk**

A robust triage process must be assured and understood by all practitioners and ensures that the limited staff resource is used effectively.

It is the plan to introduce a county wide allocation meeting once a week with school nurse and management representation. This will ensure that the more complex cases will be appropriated triaged and allocated according to need. A visible and managed waiting list will also be in place and the school nurses will work in zones to ensure an equitable countywide service.

3.9 **Recruitment and Retention**

It is essential that the service ensures ongoing recruitment to the service, as well as implementing retention initiatives, to ensure staff shortages are managed. The service is, as part of the workforce plans, looking at skill mix and identifying the roles that are required to deliver a school nursing service, and determining the qualification levels of staff able to carry out the roles.

3.10 **Chat Health**

Chat Health is a confidential texting service for young people aged 11-19. It guarantees swift access to a school nurse, during normal working hours, for signposting, advice and / or booking into an appointment clinic, as appropriate. Out of working hours, signposting advice is given particularly in relation to safeguarding. This scheme has been successfully implemented in different areas of the UK and a pilot in East Cambs and Fenland has recently been completed. The aim is to continue to build on the service in East Cambs and Fenland and to introduce this service to the whole of Cambridgeshire. Chat health is due to be launched across Cambridgeshire in October 2017.

3.11 **Direct School support including HYPAs (Health Young People Advice)**

CCS plan to introduce an allocated time for each school to identify local health needs so that they are able to plan individual PSHE sessions and / or offer themed drop in sessions. All clinics will become appointment clinics. It is expected that the majority of appointments to be booked via young people using Chat Health. GPs, schools and parents will be able to book appointments through the duty desk.

3.12 Commissioners are exploring with CCS and other key stakeholders the introduction of a HYPA model in secondary schools, a place where young people can drop in to get a range of health support - including advice and guidance on sexual health and contraception, drug and alcohol issues, emotional health and wellbeing and weight management. A range of different services may link to this provision including i-CaSH (Integrated contraception and Sexual Health), the Emotional Health and Well-being leads, drug and alcohol services and other public health services.

3.13 Contract monitoring information received for school nursing indicates that a high amount of the support requested from children and young people relate to the emotional health and wellbeing. There has been investment into the provision of emotional health and well-being, particularly as a result of the transformation of CAMHS. For example, Kooth, a free on-line counselling service providing information and support to young people aged 11 to 24 years of age, has been introduced. Keep Your Head has been launched, a young people's mental health website for young people, parents/carers, teachers and other professionals, offering a central point for good quality information on keeping well, self help and support services. There has also been a recent invitation to tender for a mental health and emotional wellbeing service across Peterborough and Cambridgeshire, which will commence delivery from January 2018. The commissioners, alongside the school nursing service, will be looking at the services now available for emotional health and wellbeing and ensuring that these services become part of a "core offer" for schools. The new services will reduce the pressure on the school nurse provision, and provide a more integrated offer for schools across the county.

3.14 SUMMARY

- The school nursing services continue to be stretched and actions need to continue to be made to consider the ongoing arrangements for the delivery of the service, including the prioritisation of recruitment and retention.

- Safeguarding continues to be a priority and protocols have been adopted and the school nursing service are following the guidance and complying with the recommendations.

- Whilst there is a longer term plan in place to develop an integrated 0 - 19 service which includes school nursing services, the school nursing service needs to deliver a robust and consistent quality service across the county. An action plan has been developed detailing key actions for transformation in the coming months. It is proposed that the commissioners will monitor this on a monthly basis, to ensure that changes are delivered.

4. ALIGNMENT WITH CORPORATE PRIORITIES

Report authors should evaluate the proposal(s) in light of their alignment with the following three Corporate Priorities.

4.1 Developing the local economy for the benefit of all

There are no significant implications for this priority.

4.2 Helping people live healthy and independent lives

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

- The role of the school nursing service is to deliver public health programmes or interventions to improve the health outcomes for school aged children. They support children and young people to make healthy lifestyle choices, enabling them to reach their full potential and enjoy life. This supports children and young people to move on to live healthy and independent lives.

4.3 Supporting and protecting vulnerable people

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

- School nurses are trained to identify the health needs of children and young people. They are skilled in working with children and young people, and whilst they offer a universal provision, will identify vulnerable children and young people and either signpost to more specialist service, or provide direct support to these children and young people.

5. SIGNIFICANT IMPLICATIONS

5.1 Resource Implications

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

- There are no finance/resource implications for CCC but the report outlines workforce and pressures on the school nursing service.

5.2 Procurement/Contractual/Council Contract Procedure Rules Implications

There are no significant implications within this category.

5.3 Statutory, Legal and Risk Implications

There are no significant implications within this category.

5.4 Equality and Diversity Implications

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

- Whilst the school nursing service is a universal service, the nurses are skilled at identifying issues and risks early amongst children and young people, assessing health needs and providing early intervention. The service will target those communities that are most in need of support, providing a progressive universal service, seeking to address health inequalities within the population.

5.5 Engagement and Communications Implications

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

- The school nursing service will continue to engage young people, families and key stakeholders such as schools and GPs in both developing and reviewing the changes in service delivery.

5.6 Localism and Local Member Involvement

There are no significant implications within this category.

5.7 Public Health Implications

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

- The school nursing service is a crucial element in delivering the Healthy Child Programme (5 - 19 years), which is a public health responsibility
- The school nursing service supports a range of public health issues:
- Anti-bullying
- promoting emotional health and wellbeing
- promoting screening and immunisations
- reducing obesity
- preventing teenage conceptions
- reducing chlamydia in young people
- reducing smoking
- reducing drug and alcohol misuse

Implications	Officer Clearance
Have the resource implications been cleared by Finance?	Yes Clare Andrews 15th September 2017.
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	Yes Paul White 14th September 2017.
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	Yes Fiona McMillian 19th September 2017.
Have the equality and diversity implications been cleared by your Service Contact?	Yes Liz Robin 15th September 2017.

Have any engagement and communication implications been cleared by Communications?	Yes Matthew Hall 28th September 2017
Have any localism and Local Member involvement issues been cleared by your Service Contact?	Yes Liz Robin 15th September 2017
Have any Public Health implications been cleared by Public Health	Yes Liz Robin 15th September 2017

Source Documents	Location
The Best Start: The Future of Children's Health Valuing School Nurses and Health Visitors in England 2017 Healthy Child Programme (5 - 19)	www.rcn.org.uk/professional-development/publications/pub-006200 www.gov.uk/government/publications/healthy-child-programme-5-to-19-years-old

ANNEX 1

School Nurses' Contribution to Child Protection, Child in Need and Team around the Child

The school nursing service will respond to requests for information about a child who is potentially at risk as soon as possible and within the same working day. The service will operate a single telephone number during office hours and school holidays for all enquiries and referrals. A minimum of 1 FTE school nurse will be available during school holiday periods.

Child Protection Conferences

The school nursing team will provide a summary report for initial child protection conferences as requested within 3 working days.

A school nurse will attend every initial child protection conference for school-aged children aged 4/5-19 providing 3 working days' notice is given. If requested, the attending school nurse will support the conference chair to identify the most appropriate health representative/s to be part of the core group and review conferences.

The school nursing team will undertake health needs assessments on children placed on child protection plans or if requested during the initial child protection conference. The only exception to this is where a child is taken into care following an initial child protection conference whereby the health needs assessment should be undertaken by the looked after children nursing team.

The health needs assessment completed by the school nurse will be undertaken with the child and family to identify any physical, mental and emotional health or wellbeing needs. The school nurse will subsequently devise an action plan to address any identified issues. The action plan will be shared with the social worker within 10 working days of the initial conference being held and therefore in time for the first core group. The continued involvement of the school nurse will be dependent upon the actions arising from the holistic health needs assessment.

Where no actions are identified for the school nurse – the school nurse will not be part of core group but should continue to receive the minutes of core group meetings and be invited review conferences. The school nurse will provide a report for the review where there is information to share. If not information that a standard letter will be sent giving apologies to the meeting. The school nurse will not attend review conferences unless they have an active role.

