# ADULTS AND HEALTH COMMITTEE

Cambridgeshire County Council

## Thursday, 23 January 2025

**Democratic and Members' Services**
Emma Duncan
Service Director: Legal and Governance

**10:00**

New Shire Hall
Alconbury Weald
Huntingdon
PE28 4YE

## Red Kite Room
## New Shire Hall, Alconbury Weald, Huntingdon, PE28 4YE

# AGENDA

**Open to Public and Press**

**CONSTITUTIONAL MATTERS**

| | | |
|---|---|---|
| **1.** | **Apologies for Absence and Declarations of Interest**<br>*Guidance on declaring interests is available in Chapter 6 of the Council's Constitution (Members' Code of Conduct)* | |
| **2.** | **Minutes - 12 December 2024** | **5 - 28** |
| **3.** | **Public Questions and Petitions** | |

**DECISIONS**

| | | |
|---|---|---|
| **4.** | **Business Plan and Budget 2025-26 to 2029-30** | **29 - 74** |

**KEY DECISIONS**

| | | |
|---|---|---|
| **5.** | **Recommissioning Drug and Alcohol Treatment Services for Adults and Children and Young People** | **75 - 104** |
| **6.** | **Recommissioning Behaviour Change Services** | **105 - 122** |
| | **DECISIONS** | |
| **7.** | **Adults and Health Committee Agenda Plan, Training Plan and Committee Appointments** | **123 - 130** |
| | **BREAK** | |
| | **HEALTH SCRUTINY** | |
| **8a.** | **Health Inequalities - Report from the Cambridgeshire and Peterborough Integrated Care Board** | **131 - 152** |
| **8b.** | **Health Inequalities - Report from Cambridge University Hospitals NHS Foundation Trust** | **153 - 158** |
| **9.** | **Cambridgeshire and Peterborough NHS Foundation Trust Mental Health Services** | **159 - 170** |
| **10.** | **Health Scrutiny Work Programme 2024-25** | **171 - 172** |
| **11.** | **Health Scrutiny Recommendations Tracker - December 2024** | **173 - 178** |


The County Council is committed to open government and members of the public are welcome to attend Committee meetings. It supports the principle of transparency and encourages filming, recording and taking photographs at meetings that are open to the public. It also welcomes the use of social networking and micro-blogging websites (such as Twitter and Facebook) to communicate with people about what is happening, as it happens. These arrangements operate in accordance with a protocol agreed by the Chair of the Council and political Group Leaders which can be accessed via the following link or made available on request: Filming protocol hyperlink

Public speaking on the agenda items above is encouraged. Speakers must register their intention to speak by contacting Democratic Services no later than 12.00 noon three working days before the meeting. Full details of arrangements for public speaking are set out in Part 4, Part 4.4 of the Council's Constitution: Procedure Rules hyperlink

The Council does not guarantee the provision of car parking on the New Shire Hall site. Information on travel options is available at: Travel to New Shire Hall hyperlink

Meetings are streamed to the Council's website: Council meetings Live Web Stream hyperlink

The Adults and Health Committee comprises the following members:

Councillor Richard Howitt (Chair) Councillor Susan van de Ven (Vice-Chair) Councillor Mike Black Councillor Chris Boden Councillor Steve Corney Councillor Adela Costello Councillor Claire Daunton Councillor Anne Hay Councillor Mark Howell Councillor Edna Murphy Councillor Keith Prentice Councillor Kevin Reynolds Councillor Geoffrey Seeff Councillor Philippa Slatter and Councillor Simone Taylor Councillor Corinne Garvie (Appointee) Councillor Cameron Holloway (Appointee) Cllr Keith Horgan (Appointee) Councillor Dr Haq Nawaz (Appointee) Councillor Clare Tevlin (Appointee)

| | |
|---|---|
| Clerk Name: | Richenda Greenhill |
| Clerk Telephone: | 01223 699171 |
| Clerk Email: | richenda.greenhill@cambridgeshire.gov.uk |

# Adults and Health Committee Minutes

Date: 12 December 2024

Time: 10.00 a.m. – 3.15 p.m.

Venue: New Shire Hall, Alconbury Weald, PE28 4YA

Present: Councillors M Black, C Boden (to 3.00pm), A Bulat, S Corney, S Count (to 2.00 p.m.) C Daunton, A Hay (to 2.00 p.m.), M Howell (to 2.00 p.m.) R Howitt (Chair), E Murphy, K Reynolds (to 2.00 p.m.), G Seeff, P Slatter, S Taylor and S van de Ven

From 2.00pm:
Councillors C Garvie (South Cambridgeshire District Council), K Horgan (East Cambridgeshire District Council) and C Tevlin (Huntingdonshire District Council)

## 278. Chair's Announcements

The Chair attended the National Children and Adult Services Conference (NCASC) with the Executive Director for Adults, Health and Commissioning and colleagues in Children's Services.

The Executive Director for Adults, Health and Commissioning informed Members about the upcoming Care Quality Commission (CQC) assessment. The Council received notification on 11 November 2024 from the CQC with a request to submit evidence, including shareholder information, partner information, a self-assessment on the operations of adult social care services, a data pack and information return, before an on-site visit within the next six months. A report would be published on the CQC website following the visit and would include a one-word judgement. The four levels were: inadequate, requires improvement, good or outstanding.

## 279. Apologies for Absence and Declaration of Interest

Apologies were received from Councillors K Prentice (substituted by Cllr A Bulat) and A Costello (substituted by Cllr S Count).

Councillor Dr H Nawaz sent apologies for the afternoon health scrutiny session.

Councillor Boden declared an interest in Agenda Item 5 as the Leader of Fenland District Council.

## 280. Minutes – 10 October 2024 and Minutes Action Log

The minutes of the meeting on 10 October 2024 were approved as an accurate record and signed by the Chair. The action log was noted.

While noting the action log, individual Members:

- clarified that Minute 272 was referring to indemnity insurance for self-employed individuals, whether acting for an agency or independently. The Executive Director for Adults, Health and Commissioning welcomed this clarification – **action required.**

- asked if any more information was available around Minute 267 'Mental Health S75 Agreement Extension'. The Executive Director for Adults, Health and Commissioning stated that an update would be taken to a future Spokes meeting – **action required.**

## 281. Petitions and Public Questions

One public question was received. The member of the public did not attend the meeting so a written response would be provided.

No petitions were received.

## 282. Adult Social Care – Accommodation for Working Age Adults – Strategic Thinking

The Committee received a report which provided an overview of the approach undertaken to address adult social care supported accommodation needs for working age adults across the county.

Members learnt that 'working age adults' was a term used for adults aged 18 to 64. The report focused on working age adults with mental health needs and learning disabilities as their primary support reason, and where housing accommodation was required.

Members learnt that accommodation problems were a country wide issue. There was a growing demand, and shortfall, of accommodation for those with complex needs.

While discussing the report, individual Members:

- clarified that the release of council estate referred primarily to County Council owned assets and sites as this offered the potential for a capital receipt for the Council and the provision of good quality housing to keep people within the county. Active conversations were also taking place with city and district council partners around potential sites and opportunities within their local plans. Members welcomed this early engagement.

- queried if Fawcett House could be considered for accommodation. Officers undertook to raise this question with the Strategic Assets Team **– action required.**

- confirmed that officers were planning for the next five to ten years with partners.

- highlighted that Local Authority assets, or registered provider assets, were eligible for housing benefit recovery.

- learnt that officers had contacted registered providers and two had already expressed an interest.

- questioned if the report encompassed those who were able to work, whether voluntarily or in paid employment, and if housing accommodation would take account of factors like location on potential employment opportunities. Members learnt that the project undertook a place-based approach and incorporated lived experiences. The importance of homes being located where individuals could access health care, and social provision and jobs was recognised.

- queried what accommodation would be required and how other counties were coping. Members learnt that some people would need 24/7 support through a 'core and cluster' approach. Officers highlighted the importance of providing a range of accommodation to support different needs.

- emphasised the need for accommodation to be able to be adapted to meet people's changing needs, avoiding the need for them to move home.

- learnt that 1 in 5 people in supported accommodation placements were placed out of county because their needs could not be met in Cambridgeshire. On average, a working aged adults waited up to 145 days for accommodation.

- queried how confident the service was in working with landlords as there were already some issues about housing children with complex needs. Members learnt that some challenges were down to housing adaptions, which was linked to a separate piece of work undertaken with district councils and housing improvement agencies.

- learnt that officers were working with children services colleagues to help contact registered landlords to generate more accommodation which would increase choices for all ages, not just working aged adults.

- learnt that there was a countywide housing board which included district councils.

- raised the concern about whether the proposals could keep pace with the increasing need, but would not address the current shortfall.

- queried the comment at section 3.1.6 that 'over half of all placements made out of county are at the request of the service user or their family,' as the Member recalled a previous decision to end this practice except where needs could not be met in-county. They further asked who covered the cost difference if an individual or family requested out-of-county placements when a need could be met in-county and the criteria for agreeing out-of-county placements requested by an individual or their family. The Executive Director for Adults, Health and Commissioning offered a written response **– action required.**

- queried the rationale for the difference in the graph listed at 3.3.4 of the report. Members learnt that the needs assessment was primarily from census data and evidence related to the current needs for services using population projections. The differences highlighted where the needs were greatest at the moment, or where evidence suggested they would continue to grow.

- questioned if there would be a savings proposal to match the current £12 million that was being built into the business plan. Officers advised that the unit price was often cheaper than traditional residential costs, and that would form part of the business case.

- sought clarification on what re-opening the Mental Health and Autism Accommodation Framework would mean in practice. Members learnt the framework had recently reopened and would enable conversations with local providers regarding needs and expectations.

- questioned how the average waiting time for accommodation compared to other counties. Officers would provide this information outside of the meeting **– action required.**

- acknowledged the report focused on working age adults, but highlighted the importance of better accommodation for the elderly in suitable locations. Members were assured that the strategy was designed for all ages.

- The Chair welcomed the joined up working with the Health and Wellbeing Strategy. He noted that there was not enough housing currently available for Years 3 to 10 and asked that the June report should include an analysis of how market shaping goals could realistically be achieved. It should also confirm if the required capital was available. He further highlighted the need to review the policy on Independent Living Schemes as current arrangements were not working. **- action required**

It was resolved unanimously to:

a) scrutinise the content of the report.

b) support the development of principles and next steps to expanding accommodation to meeting the current and future shortfall in accommodation for working age adults with complex needs.

## 283. Homelessness and Housing Related Support

The Committee received a report which provided an overview of how the County Council was investing resources and working with partners to deliver essential support to the rising number of people, often with complex support needs, who were experiencing homelessness. The report highlighted the positive impact of the service as an integral part of the local system-wide offer. The seven year contract had been in operation for three years and had reached its first break clause and approval was sought for a two year contract extension.

While discussing the report, individual Members:

- sought clarification that the report referred only to individuals with additional care needs in addition homelessness. Officers confirmed that this service provided part of the wraparound approach to support only for those experiencing complex needs.

- asked how councillors, during their case work, could ensure that appropriate housing related support was available to individuals. Officers advised that district

councils provided a standard pathway for people experiencing homelessness and would have contacts with the various support services available to them.

- recognised the work being done by charitable providers, but noted that not all charitable providers were registered providers. This created a pressure on city and district councils budgets in relation to housing benefit spend.

- asked about the implementation of a trauma informed approach and how this could be expanded across services. Members learnt that training was being rolled out across all staff and that feedback so far was positive.

- received confirmation from officers that regular contract management meetings were taking place and there were no concerns about the standard of support being provided.

- questioned how the contract could meet rising demand. Members learnt that an inflationary costs process fed into the business planning process. Many of the charitable organisations working is this area also used their services to meet this demand.

- noted the third party contributions made by Cambridge City Council and asked if there was a possibility of Fenland District Council contributing.

- queried the cost benefit analysis for the first three years of the contract. Members learnt that work was undertaken to monitor the contract through standard models, however officers were developing a new model based on best practice from Greater Manchester to help evidence the value of services.

- noted that in 2020 the Council decided to move away from the provision of hostel accommodation.

It was resolved unanimously to:

a) note the County Council's contribution to investing in a system-based approach to delivering support services to address the needs of those who are experiencing homelessness, and how this positively impacts this group of people.

b) approve a 2-year extension to the existing contract in line with current terms and conditions at a total value of £4,582,926 (£2,291,463 per annum) from 1st April 2025. This value will be adjusted for any future inflationary uplifts, awarded at the Council's discretion, as agreed through the business planning governance process.

c) delegate the authority to award the subsequent extension period to the Executive Director Adults, Health and Commissioning, in consultation with the Chair and Vice Chair of the Adults and Health Committee.

## 284. Extra Care Contract Extensions

The Committee considered a report which provided an overview of how the County Council was investing resources to deliver essential care and support to those in Extra Care Housing. The report sought approval for the continuation of this work through an extension to five existing Extra Care contracts.

While discussing the report, individual Members:

- sought clarification relating to the Ditchburn Place contract, as it was noted that the contract had been outsourced and queried what harmonisation of pay meant in practice for the workers. The Service Director for Commissioning stated that the Council championed good conditions for care providers, with a high percentage paying the living wage. Ditchburn Place was more expensive than other providers and it was important within the Council's limited resources to demonstrate fairness across the market.

- were assured that they were on target to ensure that everyone in Somers Court would have access, by the 31 March 2025, to suitable accommodation. All care assessments were undertaken by the adult social care team. Fenland District Council (FDC), Housing 21 and Cambridgeshire County Council were working collaboratively to facilitate people's preferences. FDC ensured that everyone had emergency housing status to assist when bidding on Home-Link. Accommodation had already been found for 12 individuals. Members learnt that some individuals were looking at sheltered housing within the Fenland area. Housing 21 were looking to reserve any vacancies in other local projects.

- highlighted consideration of setting up 'in-house' services in 4.1 of the report as it was a Joint Administration policy to bring services in-house.

It was resolved unanimously to:

a) approve a 2-year contract extension from 1st April 2025 at a value of £1,662,354 (£831,177 per annum) for Ditchburn Place, which will be adjusted for any future inflationary uplifts and awarded at the Council's discretion. This includes formal contract variation to reflect the need to harmonise Terms and Conditions for TUPE staff.

b) approve a 3-year contract extension from 1st April 2025 at a value of £3,578,556 (£1,192,852p per annum) for Baird Lodge, Eden Place, Millbrook House and Ness Court (Baird Lodge et al), which will be adjusted for any future inflationary uplifts and awarded at the Council's discretion.

c) delegate the authority to award the subsequent extension periods and contract variations on both contracts to the Executive Director Adults, Health and Commissioning in consultation with the Chair and Vice Chair of the Adults & Health Committee.

## 285. Adults, Health and Commissioning Business Planning Audit

The Committee received a report on the recommendations from Internal Audit in relation to the Adults, Health and Commissioning Business Planning Process 2024/25 together with an update on the progress to implement the agreed remedial actions. This had been discussed at the Audit and Accounts Committee meeting on 31 October 2024 and a resolution passed that a report should be provided to the Adults and Health Committee for consideration. All of the Internal Audit recommendations had been accepted by the Adults, Health and Commissioning Directorate.

While discussing the report, individual Members:

- welcomed the inclusion of this report at the first available opportunity following the referral by the Audit and Accounts Committee.

- queried the confidence that the targeted savings could be achieved and why it was that the findings were referred to as 'minor.' Members were advised that the description of the impact as being 'minor' was made by the Audit team. The delivery of savings was monitored through a quarterly tracker, and each project had a governance process around the financial delivery of savings to give better oversight of any shortfall.

- highlighted the importance that appropriate actions had been, or would be, actioned.

- noted the over-estimation of demand in 2024/25 and spoke of the crucial role played by demand estimates in the business planning process, especially in relation to residential care. They recognised the difficulty in producing accurate demand estimates, and encouraged more consideration of sensitivity analysis for demand estimates in business planning. The Chair stated the importance of understanding the reasons behind the underspend.

- raised concerns that the £1 million increase in debt might be due to a failure to prevent debt from building up and spoke of the need to provide good debt advice. Members were advised that early and accurate financial assessment was key to helping people understand their care fees and avoid getting into debt. Work was being undertaken to reduce the financial assessment backlog.

- queried if the underspend meant there could be levels of unmet needs.

It was resolved unanimously to note the contents of the audit report and remedial actions undertaken.

[The meeting adjourned from 12.00pm - 12.10pm]

## 286. Finance Monitoring Report December 2024

The Committee received an update on the financial position of the Adults, Health and Commissioning Directorate (including Public Health) as of the end of October 2024. The overall position was a forecast underspend of £5,388k and attention was drawn to the difficulty in estimating demand for services. There was a forecast underspend for

Public Health of £248k which would be transferred to Public Health reserves at year end. A lot of savings were still marked as black which meant that further work was needed to develop plans to deliver those savings. Overall debt for adult social care was declining slightly and welcome progress was reported in reducing aged debt over two years following focused work by the Service Directors for Finance and Procurement and Adult Social Care. A payment from the Integrated Care Board (ICB) in October had reduced the ICB debt balance to £11.4 million.

While discussing the report, individual Members:

- acknowledged the difficulties with accurate forecasting and estimates, especially after a disruptive event such as COVID-19 and repeated the suggestion made earlier in the meeting that consideration be given to the use of sensitivity analysis.

- noted that being in an Integrated Care System (ICS) encouraged collaboration, but that different accounting systems were used.

- sought further details related to the savings targets marked as black to provide confidence that the savings would be realised. Another Member asked for more detail to be provided if they were to be re-presented in future business plans.

- sought clarification on how much of the Learning Disability Partnership (LDP) remaining debt would be recoverable. The Chair stated that discussions were underway to allow a public statement to be made about the LDP. A full update would be taken to the next Spokes meeting **– action required.**

- acknowledged that underspends were mostly associated with staffing and that one-off short term funding presented issues.

- asked for an update on the use of open book accounting with some larger partners and whether this delivering any savings. The Acting Director of Public Health stated there had been a focus on the four highest value services. Work on two had been completed and a mixture of savings and recoveries had been identified in one of these. There was now a standardised monitoring approach in places across providers.

- expressed concern that the savings targets shown in black remained aspirational, and expressed the hope that more detail would be provided in the next business planning round about how proposed savings would be achieved. They further suggested that future reports should make clear the savings targets being achieved by RAG rating **– action required**

- learnt that the Council wide debt management team cost approximately £400,000 a year which currently managed debt of £160 million. The importance of keeping in mind the human impact of debt remained a key aspect of the team's work.

The Chair suggested that Members could scrutinise how attainable planned savings were as part of the business planning discussion at the January meeting. He highlighted that service delivery should be emphasised and considered as well as finances and savings.

It was resolved unanimously to:

a) note the Adults, Health and Commissioning Finance Monitoring Report as at the end of October 2024.

b) note the update on Adult Social Care debt.

## 287. Application of Adult Social Care Charges Review

The Committee received a report which outlined the findings and proposed recommendations of a review of Cambridgeshire County Council's Adult Social Care Charging Policy and application of associated legislation and guidance.

The Executive Director for Adults, Health and Commissioning informed Members that a specific aspect of the review was to take an anti-poverty view of the approach to charging, considering the impact on people due to the cost-of-living crisis and ongoing financial pressures for those within Cambridgeshire.

Members learnt that the review focused on the service's interpretation of guidance and development of a charging policy to ensure it was compliant with legislation while also assessing it against other authorities. It also looked at the use of discretion. An external resource was engaged to provide critical challenge.

The results found that the policy was compliant with the Care Act and was applied equitably in line with legislation and guidance. There were flexibilities and alternatives offered within the regulations and anticipated outcomes. The independent review made 28 recommendations and 17 were presented to Committee.

While discussing the report, individual Members:

- highlighted the importance of clear information regarding entitlement criteria for Council assistance in Older People's services.

- commented that the appeal process needed to be a meaningful process.

- noted that many of the 11 recommendations not recommended to Committee, related to investment into business analytics tools which could assist in future forecasting. The presenting officer stated the review focused on client contributions and the charging policy, therefore these recommendations were not included as they did not provide added value to those who used the service.

- questioned to what extent the recommendations would impact discussions regarding the Poverty Strategy Commission and its future planning.

- queried if there would be enough data that would be representative of the specific groups of those with lived experience of poverty due to the limited resources available which could influence business planning discussions for 2026/27.

- sought assurance that the Council was charging for the care that was being provided. Another Member highlighted that there were unpaid, or informal, carers who were not supported by the Council.

- learnt that there had not been user engagement within the review as the review focused on the implementation of regulations, the Care Act, statutory guidance and policy compliance.

- welcomed the 'invest to save' proposal to increase the capacity of the Welfare Benefits Team.

- noted that average care costs would be published to help inform self-funders.

- questioned if there were economies of scale to be made through co-location of the provision of care.

The Chair welcomed the review of the application of Adult Social Care charging through an anti-poverty lens. Not all of the proposals could be implemented in the short-term due to their cost, but he asked officers to bear those options in mind going forward. He endorsed the proposal around increased numbers of welfare benefits advisers and highlighted that the process had enabled the Council to be more transparent. The Chair hoped that this work would be raised with the Anti-Poverty Commission.

It was resolved unanimously to:

a) support the 17 recommendations set out in Appendix 2 and summarised in Section 3 of the report.

b) provide regular updates through Spokes meetings on the implementation of the recommendations.

## 288. Adults Corporate Performance Monitoring Report Q2 2024-25

The Committee received a report which provided an update on the performance monitoring information for the 2024/25 Quarter 2 period, covering July 1 to 30 September 2024.

It was resolved unanimously to note the performance information and act as necessary.

## 289. Public Health Corporate Performance Monitoring Report – Quarter 2 2024-25

The Committee received a report which updated Members on the performance of the main Public Health commissioned services for Quarter 2 2024/25.

It was resolved unanimously to:

a) acknowledge the performance and achievements.

b) support the actions undertaken where improvements are necessary.

## 290. Adults, Health and Commissioning Risk Register Update (including Public Health)

The Committee received a report which provided an update on risk in relation to Adults, Health and Commissioning, including Public Health.

While discussing the report, individual Members:

- highlighted Risk 3 ‘Arrangements to support people with Learning Disabilities result in poor outcome due to uncertainty of decoupling of funding arrangements via section 75 agreement.’ as the only area with increased risk. A Member queried how the decoupling would affect the individuals who relied on those services. The Executive Director for Adults, Health and Commissioning stated the risk had been escalated so it could be placed on the Corporate Risk Register. Service users remained the priority and continuity of care was essential throughout the decoupling process.

- highlighted Risk 8 ‘The Workforce across Adults, Health and Commissioning is under capacity and may not have the level of maturity of experience to deliver business needs.’ A Member questioned what could be done to encourage more people to undertake additional AMHPs training. Members were reassured that there was coverage across the AMHP rota and had registered an interest to review AMHP provisions against best practice standards which hoped to be conducted in early 2025.

It was resolved unanimously to note the updated Adults, and Commissioning, including Public Health Risk Register.

## 291. Adults and Health Committee Agenda Plan, Training Plan and Committee Appointments

The Chair asked an accountability report to be added to the March agenda plan **– action required**

A Member asked for an update report on the Care Academy **– action required**

A Member asked for a report to be added to the agenda plan to update the Committee on Right Care, Right Person. The Chair suggested that the item could be included in a future Finance Monitoring Report **– action required.**

While discussing the training plan, a Member asked how the Committee’s experience would be included in training post-election. The Democratic Services Officer highlighted comments regarding post-election training should be taken to the Member Development Panel.

It was resolved to review and comment on the committee agenda plan and training plan.

The meeting was adjourned between 1.20 p.m. and 2.00 p.m.

[Councillors Corney, Count, Hay, Howell and Reynolds left the meeting at 1.20 p.m.]

## Health Scrutiny

# 292. Urgent and Emergency Care

The Committee welcomed the following attendees for its scrutiny of urgent and emergency care:

- Stacie Coburn, Chief Operating Officer, Cambridgeshire and Peterborough Integrated Care System (ICS)
- Dr Andrew Anderson, GP and Integrated Care Board Clinical Lead for Urgent and Emergency Care
- Terry Hicks, Head of Clinical Operations, East of England Ambulance Service NHS Trust (EEAST)
- Marika Stephenson, EEAST Executive Lead for Cambridgeshire and Peterborough
- Sue Allan, Head of Engagement, Healthwatch Cambridgeshire

Six committee members and co-optees had carried out a site visit to Huntingdon Ambulance Station in preparation for the scrutiny session, and thanks were expressed to EEAST for offering this opportunity to see the service's work at first hand.

The Chief Operating Officer for the ICS explained that the NHS nationally was facing its busiest winter ever, and this included its highest level of demand for urgent and emergency care (UEC) services. No additional winter funding was available to the NHS this year and providers were working against a backdrop of rising infection rates, including from covid and flu. Local accident and emergency department performance against the four hour target was showing an improvement year on year and ambulance response times were also showing some improvement, but there was still more to be done. Problems still existed around system flow and ambulance offload at hospital, and local providers were working as a system to address these issues.

The ICB Clinical Lead for Urgent and Emergency Care (UEC) explained that access to general practice remained a challenge which led to some people presenting at UEC services for treatment. Service providers would prefer people to call 111 first so that they could be directed to the most appropriate service for their need. A 'call before convey' service was in place which enabled ambulance crews to ring a clinician who could support them to safely leave a patient at home where this was appropriate or refer them directly to an appropriate clinician, avoiding the need for them to transition through an Emergency Department. This process was now mandated for care home residents who did not have an individual care pathway. The ICB had been directed to create an urgent care hub, but no additional funding had been made available so initiatives like call to convey and the local Joint Emergency Team (JET) team would be notionally assigned to the hub. Efforts were continuing to keep frail people at home while frailty assessments were completed due to the rapid deterioration in condition which was often associated with hospital admittance.

The Head of Engagement at Healthwatch confirmed that the position described was consistent with the patient experience being reported to Healthwatch.

The Committee had identified four key lines of enquiry during its pre-scrutiny preparation: safety, service delivery models, partnership working and workforce. Individual Members' questioning focused on these areas:

i. Safety:

- expressed concern about a lack of continuity of care and problems getting patients to the right place for their care. The Chief Operating Officer ICS explained their aim was to get patients to the right ward first time when they were admitted to hospital through the Emergency Department, but that this was not always possible. Addenbrookes Hospital was exploring a medical workforce model which included a lead consultant each week to increase continuity of care at a senior level. A weekly multi-disciplinary review by NHS and social care staff had also been implemented to actively plan patient care and discharge.

- *v*oiced concern at the loss of patient-facing time by ambulance crews due to delayed handovers at hospital. The Chief Operating Officer EEAST stated that delayed handovers impacted both patients and staff. EEAST was still some way off the national standard for Category 2 handovers and was working with hospitals and community care teams to implement a transitional period moving to an automatic handover at 45 minutes to release ambulance crews back to duty. This had already been implemented in some other areas served by EEAST and the aim was for this to be introduced in Cambridgeshire in the next few weeks. EEAST would work with ED teams to make this work as safely as possible.

  Several members expressed concern that this would lead to more patients waiting in corridors. The Chair noted that the 45 minute handover had risks associated with it, and asked that this was placed on record.

- spoke of patients having received the wrong care in an Emergency Department (ED). The Chief Operating Officer ICS stated that the aim of health service contacts was to get patients in front of the right clinician first time. That was not always the case in an ED, but people could feel it was the only way to access services. That view needed to be re-set. Post-discharge follow up by the Voluntary Sector Alliance had been launched the previous year and had already supported over 1200 patients. Its service capacity would also be expanded over the winter. The Chair commended the efforts being made in relation to the Voluntary Sector Alliance to improve patient experience of hospital discharge, but the Committee would like to see more evidence of its effectiveness.

- spoke of the need for a process to ensure that records were handed over correctly and that clinicians had ready access to patient information. The Chief Operating Officer ICS explained that the shared care record programme across Cambridgeshire and Peterborough allowed any professionals supporting a person to access their medical records, with the person's consent. From 1st December the voluntary sector would also be able to access these records, provided the patient gave their consent.

ii. Service delivery models

- asked for more information about the Integrated Frailty Service and ambulance service calls to care homes. The Chief Operating Officer EEAST explained that ambulance crews were finding that people were being taken to ED that did not need to be there. 'Call to convey' might avoid that by offering safe care within the care home setting. An increase in call times had been seen during the initial weeks of its operation, but there had also been a reduction in the number of frail elderly people being taken to hospital.

- learned that EEAST was in the process of replacing its ageing ambulance fleet over the next 18 months to reduce the proportion of vehicles out of service.

- asked whether the criteria for admitting patients to hospital could be reviewed to reduce the number of patients being admitted. The ICB Clinical Lead for UEC explained that the aim was to identify the right point of access to services outside of the hospital environment, for example through the 111 service. They were working with partners to identify alternatives to hospital admittance where appropriate, including the use of virtual wards, as most people preferred to be cared for outside of hospital where possible.

- asked how service user experience of UEC could be improved. The ICB Clinical Lead for UEC acknowledged that ED was not a nice place to be, so reducing the amount of time people spent there was important. They championed the use of appointments at ED where appropriate to reduce the amount of time people spent on site waiting for treatment and allow EDs to even out the peaks and troughs of patient flow. Appointments could already be booked at urgent treatment centres.

- commented that a change to triage via the 111 service rather than on site would not appeal to all, noting that 111 was a scripted conversation rather than a direct conversation with a clinician. The ICB Clinical Lead for UEC stated that Cambridgeshire and Peterborough had been the first area to put GPs into the 111 service and that they reviewed around 50% of calls. This made a big difference in directing ambulances to those who needed them most. Perhaps surprisingly there had been little patient push-back to being referred away from face to face UEC appointments. It was important though to ensure that the service to which people were redirected was convenient and appropriate, and it was recognised that changing people's behaviours when they were anxious would take time.

iii. Partnership Working

- asked about the mechanism for co-ordinating responsibility across different services, and information sharing between acute services. The Chief Operating Officer ICS described the Integrated Care Board's (ICB) co-ordinating role, providing an interface between primary care, acute hospitals and EEAST through bi-monthly meetings at senior level across key organisations in addition to formal ICB board meeting. The aim was to address bottlenecks rather than moving them to another part of the system. There was also a recognised need to think about prevention through education, engaging people earlier in

condition management and working towards a more holistic societal intervention to help people stay well. Integrated neighbourhood teams were crucial to this.

[Councillor Boden left the meeting at 3.00pm]

- emphasised the importance of educating residents on when and when not to call 999.

- commended the trial in Huntingdonshire which saw the Cambridgeshire Fire and Rescue Service Community Welfare Team attending some emergency calls on behalf of EEAST. The Chief Operating Officer EEAST explained that the service routinely used community first responders to get life-saving care to people as quickly as possible. There were also military co-responders, and EEAST had a very good relationship with the local Fire Service and was able to utilise their retained teams to respond to cardiac arrest.

iv. Workforce

- asked about staff burnout in local acute Trusts and EEAST, and what was being done to address this. The Chief Operating Officer EEAST acknowledged that UEC was a difficult role where staff worked long hours with little downtime on shifts and covered big distances under challenging driving conditions. Staff were offered compensatory rest when exceeding their regulated hours, and the Trust tried to find alternative roles if people were struggling. The previous year EEAST had an 18% vacancy rate, but it was now over establishment in all three hub areas within Cambridgeshire. Its staffing profile was the best it had been in 10 years, and it was important now to put in place the training, care and welfare support to retain those staff members.

  The Chief Operating Officer ICS explained that all acute hospital providers had well-being hubs. The ICB had also invested heavily in UEC workforce in recent years to get the right skill mix and capacity.

The Chair emphasised the importance of partnership working. The local authority looked carefully at hospital discharges with a focus on putting people's welfare first. Sometimes he felt there was a sense of discharges being portrayed as numbers rather than people. He felt there was a need to have a grown-up conversation recognising the joint difficulties for health and social care. The Chief Operating Officer ICB concurred that people were at the heart of the ICB's work and that of and its system partners. They were disappointed that was the feedback the Chair had received as their sense was that teams were working together well on a daily basis in the best interests of service users. They stated their personal commitment to that approach, commenting that there was a need for an honest conversation if it was felt that was not being seen by any partners. The Chair expressed the hope that this would be fed back.

Summarising the debate, the Chair noted that it was expected to be the busiest winter ever for urgent and emergency care services. The Committee supported the efforts described to get service users to the right ward first time when they were admitted to hospital to avoid discontinuities in care. It recognised the continuing delays in patient handover at hospital and that current performance was significantly below national standards. The planned 45 minute limit on patient

handovers being implemented by EEAST was noted, and the Committee drew attention to the potential risks associated with this practice. The need to create safe alternative pathways to Emergency Department attendance was recognised. The Committee commended the efforts being made in relation to the Voluntary Sector Alliance to improve the experience of hospital discharge, but would like to see more evidence of its effectiveness. Efforts to improve patient experience through the provision of better information, a better environment and through support to patients themselves was encouraged. The Committee expressed concern about the new mandation of calls to 111 for urgent and emergency care for people in care homes without an individual care pathway, and how that might impact outcomes.
The efforts being made to encourage people to ring 111 first rather than travelling direct to an Emergency Department were recognised, but the Committee noted that only 50% of calls to 111 were currently checked by a medically qualified member of staff.

The Committee noted the experience at Hinchingbrooke Hospital when a pilot face to face service was provided to offer alternative provision to patients going direct to its Emergency Department (ED), and welcomed confirmation that this redirection would be to an alternative treatment option which was convenient and acceptable to the patient. Efforts to introduce timed appointments in EDs were supported, with the Committee recognising the benefits that this could bring to the patient experience as well as to patient flow. The Committee commended efforts towards partnership working with the local authority and prevention efforts in relation to people living with frailty and supported the person-first principle, which included ensuring appropriate social care in relation to hospital discharge. Plans by EEAST to replace ageing ambulance service vehicles were welcomed and it was hoped that this would allow targets for vehicle downtime to be achieved within 18 months.

The Committee welcomed the efforts of the Cambridgeshire Fire and Rescue Service Community Welfare Team in Huntingdonshire which used their retained team to provide a first response to some incidents of cardiac arrest in the county in support of EEAST. It agreed that the ‘no wrong front door’ policy for accessing services should be maintained, and that education should be used to encourage service users to call first before seeking treatment at an ED where appropriate. The Committee supported arrangements by EEAST for the provision of compensatory rest after excessively long work shifts and welcomed the successful efforts to drive down vacancy rates. The Committee encouraged local managers to be responsive to staff experiencing workplace stress and improving overall staff experience.

The Chair placed on record his thanks to all those attending the session to provide verbal evidence.

It was resolved unanimously to delegate authority to the Democratic Services Officer, in consultation with Committee Spokes, to produce a summary of the Committee’s feedback and recommendations, and to send these to the relevant parties.  A copy would also be published on the health scrutiny webpage on the Council’s website.

## 293. Health Scrutiny Work Programme

The health scrutiny work programme was noted.

## 294. Health Scrutiny Recommendations Tracker – December 2024

The Health Scrutiny Recommendations Tracker was and noted.

[Chair]

# Adults and Health Committee – Minutes Action Log

## Purpose:

To capture the actions recorded in the minutes of Adults and Health Committee meetings and report responses.

