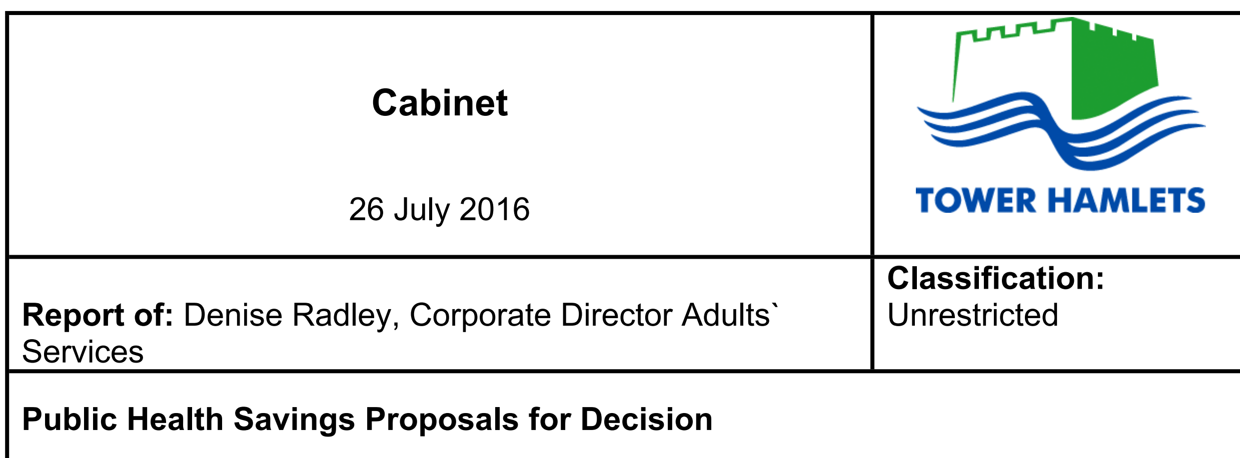

Cabinet 26 July 2016	TOWER HAMLETS
Report of: Denise Radley, Corporate Director Adults` Services	**Classification:** Unrestricted
Public Health Savings Proposals for Decision	

Lead Member	**Councillor Amy Whitelock Gibbs, Cabinet Member for Health and Adult Services**
Originating Officer(s)	Somen Banerjee, Director of Public Health
Wards affected	All
Key Decision?	Yes
Community Plan Theme	**Healthy and Supportive Community**

Executive Summary

1. This report follows on from the paper on public health savings presented to Cabinet on 10th May 2016. The previous paper highlighted:

    - The purpose and conditions of the public health grant
    - Current areas of expenditure
    - National cuts and local pressures on the grant
    - Prioritisation criteria for reviewing cuts to public health programmes
    - Proposed savings to the value of £2.3 million in 2016-17 and £ 3.7 million in 2017-18 that could be achieved with a limited adverse impact on public health outcomes and health inequalities in the borough
    - The need for additional savings to be considered during 2016/17

2. The proposals were discussed at Cabinet on 10th May and it was agreed to proceed with public and stakeholder consultation on the proposed savings and then report back through a report for decision on the proposed public health programme savings being submitted to Cabinet on 26th July.

3. This paper focusses on the consultation feedback received by the Council in response to the savings proposed and makes recommendations on savings in the public health programme to be implemented from 1st October 2016 (or before where possible).

4. The savings are being proposed under the following public health programme areas:
    - Healthy communities
    - Healthy early years

- Healthy childhood and adolescence
- Tobacco cessation
- Sexual health
- Long term conditions
- Health Outreach staff

5. A public and stakeholder consultation took place between 20th May and 16th June 2016 using a variety of methods including:
   - Council website
   - User meetings
   - Partnership meetings
   - Open to the public meetings

   For a full description see Appendix B below.

6. Over 200 responses were received on the Council website and across the consultation there was a significant degree of concern expressed at the level of cuts suggested for some of the services. There was a particularly strong response to proposed savings in the Royal London breast-feeding support service. Other services that drew significant response included the sexual health savings proposed for the Tower Hamlets Contraception and Sexual Health Service, the Health Trainers programme, the Parent and Family Support pilot and the cancer community engagement programme.

7. The level of response from the public and other stakeholders is very encouraging in that it demonstrates that public health services are very much valued within the local community and there is a strong commitment to supporting them from many service users. The service providers are also passionate and committed to the services they provide. Some challenging issues have been raised through the consultation and these will all need to be worked through and addressed as part of implementation.

8. Having considered the consultation feedback and in the light of the need to save significant sums in the public health budget this year, it is recommended that all savings that were proposed to Cabinet on 10th May are implemented. The process of identifying these savings was based upon prioritisation criteria which seek to minimise the impact on health outcomes (see below). The final templates that are included below in ANNEX A take account of the issues raised through consultation, particularly in service areas that drew a large response such as breast-feeding support, Health Trainers and sexual health.

9. The equality impact assessments that have been completed show that there is highly likely to be an impact from the savings and whereas this can be mitigated to some degree, and in some instances, it cannot be avoided altogether. The extent to which there are impacts on the different protected characteristics varies across the different programmes but it will be important in the implementation process to take account of this and work with the providers and other stakeholders to manage the process as sensitively as possible.