Where actions are identified for school nurse – the school nurse will be a member of the core group and will undertake the relevant actions and report completion to the core group and social worker. Once the school nursing actions are complete they will cease to be part of the core group but should continue to receive the minutes of core group meetings and reviews. As the school nurse role is focused on health promotion and early identification of issues there is unlikely to be an ongoing role for school nursing in a child protection plan. Accordingly, school nurses won't attend subsequent child protection plan review conferences unless the school nurse has identified there are ongoing actions for them.

If subsequent health needs or concerns arise the school nurse can be re-engaged by a written referral to the school nursing service.

Team around the Child and Child In Need meetings

A similar process applies to Child In Need and Team around the Child cases.

School nurses will attend initial CIN and TAC meetings of children on their current 'active' caseload only.

If health concerns are raised during the initial TAC/CIN then a formal referral to the School Nursing service is required. Upon receipt of a referral, the school nursing service will undertake a health needs assessment with the child and family, devise an action plan and share this with the social worker or lead professional within 10 working days of the referral being received.

No actions identified for school nurse - the school nursing service will not be part of the TAC or CIN groups but should continue to receive the minutes of meetings and reviews.

Actions identified for school nurse – the school nurse will undertake relevant actions and report completion to the social worker/lead professional. Once the school nursing actions are complete they will cease to be part of the TAC/ CIN group but should continue to receive the minutes of meetings and reviews. As the school nurse role is focused on health promotion and early identification of issues there is unlikely to be an ongoing role for school nursing in a TAC or CIN.

At any point during the TAC/CIN school nurses may be invited back in if health needs or concerns emerge.

Early Help Assessment

School nurses will undertake Early Help Assessment when they identify a child or young person with potential issues and carry out further action as appropriate (e.g. single agency referral, TAC). School nurses may act as Lead Professional for children on their 'active caseload' where they have an ongoing involvement in the child's case.

Other agencies undertaking Early Help Assessments and requiring a health assessment should make a referral to the school nurse.

Maintaining good information sharing

All school nurses will conduct a monthly review of their active CP, CIN and TAC cases on System1 and report any relevant information back to the social worker, lead professional or Multi-Agency Safeguarding Hub (MASH) as appropriate.

Dedicated school nurse clinic for child protection cases

The school nursing service will operate a monthly clinic for any children subject of a child protection plan. The clinic will offer weighing, measuring and hearing tests. The clinic will not offer health assessment or other physical examinations. Social workers requiring a health assessment should make a referral to the school nursing service for this.

Social workers are responsible for booking the child/ren onto the clinic and should ensure the child/ren are seen at the clinic **prior** to review conferences. This is to monitor and record the child/ren's growth. The school nursing service will update the child's social worker after clinic, including notification of non-attendance. Social workers will be responsible for following up non-attendance.

Agenda Item No: 7

REVIEW OF THE SMOKING HARM REDUCTION PILOT

To:	**Health Committee**
Meeting Date:	**19th October 2017**
From:	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**N/a** *Key decision:* **No**
Purpose:	**The purpose of this paper is to provide the Health Committee with the findings from the evidence based harm reduction stop smoking pilot project which aimed to enable smokers who had not been successful in stopping smoking through using the existing quit smoking model.**
Recommendation:	**The Health Committee is asked to note the findings and support the approach adopted the Sop Smoking Services.**

Officer Contact:		*Member Contact:*	
Name:	Val Thomas	Name:	Councillor Peter Hudson
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1. BACKGROUND

1.1 In September 2016 the Health Committee approved a proposal for the Stop Smoking Service, CAMQUIT to undertake a pilot harm reduction programme in Fenland, where smoking rates are the highest. There is now considerable evidence for the effectiveness and cost-effectiveness of these interventions. They have been found to increase the number of people who stop smoking from particular groups. These are smokers who find quitting smoking especially challenging and require additional support. The evidence and cost effectiveness evidence is attached for information in **Appendix 1**.

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1.2 The Health Committee supported the request to undertake a pilot and requested feedback on the findings. The pilot would run for a year and be reviewed after six months in terms of numbers accessing the pilot service. This paper presents data for the first 6 months of the pilot that is from October 2016 to April 2017.

2. MAIN ISSUES

2.1 The standard evidence based model for smoking cessation that is widely used involves setting an abrupt stop smoking date, combined with support for the next four to twelve weeks from a trained advisor and in the majority of cases the use of medicines to assist with the attempt (Nicotine Replacement Therapy (NRT). Harm reduction approaches are targeted at smokers who require an alternative approach and are used with those who may be unwilling or unable to stop in one step. They focus upon a “cut down to quit pathway”. The harm reduction pilot model offered a structured programme of cutting down with the help of support from an advisor and NRT. After a period of up to 12 weeks the current model was used with a quit date being set and the usual support available for a period of four to six weeks. Some models use a two year programme which involves the long term use of NRT. Appendix 2 lays out “abrupt” and “cut down” to quit models of stopping smoking.

2.2 The pilot adopted the following criteria for identifying the target population.

- Routine and manual, home carers and never worked/long term unemployed in Fenland to be targeted.

- Smokers from these groups who had failed to quit, who presented to or had contacted the services were offered a harm reduction approach to stopping smoking.

- If the numbers recruited were small then the offer would be made to those from the targeted groups who contacted the core service for support

2.3 These criteria were based on analysis of the profile of smokers who access the Stop Smoking Services. Population groups that had a high prevalence and/or a lower quit rate were identified as the targets for the pilot. In Cambridgeshire 51% of those who set a quit date were successful which is comparable to national quit rates but it varied with different groups and areas within the county. The harm reduction approach was therefore twofold through attracting more smokers to make a quit attempt and also increasing the success rate of those using the Services.

Routine and Manual Workers in Fenland

The most recent Public Health Outcomes Framework figures (August 2016 data for 2015) at the launch of the pilot suggested that the prevalence of smoking in Cambridgeshire had increased slightly in the previous few years, returning to a level statistically similar to the England average (16.4% v. 16.9%). The figure for the Fenland population was 26.4% which was an increase on previous years when the trend had been downwards. Smoking rates in routine and manual workers had been consistently higher than in the general population (27.2% in Cambridgeshire), and notably in Fenland where smoking rates had returned to a level worse than the average for England (39.8%).

The analysis of service activity for different groups and their quit rates are found in Table 1. It sets out the numbers accessing the service to initiate a quit attempt and the quit rates for all service users and the routine and manual groups for the county as whole and in Fenland.

Table 1: Smoking set a quit date and quitting rates in Cambridgeshire and Fenland 2015/16 (all service users & routine and manual)

	Set a quit date	Quit	% quit rate
Cambridgeshire			
All service users	4445	2261	51%
Routine and Manual	1242	651	52%
Fenland			
All service users	1021	567	56%
Routine and Manual	320	199	62%

The figures indicated that the Stop Smoking Services in 2015/16 were accessed by routine and manual smokers and this group had a higher quit rate than the average rate for Cambridgeshire.

Home Carers and Never Worked/Long Term Unemployed

The other two groups considered were home carers and never employed/long term unemployed in Fenland. These groups have poorer health outcomes and in Fenland these groups have a lower quit rate than other groups. Maintaining the health of those who are carers is an important factor in terms of demand for health and social care services.

Table 2: Smoking set a quit date and quitting rates in Cambridgeshire and Fenland 2015/16 (including home carers & never worked/long term unemployed

2015/16	Set a quit date	Quit	% quit rate
Cambridgeshire			
All service users	4445	2261	51%
Home Carers	352	162	52%
Never worked/long term unemployed	393	156	40%
Fenland	1021	567	56%
Home carers	122	56	46%
Never worked/long term	112	52	46%

unemployed			

Smokers from these three groups were accessing the services. However there was little difference between the percentage of those accessing the Stop Smoking Services in Cambridgeshire and Fenland despite the associated higher prevalence in Fenland especially amongst routine and manual groups.