## Minutes – 7th March 2024

| Minute No. | Report Title | Lead officer/s | Action | Comments | Status |
|---|---|---|---|---|---|
| 240.a | Finance Monitoring Report – January 2024 | Patrick Warren Higgs | The Committee requested a specific session for the committee on workforce. | To propose this as a topic as part of Members' development sessions. | In progress |

## Minutes – 27th June 2024

| Minute No. | Report Title | Lead officer/s | Action | Comments | Status |
|---|---|---|---|---|---|
| 263.b | Adult and Health Committee agenda plan, training plan and committee appointments | Patrick Warren - Higgs | A member requested that officers reviewed the timings of commissioning reports so that they came to committee in good time. The Executive Director: Adults, Health and Commissioning acknowledged that there would be | PWH to pick up with the Chair and Vice Chair prior to the committee meeting to update from the Chair and Vice Chair meeting. | In progress |

| | | | | | |
|---|---|---|---|---|---|
| | | | further discussions on commissioning and timings at Spokes. | | |

| Minute No. | Report Title | Lead officer/s | Action | Comments | Status |
|---|---|---|---|---|---|
| 263.c | Adult and Health Committee agenda plan, training plan and committee appointments | Patrick Warren-Higgs | Officers stated that there was ongoing work on revising the training plan. A member queried when the care together training would take place and whether this would be authority wide. They also requested some training ahead of the charges review report. | PWH to pick up with the Chair and Vice Chair. | In progress |

## Minutes – 10th October 2024

| Minute No. | Report Title | Lead officer/s | Action | Comments | Status |
|---|---|---|---|---|---|
| 265. | Minutes – 27 June 2024 and Minutes Action Log | CPFT | To circulate a briefing note on Right Care, Right Person (RCRP) to committee members. | | On-going |
| 267. | Mental Health S75 Agreement Extension | Shauna Torrance/ Rachel Hickmott | An overview of the audit deep dive should be provided to Spokes.<br><br>12.12.24: The Executive Director for Adults, Health and Commissioning | | |

| Minute No. | Report Title | Lead officer/s | Action | Comments | Status |
|---|---|---|---|---|---|
| | | | stated that an update would be taken to a future Spokes meeting. | | |
| 269. | Finance Monitoring Report | Justine Hartley | The Committee questioned if there was a demographic issue with older people who previously had an asset in the form of a house which had helped them independently pay for their care, but who might need access to council social care in upcoming years. Officers were asked to look into the national data. | The Finance and Business Intelligence teams are continuing to investigate data sources that might help the Council to track older people in care services who are crossing the threshold into Council funded care into the future. This is a difficult area as whilst there are national estimates of people who pay for their own care, estimating what assets those individuals have to predict when they might cross the threshold into Council funded care is more problematic. | On-going |
| 272. | Adults, Health and Commissioning Risk Register Update | Richard Hills | To clarify how the Council was indemnified in relation to the provision of social care services.<br><br>12.12.24: The Member clarified that this was referring to indemnity insurance for self-employed individuals, whether acting for an agency or independently. | | On-going |

| Minute No. | Report Title | Lead officer/s | Action | Comments | Status |
|---|---|---|---|---|---|
| 282. | Adult Social Care Accommodation for Working Age Adults – Strategic Thinking | Richard Hills/ Shauna Torrance | Queried if Fawcett House could be considered for accommodation. Officers undertook to raise this question with the Strategic Assets Team. | | |
| 282. | Adult Social Care Accommodation for Working Age Adults – Strategic Thinking | Richard Hills/ Shauna Torrance | Queried the comment at section 3.1.6 that 'over half of all placements made out of county are at the request of the service user or their family', as the Member recalled a previous decision to end this practice except where needs could not be met in-county. They further asked who covered the cost difference if an individual or family requested out-of-county placements when a need could be met in-county and the criteria for agreeing out-of-county placements requested by an individual or their family. The Executive Director for Adults, Health and Commissioning offered a written response. | | |

| Minute No. | Report Title | Lead officer/s | Action | Comments | Status |
|---|---|---|---|---|---|
| 282. | Adult Social Care Accommodation for Working Age Adults – Strategic Thinking | Richard Hills/ Shauna Torrance | Questioned how the average waiting time for accommodation compared to other counties. Officers offered this information outside of the meeting. | | |
| 282. | Adult Social Care Accommodation for Working Age Adults – Strategic Thinking | Richard Hills/ Shauna Torrance | The Chair asked that the June 2025 report should include an analysis of how market shaping goals could realistically be achieved. It should also confirm if the required capital was available. He further highlighted the need to review the policy on Independent Living Schemes as current arrangements were not working. | | |
| 286. | Finance Monitoring Report December 2024 | Patrick Warren-Higgs/ Rachel Hickmott | The Chair stated that discussions were underway to allow a public statement to be made about the Learning Disability Partnership (LDP). A full update would be taken to the next Spokes meeting. | | |
| 286. | Finance Monitoring Report December 2024 | Justine Hartley | Suggested that future reports should make clear the savings targets being achieved by RAG rating. | A similar table is included in the Integrated Finance Monitoring Report provided to the Strategy, Resources and Performance Committee. | On-going |

| Minute No. | Report Title | Lead officer/s | Action | Comments | Status |
|---|---|---|---|---|---|
| 291. | Agenda Plan, Training Plan and Appointments | Patrick Warren Higgs/ Richenda Greenhill | The Chair asked for a report on accountability to be added to the March agenda plan. | Added to the agenda plan for March. | Completed |
| 291. | Agenda Plan, Training Plan and Appointments | Patrick Warren Higgs/ Richard Hills | A Member asked for an update report on the Care Academy. | | |
| 291. | Agenda Plan, Training Plan and Appointments | Patrick Warren Higgs | A Member asked for a report to be added to the agenda plan to update the Committee on Right Care, Right Person. | | |

# Business Plan and Budget 2025/26 – 2029/30

| | |
|---|---|
| To: | Adults and Health Committee |
| Meeting Date: | 23 January 2025 |
| From: | Executive Director for Adults, Health and Commissioning<br>Executive Director of Finance and Resources |
| Electoral division(s: | All |
| Key decision: | No |
| Forward Plan ref: | n/a |
| Executive Summary: | This report summarises the draft 2025-30 Business Plan and Budget, as presented to the Strategy, Resources and Performance Committee on 17 December 2024, related to this committee including progress updates on the council's Strategic Framework and seven ambitions. |
| Recommendations: | The Committee is recommended to:<br>a) consider and scrutinise the proposals relevant to this Committee within the Business plan and Budget 2025-26 – 2029-30 put forward by the Strategy, Resources and Performance Committee, 17 December 2024.<br>b) recommend changes and /or actions for consideration by the Strategy, Resources and Performance Committee at its meeting on 28 January 2025 to enable a business plan and budget to be proposed to Full Council on 11 February 2025.<br>c) Receive the fees and charges schedule for this Committee included at appendix 2. |

Officer contacts:
Name: Patrick Warren-Higgs, Executive Director for Adults, Health and Commissioning
E-mail: Patrick.warren-higgs@cambridgeshire.gov.uk
Name: Michael Hudson, Executive Director of Finance and Resources
E-mail: Michael.hudson@cambridgeshire.gov.uk

# 1. Creating a greener, fairer and more caring Cambridgeshire

1.1. The Strategic Framework 2023-28 sets out the council's high-level approach for achieving the vision of a greener, fairer and more caring Cambridgeshire through seven 'ambitions':

- **Ambition 1:** Net zero carbon emissions for Cambridgeshire by 2045, and our communities and natural environment are supported to adapt and thrive as the climate changes
- **Ambition 2:** Travel across the county is safer and more environmentally sustainable
- **Ambition 3:** Health inequalities are reduced
- **Ambition 4:** People enjoy healthy, safe, and independent lives through timely support that is most suited to their needs
- **Ambition 5:** People are helped out of poverty and income inequality
- **Ambition 6:** Places and communities prosper because they have a resilient and inclusive economy, access to good quality public services and social justice is prioritised
- **Ambition 7:** Children and young people have opportunities to thrive

1.2. As the primary statement of the council's strategic direction, the Strategic Framework is the main reference point for everything the council plans and delivers for local communities. The refreshed Strategic Framework, approved at Strategy, Resources and Performance Committee in October 2024, sets out the progress the council has made towards delivering the seven ambitions since they were launched in April 2023

1.3. The council aims to achieve these ambitions by becoming 'Closer to Communities', working with residents and partner organisations to make services more responsive to the diversity of people and places in Cambridgeshire. Doing this effectively requires the council to be an evidence-led, listening organisation that is responsive to resident priorities. The annual Quality-of-Life Survey enables the council to have an ongoing dialogue with residents so it can understand what matters most to Cambridgeshire's people and communities. The insights generated from this annual survey, together with resident feedback from the council's budget engagement and consultation exercises, inform the development of council's business planning priorities and allows it track delivery progress of the seven ambitions.

# 2. Background

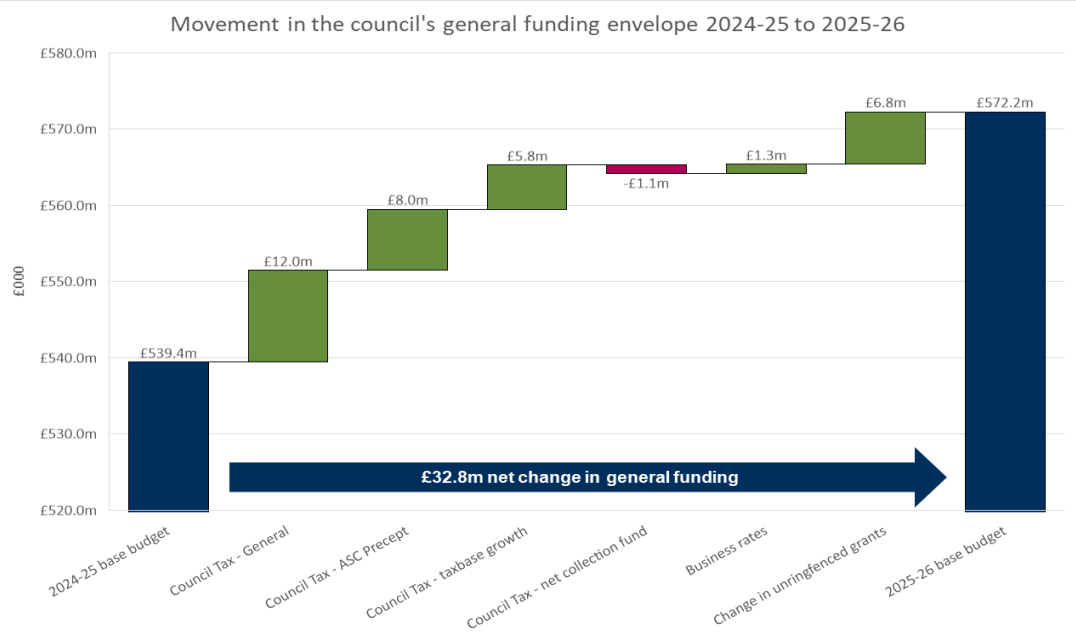
2.1 The draft 2025-30 Business Plan and Budget presented at Strategy, Resources and Performance Committee at its meeting on 17 December 2024, details how the council will continue delivering against its seven ambitions, respond to resident feedback and set a legal budget.

2.2 This committee, alongside other Policy and Service committees will consider the draft business plan and budget proposals, and any feedback will be

presented to Strategy, Resources and Performance Committee at its next meeting 28 January 2025 for consideration of recommending budget proposals to Full Council on 11 February 2025

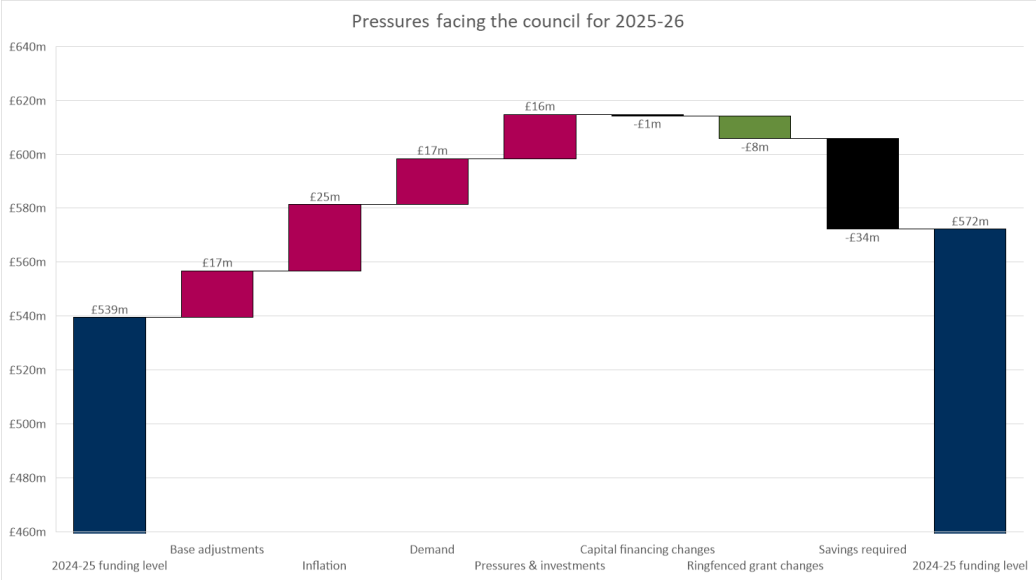
2.3 At this stage, the council is projecting to see a net increase of general funding of £32.8 million. This comprises a 4.99% increase in Council Tax, changes to the taxbase for Council Tax, increased business rates income and a net increase in general government grants.

**Chart 1 – Movement in funding envelope 2024-25 to 2025-26**




2.4 Following updates to pressure projections, we reported a projected budget gap of £39 million for 2025-26 in an update to Strategy, Resources and Performance on 31 October 2024, an increase of £16 million from the previous business plan forecasts. Whilst the budget of the council is increasing year on year, allowing it to continue investing in important local services, the budget is not growing fast enough to keep pace with the pressures arising from the issues described at 2.7. Latest estimates now show over £75 million of cost pressures, offset by a £32.8 million increase in our general funding and £8.5 million increase in ring-fenced grants, giving a gap to find of £34.2 million for 2025-26.

**Chart 2 - Pressures facing the council for 2025-26**




2.5 The overall impact of the additional investments the council is making and the compound pressures set out in the table above, means that to secure a legal budget, the council is required to find efficiencies/savings, or additional income, of £34 million for 2025-26.

2.6 To achieve this sustainably, the council will need to change the way it operates at an organisation-wide level so that it can drive maximum economic, social and environmental value from the services it provides and commissions. 'Our Future Council' change strategy, approved at Strategy, Resources and Performance Committee in October 2024, sets out a long-term vision for reshaping the way the council operates. The strategy will help enable the council to remain financially sustainable over the medium to long term and retain the capability and capacity to deliver its ambitions. In addition, each of the council's five directorates have developed proposals for the coming years that will allow the council to continue investing in priorities that will deliver its ambitions, whilst making savings through careful recalibration of the way services are provided.

Table 1 - How the balanced budget is arrived at

| | £m | £m |
|---|---|---|
| Pressures, investments and adjustments | 75.5 | |
| **Budget Changes** | | **75.5** |
| Less funding changes: | | |
| Change in ringfenced grants | | -8.5 |
| Change in general grants | -6.8 | |
| Proposed Council Tax increase | -20.1 | |
| Council Tax taxbase and collection fund | -4.6 | |
| Business rates income | -1.3 | |

| | £m | £m |
|---|---|---|
| **General funding increase** | | **-32.8** |
| **Funding envelope changes** | | **-41.3** |
| Total gap to find | | 34.2 |
| Savings identified | -32.6 | |
| Changes in income, excluding schools | -1.3 | |
| Add: reverse out previous year reserves budget | 11.8 | |
| Less: reserves use | -12.1 | |
| **Total Gap remaining** | | **0.0** |

2.7 Against that context, the report includes a further forecast for 2026-27 to 2029-30. This brings into focus key change programmes that have begun or will begin in 2025 to help determine the future shape and funding of the Council to achieve a balanced budget in each of the years remaining of the current Strategic Framework. Nevertheless, the council continues to have a budget gap in the remaining years of the medium-term:

Table 2 - Revised medium-term budget gaps

| Year | 2026-27 | 2027-28 | 2028-29 | 2029-30 |
|---|---|---|---|---|
| Latest unidentified savings gap | £17.7 million | £10.2 million | £21.8 million | £23.6 million |

2.8 The council is continuing to invest capital funding in the county's infrastructure, such as schools, roads and social care facilities. The full capital programme for 2025-30 (and onwards to 2035) is set out in tables 4 and 5 of appendix 1b, along with indicative sources of funding available. The programme for 2025-26 proposes a total budget of £140 million for capital expenditure, and a medium-term programme of £881 million

Table 3 - Capital Programme by Directorate 2025-30

| | Prev Years £000 | 2025-26 £000 | 2026-27 £000 | 2027-28 £000 | 2028-29 £000 | 2029-30 £000 | Later Yrs £000 | Total £000 |
|---|---|---|---|---|---|---|---|---|
| Children, Education and Families | 168,424 | 44,495 | 85,083 | 40,072 | 16,076 | 9,644 | 11,487 | 375,281 |
| Adults, Health and Commissioning | 462 | 8,544 | 19,857 | 18,683 | 15,451 | 15,653 | 29,650 | 108,300 |
| Place and Sustainability | 153,188 | 73,215 | 44,486 | 20,949 | 19,367 | 1,592 | 12,460 | 339,257 |
| Finance and Resources | 13,813 | 11,768 | 6,874 | 3,411 | 3,432 | 2,643 | 9,288 | 51,229 |
| Strategy and Partnerships | 4,753 | 1,189 | 170 | 30 | - | - | - | 7,117 |
| **Total Budget** | **340,640** | **139,211** | **156,470** | **83,145** | **54,326** | **29,532** | **62,885** | **881,184** |

2.9 The total programme for 2025-26 as it currently stands requires £139.2 million of funding which includes £56 million from borrowing. The cost of capital is expected to continue rising over the medium-term, exceeding £46 million by 2027-28. Although the capital programme has been prioritised to ensure that the expected cost of capital is within the prudential limit set by the capital strategy for 2025-26, we are very close to the limit in all years of the medium-term and so re-prioritisation may be required if there are any further capital spend requirements.

2.10 Subsequent to these projections made in early December 2024, the provisional local government finance settlement was announced on 18 December 2024. This confirmed several grant allocations for the council for 2025-26, with them broadly in line with our expectations. In particular, an increase in the social care grant of nearly £6.5 million (ringfenced to both children's and adults care) provides funding to underpin our inflationary and demand pressures, and a new £1.5 million children's prevention grant is likely to fund commitments in the business plan. The provisional settlement had several gaps that are awaiting the final settlement in February 2025, particularly confirming how much funding councils would get to offset the increase in employers' national insurance, and ultimately it isn't until the final settlement that our funding numbers can be fully confirmed. Broadly speaking though, notwithstanding that, the provisional settlement was in line with expectations and estimates made in this draft business plan.

2.11 At the same time, we are receiving updated taxbase and business rates estimates from district councils, and therefore a full update of the draft business plan will be presented to Strategy, Resources and Performance Committee in January.

# 3. Adults, Health and Commissioning - Directorate overview

3.1 Overall, it is proposed that Adults, Health, Commissioning, including Public Health, will receive a £385 million gross budget in 2025-26, including total growth of £31.97 million. This budget will support continued investment in services for older people and working age adults with care and support needs to maintain existing eligibility thresholds, as well as a range of public health services that aim to address the wider determinants of health. This includes proposals for an additional £3 million of non-pay related inflation funding for local care providers plus an additional £8 million inflation funding for the 5% increase in Real Living Wage, £2.1 million to meet demand for care amongst older people accessing both domiciliary and residential care, £4.8 million to help meet the rising levels of complexity amongst people with a learning disability and £3.9 million for working age and older people with mental health needs. Public health commissions services to improve physical health such as support to people to quit smoking, support healthy weight management, provide health checks for older adults and sexual health services, as well as health and wellbeing services in partnership with local NHS providers. Through these

services the council will further realise the aims of Strategic Framework Ambitions 3 and 4.

3.2 As with children and families, services for working age adults and older people with care and support needs are under significant pressure owing to wider social and national policy challenges. On average, people are living longer, meaning a greater proportion of the population is reaching an older age than in previous decades. Similarly, thanks to advancements in medical care and social attitudes, people with conditions previously considered life-limiting are also living longer than they would have done in the past. In Cambridgeshire, between 2011 and 2021, the 50-59 population grew by 22% and the 70+ population grew by 33%. The impact of this on the council is significant – for example, between 2020 and 2024 the cost of providing services for older people and people with physical disabilities increased by 64%.

3.3 Whilst people's improved longevity is to be celebrated, the national policy framework for adult social services has not kept pace with this change and remains broadly designed for the needs of the twentieth century. Successive national governments have proposed to address these fundamentally important challenges but have all failed to deliver any meaningful reform. The latest White Paper ('People at the Heart of Care') is unlikely to be implemented in full, leaving major unanswered questions about how services should be provided and funded into the future. This presents councils with ongoing difficulties in the coming years as populations continue to live longer and place increasing demand on services. Looking forward, in Cambridgeshire, the 65+ age group is forecast to grow by 12.7%, and the 80+ age group to grow by 25% by 2030.

3.4 These challenges are exacerbated by the health inequalities in the overall population, which create pressures of their own on a range of public services throughout peoples' lives, and which store up future demand for older persons services as people live fewer years in good health. For example, health outcomes differ significantly between areas of Cambridgeshire, with parts of Fenland, Cambridge City and Huntingdonshire having higher levels of deprivation and income inequality compared to areas in South and East Cambridgeshire, resulting in poorer outcomes in life expectancy, physical activity, children's health and higher levels of loneliness and obesity.

3.5 To respond effectively to the challenges of changing demographics, health disparities and demand for care support, the directorate wants everyone to live well as they age and lead a good life. This means thinking differently about services, so they place a greater emphasis on prevention and early intervention as well as embedding the 'Closer to Communities' ethos into the way services are delivered. Through better use of data and by listening to the voices of local people, the directorate will more effectively identify and address health inequalities, facilitating more active management of potential future demand growth.

3.6 Engagement with residents has highlighted that they prioritise supporting people to remain living at home and remain as independent as possible. The directorate will take every opportunity to support this aspiration, proposing

improvement to its self-service offer through a more dynamic information, advice and guidance offer that empowers people with the knowledge they require to make informed decisions when planning for their future. It is also proposed that the 'Home First' philosophy will continue to ensure that people are supported with short-term interventions in their own home to aid the recovery of independence. For example, the Reablement Service provides short term support for up to six weeks to help people regain their independence after an illness or a stay in hospital, preventing the need for longer term care and support. The directorate proposes creating greater capacity and flow in the service to allow more reablement activity to be undertaken and support more people to continue living in their own homes for longer whilst saving £465k.

3.7 Central to the 'Home First' approach is increased locality-based delivery of services.
The Care Together programme has demonstrated the power of place-based models of care by supporting the establishment of micro-provider organisations, with 41 care micro-enterprises currently providing over 4,000 hours of care capacity per week in Cambridgeshire, strengthening the local provider market and delivering care 'Closer to Communities'. Learning and evaluation from the Care Together programme will be used to inform and develop the new, place-based operating model set out in 'Our Future Council', mainstreaming this principle into the council's service design.

3.8 The directorate proposes to continue the use of strengths-based approaches in its practice to maximise people's independence and prevent, reduce or delay the need for long-term care, but where people do require longer-term care, it will be appropriate to their need and effectively reviewed as required. The Quality of Life Survey highlighted mental health as a concern for residents, and the directorate proposes a significant capital investment in independent living services and specialist accommodation schemes, with over £30 million to provide accommodation for people with complex needs. This will result in proposed savings in the revenue budget by enabling people to be more independent, including through independent living services in East Cambridgeshire and an improved accommodation model for working age adults with a learning disability or autism.

3.9 Because most care services are delivered by third party providers, the directorate has a crucial role to play in shaping the local social care market, ensuring it has the resilience and capability to effectively meet local need. Central to this is a proposed £30 million+ investment over the next five years to build a strong, stable and skilled workforce through a continued commitment to pay the Real Living Wage pay increases to care staff. Over 90% of our providers currently pay their workers the Real Living Wage and we want to ensure that the positive strides made in recognising the value of the care workforce are maintained. In 2025-26, the Real Living Wage will rise by 5% to £12.60 per hour, which will enable providers who are contracted by the council to effectively compete for workers in a market that suffers from national shortages, whilst also supporting care workers individually, with pay that reflects the immense value of their contribution to Cambridgeshire. The directorate proposes to continue investing in the development of its own social care

workforce over the coming years, growing 'in-house' experience through increasing social worker apprentice capacity and reducing the dependence on short-term and temporary staffing, with a proposed £149k investment in 2025-26.

3.10 The directorate also proposes a £523k investment to better manage contract outcomes, including costs, through increasing capacity in the contracts management and brokerage team. This will support placement decisions by assisting families with better information about different options and give a greater focus to contract management, improving value for money and standards. By maximising efficiencies across commissioned services, return on investment on contracts and by shifting the focus towards preventative contract management to design out inefficiencies, the directorate proposes savings of £1.8 million over 2025-26 and 2026-27.

3.11 Over the last financial year there has been lower than expected older people's demand pressures in Adults, Health, Commissioning. This has allowed the re-baselining of projections for 2025-26 and a proposed reduction in spend by £9.6 million. The demand and aligned financial projections will continue to be monitored throughout 2025-26.

Table 3.1 – Adults, Health and Commissioning budget position 2025-26

| Heading | 2025-26 £000 | Comments |
|---|---|---|
| **Opening gross budget** | **410,161** | |
| Base adjustments | -35,721 | Predominantly due to the ending of the learning disability pooled budget with the NHS – spend funded by NHS income is taken out |
| **Revised opening gross budget** | **374,440** | |
| Inflation | 12,756 | A range of inflationary increases including uplifts to support social care providers and Real Living Wage increases for care workers. These will support continued stability of the local care market and allow care providers to effectively compete for workers |
| Demography and Demand | 10,050 | A range of demography and demand increases that reflect the growing need for services that support working age adults and older adults with care and support needs, including domiciliary care, residential and nursing care, mental health, learning disabilities, |

| Heading | 2025-26 £000 | Comments |
|---|---|---|
| | | physical disabilities and autism |
| Pressures | 8,231 | A range of proposals to offset pressures including provision for increases in National Insurance Contributions in the provider market |
| Investments | -1,643 | A range of proposals are set out in Table 3 at Appendix 1b, with a number highlighted in the table below. These will support the directorate through invest to save activity by increasing short term capacity in certain areas to deliver future efficiency and productivity gains that will improve service user experience and outcomes |
| Capital financing changes | 0 | |
| Use of Reserves | 2,576 | Predominantly the reversal of one off use of reserves in 2024/25 to fund programmes to deliver savings |
| Savings | -21,144 | A range of revenue proposals set out in Table 3 at Appendix 1b, with a number highlighted in the table below that will deliver savings through improved ways of working, more efficient structures, re-baselined demand and more effective contracting |
| **Closing gross budget** | **385,266** | |
| **Opening income budget** | **-179,800** | |
| Income base adjustments | 36,385 | Predominantly due to the ending of the learning disability pooled budget with the NHS – income from the NHS is taken out |
| **Revised opening income budget** | **-143,415** | |
| Income inflation | -2,483 | Predominantly linked to pension and benefit increases and reflecting provider inflationary increases for those who pay the full cost of their care |
| Income generation | -260 | |
| Income grant changes | -770 | |
| **Closing income budget** | **-146,928** | |

| Heading | 2025-26 £000 | Comments |
|---|---|---|
| **Closing net budget** | **238,338** | |
| Total growth | 31,970 | |
| Change in gross budget | 10,826 | |
| Change in net budget | 7,977 | |
| Change in net budget % | 3.5% | |

Table 3.2 – Highlights of proposed Adults, Health, Commissioning investments and savings 2025-26 – 2027-28

| Proposal and Table reference number | 2025-26 £000 | 2026-27 £000 | 2027-28 £000 | Detail |
|---|---|---|---|---|
| Adult social care providers inflation (Table 3-B/R.2.001) | 3,060 | 3,290 | 3,430 | Investment in funding to meet general inflation factors relating to care providers. |
| National Insurance Provider Pressure (Table 3 – B/R.4.003) | 5,395 | | | Increased cost to adult social care as a result of NI changes - to be funded from re-baselining of adult social care inflation, the impact of the increase on people who pay the full cost for their care and an additional corporate contribution |
| Client contributions inflation (Table 3 - B/R.8b.003) | -2,404 | -2,116 | -1,717 | Client contributions inflation has been increased to reflect changes in pension / benefit levels and the impact of the NI changes on full costed income |
| Impact of increases in the Real Living Wage on adult social care contracts (Table 3 - B/R.2.002) | 7,742 | 5,889 | 6,254 | The Real Living Wage will rise by 5% to £12.60 in 2025-26. This will have an impact on the cost of purchasing care from external providers, so investment is proposed to meet that need. Real Living Wage pressures in later years are expected to follow OBR estimates and assume a 3% increase each year |
| Re-baselining ASC inflation opening position for 2025-26 (Table 3 - B/R.7.065) | -1,600 | | | £1.6 million of inflation budget not used in 2024-25 being used to offset the costs in relation to employer NI contributions |
| Re-baselining of Older People Demand (Table 3 - B/R.7.053) | -9,600 | | | Re-baselining budget for 2025-26 to reflect position seen in 2024-25. Net growth for 2025-26 and beyond is still budgeted for |

| Proposal and Table reference number | 2025-26 £000 | 2026-27 £000 | 2027-28 £000 | Detail |
|---|---|---|---|---|
| | | | | |
| Contract Management and brokerage - Invest to save (Table 3 - B/R.5.009) | 523 | | | Links to B/R.7.045 - invest to save by better managing contract outcomes, including costs, through increasing capacity in the contracts management and brokerage team. This will support placement decisions to have a greater focus through the contract management team, alongside developing the commercial aspects to deliver value for money and drive up standards |
| Contract Management and Brokerage (Table 3 - B/R.7.045) | -750 | -1,090 | | Invest to save. Maximise efficiencies across commissioned services along with maximising return on investment in those contracts. Shifting the focus away from preventative contract management to design out inefficiencies thus driving up standards and outcomes, alongside focusing on quality and delivery against the contract |
| Mental Health Supported Accommodation (Table 3 - B/R.7.006) | -267 | | | Retendering of the mental health supported accommodation framework and increasing local capacity to more effectively meet needs locally and reduce expensive off framework spend or out of county placements |
| Independent Living Services (Table 4 – B/C.1.003) | - | 9,943 | 11,322 | Capital investment in development of a range of independent living service accommodation in East Cambridgeshire, with additional capital investment planned across the county in future years (Table 4 |

| Proposal and Table reference number | 2025-26 £000 | 2026-27 £000 | 2027-28 £000 | Detail |
|---|---|---|---|---|
| | | | | B/C.1.004) |
| Specialist Accommodation Schemes (Table 4 – B/C.1.005) | 3,000 | 6,000 | 3,000 | Capital investment in specialist accommodation services providing accommodation for people with complex or challenging needs who have to be accommodated in single service accommodation or settings with a small number of other people |

The medium-term financial plan for the directorate is:

Table 3.3 – medium-term financial plan

| | 2025-26 gross to net | | Net budget | | | | |
|---|---|---|---|---|---|---|---|
| **£000** | **Spend** | **Income** | **2025-26** | **2026-27** | **2027-28** | **2028-29** | **2029-30** |
| Executive Director | 17,202 | -53,151 | -35,049 | -35,831 | -35,140 | -33,664 | -31,620 |
| LDP and Prevention | 130,059 | -6,535 | 123,525 | 126,659 | 133,175 | 141,808 | 150,704 |
| Care and Assessment | 146,538 | -44,913 | 101,625 | 106,000 | 111,724 | 119,400 | 127,564 |
| Commissioning | 60,046 | -10,908 | 49,137 | 52,330 | 55,803 | 59,734 | 63,844 |
| Public Health | 31,422 | -31,422 | 0 | 0 | 27,111 | 27,111 | 27,111 |
| **Total** | **385,266** | **-146,929** | **238,338** | **249,158** | **292,673** | **314,390** | **337,603** |

# 4. Funding

4.1 The council draws its funding from two main sources – government grants and locally generated revenue (predominantly council tax, as well as business rates, and then from charging for council services).

Government Grants

4.1.1 The Government has increasingly given councils specific, but un-ringfenced, grants to provide some support to emerging pressures, particularly relating to social care and its own priorities. The largest of these grants is the Social care support grant - £45.8 million. This grant is given to support social care costs across both Adults and Children's social care and for this reason is treated as a corporate grant and not shown explicitly in the Adults, Health and Commissioning tables.

4.1.2 The Adults, Health and Commissioning directorate receives a number of ring-fenced grants both directly from Government, and via the NHS through the Better Care Fund which supports adult social care.

4.1.3 The expected grants for Adults, Health and Commissioning are:

Table 4.1.4 – expected grants

| Grant | Amount 2025-26 |
|---|---|
| **Ringfenced grants:** | |
| Better Care Fund (from NHS) | £22.0m |
| Local Authority Better Care Grant (incorporating Improved Better Care Fund and Adult Social Care Discharge Fund) | £18.7m |
| Public Health grant | £28.6m |
| Social Care in Prisons grant | £0.3m |
| Adult Social Care Market Sustainability and Improvement Fund | £10.2m |
| **Total grants** | **£79.8m** |

Fees and charges

4.2 The total fees and charges budget for the Adults, Health and Commissioning directorate for 2025-26 is £67.2m. Examples of these fees and charges are statutory assessed social care contributions from individuals receiving care.

4.3 In accordance with the council's scheme of financial management, Executive Directors are personally responsible for reviewing annually the levels of fees and charges, in consultation with the section 151 officer and presenting a schedule of fees and charges to the relevant service committee. The planned fees and charges within the remit of this committee are included as Appendix 2.

# 5. Capital

5.1 The capital programme for this committee comprises £8.5m of expenditure in 2025-26 and a further £69.6m up to 2030. Full details are provided in tables 4 and 5 of the appendix 4 to this report. This includes the following key schemes:

Table 5.1 – Adults, Health and Commissioning key capital schemes

| Total | **Prev Years £m** | **2025-26 £m** | **2026-27 £m** | **2027-28 £m** | **2028-29 £m** | **2029-30 £m** | **Later Yrs £m** | **Total £m** |
|---|---|---|---|---|---|---|---|---|
| Disabled Facilities Grant | - | £5.5m | £5.5m | £5.5m | £5.5m | £5.5m | £27.7m | £55.3m |
| Independent Living Service – East Cambridgeshire | £0.5m | - | £9.9m | £11.3m | - | - | - | £21.7m |
| Independent Living Services | - | - | - | - | £11.0m | £11.0m | - | £22.0m |
| Specialist Accommodation Schemes | - | £3.0m | £6.0m | £3.0m | - | - | - | £12.0m |

Table 5.2 – capital funding

| **Funding** | **Total funding £000** | Previous Years £000 | 2025-26 £000 | 2026-27 £000 | 2027-28 £000 | 2028-29 £000 | 2029-30 £000 | Later Years £000 |
|---|---|---|---|---|---|---|---|---|
| **Government Approved Funding** | | | | | | | | |
| Specific Grants | 55,300 | - | 5,530 | 5,530 | 5,530 | 5,530 | 5,530 | 27,650 |
| **Locally Generated Funding** | | | | | | | | |
| Prudential Borrowing | 63,000 | 462 | 3,014 | 14,327 | 13,153 | 9,921 | 10,123 | 2,000 |
| **TOTAL FUNDING** | **108,300** | **462** | **8,544** | **19,857** | **18,683** | **15,451** | **15,653** | **29,650** |

# 6. Significant Implications

6.1 Finance implications

The proposals set out the response to the financial context and the need to review our service offer and models to maintain a sustainable budget. The full detail of the financial proposals and impact on budget will be described in the financial tables of the business plan. Proposals will seek to ensure that we make the most effective use of available resources and are delivering the best possible services given the reduced funding.

6.2 Legal implications

The proposals set out in this report respond to the statutory duty on the Local Authority to deliver a balanced budget. Cambridgeshire County Council will continue to meet the range of statutory duties to support our residents under the Care Act 2014 and other relevant legislation.

6.3 Risk implications

Services have considered risk in developing the proposals for investment and savings shown in the financial plan and these will be reflected in their usual risk management arrangements. There is a risk that budget proposals will impact on delivery of the Council's Strategic Framework, but this will be monitored, and appropriate action taken. There is a risk that assumptions within these proposals are incorrect.. Due diligence has been undertaken, as well as assessment within the reserves to mitigate such risks. In addition, the de-coupling of the Learning Disability Partnership (LDP) and ending of Pooled Budget arrangements, does present significant financial risks associated with care packages for people drawing on care and support, and the ongoing financial commitments associated with them. This risk also has implications on the delivery of savings in 25/26 and beyond.

6.4 Equality and Diversity implications

Each of the proposals will be developed alongside an Equality Impact Assessment, where required, to ensure we have discharged our duties in line with the Equality Act 2010, including the Public Sector Equality Duty, as well as met our commitment to implementing the Socio-economic Inequalities Duty.

## 7. Source Documents

7.1 Our Future Council - Change Strategy (October SR&P 2024)

7.2 Business Planning and Budget Setting 2025-26 (December SR&P 2024)

# Section 3: Detailed Finance Tables

Revenue: 2025-30

Capital: 2025-35

# Detailed Finance Tables

## Introduction

There are five types of finance tables in our Business Plan. Tables 1-3 relate to all directorates for revenue, while only some directorates have tables 4 & 5 showing the capital programme. Tables 1, 2 & 3 show a directorate's revenue budget in different presentations.

- Table 1 shows the combined impact of budget changes on directorates and service budget lines over the five year medium-term.
- Table 2 shows the impact of changes in the first year on each directorate and service budget line.
- Table 3 shows the detailed changes, line-by-line, to each directorate's budget

Tables 4 and 5 outline directorates' capital budget, with Table 4 detailing capital expenditure for individual proposals, and Table 5 showing how individual capital proposals are funded.

## Table 1

This presents the net budget split by service budget line for each of the five years of the Business Plan. It also shows the revised opening budget and the gross budget, together with fees, charges and ring-fenced grant income, for 2025-26 split by service budget line. The purpose of this table is to show how the budget for a directorate changes over the period of the Business Plan.

## Table 2

This presents additional detail on the net budget for 2025-26 split by service budget line. The purpose of the table is to show how the budget for each line has been constructed: inflation, demography and demand, pressures, investments, savings and income are added to the opening budget to give the closing budget.

## Table 3

Table 3 explains in detail the changes to the previous year's budget over the period of the Business Plan, in the form of individual proposals.

The numbers for proposals in table 3 need to be read recurrently – in other words a budget increase in a given year is taken to be permanent (because it adds to the closing budget, which becomes the next year's opening budget). A one-off or temporary budget change is shown with a number that contras the original entry. For example a one-off saving of £500k in 2025-26 would show as a -£500k in 2025-26 and a reversing entry of +£500k in 2026-27.

At the top Table 3 takes the previous year's gross budget and then adjusts for proposals, grouped together in sections, covering inflation, demography and demand, pressures, investments and savings to give the new gross budget. The gross budget is reconciled to the net budget in Section 8. Finally, the sources of funding are listed in Section 9. An explanation of each section is given below:

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

- ### Revised Opening Gross Expenditure:
  Adjustments that are made to the base budget to reflect permanent changes in a directorate. This is often to reflect a transfer of services from one area to another, or budget changes made in-year in the previous year.

- ### Inflation:
  Additional budget provided to allow for pressures created by inflation. These inflationary pressures are particular to the activities covered by the directorate, and also cover staffing inflation.

- ## Demography and Demand:
  Additional budget provided to allow for pressures created by demography and increased demand. These demographic pressures are particular to the activities covered by the directorate. Demographic changes are backed up by a robust programme to challenge and verify requests for additional budget.

- ## Pressures:
  These are specific additional pressures identified that require further budget to support.

- ## Priorities & Investments:
  These are proposals where additional budget is provided to support the ambitions and priorities of the council

- ## Use of reserves:
  This shows the change in budget for reserves draw-downs, used to fund specific service lines in the main directorate tables, or used to contribute to overall funding in the corporate table (section H). For directorates, these numbers are not necessarily the absolute value of reserves being used, just the budget changes. A list of actual reserves uses can be found in section 2 of the business plan (the medium-term financial strategy).

- ## Savings:
  These are savings proposals that indicate services that will be reduced, stopped or delivered differently to reduce the costs of the service. They could be one-off entries or span several years.

- ## Total Gross Expenditure:
  The newly calculated gross budget allocated to the directorate after allowing for all the changes indicated above. This becomes the Opening Gross Expenditure for the following year.

- ### Income:
  This lists the fees, charges and grants that offset the directorate's gross budget. The section starts with the carried forward figure from the previous year and then lists changes applicable in the current year.

- ### Total Net Expenditure:
  The net budget for the directorate after deducting fees, charges and ring-fenced grants from the gross budget.

- ### Funding Sources:
  How the gross budget is funded – funding sources include cash limit funding (central funding from Council Tax, business rates and government grants), fees and charges, and individually listed ring-fenced grants.

## Table 4

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

## Table 5

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

Note that there may be small rounding differences between tables that show the same gross, income and net budget information.