Recommendations:

The Mayor in Cabinet is recommended to:

1. Consider the consultation feedback and service responses set out in ANNEX B.
2. Agree to implement the savings as set out in the templates in ANNEX A.

1. REASONS FOR THE DECISIONS

1.1 To agree public health expenditure savings to the value of approximately £2.3 million and contribute to balancing the public health grant budget in 2016-17 and subsequent years.

2. ALTERNATIVE OPTIONS

2.1 To do nothing would result in substantial overspend.

2.2 Make savings in different areas - as set out in the May Cabinet report, the Director of Public Health has utilised a robust prioritisation criteria in order to identify savings which are likely to impact least on health outcomes.

3. DETAILS OF REPORT

3.1 See the attached paper titled "Public Health Savings Proposals – Phase 1" Appendix A, along with ANNEX A (savings templates) and ANNEX B (summary report on Consultation Feedback).

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 The overall Public Health grant allocation for 2016/17 is £36.883m in 2016/17, including funding for 0-5 year old provision which transferred to all Councils nationally in October 2015. On a like for like basis, this is a reduction of £3.1m on the previous year. Further reductions in the level of the Public Health Grant have also been announced by the Department of Health and the implications of this is being considered as a part of the Council's outcome based budgeting approach to the MTFS.

4.2 The service has identified that total savings of up to £5m will need to be delivered in order for Public Health expenditure to be contained within the grant allocation in 2016/17. Saving proposals totalling £2.3m

have been identified to date as deliverable in the current financial year, with approaches to deliver the remaining £2.7m still required for 2016/17; this will be monitored through the regular budget monitoring processes.

4.3 The 2016/17 savings identified of £2.3m are part year savings and the full year effect of these in 2017/18 is £3.7m, therefore further on-going savings of £1.3m are required, together with the need for further savings following on-going Public Health grant reductions, which will need to be identified through the Council's outcomes based budgeting approach.

4.4 Given the level of savings required, a robust monitoring arrangement will need to be established to ensure the savings are delivered as planned and to highlight any potential slippage or delay. The progress on savings will form part of the council's regular budget monitoring report to members.

5. LEGAL COMMENTS

5.1 Under section 2B of the National Health Service Act 2006, each local authority has a duty to take steps, as it considers appropriate, for improving the health of the people in its area. A local authority may also be required by regulations under section 6C of the NHS Act to take steps to protect the public in England from disease or other dangers to health. Local Authorities must have regard to published guidance including the revised Best Value statutory guidance issued by the Department for Community & Local Government (2011), which is equally applicable to local authorities' public health functions.

5.2 The Council is obliged as a best value authority under section 3 of the Local Government Act 1999 to "make arrangements to secure continuous improvement in the way in which its functions are exercised having regard to a combination of economy, efficiency and effectiveness'. The duty to secure best value under the Local Government Act 1999 will also apply to these public health responsibilities. The fulfilment of this duty is addressed in paragraph 7 below.

5.3 The Department of Health allocates ring fenced public health grants to local authorities in England so that the local authorities can discharge their public health functions. The funds are to be used for-

- improve significantly the health and wellbeing of local populations;
- carry out health protection and health improvement functions delegated from the Secretary of State;
- reduce health inequalities across the life course, including within hard to reach groups;
- ensure the provision of population healthcare advice.

5.4 Local authorities will need to forecast and report against the sub-categories in the Revenue Account (RA) and Revenue Outturn (RO) returns to the Department for Communities and Local Government (DCLG) who will share data with Public Health England (PHE). Reporting is quarterly and year end.

5.5 The Council is required when exercising its functions to comply with the duty set out in section 149 of the Equality Act 2010, namely to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity between those who share a protected characteristic and those who do not, and foster good relations between those who share a protected characteristic and those who do not. This is addressed in the One Tower Hamlets considerations below.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1 A primary objective of the Public Health Grant is to address health inequalities. The majority of programmes funded through the grant are concerned with supporting the health and wellbeing of those with greatest risk of poor health outcomes and the prioritisation criteria have incorporated equity considerations.

7. BEST VALUE (BV) IMPLICATIONS

7.1 Best Value is a core objective of the plans outlined as they are seeking to secure the best outcomes for the population in the context of reduced resource.

8. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

8.1 There are limited implications for a greener environment although sustainability and health do have strong association.

9. RISK MANAGEMENT IMPLICATIONS

9.1 The core purpose of the public health savings proposals is to mitigate the risk of overspend whilst seeking to do this in a considered way that mitigates against the risk of destabilising both established and new programmes that are delivering value for the people in Tower Hamlets.

9.2 The savings are premised on sign off at the July cabinet - further delay would reduce savings that could be achieved in 16/17

9.3 Discussions have already taken place with a number of the providers on how the savings, if agreed, would be implemented. This may or may not have an adverse impact on the outputs that are being delivered. That will be agreed with providers on a case by case basis and the priority will be to maintain, as far as possible, the health outcomes.