Table 3: Proportion of the pilot target groups who access the Stop Smoking Services in Cambridgeshire and Fenland

	Routine and Manual	Carers	Never worked/long term unemployed
Cambridgeshire	28%	8%	7%
Fenland	31%	12%	9%

These factors determined the approach of the pilot as it suggested, given the higher prevalence or high risk of negative impacts, that there were many smokers who were not using the services. This was associated with a reluctance to adopt the abrupt stop smoking approach especially in the case of routine and manual workers who if engaged in Fenland have a high level of success in stopping smoking

2.4 The challenge of calculating the cost of introducing a harm reduction approach was identifying how many smokers would be attracted to using this type of intervention. The evidence for harm reduction does not indicate the impact of their introduction upon the numbers accessing services. Table 3 indicates the percentages and numbers of smokers in Fenland amongst the different groups in 2015.

Table4: Estimated numbers of smokers in harm reduction target groups, Fenland

Total population aged 16+, Fenland, 2015		81,756		
Target group		Routine and manual workers	Never worked / long-term unemployed	Carers
Population in target group	Percentage	44.8%	5.4%	13.2%
	Number	36,593	4,440	10,805
Smokers in target group	Prevalence	39.8%	26.4%	26.4%
	Number	14,554	1,173	2,856

Notes and sources:

Total population aged 16+ based on Office for National Statistics mid-year 2015 population estimates

Percentage of population aged 16+ from routine and manual occupations, based on NS-SeC categories 5-7, Office for National Statistics Census 2011, DC6114EW

Percentage of population aged 16+ never worked / long-term unemployed, based on NS-SeC category 8, Office for National Statistics Census 2011, DC6114EW

Percentage of population aged 16+ providing unpaid care, Office for National Statistics Census 2011, LC3304EW

Smoking prevalence taken from Public Health Outcomes Framework indicator 2.14, based on Annual Population Survey data

Smoking prevalence estimates for never worked / long-term unemployed and carers based on estimates for the general population

2.5 The above table demonstrated the challenge for Fenland in terms of the number of smokers in these groups. Surveys consistently find that a majority of smokers want to quit. In 2008, 68% of current smokers in Great Britain reported that they wanted to quit, with 22% saying

they would very much like to give up and a further 23% saying they wanted to stop "quite a lot". However, only about 30-40% of smokers attempt to quit in a year. In 2014 it was estimated that 39% of smokers attempted to quit and 19% were successful. Again in 2017 it was estimated that 34% of smokers attempted to quit and 19% were successful. Support for quitting with the help of the Stop Smoking Services increases the success rate by four but only 2-3% smokers access the services in the England per year.

2.6 In this context the preferred option for the harm reduction pilot was to focus upon those smokers from the targeted groups who had accessed the Stop Smoking Services and failed to quit smoking using the abrupt method. It is known that smokers who are motivated to quit (already accessed the Service) are more likely to be successful when trying to stop smoking. Pragmatically having clear criteria for recruitment to the pilot would make it easier for the GP practices that provide stop smoking services to implement the pilot.

2.7 The following estimated costs were used to identify the funding required for implementation. The staff and NRT costs that were current at the time were applied.

- Harm reduction cutting down £171 for support programme + £199 medication costs = £370
- Structured abrupt quit attempt £93 for the support programme + £199 medication costs = £292
- **TOTAL cost of harm reduction programme estimate for one smoker = £662**

Please note that this is not the cost per quitter as that calculation takes into account the quit rate and the marketing for the whole service.

The Stop Smoking Service data indicated that there were in 2015/16 in Fenland, 303 unsuccessful quitters with 163 from the targeted groups.

Table 5: Costs for targeted pilot for harm reduction for quitting smoking

Fenland	**Number of targeted smokers**	**Harm reduction cutting down to quit £**	**Abrupt quit attempt**	**Total cost**
Routine and manual	94	£34,780	£27,448	£62,228
Home carers	36	£13,300	£10,512	£23,812
Never worked/long term unemployed	33	£12,210	£9,636**F**	£21,846
Totals	**163**	**£60,290**	**£47,596**	**£107,886**

The cost of the abrupt quit attempt would not be an additional cost, so the additional funding for implementing the pilot was estimated to be £60,290.

2.8 Data from the pilot was analysed after the first six months and clearly demonstrated that the target population did not engage with the harm reduction approach. A total of 227 people from the targeted groups were invited to take part in the Harm Reduction pilot. All clients who registered their interest were telephoned by a trained stop smoking advisor within 48 hours. This telephone conversation further explained the programme and booked clients for an appointment at a local stop smoking clinic or to arrange a telephone consultation. Only

seven people from the routine and manual, carers and the never worked groups registered interest in taking part in the pilot. In view of this low number the invitation was extended to skilled technical or craft i.e. intermediate occupations which elicited only two more interested responses. The outcomes of those clients who registered their interest are also disappointing and are found in Table 6.

Table 6: Outcomes of clients who registered their interest in the Harm Reduction Pilot

Routine and manual, carers, never worked group:

Failed to start the programme:	4
Started the programme but did not quit	1
Quit smoking but with an abrupt quit attempt:	2
TOTAL	**7**

Intermediate group:

Failed to start the programme:	1
Quit smoking but with an abrupt quit attempt:	1
TOTAL	**2**

2.9. It is difficult to explain why the response rate was so low and the outcomes all unsuccessful. Table 7 shows the Stop Service activity for 2016/17. Overall there was little change between 2015/16 and 2016/17 in the level of activity and the numbers of quitters in each group and their success rates.

Table 7: Stop Smoking Service Activity 2015/16 and 2016/17

	Set a quit date		**Quit**		**% quit rate**	
	2015/16	**2016/17**	**2015/16**	**2016/17**	**2015/16**	**2016/17**
Cambridgeshire						
All service users	4445	4243	2261	2253	51%	53%
Routine and Manual	1242	1177	651	638	52%	54%
Home carers	352	344	162	172	46%	50%
Never worked/long term unemployed	393	386	156	146	40%	38%
Fenland	1021	1029	567	569	56%	55%
Routine and manual	320	339	199	202	62%	60%
Home carers	122	130	56	65	46%	50%
Never worked/long term unemployed	112	107	52	47	46%	44%

2.10. The 2016 smoking prevalence information shows that the overall downward trend and comparability to the England figure had been maintained. The Cambridgeshire prevalence was 15.2% and England 15.5%. The Fenland prevalence was 21.6% which was in line with the downward trend that had occurred prior to 2015. Routine and manual prevalence statistics are not available.

2.11 The Stop Smoking Services made considerable efforts to contact and engage former clients to take part in the pilot. All targeted clients received an Invitation, booklet and registration form. This invitation was followed up by a phone call two weeks after the letters were sent.

No-one attended the event launch to which all targeted clients were invited. Those who registered were called (up to 3 attempts were made) to engage them in the programme. The people that did start the programme were given an assessment appointment and follow up sessions which included all the different types of support. The target population was also expanded to include another socio-economic group but this had virtually no effect. It should also be noted that the pilot ran over a period when historically recruitment to the Service is at greatest, that is during the Stoptober campaign, post Christmas promotion and No Smoking Day campaign in March.

2.12 The intensive engagement programme along with the continued fall in prevalence and the unchanged levels of activity and numbers of quitters accessing services suggests that some smokers have found an alternative means of support to help them stopping smoking. There have been numerous reviews of the impact of e cigarettes which positively support the use of e cigarettes to support a quit attempt. A Cochrane Review in 2014 and Public Health Evidence review in 2015 both concluded that electronic cigarettes can help people to quit smoking and contributing to the decline in smoking. In April any further efforts to recruit clients to the Programme were discontinued as the efforts required and the outcomes were not considered to be cost-effective.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

The report above sets out the implications for this priority in 1.1, 2.7 and Appendix1

3.2 Helping people live healthy and independent lives

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

- Tobacco smoking is the single greatest cause of illness and premature death in England with, 78,000 deaths estimated to be attributed to smoking in 2014.
- The number of deaths attributable to smoking remains greater than the total of preventable deaths caused by obesity, alcohol, traffic accidents, illegal drugs and HIV infections combined
- Smoking kills about 754 people in Cambridgeshire each year, which is on average nearly 15 deaths every week

3.3 Supporting and protecting vulnerable people

The report above sets out the implications for this priority in paragraph

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

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

- There is robust evidence that harm reduction approaches are a cost effective intervention for reducing smoking. This is detailed in Appendix 2.
- The cost benefits vary according to the service costs and the stop smoking rates and these vary in different population groups. The outcomes of the pilot were very limited and the pilot was discontinued after 6 months as it was considered as being not cost-effective.
- Funding for implementing the pilot was from the public health grant

4.2 Statutory, legal and risk implications

- There are no significant statutory, legal and risk implications

4.3 Equality and Diversity

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

- This pilot targeted routine and manual, carers and never worked/long term unemployed smokers in Fenland.
- These groups have higher rates of smoking and can require a longer period of support to quit than smokers in other population groups.