## Section 3 - B: Adults, Health and Commissioning

### Table 1: Revenue - Summary of Net Budget by Service Line

**Budget Period: 2025-26 to 2029-30**

| Net Revised Opening Budget 2024-25 £000 | Policy Line | Gross Budget 2025-26 £000 | Income Budget 2025-26 £000 | Net Budget 2025-26 £000 | Net Budget 2026-27 £000 | Net Budget 2027-28 £000 | Net Budget 2028-29 £000 | Net Budget 2029-30 £000 |
|---|---|---|---|---|---|---|---|---|
| | **Executive Director** | | | | | | | |
| -37,360 | Executive Director - Adults, Health and Commissioning | 11,533 | -52,974 | -41,441 | -43,182 | -44,574 | -45,087 | -45,100 |
| 209 | Staffing Inflation - AHC | 1,796 | - | 1,796 | 3,655 | 5,578 | 7,567 | 9,624 |
| 3,130 | Performance and Strategic Development | 3,214 | -177 | 3,037 | 3,037 | 3,197 | 3,197 | 3,197 |
| 644 | Principal Social Worker | 660 | - | 660 | 660 | 660 | 660 | 660 |
| **-33,377** | **Subtotal Executive Director** | **17,202** | **-53,151** | **-35,949** | **-35,831** | **-35,140** | **-33,664** | **-31,620** |
| | **Service Director – LDP and Prevention** | | | | | | | |
| 320 | Service Director – LDP and Prevention | 328 | -92 | 235 | 235 | 235 | 235 | 235 |
| 11,330 | Prevention and Early Intervention | 11,943 | -410 | 11,533 | 11,229 | 11,234 | 11,241 | 11,248 |
| 2,422 | Transfers of Care | 2,482 | - | 2,482 | 2,482 | 2,482 | 2,482 | 2,482 |
| 4,131 | Autism and Adult Support | 4,348 | -179 | 4,170 | 4,652 | 5,154 | 5,712 | 6,297 |
| | *Learning Disabilities* | | | | | | | |
| 111 | LD Head of Service | -76 | - | -76 | -306 | -536 | -536 | -536 |
| 40,380 | LD - City, South and East Localities | 45,824 | -2,989 | 42,835 | 44,237 | 47,057 | 50,722 | 54,491 |
| 36,104 | LD - Hunts and Fenland Localities | 40,742 | -2,373 | 38,369 | 39,687 | 42,228 | 45,502 | 48,871 |
| 12,654 | LD - Young Adults Team | 13,787 | -284 | 13,503 | 13,972 | 14,851 | 15,984 | 17,151 |
| 10,283 | LD - In House Provider Services | 10,681 | -208 | 10,473 | 10,471 | 10,469 | 10,467 | 10,464 |
| **117,735** | **Subtotal Service Director – LDP and Prevention** | **130,059** | **-6,535** | **123,525** | **126,659** | **133,175** | **141,808** | **150,704** |
| | **Service Director – Care and Assessment** | | | | | | | |
| 1,045 | Service Director - Care and Assessment | 1,068 | - | 1,068 | 1,068 | 1,068 | 1,068 | 1,068 |
| 5,388 | Assessment and Care Management | 5,526 | -46 | 5,480 | 5,479 | 5,477 | 5,475 | 5,474 |
| 1,563 | Safeguarding | 1,608 | - | 1,608 | 1,608 | 1,608 | 1,608 | 1,608 |
| 2,089 | Adults Finance Operations | 2,137 | - | 2,137 | 2,137 | 2,137 | 2,137 | 2,137 |
| | *Older People's and Physical Disabilities Services* | | | | | | | |
| 36,734 | Older Peoples Services - North | 55,588 | -20,612 | 34,976 | 36,747 | 39,212 | 42,487 | 46,018 |
| 43,451 | Older Peoples Services - South | 64,105 | -22,064 | 42,041 | 44,026 | 46,655 | 50,246 | 54,099 |
| 6,608 | Physical Disabilities - North | 8,040 | -1,072 | 6,968 | 7,276 | 7,586 | 7,982 | 8,367 |
| 7,002 | Physical Disabilities - South | 8,466 | -1,119 | 7,347 | 7,660 | 7,983 | 8,397 | 8,794 |
| **103,881** | **Subtotal Service Director – Care and Assessment** | **146,538** | **-44,913** | **101,625** | **106,000** | **111,724** | **119,400** | **127,564** |
| | **Service Director - Commissioning** | | | | | | | |
| 844 | Service Director - Commissioning | 1,117 | - | 1,117 | 1,281 | 1,453 | 1,637 | 1,831 |
| 2,883 | Adults Commissioning - Staffing | 3,461 | - | 3,461 | 3,561 | 3,415 | 3,411 | 3,408 |
| 1,423 | Children's Commissioning - Staffing | 1,450 | - | 1,450 | 1,450 | 1,450 | 1,450 | 1,450 |
| 5,330 | Adults Commissioning - Contracts | 9,410 | -3,950 | 5,461 | 5,467 | 5,363 | 5,364 | 5,364 |

## Section 3 - B: Adults, Health and Commissioning

### Table 1: Revenue - Summary of Net Budget by Service Line

**Budget Period: 2025-26 to 2029-30**

| Net Revised Opening Budget 2024-25 £000 | Policy Line | Gross Budget 2025-26 £000 | Income Budget 2025-26 £000 | Net Budget 2025-26 £000 | Net Budget 2026-27 £000 | Net Budget 2027-28 £000 | Net Budget 2028-29 £000 | Net Budget 2029-30 £000 |
|---|---|---|---|---|---|---|---|---|
| 6,229 | Housing Related Support | 7,062 | -596 | 6,466 | 6,659 | 6,862 | 7,079 | 7,309 |
| 2,239 | Integrated Community Equipment Service | 5,189 | -2,851 | 2,338 | 2,424 | 2,553 | 2,638 | 2,724 |
| | *Mental Health* | | | | | | | |
| 3,959 | Mental Health - Staffing | 4,125 | -61 | 4,064 | 4,104 | 4,146 | 4,189 | 4,234 |
| 2,609 | Mental Health Commissioning | 3,286 | -542 | 2,744 | 2,835 | 3,149 | 3,250 | 3,357 |
| 8,084 | Adult Mental Health | 11,002 | -649 | 10,353 | 11,630 | 13,062 | 14,672 | 16,336 |
| 9,186 | Older People Mental Health | 13,944 | -2,261 | 11,683 | 12,919 | 14,350 | 16,044 | 17,833 |
| **42,785** | **Subtotal Service Director - Commissioning** | **60,046** | **-10,908** | **49,137** | **52,330** | **55,803** | **59,734** | **63,844** |
| | **Public Health** | | | | | | | |
| 9,467 | Children Health - Main | 9,467 | - | 9,467 | 9,467 | 9,467 | 9,467 | 9,467 |
| 957 | Children Health - Other | 957 | - | 957 | 957 | 957 | 957 | 957 |
| 5,123 | Drug and Alcohol Misuse | 6,927 | -1,804 | 5,123 | 5,123 | 5,123 | 5,123 | 5,123 |
| 5,468 | Sexual Health and Contraception | 5,613 | -145 | 5,468 | 5,468 | 5,468 | 5,468 | 5,468 |
| 2,219 | Behaviour Change Services | 2,597 | -558 | 2,039 | 2,039 | 2,039 | 2,039 | 2,039 |
| 664 | Smoking Cessation | 1,550 | -886 | 664 | 664 | 664 | 664 | 664 |
| 704 | NHS Health Checks | 704 | - | 704 | 704 | 704 | 704 | 704 |
| 147 | Other Health Improvement | 147 | - | 147 | 147 | 147 | 147 | 147 |
| 154 | General Prevention Activities | 24 | - | 24 | 24 | 24 | 24 | 24 |
| 214 | Adult Mental Health and Community Safety | 321 | -107 | 214 | 214 | 214 | 214 | 214 |
| -25,117 | Public Health Service | 3,116 | -27,923 | -24,807 | -24,807 | 2,304 | 2,304 | 2,304 |
| **0** | **Subtotal Public Health** | **31,422** | **-31,422** | **0** | **0** | **27,111** | **27,111** | **27,111** |
| | | | | | | | | |
| **231,025** | **Adults, Health and Commissioning Budget Total** | **385,266** | **-146,929** | **238,338** | **249,158** | **292,673** | **314,390** | **337,603** |

## Section 3 - B: Adults, Health and Commissioning

### Table 2: Revenue - Net Budget Changes by Service Line

**Budget Period: 2025-26**

| Policy Line | Net Revised Opening Budget | Net Inflation | Demography & Demand | Pressures | Priorites & Investments | Use of Reserves | Savings | Income Changes | Net Budget |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Executive Director** | | | | | | | | | |
| Executive Director - Adults, Health and Commissioning | -37,360 | -53 | - | 19 | -1,105 | 1,215 | -3,076 | -1,081 | -41,441 |
| Staffing Inflation - AHC | 209 | 1,587 | - | - | - | - | - | - | 1,796 |
| Performance and Strategic Development | 3,130 | -2 | - | 68 | - | - | - | -160 | 3,037 |
| Principal Social Worker | 644 | - | - | 15 | - | - | - | - | 660 |
| **Subtotal Executive Director** | **-33,377** | **1,532** | **-** | **103** | **-1,105** | **1,215** | **-3,076** | **-1,241** | **-35,949** |
| **Service Director – LDP and Prevention** | | | | | | | | | |
| Service Director – LDP and Prevention | 320 | - | - | -85 | - | - | - | - | 235 |
| Prevention and Early Intervention | 11,330 | 6 | - | 271 | 155 | - | -228 | - | 11,533 |
| Transfers of Care | 2,422 | 13 | - | 47 | - | - | - | - | 2,482 |
| Autism and Adult Support | 4,131 | 112 | 398 | 49 | - | - | -520 | - | 4,170 |
| *Learning Disabilities* | | | | | | | | | |
| LD Head of Service | 111 | -9 | - | 3 | -737 | 556 | - | - | -76 |
| LD - City, South and East Localities | 40,380 | 1,347 | 2,256 | 475 | - | - | -1,623 | - | 42,835 |
| LD - Hunts and Fenland Localities | 36,104 | 1,252 | 1,981 | 438 | - | - | -1,405 | - | 38,369 |
| LD - Young Adults Team | 12,654 | 489 | 633 | 168 | - | - | -441 | - | 13,503 |
| LD - In House Provider Services | 10,283 | -21 | - | 211 | - | - | - | - | 10,473 |
| **Subtotal Service Director – LDP and Prevention** | **117,735** | **3,189** | **5,268** | **1,575** | **-582** | **556** | **-4,217** | **-** | **123,525** |
| **Service Director – Care and Assessment** | | | | | | | | | |
| Service Director - Care and Assessment | 1,045 | 7 | - | 16 | -500 | 500 | - | - | 1,068 |
| Assessment and Care Management | 5,388 | -2 | - | 95 | - | - | - | - | 5,480 |
| Safeguarding | 1,563 | 17 | - | 27 | - | - | - | - | 1,608 |
| Adults Finance Operations | 2,089 | - | - | 47 | - | - | - | - | 2,137 |
| *Older People's and Physical Disabilities Services* | | | | | | | | | |
| Older Peoples Services - North | 36,734 | 1,556 | 1,026 | 1,566 | - | - | -5,781 | -125 | 34,976 |
| Older Peoples Services - South | 43,451 | 1,839 | 1,080 | 1,779 | - | - | -5,974 | -135 | 42,041 |
| Physical Disabilities - North | 6,608 | 246 | 223 | 86 | - | - | -195 | - | 6,968 |
| Physical Disabilities - South | 7,002 | 249 | 244 | 93 | - | - | -240 | - | 7,347 |
| **Subtotal Service Director – Care and Assessment** | **103,881** | **3,912** | **2,573** | **3,709** | **-500** | **500** | **-12,190** | **-260** | **101,625** |
| **Service Director - Commissioning** | | | | | | | | | |
| Service Director - Commissioning | 844 | 201 | - | 72 | -305 | 305 | - | - | 1,117 |
| Adults Commissioning - Staffing | 2,883 | 2 | - | 53 | 523 | - | - | - | 3,461 |
| Children's Commissioning - Staffing | 1,423 | 0 | - | 27 | - | - | - | - | 1,450 |
| Adults Commissioning - Contracts | 5,330 | - | - | - | 326 | - | -192 | -3 | 5,461 |
| Housing Related Support | 6,229 | 236 | - | 76 | - | - | -75 | - | 6,466 |
| Integrated Community Equipment Service | 2,239 | 67 | 35 | - | - | - | - | -2 | 2,338 |
| *Mental Health* | | | | | | | | | |
| Mental Health - Staffing | 3,959 | 60 | - | 45 | - | - | - | - | 4,064 |
| Mental Health Commissioning | 2,609 | 110 | - | 35 | - | - | - | -9 | 2,744 |
| Adult Mental Health | 8,084 | 286 | 1,236 | 1,253 | - | - | -506 | - | 10,353 |
| Older People Mental Health | 9,186 | 547 | 938 | 1,284 | - | - | -272 | - | 11,683 |
| **Subtotal Service Director - Commissioning** | **42,785** | **1,510** | **2,209** | **2,844** | **544** | **305** | **-1,045** | **-15** | **49,137** |

## Section 3 - B: Adults, Health and Commissioning

### Table 2: Revenue - Net Budget Changes by Service Line

**Budget Period: 2025-26**

| Policy Line | Net Revised Opening Budget<br>£000 | Net Inflation<br>£000 | Demography & Demand<br>£000 | Pressures<br>£000 | Priorites & Investments<br>£000 | Use of Reserves<br>£000 | Savings<br>£000 | Income Changes<br>£000 | Net Budget<br>£000 |
|---|---|---|---|---|---|---|---|---|---|
| **Public Health** | | | | | | | | | |
| Children Health - Main | 9,467 | - | - | - | - | - | - | - | 9,467 |
| Children Health - Other | 957 | - | - | - | - | - | - | - | 957 |
| Drug and Alcohol Misuse | 5,123 | - | - | - | - | - | - | - | 5,123 |
| Sexual Health and Contraception | 5,468 | - | - | - | - | - | - | - | 5,468 |
| Behaviour Change Services | 2,219 | - | - | - | - | - | -180 | - | 2,039 |
| Smoking Cessation | 664 | - | - | - | - | - | - | - | 664 |
| NHS Health Checks | 704 | - | - | - | - | - | - | - | 704 |
| Other Health Improvement | 147 | - | - | - | - | - | - | - | 147 |
| General Prevention Activities | 154 | - | - | - | - | - | -130 | - | 24 |
| Adult Mental Health and Community Safety | 214 | - | - | - | - | - | - | - | 214 |
| Public Health Service | -25,117 | 130 | - | - | - | - | -306 | 486 | -24,807 |
| **Subtotal Public Health** | **0** | **130** | **-** | **-** | **-** | **-** | **-616** | **486** | **0** |
| **Adults, Health and Commissioning Budget Total** | **231,025** | **10,273** | **10,050** | **8,231** | **-1,643** | **2,576** | **-21,144** | **-1,030** | **238,338** |

## Section 3 - B: Adults, Health and Commissioning

### Table 3: Revenue - Overview

**Budget Period: 2025-26 to 2029-30**

| Ref | Title | 2025-26 £000 | 2026-27 £000 | 2027-28 £000 | 2028-29 £000 | 2029-30 £000 | Description |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| **1** | **OPENING GROSS EXPENDITURE** | **410,161** | **385,266** | **399,418** | **417,066** | **440,610** | |
| B/R.1.001 | Base Adjustments | 2,785 | - | - | - | - | Adjustments made to the expenditure budget as part of budget preparation for 2024-25, in line with officer delegations. |
| B/R.1.002 | Permanent Virement - PVs | 1,731 | - | - | - | - | Budget movements in 2024-25 reflected in the base, in line with officer delegations and/or committee decisions made in 2024-25. |
| B/R.1.003 | Adjustment to Public Health funded spend between Directorates | 184 | - | - | - | - | Adjustment between Directorates for spend funded by Public Health grant. |
| B/R.1.008 | Base adjustment for cessation of Learning Disability Partnership pooled budget with the NHS Integrated Care Board | -33,353 | - | - | - | - | Base adjustment for cessation of Learning Disability Partnership. |
| B/R.1.009 | Base adjustment for ending of shared service arrangements with Peterborough City Council | -7,068 | - | - | - | - | Base adjustment for the ending of shared service arrangements and shared commissioning with Peterborough City Council |
| **1.99** | **REVISED OPENING GROSS EXPENDITURE** | **374,440** | **385,266** | **399,418** | **417,066** | **440,610** | |
| **2** | **INFLATION** | | | | | | |
| B/R.2.001 | Adult social care providers inflation | 3,060 | 3,290 | 3,430 | 3,686 | 3,859 | Investment in funding to meet general inflation factors, relating to care providers. |
| B/R.2.002 | Impact of increases in the Real Living Wage (RLW) on Adult Social Care Contracts | 7,742 | 5,889 | 6,254 | 6,691 | 7,157 | The Real Living Wage will rise by 5% to £12.60 in 2025-26. This will have an impact on the cost of purchasing care from external providers, so investment is proposed to meet that. RLW pressures in later years are expected to follow OBR estimates and assume a 3% increase each year. |
| B/R.2.003 | AHC inflation - miscellaneous other budgets | 237 | 220 | 193 | 226 | 232 | Forecast pressure for inflation relating to miscellaneous other budgets. |
| B/R.2.004 | Staff pay inflation | 1,797 | 1,859 | 1,923 | 1,989 | 2,057 | Assumed 3.5% increase per annum. |
| B/R.2.005 | 2024-25 Staff pay inflation upside | -210 | - | - | - | - | Reduction in inflation due to 2024-25 budgeted AHC staff pay inflation being more than the agreed pay award. |
| B/R.2.501 | Staff pay inflation (Public Health grant funded) | 128 | 132 | 137 | 142 | 147 | Assumed 3.5% increase per annum for staff funded via the Public Health grant. |

## Section 3 - B: Adults, Health and Commissioning

### Table 3: Revenue - Overview

**Budget Period: 2025-26 to 2029-30**

| Ref | Title | 2025-26 £000 | 2026-27 £000 | 2027-28 £000 | 2028-29 £000 | 2029-30 £000 | Description |
|---|---|---|---|---|---|---|---|
| B/R.2.502 | Miscellaneous other inflation funded from Public Health grant | 2 | 2 | 2 | 2 | 2 | Forecast pressure for inflation relating to miscellaneous other budgets funded from the Public Health grant. |
| **2.99** | **Subtotal Inflation** | **12,756** | **11,392** | **11,939** | **12,736** | **13,454** | |
| **3** | **DEMOGRAPHY AND DEMAND** | | | | | | |
| B/R.3.001 | Additional funding for Older People demand | 2,106 | 2,510 | 2,735 | 2,967 | 3,207 | Additional funding to ensure we meet the demand for care amongst older people providing care at home as well as residential and nursing placements. Forecast increases in the older people population are modelled forward, with account being taken of increasing complexity of cases coming through the service. Net growth for 2025-26 is still budgeted for. |
| B/R.3.002 | Additional funding for Physical Disabilities demand | 467 | 477 | 406 | 356 | 302 | Additional funding to ensure we meet the increased demand for care for people with physical disabilities. The current pattern of activity and expenditure is modelled forward using population forecasts and activity data. Account is then taken of the increasing need of people who use our services. This work has supported the case for additional funding of £467k in 2025-26. Net growth for 2025-26 is still budgeted for. |
| B/R.3.003 | Additional funding for Autism and Adult Support demand | 398 | 417 | 436 | 456 | 477 | Additional funding to ensure we are able to support the increasing number of adults with autism. Demand funding reflects both expected increases in numbers of people being supported and increasing needs of those people already receiving services. |
| B/R.3.004 | Additional funding for Learning Disability demand | 4,870 | 5,008 | 5,131 | 5,228 | 5,300 | Additional funding to ensure we meet the rising level of needs amongst people with a learning disability. This largely reflects increasing needs of those people already receiving services, but some small increase in numbers is also assumed. |
| B/R.3.005 | Additional funding for Older People Mental Health Demand | 938 | 979 | 1,021 | 1,064 | 1,108 | Additional funding to ensure we meet the increased demand for care amongst older people with mental health needs, providing care at home as well as residential and nursing placements. The current pattern of activity and expenditure is modelled forward using population forecasts to estimate the additional budget requirement for each age group and type of care. This work has supported the case for additional funding of £938k in 2025-26 to ensure we can continue to provide the care for people who need it. |

## Section 3 - B: Adults, Health and Commissioning

### Table 3: Revenue - Overview

**Budget Period: 2025-26 to 2029-30**

| Ref | Title | 2025-26 £000 | 2026-27 £000 | 2027-28 £000 | 2028-29 £000 | 2029-30 £000 | Description |
|---|---|---|---|---|---|---|---|
| B/R.3.006 | Additional funding for Adult Mental Health Demand | 1,236 | 1,271 | 1,308 | 1,345 | 1,383 | Additional funding to ensure we meet the increased demand for care amongst working age adults with mental health needs. The current pattern of activity and expenditure is modelled forward using population forecasts and data relating to the prevalence of mental health needs. This work has supported the case for additional funding of £1,236k in 2025-26 to ensure we can continue to provide the care for people who need it. |
| B/R.3.007 | Additional funding for demand for Community Equipment | 35 | 35 | 35 | 35 | 35 | Over the last five years, our strategy has seen a positive movement in supporting people to live at home for longer, maximising their independence through the use of community equipment as a key element of our prevention and early intervention approach. Additional funding is required to maintain the proportion of people supported to live independently, through the provision of community equipment and home adaptations. |
| **3.99** | **Subtotal Demography and Demand** | **10,050** | **10,697** | **11,072** | **11,451** | **11,812** | |
| **4** | **PRESSURES** | | | | | | |
| B/R.4.001 | Adult Social Care market pressures - workforce development | -88 | - | - | - | - | Ending of one-off funding to support workforce development in the Adult Social Care market. Total investment over the 2 year period was £240k. |
| B/R.4.002 | Rebaselining mental health opening position for 2025-26 | 1,898 | - | - | - | - | Mental health budgets have seen pressures in 2024-25 from rising numbers and complexity of people needing care. This line re-baselines the budget to give an opening position for 2025-26 that reflects this increased cost. |
| B/R.4.003 | Impact of Employer National Insurance changes on the ASC provider market | 5,395 | - | - | - | - | Expected impact of the increase in employer NI rates and threshold changes on ASC provider costs. |
| B/R.4.004 | Impact of Employer National Insurance changes on the Council's ASC workforce costs | 1,026 | - | - | - | - | Expected AHC staffing cost increase due to planned NI rate and threshold changes. |
| **4.99** | **Subtotal Pressures** | **8,231** | **-** | **-** | **-** | **-** | |
| **5** | **PRIORITIES AND INVESTMENTS** | | | | | | |
| B/R.5.001 | Adults Retention Payments | 10 | -49 | - | - | - | An investment was made into retention payments in previous years; this line reflects the planned reduction of the new budget required for that over time as other costs come down. |

## Section 3 - B: Adults, Health and Commissioning

### Table 3: Revenue - Overview

**Budget Period: 2025-26 to 2029-30**

| Ref | Title | 2025-26 £000 | 2026-27 £000 | 2027-28 £000 | 2028-29 £000 | 2029-30 £000 | Description |
|---|---|---|---|---|---|---|---|
| B/R.5.005a | Investment in staffing to deliver cost avoidance savings | - | - | -150 | - | - | Ending of 3-year investment from reserves to support a Residential / nursing project - links to saving B/R.7.009. |
| B/R.5.005b | Investment into review of In house provision and opportunities | -100 | - | - | - | - | Ending of one-off investment funded from reserves to support scoping of opportunities associated with delivery of in-house services savings. |
| B/R.5.005c | Investment into review of Discharge pathways | -500 | - | - | - | - | Ending of one-off investment funded from reserves to undertake a diagnostic review of local hospital discharge pathways to ensure we are embedding the home first approach and maximising opportunities to support people to optimise their recovery and independence post discharge. |
| B/R.5.005d | Investment into review of prevention agenda | -305 | -58 | - | - | - | Ending of one-off investment funded from reserves to support expansion of Care Together programme to deliver an all-age locality prevention strategy to manage demand. This includes further developing the prevention agenda across the breadth of adult social care, to support people's independence and prevent the need to access adult's services. It also includes exploration of opportunities to enhance the council's digital offer, to promote more self-service. |
| B/R.5.005e | Investment into review of Learning Disability spend | -648 | - | - | - | - | Ending of one-off investment funded from reserves to ensure capacity and resource to support delivery of change in services for people with learning disabilities. Links to savings B/R.7.016 - B/R.7.018. |
| B/R.5.005f | Investment in expansion of LD Shared Lives outreach | -89 | -46 | - | - | - | Ending of one-off investment funded from reserves in additional resource to support the expansion of the outreach service for people with learning disabilities. |
| B/R.5.005g | Investment required for decoupling of Learning Disability pooled budget | -1,115 | - | - | - | - | Ending of one-off investment funded from reserves in capacity and resource to support the work needed to decouple the Learning Disability Partnership pooled budget arrangement with Cambridgeshire and Peterborough Integrated Care Board (C&P ICB). Links to saving B/R.7038. |
| B/R.5.008 | Social Work apprenticeships | 149 | 6 | -35 | -120 | - | Links to B/R.7.040 - invest to save work through growing social work experience in house by increasing social worker apprentice capacity, reducing the dependence on short-term and temporary staffing. |

## Section 3 - B: Adults, Health and Commissioning

### Table 3: Revenue - Overview

**Budget Period: 2025-26 to 2029-30**

| Ref | Title | 2025-26 £000 | 2026-27 £000 | 2027-28 £000 | 2028-29 £000 | 2029-30 £000 | Description |
|---|---|---|---|---|---|---|---|
| B/R.5.009 | Contract Management and brokerage - Invest to save | 523 | - | - | - | - | Links to B/R.7.045 - invest to save by better managing contract outcomes, including costs, through increasing capacity in the contracts management and brokerage team. This will support placement decisions to have a greater focus through the contract management team, alongside developing the commercial aspects to deliver value for money and drive up standards. |
| B/R.5.010 | Double Up Care provision - Invest to save | 177 | - | -177 | - | - | Links to B/R.7.052 - invest to save through increasing new capacity to undertake reviews of double-up and high-cost care packages to identify opportunities to support greater independence, reduce long term care costs and improve outcomes. |
| B/R.5.011 | Quality Assurance Forum | 100 | - | - | - | - | Links to B/R.7.058 - invest to save through putting capacity in place to introduce a quality assurance forum ensuring a strength-based approach of practice and decision making, focused on achieving individual outcomes is embedded. |
| B/R.5.012 | Reablement - Physiotherapy Interventions | 155 | - | - | - | - | Links to B/R.7.061 - invest to save through more timely interventions, with a specific focus on physiotherapy, for people accessing support from prevention and early intervention services to maximise independence. |
| B/R.5.013 | Service User Flow and Demand | - | 150 | -150 | - | - | Links to B/R.7.062 - invest to save through additional capacity, enabling a review of use of resources to best manage the demand on our services, and allocation of resources to meet that demand. |
| B/R.5.014 | Brokerage e-procurement expansion - invest to save | - | 103 | -103 | - | - | Links to B/R.7.064 - invest to save through exploring the opportunity to develop our e-brokerage system, enabling more accurate timely and cost-effective placement activities. |
| **5.99** | **Subtotal Priorities & Investments** | **-1,643** | **106** | **-615** | **-120** | **-** | |
| **6** | **USE OF RESERVES** | | | | | | |
| B/R.6.005h | Funding from Adults reserves for invest to save schemes | 256 | 104 | 150 | - | - | Investment from Adult's reserves funding to contribute towards the cost of one-off investments to support delivery of adult's savings. Links to investments B/R.5.005a-g. This reserve movement was added in the 2024-25 Business Plan. A total of £510k was drawn down in 2042-25. £256k of this will be unwound in 2025-26, £104k in 2026-27 and £150k in 2027-28. |

## Section 3 - B: Adults, Health and Commissioning

### Table 3: Revenue - Overview

**Budget Period: 2025-26 to 2029-30**

| Ref | Title | 2025-26 £000 | 2026-27 £000 | 2027-28 £000 | 2028-29 £000 | 2029-30 £000 | Description |
|---|---|---|---|---|---|---|---|
| B/R.6.005i | Funding from Just Transition Fund for invest to save schemes | 2,320 | - | - | - | - | Ending of investment from Just Transition funding to contribute towards the cost of one-off investments to support delivery of adult's savings. Links to investments B/R.5.005a-g. This reserve movement was added in the 2024-25 business plan. A total of £2,320k was drawn down in 2024-25 and this will be fully unwound in 2025-26. |
| **6.99** | **Subtotal Use of Reserves** | **2,576** | **104** | **150** | **-** | **-** | |
| **7** | **SAVINGS** | | | | | | |
| B/R.7.002 | Expansion of Direct Payments | -60 | - | - | - | - | The legacy savings generated in 2022-23 have facilitated a comprehensive review of the Self-Directed Support Programme. This programme is being re-focused on delivery for the periods 2024-25 and 2025-26, with clear timescales and designated responsibilities established. The scope of this work encompasses a variety of activities, including market shaping and development, process and system enhancements, practice improvements, a concentrated effort on the utilisation of direct payments during the transition from children to adults' services, and the further advancement of Individual Service Funds. |
| B/R.7.003 | Decommissioning of block contracts for car rounds providing homecare | -100 | - | - | - | - | We have provision to deliver homecare in the county using cars, enabling people to return from hospital, and providing care for people in hard-to-reach places. However, with demand being met by mainstream homecare providers, the homecare cars had a very low level of use and were no longer cost effective. Decommissioning of these contracts has therefore taken place over recent months, with no negative impacts for people requiring home care. |
| B/R.7.006 | Mental Health supported accommodation | -267 | - | - | - | - | Retendering of the mental health and autism supported accommodation framework provision. This covers a projected saving from reopening the Mental Health and Autism Supported Accommodation Framework. By increasing local capacity, we will be able to reduce the number of "off framework" or out of county placements, which are often more expensive in nature. |
| B/R.7.009 | Mental Health residential and community | -357 | -262 | - | - | - | A three-year investment from 2024-25 to deliver savings, focusing on improvements in current commissioned provision of mental health social care services in the following areas: - More efficient use of existing resources in care homes to meet the needs of people who receive one to one care. This will be delivered through commissioning care differently, moving to commissioning care across a group of individuals in a care home, rather than on an individual person by person basis; - The Mental Health social work teams are delivering a strengths based approach to increasing the independence levels of people with mental health needs over time within a supportive environment thereby reducing their care hours where it is safe and makes sense to do so. Links to investment B/R.5.005. |

## Section 3 - B: Adults, Health and Commissioning

### Table 3: Revenue - Overview

**Budget Period: 2025-26 to 2029-30**

| Ref | Title | 2025-26 £000 | 2026-27 £000 | 2027-28 £000 | 2028-29 £000 | 2029-30 £000 | Description |
|---|---|---|---|---|---|---|---|
| B/R.7.013 | Prevent, reduce and delay needs presenting - reablement | -465 | - | - | - | - | Our reablement service provides short term support for up to six weeks to help people regain their independence, for example after an illness or a stay in hospital, preventing the need to go into longer term care support. We aim to achieve greater capacity and flow in the service to allow more reablement activity to be undertaken and support more people to continue living in their own homes for longer. |
| B/R.7.014 | Accommodation - Supported Living, core and cluster capacity | - | -230 | -230 | - | - | Development of a supported living offer to manage future demand. Ensuring local capacity to meet needs at sustainable costs, reducing the need for more costly out of area placements. |
| B/R.7.016 | Learning Disability Low Cost placement review | -130 | - | - | - | - | Review of packages to ensure the right level of care and support is provided and people remain as independent as possible in their own homes. Links to investment B/R.5.006. |
| B/R.7.018 | Learning Disability Respite Utilisation | -95 | - | - | - | - | Increase respite utilisation rates by optimising scheduling and maximising use of the service. |
| B/R.7.026 | Independent Living Service - East Cambridgeshire | - | - | -119 | - | - | We are exploring alternative accommodation models of delivery for residential and nursing care provision, including a tenancy based model that offers more choice and control for people at a lower cost to the council. This will mean the proposed scheme here has moved into later years, for deliverability. |
| B/R.7.038 | Savings from ending of Learning Disability pooled budget arrangements | -2,387 | -3,370 | -412 | - | - | Ensuring appropriate health contributions to packages of care jointly funded by the council and the ICB following the ending of the current Learning Disability Partnership pooled budget arrangement with C&P ICB. |
| B/R.7.039 | Enhanced response service | -228 | - | - | - | - | The Enhanced Response Service (ERS) provides a mobile person response for telecare activations, where no informal carer is available. The proposal is a reduction in operating times from a 24/7 service to move to provision between 7am to 10pm in line with reablement and wider urgent community response services. |
| B/R.7.040 | Social Work apprenticeships | -162 | - | 41 | 121 | - | This is an invest to save proposal that will increase social worker apprenticeship capacity across the adults, health and commissioning directorate, reducing the dependence on short-term and temporary staffing. This supports the council's ability to develop its own workforce, cultivates a continuous learning culture and elevates the council's status as an employer of choice for social work development. Links to investment B/R.5.008. |

## Section 3 - B: Adults, Health and Commissioning

### Table 3: Revenue - Overview

**Budget Period: 2025-26 to 2029-30**

| Ref | Title | 2025-26 £000 | 2026-27 £000 | 2027-28 £000 | 2028-29 £000 | 2029-30 £000 | Description |
|---|---|---|---|---|---|---|---|
| B/R.7.043 | Housing Related Support Funding - Travellers Sites | -25 | - | - | - | - | Due to changes in arrangements, support funding allocated to Hunts Travellers site to deliver support to site residents whilst under management of Place for People is no longer required. A historic funding arrangement and it has been identified that this funding is no longer being utilised as arrangements to meet the needs of this group have changed. |
| B/R.7.044 | Extra Care - Additional Hours Budget | -350 | - | - | - | - | Historically, we have budgeted for additional costs within extra care settings, to reflect further support that may be needed for people living there. Following a review of use of this budget allowance over recent years, we can see that actual costs have not been at the level allowed for. |
| B/R.7.045 | Contract Management and Brokerage | -750 | -1,090 | - | - | - | The Adults, Health, and Commissioning Directorate is keen to maximise efficiencies across commissioned services, along with maximising the return on the investment in those contracts. This proposal seeks to invest resources into the Contracts and Brokerage team to broaden the scope of work and generate further savings. This will shift the team's focus towards preventative contract management to design out inefficiencies thus driving up standards and outcomes. But, at the same time focusing on the quality and delivery against the contract. We will also work on helping families with better information about all placements options to enable true choice to be exercised where there is no need for the more expensive choice. Links to investment B/R.5.009. |
| B/R.7.046 | Directorate Structure Redesign | -500 | -500 | - | - | - | To review and re-design the structure of the Directorate to ensure we are fit for purpose, to meet a locality model of delivery, that achieves the strategic ambitions of the council. |
| B/R.7.052 | Double Up Care provision | -500 | -400 | - | - | - | Double up of home care provision is a service provided for people who have been assessed as needing two or more carers to meet all, or some of their homecare needs. This proposal will provide additional capacity to review such packages and work with the person to use alternative moving and handling equipment or by improving support to care staff to reduce the need for two or more carers. This approach results in - creating more independence for the individual; and reducing costs to the council. Links to investment B/R/5/010. |
| B/R.7.053 | Rebaselining Older People demand | -9,600 | - | - | - | - | In 2024-25, growth was built into the budget for 2024-25 to reflect expected increased numbers and complexity of the care and support for people needing care, but much of this change did not take place. We have therefore re-baselined the budget for 2025-26. Net growth for 2025-26 and beyond is still budgeted for. |

## Section 3 - B: Adults, Health and Commissioning

### Table 3: Revenue - Overview

**Budget Period: 2025-26 to 2029-30**

| Ref | Title | 2025-26 £000 | 2026-27 £000 | 2027-28 £000 | 2028-29 £000 | 2029-30 £000 | Description |
|---|---|---|---|---|---|---|---|
| B/R.7.054 | Rebaselining Autism demand | -491 | - | - | - | - | Additional demand funding was built into the budget for 2024-25 on a one off basis to reflect a waiting list of people with autism requiring assessment. Growth is allowed for from 2025-26 onwards. |
| B/R.7.055 | Housing Related support | -80 | - | - | - | - | Underspend on inflationary budget allocated to Housing Related Support services. |
| B/R.7.056 | Maximise use of grant funding | -843 | - | - | - | - | We will maximise the use of grant funding to support the work of the Adults, Health and Commissioning Directorate. |
| B/R.7.057 | Release social care grant | -633 | - | - | - | - | When the social care grant was first introduced by government in 2019, part of the allocation was transferred to adult social care. Most of the original grant, and all of the grant uplifts since, sit within the wider council funds as it is an un-ringfenced grant. This line transfers the balance of the grant in a similar way. |
| B/R.7.058 | Quality Assurance Forum | -550 | -1,100 | - | - | - | Cambridgeshire County Council is committed to supporting people to live full and independent lives within their local communities through the delivery of a personalised and transformed approach to care and support. A Quality Assurance Forum will be introduced to consider the quality of our approach and practice, ensuring a strengths-based focus on achieving individual outcomes, and taking all opportunities to ensure early intervention and prevention options have been considered. Links to investment B/R.5.011. |
| B/R.7.059 | Discharge fund | - | -250 | -250 | - | - | We will maximise the use of the ringfenced discharge grant to reflect the focus of this work on hospital discharge pathways. This will align spend against areas of expenditure, to release general revenue funding, that can be used corporately to meet other demand across the directorate. |
| B/R.7.060 | Accommodation model | - | - | -500 | -500 | - | This proposal covers the development of specialist accommodation to meet the needs of people over the age of 18 with a learning disability and/or autism. |
| B/R.7.061 | Reablement - Physiotherapy Interventions | -355 | -300 | - | - | - | To secure timely physiotherapy intervention for people accessing support from Prevention & Early Intervention services. This will improve people's health, wellbeing and independence and reduce longer term needs. Links to investment B/R.5.012. |
| B/R.7.062 | Service User Flow and Demand | - | - | -2,500 | - | - | Review how we use our staffing and financial resources to ensure that we manage the flow and demand of people using our services most effectively. Links to investment B/R.5.013. |

## Section 3 - B: Adults, Health and Commissioning

### Table 3: Revenue - Overview

**Budget Period: 2025-26 to 2029-30**

| Ref | Title | 2025-26 £000 | 2026-27 £000 | 2027-28 £000 | 2028-29 £000 | 2029-30 £000 | Description |
|---|---|---|---|---|---|---|---|
| B/R.7.063 | Enhance Response Service - Falls Support | - | -311 | - | - | - | The Enhanced Response Service (ERS) provides a mobile person response for telecare activations, where no informal carer is available. Currently, the service provides a falls support element of provision which predominantly addresses health related needs and is outside the scope of social care provision. This proposal is a reduction in the service to remove the falls support element of the service offer. |
| B/R.7.064 | Brokerage - E-Procurement | - | - | -289 | - | - | The proposal is to develop and expand the use of an e-brokerage system / approach into residential and nursing care services. This will enable care providers to use a digital system in which to broker and manage the progress of placement referrals, offers, and contracts. As a result, it will lead to more effective, efficient and accurate approach. It is anticipated this will also lead to a change in the current provision, with a more cost efficient offer. Links to investment B/R.5.014. |
| B/R.7.065 | Rebaselining ASC inflation opening position for 25-26 | -1,600 | - | - | - | - | Unused inflation contingency budget for 2024-25 being reinvested into provider uplifts for 2025-26. |
| B/R.7.501 | Savings from recommissioning of Public Health contracts | -106 | -134 | -139 | -144 | -149 | Contracts within public health services will be reviewed at the point they need recommissioning. |
| B/R.7.502 | Public Health grant uplift applied to Children's obesity prevention work | -200 | - | - | - | - | Some services within Children, Education & Families will be funded through the public health grant uplift, freeing up budget that would otherwise be required. |
| B/R.7.503 | Improved Better Care Fund funding for falls prevention | -130 | - | - | - | - | Falls prevention activities to be funded through the Improved Better Care Fund releasing Public Health grant for spend on other public health priorities. |
| B/R.7.504 | Digital NHS health checks | -100 | - | - | - | - | Build on existing digital delivery of Public Health services where face-to-face contact is not mandated. Explore options in behaviour change, NHS Health Checks, sexual health and drug and alcohol services and Healthy Child Programme. Users encouraged to self-serve and sign posted to digital resources as first contact. |
| B/R.7.505 | Behaviour Change services - place based working | -80 | - | - | - | - | Wherever appropriate aligning delivery of Public Health commissioned services to place based models. This will enable services to be delivered in a way that is closer to communities, building on local community provision and more responsive to any opportunities that emerge. It will also afford the opportunity to create savings from avoiding duplication of services, lower travel cost and shared accommodation costs. |