9.4 The saving of £200k proposed for acute Genito-Urinary Medicine (GUM) may be challenging as it requires robust negotiations through the London Sexual Health Collaborative on price with certain providers in London although initial indications suggest the saving is feasible.

9.5 Any additional risks highlighted in the consultation feedback will be addressed through the implementation process in collaboration with affected providers.

10. CRIME AND DISORDER REDUCTION IMPLICATIONS

10.1 Significant proportions of the population regularly use illegal tobacco - reducing smoking prevalence will also have a positive impact.

Linked Reports, Appendices and Background Documents

The main report is attached with appendices

Linked Report

- NONE

Appendices

- APPENDIX Public Health Savings Proposals
- ANNEX A Savings Templates and Equality Impact Assessments
- ANNEX B Public Consultation Feedback

Local Government Act, 1972 Section 100D (As amended)
List of "Background Papers" used in the preparation of this report

- NONE.

Officer contact details for documents:

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APPENDIX A

Public Health Savings Proposals

1. Purpose of this report

1.1 In 15/16 and 16/17, the public health grant allocation from the Department of Health has been reduced. This has resulted in a loss of public health reserves to fund any additional pressures on the budget as well as reduced funding for 16/17. For Tower Hamlets this means that savings of £5m are needed in 16/17 to meet the public health grant allocation of £36.9m.

1.2 This paper sets out:

1. Why public health investment is needed
2. What the public health grant is for
3. Why the savings are needed
4. How savings proposals have been prioritised
5. What savings have been proposed and why
6. Potential risks and mitigations
7. Plans for consultation

2. Why is public health investment needed in Tower Hamlets?

2.1 Health is a foundation for wellbeing. The purpose of the public health grant is to help people live healthier lives.

2.2 The need for public health investment is particularly high in Tower Hamlet because, on average, the health of people in the borough is not as good as elsewhere.

2.3 For example, compared to London and England, Tower Hamlets has amongst the highest levels of early deaths from conditions such as cancer, heart disease, stroke, lung disease and liver disease.

2.4 This is because the prevalence of these conditions is closely linked to deprivation and Tower Hamlets has higher levels of deprivation than elsewhere.

2.5 In addition, health within the borough varies with deprivation. For example, life expectancy in the most deprived areas of the borough is 8.8 years lower for men and 3.9 years lower for women than in the least deprived areas.

2.6 This means that public health investment is needed across the borough but also need to be targeted at population groups with particularly high health need.

3. What is the public health grant?

3.1 The ring fenced public health grant is allocated to local authorities in England so that they can discharge their public health functions. The Department of Health states that the funds should be used to:

- significantly improve the health and wellbeing of local populations
- carry out the health protection and health improvement functions delegated from the Secretary of State
- reduce health inequalities across the life course, including within hard to reach groups
- ensure the provision of population healthcare advice

3.2 Whilst there is local discretion in how the grant is used based on local needs, there is a mandatory requirement that this should include investment in

- sexual health testing/treatment
- contraception
- health checks
- local authority role in health protection
- public health advice
- National Child Measurement Programme
- Children 0-5 services (from Oct 15/16)

3.3 The expectation is that funds are used in year but funding can be carried over as part of the public health reserve. In using funding carried over, the grant conditions still need to be complied with.

4. What is the public health grant used for in Tower Hamlets?

4.1 Overall, the public health grant is used to invest in programmes to help people to

- promote their mental wellbeing
- build positive health habits into their daily life
- be free from behaviours harmful to health
- seek early help for health conditions
- live in environments that are safe and health promoting

4.2 In 15/16, the public health grant allocation for Tower Hamlets was £39.9m. Table 1 summarises how this funding was allocated. The programmes are commissioned mainly through providers in the NHS or the voluntary sector or delivered directly by the council.

Table 1 Public Health Grant spend in Tower Hamlets linked to Public Health aspirations

	Public health aspirations	**Main areas of PH grant allocation (bold = high spend areas)**

Maternity and early years	More parents:
	• enjoying good health and wellbeing
	
	More 0-5 year olds:
	• laying foundations for lifelong physical and mental wellbeing
	  ○ early attachment
	  ○ healthy early nutrition
	  ○ development through play
	  ○ good oral health
	  ○ fully immunised
	• free from health harms
	  ○ impacts of tobacco, alcohol, drugs
	  ○ neglect or abuse
		Externally Commissioned:
		Family Nurse Partnership and Health Visiting (from October 2015 – £7.7m)
		Breast feeding (£471k)
		Parents and infant wellbeing (£160k)
		Active play (£54k)
		Healthy start vitamins (£44k)
		Fluoride varnish (£150k)
		
		Internal funding to directorates:
		Early years accreditation (£50k)

Childhood and adolescence	More children and adolescents:
	• practicing and embedding habits for lifelong physical and mental wellbeing
	  ○ foundations for mental wellbeing
	  ○ life skills for fulfilling relationships
	  ○ regular physical activity
	  ○ healthy eating
	  ○ good oral health
	• free from health harms
	  ○ tobacco, alcohol, drugs
	  ○ neglect or abuse
		Externally Commissioned:
		School nursing (£1.6m)
		Young People sexual health (£600k)
		Child and family weight management (£430k)
		Active Play (£64k)
		School Cycling (£80k)
		