4.4 Engagement and communication implications

- There is no significant engagement and communication implications as the smokers targeted with the intervention were those who have already accessed the services and have had a failed quit attempt.

4.5 Localism and Local Member

- There are no localism or local member issues

4.6 Public Health

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

- This has a significant public health impact. Stopping smoking is the prevention intervention which has the greatest impact on health.
- This intervention targets those groups which have a high prevalence of smoking and in general find it challenging to stop smoking.

Implications	**Officer Clearance**
Have the resource implications been cleared by Finance?	Yes 4 October 2017 Name of Financial Officer: Clare Andrews

Has the impact on Statutory, Legal and Risk implications been cleared by LGSS Law?	Yes 29 September 2017 Name of Legal Officer: Fiona McMillan
Have Procurement implications been cleared?	Yes 29 September 2017 Name of Officer: Paul White
Are there any Equality and Diversity implications?	No 4 October 2017 Name of Officer: Liz Robin
Have any engagement and communication implications been cleared by Communications?	Yes: 5 October 2017 Name of Officer: Matthew Hall
Are there any Localism and Local Member involvement issues?	No 4 October 2017 Name of Officer: Liz Robin
Have any Public Health implications been cleared by Public Health	Yes 4 October Name of Officer: Liz Robin

Source Documents	**Location**
NICE guidelines [PH45] Smoking: harm reduction	https://www.nice.org.uk/guidance/PH45
Lader D, Goddard, E. Smoking-related behaviour and attitudes. 2004.	Office for National Statistics
Smoking-related behaviour and attitudes, 2008.	Office for National Statistics
Lader D. Opinions Survey Report No. 40 Smoking-related behaviour and attitudes, 2008/09. Office for National Statistics	Office for National Statistics
McRobbie H, Bullen C, Hartmann-Boyce J, Hajek P. Electronic cigarettes for smoking cessation and reduction. The Cochrane Library, Dec. 2014.	The Cochrane Library, Dec. 2014. DOI: 10.1002/14651858.CD010216.pub2
Public Health England: E-cigarettes: an evidence update 2015	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/457102/Ecigarettes_an_evidence_update_A_report_commissioned_by_Public_Health_England_FINAL.pdf
Public Health England Health matters: smoking and quitting in England, 2015	https://www.gov.uk/government/publications/health-matters-smoking-and-quitting-in-england/smoking-and-quitting-in-england

Review of Harm Reduction Pilot for Smoking Paper to Health Committee

Appendix 1: Evidence of Effectiveness and Cost Effectiveness

1. Harm-reduction refers to any attempt to reduce the harm, psychological or physical, from smoking without complete cessation (West *et al*, In Press). NICE has outlined evidence-based harm reduction recommendations within their Public Health Guidance 45 (NICE, 2013). This guidance is supported by Public Health England (PHE), the Department of Health (DH), Action on Smoking and Health (ASH), and the National Centre for Smoking Cessation and Training (NCSCT). Interventions can involve behavioural support and medication to support quitting (Nicotine Replacement Therapy). It generally takes three forms;

    - Temporary abstinence: (e.g. longer-term in situations where smoking may not be an option such as in hospital or prison, or shorter term such as during the working day) with or without the help of medication (Nicotine Replacement Therapy –NRT) or behavioural support
    - Cut-down to quit: reducing smoking with medication (NRT) and behavioural support. (Or possibly e-cigarettes.
    - Longer term medication (NRT) used as a replacement for some or all of smoking and behavioural support

2. There is a well-established evidence base for harm reduction interventions. Although abrupt quitting remains the best option for smokers but reducing levels of smoking is able to provide some benefits.

    - Not all smokers are able, or willing to successfully quit smoking over the long term. These approaches could offer greater benefit to these heavier and more addicted smokers. It is known that people from routine and manual groups, who tend to be more dependent on nicotine, are more likely to cut down first, rather than stop 'abruptly' (Siahpush *et al*, 2010).
    - Low-level smokers (i.e. those smoking fewer than 15 cigarettes per day) have been found to have a 17% reduced mortality risk than other smokers (Doll 2004).
    - Smokers who reduce their level of tobacco intake are significantly likely to attempt a quit attempt in the near future and more likely to quit after six months

3. NICE PH 45 Guidance 2013 is underpinned by a number of economic reviews of harm reduction interventions for stopping smoking. They provide evidence that all harm reduction interventions are cost effective when compared to doing nothing. The level of cost effectiveness will depend upon the cost, duration and outcome of the intervention i.e. cut down or quit.

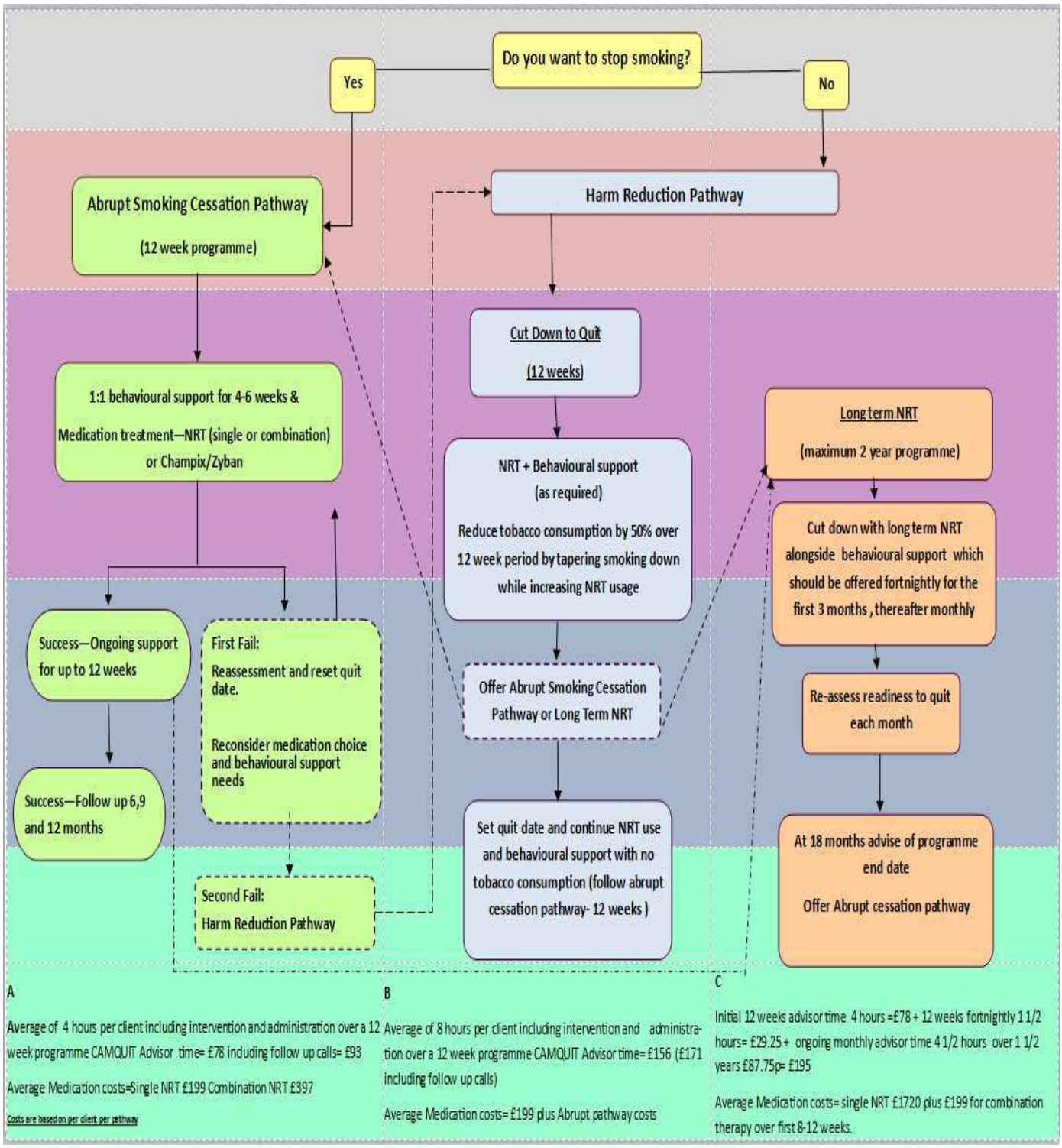
    - For interventions that lead to cutting down or quitting the cost per QALY was modelled at £437 to £8464. For temporary abstinence the cost per QALY was modelled at £765 to £8464 (Below the NICE threshhold of cost-

effectiveness of £20,000).