## Section 3 - B: Adults, Health and Commissioning

### Table 3: Revenue - Overview

**Budget Period: 2025-26 to 2029-30**

| Ref | Title | 2025-26 £000 | 2026-27 £000 | 2027-28 £000 | 2028-29 £000 | 2029-30 £000 | Description |
|---|---|---|---|---|---|---|---|
| B/R.7.507 | Public Health Role within Local Authority | - | -200 | -500 | - | - | Services provided by public health will be reviewed to ensure they align with the corporate priorities and focus on the priorities for Cambridgeshire. It is anticipated that, through this, efficiencies will be identified here or in other services. |
| **7.99** | **Subtotal Savings** | **-21,144** | **-8,147** | **-4,898** | **-523** | **-149** | |
| | | | | | | | |
| | **TOTAL GROSS EXPENDITURE** | **385,266** | **399,418** | **417,066** | **440,610** | **465,727** | |
| **8** | **INCOME** | | | | | | |
| | **Opening Income Budget** | **-179,800** | **-146,928** | **-150,260** | **-124,393** | **-126,220** | |
| B/R.8a.001 | Income Base Adjustments | -1,854 | - | - | - | - | Adjustments to income budgets made in 2024-25, in line with officer delegations |
| B/R.8a.002 | Permanent Income Virements - PVs | -1,998 | - | - | - | - | Permanent virements of income budgets in 2024-25 reflected in the base, in line with officer delegations and/or committee decisions in 2024-25 |
| B/R.8a.107 | Change in income reflecting end of Learning Disability pooled budget arrangements | 33,353 | - | - | - | - | Change in income reflecting end of Learning Disability pooled budget arrangements. |
| B/R.8a.501 | Income Base Adjustments - Public Health | -184 | - | - | - | - | Adjustment between Directorates for spend funded by Public Health grant |
| B/R.8a.502 | Income Base adjustment - Public Health - ending of shared service with Peterborough City Council | 7,068 | - | - | - | - | Reduction in income following the ending of shared service arrangements and shared commissioning with Peterborough City Council |
| **8a.99** | **Revised opening income budget** | **-143,415** | **-146,928** | **-150,260** | **-124,393** | **-126,220** | |
| B/R.8b.003 | Fees and charges inflation | -79 | -66 | -52 | -66 | -68 | Increase in external charges to reflect inflationary increases. |
| B/R.8b.004 | Client contributions inflation | -2,404 | -2,116 | -1,717 | -1,761 | -1,836 | Increase in anticipated contributions paid for care in line with the current charging policy and national regulations. |
| **8b.99** | **Subtotal Income - inflation** | **-2,483** | **-2,182** | **-1,769** | **-1,827** | **-1,904** | |

## Section 3 - B: Adults, Health and Commissioning

### Table 3: Revenue - Overview

**Budget Period: 2025-26 to 2029-30**

| Ref | Title | 2025-26 £000 | 2026-27 £000 | 2027-28 £000 | 2028-29 £000 | 2029-30 £000 | Description |
|---|---|---|---|---|---|---|---|
| B/R.8c.006 | Increased income from reducing Financial Assessments backlog | -90 | - | - | - | - | In 2024-25, the financial assessments service resolved many backlog cases caused by staff shortages and complex case management, resulting in increased council income. |
| B/R.8c.007 | Increased Health income | -120 | - | - | - | - | Increased Continuing Health Care capacity generating additional Health income. |
| B/R.8c.008 | Fees and charges review | -50 | - | - | - | - | The review will evaluate services that are billed outside of the Adult Charging Policy, which are not subject to financial assessment and are considered ordinary living expenses. These charges are in addition to any assessed contributions for council-provided care and support. |
| B/R.8c.009 | Timely Application of Charging Policy | - | -270 | - | - | - | Service improvements to reduce average time to complete financial assessment, from 12 weeks to 8 weeks, thereby increasing income through charging client contributions closer to start date of care. |
| **8c.99** | **Subtotal Income - generation** | **-260** | **-270** | **-** | **-** | **-** | |
| B/R.8d.101 | Change in AHC spend funded by Public Health Grant | -411 | -200 | 940 | - | - | Change in Adults, Health and Commissioning spend funded by the ring-fenced Public Health grant, including reflecting expected treatment as a corporate grant from 2027-28, due to anticipated removal of ring-fence. |
| B/R.8d.102 | Uplift in Better Care Fund | -845 | -880 | -915 | - | - | Annual uplifts in the Better Care Fund utilised to contribute to the demand pressures in Adult Social Care in line with the national conditions of the grant. |
| B/R.8d.502 | Change in spend funded by Public Health Grant | 670 | 200 | 27,611 | - | - | Changes to Public Health funding between Directorates and assumption that the Public Health grant ring-fence will remain in place until 2026-27 but be removed thereafter. |
| B/R.8d.503 | PH Grant uplift 25/26 | -184 | - | - | - | - | Increase in Public Health grant assumed for 2025-26 to be applied to public health priorities delivered in other Directorates. |
| **8d.99** | **Subtotal Income - grant changes** | **-770** | **-880** | **27,636** | **-** | **-** | |
| | | | | | | | |
| | **Closing Income Budget** | **-146,928** | **-150,260** | **-124,393** | **-126,220** | **-128,124** | |
| | | | | | | | |
| | **TOTAL NET EXPENDITURE** | **238,338** | **249,158** | **292,673** | **314,390** | **337,603** | |

## Section 3 - B: Adults, Health and Commissioning

### Table 3: Revenue - Overview

**Budget Period: 2025-26 to 2029-30**

| Ref | Title | 2025-26 £000 | 2026-27 £000 | 2027-28 £000 | 2028-29 £000 | 2029-30 £000 | Description |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| **FUNDING SOURCES** | | | | | | | |
| **9** | **FUNDING OF GROSS EXPENDITURE** | | | | | | |
| B/R.9.001 | Budget Allocation | -238,338 | -249,158 | -292,673 | -314,390 | -337,603 | Net spend funded from general grants, business rates and Council Tax. |
| B/R.9.002 | Fees & Charges | -67,172 | -69,624 | -71,393 | -73,220 | -75,124 | Fees and charges for the provision of services. |
| B/R.9.003 | Better Care Fund | -21,992 | -22,872 | -23,787 | -23,787 | -23,787 | The NHS and County Council pool budgets through the Better Care Fund (BCF), promoting joint working. This line shows the revenue funding flowing from the BCF into Social Care. |
| B/R.9.004 | Social Care in Prisons Grant | -330 | -330 | -330 | -330 | -330 | Social Care in Prisons grant. This grant is used to deliver care to those who meet eligibility under the Care Act for services whilst in Littlehey prison. |
| B/R.9.005 | Improved Better Care Fund | -15,170 | -15,170 | -15,170 | -15,170 | -15,170 | Improved Better Care Fund grant. |
| B/R.9.006 | Adult Social Care Market Sustainability and Improvement Fund | -10,168 | -10,168 | -10,168 | -10,168 | -10,168 | Adult Social Care Market Sustainability and Improvement Fund. |
| B/R.9.007 | Adult Social Care Discharge Fund | -3,545 | -3,545 | -3,545 | -3,545 | -3,545 | Adult Social Care Discharge Fund. |
| B/R.9.008 | Public Health Funding | -28,551 | -28,551 | - | - | - | Direct expenditure funded from Public Health grant. As the ring fence is assumed to be removed in 2027-28, the grant will be treated corporately and replaced with budget allocation for Public Health services. |
| **9.99** | **TOTAL FUNDING OF GROSS EXPENDITURE** | **-385,266** | **-399,418** | **-417,066** | **-440,610** | **-465,727** | |

# Section 3 - B: Adults, Health and Commissioning

## Table 4: Capital Programme

**Budget Period: 2025-26 to 2034-35**

| Summary of Schemes by Start Date | Total Cost £000 | Previous Years £000 | 2025-26 £000 | 2026-27 £000 | 2027-28 £000 | 2028-29 £000 | 2029-30 £000 | Later Years £000 |
|---|---|---|---|---|---|---|---|---|
| Ongoing | 52,573 | - | 5,544 | 3,914 | 4,361 | 4,451 | 4,653 | 29,650 |
| Committed Schemes | 21,727 | 462 | - | 9,943 | 11,322 | - | - | - |
| 2025-2026 Starts | 12,000 | - | 3,000 | 6,000 | 3,000 | - | - | - |
| 2028-2029 Starts | 22,000 | - | - | - | - | 11,000 | 11,000 | - |
| **TOTAL BUDGET** | **108,300** | **462** | **8,544** | **19,857** | **18,683** | **15,451** | **15,653** | **29,650** |

| Ref | Scheme | Description | Scheme Start | Total Cost £000 | Previous Years £000 | 2025-26 £000 | 2026-27 £000 | 2027-28 £000 | 2028-29 £000 | 2029-30 £000 | Later Years £000 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **B/C.1** | **Adult Social Care** | | | | | | | | | | |
| B/C.1.001 | Disabled Facilities Grant | Funding provided through the Better Care Fund, in partnership with local housing authorities. Disabled Facilities Grant enables accommodation adaptations so that people with disabilities can continue to live in their own homes. | Ongoing | 55,300 | - | 5,530 | 5,530 | 5,530 | 5,530 | 5,530 | 27,650 |
| B/C.1.002 | Integrated Community Equipment Service | Funding to continue annual capital investment in community equipment that helps people to sustain their independence. The Council contributes to a pooled budget purchasing community equipment for health and social care needs for people of all ages. | Ongoing | 4,000 | - | 400 | 400 | 400 | 400 | 400 | 2,000 |
| B/C.1.003 | Independent Living Service : East Cambridgeshire | Independent Living Service accommodation in Ely | Committed | 21,727 | 462 | - | 9,943 | 11,322 | - | - | - |
| B/C.1.004 | Independent Living Services | Independent Living Service accommodation in Fenland, Huntingdonshire and South Cambridgeshire, providing accommodation for 80 people in total across the three schemes. | 2028-29 | 22,000 | - | - | - | - | 11,000 | 11,000 | - |
| B/C.1.005 | Specialist Accommodation Schemes | Specialist accommodation service providing accommodation for people with complex or challenging needs who have to be accommodated in single service accommodation or settings with a small number of other people. | 2025-26 | 12,000 | - | 3,000 | 6,000 | 3,000 | - | - | - |
| | **Total - Adult Social Care** | | | **115,027** | **462** | **8,930** | **21,873** | **20,252** | **16,930** | **16,930** | **29,650** |

## Section 3 - B: Adults, Health and Commissioning

### Table 4: Capital Programme
**Budget Period: 2025-26 to 2034-35**

| Summary of Schemes by Start Date | Total Cost £000 | Previous Years £000 | 2025-26 £000 | 2026-27 £000 | 2027-28 £000 | 2028-29 £000 | 2029-30 £000 | Later Years £000 |
|---|---|---|---|---|---|---|---|---|
| Ongoing | 52,573 | - | 5,544 | 3,914 | 4,361 | 4,451 | 4,653 | 29,650 |
| Committed Schemes | 21,727 | 462 | - | 9,943 | 11,322 | - | - | - |
| 2025-2026 Starts | 12,000 | - | 3,000 | 6,000 | 3,000 | - | - | - |
| 2028-2029 Starts | 22,000 | - | - | - | - | 11,000 | 11,000 | - |
| **TOTAL BUDGET** | **108,300** | **462** | **8,544** | **19,857** | **18,683** | **15,451** | **15,653** | **29,650** |

| Ref | Scheme | Description | Scheme Start | Total Cost £000 | Previous Years £000 | 2025-26 £000 | 2026-27 £000 | 2027-28 £000 | 2028-29 £000 | 2029-30 £000 | Later Years £000 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **B/C.2** | **Capital Programme Variation** | | | | | | | | | | |
| B/C.7.001 | Variation Budget | The Council includes a service allowance for likely Capital Programme slippage, as it can sometimes be difficult to allocate this to individual schemes due to unforeseen circumstances. This budget is continuously under review, taking into account recent trends on slippage on a service by service basis. | Ongoing | -8,289 | - | -450 | -2,391 | -2,148 | -1,650 | -1,650 | - |
| B/C.7.002 | Capitalisation of Interest Costs | The capitalisation of borrowing costs helps to better reflect the costs of undertaking a capital project. Although this budget is initially held on a service basis, the funding will ultimately be moved to the appropriate schemes once exact figures have been calculated each year. | Ongoing | 1,562 | - | 64 | 375 | 579 | 171 | 373 | - |
| | **Total - Capital Programme Variation** | | | **-6,727** | **-** | **-386** | **-2,016** | **-1,569** | **-1,479** | **-1,277** | **-** |
| | **TOTAL BUDGET** | | | **108,300** | **462** | **8,544** | **19,857** | **18,683** | **15,451** | **15,653** | **29,650** |

## Section 3 - B: Adults, Health and Commissioning

### Table 4: Capital Programme
**Budget Period: 2025-26 to 2034-35**

| Summary of Schemes by Start Date | Total Cost £000 | Previous Years £000 | 2025-26 £000 | 2026-27 £000 | 2027-28 £000 | 2028-29 £000 | 2029-30 £000 | Later Years £000 |
|---|---|---|---|---|---|---|---|---|
| Ongoing | 52,573 | - | 5,544 | 3,914 | 4,361 | 4,451 | 4,653 | 29,650 |
| Committed Schemes | 21,727 | 462 | - | 9,943 | 11,322 | - | - | - |
| 2025-2026 Starts | 12,000 | - | 3,000 | 6,000 | 3,000 | - | - | - |
| 2028-2029 Starts | 22,000 | - | - | - | - | 11,000 | 11,000 | - |
| **TOTAL BUDGET** | **108,300** | **462** | **8,544** | **19,857** | **18,683** | **15,451** | **15,653** | **29,650** |

| Ref | Scheme | Description | Scheme Start | Total Cost £000 | Previous Years £000 | 2025-26 £000 | 2026-27 £000 | 2027-28 £000 | 2028-29 £000 | 2029-30 £000 | Later Years £000 |
|---|---|---|---|---|---|---|---|---|---|---|---|

| Funding | Total Funding £000 | Previous Years £000 | 2025-26 £000 | 2026-27 £000 | 2027-28 £000 | 2028-29 £000 | 2029-30 £000 | Later Years £000 |
|---|---|---|---|---|---|---|---|---|
| **Government Approved Funding** | | | | | | | | |
| Specific Grants | **55,300** | - | 5,530 | 5,530 | 5,530 | 5,530 | 5,530 | 27,650 |
| **Total - Government Approved Funding** | **55,300** | **-** | **5,530** | **5,530** | **5,530** | **5,530** | **5,530** | **27,650** |
| **Locally Generated Funding** | | | | | | | | |
| Prudential Borrowing | **53,000** | 462 | 3,014 | 14,327 | 13,153 | 9,921 | 10,123 | 2,000 |
| **Total - Locally Generated Funding** | **53,000** | **462** | **3,014** | **14,327** | **13,153** | **9,921** | **10,123** | **2,000** |
| **TOTAL FUNDING** | **108,300** | **462** | **8,544** | **19,857** | **18,683** | **15,451** | **15,653** | **29,650** |

# Section 3 - B: Adults, Health and Commissioning

## Table 5: Capital Programme - Funding

**Budget Period: 2025-26 to 2034-35**

| Summary of Schemes by Start Date | Total Funding £000 | Grants £000 | Develop. Contr. £000 | Other Contr. £000 | Capital Receipts £000 | Prud. Borr. £000 |
|---|---|---|---|---|---|---|
| Ongoing | 52,573 | 55,300 | - | - | - | -2,727 |
| Committed Schemes | 21,727 | - | - | - | - | 21,727 |
| Completed Schemes | - | - | - | - | - | - |
| 2025-2026 Starts | 12,000 | - | - | - | - | 12,000 |
| 2028-2029 Starts | 22,000 | - | - | - | - | 22,000 |
| **TOTAL BUDGET** | **108,300** | **55,300** | **-** | **-** | **-** | **53,000** |

| Ref | Scheme | Scheme Start | Total Funding £000 | Grants £000 | Develop. Contr. £000 | Other Contr. £000 | Capital Receipts £000 | Prud. Borr. £000 |
|---|---|---|---|---|---|---|---|---|
| **B/C.1** | **Adult Social Care** | | | | | | | |
| B/C.1.001 | Disabled Facilities Grant | Ongoing | 55,300 | 55,300 | - | - | - | - |
| B/C.1.002 | Integrated Community Equipment Service | Ongoing | 4,000 | - | - | - | - | 4,000 |
| B/C.1.003 | Independent Living Service : East Cambridgeshire | Committed | 21,727 | - | - | - | - | 21,727 |
| B/C.1.004 | Independent Living Services | 2028-29 | 22,000 | - | - | - | - | 22,000 |
| B/C.1.005 | Specialist Accommodation Schemes | 2025-26 | 12,000 | - | - | - | - | 12,000 |
| | **Total - Adult Social Care** | | **115,027** | **55,300** | **-** | **-** | **-** | **59,727** |
| **B/C.2** | **Capital Programme Variation** | | | | | | | |
| B/C.7.001 | Variation Budget | Ongoing | -8,289 | - | - | - | - | -8,289 |
| B/C.7.002 | Capitalisation of Interest Costs | Ongoing | 1,562 | - | - | - | - | 1,562 |
| | **Total - Capital Programme Variation** | | **-6,727** | **-** | **-** | **-** | **-** | **-6,727** |
| | | | | | | | | |
| | **TOTAL BUDGET** | | **108,300** | **55,300** | **-** | **-** | **-** | **53,000** |

# A&H Schedule of Fees & Charges: Proposed rates for 2025-26

Unless otherwise specified, prices for 2025-26 start from 1 April 2025

| Directorate | Reporting Committee | Policy Line | Service | Description of charge | Stat / non stat | Current charge for 2024-25 | Proposed charge for 2025-26<br>General Inflation rates for non-stat rates 2.25% or<br>5.5% if covers CCC staff costs | Full Cost Recovery, Agreed Discount or Statutory Limit | Additional information |
|---|---|---|---|---|---|---|---|---|---|
| **Adults, Health and Commissioning** | **Adults and Health** | **Adults, Health and Commissioning** | **Adults, Health and Commissioning** | Deferred payment set up / administration charge | Non-Statutory | £238 for setting up the agreement<br><br>£88 for a change in the agreement<br><br>£144 for closing | £716.99 DPA Setup<br><br>£91.19 DPA Annual Fee<br><br>£347.12 DPA Close/Redemption<br><br>Other fees:<br>£44.80 Ad hoc statement<br><br>£46.41 Supplemental fee for Second Charge agreement<br><br>£POA Home Valuation/ReValuation | Full Cost Recovery | Uplift to cover increase in operating costs and legal services. |
| **Adults, Health and Commissioning** | **Adults and Health** | **Adults, Health and Commissioning** | **Adults, Health and Commissioning** | Self funder arrangement fee | Non-Statutory | £521.51 annually recurring charge | £550.20 annually recurring charge<br><br>(applied as £42.21 per 4-weekly invoice, equivalent to £10.55 per week). | Full Cost Recovery | For those that have capital above the LA funding threshold (£23k) but would like their care arranged by CCC.<br><br>Invoices are on a 4-week basis; fees are applied at £42.21 per 4-week invoice, equivalent to £10.55 per week). |
| **Adults, Health and Commissioning** | **Adults and Health** | **Adults, Health and Commissioning** | **Adults, Health and Commissioning** | Transport to and from day care centres / day activities | Non-Statutory | Minimum £3.00 return journey per day | From £3.10 | Full Cost Recovery | Per return journey. |
| **Adults, Health and Commissioning** | **Adults and Health** | **Adults, Health and Commissioning** | **Adults, Health and Commissioning** | Learning Disability Training provision | Non-Statutory | £85 per person per day | £90 per person per day | Full Cost Recovery | Covers training fees for training external providers. New Members of staff require 2 days training, then annual 1 day refresher |
| **Adults, Health and Commissioning** | **Adults and Health** | **Adult Social Care Client Funds** | **Adult Social Care Client Funds** | Appointeeship fees | Non-Statutory | Set Up resi £106<br>Set Up community £152<br><br>£12 per week residential<br>£15 per week community<br><br>Wind Up fee £359 | Set Up resi £111.83<br>Set Up community £160.36<br><br>£12.66 per week residential<br>£15.83 per week community<br><br>Wind Up fee £378.75 | Full Cost Recovery | |
| **Adults, Health and Commissioning** | **Adults and Health** | **Adult Social Care Client Funds** | **Adult Social Care Client Funds** | Appointeeship fees | Non-Statutory | £12 per week residential<br>£15 per week community | £12.66 per week residential<br>£15.83 per week community | Full Cost Recovery | |

# A&H Schedule of Fees & Charges: Proposed rates for 2025-26

Unless otherwise specified, prices for 2025-26 start from 1 April 2025

| Directorate | Reporting Committee | Policy Line | Service | Description of charge | Stat / non stat | Current charge for 2024-25 | Proposed charge for 2025-26<br>General Inflation rates for non-stat rates 2.25% or<br>5.5% if covers CCC staff costs | Full Cost Recovery, Agreed Discount or Statutory Limit | Additional information |
|---|---|---|---|---|---|---|---|---|---|
| **Adults, Health and Commissioning** | **Adults and Health** | **Adult Social Care Client Funds** | **Adult Social Care Client Funds** | Deputyship fees | Non-Statutory | Set up fee £745 (set by the Court of Protection)<br><br>Wind Up fee £359<br><br>Property management £300 | Set up fee £745 (set by the Court of Protection)<br><br>Wind Up fee £378.75<br><br>Property management £300 | Full Cost Recovery | |
| **Adults, Health and Commissioning** | **Adults and Health** | **Across Care policy lines** | **Adult Social Care** | Client contributions | The Care Act 2014 provides the legal framework for charging for care and support. | Charges are based on assessed ability to pay | Charges are based on assessed ability to pay | Charges are based on assessed ability to pay | Client contributions towards the cost of care are covered by a separate charging policy which is available here: https://www.cambridgeshire.gov.uk/asset-library/Adult-Social-Care-charging-policy-April-2020-updated-July-2023.pdf |
| **Adults, Health and Commissioning** | **Adults and Health** | **Across Care policy lines** | **Adult Social Care** | Peace of Mind charge | Non-Statutory | £16.90 | Other option being explored - see Additional Info | N/A | 2025/26 - We are exploring the option of increasing the charge to match the lowest hourly care rate across all the Extra Care schemes. As current charge is historical and hasn't been increased for more than 5 years, we may need to determine how we increase incrementally to bring the charge up at a workable level for customers |

# Recommissioning Drug and Alcohol Treatment Services for Adults and Children and Young People

| | |
|---|---|
| To: | Adults and Health Committee |
| Meeting Date: | 23 January 2025 |
| From: | Executive Director, Adults, Health, and Commissioning |
| Electoral division(s): | All |
| Key decision: | Yes |
| Forward Plan ref: | KD2025/005 |

Executive Summary: This report aims to secure the support of the Adults, Health, and Commissioning Committee for recommissioning both Children and Young People's and adult drug and alcohol treatment services. The report provides the Adults, Health and Commissioning Committee with the background information and complexities associated with the recommissioning of both Children and Young People's and adult drug and alcohol treatment services.

Recommendation: The Committee is asked to approve the following recommendations:

a) A new Section 75 with the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) for it to continue to provide the Children and Young People's Drug and Alcohol treatment Service for 7 years at a total value of £3,218,047, with the option of breaks at years 3 and 5.

b) Undertake a market analysis to determine if a competitive or direct award is the appropriate procurement route for the adult Drug and Alcohol Treatment Service under the Provider Selection Regime regulations.

c) If the National Drug Strategy additional grant funding is not extended or only to a minimum level, undertake a review of the improvements arising from the funding to inform decisions relating to the allocation of additional funding from any uplift in the core Public Health Grant to the Drug and Alcohol Treatment services.

d) Bring a report to the Adults, Health and Commissioning Committee with the proposed service model based on the needs assessment currently in train, any confirmed additional grant funding, and the results of the market analysis to determine the appropriate

procurement option. Current base value: £33,282,466 over seven years.

e) The Adults, Health, and Commissioning Committee to review and approve the recommendations initially and then they will be taken to the Children and Young People's Committee for information.

f) To delegate authority for awarding and executing the Section 75 for providing the Children and Young People's Drug and Alcohol Treatment Service and the Adult Drug and Alcohol Treatment Service contract both starting 1 April 2026, to the Executive Director Adults, Health and Commissioning in consultation with the Chair and Vice-Chair of the Adults, Health and Commissioning Committee for a total of 7 years with the option of breaks at the 3 and 5 years.

Officer contact:
Name:Val Thomas
Post: Deputy Director of Public Health
Email: val.thomas@cambridgeshire.gov.uk

# 1. Creating a greener, fairer, and more caring Cambridgeshire

1.1 Net zero carbon emissions for Cambridgeshire by 2045, and our communities and natural environment are supported to adapt and thrive as the climate changes
Specialist drug and alcohol service support this ambition through:

- Commissioned treatment providers encourage the use of nature areas across Cambridgeshire, giving more people in recovery access and experience of green spaces.
- Commissioned treatment providers have worked with service users to regenerate the gardens within their fixed sites to encourage wildlife and growing of plants/vegetables and promoting benefits of green outdoor space.
- Commissioned treatment provider promotes the use of electric bikes to conduct home visits in Cambridge City.

1.2 Travel across the county is safer and more environmentally sustainable
Specialist drug and alcohol service support this ambition through:

- Providing place-based services, improving accessibility and treatment engagement.
- Supporting travel costs, promoting use of public transport to enable attendance at health appointments.

1.3 Health inequalities are reduced.
People misusing drug and alcohol generally have poorer health outcomes than other population groups. Specialist drug and alcohol service work to decease inequalities in health outcomes through treatment and supporting service users to address the determinants of health that influence their health outcomes.

- Reducing drug and alcohol dependency and supporting long term recovery will contribute to a reduction in health inequalities and improvements in a wide range of health outcomes.
- Addressing drug and alcohol dependency reduces risk of rough sleeping and homelessness, reduces risks of eviction, and improves chances of maintaining stable accommodation to meet individual needs

1.4 People enjoy healthy, safe, and independent lives through timely support that is most suited to their needs.
Specialist drug and alcohol services support this ambition through:

- Promoting long term recovery and behaviour change.
- Supporting trauma informed care.
- Addresses homelessness and increases access to stable and safe accommodation.
- Increases access to primary care and addresses health conditions
- Provides a personalised care approach, peer led support to promote long term change, reducing relapse.

1.5 Helping people out of poverty and income inequality.
Specialist drug and alcohol service support this ambition through:

- Promotes long term recovery.
- Addresses homeless/housing needs, provides access to welfare benefits (dedicated CAB workers), addressing long term debts.
- Provides access to personalised budgets to support recovery.
- Direct access to the dedicated individual placement service (IPS) enabling those with drug and alcohol dependency issues to access employment and return to the workplace.

1.6 Places and communities prosper because they have a resilient and inclusive economy, access to good quality public services and social justice is prioritised.
Specialist drug and alcohol service support this ambition through:

- Promotes long term recovery and stability including volunteering opportunities.
- Reduces crisis situations, reduces anti-social behaviour and negative impact of drug/alcohol use on local communities
- Direct access to the dedicated individual placement service (IPS) enabling those with drug and alcohol dependency issues to access employment and return to the workplace.
- Supports access to other local services to address long term health and social issues.

1.7 Children and young people have opportunities to thrive.
Specialist drug and alcohol service support this ambition through:

- A dedicated team of practitioners (family safeguarding team) to provide intensive support to parents who use substances to improve the life changes of their children.
- A dedicated service for children who are impacted by parental drug and alcohol use.
- A dedicated young people's service providing prevention, early intervention and specialist drug and alcohol treatment to increase awareness, address issues and prevent escalation of use.

# 2. Background

2.1 Drug and alcohol prevention and treatment services are funded from the local authority Public Health Grant. The services are not specifically mandated, but the Public Health Grant conditions include the following statement: A local authority must, in using the grant, "…have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services…"

2.2 The current Cambridgeshire County Council (CCC) Children and Young People's (CYP) and adult specialist Drug and Alcohol Treatment service contracts in Cambridgeshire will end on 31st March 2026. All possible contract extensions will have been exhausted and therefore both services will require re-commissioning. Contract awards are planned for December 2025 with contract start dates of the 1 April 2026.

2.3 The Cambridgeshire Children and Young People's Substance Misuse Service (CASUS) is delivered through a Section 75 Agreement with the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT). The Section 75 Agreement commenced on 1st July 2019 for an

initial 3-year term. It has been extended on 2 occasions to bring the Agreement in line with the adult drug and alcohol treatment contract which terminates on 31 March 2026 (total contract length 6 years 9 months). The service provides specialist substance use treatment for children and young people across Cambridgeshire, delivering an integrated model of treatment (mainstream, mental health, and criminal justice provision).

2.4 The current CCC Adult Integrated Drug and Alcohol Treatment provider is Change Grow Live (CGL), a large third sector organisation and one of the market leaders in this sector. The contract commenced on the 1st of October 2018 and ends 31 March 2026. The contract (originally 5.5 years) has been extended by a further 2 years (to 31 March 2026) beyond the original terms of the contract which would have ended on 31 March 2024 (3.5+1+1).

2.5 A number of contract variations have been made to the CGL contract since its inception in October 2018 primarily due to the receipt of additional national short term grant funding associated with the new National Drug Strategy "From Harm to Hope". This requires the delivery of national ambitions for increasing and improving the capacity and quality of treatment services to reduce harm and improve recovery rates. The Drugs Strategy is for 10 years, and the additional funding has been for the first three years. There has not been any formal confirmation that the grants, which have been substantial, will continue after March 31, 2025.

2.6 The CGL Adult Treatment Service provides all elements of substance misuse treatment including early intervention advice and support, pharmacological treatment, harm reduction services, pharmacy delivered services (including needle and syringe programmes), psychosocial support, recovery support, community/inpatient detox, and residential rehabilitation. Under the last recommissioning exercise in 2017/18, the Cambridgeshire adult treatment service was completely re-modelled to include a psychology led therapeutic delivery component as well as an innovative co-produced peer led community recovery service.

# 3. Main Issues

3.1 There is substantial evidence that demonstrates the value of drug and alcohol treatment services. Estimates show that the social and economic annual costs of alcohol related harm amount to £21.5 billion and from illicit drug use £10.7 million. The combined benefits of drug and alcohol treatment amount to £2.4 billion every year, resulting in savings in areas such as crime, Quality-Adjusted Life Years (QALYs) improvements and health and social care. Alcohol and drug prevention, treatment and recovery: why invest? - GOV.UK (www.gov.uk).

## CYP Commissioning Model

3.2 There are different models for commissioning CYP and adult drug and alcohol treatment services. In Cambridgeshire, the two services are commissioned and delivered separately. In other areas there are examples of services that are integrated into an 'all age' service.

The recommended model here is to continue with the separate agreements as there are a number of key benefits of adopting this approach.

- The CYP Service has been developed to meet the specific needs of the patient/user group, and the Service is continuously evolving.

- The current CYP Service is a co-occurring conditions service which means that young people receive combined support to meet their substance use needs alongside any mental health needs.

- The Service has input and oversight from an adolescent psychiatrist, which is a skill set that is difficult to recruit.

3.3 There are examples in the country of integrated 'all age' services however there are risks associated with merging services which include dis-investment in the CYP service element (absorbed by the adult service pressure), losing CYP clinical specialism, losing links with CYP partner services and treating young people as mini adults rather than children with needs that require a different treatment approach.

Going forward collaboration and integration with other CYP services would be the preferred model, for example the school-Aged Health Improvement and Prevention Service (SHIPS).

3.4 It is recommended that a new Section 75 is agreed with the CPFT CASUS Service which has consistently performed well across the key indicators. This has been discussed and agreed with the Procurement Team.

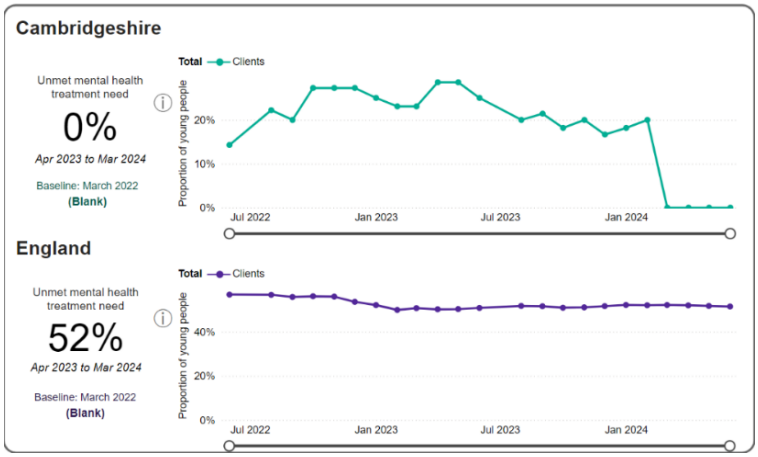
Figure 1 shows the number of young people in treatment which is higher than the England comparator figure.

**Figure 1: Cambridgeshire CYP Numbers in Treatment (***Source: NDTMS, Office for Health Improvement & Disparities*

| CYP | Cambridgeshire Baseline performance March 2022 | Cambridgeshire most recent performance March 2024 | Cambridgeshire % difference against baseline March 2022 | England % difference against baseline March 2022 |
|---|---|---|---|---|
| | 100 | 152 | 52% | 28% |

The unmet mental health needs for CYP in the current treatment service are significantly lower than the England rates 52% and East of England (30%). (Figure 2)

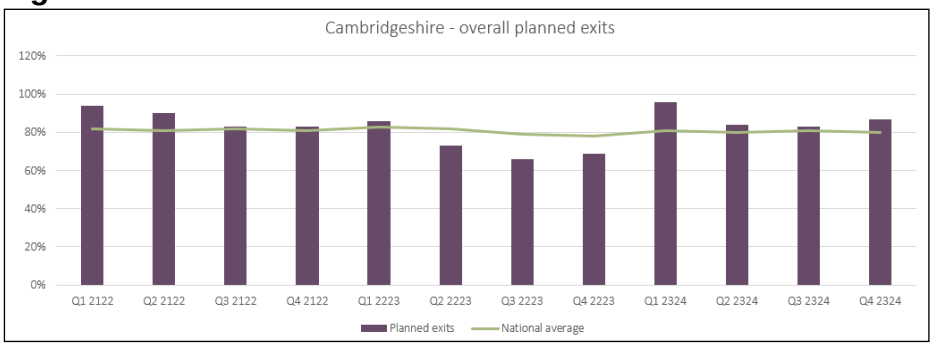
**Figure 2: CYP unmet mental health needs in the current Service**




*Source: NDTMS, Office for Health Improvement & Disparities*

In terms of planned exits, following a dip during the COVID-19 pandemic planned exits have remained above the national figure.

**Figure 3: Planned exits from the CYP Service**




*Source: NDTMS, Office for Health Improvement & Disparities*

3.5 The strengths and performance of the Service support the recommendation for a Section 75 Agreement for seven years with potential breaks at years three and five. The rationale for a longer Section 75 Agreement is that the Service is performing very well, with no empty posts and evidence of ongoing development. Any change of provider would run the risk of losing the very skilled and committed workforce.

<u>CYP Drug and Alcohol Treatment Service Funding Model</u>

3.6 The value of the original Section 75 Agreement for the CYP Drug and Alcohol Service was £1.1 million (2.9 months). The Section 75 Agreement has been extended twice and as the service is delivered by an NHS provider it has received NHS agenda for change uplifts (staff pay awards) throughout the term. The total value of the Agreement over the extended term is £2.8 million.

3.7 It recommended that this base level of funding from the core Public Health Grant is maintained in any new agreement with the following values over 7 years. It should be noted that the Service has not received any inflationary uplifts in the course of this Section 75 excepting the NHS Agenda for Change uplifts. Commissioners have worked with the Provider to manage the pressures, but they are under ongoing review.

**Annual base value £459,721**
**Total base value: £3,218,047**

This excludes any additional Agenda for Change uplifts.

Adult Drug and Alcohol Treatment Services

3.8 As this is a Public Health Service it will be subject to the Provider Selection Regime (PSR) Procurement Regulations. (These are the regulations used by the NHS and must be used for procuring Public Health services). There are a number of procurement options in the PSR regulations which include direct award options as well as competitive procurements.

3.9 **PSR Direct Award:** There are a number of PSR direct award options. Direct award C would be the applicable option and is defined as:

"W*here there is an existing provider for the services and that existing provider is satisfying the original contract and will likely satisfy the proposed new contract and the services are not changing considerably."*

3.10 This can provide flexibility in selecting a provider and enables the continued development of stable partnerships and delivery of integrated care. It avoids service instability in treatment provision (services users and workforce) and local performance. National sector guidance Commissioning quality standard: alcohol and drug services - GOV.UK states:

*"To avoid instability in treatment provision, the partnership only uses competitive tendering if necessary. Where competitive tendering processes are required, they prioritise quality and clinical safety, while also ensuring legal compliance and value for money."*

3.11 The current provider is satisfying the original agreement but information from the needs assessment and financial pressures may necessitate changes in the model.

3.12 **PSR Competitive Process**: There are risks associated with direct awards. A competitive approach offers less risks than a direct award in terms of delivering value for many and avoiding a challenge from other potential providers.

3.13 The Procurement Team advised that under the PSR regulations a market analysis should be undertaken before proceeding with a competitive tender.

3.14 Re-commissioning the adult services present a challenge due to the uncertainty around the continuation of additional funding for delivering the National Drugs Strategy that has significantly increased the value of the adult treatment services. This grant is due to end in March 2025. However, an abrupt ending of this substantial funding stream will have an impact upon the Drug and Alcohol services along with other partner organisations, including the Criminal Justice system. For example, the funding has developed services working with the homeless and for those leaving prison.

3.15 This has been widely recognised across the country with representation from many organisations at regional and national levels. The Office for Health Improvement and Disparities (OHID), which manages the additional funding at national and regional levels, is

advising on the post March 2025 funding situation, but has not been able to formally confirm the continuation of this funding at the time of writing this paper.

3.16 Given the uncertainty around this funding the risks have been identified, and contingency measures have been developed to mitigate the impact upon services. This includes the allocation of £400,000 of Public Health reserves to support spend in 2025/26 if current grant funding ends on 31st March 2025. This will be targeted at maintaining services for those people already in treatment.

Improvements in Adult Drug and Alcohol Treatment Service Outcomes associated with the National Drugs Strategy additional funding

3.17 The additional grant funding has enabled considerable improvements in services.

## Increase in numbers in treatment

3.18 The top ambition of the National Drug Strategy is to increase overall numbers in drug and alcohol specialist treatment services. Cambridgeshire was set a target to increase the total numbers in treatment to 2843 by 31st March 2025 (baseline in March 2022 was 2555). CGL achieved this target in April 2024 and numbers in treatment continue to grow. Cambridgeshire has seen an increase in treatment numbers across all drug types against baseline (March 2022) except alcohol which has increased but at a slightly lower rate than the national average.