		Internal funding to directorates:
		Free school meals (£2.8m)
		Healthy Lives – schools (£275k)
		Peer education – smoking (£71k)
		Substance misuse (£240k)
		Teenage pregnancy (£92k)
		Peer led SRE (£95k)
		Mindfulness in schools (£43k)

Adults	More adults:
	• living healthily
	  ○ maintaining mental wellbeing
	  ○ regular physical activity
	  ○ healthy eating
	  ○ good sexual wellbeing
	• free from health harms
	  ○ tobacco, alcohol, drugs, risky sex
	  ○ neglect or abuse
	• aware of and taking action on
	  ○ risk of health conditions
	  ○ symptoms of health conditions
		Externally Commissioned :
		Genitourinary medicine (£5.3m)
		Integrated sexual health (£1.4m)
		Weight management (£826k)
		Tobacco – specialist (£420k)
		Tobacco – universal (£440k)
		Sexual Health Promotion (£310)
		Health checks (£207k)
		Mental wellbeing awareness (£139k)
		Cancer early awareness (£96k)
		Domestic violence (£65k)
		
		Internal funding to directorates:
		Drugs and alcohol (£8.6m) (both commissioning and internal)

Environment and communities	More people:
	• living in healthy environments
	  ○ Safe and health enhancing
	  ○ Supporting physical activity, healthy eating
	• living in healthy communities
	  ○ Strong networks supporting healthy lives
	• accessing high quality services
	  ○ Integrated, prevention orientated, accessible, high quality
	• whose health is supported by good income, education, housing and employment
		Externally Commissioned :
		Health Trainers (£1.1m)
		Making every contact count (£30k)
		Food for health awards (£72k)
		Tobacco/alcohol enforcement (£263k)
		Can do community (£70k)
		Social isolation pilots (£120k)
		ESOL health literacy (£58k)
		Community gardeners (£50k)
		
		Internal funding to directorates:
		Healthy housing (£35k)
		Health outreach workers (£570k)

4.3 Further detail on these programmes is provided in the savings templates in Appendix A.

5. Why savings are needed

5.1 The Department of Health allocates the public health grant to local authorities on an annual basis to fund the public health programmes described in the previous section.

5.2 In 15/16, the whole year allocation for the public health grant was £39.9m (this is composed of the allocation at the start of the year £32.2m and the whole year value of Health Visiting and Family Nurse Partnership of £7.7m for which the council became responsible in October 2015).

5.3 However, in 15/16, the government also announced an in year cut of £2.2m to the public health grant. This removed £2m of public health reserves available to be carried forward to 16/17 to manage any pressures on the public health budget.

5.4 For 16/17, this represents a £3.1m reduction from the whole year allocation of 15/16.

5.5 The level of cuts required for 16/17 are

- to meet the reduction in the allocation (£3.1m)
- to address projected increased pressures on the public health budget (including rising costs of acute sexual health services and free school meals) that can no longer be accommodated through public health reserves due to the in year cut of 15/16 (£1.9m)

5.6 The overall savings needed are therefore £5m for 16/17 (table 2)

5.7 In February 2016, allocations for the Public Health Grant for 16/17 and indicative grant for 17/18 was announced as follows, therefore a further reduction of £0.9m is expected in 2017/18 (table 2):

16/17 = £36.9m
17/18 = £36.0m

Table 2 Summary of savings requirement on public health grant 2016/17 and indicative reduction 2017/18 which will be incorporated into the 2017/18 Outcomes Based MTFS.

	Total
	£000's
15/16 Allocation - full year effect	39,900
16/17 Allocation	36,800
Grant Shortfall	3,100
Pressures	
Sexual Health Services and Free School Meals	1,900
2016/17 Total Shortfall	5,000
2017/18 Grant reduction	900

6. Approach to making savings

6.1 The combination of projected cost pressures, national cuts and their late announcement provide a challenge to ensuring that the Public Health budget is balanced for 16/17 and that cuts are applied in way that pragmatically maintains coherence and stability for the public health function serving the population.

6.2 At the same time it provides an opportunity to radically review how the public health grant is used and drive innovation, creative and cost effective approaches whilst building on the existing foundations of provision.

6.3 Based on these considerations, the approach to making savings will have three phases.

- Initial review of public health investments has identified £2.3m savings that can be made taking into account part year effects based on an assumption that they can be agreed at the Cabinet on July 2016. The whole year effect of these savings is £3.7m.

- The remaining £2.7m savings will be identified during the Council's budget setting process using an outcomes based approach to the 2017/18 medium term financial plan.

- Taking a longer term perspective, an in depth review of the PH budget will take place to establish a longer term commissioning strategy in the context of planned cuts expected over the next five years (to report in October 2016). The public health savings programme for 17/18 onwards will be aligned with the corporate

process and included in the MTFS plans and public consultation proposals.

6.4 In prioritising the £2.3m savings in 16/17 proposed in this paper, the approach has been to identify those areas where public health investment has the greatest impact on population health and addressing health inequalities, and those where the impacts are least, to ensure proposals for savings are based on a robust and consistent set of criteria.