- Providing licensed nicotine-containing products (i.e. NRT) for a period of up to 10 years is considered a cost-effective use of resources for an intervention that achieves a quit rate of 6%, and this falls to five years for an intervention with a 4% quit rate (NICE, 2013).
- Compared with other smokers, a person aged 25 years who reduces (defined as reducing to less than 15 per day), their smoking levels will live for an additional two years and will save the NHS £882.
- A smoking intervention that achieves one additional 'reducer' aged 50 will save the NHS approximately £767 over the person's lifetime. An intervention that leads to one quitter will save the NHS £1,412 over the same period

4. Harm reduction approaches will incur an additional cost in terms of staff time and medication (NRT). Although the cost is dependent on the product price, dosage, duration of use and existing local commissioning arrangements.

Appendix 2: Stop Smoking Services Model that Incorporates Harm Reduction Interventions



Agenda Item No: 8

IMMUNISATION UPTAKE IN CAMBRIDGESHIRE ACTION PLAN

To:	**Health Committee**
Meeting Date:	**19 October 2017**
From:	**Head of Public Health Business Programmes**
Electoral division(s):	**All**
Forward Plan ref:	**N/a** *Key Decision:* **No**
Purpose:	**What is the Committee being asked to consider? The committee if being asked to receive and comment on this report.**
Recommendation:	**There are no specific recommendations, but the work shall continue as outlined in the report**

	Officer contact:		***Member contact:***
Name:	Kate Parker	Names:	Cllr Peter Hudson
Post:	Head of Public Health Business Programmes	Post:	Chairman, Health Committee
Email:	Kate.parker@cambridgeshire.gov.uk	Email:	Peter.Hudson@cambridgeshire.gov.uk
Tel:	01223 379561	Tel:	01223 706398

1. BACKGROUND

1.1 The Health committee asked to receive an updated report on the work of the Task and Finish Group that was set up to improve immunisation uptake in Cambridgeshire. While some of this work has been completed more is ongoing.

1.2 The Health committee also provided funding to improve uptake and **Appendix 2** of the attached report gives details of the specific project that was undertaken jointly, using this money, to improve Influenza immunisation uptake among pregnant women in Cambridgeshire.

2. MAIN ISSUES

2.1 Due to concern about low uptake for some vaccination programmes in Cambridgeshire, Cambridgeshire county Council, Public Health England and NHS England set up a Task and Finish Group to review the issues leading to low uptake and to develop a plan to improve uptake. The findings of the Task and Finish Group have already been reported in a paper that described the background, methodology, data findings, key themes identified as barriers to uptakes and discussion. The paper summarised the findings of the group and made recommendations for action.

2.2 Recommendations for action were made under key headings of access; health beliefs and knowledge; and data quality

2.3 This attached report provides an update on implementation of the action plan.

Public Health England

NHS England

IMMUNISATION UPTAKE IN CAMBRIDGESHIRE ACTION PLAN

Authors: Colleen Greenwood

Report: Cambridgeshire Immunisation Task and Finish Group

Date: September 2017

1. Introduction

1.1. Following concern about low uptake for some vaccination programmes in Cambridgeshire, Cambridgeshire County Council, Public Health England and NHS England set up a Steering Task and Finish Group. A paper was produced by Dr Karen Lake which outlined the findings of the Immunisation subgroup. Data was presented on Immunisation uptake in Cambridgeshire, specifically for childhood primary vaccinations and the prenatal pertussis programme for pregnant women. The paper described the background, methodology, data findings, key themes identified as barriers to uptakes, and discussion. The paper summarised the findings of the group and makes recommendations. The paper is attached.

Final report Cambs immunisation 2016.dc

2. Summary of report

2.1. The report showed that Cambridgeshire had a lower uptake than the average in East Anglia, and lower uptakes than statistical neighbouring local authorities. The pre-school booster age 5years was the lowest uptake out of all the childhood immunisations. There was significant variation in uptakes amongst Cambridgeshire practices, some practices were significant outliers.

2.2. Data was gathered from a variety of sources, to identify barriers to uptake and potential solutions, which showed some key themes emerging: Access, parent health beliefs and data quality.

2.3. Possible solutions were discussed and key recommendations are detailed below.

3. Key Recommendations

Themes	Recommendations
Improving Access to immunisations	
1.Access	1. Ensure CHIS have a robust process/procedure in place to lift suspensions on child immunisation non attendees regularly 1. Reduce waiting list, CHRD contact practices with waiting list to arrange increase in clinic capacity 2. Practices to consider opportunistic appointments for frequent non attendees, 3. Practices to consider holding clinics out of hours 4. Local Maternity providers to re consider offering prenatal pertussis vaccination programme 5. Practices [that arrange own appointments] to send text reminder to parents before appointment 6. CHIS [that arrange appointments] to send text reminders to parents
Increasing awareness and knowledge of the benefits of vaccinations	
1. Health beliefs and knowledge	8. Local Authority Health Promotion campaign that is sustainable and ongoing
Improving data quality	
5.Data Quality	9. Practices to ensure accurate GP practice list, deduct Ghost patient

	10. Practices to ensure accurate data base of eligible pregnant women
Evaluation	
6. Evaluation and Review post implementation	11. Review immunisation uptakes in 12 months following implementation of key recommendations

4. Action plan

4.1 An action plan was devised from the key recommendations and is attached as appendix 1. This has been updated regularly as a separate document whilst work is ongoing.

5. Progress to date

5.1 To date the following actions have been completed and the outcomes are as follows:

Suspensions lists. The current CHIS provider sends two appointment letters to the family for the child to attend for immunisations. If the child DNA's twice the child is suspended and is added to the GP suspension list. The GP practice is sent a list every week of their children suspended for them to chase and ensure the details are correct, the family are still in the area and have not moved and if still registered and active, to encourage an appointment for immunisation. The GP then notifies CHIS if they wish the suspension to be taken off or if the vaccination has been given.

Reduce waiting lists. The CHIS was put out to tender last year by NHSE and the tender was won by Provide, a Community Interest Company. Since Provide took over we have been working together to reduce the waiting lists at surgeries within Cambridgeshire. When Provide took over in April there were 2170 children in Cambridge on the waiting list. There are now 1300. We are currently attempting to address long waiting lists in 3 GP surgeries in Cambridgeshire. Provide are actively engaging with surgeries to reduce this waiting list further.

Work with practices. The screening and immunisation team identified the bottom performing practices within Cambridgeshire based on uptake of MMR2 and preschool booster. This amounted to 16 practices. All 16 practices were contacted with an individual report highlighting their uptake for the childhood programmes, flu, shingles and pertussis vaccination coverage. This report highlighted their uptake compared to the CCG average (or the England average for the COVER data) and provided a gap analysis, showing how many more patients would be needed to be vaccinated to achieve the set targets.