## Reduction in unmet need

3.19 An increase in numbers of people receiving treatment has influenced Cambridgeshire's unmet treatment need rate. Comparing recent data March 2024 against the baseline March 2022 (grant funding commenced 1 April 2022), the unmet need rates for Cambridgeshire have reduced for all drug types apart from 'opiates only' which have increased but at a slower rate compared to national.

Treatment Outcomes
Treatment rate outcomes have improved and overall, they are above the national figures.

**Figure 4: Adult National treatment outcomes measures**

| National outcome measures (Adults) | Cambridgeshire March 2024 % | England March 2024 % |
|---|---|---|
| Treatment progress measure (successful completions, drug free in treatment or reduction in drug use) | 48% | 47% |
| Deaths in structured treatment | 1.20% | 1.28% |
| Criminal justice clients in contact with structured treatment | 89.0% | 64.3% |

## Prevention

3.20 There have also been some significant gains in prevention outcomes since the introduction of the grant in particular tackling Hepatitis C. Cambridgeshire's Hepatitis C testing numbers have increased by 20% (March 2024) compared to the baseline in March 2022 and remain significantly higher than the England average. Cambridgeshire are thereby making significant steps towards the national Hepatitis C micro-elimination goal where all those in structured treatment are offered testing regularly. Additionally, Cambridgeshire has continued to see increases in the distribution and availability of naloxone in the community (reverses opioid overdoses) which saves lives. The current distribution rate is higher than the England average.

## Other impacts and improvements

3.21 The additional grant has also enabled softer outcomes which includes funding of transport costs to facilitate access to clinical appointments, collection of medication from pharmacies and overall engagement in treatment. The grant has also funded 2 specialist citizen advice bureau workers dedicated to the treatment service to help address cost of living pressures which have resulted in £900,000 income gain to service users (access to entitled benefits) and £56,000 worth of debts written off.

### Adult Drug and Alcohol Treatment Services Funding

3.22 The value of the current CGL contract for the initial 5.5-year term was £26.8 million and with the additional 2-year extension adding £9.7 million. This is funded from the core Public Health Grant. The total value of the current core contract is £36.7 million over 7.5 years with a current annual value of £4,853,000

3.23 The contract variations over the course of the 7.5-year contract total £6.3 million primarily due to the additional Drug Strategy funding. The total CGL contract value over the full 7.5-year contract term (including all variations) is £43 million.

3.24 If the national drug and alcohol grants end in March 2025 this would mean a total reduction of income into the local treatment system of £1.7 million annually in Cambridgeshire. To put this into context the core commissioned treatment service contracts cost is £5.3 million per annum in Cambridgeshire (CYP and Adult) so the additional grant income represents a significant portion of the treatment system spend. This means that the improvements associated, and described above, with the additional grant funding are at risk of being eroded.

3.25 Included in this total contract value is additional funding from the Office of the Police and Crime Commissioner and the Probation Service have provided low value funding for co-commissioning elements of the current adult Drug and Alcohol treatment service. Over the past three years (including 2024/25) this funding totals £480,000, continuation of these grants has not been confirmed beyond 31 March 2026.

3.26 There is uncertainty around the funding allocation for the adult Drug and Alcohol Services due to lack of formal confirmation about continuation of the additional national grant funding. However, it is recommended that the core Public Health Grant funding is

maintained at the current value over seven years, irrespective of any currently unknown additional grant funding. As with the CYP Service the Adult Service has not received any inflationary uplifts over the course of contract and pressures have been managed but they are under ongoing review.

**Annual base value £4,754,638**
**Total base value: £33,282,466**

This excludes any additional Agenda for Change uplifts (if the new provider is an NHS organisation).

3.27 Any new commission will take the learning from the service improvements arising from the additional funding, but they will overall be difficult to maintain, and the challenge will be exacerbated by ongoing inflationary pressures. There will be limited mitigation from the agreed additional Public Health funding of £400,000 for 2025/26 if the extra grant funding is not maintained which will help ensure that the additional new service users are able to continue and hopefully complete their treatment. The newly commissioned service will start in April 2026, and it is recommended that the existing funding from the core Public Health Grant is maintained but also any associated uplifts are used in part to maintain these improvements and address any cost pressures that cannot be effectively managed.

Contract Length

3.28 As with the CYP agreement it is recommended that the contract length is for seven years with potential breaks at years three and five. The rationale for a longer contract is the complexity of the services, the destabilisation that a new provider brings with staff losses and recruitment issues, as it is a very specialist workforce. The financial pressures on adult services mean that there is a need to develop them which given the high and complex level of need will take time to embed.

Ongoing development of the new service model.

3.29 The re-commissioning of both the Adult and CYP Drug and Alcohol contracts in Cambridgeshire will provide the opportunity for service model change and development.

3.30 The new service specification and service model will need to reflect the learning in recent years alongside the needs assessment that is currently being undertaken.
The needs assessment will identify the changing demographic of service users, changing profile of drug use, requirements of vulnerable groups and the move towards place-based provision.

3.31 In view of the fluid funding for the service and the ongoing needs assessment it is recommended that the final Adult Drug and Alcohol proposed service model, and the available funding is brought back to Adults Health and Commissioning Committee for final approvals. This will enable the final funding pressures to be presented and how this will affect the new service model alongside considering the options of any additional core Public Health Grant funding if necessary.

# 4. Alternative Options Considered

4.1 This current Section 75 Agreement for CYP and the contract for Adult Drug and Alcohol Treatment Services cannot have any further extensions and therefore there is not any alternative to them being recommissioned.

4.2 The current CYP service is provided through a Section 75 with CPFT. The rationale for the recommendation of establishing a new Section 75 as opposed to undertaking a competitive procurement is described above. The kay factors are described in 3.2 as follows.

- The CYP Service has been developed to meet the specific needs of the patient/user group, and the Service is continuously evolving.
- The current CYP Service is a co-occurring conditions service which means that young people receive combined support to meet their substance use needs alongside any mental health needs.
- The CYP Service has input and oversight from an adolescent psychiatrist, which is a skill set that is difficult to recruit.

Additionally, the CYP Service is performing very well, with no empty posts and evidence of ongoing development. Any change of provider would run the risk of losing the very skilled and committed workforce.

4.3 Two procurement options, (described in 3.7) that are in line with PSR Procurement Regulations, have been considered for the recommission of the adult Service. Based on the advice of the Procurement Team a market analysis will be undertaken to determine if a direct award can be made to the current provider or whether a competitive process will be required to avoid any challenge to a direct award. The outcome of this along with the needs assessment will be included in a future report to the Committee.

# 5. Conclusion and reasons for recommendations

5.1 There are number recommendations in this report. In summary they seek approval to proceed to re-commissioning the CYP and Adult Drug and Alcohol Treatment Services, but they also reflect the complexities that this involves. These complexities demand that a further report is brought to Committee for approval when additional information will be presented to inform the Committee’s decisions.

5.2 The recommissioning is necessary because of the end of the Section 75 Agreement for both the CYP and Adult Services.

5.3 The procurement complexity is because PSR Regulations include the option of a direct award to the current provider as well as a competitive procurement process. The recommendation for a market analysis will enable any risks of a direct award to be excluded or minimised.

5.4 A second complexity arises from the uncertainty around the future of the additional Drug and Alcohol grant funding that has implications for maintaining the improvements afforded from the funding and also managing the ongoing cost pressures created by inflationary pressures. The planned future report to Committee should be able to confirm if the additional funding will be prolonged. This will enable the new Service to be financially planned with realistic deliverables in the context of ongoing cost pressures but also maintaining the improvements that have been secured with the additional funding. It is recommended that any uplift to the Public Health Grant could be in part allocated to the Drug and Alcohol Service to help mitigate the ongoing cost pressures and maintaining the improvements. This would be if following analysis of the needs and delivery model along with the confirmed funding envelope there are ongoing pressures.

# 6. Significant Implications

## 6.1 Finance Implications

The financial implications are described above.

CYP Drug and Alcohol Treatment Service: 3.6
Adult Drug and Alcohol Treatment Service: 3.22

Key issues for both are ongoing inflationary pressures. The adult services have complex financial issues arising from additional grant funding. Progress and ongoing issues related to these issues will be included in the follow up report to Committee

## 6.2 Legal Implications

We will work with Pathfinder Legal Services Ltd to fully explore any risks and ensure they are addressed and that all legal and governance requirements for both the new Section 75 Agreement and competitive tender are met.

Pathfinder Legal Services Ltd will assist in drafting the new Section 75 Agreement and contract and assist in any other legal issues that arise during the procurement stage.

## 6.3 Risk Implications

The contract and Section 75 Agreement must have strong requirements for early identification of any risks and a clear system for escalation and addressing them in collaboration with commissioners where appropriate.

Both agreements will require robust key performance indicators. The service models and the performance indicators will require ongoing development and review. Poor performance will need to be captured and addressed through contractual levers and the Section 75 agreement.

## 6.4 Equality and Diversity Implications

People who access Drug and Alcohol Treatment Services generally experience health and other inequalities that arise from a range of socio-economic circumstances and are

compounded by misuse of drugs and alcohol. The Services aim to address not only drug and alcohol misuse but also the wider factors that influence their substance misuse and their overall health and wellbeing outcomes.

A completed Equality, Impact Assessment (EqIA) form is attached as an appendix to this report.

### 6.5 Climate Change and Environment Implications

The Drug and Alcohol Treatment services can impact upon the environment and climate change though the delivery of services. Key actions that contribute are as follows.

- Commissioned treatment providers encourage the use of nature areas across Cambridgeshire, giving more people in recovery access and experience of green spaces.
- Commissioned treatment providers have worked with service users to regenerate the gardens within their fixed sites to encourage wildlife and growing of plants/vegetables and promoting benefits of green outdoor space.
- Commissioned treatment provider promotes the use of electric bikes to conduct home visits in Cambridge City.
- Providing place-based services, improving accessibility and treatment engagement.
- Supporting travel costs, promoting use of public transport to enable attendance at health appointments.

In addition, the proposed commissioning approach will embed and support the Council's net zero carbon emissions ambitions through a more place-based approach to service delivery, where feasible. This will mean that service users will be able to access services locally and not have to travel. In addition, any commissioned service will be expected to provide a digital option for accessing services, if appropriate.

The procurement will include a quality question relating to carbon emissions. Carbon emission monitoring will be embedded into the service specification and contract and will be part of performance monitoring.

Any commissioned provider will need to demonstrate how their service will contribute to ensuring that staff and service users are safe when travelling. If service delivery involves staff travelling, environmentally sustainable options should be adopted.

## 7. Source Documents

7.1 Alcohol and drug prevention, treatment and recovery: why invest? - GOV.UK (www.gov.uk).
National Drug Treatment Monitoring System, Office for Health Improvement & Disparities
NDTMS - Home
Commissioning quality standard: alcohol and drug services - GOV.UK

# Equality Impact Assessment blank template (Word)

This Equality Impact Assessment (EqIA) form is a template document for colleagues completing EqIAs to know what questions will be asked when they complete the online form.

**The online EqIA process should be completed for all EqIAs, but this black template should enable collaboration between colleague before completing on online form.**

| **Stage 1: Action being taken/details of person completing the form** | |
|---|---|
| **Details of person undertaking assessment** | |
| Form reference | EQIA-06614 |
| Your name | Scott Davidson |
| Your job title | Senior Public Health Manager – Drugs and Alcohol |
| Your directorate | Adult Health and Social Care |
| Your service | Drugs & Alcohol Treatment Services |
| Your team | Drugs & Alcohol Commissioning Team |
| Your email | Scott.Davidson@cambridgeshire.gov.uk |
| Proposal being assessed | Paper to Adults & Health Committee Retendering of Drug and Alcohol Treatment Services required due to contract expiration |
| Business plan proposal number (if applicable) | |

| **Stage 2: Proposal details** | |
|---|---|
| What is the name and description of the policy being assessed? | A paper has been submitted to the Adults and Health Committee highlighting the impending retendering of the Drugs and Alcohol treatment services within Cambridgeshire significant loss of grant funding that is currently enhancing drug and alcohol treatment provision. |
| What type of policy is this? | • New ☐<br>• Major change ☒<br>• Minor change ☐ |
| Is this EqIA supporting a committee paper/business case? | Yes ☒<br>No ☐ |

| **Stage 3: Identifying impacts on affected groups (screening question)**<br>Is it foreseeable that people from any protected characteristic group(s) or people experiencing socio-economic inequalities will be impacted by the implementation of this proposal? |
|---|
| Yes ☒<br><br>No ☐ |

**If you select 'NO' - you will complete a screening form**

You will be asked you to provide an evidence-based analysis of your assessment that your plans will have no impacts for people with protected characteristics or our priority group of socio-economic inequalities. You are asked to explain each group in turn. Where the justification is the same, you can avoid duplication by saying for later groups that the explanation under an earlier group applies. For example, you might explain that your EqIA is for a revised procedure which combines two previous procedures which both had robust and effective EqIAs in place, without making any significant changes to them. Therefore, there will be no impact on people from these changes.

**If you selected 'YES'** for the above screening question, you would go on to complete the full EqIA as below (see stage 4).

| **Stage 4: Impact and evidence**<br>From your assessment, using your data/evidence gathered, what is the potential direct or indirect impact of the proposed change on these groups that are protected characteristics in the Equality Act 2010? (Please tick relevant box for each characteristic, and assess whether the policy may produce positive, negative, or neutral impacts.) |
|---|
| **Age**<br><br>Neutral impact ☐<br><br>Positive impact ☐<br><br>Negative impact ☒<br><br>**Disability**<br><br>Neutral impact ☐<br><br>Positive impact ☐<br><br>Negative impact ☒ |

### Gender reassignment

Neutral impact ☐

Positive impact ☐

Negative impact ☒

### Marriage/civil partnership

Neutral impact ☐

Positive impact ☐

Negative impact ☒

### Pregnancy and maternity

Neutral impact ☐

Positive impact ☐

Negative impact ☒

### Race

Neutral impact ☐

Positive impact ☐

Negative impact ☒

### Religion/belief

Neutral impact ☐

Positive impact ☐

Negative impact ☒

### Sex

Neutral impact ☐

Positive impact ☐

Negative impact ☒

**Sexual orientation**

Neutral impact ☐

Positive impact ☐

Negative impact ☒

**Care experienced**

Neutral impact ☐

Positive impact ☐

Negative impact ☒

**Other identified groups -** Groups with different socio-economic groups, area inequality(rurality), income, resident status (migrants)/ language barriers. Begin to think intersectional here.

Neutral impact ☐

Positive impact ☐

Negative impact ☒

**You identified positive/negative impacts – please explain each one and supporting evidence:** (This can include relevant national/local data, research, monitoring information, service user feedback, complaints, audits, consultations, EqIAs from other projects or other local authorities, review of customer complaints and feedback and staff surveys; or use of census data):

**Impact on Age**

Although Drugs and Alcohol treatment services in Cambridgeshire aim to be accessible for all, there is differential uptake across age groups, indicating that age-related factors may influence service engagement. This could lead to health inequalities if some age groups are not accessing adequate support.

The following section outlines the current service model and analysis of recent user data to highlight patterns and potential barriers to access. We describe our approach to better understanding and addressing these disparities to ensure more inclusive service provision.

The current service provision is split with CGL Cambridgeshire providing the adult drug treatment service and CPFT providing the structured drug treatment provision for young people through CASUS.

As of March 2024, 2835, adults had accessed structured drug and alcohol treatment during the previous 12 months. Of the clients counted to have accessed adult drug treatment services:

407 clients fell within the 18–29-year-old range (14.35%)
1626 clients fell within the 30–49-year-old range (57.35%)
802 clients fell within the 50+ year-old range (28.3%)

*Source OHID NDTMS*

As of March 2024 152, young people had accessed structured drug and alcohol treatment during the previous 12 months. Of the clients counted to have accessed young people's services:

31 clients fell within the under 15-year-old range (20.4%)
45 clients fell within the 15-year-old range (29.6%)
33 clients fell within the 16-year-old range (21.7%)
43 clients fell within the 17-year-old range (28.3%)

*Source OHID NDTMS*

**Unmet treatment need - March 2024 in comparison to June 2019**

The tables below reflect the Opiate and Crack Cocaine users (OCU) profile alongside alcohol only.

Unmet treatment need - June 2019

**Cambridgeshire**

OCU unmet need by age groups (Jul 2018 to Jun 2019)

| Group | Unmet treatment need | Lower bound | Upper bound | Numbers in treatment (aged 15-64) | Prevalence estimate (2019-20) |
|---|---|---|---|---|---|
| 15-24 | 86.0% | 82.1% | 88.8% | 27 | 192 |
| 25-34 | 59.6% | 52.2% | 65.4% | 254 | 629 |
| 35-64 | 48.7% | 42.0% | 54.8% | 878 | 1,712 |
| *Total* | *54.2%* | *47.2%* | *60.3%* | *1,159* | *2,533* |

**Cambridgeshire**

Alcohol unmet need by age group (Jul 2018 to Jun 2019)

| Age group | Unmet treatment need | Numbers in treatment (aged 18+) | Prevalence estimates (2019-20) |
|---|---|---|---|
| 18-24 | 93.4% | 69 | 1,047 |
| 25-34 | 84.6% | 215 | 1,397 |
| 35-54 | 77.5% | 529 | 2,356 |
| 55+ | 76.7% | 177 | 761 |
| *Total* | *82.2%* | *990* | *5,561* |

Unmet treatment need - March 2024

**Cambridgeshire**

OCU unmet need by age groups (Apr 2023 to Mar 2024)

| Group | Unmet treatment need | Lower bound | Upper bound | Numbers in treatment | Prevalence estimate (2019-20) |
|---|---|---|---|---|---|
| 15-24 | 87.0% | 83.4% | 89.6% | 25 | 192 |
| 25-34 | 73.3% | 68.4% | 77.1% | 168 | 629 |
| 35-64 | 40.6% | 32.8% | 47.7% | 1,017 | 1,712 |
| *Total* | *52.2%* | *44.9%* | *58.6%* | *1,210* | *2,533* |

**Cambridgeshire**

Alcohol unmet need by age group (Apr 2023 to Mar 2024)

| Age group | Unmet treatment need | Numbers in treatment | Prevalence estimates (2019-20) |
|---|---|---|---|
| 18-24 | 90.8% | 96 | 1,047 |
| 25-34 | 80.5% | 272 | 1,397 |
| 35-54 | 69.1% | 729 | 2,356 |
| 55+ | 63.9% | 275 | 761 |
| *Total* | *75.3%* | *1,372* | *5,561* |

*Source OHID NDTMS*

The earliest data we have on unmet treatment need from the NDTMS toolkit dates to June 2019. Over the passage of the drugs and alcohol treatment contract we have seen evidence of progression against a number of the age ranges e.g.

The 35-64 age range of OCU has seen a drop in unmet need of 8.1%
The 35-64 age range of Alcohol users has seen a drop in unmet need of 12.8%

However, there has been a rise in the unmet need rate in the below age range:

The 25-34 age range of OCU has seen a rise in unmet need of 13.7%

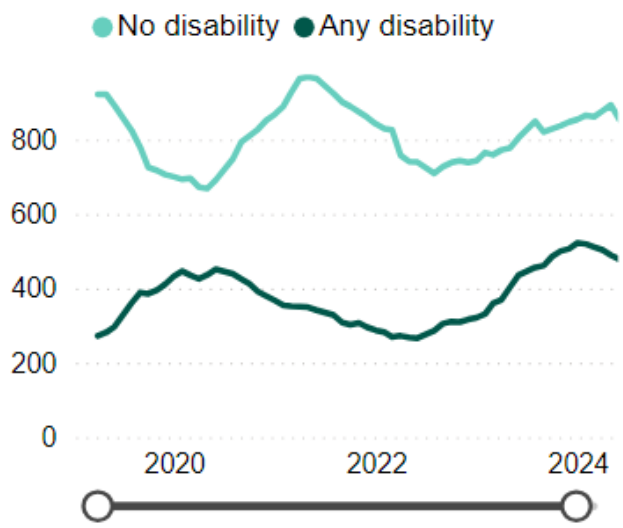
The current treatment providers have over the duration of the contract made some headway in meeting the unmet treatment needs although the impact of COVID and the response required during this period will no doubt have affected service abilities to address unmet need more substantially.

As part of the needs analysis supporting the retender of drug treatment services, we hope to be able to identify what within the current provision has enabled the advances and what challenges have been faced engaging specific age groups. The hope being to be able to retain within any future service models key components that engagement with all ages.

We are exploring as part of the needs analysis what evidence there is to support the existence of a separate young person's treatment provision. At this stage we do not know if the commissioning of a combined adult and young people drug treatment service would be detrimental to the young people. It is envisaged that mobilisation into a new service model could be disruptive all service users and perhaps if the specific young people's service was lost this will be felt more disproportionately across the younger people age groups.

**Impact on disability**

Individuals with disabilities may experience unique barriers to accessing and engaging with services. Recent data show an increase in the proportion of service users reporting a disability, which may suggest better identification of need seen in the work of treatment providers or greater service accessibility. It indicates a need for tailored support to ensure equitable access. The graph below provides an indication of the increase in the numbers accessing services who state at the point of engagement they have a disability. The data covers the rolling 12-month period leading up to March 2024. This increase corresponds with the increase in numbers accessing treatment although the trend rate over recent years appears steeper.




*Source OHID NDTMS*

The needs analysis accompanying the retender will be exploring the needs of those with a disclosed disability by taking into consideration other specific needs assessments conducted within the Local Authority along with existing treatment data.

The below shows the number in treatment over the rolling 12-month period up to March 2024 and highlights the types of disabilities being disclosed by service users and subsequently what types of disability may be affected by the retendering process.

| Disability | Number (* below 5) |
|---|---|
| Behaviour | 318 |
| Hearing | 24 |
| Manual | 6 |
| Learning | 38 |
| Mobility | 70 |
| Perception | * |
| Personal | * |
| Progressive | 76 |
| Sight | 11 |
| Speech | * |
| Other disability | 38 |
| Not stated disability | 54 |
| No disability | 861 |
| Any disability | 511 |

*Source OHID NDTMS*

Any remodelling of current treatment provision will need to take into consideration the service access needs of the above groups to ensure any adjustments do not disproportionately affect any specific group,

**Impact on Gender Reassignment**

Those considering or undergoing gender reassignment or those whose gender identity differs from the sex they were assigned at birth, are not specifically recorded in NDTMS data collection. This lack of data is a significant limitation, as it impedes understanding of the representation and potential specific needs of this group within the treatment population. The extent of representation within the treatment population is not currently known. It is possible that those undergoing gender reassignment whilst in drug treatment may define themselves in any of the below categories counted by the NDTMS.

As of March 2024, the current sexuality breakdown of those 1426 accessing treatment within a 12-month rolling period is:14.26

84.57% Heterosexual
2.10% Gay/Lesbian
3.02% Bisexual
0.28% Other sexuality
0.22% Person asked and does not know or is not sure
5.75% Not stated sexuality
4.06% Where the data has not been reported

*Source OHID NDTMS*

As part of the needs analysis accompanying the drug and alcohol service retendering, we hope to uncover if any specialist or tailored provision to identify and support specific groups is in place or if a gap in provision is identified.

In the event of a reduction to treatment provision and the capacity of our services, the ability to meet the specific needs of smaller demographic groups may become difficult. Population data suggests that this is a small demographic of people, and in-house tailored support is likely to be financially & practically non-viable. As a minimum, however, we would expect services to be able to signpost to support services as required. We will also be expecting providers to have staff who are adequately trained to respond to the needs of this specific group. At this time given the lack of data on the specific numbers and details concerning their specific needs, we cannot determine if this group will be disproportionately affected by any service model changes.

**Impact on Marriage/Civil Partnerships**

Those accessing drug and alcohol treatment do not have their marital/civil partnership status gathered as part of data collection, which may impact our ability to understand the impact of this characteristic on treatment access and outcomes. However, it is not expected that a person's marital status will result in them being disproportionately affected by a change in service model. As protections to this group are linked primarily to conditions of employment no specific provision has been made within drug and alcohol treatment to provide bespoke options individuals based on marital or civil partnership status.

**Impact on Pregnancy & Maternity**

Local March 2024 data below indicates that on average 1.9% of new treatment starters are pregnant. While this group represents a low proportion of the treatment population, pregnant individuals often have unique health and social care needs, including additional considerations for both their own health and the well-being of their unborn child.

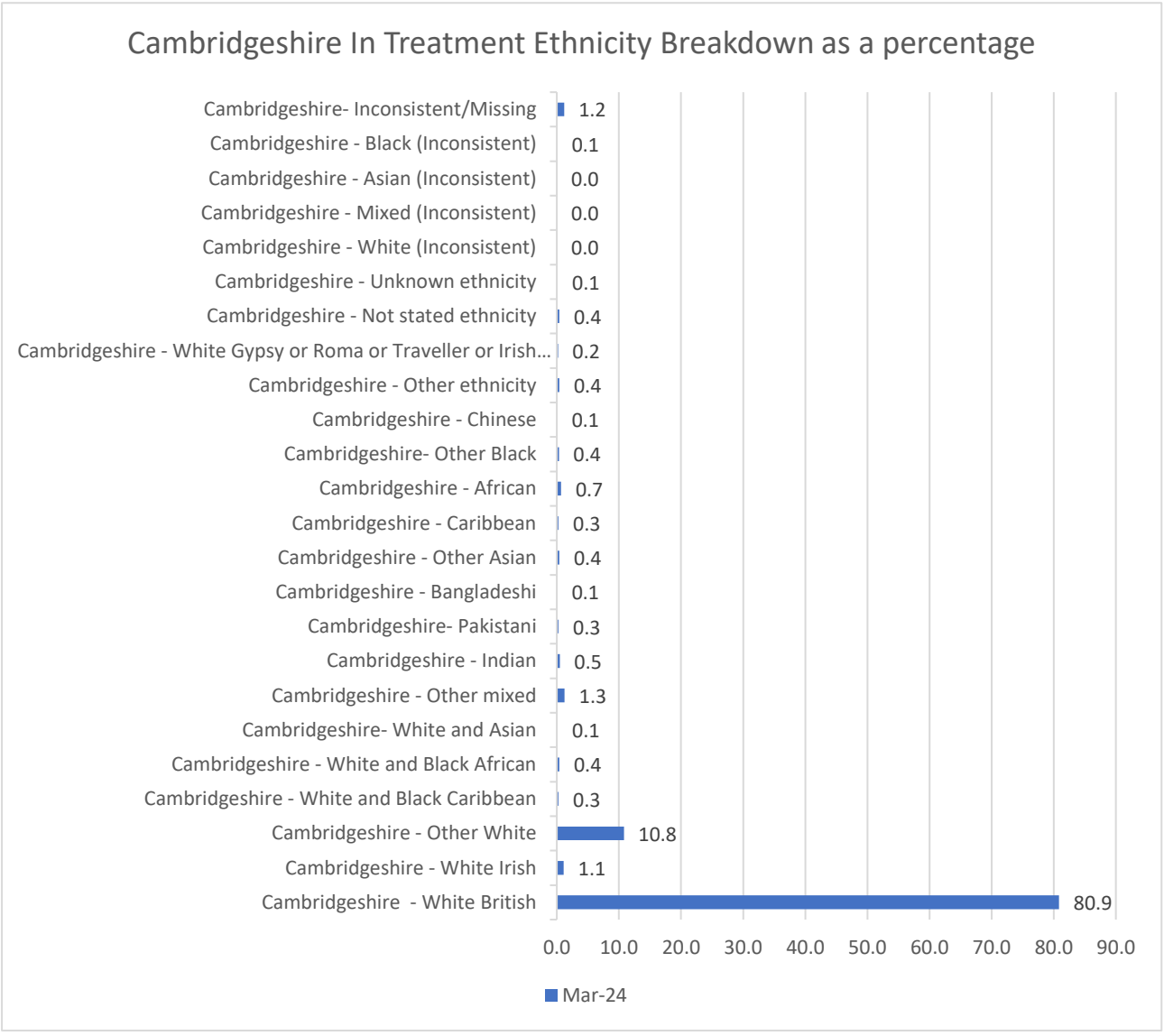
| At start of treatment journey | 1 Apr – 30 Jun<br>% | 1 Apr – 30 Sep<br>% | 1 Apr – 31 Dec<br>% | 1 Apr – 31 Mar<br>% |
|---|---|---|---|---|
| Female pregnant | 1.4% | 1.7% | 2.8% | 1.8% |

*Source OHID NDTMS*

The needs analysis accompanying the retendering of drug treatment services will be reviewing what specific provision is in place to meet the needs of this specific cohort and there any gaps in provision. Any adjustments to treatment models will need to consider any disproportionate effect they may have on this group. We currently have no evidence that indicates that this group will be disproportionately affected by a service retendering process however changes to the service model may directly and indirectly effect service access for this group if any bespoke provision that support this groups is subsequently lost.

**Impact on Race**
Drug use choice can be driven by cultural factors, and population data indicates that drug use differs according to race; the Crime Survey for England and Wales 2022 showed that the prevalence of having used illicit drugs in the last year varies by ethnic background, by up to 11.4%. We do not want to indirectly affect specific racial groups by focusing resources on specific drug user types to the detriment of other user groups.

Currently we have no evidence that the retender process will have a disproportionate effect on any racial group, but the needs analysis accompanying the retendering exercise aims to identify if there are any barriers to access or gaps in provision for any specific racial demographic. The intent is to make sure that any decisions to adjust the treatment model do not disproportionately affect or favour ethnic groups.
March 2024 data below indicates that the below various ethnicities are currently represented in the treatment population, which will continue to be monitored to ensure that all groups have equitable access to services.




*Source OHID NDTMS*

**Impact on Religious Belief**
Religious belief is a separate but important characteristic that can influence how individuals engage with drug and alcohol treatment services. While cultural factors may shape broader behaviours and values, religious beliefs can specifically affect a person's decisions, coping strategies, and openness to treatment methods.
The religious groups as of March 2024 currently reported as represented in the treatment population are as below:

| Religion/Belief | Number (* low numbers) |
|---|---|
| Baha'i | 0 |
| Buddhist | * |
| Christian | 272 |
| Hindu | * |
| Jain | 0 |
| Jewish | * |
| Muslim | 11 |
| Pagan | * |
| Sikh | * |
| Zoroastrian | 0 |
| Other religion | 45 |
| No religion | 815 |
| Declined to disclose | 16 |
| Unknown religion | 241 |
| Inconsistent/missing religion | 10 |

*Source OHID NDTMS*

The needs analysis accompanying the retender process for the drugs alcohol treatment contract will be exploring if any specific interventions are in place that support from different religious backgrounds, if there are gaps in provision or if the provision is disproportionately supportive to any group.

Any remodelling of service will need to ensure that no specific religious group is adversely affected by the model of provision offered. Currently we have no evidence to indicate that any religious group will be disproportionately affected by the retendering process.

**Impact on Sex**
The prevalence of drug and alcohol use and treatment need differs between males and females. The needs analysis accompanying the Drugs and Alcohol contract retendering will be considering the representation in drug treatment across the sexes and determine if there are any provisions or gaps in provisions that are adversely affecting a specific sex.

Any remodelling of drug treatment provision will need to ensure that it does not directly or indirectly affect either sex. The hope is that the needs assessment will be able to identify practices that have supported specific sexes and make recommendations for improvements where gaps in provision are found.

A comparison of unmet need data March 2022 to March 2024 shows that the current treatment provides have been able reduce unmet need across both sexes.

**Cambridgeshire**

OCU unmet need by sex (Apr 2023 to Mar 2024)

| Group | Unmet treatment need | Lower bound | Upper bound | Numbers in treatment (aged 15-64) | Prevalence estimate (2019-20) |
|---|---|---|---|---|---|
| Female | 34.5% | 26.1% | 41.1% | 356 | 544 |
| Male | 57.1% | 50.9% | 62.6% | 854 | 1,989 |
| *Total* | *52.2%* | *45.5%* | *58.1%* | *1,210* | *2,533* |

**Cambridgeshire**

Alcohol unmet need by sex (Apr 2023 to Mar 2024)

| Sex | Unmet treatment need | Numbers in treatment (aged 18+) | Prevalence estimates (2019-20) |
|---|---|---|---|
| Male | 79.3% | 876 | 4,223 |
| Female | 62.9% | 496 | 1,338 |
| *Total* | *75.3%* | *1,372* | *5,561* |

**Cambridgeshire**

OCU unmet need by sex (Apr 2021 to Mar 2022)

| Group | Unmet treatment need | Lower bound | Upper bound | Numbers in treatment (aged 15-64) | Prevalence estimate (2019-20) |
|---|---|---|---|---|---|
| Female | 37.7% | 29.6% | 43.9% | 339 | 544 |
| Male | 59.4% | 53.6% | 64.6% | 807 | 1,989 |
| *Total* | *54.8%* | *48.4%* | *60.3%* | *1,146* | *2,533* |

**Cambridgeshire**

Alcohol unmet need by sex (Apr 2021 to Mar 2022)

| Sex | Unmet treatment need | Numbers in treatment (aged 18+) | Prevalence estimates (2019-20) |
|---|---|---|---|
| Male | 84.2% | 668 | 4,223 |
| Female | 63.2% | 492 | 1,338 |
| *Total* | *79.1%* | *1,160* | *5,561* |

*Source OHID NDTMS*

There is currently no evidence that a retendering of drug treatment services would disproportionately affect a specific sex.

**Impact on Sexual Orientation**

National data from the Crime Survey for England and Wales (CSEW) highlights that non-heterosexual individuals report significantly higher rates of illicit drug use, with 17.1% to 30.8% of these groups having used drugs in the past year, compared to just 8.3% of heterosexuals. Understanding the breakdown of sexuality within treatment services helps ensure inclusivity and accessibility for all groups, considering this difference in drug use. As of March 2024, the current sexuality breakdown of those 1426 accessing treatment within a 12-month rolling period is:

84.57% Heterosexual
2.10% Gay/Lesbian
3.02% Bisexual
0.28% Other sexuality
0.22% Person asked and does not know or is not sure
5.75% Not stated sexuality
4.06% Where the data has not been reported

*Source OHID NDTMS*

The ongoing needs analysis will explore if there are any specific gaps in provision for any specific sexualities. Currently we have no evidence to suggest that a retendering process would disproportionately affect any specific sexuality.

**Impact on Care Experienced**

Care-experienced individuals, particularly those with children under the age of 18, may have unique needs when accessing drug and alcohol treatment services. Those with a history of adverse childhood experiences or trauma may face additional challenges in engaging with services.

Cambridgeshire data from March 2024 shows that those adults entering treatment (who have children under the age of 18 living with them) had children identified under the following status.

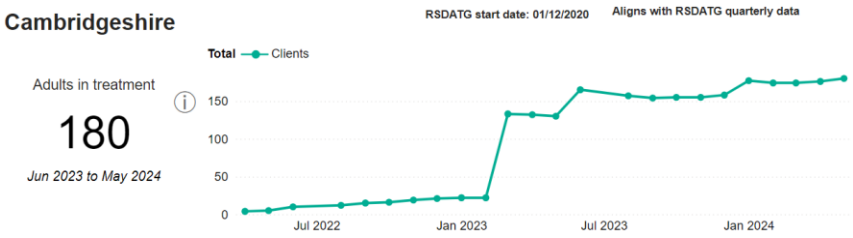
6.8% accessing Early Help compared to 5.7% March 2022
9.1% accessing Children in Need support compared to 9.1% March 2022
15.3% had a child protection plan compared to 12.8% March 2022
3.1% looked after child compared to 2.6% March 2022

*Source OHID NDTMS*

The needs analysis accompanying the drug treatment retender will be reviewing the provision available in treatment services to support young people with care needs and exploring if there are any gaps in provision for the care experienced. We currently have no evidence that indicates that those who have experienced care will be disproportionately affected by the retendering process although we are mindful adverse childhood experience and past trauma that can make the mobilisation period of new contract more keenly felt to be disruptive by this particular group.

**Impact on Other identified groups**
Individuals who are homeless or at risk of homelessness face unique and significant barriers to accessing drug and alcohol treatment services. These barriers include issues such as lack of stable housing, hidden homelessness (e.g., those staying with friends or in temporary accommodation), and the compounding effects of social isolation and mental health challenges. Addressing the needs of this group is crucial, as homelessness is a significant risk factor for substance misuse and can exacerbate the difficulty of engaging in treatment services.

The current treatment provider CGL has established a specific provision that has enabled drug and alcohol treatment support for the homeless and at risk of homelessness population, through the additional enhanced grant funding. The below graph evidences the number who have been supported into drug and alcohol treatment over the grant period.




*Source OHID NDTMS*

There is also a women's only worker funded through this grant who supports women who experience homelessness, who are often hidden in national statistics.

The aim of the needs analysis accompanying the retender will be to help identify what parts of the current provision are essential to retain and embed in any future service specifications. It is possible that disruptions to treatment provision may be keenly felt by this service user cohort but without the findings of the needs analysis, specifically the qualitative analysis, we currently have no evidence to confirm that this group will be disproportionately affected by the retender exercise.

**Stage 5: Mitigating impact actions**

Queston: Now you have identified the foreseeable impacts of the policy, please repeat any negative or positive impacts for each group and state a) any mitigating actions for each negative impact and/or b) any actions you can take to enhance positive impacts them.

| Identified impact on protected group | Action to mitigate or enhance | Officer responsible for action | Completion date |
|---|---|---|---|
| Age | Needs analysis to consider this characteristic in any recommendations for service remodelling | Susie Talbot | March 2024 |
| Disability | Needs analysis to consider this characteristic in any recommendations for service remodelling | Susie Talbot | March 2024 |
| Gender Reassignment | Needs analysis to consider this characteristic in any recommendations for service remodelling | Susie Talbot | March 2024 |
| Marriage/Civil Partnership | Needs analysis to consider this characteristic in any recommendations for service remodelling | Susie Talbot | March 2024 |
| Pregnancy/Maternity | Needs analysis to consider this characteristic in any recommendations for service remodelling | Susie Talbot | Jan 2025 |
| Race | Needs analysis to consider this characteristic in any recommendations for service remodelling | Susie Talbot | Jan 2025 |
| Religious Belief | Needs analysis to consider this characteristic in any recommendations for service remodelling | Susie Talbot | Jan 2025 |
| Sex | Needs analysis to consider this characteristic in any | Susie Talbot | Jan 2025 |

| | | | |
|---|---|---|---|
| | recommendations for service remodelling | | |
| Sexual orientation | Needs analysis to consider this characteristic in any recommendations for service remodelling | Susie Talbot | Jan 2025 |
| Care Experienced | Needs analysis to consider this characteristic in any recommendations for service remodelling | Susie Talbot | Jan 2025 |
| Other groups | Homelessness and at-risk of homelessness. Needs analysis to consider this characteristic in any recommendations for service remodelling | Susie Talbot | Jan 2025 |

| Did you engage with an EqIA Super User when developing your EqIA? |
|---|
| Yes ☐<br><br>No ☒ |

| **Stage 6: Sign off and approval** |
|---|
| To ensure a robust, respectful, and transparent approval process:<br><br>• Please do not enter your own details here, even if you are a Head of Service (or equivalent) or. This is to ensure that someone else reviews your work.<br>• Please do not enter the details of someone you line manage and/or with less authority than you.<br><br>**Please find and select your Head of Service (or equivalent).**<br><br>**Val Thomas – Acting Director Public Health** |

# Recommissioning Behaviour Change Services

| | |
|---|---|
| To: | Adults and Health Committee |
| From: | Executive Director, Adults, Health, and Commissioning |
| Electoral division(s): | All |
| Key decision: | Yes |
| Forward Plan ref: | KD2025/006 |
| Executive Summary: | This report is seeking the Committee's approval for re-commissioning the Behaviour Change Services. It outlines the current Service and the provisional changes to service delivery that will be finalised when a number of research and consultation processes have been completed. The outcome is to secure Committee approval for recommissioning a place-based service delivery model. |
| Recommendation: | The Committee is asked to approve the following recommendations: |

a) To re-commission for Cambridgeshire residents only an integrated behaviour change service through the Provider Selection Regime competitive regulations for seven years, with contract break options at 3,5 and 6 years at a total value of £12,470,397 at 2024/25 prices including Integrated Care Board funding. Inflationary uplifts will be applied as considered appropriate and in line with the Council's Business Plan across the life of the contract.

b) To develop a place-based commissioning and financial model following completion of the four areas of work described in paragraph 3.11 and to bring the finalised model back to the Adults, Health, and Commissioning Committee in March 2025, prior to commencing the procurement.

c) To delegate authority for awarding and executing the contract for providing the Behaviour Change Service starting 1st October 2025 to the Executive Director Adults, Health, and Commissioning in consultation with the Chair and Vice-Chair of the Adults and Health Committee for a total of 7 years, with the option of breaks at Years 3, 5 and 6.