6.5 To provide an evidence base for decisions, the following criteria have been considered:

- Purpose of the programme
- Key outputs from the service
- Health outcomes addressed
- Evidence base for this type of activity
- Evidence building potential
- Population reach
- Extent to which addressing high need population
- Current performance
- Opportunities to deliver at lower cost (value for money)
- 'Must do` (mandatory or political commitment)

6.6 These criteria have been applied to all public health initiative to inform decisions on:

- What to stop?
- What to reduce?
- What to deliver in a different way?

6.7 A priority based budgeting exercise has been undertaken to identify public health priorities that should be protected as far as possible and those areas where savings can be most safely applied.

7. Overview of proposed savings

7.1 The proposed overall savings to each high level programme are as follows.

Table 3 Proposed savings by programme (see templates for details)

	Base budget considered in phase one savings	16/17 Savings	%	Whole Year Effect in 17/18	%
Healthy Place	1,331,257	191,380	14	312,760	23
Healthy Early Years	8,500,856	169,300	2	669,502	8
Healthy childhood/adolescence	2,634,764	121,696	5	193,980	7
Tobacco Cessation	1,367,940	399,000	35	512,000	37
Sexual health non acute GUM	3,079,529	419,336	14	764,336	25
Sexual health acute GUM	5,400,000	200,000	4	200,000	4
Long term conditions	1,281,457	296,258	23	438,514	34
Public health staff (outreach)	570,000	440,000	77	440,000	77
Reduction of non-recurrent funding (pilots)	226,880	132,412	58	226,880	100
Total	24,392,683	2,369,382	10	3,757,972	15

7.2 The details within each programme are set out in the savings templates. Each template sets out:

- Aspirations of the programme
- Current investment
- Proposals, implications and risk mitigations

7.3 Overall, the principle has to been to preserve investment in early years as far as possible as this is where the strongest evidence is around long term health impact.

7.4 The greatest levels of savings are from tobacco, sexual health, long term conditions and public health staffing (health outreach).

7.5 The rationale for tobacco savings relates to declining smoking prevalence reflected in declining footfall to services. In addition, when we compare our level of spend on these services to other boroughs with similar levels of need, we are spending more per head on smoking cessation services. The principle has been to make greater cuts in universal services and seek to preserve targeted services as declines in prevalence have been significantly lower in more deprived groups.

7.6 The rationale for sexual health savings is primarily duplication of provision between contraception and sexual health services (CASH) as well as the potential to address issues such as overcharging of acute GUM services by providers (addressed through London collaborative commissioning negotiating arrangements that Tower Hamlets is signed up to). The principle has been to preserve lower cost primary care and pharmacy services and reconfiguration of the model of provision to encourage people with lower needs to access these services.

7.7 The rationale for long term conditions cuts relating to the Fit4Life adult obesity service is the evidence that compared to other boroughs with similar levels of need, we are spending significantly more per head on adult obesity services.

7.8 The rationale for the public health staffing cuts is that the programme of health outreach workers proposed is not required at the level proposed. The initial proposal was 12 health outreach workers and initial piloting in Ideas Stores indicates that 4 would be adequate. Whilst the outreach workers do meet a need in this setting to provide health information to local people it is not considered that the workload would warrant continued expansion particularly in the context of similar programmes such as the health trainers programme. Three have been recruited so far so this proposal would not involve redundancies.

7.9 Public health have historically set aside non recurrent funding for pilots. There are a number of pilots that are due to end in 16/17 and the same level of non-recurrent funding can no longer be used due to the significant cost pressures on the reduced public health grant. Since these programmes are one-off, time-limited pilots to test and learn from new approaches, they are not service cuts and hence are not included in the savings templates for consultation. The pilots are summarised in the table below. Lessons from these pilot projects will be applied to mainstream services going forward so that valuable findings are not lost.

Table 4 Funding for pilots ending in 16/17

Programme	**Funding**
Healthier fast food pilot	34,690
Loneliness: neighbourhood perspectives	35,141
Loneliness in Care Homes	27,049
Flourishing Minds	75,000
Digital Mental Health	33,000
Total	**204,880**

8. Risks and mitigations

8.1 The core purpose of the public health savings proposals is to mitigate the risk of overspend whilst seeking to do this in a considered way that mitigates against the risk of destabilising both established and new programmes that are delivering value for the people in Tower Hamlets.

8.2 The savings are premised on sign off at the July Cabinet - further delay would reduce savings that could be achieved in 16/17

8.3 Discussions have already taken place with a number of the providers on how the savings, if agreed, would be implemented. This may or may not have an adverse impact on the outputs that are being delivered.

That will be agreed with providers on a case by case basis and the priority will be to maintain, as far as possible, the health outcomes.

8.4 The saving of £200k proposed for acute GUM may be challenging as it requires robust negotiations through the London Sexual Health Collaborative on price with certain providers in London although initial indications suggest the saving is feasible.

8.5 Any additional risks highlighted in the consultation feedback will be addressed through the implementation process in collaboration with affected providers.

9. Consultation

9.1 A public and stakeholder consultation was carried out between 20th May and 16th June.

9.2 Over 200 responses were received through the Council web pages. The overwhelming majority of these perceived the savings to be likely to have a negative impact in the community and on health inequalities although some recognised the need to reduce budgets where funding had been removed.