All practices were asked to engage with the screening and immunisation team to work together to look at improving uptake. Seven practices so far have requested a visit from the Screening and immunisation coordinator to look at their particular issues and possible ways to work around these. To date 3 visits have been carried out. The screening and immunisation team will then put together a document which will outline the challenges faced by the practices and any common themes.

These visits have concentrated on looking at when clinics are held, offering out of hours vaccination clinics and utilising opportunistic vaccination opportunities.

Working with acute Trusts. The screening and immunisation manager and coordinator have visited both Heads of Midwifery at the Rosie and Hinchingbrooke hospitals to discuss offering flu and pertussis vaccination to pregnant women within the maternity units. The Rosie have been making progress on this and have now requested we train their midwives in order for this to happen. They have not yet started this but are actively engaged and we believe this will commence soon. Discussions with Hinchingbrooke took place before the merger with Peterborough and Stamford Hospitals and that merger has delayed us moving this any further forward. As the vaccination is offered in Peterborough hospital in the antenatal clinic to women attending for their anomaly scan, we have asked for an equitable service to be considered in Hinchingbrooke Hospital. We are waiting to hear back from the Head of Midwifery for NWAFT regarding this.

GP & Child Health record services to ensure accurate patient/child contact details. The new CHIS provider has asked all non SystmOne practices to provide

them with details of all the under 5 children registered with them to ensure demographic details are correct and that all vaccinations given to under 5's are recorded correctly. CHIS are sending weekly suspension lists of children who have DNA'd twice for the GP to check that they are still registered with the practice and have not moved and to inform CHIS if the child has been vaccinated.

GP's ensure accurate database for pregnant women. Some of the improvement seen in the uptake of prenatal pertussis has been because of improvements in the data collections. GP surgeries are reminded to ensure that pregnant women are coded correctly and removed from coding for pregnancy if they miscarry or terminate their pregnancy.

6. Concluding report

5.1 A review of immunisation uptake will take place once all the actions and key recommendations have been implemented, comparing current uptake to that identified in the initial paper and this report will be presented to the Cambridgeshire and Peterborough Health Protection Steering Group. Work with maternity units to improve knowledge around the prenatal pertussis and pregnant women's flu vaccination programme has been ongoing for over a year and work with individual practices began in mid-2017, so improvements in uptake for the childhood immunisation programme may not be seen until Q4 2017-18. However, improvements in data quality and correction of data should show before this. The current data is presented below in Appendix 2. This shows an improvement being seen already in the uptake of childhood immunisations particularly in MMR1.

Public Health England

NHS England

Appendix 1

1. Action Plan- Improving Immunisation Uptake in Cambridgeshire- Jan 2017 Updated September 2017

No.	Recommendation	Action Required	Responsibility (whom – can be either a department, service or person)	Target Date (when by)	Progress/ Comments	Completed (Yes/No)
1	Removing potential barriers for parents/children accessing Immunisation services	1. Ensure Child Health Information System (CHIS) have a robust process/procedure in place to lift suspensions on child immunisations for non-attendees	CHIS- Provide		**Identified as an SI. Processes put in place to lift suspensions**	*Yes - completed*
		2. Reduce waiting lists- Child health records departments to contact practices with waiting lists to arrange increase in capacity or to contact Screening and	CHIS- Provide Susan Frost Screening and Immunisation Coordinator	30th Sept 17	***CHIS taken over By Provide on 1st April 2017. Currently concentrating on routine invitations but waiting lists patients identified and will be actioned in due course CHIS send reminder of***	*Commenced and ongoing*

		immunisation team to contact practices			***waiting times on clinic lists***	
		3. Practices to consider holding clinics out of school hours	Individual practices Screening and Immunisation team (SIT)	30th Sept 17	***Local Imms coordinator [SIC] to contact practices directly***	*Commenced, ongoing*
		4. Practices to consider opportunistic appointments for non-attendees	Individual practices Screening and Immunisation team	30th Sept 17	***SIT to identify individual practices with lower uptake and offer supportive visit to encourage practices to adopt initiatives that may improve uptake***	
		5. Acute Trusts who provide Maternity services to consider offering pertussis vaccinations	NHS England Colleen Greenwood	30th APRIL 2017	***Rosie and Hinchingbrook hospitals visited and HoM's engaged with offering flu and pertussis vaccinaton. Work ongoing. Rosie hospital have engaged and training of their***	*Commenced ongoing*

		6. GP's & CHIS to send text reminders to parents for appt.	GP/CHIS	30th Sept 17	***staff is about to commence.*** ***Current CHIS provider changed in April. Waiting for systems to embed before changes can be implemented.***	*Not yet started*
2	Improving Parental Knowledge regarding health beliefs	Sustainable Local Authority Health Promotion campaign	Local authority	31st Dec 2017		*NO*
3	Improving Data Quality	1. GP & Child Health record services to ensure accurate patient/child contact details	GP Practices/CHIS/Health Visitors	30th SEPT 2017	***CHIS have sent letters to practices to ask for information to update CHIS records to ensure accurate records held.***	*Commenced and ongoing*
		2. GP's to deduct Ghost patient(s)	GP practices	30th SEPT 2017		*NO*
		3. GP's ensure accurate database for pregnant women	GP practices	30th SEPT 2017	***Work has begun on this for ImmForm collection for pertussis collection and data much improved***	*Commenced and ongoing*

4	Evaluate & review data following implementation of recommendations	Review Immunisation uptakes after a 12 month period	Screening and Immunisation teams	31st January 2018		*NO*

Public Health England

NHS England

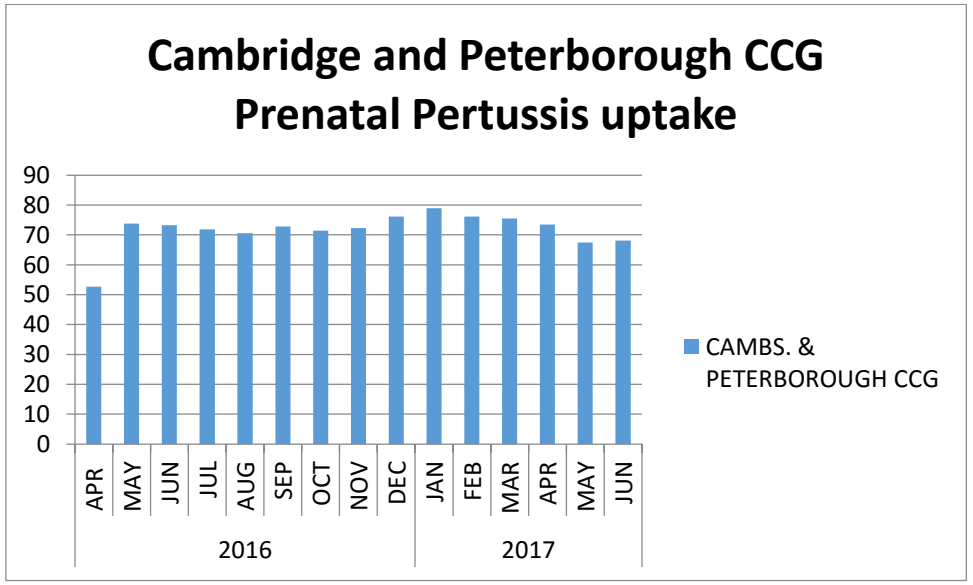
Appendix 2.

COVER data April 2015- March 2017

Source: https://www.gov.uk/government/statistics/cover-of-vaccination-evaluated-rapidly

Highlighted cells represent highest uptake achieved over 8 quarters.