Officer contact:
Name: Val Thomas
Post: Deputy Director of Public Health
Email: val.thomas@cambridgeshire.gov.uk

# 1. Creating a greener, fairer, and more caring Cambridgeshire

1.1 Ambition: The proposed commissioning approach will support the Council's net zero carbon emissions ambitions through the adoption of a place-based approach to service delivery. This will mean that service users will be able to access services locally and not have to travel. In addition, any commissioned services will be expected to provide a digital option for accessing services, if appropriate.

1.2 Ambition 2: Any commissioned provider will need to demonstrate how their service will contribute to ensure that staff and service users are safe when travelling. If service delivery involve staff travelling environmentally sustainable options should be adopted.

1.3 Ambition 3: The commissioned services will have delivery targets for increasing uptake of the service in areas of deprivation and specific population groups that have low uptake and poorer health outcomes than other areas and the wider population.

1.4 Ambition 4: The Behaviour Change Services are focused upon supporting and enabling people to adopt healthy behaviours that will help prevent them from having poor health.

1.5 Ambition 5: The Behaviour Change Service recognises that people health related behaviours are influenced by their socio-economic circumstances. If help is required with a service user's socio-economic circumstances the Service will seek to advise and signpost to appropriate support.

1.6 Ambition 6: The Behaviour Change Services support people who are not in work because of a health condition and alongside helping them to improve their health the Services will refer people not in work to other forms support that will support them to find employment.

1.7 Ambition 7: The Behaviour Change Services are targeted at adults that often have families with children and young people. Improving the health behaviours of parents/carers will impact on the health and wellbeing of children and young people who live with them and will help them to thrive.

# 2. Background

2.1 Behaviour Change Services are commissioned to support improvements in health outcomes and reduction in health inequalities in Cambridgeshire. Improving health outcomes is complex and requires influencing health related behaviours, the environments in which people live and the socio-economic determinants of their health.

2.2 Historically overall residents of Cambridgeshire have experienced relatively good health outcomes but there are some people who experience poor health and there are some significant health inequalities.

2.3 Overall, in Cambridgeshire as nationally, life expectancy and healthy life expectancy for both men and women rose between 2001 until approximately 2011, when growth appeared to stall for most areas with no improvement over the last ten years.

There are inequalities in life expectancy between different areas which are linked to deprivation. Fenland has the lowest life expectancy which is significantly lower than the England average. Data is not available for Healthy Life Expectancy at district levels, but given the variations seen for life expectancy we would expect to see the same differences for healthy life expectancy.

2.4 Health behaviours affect health outcomes and those that have the most impact are diet, physical activity, smoking, and alcohol. Although many of the rates are lower than national averages there are still significant numbers of people who are at risk through their health behaviours and there is significant variation between areas and groups of people.

2.5 A substantial proportion of adults and children are either overweight or obese in Cambridgeshire. Around 61% of adults are either overweight or obese but the rate in Fenland is 71%. Similarly at the Cambridgeshire level around 30% of 11-year-olds are overweight or obese yet in Fenland the figure is 40% and in Cambridge City the figure is 19%.

2.6 Smoking rates have improved significantly in recent years but again there is variation. The Cambridgeshire adult smoking rate in 2023 was 10.8% but in Fenland it was 24%. Smoking prevalence in groups such as routine and manual workers (RMWs) and those with poor mental health tends to be significantly higher. (Public Health Outcomes Framework - Data | Fingertips | Department of Health and Social Care)

2.7 There is robust evidence that adopting healthier behaviours is key to improving and preventing these poor health outcomes. The National Institute for Health and Care Excellence (NICE) provides wide ranging evidence for changing health behaviours These include individual approaches e.g. Overview | Behaviour change: general approaches | Guidance | NICE but also, environmental interventions e.g. Overview | Physical activity and the environment | Guidance | NICE

Current Service Delivery

2.8 Cambridgeshire County Council (CCC) currently commissions an integrated behaviour change service that is delivered across Cambridgeshire and Peterborough. Peterborough City Council (PCC) delegated authority to CCC to commission the service on its behalf. The new service will be recommissioned for Cambridgeshire residents only as both CCC and PCC will be adopting place-based model which is described later in this paper.

2.9 Integrated behaviour change service encourage and support sustainable positive health behaviours and usually provide the following types of interventions.

- Providing information, advice, and guidance
- Providing access to self-help tools
- Delivering high quality, evidence-based lifestyle interventions
- Ensuring effective referral pathways from key partners, such as Primary Care.

2.10 This is the current model in Cambridgeshire which includes primary prevention, secondary prevention, and treatment services. There are essentially three service tiers with different

providers delivering the various elements. All providers operate under the public-facing 'Healthy You' brand.

Tier One Services: Primary Prevention

2.11 The Tier 1 Service is a universal service, with includes population level and targeted interventions. It includes a wide range of physical activity and healthy eating services that focus on prevention and early intervention which are delivered in the community.

2.12 They are delivered by the five district councils and Peterborough City Council. These function as a consortium led by Cambridge City Council and in partnership with the charity Living Sport, their contracts commenced in 2020 with a 3 year plus 1 plus 1 contract.

2.13 An important part of primary prevention is supporting the development of environments that support healthy behaviours. The Tier 1 Service works with broader initiatives in the local areas to support and maximise their impact, for example working with schools/workplaces to increase opportunities for active commuting to school and work.
A fundamental dimension of the Tier 1 Service is its integration with all the other parts of the Service.

Tier 2 Services

2.14 Everyone Health is private sector organisation and provides the Tier 2 services It provides the core service and has the highest value contract. Like the district contracts the service was commissioned in 2020 with a 3+1+1 contract due to end on 30th September 2025.

2.15 It has a focus on providing support to individuals for them to adopt healthier behaviours.

- The health trainer service provides users with behavioural change support and a number of specialist areas have been developed alongside the generic health trainers. These focus on specific behaviours or supporting specific groups that have a high level of risk-taking behaviours: alcohol, older people/falls prevention, mental health, Eastern European, carers and diabetes.
- Tier 2 weight management services are provided that offer group support. Some activity is diverted into commercial weight management services, but these remain free to service users.
- Stop Smoking services are delivered that includes providing specialist advice for other providers such as GP practices.
- Outreach and workplace NHS Health Checks
- Training: Behaviour Change Maintenance, Mental Health First Aid
- National Child Measurement Programme (NCMP)

Tier 3 Service: Adult Weight Management Services

2.16 Tier 3 Adult Weight Management services provide specialist assessment, treatment, and support for individuals, aged 18 or over, with severe and complex obesity. Two Tier 3 Adult Weight Management contracts are currently commissioned.

- Everyone Health delivers its own in-house service ‘Fresh Start’ and also sub-contracts with Cambridge University Hospitals (CUH – Addenbrookes) which is a specialist service that treats those with underlying complex clinical issues.

- Due to increased demand an additional Tier 3 service was commissioned in 2023 from the private sector organisation Morelife. This Tier 3 service provides virtual group, digital self-led and community programmes. Its contract started on the 1st September 2020 and will end on the 31st October 2025.

2.17 Co-ordination of all the different service elements is provided by Everyone Health across all tiers, and it operates a central triage system that service users can access.

2.18 Performance overall for all elements of the service provides evidence that it is effective in delivering positive behaviour change at levels that are comparable or above national benchmarks. It is recommended that the new service will include the delivery of these key service elements but through a different delivery model that is place based and will afford greater accessibility and service integration at local level.

# 3. Main Issues

## New Service Model

3.1 Since the behaviour change services were last commissioned the strategic and commissioning landscape has changed considerably. The current focus is on developing place-based commissioning with models that integrate services at a local level.

3.2 A place-based service model will bring a range of benefits and opportunities for innovation. It will provide the opportunity to integrate internal local authority services, for example libraries along with local district/city and integrated care system services including GP practices. The development of community hubs affords another opportunity for local integration of services. Currently there is duplication of services, for example health trainers provide the same function as the NHS health coaches. This could be avoided through increased integration of these services which lends itself to a place-based model.

3.3 More generally place based services are developed locally to better address the needs of the local population, with improved use of local community assets and access to services for local residents. Addressing health behaviours demands exploring the barriers to behaviour change which usually reflect the local environment and socio-economic circumstances. A place-based model will enable organisations and communities working in these areas to collaboratively develop local solutions including local policies to address these wider issues. The commissioned place-based services would need to work closely with local partners alongside communities to elicit place-based changes that are broader than the current service scope such as working to improve the food environment/planning policy, access to physical activity opportunities.

3.4 There are inherent challenges in place-based models not least the identification of the geography of the model, what the needs are, what is currently in place and the funding

model. The preferred place geography for these services is district level because of the key policies affecting health behaviours, notably planning and physical activity opportunities (leisure services). However, the ongoing review of the current services, local needs and stakeholder engagement will shape the final recommended model.

3.5 The Tier 1 Prevention Services are already commissioned at district levels and partner working has been developed across the areas. A recent example of when place based working has been effective is where district leisure service teams have developed interventions in their own areas which have mitigated some of the demand pressures on the Tier 2 weight management services.

3.6 CCC is in the process of developing place-based working and commissioning for example through its Closer to Communities initiatives. This is mirrored in the strategic and operational direction of other partners and there are clear synergies with this re-commission.

## Local Authority Commissioning

3.7 The current service contract is for the provision of services across Cambridgeshire and Peterborough with the exception of the Tier 1 services which are already delivered at district level. CCC holds the contract on half of Peterborough City Council through a Partnering and Delegation agreement. Going forward PCC will be adopting a place-based model and consequently a shared service between CCC and PCC will not be commissioned. Services will be commissioned only for Cambridgeshire residents.

3.8 It is recommended that that the service(s) are funded for seven years with break options at years 3, 5 and 6 years. This contract length is based on anticipating that the place-based model will take some time to develop and embed at place levels. It will involve different partners, and time will be required to develop collaborative approaches.

## Service scope

3.9 As described above the current service delivers a wide range of services. Recent experience is that the current services have had to deal with inflationary cost pressures and very substantial increases in demand for weight management services. It will be necessary to prioritise services in the context of these pressures. It is also envisioned that the Tier 3 clinical weight management services would be commissioned at CCC level as it provides very specialist clinical services, and this would require the continuation of the central triage function.

3.10 Although the current service overall performs well, it is not configured to adopt a place-based model and the opportunities that this affords. Also given the extremely high levels of demand for weight management services it will be important to explore options for managing the demand.

3.11 Currently there are four areas of work that provide further information about areas for development and will inform the model that is commissioned. They will be completed by the end of January and will support the assessment of the current service and needs of the local population. The invitation to tender will be issued following final approval at the March 6th Adults and Health Committee.

**Needs Assessment.** A Behaviour Change Needs Assessment including an externally procured, independent qualitative report into the barriers, attitudes and access experiences of service users and service providers across Cambridgeshire and Peterborough is currently underway. The report will be available in January 2025.

**Service Evaluation.** An externally provided, independent evaluation review of the current *Healthy You* Integrated Healthy Lifestyle Service has been procured. The full report and recommendations will be available at the end of January 2025.

**Behavioural Insights Research.** Sheffield University has been commissioned to undertake behavioural insight research into the main health related behaviours. This work will not be completed until the spring of 2025 but currently there is sufficient insights from the research to inform the re-commission.

**Local Stakeholder Inputs:** Stakeholder holder views were sought at an event in December 2024. Representation from stakeholder organisations included CCC, the local NHS, district, and city local authorities and the VCSE. There are also ongoing discussions with specific partners to explore the opportunities and options.

## The Financial Model

3.12 The financial model for place-based services will require careful consideration of needs and existing services. It is recommended that a universal model is adopted with all service elements being delivered in each place. However, weighting would be used in areas where there are poorer health outcomes. For example, there are areas which have high rates of cardiovascular disease (CVD) and would benefit from an increased allocation for NHS Health Checks (identifies people with a high risk of CVD) along with higher targets for the key performance indicators.

3.13 The value of the commission over the full proposed seven-year contract is £12, 470,397. This currently includes over £1 million pounds of Integrated Care Board (ICB) funding for weight management services. This is currently being reviewed with the ICB in view of the increased demand and introduction of the new weight loss drugs.

## The Procurement Model

3.14 As this is a Public Health Service this service will be required to adopt the Provider Selection Regime (PSR) Procurement Regulations. These are the regulations used by the NHS and under which Public Health Services must be procured. There are a number of procurement options in the PSR regulations that include direct award and a competitive process. The direct award options were excluded as the recommission did not meet the following direct award criteria.

- Direct award process A: where there is an existing provider for the services and that provider is the only capable provider.
- Direct award process B: where people have a choice of providers, and the number of providers is not restricted by the Council.
- Direct award process C: where there is an existing provider for the services and that existing provider is satisfying the original contract and will likely satisfy the proposed

new contract and the services are not changing considerably. Adopting a place-based model is categorised as a new service model.

- Most suitable provider process: where the Council is able to identify the most suitable provider without running a competitive process.

3.15 Consequently, the CCC Procurement team have advised that that this would be a competitive tender recommission and subject to PSR regulations.

3.16 In terms of procuring a place-based model the Procurement Team has advised that the six lots could be tendered. One for each of the districts/city and a sixth lot will for the Tier 3 weight management service including triage.

3.17 A market engagement exercise will be undertaken to ascertain the appetite of the market for the different lots.

3.18 **Provisional Procurement timeline**

Table 1 details the provisional timeline for governance and procurement processes.

Table 1: Governance and Procurement Provisional Timeline

| **Action** | **Date** |
|---|---|
| Research and evaluation to determine new service model<br>Needs assessment<br>Evaluation of current service<br>Behavioural insights research<br>Local stakeholder input<br>Service specification developed | October 2024 – February 2025 |
| Initial Adults, Health, and Commissioning Committee approval for re-commissioning the service | January 29, 2025 |
| Final Adults, Health, and Commissioning Committee approval for re-commissioning the service | March 8th, 2025 |
| Invitation to tender | March 17th, 2025– 28 April 2025 |
| Tender evaluation | May 1, 2025, May 26th, 2025 |
| Contract (s) award | June 16th, 2025 |
| Contract commencement lead time | June 17th September 30th, 2025 |
| New Service (s) launch | October 1, 2025 |

# 4. Alternative Options Considered

4.1 The current Behaviour Change Services contracts ends on the 30 September 2025 and there are not any extension options that would enable it to be prolonged. Therefore, in line

with Procurement advice a competitive tender will be undertaken in line with the Provider Selection Regime for this type of service.

4.2 The current contract is held by CCC, but the Service is provided across Cambridgeshire and Peterborough. PCC delegated authority to CCC to enter into the contract on its behalf through a Partnering and Delegation Agreement. Both local authorities are pursuing the adoption of a place-based service delivery model which does not lend itself to one overarching contract across the two areas.

4.3 The adoption of a place-based model supports the Council's ambition for service delivery that is developed for local area or group. It also supports the system wide commitment to increased integration of services at place enabling a more efficient use of resources and addressing local needs through local engagement of communities and organisations.

# 5. Conclusion and reasons for recommendations

5.1 This paper recommends the re-commissioning of the Behaviour Change Services. This is necessary as the contract will end on 30 September 2025 and there are not any further extensions to the contract. The Service includes a number of prevention and treatment services with a focus upon behaviour change. Behaviour Change research and intervention methods are well evidenced for supporting people to adopt more healthy behaviours.

5.2 The recommendation for adopting a place-based model for delivery is that it is better able to meet local needs through using community assets, increase the integration of services with a more efficient use of resources and improve access to services by community members.

# 6. Significant Implications

## 6.1 Finance Implications

The financial implications are detailed in Section 3.5.

## 6.2 Legal Implications

This is a complex recommission and will require potentially multiple contracts. We will work with Pathfinder Legal Services to fully explore any risks and ensure that these are addressed before progressing.

The Council shall instruct Pathfinder Legal Services Ltd to assist in advising and drafting the contract and provide support when needed.

## 6.3 Risk Implications

The adoption of a place-based model represents a new approach to commissioning services and there are potential risks related to finance and performance. The contract and

Section 75 must have strong requirements for early identification of any risks and a clear system for escalation and addressing them in collaboration with commissioners where appropriate.

### 6.4 Equality and Diversity Implications

The commissioning of this service will put equality and diversity requirements at the centre of the services and their consideration will be fundamental in the delivery model.

A completed Equality, Impact Assessment (EqIA) form (Equality Impact Assessment Hub) is attached as an appendix to this report.

### 6.5 Climate Change and Environment Implications

The proposed commissioning approach will support the Council's net zero carbon emissions ambitions through the adoption of a place-based approach to service delivery. This will mean that service users will be able to access services locally and not have to travel. In addition, any commissioned services will be expected to provide a digital option for accessing services, if appropriate.

Any commissioned provider will need to demonstrate how their service will contribute to ensuring that staff and service users are safe when travelling. If service delivery involves staff travelling, environmentally sustainable options should be adopted.

The procurement will include a quality question relating to carbon emissions. Carbon emission monitoring will be embedded into the service specification and contract and will be part of performance monitoring.

## 7. Source Documents

7.1 Overview | Behaviour change: general approaches | Guidance | NICE

7.2 Overview | Physical activity and the environment | Guidance | NICE

# Equality Impact Assessment Recommissioning Behaviour Change Services

| Stage 1: Action being taken/details of person completing the form | |
|---|---|
| **Details of person undertaking assessment** | |
| Form reference | EQIA-00069 |
| Your name | Rose Earland |
| Your job title | Senior Public Health Manager – Nutrition & Lifestyles |
| Your directorate | Adults, Health, and Commissioning |
| Your service | Public Health |
| Your team | Behaviour Change |
| Your email | Rose.earland@cambridgeshire.gov.uk |
| Proposal being assessed | Behaviour Change Services recommissioning |
| Business plan proposal number (if applicable) | n/a |

| Stage 2: Proposal details | |
|---|---|
| What is the name and description of the policy being assessed? | Behaviour Change Services recommissioning<br><br>Behaviour Change Services are commissioned to support improvements in health outcomes and reduction in health inequalities in Cambridgeshire. The current service is an integrated service delivery model that includes primary prevention, secondary prevention along with treatment services. There are three service tiers with different providers delivering the various elements. All providers operate under the public-facing 'Healthy You' brand.<br><br>**Public Health Outcomes**<br>This service contributes to the delivery of key public health outcomes found in the Public Health Outcomes Framework:<br><br>• Healthy life expectancy<br>• Disability free life expectancy<br>• Mortality rate from causes considered preventable<br>• Child excess weight (Reception and Year 6)<br>• Percentage of children aged 5-16 sufficiently physically active<br>• Percentage of adults classified as overweight or obese<br>• Proportion of the population meeting the recommended '5-a-day' on a usual day<br>• Percentage of physically (in)active adults<br>• Smoking prevalence in adults<br>• Admission episodes for alcohol-related conditions<br>• Emergency hospital admissions due to falls in people aged 65 and over |

| | |
|---|---|
| | • Hip fractures in people aged 65 and over<br>• Cumulative percentage of the eligible population aged 40-74 offered/received an NHS health checks<br>• Gap in the employment rate between those with a long-term health condition and the overall employment rate<br>• Gap in the employment rate between those with a learning disability and the overall employment rate<br>• Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate<br>• Inequality in life expectancy at birth<br>• Inequality in life expectancy at 65<br><br>The current service contract ends on 30/09/24 and a new service is being recommissioned. The focus now is on developing place-based commissioning with service models that integrate services at a local level.<br><br>Information from the following sources has been used to assess who would be affected by the new service:<br><br>• Service evaluation - An externally provided, independent evaluation review of the current *Healthy You* Integrated Healthy Lifestyle Service<br><br>• Local stakeholder inputs - The views of stakeholders will be sought at an engagement event in December 2024. Representation will include the local NHS, district and city local authorities and the CVS. There are also ongoing discussions with specific partners to explore the opportunities and options.<br><br>• Behavioural insights research - Sheffield University has been commissioned to undertake behavioural insight research into the main health related behaviours. This work will not be completed until the spring of 2025 but currently there is sufficient insights from the research to inform the re-commission |
| What type of policy is this? | • New ☐<br>• Major change ☐<br>• Minor change ☒ |
| Is this EqIA supporting a committee paper/business case? | Yes ☒<br>No ☐ |

**Stage 3: Identifying impacts on affected groups (screening question)**
Is it foreseeable that people from any protected characteristic group(s) or people experiencing socio-economic inequalities will be impacted by the implementation of this proposal?

Yes ☒

No ☐

**If you select 'NO' - you will complete a screening form**

You will be asked you to provide an evidence-based analysis of your assessment that your plans will have no impacts for people with protected characteristics or our priority group of socio-economic inequalities. You are asked to explain each group in turn. Where the justification is the same, you can avoid duplication by saying for later groups that the explanation under an earlier group applies. For example, you might explain that your EqIA is for a revised procedure which combines two previous procedures which both had robust and effective EqIAs in place, without making any significant changes to them. Therefore, there will be no impact on people from these changes.

**If you selected 'YES'** for the above screening question, you would go on to complete the full EqIA as below (see stage 4).

**Stage 4: Impact and evidence**
From your assessment, using your data/evidence gathered, what is the potential direct or indirect impact of the proposed change on these groups that are protected characteristics in the Equality Act 2010? (Please tick relevant box for each characteristic, and assess whether the policy may produce positive, negative, or neutral impacts.)

**Age**

Neutral impact ☒

Positive impact ☐

Negative impact ☐

**Disability**

Neutral impact ☐

Positive impact ☒

Negative impact ☐

**Gender reassignment**

Neutral impact ☒

Positive impact ☐

Negative impact ☐

**Marriage/civil partnership**

Neutral impact ☒

Positive impact ☐

Negative impact ☐

**Pregnancy and maternity**

Neutral impact ☒

Positive impact ☒

Negative impact ☐

**Race**

Neutral impact ☒

Positive impact ☐

Negative impact ☐

**Religion/belief**

Neutral impact ☒

Positive impact ☐

Negative impact ☐

**Sex**

Neutral impact ☒

Positive impact ☐

Negative impact ☐

**Sexual orientation**

Neutral impact ☒

Positive impact ☐

Negative impact ☐

**Care experienced**

Neutral impact ☒

Positive impact ☐

Negative impact ☐

**Other identified groups -** Groups with different socio-economic groups, area inequality(rurality), income, resident status (migrants)/ language barriers. Begin to think intersectional here.

Neutral impact ☐

Positive impact ☒

Negative impact ☐

**You identified positive/negative impacts – please explain each one and supporting evidence:** (This can include relevant national/local data, research, monitoring information, service user feedback, complaints, audits, consultations, EqIAs from other projects or other local authorities, review of customer complaints and feedback and staff surveys; or use of census data):

Disability - A place-based approach will enable better access to local services for individuals with physical disabilities. The learning disabilities needs assessment produced actions to be incorporated into the new service specification. For example, ensuring staff members have relevant training to make reasonable adjustments during sessions for learning disabilities.

Other identified groups:

Area inequality (rurality) - A place-based approach will ensure services are developed locally to better address the needs of the local population, with better use of local community assets and improve access to local residents.

Deprivation/socioeconomic group - The service will target delivery in areas of deprivation and a place-based approach with allow better utilisation of local connections/facilities/assets.

Language barriers - A place-based approach will allow better utilisation of local connections/facilities/assets to make services accessible in languages.

**Stage 5: Mitigating impact actions**

Queston: Now you have identified the foreseeable impacts of the policy, please repeat any negative or positive impacts for each group and state a) any mitigating actions for each negative impact and/or b) any actions you can take to enhance positive impacts them.

| Identified impact on protected group | Action to mitigate or enhance | Officer responsible for action | Completion date |
|---|---|---|---|
| Disability | Enhance – A place-based approach will enable better access to local services for individuals with physical disabilities.<br><br>The learning disabilities needs assessment produced actions to be incorporated into the new service specification. For example, ensuring staff members have relevant training to make reasonable adjustments during sessions for learning disabilities. | Paul Stokes | 31/03/25 |
| Area inequality (rurality) | Enhance – A place-based approach will ensure services are developed locally to better address the needs of the local population, with better use of local community assets and improve access to local residents. | Paul Stokes | 31/03/25 |
| Deprivation/socioeconomic group | Enhance – We will target delivery in areas of deprivation and a place-based approach with allow better utilisation of local connections/facilities/assets | Paul Stokes | 31/03/25 |
| Language barriers | Enhance – A place-based approach will allow better utilisation of local connections/facilities/assets to make services accessible in languages. | Paul Stokes | 31/03/25 |

Did you engage with an EqIA Super User when developing your EqIA?

Yes ☐

No ☒

**Stage 6: Sign off and approval**

To ensure a robust, respectful, and transparent approval process:

- Please do not enter your own details here, even if you are a Head of Service (or equivalent). This is to ensure that someone else reviews your work.
- Please do not enter the details of someone you line manage and/or with less authority than you.

**Please find and select your Head of Service (or equivalent).**

# Adults and Health Policy and Service Committee Agenda Plan

Agenda Item No. 7

January 2025

Notes

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.

The following are standing agenda items which are considered at every Committee meeting:

- Minutes of previous meeting and Action Log
- Agenda Plan, Training Plan and Appointments to Outside Bodies and Internal Advisory Groups and Panels

| Committee date | Agenda item | Lead officer | Reference if key decision | Deadline for reports | Agenda despatch date |
|---|---|---|---|---|---|
| 23/01/25 | Re-Commissioning Drug and Alcohol Treatment Services for Adults and Children and Young People | V Thomas | KD2025/005 | 10/01/25 | 15/01/25 |
| | Scrutiny of Draft Business Plan and Budget | P Warren-Higgs | Not applicable | | |
| | Re-commissioning Behaviour Change Services | V Thomas | KD2025/006 | | |
| | Health Scrutiny items | | | | |
| | Tackling Health Inequalities | R Greenhill | Not applicable | | |
| | Access to Cambridgeshire and Peterborough NHS Foundation Trust Mental Health Services | R Greenhill | Not applicable | | |

| Committee date | Agenda item | Lead officer | Reference if key decision | Deadline for reports | Agenda despatch date |
|---|---|---|---|---|---|
| | Health scrutiny work plan | R Greenhill | Not applicable | | |
| | Health scrutiny recommendations tracker | R Greenhill | Not applicable | | |
| 06/03/25 | Finance Monitoring Report | J Hartley | Not applicable | 21/02/25 | 26/02/25 |
| | Adults, Health and Commissioning Corporate Performance Monitoring Report – Quarter 3 | S Bye | Not applicable | | |
| | Customer Care Annual Report | L Cook | Not applicable | | |
| | Risk Register | S Bye | Not applicable | | |
| | Accountability | TBC | TBC | | |
| | Adult Social Care Strategy Development | Richard Hills and Sarah Bye | Not applicable | | |
| | Review of In-House Services – Recommended Approach | Richard Hills and Shauna Torrance | KD2025/033 | | |
| | Re-Tender of the Community Navigators Service | Shauna Torrance and Antonina Belcheva | KD2025/034 | | |
| | Re-tender of the Handyperson Service | Shauna Torrance and Diana Mackay | KD2025/035 | | |
| | Mental Health and Autism Accommodation Framework Contract Extension | Shauna Torrance and Guy Fairbairn | KD2025/036 | | |

| Committee date | Agenda item | Lead officer | Reference if key decision | Deadline for reports | Agenda despatch date |
|---|---|---|---|---|---|
| | Health Scrutiny items | | | | |
| | Dental Provision in Cambridgeshire | R Greenhill | Not applicable | | |
| | Annual Health Checks for People with Learning Disabilities | R Greenhill | Not applicable | | |
| | Approval Process for Responses to NHS Quality Accounts 2024/25 | R Greenhill | Not applicable | | |
| | Draft Health Scrutiny Annual Report 2024/25 | R Greenhill | Not applicable | | |
| | Health scrutiny work plan | R Greenhill | Not applicable | | |
| | Health scrutiny recommendations tracker | R Greenhill | Not applicable | | |
| 19/06/25 | Notification of the Chair and Vice Chair of the Adults and Health Committee 2025/26 | R Greenhill | Not applicable | 06/06/25 | 11/06/25 |
| | Appointment of Co-opted Members for Health Scrutiny Business Only | R Greenhill | Not applicable | | |
| | Finance Monitoring Report | J Hartley | Not applicable | | |
| | Finance Monitoring Report: Outturn 2024/25 | J Hartley | Not applicable | | |
| | Adults, Health and Commissioning - Performance Monitoring Report – Quarter 4 | S Bye | Not applicable | | |
| | Risk Register | S Bye | Not applicable | | |
| | | | | | |

| Committee date | Agenda item | Lead officer | Reference if key decision | Deadline for reports | Agenda despatch date |
|---|---|---|---|---|---|
| | Health Scrutiny items | | | | |
| | Health scrutiny work plan | R Greenhill | Not applicable | | |
| | Health scrutiny recommendations tracker | R Greenhill | Not applicable | | |
| *[18/09/25] Reserve date* | | | | *[05/09/25]* | *[10/09/25]* |
| | | | | | |
| 09/10/25 | Finance Monitoring Report | J Hartley | Not applicable | 26/09/25 | 01/10/25 |
| | | | | | |
| | Health Scrutiny items | | | | |
| | Health scrutiny work plan | R Greenhill | Not applicable | | |
| | Health scrutiny recommendations tracker | R Greenhill | Not applicable | | |
| 09/12/25 (Tuesday) | Finance Monitoring Report | J Hartley | Not applicable | 26/11/25 | 01/12/25 |
| | Risk Register | S Bye | Not applicable | | |
| | | | | | |
| | Health Scrutiny items | | | | |
| | Health scrutiny work plan | R Greenhill | Not applicable | | |
| | Health scrutiny recommendations tracker | R Greenhill | Not applicable | | |
| 22/01/26 | Finance Monitoring Report | J Hartley | Not applicable | 09/01/26 | 14/01/26 |

| Committee date | Agenda item | Lead officer | Reference if key decision | Deadline for reports | Agenda despatch date |
|---|---|---|---|---|---|
| | | | | | |
| | Health Scrutiny items | | | | |
| | Health scrutiny work plan | R Greenhill | Not applicable | | |
| | Health scrutiny recommendations tracker | R Greenhill | Not applicable | | |
| 05/03/26 | Finance Monitoring Report | J Hartley | Not applicable | 20/02/26 | 25/02/26 |
| | | | | | |
| | Health Scrutiny items | | | | |
| | Health scrutiny work plan | R Greenhill | Not applicable | | |
| | Health scrutiny recommendations tracker | R Greenhill | Not applicable | | |
| 18/06/26 | Notification of the Chair and Vice Chair of the Adults and Health Committee 2026/27 | R Greenhill | Not applicable | 05/06/26 | 10/06/26 |
| | Finance Monitoring Report | J Hartley | Not applicable | | |
| | Finance Monitoring Report: Outturn 2025/26 | J Hartley | Not applicable | | |
| | Risk Register | S Bye | Not applicable | | |
| | | | | | |
| | Health Scrutiny items | | | | |
| | Health scrutiny work plan | R Greenhill | Not applicable | | |
| | Health scrutiny recommendations tracker | R Greenhill | Not applicable | | |

Please contact Democratic Services democraticservices365@cambridgeshire.gov.uk if you require this information in a more accessible format.

| Topic | Session lead | Confirmed date |
|---|---|---|
| CQC Assurance | Rhiannon Sanders and Fran Marshall | Monday 21st October 13:00 – 14:00 |
| ASC Strategy, ASPIRE and Practice Principles | Sarah Bye and Fran Marshall | Wednesday 19th February 13:00 – 14:00 |

Following this there will be a pause for the pre and post-election periods. We will reach out to Members after this time to establish what they would like development sessions on.

Future Development session

| | |
|---|---|
| Accessing Adults Social Care<br>Information on our front door – number of calls, response times, online tools and forms etc.<br>How the referral process works.<br>Financial Assessments | Kerry Scott Logan<br>Richard Gibson |
| Public Health<br>Plans, ambitions and strategies once the new DPS is in post. | New DPH |
| Safeguarding – amended version of the internal mandatory safeguarding training including process and what happens when. If there is an appetite Kirstin Clarke and Julie Rivett can offer a more detailed overview of the statutory duty under Section 42. | |
| Mental Health<br>Overview of how people access mental health support in the community.<br>If there is an appetite, we can offer an additional session on an overview of the Mental Health Service via CPFT. | |

| | |
|---|---|
| Market Shaping – including Accommodation and demand profiles and pipeline of capacity | Shauna Torrence/ Gurdev Singh |
| Care Together – Linked to Market Shaping and Strategy<br>An update/ review on the progress of Care Together (towards the end of 2025) | |
| Compliments and Complaints – Process and Statutory Duty | |
| LDP Review update | |

Agenda Item No: 8(a)

# Health Inequalities: Report from the Integrated Care Board

| | |
|---|---|
| To: | Adults and Health Committee |
| Meeting Date: | 23 January 2025 |
| From: | Louis Kamfer, Deputy Chief Executive<br>NHS Cambridgeshire and Peterborough ICB;<br>Jonathan Bartram, Programme Director<br>NHS Cambridgeshire and Peterborough ICB |
| Electoral division(s): | All |

Officer contact:
Name: Jonathan Bartram
Post: Programme Director
Email: Jonathan.bartram1@nhs.net

# 1. Background

1.1. Health inequalities in England refer to the systematic, avoidable, and unfair differences in health that exist between different groups of people or populations. There are many kinds of health inequality, and many ways in which the term is used, but generally, health inequalities arise from the unequal distribution of social, environmental, and economic conditions within societies which can significantly impact an individual's overall health and wellbeing.

1.2. Inequalities in health reflect the inequalities in society at large and are closely related to personal and socio-economic factors, such as income, education, housing, gender, age, ethnicity, disability, geography and social inclusion. Image 1 has been adapted from the Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute's County Health Rankins Model which shows the various influences on population health and health outcomes.

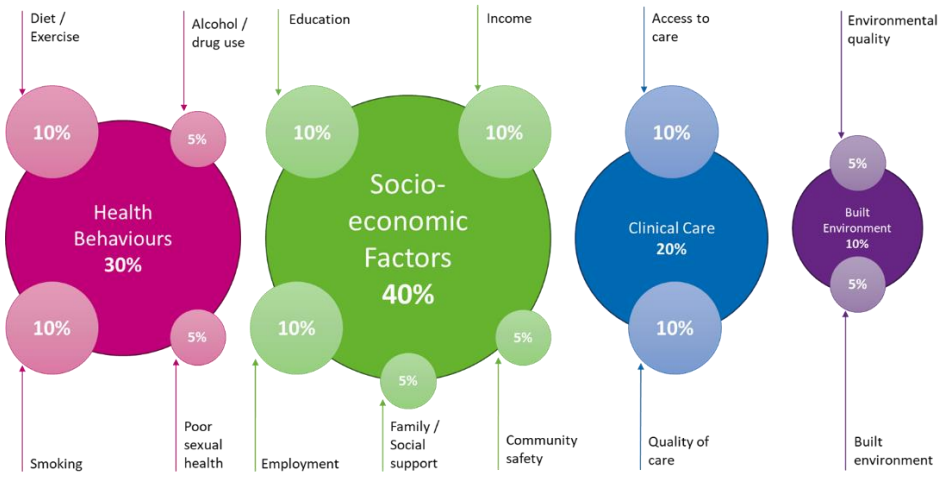



Image 1: Influences on health outcomes

1.3. Life expectancy is a key measure of a population's health status. Inequality in life expectancy is therefore one of the foremost measures of health inequality. In England, there is a systematic relationship between deprivation and life expectancy, also known as the inequality gradient.

1.4. Since the early 20th Century, life expectancy in England has risen significantly due to advancements in healthcare, sanitation, and living conditions. In 1900, life expectancy was approximately 45 years for men and 49 for women. By the 21st Century, these figures had increased to over 79 years for men and 83 years for women.

1.5. However, since 2011 improvements in mortality rates have slowed, causing life expectancy gains to stall. In the years between 2011 and 2019, life expectancy at birth in England has been increasing at a slower rate than in previous decades. In recent years however, improvements in life expectancy have stalled and have started to decline, most notably for women living in the most deprived 10 per cent of areas of the country.

1.6. In 2017–19, women living in the least-deprived 10 per cent of areas could, at birth, expect to live to 86.4 years old, whereas women in the most-deprived 10 per cent of areas could expect to live to 78.7 years: a gap in life expectancy of almost 8 years. For men, this gap was even

wider, with a difference of 9.4 years between those in the least-deprived 10 per cent of areas (83.5 years) and the most-deprived 10 per cent of areas (74.1 years).

1.7. About one-third of the inequalities in life expectancy, between the most and least deprived decile of areas, are caused by higher mortality rates from heart and respiratory disease, and lung cancer in the most deprived areas. These conditions are exacerbated by risk factors such as smoking and obesity, rates of which are higher among more deprived groups, but are, more importantly, largely preventable.

1.8. Inequalities in life expectancy have been exacerbated by the Covid-19 pandemic. The gap in life expectancy between the local authorities in England with the highest and lowest life expectancy was 7.4 years in 2017–19 and it grew to 8.7 years in 2020–22.

1.9. Another indicator of health inequality is healthy life expectancy at birth. This is defined as being an estimate of the average number of years that would be lived in a state of 'good general health' by babies born in a given time period, given mortality levels at each age and the level of good health at each age for that time period. Healthy life expectancy in England in 2020-22 was lower than in 2011-13, falling by 0.8 years in males and 1.2 years in females during that time. So not only has life expectancy stalled, but males and females spend more years in poor health.