9.3 A number of face to face discussions were conducted both at regular partnership or interest group meetings and at four open to the public sessions. Again the feedback was mostly of disappointment at how the public health programme would be impacted but there were some constructive conversations on how partners and service providers would work with the Council's public health team to mitigate negative impacts.

9.4 There was a strongly negative response through the consultation to the proposal to reduce funding to the breast feeding support service, even though the overall levels of savings in the maternity and early years and children and young people public health programmes are significantly below the level of savings being proposed for others areas such as smoking cessation and long term conditions. Commissioners are in discussion with Barts Health about the future funding for the service and have identified that some service efficiencies can help to achieve the saving proposed without full impact on the patient facing breast-feeding support.

9.5 Proposed savings to the Health Trainers programme, the Fit4Life (adult weight management) programme and the cancer public engagement programme all attracted concerned feedback from partner organisations such as the Local Medical Committee (LMC), and from service providers, service users and the public. Mitigations on the impacts on these programmes are set out in the savings templates in ANNEX A.

9.6 A more detailed summary of all the feedback that was received is provided in ANNEX B below.

9.7 The consultation responses have been reviewed and considered by officers and in light of the financial position of the Council and the lack of alternative options this report recommends the Mayor in Cabinet to accept the savings proposals detailed in ANNEX A below.

ANNEX A PUBLIC HEALTH SAVINGS – list of proposed savings

Full list of savings proposed for Public Health Services in 2016-17 and 2017-18					
Contract/Service Name	**Baseline contract value 2015/16 £**	**Savings Proposals 16-17 £**	**Budget in 16-17 £**	**% Reduction 16/17** (part year)	**% Reduction 17/18 (whole year)**
PH001 Healthy Place					
Health Trainers	1,099,602	110,000	989,602	10	20
Can Do Community	92,760	46,380	46380	50	100
Environmental Health Pilot - Private Rented	35,000	35,000	0	100	100
PH002 Maternity & Early Years					
Breast Feeding Support	328,031	32,800	295,231	10	20
UNICEF Baby Friendly Accreditation	143,000	18,940	124,060	18	20
Locality Parent & Infant Wellbeing Coordinators	159,845	0	159,845	0	100
Healthy Start Vitamins	55,929	7,950	47,979	14	28
Health Visiting Reserve	399,751	69,610	330,141	17	100
Brushing for Life	60,000	40,000	20,000	67	67
PH003 Children`s Health					
Healthy Families	60,000	20,000	40,000	33	33
Active Cycling in Schools	80,162	40,162	40,000	50	100
Educational Psychology	40,000	40,000	0	100	100
Child & Family Weight management	430,683	21,534	409,149	5	10
PH004 Smoking Cessation					
Tobacco Cessation Specialist	226,800	5,000	221,800	2	4
Specialist Varenicline	45,000	15,000	30,000	33	33
Tobacco Cessation - BME	213,140	5,000	208,140	2	5
Tobacco Enforcement	263,000	163,000	100,000	62	62
Pharmacy Smoking Cessation	330,000	117,000	213,000	35	41
GP NIS Smoking	194,000	14,000	180,000	7	48
Peer Education (tobacco)	80,000	80,000	0	100	100
PH005 Sexual Health					
Integrated Sexual Health - Young People	601,000	15,000	586,000	2	2
Integrated Sexual Health - CASH	1,391,600	250,000	1,141,600	18	36
Enhanced Health Promotion High Risk Groups	169,557	6,000	163,557	4	4
Living Well with HIV	49,960	2,000	47,960	4	4
Health Promotion – Commercial Sex Workers	50,000	25,000	25,000	50	100
Health Promotion Undiagnosed HIV	39,960	3,000	36,960	8	8
NELNET	10,000	10,000	0	100	100
Peer Education (sexual health)	£178,336	108,336	70,000	61	100

GUM cost containment through the London Sexual Health Commissioning Collaborative		200,000			
PH006 Long Term Conditions					
Making Every Contact Count	10,000	10,000	0	100	100
Fit 4 Life Centre	331,960	51,225	280,236	15	31
Fit 4 Life Groups	269,809	41,638	227,988	15	631
Fit 4 Life AWM	208,312	32,150	176,023	15	31
EMIS Web	25,000	9,000	16,000	36	36
Cancer Public Engagement L1	26,489	13,245	13,244	50	100
Cancer Public Engagement L2	28,000	14,000	14,000	50	100
Bowel Cancer Screening Promotion in Primary Care	40,000	40,000	0	100	100
TB Outreach	85,000	85,000	0	100	100
PH007 Staff Team					
Health outreach team	570,000	440,000	130,000	77	77
TOTAL	**8,621,686**	**2,236,970**	**6,384,716**	**26**	**40**