				COVER Data 2015-16					COVER Data 2016-2017			
Cambridge Local Authority				Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4
Age	**Immunisations**	**Target**										
1	DTaP/IPV/Hib	95.00%		93.1	94.7	93.6	94.2		93.8	94.1	94.2	94.2
	Pneumococcal	95.00%		92.9	94.4	93.7	94.6		94.3	94.3	94.3	95.2
	Rotavirus	95.00%				87.1	88.5		87.6	89.5	87.5	89.1
	Meningitis B	95.00%								93.4	93.0	94.6
2	DTaP/IPV/Hib	95.00%		95.6	93.3	93.6	93.5		93.7	95.4	94.8	95.6
	HIB/Meningitis C	95.00%		91.9	89.4	90.2	91.0		89.6	92.0	92.7	93.0
	Pneumococcal	95.00%		91.3	90.0	90.5	90.7		89.9	92.0	92.9	93.0
	MMR Vaccination	95.00%		91.7	89.1	90.2	91.0		89.4	91.6	92.9	92.8
5	DTaP/IPV/Hib	95.00%		94.7	93.8	94.1	93.4		93.1	93.7	93.9	95.0
	DTaP/IPV booster	95.00%		85.7	85.4	86.0	84.5		82.6	82.1	84.1	86.4
	HiB/Men C booster	95.00%		91.3	90.0	90.6	89.5		87.6	88.6	90.2	92.1
	MMR 1st dose	95.00%		92.3	90.9	91.4	93.2		92.4	93.7	93.5	95.2
	MMR 2nd dose	95.00%		89.8	84.7	84.8	84.9		82.7	83.8	85.1	88.8


Cambridge and Peterborough CCG
Prenatal Pertussis uptake
90
80
70
60
50
40
30
20
10
0
APR
MAY
JUN
JUL
AUG
SEP
OCT
NOV
DEC
JAN
FEB
MAR
APR
MAY
JUN
2016
2017
CAMBS. & PETERBOROUGH CCG

Public Health England

NHS England

Appendix 3

Glossary

CHIS	Child Health Information Service - records child health data on routine health checks and immunisations and sends invitation to attend for routine health checks and immunisations
CHRD	Child Health Records Department
DNA	Did not attend, The acronym is often used as a verb in health discussions e.g. DNA'd
NHSE	NHS England
NWAFT	North West Anglia Foundation Trust. Formed by the merger of the previous Peterborough and Stamford Trust and Hinchingbrooke Hospital
PHE	Public Health England
SystmOne	A clinical computer system supplied by TPP (The Phoenix Partnership) that includes many modules including GP and child health systems

Appendix 2: A report of an intervention project to increase Influenza Vaccination uptake among pregnant women in Cambridgeshire in the 2016/17 'Flu season

Introduction

In 2016, the Cambridgeshire Health Committee made funds available to Public Health to improve vaccination uptake.

In consultation with NHSE and PHE, it was agreed that the local authority would focus on flu vaccination uptake in pregnant women. The agreed intervention was a personalised GP invitation from practices to pregnant women on their list and a follow up call, over one flu season (1 September 2016 to 31 January 2017) to improve the uptake of influenza vaccination in pregnant women. The project aimed at achieving three outcomes:-

1. To increase 2016 / 2017 influenza vaccination uptake in pregnant women by at least 15% compared to 2015/16
2. To increase odds for 2016 / 2017 influenza vaccination uptake in pregnant women
3. To achieve at least the same uptake as the highest performing statistical neighbour [local authority][1].

Financial reimbursement, calculated using on 31st January 2016 Immform data, was determined to be £2 per pregnant woman registered for practices in Group 2 and £4 per pregnant woman registered for practices in Group 3. The additional reimbursement for Group 3 was to cover resources required to make the follow up call. Cambridgeshire County Council expressed the right to reduce reimbursement for this project if there was more than 10% increase in the target population in 2016 / 17. However, the council committed to paying minimum of £1.50 per pregnant woman for Group 2 practices and £3 per pregnant woman registerd for Group 3 practices. Additionally each participating practice was offered a one-off £100 to cover set up

[1] The statistical neighbours for Cambridgeshire in order of proximity are Oxfordshire, Warwickshire, Gloucestershire, Leicestershire, Suffolk, Worcestershire, Buckinghamshire, Hampshire, Northamptonshire, Somerset, Staffordshire, Essex, North Yorkshire, Hertfordshire and West Sussex.

costs. Theoretically, a total sum of £16,000 was allocated, however, only around £6000 was claimed by the practices.

There were 7,231 pregnant women in the 75 practices (4, 131 in control group and 3,094 in one of the two intervention groups). This report provides an evaluation of the project.

Background

Influenza infection in pregnant women can lead to serious complications for the mother and unborn infant. Influenza infection can lead to still birth, to the baby being small for gestational age, and in some cases even maternal and infant death. In Cambridgeshire, in 2015-2016 only 33.1% of pregnant women had the influenza vaccine.

Method

All GP practices in Cambridgeshire (76 practices) were invited to participate in the project via NHS gateway. Based on other areas of public health initiatives, participation response was expected from 35%-40% of the practices invited. The practices self selected to one of the three groups below:-

Group 1) the practice undertook their routine intervention (control). Routine intervention was defined as their current practice and varied between practices ranging from an email / letter on the practice letterhead, to promotion of flu vaccine through leaflets and posters, and opportunistic or planned flu clinics.

Group 2) the practice sent personalised invitations by e mail, text message or letter, with a link to the Department of Health leaflet '*Pregnancy: How to help protect you and your baby'* included in the electronic communication and a hard copy of the leaflet enclosed with the letters (intervention); .

Group 3) the practice sent personalised invitations by e mail, text message or letter, with a link to the Department of Health leaflet and the practice nurse made a follow up contact by phone to the pregnant women (intervention).

A twofold analysis carried out at population level was 1) basic comparison of the odds of uptake between groups to test for association between intervention and uptake and 2) comparison of uptake before and after the intervention for each practice in the three groups to test the effectiveness of intervention on influenza vaccination uptake.

Evaluation

Although the national target of 55% was not achieved, the project satisfactorily achieved the three objectives set out at the start. The intervention increased influenza vaccination uptake in pregnant women in 2016 / 2017 by more than 15% in intervention groups, improved the odds of uptake, and also achieved the highest uptake amongst statistical neighbours.

Results show very strong evidence that the odds of receiving the vaccine is 1.5 times higher among patients of practices delivering a personalised e-mail, text or letter followed up with a phone call compared with patients of practices delivering only their routine intervention.

The third objective of this intervention study was to achieve at least the same uptake as the highest performing statistical neighbour [local authority]. With just 33.1% uptake, Cambridgeshire was one of the lowest, if not the lowest performing local authority for uptake of influenza vaccination amongst pregnant women in the year 2015/2016.

The table below provides comparative figures for flu vaccination uptake by pregnant women in general practice for a number of local authority areas (statistical neighbours for Cambridgeshire) for the past two vaccination seasons. This comparison of the provisional data at local authority level shows an increase in uptake of flu vaccination amongst pregnant women in Cambridgeshire of 15.4% from 2015-16 uptake. The

data shows Cambridgeshire had the highest increase in the proportion of uptake between 2015/16 and 2016/17. The next highest increase amongst statistical neighbours is 6.8% in West Sussex.

Local Authority	2016/17	2015/16	change	Increase / decrease
Cambridgeshire	48.5	33.1	15.4	↑
Oxfordshire	52.7	49.6	3.1	↑
Warwickshire	49.4	46.0	3.4	↑
Gloucestershire	46.7	43.9	2.8	↑
Leicestershire	48.3	47.2	1.1	↑
Suffolk	52.3	47.2	5.1	↑
Worcestershire	47.2	45.6	1.6	↑
Buckinghamshire	45.0	43.0	2.0	↑
Hampshire	50.1	47.6	2.5	↑
Northamptonshire	39.5	37.4	2.1	↑
Somerset	43.8	42.5	1.3	↑
Staffordshire	48.7	44.0	4.7	↑
Essex	40.4	37.9	2.5	↑
North Yorkshire	54.0	49.4	4.6	↑
Hertfordshire	49.0	44.9	5.9	↑
West Sussex	46.2	40.8	6.8	↑
Peterborough (for information, not used for analysis in project)	39.1	28.1	11	↑

Conclusion

If the intervention of endorsed letter or message and phone call is shown to be effective in improving influenza vaccine uptake, it can be a low cost strategy to improve the low vaccination uptake among pregnant women, which can be easily adopted in GP settings. This would also prove a cost-effective intervention, as increased influenza vaccination uptake would prevent unnecessary influenza-related

hospitalisation, excess morbidity and mortality among pregnant women and young infants. A superficial calculation from this study shows that 160 more women were vaccinated in Group 3 than was expected. The total spend for this group (theoretically, as many practices did not claim reimbursement) is £3,732 (933 * £4), which means around £23 per extra individual vaccinated.