1.10. For the three aggregated years 2020–22, although male life expectancy in England was 78.8 years, average healthy male life expectancy was only 62.4 years (i.e., 16.4 of those years (21 per cent) would have been spent in poor health). Female life expectancy was 82.8 years, of which 20.1 years (24 per cent) would have been spent in poor health. Therefore, although females live an average of four years longer than males, they spend a higher proportion and more years of their lives in poor health.

1.11. Despite it seemingly being a healthy place to live, we know that significant inequalities in life expectancy and healthy life expectancy exist across Cambridgeshire and Peterborough. Despite female and male life expectancy in Cambridgeshire being persistently higher than in Peterborough, inequalities in Cambridgeshire exist at both district and ward levels.

1.12. As image 2 shows, there are considerable variations in both male and female life expectancies at birth across Cambridgeshire. Life expectancy at birth is higher than the England average in all districts except for in Fenland, which is significantly lower than the England average for both male and females. Life expectancy at birth for both males and females is highest in South Cambridgeshire.

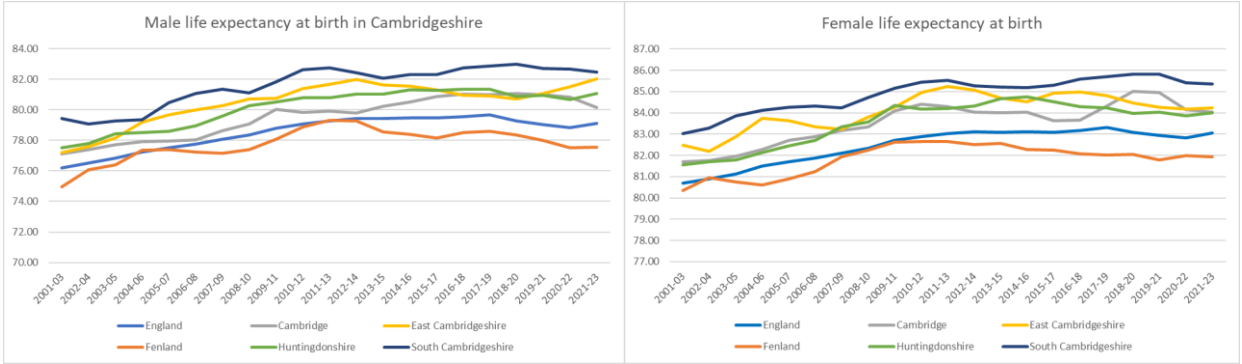



Image 2: Male and female life expectancy at birth across Cambridgeshire Districts

1.13. In terms of healthy life expectancy, for both males and females, Peterborough's healthy life expectancy at birth is lower than Cambridgeshire and lower than the England average (significantly lower than England for females). However, according to data from the Office for Health Improvement and Disparities' Public health profiles 2018-20, for men across Cambridgeshire, the percentage of years spent not in good health is 20.8 per cent which is slightly worse than the England average of 20.6 per cent. For females in Cambridgeshire, the percentage of years spent not in good health is 19.8 per cent which is better than the England average of 23.2 per cent. Healthy life expectancy data not available at lower tier local authority level.

1.14. Healthy life expectancy has fluctuated over the years for which data is available, but overall has not improved over the last decade for either males or females. If district-level data was available, we would expect to see considerable variations within Cambridgeshire in the same way that we have seen for standard life expectancy.

1.15. These trends follow the broader conclusions that both life expectancy and healthy life expectancy at birth are lowest for those people living in more deprived areas. Which means that those living in the more deprived areas not only tend to die earlier, but also spend a greater proportion of their lives in poor health.

1.16. Between 50-60 per cent of the gap in life expectancy between the most and least deprived quintiles of Cambridgeshire is due to circulatory conditions, cancer and respiratory conditions (OHID Segment Tool: Segment Tool).

1.17. The Marmot Review into health inequalities in England entitled 'Fair Society, Healthy Lives,' published 11 February 2010, provides an evidence-based strategy to address the social determinants of health, i.e., the conditions in which people are born, grow, live, work and age, and which all contribute to the health inequalities which have been described.

1.18. According to a report by the Institute of Health Equity entitled Health Inequalities, Lives Cut Short (January 2024), between 2011 and 2019, 890,000 people died earlier than they would have done if they had lived in areas with the same age and sex specific death rates as the least deprived area quintile.

1.19. The report adds further weight to two previous reports published by the Institute of Health Equity in 2020 regarding health inequalities (Health Equity in England: The Marmot Review 10 years On and the COVID-19 Marmot Review) and makes a strong argument that most of our health is determined by our social circumstances, with the NHS accounting for approximately 20 per cent of population health, as previously highlighted in Image 1.

1.20. Tackling health inequalities and improving the health for those groups who typically experience the worst outcomes therefore requires significant collaboration. When local partners (the NHS, councils, voluntary sector and others) work together, they can create better services based on local need and is a fundamental reason for the creation of ICSs. This is vital in terms of addressing the multiple factors that contribute to health inequalities and the disparities we see in terms of life expectancy and healthy life expectancy across Cambridgeshire and the wider ICS.

1.21. The remainder of this paper provides an overview of NHS Cambridge and Peterborough ICB's role in tackling health inequalities, and the alignment to NHS England's five key priorities and Core20PLUS5 approach.

## 2. Main Issues

2.1. Cambridgeshire and Peterborough (C&P) ICB's overarching ambition is to increase the number of years people live in good health and reduce premature mortality. To achieve this, there has been a renewed focus on primary and secondary prevention, partnership working to address the root causes of health inequalities and promoting population health management approaches.

2.2. To help measure the whole system's success in keeping the population well and reducing illness, the Cambridgeshire and Peterborough ICS Outcomes Framework has been developed. Hosted on the Cambridgeshire and Peterborough Insight website, the framework has been developed based on the overarching aims of the Health & Wellbeing Integrated Care Strategy, supports the evolution and delivery of the ICB's Joint Forward Plan, and helps guide the development of place-based partnership delivery plans. One of the ambitions of the Outcomes Framework is to monitor several healthcare inequality metrics. These metrics will evolve to help identify disparities in health outcomes through the lenses of deprivation, ethnicity and other protected characteristics.

2.3. NHS Cambridgeshire and Peterborough ICB is committed to driving tackling health inequalities and as part of our Joint Forward Plan set out an ambitious approach to tackling healthcare inequalities in terms of access, experience and outcomes by focusing on the key strategic priorities set by NHS England and embedding the Core20PLUS5 approach. The plan set out the following:

- Ensure reducing health inequalities is a priority for everyone and embedding a 'Core20PLUS' approach.
- Be informed by our data and wider insights and be evidence-led in our approaches.
- Promote healthy lifestyles and behaviours and increase access to early intervention services.
- Improve access to healthcare services for vulnerable and marginalised populations.
- Improve the quality of care and patient experience across the ICS.
- Work with local people and communities to better understand the challenges they experience and coproduce solutions that best meet their needs.

2.4. To deliver these objectives, the ICB refreshed its health inequalities governance through the establishment of the Population Health Improvement (PHI) Board, which brings together the ICB's prevention, population health management and health inequalities programmes. The PHI Board is currently co-chaired by the Deputy Chief Executive of the ICB and the Acting Director of Public Health for Cambridgeshire.

2.5. To ensure the ICB discharges its statutory duty to have regard to the need to reduce inequalities and to ensure effective co-ordination of the healthcare inequalities agenda, the ICB has also established a system-wide Healthcare Inequalities Strategic Oversight Group (HISOG), with further sub-groups including a NHS Provider Health Inequalities group and a PCN Health Inequalities leads network. These sub-groups have been established to ensure

strategic alignment, serve as collaborative forums, help identify opportunities for partnership working, and to share best practice across the system,

2.6. The HISOG, managed by a central team within the ICB's Strategic Commissioning Unit and co-chaired by both ICB and Public Health representatives, is responsible for coordinating and driving action across NHS providers and wider ICS partners in relation to the five strategic priorities and delivery against the Core20PLUS5 approach as described earlier.

2.7. In January 2024, the PHI Board approved the recommendations to align the Cambridgeshire and Peterborough healthcare inequalities programme to NHSE's strategic priorities and embedding a Core20PLUS5 approach. These are summarised below:

2.8. <u>NHSE England's Strategic Priorities:</u>

2.8.1. Restore NHS services inclusively: pre-existing disparities in access, experience and outcomes have been exacerbated by the Covid pandemic. Systems are asked to utilise and monitor data efficiently, delineated by ethnicity, deprivation and other protected characteristics.

2.8.2. Mitigate against digital exclusion: systems are asked to offer face-to-face care to those unable to use remote services and to conduct analysis of who is accessing services and by what means, broken down by relevant protected characteristics and health inclusion groups.

2.8.3. Ensure datasets are complete and timely: systems are asked to improve the collection and recording of ethnicity data across primary care, outpatients, A&E, mental health, community services and specialised commissioning.

2.8.4. Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes: systems are asked to focus on the ongoing management of long-term conditions; improving the percentage of annual health checks for people with a learning disability and those with serious mental health; and implementation of continuity of carer for women from Black, Asian and other minority ethnic groups.

2.8.5. Strengthen leadership and accountability: systems are asked to identify named leads for tackling health inequalities and increase access to training and support.

2.9. <u>Core20PLUS5 approach:</u>

The approach offers a multi-year focused delivery approach to enable prioritisation of energies and resources in the delivery of NHS commitments to tackle health inequalities.

The approach defines a target population – the 'Core20PLUS' – and identifies '5' clinical areas requiring accelerated improvement:

'Core20': The most deprived 20 per cent of the national population as identified by the national Index of Multiple Deprivation (IMD).

'PLUS': ICS-determined population groups experiencing poorer than average health access, experience and outcomes, but not captured in the 'Core20' alone. This should be based on population health data at a local ICS-level

'5': The final part sets out five clinical areas of focus for adults:

1. Maternity – ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups.
2. Severe mental illness (SMI) – ensuring annual physical health checks for people with SMI to at least nationally set targets.
3. Chronic respiratory disease – a focus on Chronic Obstructive Pulmonary Disease driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.
4. Hypertension case-finding and optimal management and lipid optimal management – to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.
5. Cancer Screening – to ensure 75 per cent of cases are diagnosed at stage 1 or 2 by 2028.

2.10. Smoking cessation has also been included as a cross-cutting priority for the Core20PLUS5 approach to tackling healthcare inequalities given that it remains the single greatest cause of preventable death. Generally, in Cambridgeshire, rates of conditions and deaths attributed to smoking are generally below the England rate, whilst Peterborough's rates are above. That said, smoking accounts for approximately half of the difference in life expectancy between the most and lead affluent communities in England with the gap in smoking prevalence between the most and least deprived areas increasing each year. The evidence clearly shows that stopping smoking is most effective in preventing poor health outcomes.

2.11. Five separate clinical priority areas have also been identified for children and young people (CYP), which are: asthma, diabetes, epilepsy, oral health, mental health.

2.12. For Cambridgeshire and Peterborough, 62 Lower Super Output Areas (LSOAs) are in the 20 per cent most deprived nationally; 46 are in Peterborough, while 11 are in Fenland. 13 per cent of the Cambridgeshire and Peterborough registered population live within the 20 per cent most deprived areas with the geographical distribution varying considerably: 95 per cent (107,000) living in the north of the ICS footprint, compared with 5 per cent (5,000) in the south.

2.13. Examples of 'PLUS' groups within Cambridgeshire and Peterborough include, and this is not an exhaustive list:

- Gypsy, Roma, and Travellers (GRT) is an umbrella term to describe people from a range of ethnicities who face similar challenges in terms of access to healthcare and the outcomes they receive. GRT is one of the largest ethnic minority groups with approximately 7000+ living within the ICS footprint. GRT populations have a life expectancy 10-12 years less than that of the non-traveller population.
- There are approximately 1,500-1,700 people who are homeless within Cambridgeshire and Peterborough with the average age of death for those experiencing homelessness being 45 for men and 43 for women. Population growth, combined with increasing housing costs and lack of affordable housing is one of the possible reasons for increasing homelessness issues. People who rough sleep, because of their lack of secure accommodation and often co-existing health issues or other vulnerabilities, represent the most disadvantaged groups in society. The average life expectancy for those experiencing homelessness is 45 for men and 43 for women.

- Cambridgeshire and Peterborough has a large transient migrant population, with influxes of migrant workers predominantly from Eastern Europe, most markedly in the Fenland and Peterborough areas. Language barriers, cultural differences and health literacy are identified as being key drivers of inequalities amongst such migrant and broader ethnic minority populations.

2.14. The following sections highlight some of the key work programmes and initiatives to address healthcare inequalities. For ease, a summary table can be found at Appendix A to show alignment to NHSE's strategic priorities and Core20PLUS5 approach.

2.15. Prevention

As outlined previously, cardiovascular disease (CVD) is one of the major contributors to the life expectancy difference between the most and least deprived areas within Cambridgeshire, contributing to almost 25 per cent of the gap in women (Office for Health Improvement and Disparities: Segment Tool). The 'Your Healthier Future' (YHF) programme, launched by the ICB in conjunction with the Cambridgeshire and Peterborough public health teams, launched a 2-year programme which targets key clinical and behavioural risks associated with CVD. The programme risk stratifies people with a high or increasing risk of a major adverse cardiovascular events and enables GP practices to better support patients and reduce premature mortality.

2.16. The programme has five elements which focus on:

- Lipid detection and optimisation: identify and treat at-risk patient groups with high cholesterol – launched July 2024
- NHS health checks: improve uptake of NHS health checks to better identify CVD risk factors and maximise secondary prevention measures – anticipated to launch January 2025
- Hypertension Detect: identify patients with or at risk of high blood pressure – launched November 2024
- Hypertension Perfect: optimise treatment for patients with known high blood pressure – launched November 2024
- BMI and personalised care: improve quality of information practices hold to identify patients at risk and who will benefit from future support – due to launch February 2025.

2.17. The Lipid Detection and Optimisation pathway has resulted in those practices which utilise the enhanced support from Eclipse, a population health management tool, initiating more than twice as many patients onto lipid lowering therapies in the period since the start of the programme. The data for the hypertension pathways are currently in development.

2.18. Initial data shows the programme is having a positive impact upon Core20PLUS groups. In terms of deprivation, responses to the contacts made by Eclipse are broadly equitable across all deprivation deciles. However, once contact is made, those from the most deprived two deciles (Core20) are more likely to take up a lipid lowering therapy than those from other deciles. In terms of ethnic minority patient groups, mental health and learning disability groups, early results show the YHF programme is achieving proportionately higher uptake rates for lipid lowering therapies, directly contributing to delivering better outcomes for Core20PLUS populations through preventative measures.

2.19. Further work and analysis are being undertaken following the development of a new minimum data set for the established pathways which will report in greater detail the impact of the programmes respect of both outcomes and inequalities.

2.20. In 2025/26, we will extend the YHF approach to identify and support further patients with reversible risk. This is likely to focus on optimising patients with several long-term conditions (multi-morbidity) because the evidence suggests this will have the greatest impact on preventing serious illness and helping patients avoid admission to hospital.

2.21. In addition, and in line with the strategic priorities to tackle health inequalities, the primary care based annual physical health check team continue to deliver the enhanced 12-point Serious Mental Illness (SMI) annual physical health checks across Cambridgeshire and Peterborough. Although there are some areas where the 6-point SMI annual physical health check is available, work is ongoing to ensure equity across the system.

2.22. The 12-point model continues to be considered a best practice approach and is recognised nationally as offering best practice for patients. At the end of 23-24, Cambridgeshire and Peterborough had an 80 per cent uptake rate in SMI annual physical health checks, which is ahead of the target (60 per cent) and performance last year. This equates to 5541 AHC completed in 23-24.

2.23. Across Cambridgeshire and Peterborough, the NHS Treating Tobacco Dependency programme, an NHS Long Term Plan prevention programme and a cross-cutting priority of the Core20PLUS5 approach, has resulted in new smoke-free pathways being established in all acute and mental health inpatient hospitals and maternity units. Since commencement of the pathways in 2023, provider data up to end of Q2 2024/25 reported a total of 2,334 smokers having been identified and referred to in-house specialist stop smoking services; 950 people having initially setting a quit date; and 532 (56 per cent) having quit smoking as measured by the standard 28-day quit target.

2.24. In July 2024, the ICB approved the request to utilise a proportion of the health inequalities funding allocated to the ICB to expand the treating tobacco dependency programme given the overwhelming evidence which demonstrates the positive impact it has on tackling health inequalities, preventing ill health, and the wider socio-economic benefits. The additional funding will support further development of the existing pathways whilst also seeking new opportunities to expand smoking cessation pathways in outpatient and emergency departments, whilst strengthening the discharge pathways into community stop smoking services.

2.25. <u>Elective Waits</u>

In April this year, the ICB conducted an analysis of the elective waiting times which was presented at both the Planned Care Board and HISOG. The analysis examined waiting times for patients based on ethnicity, age and deprivation levels. It showed that waiting times are disproportionately longer for different ethnic groups, particularly for those waiting over 52 and 62 weeks. In addition, as levels of deprivation increase, so do average waiting times. It must be noted that waiting lists are managed on clinical risk. Other systems have explored management of waiting lists through other methods which C&P ICS continue to monitor, but to date these have not been very successful. Since the report was completed in April 2024, the over 52 week waiting list has reduced from 10,188 people waiting over 52 weeks to 5,442

(Dec 2024). Since receiving the report further work has been undertaken on the data quality at all providers and the ICB plans to re-run the data to assess impact and determine further actions to be undertaken.

2.26. Patients under the age of 18 experience longer waiting times compared to older groups. Furthermore, elective admission rates for children from the most deprived quintile were found to be statistically comparable to those from the least deprived quintile for both genders in the 2022/23 period. Whilst average waiting times for males and females are similar, a high percentage of males face waits exceeding 52 and 62 weeks. CYP waiting times are a national priority. For Cambridgeshire and Peterborough ICS, Ear, Nose and Throat (ENT) remains the highest risk with Ophthalmology in the North also challenged. Both North West Anglia NHS Foundation Trust (NWAFT) and Cambridge University Hospitals NHS Foundation Trust (CUHFT) have been working collectively on solutions which has included CUHFT Ophthalmologist providing additional clinics at NWAFT. Overall, waiting times for CYP have reduced since April 2024 by 2-3 weeks, but this remains a key focus for the system.

2.27. The elective wait analysis is also being replicated at the provider level to help identify disparities in speciality pathways. In addition, further analysis of Did Not Attend (DNA) rates in outpatients is planned in 2025/26 to identify disparities and help identify opportunities to address these.

2.28. <u>Cancer Screening</u>

Increasing the number of cancers identified at stage 1 or 2 to 75% through earlier diagnosis is a key priority for C&P ICS. Two key programmes are supporting this work 1) Targeted Lung Health Checks 2) Cervical Screening – Neighbourhood programmes.

2.29. Lung cancer remains the biggest cancer killer across the UK, with more than one in five cancer deaths (21%) attributed to lung cancer. People diagnosed at the earliest stage are nearly 20 times more likely to survive for five years than those whose cancer is caught late; however evidence suggest that less than a third of lung cancers are diagnosed at either stage one or two when treatment with a curative intent is more likely. Targeted Lung Health Checks (TLHC) is a national screening programme delivered by local systems to identify lung cancer at stage 1 or 2. The programme is targeted at populations where there are high levels of smoking, deprivation and poor lung cancer outcomes. The roll out of TLHC is due to start in March 2025 across C&P ICS starting in the North with full roll out by 2028/29 to all in scope across C& P ICS.

2.30. C&P ICS cervical screening uptake is below the national target of 80% and below the national average. For the ages 25-49 in Q4 23/24 C&P uptake was 65.38% with the national coverage of 67.59%. For the ages of 50-64 C&P uptake was 74.88% with the national position at 75.18%. Working with North and South Place, additional Cancer Alliance funding has been identified to deliver targeted work through the integrated neighbourhood teams. Different approaches are being taken based on the preference of place. North Place is focusing on practices with low uptake for both age cohorts and supporting practices to contact and engage with individuals. South Place is utilising their community events to promote the benefits of screening while also aligning to other funding streams such as the establishment of Women's Health Hubs.

2.31. Ethnicity Coding

Evaluation of GP ethnicity coding completeness carried out in June 2024 showed that ethnicity coding completeness has improved across GP practices by 8 percentage points from 88 per cent completeness in July 2022 to 96 per cent completeness in June 2024. In addition, the percentage of patients coded as Black, Asian or any other ethnic minority group has increased from 13 per cent to 16 per cent. Similar work is now taking place within the hospital providers to improve disparities in ethnicity completeness rates and inconsistencies in which the data has been coded. For example, at Cambridgeshire and Peterborough NHS Foundation Trust (CPFT), the Performance and Analytics oversaw a project to improve ethnicity recording which resulted in a reduction of 'not stated' ethnicity coding from 18 per cent to less than 5 per cent.

2.32. High intensity use programme

The Cambridgeshire and Peterborough high intensity use (HIU) programme has been designed to effectively identify and manage those who utilise healthcare services more frequently to reduce demand and help increase capacity across the system.

2.33. High intensity use of services is linked to health inequalities, with those attending most frequently generally low in numbers, but their impact on the wider health system is significant. In Cambridgeshire & Peterborough (C&P) approx. 110 individuals (0.01 per cent of the total population) attended A&E departments in the system 20 or more times in a 12-month period between March 2023 and February 2024. This resulted in 2,004 A&E attendances (1.3 per cent of the overall total).

2.34. Over the same period, patients attending A&E 5 or more times represented less than 0.5 per cent of the registered population in C&P but accounted for more than 1 in 10 (11.8 per cent) of A&E attendances, with a total of 17,652 attendances.

2.35. Previous work carried out by the British Red Cross to explore high intensity use has generally shown those who attend A&E most frequently are people living in the most deprived communities; are more likely to be admitted to hospital than people who attend less frequently; have poorer physical and mental health; and experience poorer than average health outcomes despite the high use of services.

2.36. Utilising funding from the health inequalities allocation and the Better Care Fund, supported through the Cambridgeshire and Peterborough Health and Wellbeing Board, the ICB has established a two-tiered HIU programme as follows:

- Tier 1: A specialist service focusing on people who are already high users of urgent and emergency NHS services, particularly focusing on those who have attended A&E 10 or more times in the previous 12-months; and
- Tier 2: A targeted service focusing on those people identified by general practice and Integrated Neighbourhood teams who are at increasing risk of utilising A&E services, and/or being admitted to a hospital bed in the future.

2.37. Both approaches centre on a model that offers a more proactive and personalised approach to addressing high or increasing use of services, working with partners to understand the gaps in service use, current gaps in care and support, and explore opportunities for care and support to be better coordinated through pathway transformation and personalised care

approaches. The model acknowledges that no single organisation or system partner can do this alone.

2.38. The Tier 1 Service, which is being delivered in partnership with Cambridgeshire County Council, commenced in October 2024. The team is hosted within the Council's Communities Service Directorate and works across the ICS footprint with a lead aligned to both North and South Place. The service has been initially funded for 18-months with the specific aim of reducing A&E attendances, non-elective hospital admissions, 999 and 111 calls, and ambulance conveyances within the selected cohort.

2.39. Despite only recently launching, the service is already having a profound impact on the lives of those who are being supported by the approach with key trends emerging:

- A&E attendances are reducing – individuals' reliance on emergency services as they build trust and resilience and are connected to community-based support.
- Mental health is a core issue – many referrals to the HIU service involve long-term mental health challenges compounded by addiction, social isolation, or trauma.
- Relational support is key – tailored, non-judgemental support helps individuals navigate complex systems without feeling stigmatised.
- Collaborative working – the HIU link workers break down silos between health, social care and community services
- Boundaries build trust – clear, consistent boundaries allow the team to deliver high levels of support while promoting independence.

2.40. The Tier 2 HIU service, which has been operational since November 2023, has resulted in the development of approximately 5,000 personalised care plans for those individuals identified by staff working within primary care and across integrated neighbourhoods requiring proactive support to manage conditions and to reduce the reliance on urgent and emergency care. An analysis of the impacts the Tier 2 service is having is currently underway with the final report available in April 2025.

2.41. <u>Children and young people (CYP)</u>

In response to the Core20PLUS5 CYP priorities, the ICB appointed a clinical lead in April 2024 to deliver the national bundle of care for CYP epilepsy. The bundle focuses on:

1) Addressing variation in care between epilepsy services,
2) Supporting mental health and wellbeing of CYP with epilepsy,
3) Improving referrals into tertiary services,
4) Improving transition from paediatric to adult epilepsy services.

2.42. There will also be a focus on ensuring that the local epilepsy12, a national clinical audit system, data is maintained and kept up to date. This data is key to identifying local variation in CYP epilepsy care and benchmarking both regionally and nationally. Additionally, CUH is hosting Psychology Adding Value in Epilepsy Pilot (PAVES), which links into a key delivery requirement of the national bundle of care.

2.43. The delivery of the CYP national pilot and CYP national asthma bundle of care has been hosted by Cambridgeshire Community Services (CCS) since April 2023. The strategic clinical leadership of this sits under CUH. To date, the team have worked with ICB practices based in areas of higher deprivation and with poorer asthma outcomes. Through the pilot work and

the delivery of the national bundle, the team are covering the areas of clinical focus outlined within the Core20PLUS5 approach which aims to address reliance on reliever medications and decrease the number of asthma attacks. In addition, a respiratory physio community clinic has been established to address the need of CYP with complex chest conditions / complex disabilities to prevent frequent admission to hospital with chest infections.

2.44. A CYP Diabetes GIRFT visit was undertaken earlier this year which identifies key areas for improvement that are being actioned in relation to transitions particularly. In addition, a tertiary service has been established at CUH for supporting and managing CYP with excess weight which could lead to future co-morbidities.

2.45. CYP mental health remains a priority for the ICB to ensure children are ready to enter education and exit, prepared for the next phase of their lives. With the prevalence of issues affecting children and young people's mental health increasing, a central approach being taken to address health inequalities in access to mental health services is through the embedding of co-produced quality improvement initiatives, with a commitment to listen to, discuss and act on the voices of young children, young people and their families. The Cambridgeshire and Peterborough Children and Young People's Mental Health strategy identified the following key priorities:

- Improving access and equity to emotional wellbeing and mental health help and treatment for 0-25 year olds
- Targeting children and young people who are at increased risk of developing mental health issues
- Improve the safety and experience of young people transitioning from children's services to adult mental health services.

2.46. As part of the CYP MH strategy, the 'Keyworker collaborative' (hosted by two third sector organisations) is a programme designed to prioritise children and young people who are living with Learning Disability and/or Autism who have other complex behaviour or mental health needs that could increase risk of hospitalisation. The keyworker function includes:

- support to remain in their local communities
- support during inpatient admission, to help avoid longer than stays than needed
- reduce risk of re-admission
- resettlement into their communities.
- dynamic process of early identification and linked to the Dynamic Support Register

Keyworkers help develop self-advocacy and empowerment and encourage children and young people/adults to actively engage in planning for their future.

2.47. The Access & Inequalities Vaccine Project seeks to improve uptake of childhood and respiratory immunisations in Cambridgeshire and Peterborough. Focusing specifically on Core20PLUS population groups, which have particularly low vaccine uptake, the project provides additional opportunities for these population groups to take up the offer of a vaccination. This includes supporting GP practices with low uptake rates and organising pop-up community clinics to target specific populations. The project commenced in July 2024 and a total of 1072 additional vaccinations were given in Q2 of 2024/25, across 7 different sites. Sites included GP practices situated in deprived areas, asylum seeker accommodation and

university campuses. The project was initially funded for 12 months but will now continue until June 2026 because of additional funding into the project.

2.48. Impact assessment process

In their NHSE-commissioned report on Reducing Health Inequalities through New Models of Care, the Institute of Health Equity recommended that Health Inequalities Impact Assessments (HIIAs) are undertaken as an integral part of policy development and decision making to reduce health inequalities.

2.49. In September 2024, a new consolidated two-stage impact assessment process was implemented across the ICB which will be overseen by the Strategic Commissioning Unit. The updated process ensures compliance with the ICB's statutory duty under both the Health Care Act 2012 and the Public Sector Equality Duty 2011 to evaluate the impacts of its decisions, while embedding the need to assess the impact in relation to equality and health inequalities and those population groups most at risk of experiencing health inequalities.

2.50. Embedding a robust health inequality impact assessment process, one of the recommendations included in the Cambridgeshire and Peterborough Health Inequality Strategy, ensures that all proposals that seeks ICB funding, decommissioning or transformation of services, are accompanied by a robust impact assessment. The process has been designed after many months of collaboration with internal and external stakeholders to assure the safety, quality and fairness of the services that the ICB commissions.

2.51. Inclusion Health

Inclusion health is an umbrella term used to describe people who are socially excluded, who typically experience multiple interacting risk factors for poor health, such as stigma, discrimination, poverty, violence, and complex trauma. People in inclusion health groups tend to have poor experiences of healthcare services because of barriers created by service design. These negative experiences can lead to people in inclusion health groups avoiding future contact with NHS services and being least likely to receive healthcare despite have high needs. This can result in significantly poorer health outcomes and earlier death among people in inclusion health groups compared with the general population.

2.52. In November 2023, NHS England published a national inclusion health framework to help meet the healthcare needs of people in inclusion health groups. Cambridgeshire & Peterborough ICB was successful in an EoI process to be a part of the second wave of the national Inclusion Health Learning Programme in partnership with Pathway, Groundswell and NHS England. Seven systems were chosen from a total of 22 ICSs who applied. Six learning sessions took place throughout Q1 2024/25 with representation from across Cambridgeshire and Peterborough ICS including the ICB, North/South Care Partnerships, local authorities, public health and the VCSE sector.

2.53. At the end of June 2024, and building on the inclusion health learning programme, C&P ICB held a system wide Knowledge Sharing Event to highlight examples of initiatives already in place to address health inequalities amongst inclusion health groups; to share the outcomes of the recent homeless health needs audit; and to facilitate discussions around the new inclusion health framework published by NHSE. The event was attended by more than 80 people with representation from across the system including from primary care, secondary

care, local authority, public health, and the voluntary sector. The feedback from the event was overwhelmingly positive.

2.54. As a result of this programme, the ICB hosted an inclusion health knowledge sharing event for ICS partners to help develop a collective understanding of 'inclusion health' and the healthcare inequalities faced from those with lived experience. The event also showcased some of the projects and initiatives already in place which have been implemented to address healthcare inequalities amongst inclusion health groups such as the Wildflowers Project, Changing Futures Programme, and the Peterborough Homeless Health Hub. A new inclusion health network has since been established to maintain momentum in this space and to help facilitate connections across the system.

2.55. In addition, the Homeless Health Needs Audit (HHNA), which was commissioned by the ICB and developed in partnership with Homeless Link, was published in January 2024. The needs audit provides a detailed insight into the health needs of the homeless population within Cambridgeshire and Peterborough to help inform future commissioning decisions. The HHNA uses a survey methodology to assess the health needs of people experiencing homelessness with a total of 228 surveys completed and with the initial support of 60 homelessness service providers.

2.56. Voluntary, Community and Social Enterprise Sector (VCSE)

Significant progress has been made since the ICS VCSE Strategy launched in 2022. Highlights include development and expansion of the Voluntary Sector Network, including the establishment of a clear structure and strategic steering board; launch of the £2million Healthier Future's Fund and two rounds of the ICB/Assura Community Grants Programme; VCSE representation roles on all ICB committees and accountable business units; development of a VCSE data catalogue; approval of a research business case in partnership with Anglia Ruskin University to support the future sustainability and enhancement of our system-wide volunteering workforce; and ICB training and development offers made to the sector.

2.57. In March 2024, the ICB secured funding from NHS England to review the ICS VCSE Strategy and assess relationship maturity using the national VCSE Quality Development Tool. This involved facilitated workshops with diverse VCSE organisations and ICS partners to assess the six development areas and identify opportunities for future action. A broader consultation has since been launched to gather additional feedback. This included a survey, dedicated workshops, and discussions on the action plan at various forums, including North and South Place Partnership Boards, Health Inequalities Strategic Oversight Group, ICB Leadership and Culture Enabling Group, and the system Aligning Support to the VCSE steering group. The final action plan, aligned with the Strategy's four strategic goals, is currently going through the ICB governance for approval.

2.58. Our first Participation and Involvement Network Summit took place in September 2024, attended by over 50 co-production experts from across the system. The purpose was to explore how we further amplify and embed people's voices to lead change and inform decision making, so that co-production becomes common practice. The Network, established by the ICB in December 2023, has since expanded to include over 100 members from a diverse range of sectors and organisations, driven by collective challenges and a desire to collaborate.

2.59. Summary

The Committee is asked to acknowledge the breadth of work associated with the healthcare inequalities programme and the contribution the ICB is making in terms of reducing health inequalities across Cambridgeshire and Peterborough.

The Committee is also asked to acknowledge that tackling health inequalities requires a coordinated approach across system partners that goes beyond the remit of the healthcare inequalities programme, the ICB and the NHS.

# 3. Source documents


3.1. British Red Cross; Nowhere else to turn: Exploring the high intensity use of accident and emergency services, November 2021 (Nowehere else to turn: Exploring the High Intensity Use of Accident and Emergency Services)

3.2. Cambridgeshire and Peterborough Joint Strategic Needs Assessment 2023 (Cambridgeshire & Peterborough Insight – JSNA 2023)

3.3. Department of Health and Social Care, Fingertips (Fingertips | Department of Health and Social Care)

3.4. Institute of Health Equity; Reducing health inequalities through new models of care: A resource for new care models (reducing-health-inequalities-through-new-models-of-care-a-resource-for-new-care-models.pdf)

3.5. NHS Cambridgeshire and Peterborough ICB Joint Forward Plan 2024-29 (ICB Joint Forward Plan 2024-29)

3.6. NHS England Inclusion Health Framework; Action on inclusion health, October 2023 (NHS England » A national framework for NHS – action on inclusion health)

3.7. NIHR Case Study; How health and care systems can improve ethnicity data collection to help combat inequality, September 2024 (NIHR Case Study)

3.8. The Health Foundation; Interpreting the latest life expectancy data, February 2024 (Interpreting the latest life expectancy data - The Health Foundation)

3.9. The Health Foundation; Life expectancy and health life expectancy at birth by deprivation, January 2022 (Life expectancy and healthy life expectancy at birth by deprivation | The Health Foundation)

3.10. The Kings Fund; Tackling health inequalities: seven priorities for the NHS, September 2024 (Tackling Health Inequalities | Seven Priorities For The NHS | The King's Fund)

3.11. The King Fund; What are health inequalities, June 2022 (What Are Health Inequalities? | The King's Fund)

3.12. The Kings Fund; What is happening to life expectancy in England, April 2024 (What Is Happening To Life Expectancy In England? | The King's Fund)

# 4. Appendices

**Appendix A** – Summary table of key health inequality initiatives / programmes and their alignment to NHSE's strategic priorities and Core20PLUS5 approaches

# Appendix A: Health Inequality programmes / initiatives summary table

## 1) NHSE Strategic Priorities

| Priority 1: Restoring services | Priority 2: Digital exclusion | Priority 3: Complete datasets | Priority 4: preventative programmes | Priority 5: Leadership | Funding | Inclusion health |
|---|---|---|---|---|---|---|
| Waiting lists analysis by ethnicity, deprivation and other protected characteristics.<br><br>Waiting well initiatives in place. | Data analysis to identify disparities in accessing face to face, telephone, video consultations broken down by deprivation and ethnicity.<br><br>Digital inclusion element included in new health inequalities impact assessment process. | Ongoing improvements in ethnicity coding across Primary Care, maternity, and outpatients. | Launch of Your Healthier Future Programme in 2024 focusing on lipid detection and optimisation and hypertension case finding.<br><br>Prevention programmes continue to be driven by PHM approaches. | Named exec lead within ICB and NHS providers.<br><br>PCN Health Inequality leads identified and new PCN HI network established.<br><br>Healthcare inequalities programme reporting and governance arrangements updated in 2024. | New ICB system investment governance process implemented to assess spend and investments.<br><br>The process incorporates how funding will tackle health inequalities as part of MCDA framework. | Inclusion health network established following successful engagement event in June 2024.<br><br>Engagement with residents with lived experience to help shape service design / redesign as part of Voluntary Sector Network and delivery of VCSE strategy. |

## 2) Core20PLUS5 Approach (Adults)

| Maternity. | Severe mental illness (SMI). | Chronic respiratory disease (COPD). | Early Cancer Diagnosis | Hypertension case finding. | Smoking cessation. | LD health checks. |
|---|---|---|---|---|---|---|
| Continuity of Carer trajectories revised and presented to LMNS Board in September 2024.<br><br>Maternity smoking cessation incentive scheme launched. | 2023/24 – 80% uptake of SMI annual health checks against ambition of 60%.<br><br>Ongoing monitoring of 12-point check across system to ensure equitability. | Ongoing monitoring of vaccine uptake amongst patients with COPD and by ethnicity and deprivation to inform outreach activity.<br><br>Launch of vaccine inequality programme in 2024.<br><br>Plans to align respiratory to Your Healthier Programme in 2025/26. | Additional funding secured to promote engagement and uptake amongst Core20PLUS groups.<br><br>Launch of Cancer Alliance programme supporting early detection of liver disease and other cancers within the homeless population. | Launch of Your Healthier Future programme which will target disparities through hypertension case finding and optimisation and lipid detection and management. | All pathways of the TTD programme have been established (maternity, mental health and acute inpatient).<br><br>Further investment secured to broaden reach of programme through utilisation of HI funding. | Disparities in LD health checks by deprivation analysed to inform future programme of work.<br><br>Gap in uptake by deprivation narrowed in 2023/24 compared to 2022/23. |

## 3) Core20PLUS5 Approach (CYP)

| Asthma | Mental Health | Diabetes | Epilepsy | Oral Health |
|---|---|---|---|---|
| CYP pilot hosted by Cambridgeshire Community Services NHS Trust.<br><br>Pilot covering the areas of clinical focus in Core20PLUS5 to decrease the number of asthma attacks. | Innovation opportunities identified to improve access to mental health services for CYP (Lumi Nova) with aim to commissioning in 2025/26. | CYP Diabetes GIRFT system review visit took place virtually in October 2024.<br><br>Several areas were highlighted for further development. | Ongoing updates and maintenance of epilepsy12 data.<br><br>This data is being used to identify local variation in CYP epilepsy care and benchmarking both regionally and nationally. | System-wide paediatric dental pathway task and finish group established to introduce initiatives to support access and earlier intervention. |

# Health Inequalities: Report from Cambridge University Hospitals NHS Foundation Trust

| | |
|---|---|
| To: | Adults and Health Committee |
| Meeting Date: | Thursday 23 January 2025 |
| From: | Medical Director, Cambridge University Hospitals NHS Foundation Trust |
| Electoral Division(s) | All |

Report author:
Dr Ashley Shaw, Medical Director, Cambridge University Hospitals NHS Foundation Trust

# 1. Background

1.1 Health inequalities are the difference in the status of people's health. This can be measured in a number of different ways, but is most commonly seen as years of healthy life expectancy or life expectancy.

1.2 Health inequalities are experienced between different groups of people and are often analysed across four main categories: socio-economic (e.g. income); geography (e.g. region); specific characteristics (e.g. ethnicity or sexuality); and socially excluded groups (e.g. people who are seeking asylum or experiencing homelessness).