Non-recurrent pilot programmes	**Full pilot programme value**	**Cost in 16-17 (part year)**	**Part year saving**	**% saving in 16/17**	**% saving in 17/18**
Healthier Fast Food	64,470	34690	29,780	46	100
Loneliness: Neighbourhood Perspectives	59,822	35141	24681	41	100
Loneliness in Care Homes	60,000	27049	32,951	55	100
Private rented Housing Pilot	35,000	0	35,000	100	100
Flourishing Minds	85,000	75,000	10,000	12	100
Digital Mental Health	33,000	33,000	0	0	100
Total	**337,292**	**204,880**	**132,412**	**39**	**100**

Public Health savings proposals by programme

<table>
<tr><td rowspan="2">OPP TITLE:</td><td colspan="6">PH 001/2016-17 PUBLIC HEALTH GRANT - Healthy Communities Programme</td></tr>
<tr><td colspan="6"></td></tr>
<tr><td>DIRECTORATE</td><td colspan="6">ADULTS</td></tr>
<tr><td>SERVICE:</td><td colspan="6">PUBLIC HEALTH</td></tr>
<tr><td>Associate Director - Public Health</td><td colspan="2">Esther Trenchard-Mabere</td><td colspan="4">THEME: Healthy & Supportive Community</td></tr>
<tr><td>SAVINGS OPPORTUNITY</td><td>BASE BUDGET £000</td><td>Savings 16/17 £000</td><td>Additional Savings 17/18 £000</td><td>Total Saving</td><td>Start before June 2014</td><td>Is an EA Req?</td></tr>
<tr><td>Administrative Efficiencies</td><td>1,425,628</td><td>191,380</td><td>226,211</td><td>417,591</td><td></td><td>Yes</td></tr>
<tr><td>FTE Reductions</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="7">DETAILS OF SAVINGS OPPORTUNITY</td></tr>
</table>

1. Background

The public health aspirations of the healthy communities and healthy environment programmers are that Tower Hamlets has:

- Strong networks and partnerships connecting people, shaping services and supporting healthier lives
- Community assets (define) that are fully utilised to support health and wellbeing
- Services that are integrated by a shared commitment and approach to improving health and wellbeing
- Easy access to affordable healthy food
- Housing that is health enhancing and free from health harms
- Community assets and services promoting community cohesion and addressing abuse, violence, discrimination and the impacts of crime.

2. Current investment

The priority within this set of investments is services and initiatives supporting promotion of health and wellbeing that are produced together with local communities that build on community assets, that tackle environmental determinants of health and that have reach to the most deprived groups.

- Health Trainers - individual and group level support for residents to adopt healthier lives targeting deprived communities in greatest health need £1.1m
- Can Do Community - support to local people and groups wishing to deliver community led solutions and create healthier local environments £93k
- Food for Health – healthy food award scheme that helps improve the healthiness of the food offered by restaurants, cafes and shops £72k
- Buywell – programme aimed at improving the availability of good quality and affordable fruit and vegetables in convenience stores and markets in Tower Hamlets £49k
- Healthier fast food pilot £35k (non-recurrent - programme ending 16/17)
- Private rented housing pilot - EHO scheme £35k (non-recurrent - programme ending 16/17)
- Loneliness: neighbourhood perspectives £35k (non-recurrent - programme ending 16/17)
- Food growing network (a network of allotments and community growing sites that public health supports to promote healthier lives) £8.3k

3. Proposed budget reductions 16/17 and 17/18

- Health Trainers (£1.1m) reduced by £110k and further reduction £110k in 17/18
- Can Do community development (£93k) reduced by £46k and further £46k in 17/18

4. For review in Phase 2:

- Buywell (£49k)

IMPLICATIONS

The physical, social and economic environments in which we live and work are important for health. Public health will continue to invest in activity that helps to make Tower Hamlets a healthier place for example working with food retailers to deliver healthy food and continuing to support the Health Trainer organisations to engage with local people on how they can maintain good health or access the right type of support when they need it.

Health Trainers (£1.1m) reduced by £110k and further reduction of £110k in 17/18

Health Trainers help people to maintain good health - e.g. helping people to eat healthier diets and increase their level of physical activity - together with assessment and signposting to other appropriate services. The Health Trainers provide a service to local residents who want to adopt healthier lives but who have little contact with services. Reduction in the service will mean a reduction in the numbers of people that can be helped by the service.

The implications are that the reduction of Health Trainer funding will result in the following reductions per year (full year effect):

- 1600 fewer new contacts with people out of a target 8,000 per year who are then given health promotion information/signposted to appropriate services
- 960 fewer people participating in healthy living group activities out of a target 4,400 in total
- 320 less people supported with a 1-1 intervention out of a target 1,600 in total.

Health Trainers currently significantly exceed the target numbers set out above so although there will be a reduction in the numbers engaged this should not have a damaging impact on the ability of residents to access the service. The service will continue to be monitored to ensure that it is targeted towards highest need groups within the population. Finally, synergies with the Health Outreach worker programme may also mitigate reductions in outputs.