Due to time constraints this was not run as a Randomised Controlled Trial (RCT) and therefore, whilst interpreting results one should be mindful of selection bias. The findings cannot establish that the increase in uptake of vaccination was solely an effect of the personalised invitation letter and follow up call

HEALTH COMMITTEE TRAINING PLAN	Updated October 2017	

Ref	Subject	Desired Learning Outcome/Success Measures	Priority	Date	Responsibility	Nature of training	Attendance by:	Cllrs Attending	Percentage of total
1.	***Health Committee Induction Training***	To provide the new committee members with an overview of the Health Committee's remit. To provide members with background information on the Public Health executive function of the committee and its statutory health scrutiny function.	1	14th June	Democratic Services / Public Health	Training Seminar	For new members of Heath Committee (all members welcome)	9	**Completed** 60% of full committee
2.	***Finance Training***	To provide members with a background information around the council's finance process and familiarise new members with the specific details of the Public Health Directorate budgets	2	14th July 9.30-10.45	Public health	Training seminar	All members of Health Committee	9	**Completed** 60% of full committee
3.	***Sustainable Transformation Programme*** ***Please note still awaiting confirmation from the CCG***	To provide new committee members with an overview of the Sustainable Transformation Programme	1	Nov 6th 11.30	Public Health	Scrutiny Training	All members of Health Committee		

Ref	Subject	Desired Learning Outcome/Success Measures	Priority	Date	Responsibility	Nature of training	Attendance by:	Cllrs Attending	Percentage of total
4.	***Health Committee Priorities 2017-18***	To develop and identify Public Health priority areas for the Health Committee to focus for 2017-18	1	21st July 2-4pm	Public Health	Development session	All members of Health Committee	8	**Completed** 53% of full committee
5.	***Public Health Business Planning (part 1)***	To discuss and advice on proposals for public health savings for 2018/19 as part of the councils business planning	1	22nd Sept 10-11.30 – 1pm	Public Health	Development Session	All members of Health Committee	5	**Completed** 33% of full committee
6.	***Public Health Business Planning (part 2)*** ***This may not be required***	To review final proposals for public health savings for 2018/19. Please note that this session may not be necessary and may be used for STP training.	2	Nov tbc	Public Health	Development Session	All members of Health Committee		

- In order to develop the annual committee training plan it is suggested that:
  - The relevant Executive/Corporate/Service Directors review training needs and develop an initial draft training plan;
  - The draft training plan be submitted to a meeting of the relevant committee spokesmen/women for them (in consultation with their Groups as appropriate) to identify further gaps/needs that should be addressed within the training plan;
  - The draft plan should be submitted to each meeting of the committee for their review and approval. Each committee could also be requested to reflect on its preferred medium for training (training seminars; more interactive workshops; e-learning etc and also to identify its preferred day/time slot for training events.)

Each attendee should be asked to complete a short evaluation sheet following each event in order to review the effectiveness of the training and to guide the development of future such events

HEALTH POLICY AND SERVICE COMMITTEE AGENDA PLAN	Published 2 October 2017	Cambridgeshire County Council

Notes

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

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

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

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
19/10/17	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable	06/10/17	10/10/17
	Business Planning 2018-19 (provisional)	Chris Malyon/ Liz Robin	Not applicable		
	Pressures in the school nursing services	tbc	Not applicable		
	Immunisation Task and Finish Group report	tbc	Not applicable		
	Scrutiny Item: Sustainability and Transformation Plan update [standing item]	Scott Haldane	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
	Update on pilot harm reduction project for stopping smoking	Val Thomas	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Ruth Yule	Not applicable		
	Agenda plan and appointments to outside bodies	Ruth Yule	Not applicable		
16/11/17	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable	03/11/17	07/11/17
	Business Planning 2018-19 (provisional)	Chris Malyon/ Liz Robin	Not applicable		
	Scrutiny Item: Sustainability and Transformation Plan (STP) update [standing item]	Scott Haldane	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Integrated commissioning of children's health and wellbeing services	Liz Robin	Not applicable		
	Healthy Schools Support Service	Liz Robin	2017/052		
	Delayed transfers of care from hospital	Liz Robin	Not applicable		
	Air quality in Cambridgeshire	Liz Robin	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Ruth Yule	Not applicable		
	Agenda plan and appointments to outside bodies	Ruth Yule	Not applicable		
14/12/17	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable	01/12/17	05/12/17
	Business Planning 2018-19 (provisional)	Chris Malyon/ Liz Robin	Not applicable		
	Scrutiny Item: Development of Primary Care in Northstowe	Sue Watkinson	Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
	Scrutiny Item: Sustainability and Transformation Plan (STP) update [standing item]	Scott Haldane	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Update on Relocation of Out of Hours Service	Jessica Bawden, CCG	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Ruth Yule	Not applicable		
	Agenda plan and appointments to outside bodies	Ruth Yule	Not applicable		
16/01/18	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable	03/01/18	05/01/18
	Public Health Risk Register update		Not applicable		
	Scrutiny Item: Non-Emergency Patient Transport (NEPT) Service Performance: Six Month Update	Kyle Cliff, CCG	Not applicable		
	Scrutiny Item: Sustainability and Transformation Plan (STP) update [standing item]	Scott Haldane	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Ruth Yule	Not applicable		
	Agenda plan and appointments to outside bodies	Ruth Yule	Not applicable		
[08/02/18] Provisional meeting			Not applicable	*26/01/18*	*30/01/18*
15/03/18	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable	02/03/18	06/03/18

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
	Scrutiny Item: Sustainability and Transformation Plan (STP) update [standing item]		Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Ruth Yule	Not applicable		
	Agenda plan and appointments to outside bodies	Ruth Yule	Not applicable		
[19/04/18] Provisional meeting				*06/04/18*	*10/04/18*
17/05/18	Notification of Chairman/woman and Vice-Chairman/woman	Ruth Yule	Not applicable	04/05/18	08/05/18
	Co-option of District non-voting Members	Ruth Yule	Not applicable		
	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		
	Scrutiny Item: NHS Quality Accounts (provisional)	Kate Parker	Not applicable		
	Scrutiny Item: Sustainability and Transformation Plan (STP) update [standing item]	Scott Haldane	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Ruth Yule	Not applicable		
	Agenda plan and appointments to outside bodies	Ruth Yule	Not applicable		

Notice made under the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 in compliance with Regulation 5(7)

Decisions to be made in private as a matter of urgency in compliance with Regulation 5(6)

1. At least 28 clear days before a private meeting of a decision-making body, public notice must be given which must include a statement of reasons for the meeting to be held in private.
2. At least 5 clear days before a private meeting of a decision-making body, further public notice must be given which must include a statement of reasons for the meeting to be held in private, details of any representations received by the decision-making body about why the meeting should be open to the public and a statement of the Council's response to such representations.
3. Where the date by which a meeting must be held makes compliance with the above requirements impracticable, the meeting may only be held in private where the decision-making body has obtained agreement from the Chairman of the Council.
4. Compliance with the requirements for the giving of public notice has been impracticable in relation to the business detailed below.

Forward plan reference	Intended date of decision	Matter in respect of which the decision is to be made	Decision maker	List of documents to be submitted to the decision maker	Reason for the meeting to be held in private
…/…	[Insert Committee date here]		[Insert Committee name here]	Report of … Director	The decision is an exempt item within the meaning of paragraph … of Schedule 12A of the Local Government Act 1972 as it refers to information ….

5. The Chairman of the Council has agreed that the Committee may hold a private meeting to consider the business referred to in paragraph 4 above because the meeting is urgent and cannot reasonably be deferred for the reasons stated below.

Date of Chairman's agreement	Matter in respect of which the decision is to be made	Reasons why meeting urgent and cannot reasonably be deferred

For further information, please contact Quentin Baker on 01223 727961 or Quentin.Baker@cambridgeshire.gov.uk