1.3 As well as a moral and social responsibility, the NHS commissioners and providers have a legal duty to consider health inequalities as part of the planning for, and delivery of, services.

1.4 Cambridge University Hospitals NHS Foundation Trust (CUH), including Addenbrooke's and the Rosie Hospital, provides services as a local hospital for people in Cambridge and the surrounding areas. It is the Major Trauma Centre for the East of England and provides specialist care for the Eastern region (and nationally) in a number of areas, including transplantation, cancer services, neurosciences, rare diseases, and paediatrics.

1.5 CUH also hosts screening services for abdominal aortic aneurysm, breast cancer, cervical cancer, bowel cancer, diabetic retinopathy, and antenatal and new-born screening.

1.6 CUH works with the University of Cambridge, partners in industry, and other NHS Trusts to deliver high quality medical research.

1.7 CUH is a part of the Cambridge and Peterborough Integrated Care System, and is part of the 'South Place' a collaboration with primary care providers in the southern half of the ICS.

# 2. Main Issues

2.1 The role of CUH in the various aspects of health inequality can be divided in to three broad categories: those where the solutions are entirely within the gift of CUH; those where CUH need to work as part of a system approach; and those where CUH needs to act as an advocate for those with health needs to other organisations.

2.2 These can then be overlaid with the four main categories of challenges listed in 1.2, and applied to the services that we provide.

2.3 Listed below are some examples of the work being undertaken across our various services in the various domains to try and address the health inequalities in our region.

2.4 The CUH website has recently been upgraded and is ranked in the top 3 in the country by the Shaw Trust for accessibility. Information can be accessed in over 30 languages and we are reviewing all patient leaflets. Each policy is subjected to an Equality Impact Assessment screening tool.

2.5 Screening programmes all use invitation letters in the language recorded as the patients preferred, as well as English.

2.5.1 Abdominal aortic screening uses demographic data to identify populations with low uptake of screening, liaising with local GPs and undertaking additional sessions close to patients to boost uptake in areas with reduced uptake.

2.5.2 Breast cancer screening uses mobile vans and extending working days to reach a broad range of communities and tracks uptake by postcode to address inequality. The team work with faith groups to increase uptake in ethnic minority groups and have recently engaged with the Gipsy Roma Traveller community to understand the challenges in providing services in this population.

2.5.3 Antenatal and new-born screening programmes have almost 100% coverage of patients from all communities for the diagnosis of inherited genetic diseases.

2.5 Access to Care: We have recently opened Community Diagnostic Centres in Ely and Wisbech in order that more services can be offered closer to the patient's home.

2.5.1 We have a programme of work in Outpatients to reduce the need for face to face attendance with virtual clinics, patient not present, teledermatology and patient initiated to follow up. In addition we are reviewing the operational hours and availability of clinics, to meet the needs of those on zero hour contracts or other responsibilities.

2.5.2 The Trust uses MyChart for all of our patients; which is fully digital and where patients are able to securely access their health information held within their record in our Epic electronic patient record system.

MyChart is designed to improve communication between patients and their clinical teams at our hospitals, and enable patients to be more involved and informed about their care by having access to their information.

2.5.3 Virtual ward: For some patients, we are able to discharge them to their own home and monitor them remotely. In order to maintain equity, mobile devices are provided to patients to enable them to participate in this and reduce their length of stay in hospital.

2.6 Specific Characteristics: The Trust is working to improve its data collection with regard to protected characteristics. Ethnicity data is best in region at >91%, but other characteristics are less reliably collected and recorded for a combination of reasons.

2.7 Socially excluded groups: CUH has engaged with homeless charities to try and improve services for this population, particularly through the Emergency Department. We have forged links with the Gipsy, Roma and Traveller community, building communication links and attending the Midsummer Fair in Cambridge.

2.8 Medical research is a key aspect of the work at CUH. As part of our strategy we are actively looking to widen participation in clinical research trials and we work with numerous partners to ensure as diverse a group of participants as possible.

2.8.1 The NIHR BioResource national coordinating centre is located in Cambridge (with 18 regional BioResource centres across England) – CUH's Professor John Bradley leads on this nationally. The BioResource Centres provide local interaction, support and recruit new

volunteers. Any one is able to register if they want to be considered/contacted for research purposes. The BioResouce programmes are major initiatives between Centres and partners to tackle specific health conditions.

There is a new research programme from the NIHR BioResource – Improving Black Health Outcomes (IBHO) BioResource, which is focused on improving our knowledge and understanding of health conditions and their unique impacts on UK Black communities. This new research initiative is dedicated to studying health conditions that disproportionately affect people from Black communities. The IBHO invites individuals from Black ethnic backgrounds to participate in research aimed at improving how these conditions might develop and specifically affect those from Black communities.

2.8.2 UPTURN is a new 5-year, £2.8m research programme funded by the National Institute for Health and Care Research and led by Dr Jonathan Fuld**.** The study aims to help people with Chronic Obstructive Pulmonary Disease (COPD) take up, and therefore benefit from, Pulmonary Rehabilitation (PR). The UPTURN programme grant seeks to increase the uptake of pulmonary rehabilitation while lessening known health inequalities. Up to one third of COPD patients do not attend their initial PR assessment or fail to take up the programme, and therefore never get the benefit of the treatment. These are the issues UPTURN aims to address. Some ethnic minority groups have higher rates of COPD than others and low attendance at PR assessment. The UPTURN study will work with patients from the Bangladeshi and Black African & Caribbean communities, their families, and health care professionals to co-design a support package that will work for all but with the ability to be tailored to answer patients' specific questions and concerns about PR.

2.9 Smoking cessation: CUH has introduced a dedicated inpatient smoking cessation service, which is led by our Respiratory Consultant Dr Theresia Mikolasch. This new service provides tailored quit plans, individual counselling, and pharmacotherapy support to help patients achieve their smoke-free goals.

All current smokers must be offered advice, support and treatment to support them to remain temporarily abstinent whilst in hospital. Advice for temporary abstinence creates a teachable moment and often encourages long-term smoking cessation. This is a cost-effective way of improving health outcomes. In practice, this means that all patients must have their smoking status established at the point of admission.

Patients are then referred to a community based service on discharge.

## Areas for Development

2.10.1 Data: The collection of, and analysis, of data to understand better the needs and challenges of different communities is a priority for the Trust.

2.10.2 Data Sharing: CUH has committed to the Cambridge & Peterborough Shared Care Record and aims to go live with this in 2025. This will enable clinicians to be able to view the medical records relating to their patient from other providers, for example the CUH records would be available for review by colleagues in Peterborough, should they be needed.

2.10.3 Access to Care: It is a priority of CUH to develop new models of care which will enable

patients to be treated in their own home, for all or part of their care. This will enable us to meet the challenge of a rapidly growing, and ageing population in our area.

2.10.4 Access to Care: The Outpatient Modernisation programme at CUH will aim to be more accessible to patients, reducing the number of journeys to the campus and be available at times to suit individual patients.

2.10.5 Access to Research: We are aiming to increase diversity within the research setting, to enable participation from a wider geographic and demographic distribution.

2.11 In summary, Health Inequalities are a major priority for Cambridge University Hospitals and the wider NHS. We are committed to work to reduce these inequalities alongside our partners across the health and social care system to improve the lives of our population.

## 3. Source documents

None

Agenda Item No:

# Cambridge & Peterborough NHS Foundation Trust: Operational Board Report

To: Adults and Health Committee

Meeting Date:

From: Scott Haldane
Executive Director
Cambridge & Peterborough NHS Foundation Trust (CPFT)

Electoral division(s): *[Democratic Services will complete this]*

Officer contact:
Name: Holly Sutherland
Post: Chief Operating Officer, CPFT
Email: Holly.Sutherland@CPFT.nhs.uk
Tel: 07761565221

NHS
Cambridgeshire and Peterborough
NHS Foundation Trust

## 1. Background

1.1 CPFT have been invited to attend the Health and Scrutiny Committee to provide an update across a range of key lines of enquiry. The principal areas of review/request for an update for this session are:

- Referrals and waiting lists for CPFT services.
- Locality based treatment, using support to people with eating disorders as a case study. Committee members would welcome a site visit linked to the case study if possible, and would be guided by you on the number of councillors this might involve as they have no wish to disrupt service provision (this item is covered under the Referrals section).
- Suicide Prevention.
- CPFT finances.
- Priorities for the new leadership team.

1.2 The following sections of the paper provide an update on each of these issues in turn.

## 2. Referrals and Waiting Lists

2.1 CPFT routinely monitors its full range of health and wellbeing NHS metrics, which comprise national, commissioning and local indicators. In total the CPFT Integrated Performance Report (IPR) contains around 90 key performance indicators (KPIs).

2.2 CPFT mainly applies a “by exception” basis of reporting, meaning that it focuses on those KPIs/Metrics which Statistical Process Control (SPC) charts indicate are subject to “special cause variation” and therefore potentially require improvement action, particularly if they are off target.

2.3 Accordingly, this report highlights some recent areas of concern and welcomes discussion about how the Trust and partners can work together to ensure that our service users receive the best possible health and wellbeing services.

2.4 The data relates to the period ending November 2024; where December 2024 data is included, please note that there may be latency effects due to the time some data takes to be recorded on Trust systems.

2.5 Over recent months relative demand and capacity has been a continuous challenge for CPFT. Demand by itself is challenging for both physical and mental health services, so we monitor new referrals, as well as focusing on inpatient and community-based patient flow being maintained at optimal levels.

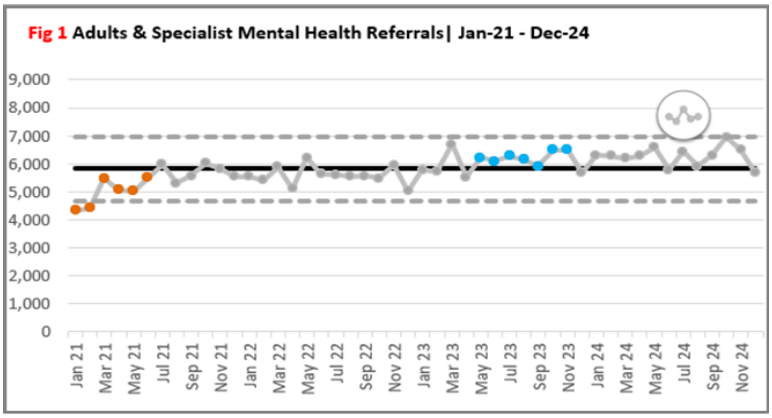
2.6 High Levels of demand over recent months have been compounded by challenges stemming from staff turnover and vacancies, resulting in intermittent high sickness levels, this tends to be heightened during the winter quarter when respiratory type illness peaks.

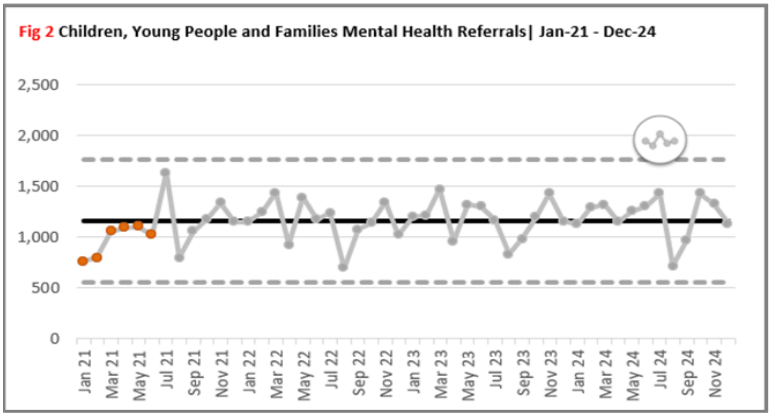
2.7 At a national level, new referrals for mental health conditions have seen a very substantial increase over the last 7 years; the national data between 2017 and 2024 shows a 47%

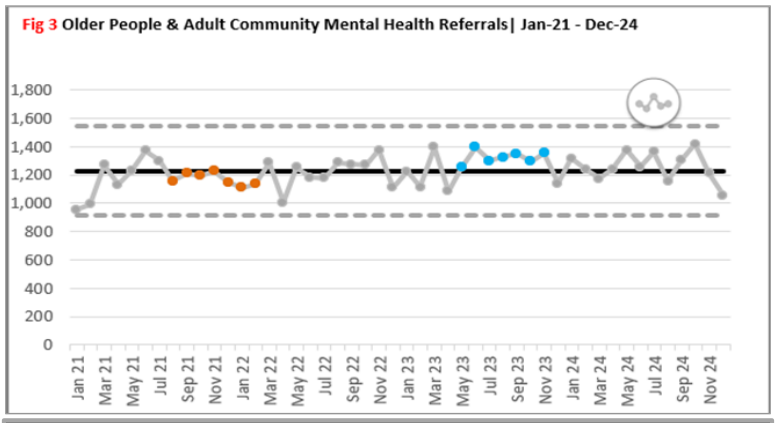
increase, from 3.5 to 5.2 million[1]. Of note has been the increase in demand for ADHD, autism, and related conditions. These national trends have been reflected in referral patterns seen at CPFT.

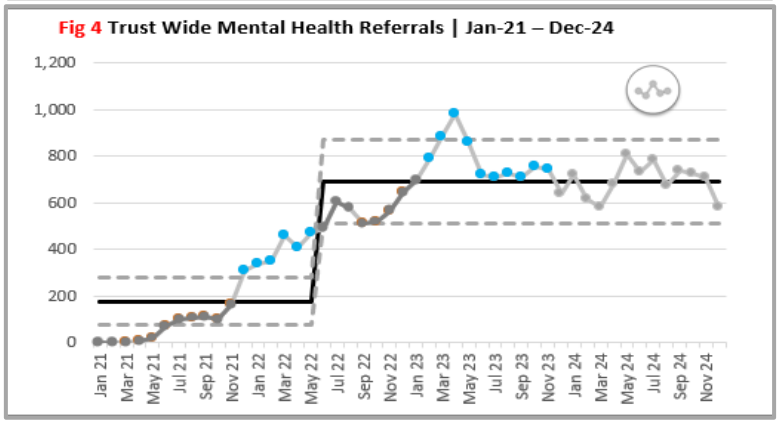
2.8 Figures 1 to 4 below illustrate new referral numbers to CPFT by directorate between January 2021 and December 2024. We can see that Mental Health referrals for Adults Specialist Mental Health (ASMH) average over 6,200 per month; for Children, Young people and Families (CYPF) referrals average 1,100 per month, for Older People & Adult Community services (OPAC), average referrals per month are 1,275 and for Trust-wide services average referrals number 700. In total, CPFT receives 9,400 new Mental Health referrals per month.

2.9 The increase in Mental Health referrals over the last few years has been a particular challenge for CPFT. The Trust is actively in discussions with commissioning and the Integrated Care Board ICB Colleagues on areas to review and address these increases. This work is also intended to ensure that the underpinning Service Specifications and related commissioning contracts reflect appropriate demand, as well as 'best practice' across the NHS.



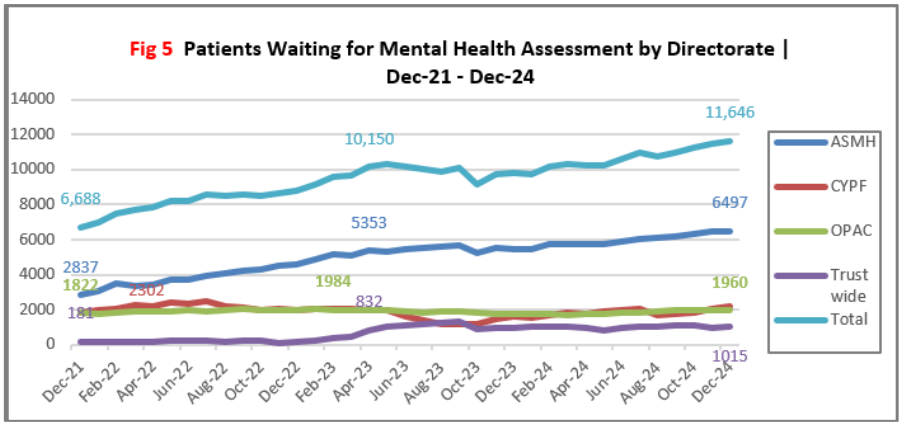



**Note:** Figure 4 shows Trust wide teams; these teams work across directorates. The steep curve in the number of referrals reflects their different establishment dates over the period eg CPFT Safeguarding Adults team was created in November 21.

2.10 In addition to Mental Health services, Older People And Adult Community services (OPAC) receives an average of 14,500 referrals and CYPF over 1,300, for Physical Health services.

2.11 Given the substantial increase in demand for Mental Health services, CPFT has seen its waiting-list for assessment grow considerably over the period; the total waiting-list has risen from just under 6,700 in December 2021 to just over 11,600 at December 2024 (Fig 5). This rise has been seen across all Directorates, although a disproportionately high level is accounted for by increases for ADHD and Autism services.




2.12 Throughout this period, CPFT has striven to ensure that patients are prioritised according to "clinical need" and are assisted to "wait well". Regionally, CPFT has a below average

number of patients waiting for mental health assessment and a below average number of long-waiters.

2.13 The Trust continuously monitors waiting lists, holding multi-disciplinary meetings to maintain momentum and ensure that waiting list management is embedded.

2.14 Along with increased referrals for ADHD and Autism services, CPFT has also experienced substantial increases for Eating Disorder services, both in CYPF and ASMH services, again in line with national trends[2]. Average referrals for patients with an eating disorder for CYPF have risen to 20 patients per month; for ASMH the average number is 118 per month.

2.15 In order to monitor and ensure that Eating Disorder patients are prioritised according to clinical need, CPFT is subject to 2 KPIs which are reported to Board monthly: *Proportion of Urgent Eating Disorder referrals seen within 7 days*, and the *Proportion of Routine Eating Disorder referrals seen within 4 weeks* (see Fig 6 & Fig 7 below).

2.16 Given the increased volumes, both KPIs provide CPFT with significant challenge to meet the 95% targets on a consistent basis. Over the past 18 months, the target for Urgent Referrals has been achieved for 10 months; for Routine, it has been met for 5 months.

2.17 Reasons for non-achievement of targets are reported every month and in the context of referrals for eating-disorders, poor quality initial referral information and difficulties contacting patients to confirm appointments are frequent reasons for failure to hit the timescales.

2.18 Based on the request from the Scrutiny Committee to better understand locality-based treatment for people with eating disorders as a case study, the Trust would be very happy to support and host a service/site visit linked to such a case study. It would be helpful if we could explore this request and the sense of objective at the meeting itself.

**Fig 6 Responsive: CYP ED Urgent Referrals seen in 7 days (PV-1140) (R14) - Trustwide**

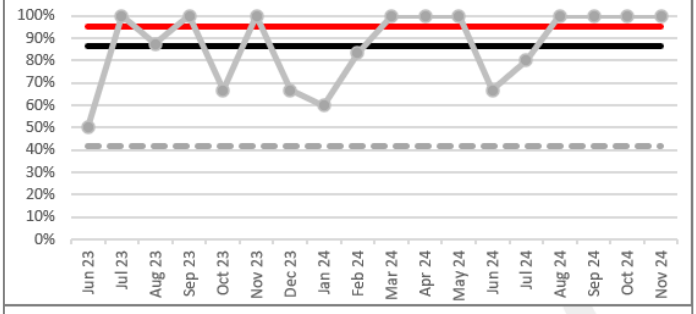
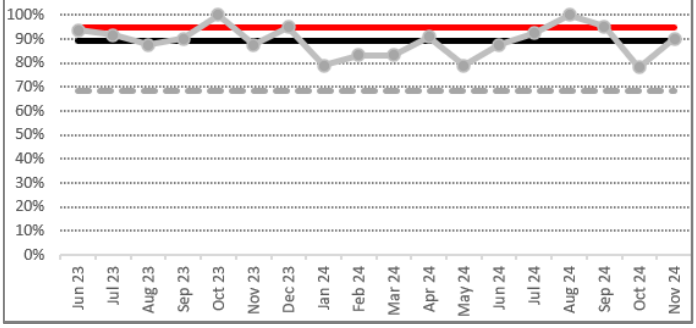



**Fig 7 Responsive: CYP ED Routine Referrals seen in 4wks (PV-1141) (R15) - Trustwide**




**Note:** In Fig 6 and Fig 7, the upper solid line (red) denotes the 95% target.

2.19 Given the consistently high levels of demand for resources, another key area of focus for CPFT is ensuring optimised inpatient flow, so that the use of inpatient beds is as efficient as possible. Over time, we have seen increased average length of stay (LOS) in CPFT beds, in line with national trends and can be partially explained by the increased acuity levels of presenting patients but has also been impacted by changes that were introduced during the pandemic.

2.20 These issues place premium focus on the need to ensure the patients who are “clinically ready for discharge” i.e. no longer require inpatient care are discharged on the correct pathway without delay.

2.21 This represents another key area of challenge for CPFT; over recent time patients ready and delayed per month have averaged 25 for physical health and 14 for mental health.

2.22 Reasons for delays include availability of suitable onward accommodation, predominantly with Social Care and we are engaging with our Local Authority colleagues to improve escalation and progress.

2.23 Most services are seeing sustained increase in demand and in some cases acuity, we are actively engaging with the ICB, and utilising the local Mental Health and Learning Disability Partnership (MHLDA), part of the governance architecture of the Integrated Care System, to help highlight the demand and therefore the resource that will be required to maintain the

services that only CPFT can deliver as the principal secondary care Provider for Community and Mental Health Services.

2.24 Understanding and using population health data to ensure that we are addressing the needs of our population is vital going forward and we need system support and engagement to ensure that mental health and community services are given the same parity and access to resource as acute Trust activity. This point also relates to the engagement work with the ICB and Commissioners as set out in paragraph 2.9 above.

# 3. Suicide Prevention

3.1 A number of initiatives are supporting and contributing to CPFT's focus on suicide prevention:

3.2 In line with national practise, CPFT have adopted the **Patient Safety Incident Response Framework (PSIRF)**, a new NHS-wide approach to creating effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. Suicides are now investigated using PSIRF which replaces the previous Serious Incident Framework. PSIRF promotes a systems-based approach with a strong focus on learning and on the meaningful involvement of families/carers and staff. CPFT staff have been very positive about this approach to date, in particular the collaborative element.

3.3 CPFT are a participant in NHSEs **Culture of Care Programme.** This programme aims to improve the culture of inpatient Mental Health, Learning Disability and Autism wards for patients and staff so that they are safe, therapeutic and equitable places to be cared for, and fulfilling places to work. This works supports suicide prevention. Aligned to this, CPFT have been focussing on improvement work using the National Confidential Inquiry into Suicide and Safety in Mental Health (NCIHS) 'Safer Services' toolkit.

3.4 **'Learning from Deaths' (LfD)** is a national framework to help standardise and improve how NHS Providers identify, report, investigate and learn from deaths. A huge amount of work has taken place in CPFT in the past 12-18 months to improve our processes in relation to LfDs. Investment has been made in expanding our team and there has been a significant focus on embedding learning. A number of new learning events have been established including 'Lessons in Practice', 'LfDs - in-depth case reviews' and '7-minute briefings'.

# 4 CPFT Finances

4.1 As with all NHS bodies, the financial performance of the organisation is regularly reported through the Trust Board meeting in Public and its associated Board Sub-Committees. An update is also shared with the Trust's Council of Governors, as well as being consolidated at Integrated Care Board level as part of regular updates of all System partners that make up the Integrated Care System.

4.2 The attached slide deck (Appendix 1) summarises the Trust's financial performance through to the end of November (Month 8). As can be seen from the attached, CPFT reported a YTD deficit of £7.23m against a planned deficit of £4.07m, showing a £3.16m

adverse variance. In Month 8 the Trust reported a £1.03m deficit against a planned surplus of £0.67m, £1.71m adverse.

4.3 Underpinning the financial performance are a number of assumptions, risks and dependencies that are currently the subject of ongoing discussions with Commissioners and within the Trust. A further verbal update will be provided at the meeting.

## 5. Priorities for the new Leadership Team

5.1 Steve Grange took up post as the Trust's new CEO on 1st October 2024. Over the course of the last 3 months, Steve has been very active in assimilating his new organisation, the services that CPFT delivers, the incredible staff that are employed through the Trust, and shaping views on how we should be performing moving forward.

5.2 In addition, the Trust has also been involved in a Well Led Governance Review, being supported by Grant Thornton. CPFT are also about to be involved in a further review in consort with CQC looking at the Well Led domain within their Current Assessment Framework.

5.3 All of the above will provide a context for refreshing the Trust's governance 'architecture', a backdrop for a reset of the Trust's Strategic direction and, by association, the roles and responsibilities of the core Leadership Team. Steve Grange will provide a further update at the meeting.

**Notes**

[1] NHS England data for mental Health New Referrals 2027 - 2024

[2] Mental Health of Children and Young People in England, 2023

# Finance Report – December 2024 (Month 8)

Cambridgeshire and Peterborough NHS Foundation Trust

Pride in our care

# Financial position

**Position:**

- £7,228k deficit against £4,069k deficit plan: £3,159 adverse.
- M8 reported deficit of £1.03m against a planned surplus of £0.67m: £1.71m adverse.

**Concerns:**

- Pay award allocation pressure £1,427k.
- Forecast efficiency under delivery £5,721k.
- Stretch target under delivery £2,000k.

**Uncertainty:**

- Pay award income risk from Local Authority, low value contracts, R&D £1,125k.
- Provider Collaborative Phoenix income /stranded costs funding.

# Trust Summary – Financial Position

| Financial Position | In-Month £m | YTD £m | Forecast £m |
|---|---|---|---|
| **Financial Performance** | | | |
| Plan | 0.67 | (4.07) | 0.00 |
| Actual | (1.03) | (7.23) | 0.00 |
| Variance = Surplus/(Deficit) | (1.71) | (3.15) | 0.00 |
| RAG (R = adverse to plan; G = favourable to plan) | | | |
| **Capital (including IFRS16 leases)** | | | |
| Plan | 0.93 | 5.41 | 8.97 |
| Actual | 0.24 | 2.37 | 9.26 |
| Variance = Surplus/(Deficit) | 0.69 | 3.04 | (0.29) |
| RAG (R = adverse to plan; G = favourable to plan) | | | |
| **Efficiencies** | | | |
| Plan | 1.83 | 10.71 | 18.34 |
| Actual | 0.95 | 7.64 | 12.61 |
| Variance = Surplus/(Deficit) | (0.88) | (3.08) | (5.72) |
| RAG (R = adverse to plan; G = favourable to plan) | | | |

| Key Financial Metrics | YTD | Prior Month |
|---|---|---|
| **BPPC** | | |
| Volume | 86.5% | 86.3% |
| Value (£) | 78.6% | 77.3% |
| Target - Volume | 95% | 95% |
| Target - Value (£) | 95% | 95% |
| **Liquidity** | | |
| Cash Balance (see SoFP for narrative) | £23.03 | £28.68m |
| Working Capital (current assets - current liabilities) | 20.16 | 22.77 |
| Current Ratio (current assets / current liabilities) | 1.38 | 1.41 |
| Quick Ratio (liquid assets /current liabilities) | 1.38 | 1.41 |
| Cash Ratio (cash / current liabilities) | 0.44 | 0.52 |

## Key Variances 2024/25 YTD

- The Trust reported a YTD deficit of £7.23m against a planned deficit of £4.07m, showing a £3.15m adverse variance.
- Out of Area MH Placements are £0.74m adverse to plan YTD. This is due to an overspend of £1.10m in Adults & Specialty MH, and Older People & Community offsetting this with an underspend of £0.36m.
- Bank and Agency costs are £13.29m above plan YTD, with Medical Agency making up £2.95m of this (22%). Medical Agency has seen a reduction of £0.06m since last month.
- Estates costs are above plan by £0.66m. This is primarily due to a combination of underachievement of efficiency schemes (£0.2m); overspends on rent and rates (£0.5m); PFI service charges above plan (£0.2m); Demolition Costs for the Old Resource Centre (£0.3m); offset by lower than planned utilities expenditure YTD due to seasonality (£0.5m).
- Efficiencies – YTD £7.64m of savings have been achieved, but there is a £3.08m underachievement. Pay efficiencies have underachieved by £2.37m and Non-Pay efficiencies have underachieved by £0.71m. A significant proportion of these adverse variances are due to lower than planned take up of the Direct Engagement scheme, as well as delayed implementation of the bank plus changes, higher than expected Medical Agency usage and lower than planned Estates benefits being realised. Work is ongoing to further identify schemes to bridge these gaps and achieve the 2024/25 full year target.
- Cash – There is a £5.64m reduction from the Month 7 cash balance. Efforts continue to ensure that all relevant invoices are raised and payment from commissioners are received promptly.
- Capital spend YTD is below plan by £3.05m, of which £1.81m relates to an underspend on leases across the Trust.

# Health Scrutiny Work Programme 2024/25

Healthwatch has a standing invitation to participate in all health scrutiny sessions and/ or provide written evidence.

| Committee date | Agenda item | Expected attendees |
|---|---|---|
| 23/01/25 | Tackling Health Inequalities | Louis Kamfer, Deputy Chief Executive, Cambridgeshire and Peterborough Integrated Care Board (ICB)<br><br>Jonathan Bartram, ICB Programme Director for Health Inequalities<br><br>Dr Ashley Shaw, Medical Director at Cambridge University Hospitals NHS Foundation Trust<br><br>Jess Slater, Chief Executive, Healthwatch Cambridgeshire and Peterborough |
| 23/01/25 | Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) Mental Health Services | Steve Grange, Chief Executive, CPFT<br><br>Holly Sutherland, Chief Operating Officer<br><br>Dr Cathy Walsh, Chief Medical Office<br><br>Lauren Gable, Chief Finance Office<br><br>Jess Slater, Chief Executive, Healthwatch Cambridgeshire and Peterborough |
| 06/03/25 | Dental Provision in Cambridgeshire | TBC |

| Committee date | Agenda item | Expected attendees |
|---|---|---|
| | Annual Health Checks for People with Learning Disabilities | TBC |
| | Approval Process for Responses to NHS Quality Accounts 2024/25 | R Greenhill |
| | Draft Health Scrutiny Annual Report 2024/25 | R Greenhill |
| | Draft Health Scrutiny Work Plan 2025/26 | R Greenhill |
| | Health scrutiny recommendations tracker | R Greenhill |

# Adults and Health Committee

## Health Scrutiny Recommendations Tracker

Purpose:
To record the recommendations made by the Adults and Health Committee in the discharge of its health scrutiny function, and their outcomes.

### Meeting 14th December 2023

| Report title | Officer/s responsible | Recommendation/s | Outcomes | Status |
|---|---|---|---|---|
| Improving Health Outcomes for People with Learning Disabilities | C Anderson, Chief Nursing Officer, ICS | The Committee requests a short written update in 12 months' time (January 2025) on the outcome of the pilot project to align annual health care checks for people with learning disabilities with their birthdays. This should state whether this initiative will be rolled out across the county; and, if so, the timescale for doing so. | This information will be provided for the scrutiny session on annual health checks for people with learning disabilities which has been scheduled for March 2025. | On-going |
| Improving Health Outcomes for People with Learning Disabilities | P Warren-Higgs, Executive Director Adults, Health and Commissioning/ C Anderson, Chief Nursing Officer, ICS | Recommends that County Council officers work with Health Service partners to offer basic healthcare training to carers so that they can carry out basic health checks and support such as mouth care and inspections; foot care inspections; and supporting good eating techniques to reduce the risk of aspiration for people with learning disabilities. | On-going work with health partners to establish appropriate available training options for those carers supporting those with LD in these specific areas and access routes into these specific training programmes.<br><br>Reminders sent 24.05.24,16.08.24 & 06.11.24, 08.01.25 | On-going |

| Report title | Officer/s responsible | Recommendation/s | Outcomes | Status |
|---|---|---|---|---|
| Improving Health Outcomes for People with Learning Disabilities | C Anderson, Chief Nursing Officer, ICS | Requests a short written evaluation in 12 months' time (January 2025) of the learning from the keyworker pilot project. This should include the number of people with learning disabilities receiving the support of a keyworker against the known population of people with learning disabilities in Cambridgeshire in December 2023 and December 2024 (separate figures for adults and children); and an assessment of the impact in practical terms of the keyworker programme in improving access to and the experience of health care services by people with learning disabilities, including supporting the transition from children's to adult services. | Reminder sent 06.11.24 | Follow up requested by January 2025 |
| Improving Health Outcomes for People with Learning Disabilities | R Greenhill, Democratic Services Officer | The Committee will seek feedback from people with learning disabilities about their experience of having a keyworker in 12 months' time via the Learning Disability Partnership, Voiceability and Healthwatch Cambridgeshire. | 11.11.24: Requests for feedback sent to the Learning Disability Partnership, Voiceability and Healthwatch Cambridgeshire. | Feedback awaited |
| Improving Health Outcomes for People with Learning Disabilities | C Anderson, Chief Nursing Officer, ICS | Requests a short written evaluation in 12 months' time (January 2025) of the pilot project being run in two special schools to deliver health services in an education setting. This should include whether the programme will be extended, maintained or discontinued. | Reminder sent 06.11.24 | Response requested by January 2025 |
| Improving Health Outcomes for People with | C Anderson, Chief Nursing Officer ICS | Notes that all organisations that provide NHS care have been legally required to follow the Accessible Information Standard since 2016. The Committee requests an update in 12 | Reminder sent 06.11.25<br><br>To be followed up as part of the scrutiny session on annual health | To be followed up during scrutiny |

| Report title | Officer/s responsible | Recommendation/s | Outcomes | Status |
|---|---|---|---|---|
| Learning Disabilities | | months' time (January 2025) on the progress made in rolling out health care information in easy read format across Cambridgeshire's health services. | checks for people with learning disabilities in March 2025. | session in March 2025 |
| Improving Health Outcomes for People with Learning Disabilities | R Greenhill, Democratic Services Officer | The Committee will consult the Learning Disability Partnership, Voiceability and Healthwatch in 12 months' time to request their perspectives on the progress made in rolling out health care information in easy read format across Cambridgeshire's health services. | 11.11.24: Requests for feedback sent to the Learning Disability Partnership, Voiceability and Healthwatch Cambridgeshire. | Responses awaited |
| Improving Health Outcomes for People with Learning Disabilities | C Anderson, Chief Nursing Officer | Requests an update in 12 months' time (January 2025) on the number of NHS healthcare professionals in Cambridgeshire who have completed the Oliver McGowan training course at each level, the percentage figures for staff trained out of the total staff number identified as needing to undertake this training; and a comparison of Cambridgeshire's performance against national training completion rates. | Reminder sent 06.11.24<br><br>This can be followed up as part of the scrutiny session on annual health checks for people with learning disabilities in March 2025. | Follow up requested January 2025 |
| NHS Workforce Development – Primary Care and Nursing Workforce | P Warren-Higgs, Executive Director for Adults, Health and Commissioning | Requests that County Council officers liaise with the Chief People Officer at the ICS to explore the potential for joint working in relation to the County Council's new social care academy, the Cambridgeshire Academy for Reaching Excellence (CARE). A short written update is requested in three months' time. | Reminders sent 24.05.24, 16.08.24 & 06.11.24, 08.01.25 | Response requested by April 2024 |

## Meeting 7th March 2024

| Report title | Officer/s responsible | Recommendation/s | Outcomes | Status |
|---|---|---|---|---|
| The Provisions of NHS Dental Services in Cambridgeshire | P Warren-Higgs/ N Briggs, CFO ICB/ C Iton, Chief People Officer, ICB | The Committee requests that County Council officers and the ICB discuss wider collaboration in relation to the ICB's workforce strategy, including dentistry, and the opportunities offered by the new Care Academy. | Reminders sent 24.05.24,16.08.24 & 06.11.24, 08.01.25 | On-going |

## Meeting 10th October 2024

| Report title | Officer/s responsible | Recommendation/s | Outcomes | Status |
|---|---|---|---|---|
| Maternity Services at Cambridge University Hospitals NHS Foundation Trust | Roland Sinker CBE, Chief Executive CUH | The Committee recommends the Trust adopt a target figure of 100% on safeguarding training. | 26.11.24 CUH response: We set a Trust target for all mandatory training including safeguarding to 90%. This allows for movement of staff due to our 12-13% turnover rate per year. We do however monitor long term non-compliance with mandatory training and this is reviewed for all staff during their appraisals. | Completed |
| Maternity Services at Cambridge University Hospitals NHS Foundation Trust | Jan Thomas, Chief Executive ICB | The Committee recommends that the issue of women's health hubs is re-visited locally in terms of providing an equitable approach to the treatment of women's and men's health. | 19.11.24: The Chair of the ICB has advised that the Cambridgeshire and Peterborough ICB has recently approved funding for the establishment of women's health hubs as per the Government's guidelines for implementation. Funding is being distributed | Completed |

| Report title | Officer/s responsible | Recommendation/s | Outcomes | Status |
|---|---|---|---|---|
| | | | to both North and South Place Partnerships and directed into areas of higher deprivation. At least one hub will be operational by 31st December 2024. | |
| Maternity Services at Cambridge University Hospitals NHS Foundation Trust | Roland Sinker CBE, Chief Executive CUH | The Committee welcomes the work to date in relation to triage, but notes that 20% of patients due to be seen within 15 minutes are being seen after an hour. The Trust is encouraged to continue with efforts to address this, and the Committee requests a short briefing note in February 2025 to provide an update on progress. | | Due February 2025 |
| Maternity Services at Cambridge University Hospitals NHS Foundation Trust | Roland Sinker CBE, Chief Executive CUH | The Committee accepts the offer of a revised Appendix 2 containing a complete set of figures for the Friends and Family Test score and further detail around what might lay behind the deterioration in scores during 2024. | 26.11.24: Revised figures and narrative circulated electronically to committee members, co-opted members and CYP Spokes. | Completed |
| The Redevelopment of Hinchingbrooke Hospital | Deborah Lee, Senior Responsible Officer | The Committee welcomes and encourages the wider vision around the development of the Hinchingbrooke Hospital campus and requests further information about this over time. | | On-going |

12th December 2024

| Report title | Officer/s responsible | Recommendation/s | Outcomes | Status |
|---|---|---|---|---|
| Urgent and Emergency Care | ICB Clinical Lead for Urgent and Emergency Care | The Committee recommends full scrutiny of the new policy to mandate calls to 111 for urgent and emergency care for people in care homes without an individual care pathway. A written response is requested on whether this recommendation has been accepted by the Integrated Care Board by the end of January 2025 and, if so, how this scrutiny will be conducted. | | Response due by end of January 2025 |
| Urgent and Emergency Care | EEAST Liaison Group | The Committee recommends that the EEAST Liaison Group monitors plans to replace the Trust's ageing fleet of ambulances and whether this achieves the target for reductions in vehicle downtime within 18 months. | | Review December 2025 |
| Urgent and Emergency Care | Chief Operating Officer, ICS | The Committee commends the efforts being made in relation to the Voluntary Sector Alliance to improve the experience of hospital discharge, but would like to see more evidence of its effectiveness. A briefing note is requested by the end of February 2025. | | Response due end of February 2025 |