Can Do community development reduced by £46k and further £46k in 17/18

This programme aims to provide support to local people and groups wishing to deliver community led activities to help overcome the barriers to healthy eating, active lives, mental wellbeing and creating healthy environments. The programme addresses these barriers through individual projects and also supports the development of local community leaders, as part of developing a social movement for better health in Tower Hamlets. The evidence for the sustainability of the projects and for significant health impacts is not fully evidenced and therefore it is proposed to discontinue the public health grant funding to the programme; the voluntary sector organisations that deliver the programme may seek alternative funding.
The implications are that the cessation of the Can Do programme will result in:

- 9 fewer community led projects successfully delivered
- Estimated reduction of 300 beneficiaries each year so the number would be reduced to 150 in 2016-17 and to zero in 2017-18

However, given the limited evidence of the impact of this programme, the proposal is that this is not the most effective use of public health funding when the overall budget is becoming more restricted.

The reductions in the Health Trainer and Can Do budgets are expected to have a half year effect in 2016-17 and a full year effect in 2017-18.

EQUALITIES SCREENING

TRIGGER QUESTIONS	YES/NO	IF YES - please provide further details on how this impacts on each equalities groups
Does the change affect who provides the service?	**Possible**	This is not anticipated, but it is possible current providers may decline to continue to provide Health Trainers on the proposed reduced contracts
Does the change reduce resources available to address inequality?	Yes	The projects are aimed at people less likely to already be using services and these are often those suffering from higher levels of deprivation and consequently poorer health outcomes. A reduction in service could therefore disproportionately affect these groups. The remaining services e.g. Health Trainers, will be supported to target work on the most vulnerable groups and individuals.
Does the change impact on local suppliers?	Yes	Can Do and Health Trainers are run by local providers so this will impact on their revenue streams.

Does the change impact on the Third Sector?	Yes	Can Do and Health Trainers are run by providers in the voluntary and not for profit sector so this will impact on their revenue streams.
Does the change reduce resources available to support vulnerable residents?	Yes	The projects are aimed at people less likely to already be in touch with services and these are often those suffering from higher levels of deprivation and consequently poorer health outcomes. A reduction in service could therefore disproportionately affect these groups. The remaining services e.g. Health Trainers, will be supported to target work on the most vulnerable groups and individuals.
CHANGES TO A SERVICE		
Does the change alter who is eligible for the service?	No	
Does the change alter access to the service?	Yes	The Can Do programme will stop and there will be a reduction in capacity for the Health Trainers so fewer sessions are likely to be run and with fewer people supported to make healthier choices.
Does the change involve revenue raising?	No	
Does the change involve a reduction or removal of income transfers to service users?	No	
Does the change affect who provides the service, i.e. outside organisations?	Possible	Current providers may decline to continue to provide Health Trainers with reduced budgets, in which case services would need to be reprocured
Does the change involve direct impact on front line services?	Yes	Health Trainers are the main primary prevention service for adults funded by public health, helping people to eat healthier diets and increase their level of physical activity, together with assessment and signposting to other appropriate services. Health Trainers, will be supported to target work on the most vulnerable groups and individuals.
CHANGES TO STAFFING		
Does the change involve a reduction in staff?	Yes	Providers of Health Trainers may deliver reduced service by reducing numbers of staff. Staff employed on Can Do, will no longer be working on this project and current providers may terminate their employment. In both case these are not directly employed by the council.
Does the change involve a redesign of the roles of staff?	No	

Budget Savings Proposals
Full Equality Analysis – Healthy Communities

Section 1: General Information

1a) Name of the savings proposal
Public Health Grant Savings – Healthy Communities

1b)Service area
Public Health

1c) Service manager
Tim Madelin

1d) Name and role of the officer/s completing the analysis

Tim Madelin – Healthy Communities and Environment Lead
Keith Williams - Public Health Commissioning Programme Manager
Susie Crome - Public Health Locality Manager

Section 2: Information about changes to services

2a) In brief please explain the savings proposals and the reasons for this change

In the first phase of savings plans, public health has been required to make £2.3million savings from the public health grant in response to reductions in the level of grant by central government. Public Health has considered how to make the savings with the minimum impact on population health and least exacerbation of health inequalities using a priority-based approach. In relation to Health trainers the proposal is to reduce the £1.1m budget by £110k in 16/17 and a further reduction of £110k in 17/18.

Health Trainers help people to maintain good health - e.g. helping people to eat healthier diets and increase their level of physical activity - together with assessment and signposting to other appropriate services. The Health Trainers provide a service to local residents who want to adopt healthier lives but who have little contact with services. Reduction in the service will mean a reduction in the numbers of people that can be helped by the service.

The implications are that the reduction of Health Trainer funding will result in the following reductions per year (full year effect):

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Health Trainers currently significantly exceed the target numbers set out above so there will be a reduction in the numbers engaged this may have a damaging impact on the ability of residents to access the service. The service will continue to be monitored to ensure that it is targeted towards highest need groups within the population. Finally, synergies with the Health Outreach worker programme may also mitigate reductions in outputs.

2b) What are the equality implications of your proposal?
All savings proposals have been screened for equalities relevance using the test of relevance questionnaire attached (Appendix A).

The Health Trainers have disproportionately more people of Bangladeshi ethnicity as clients, a group which has higher levels of deprivation and children in poverty. The service sees more women than men. They see a lower proportion of people with disabilities although this is not entirely surprising as many of their sessions relate to physical activity and there is a disability targeted service Ability Bow that deals with this group.

The main census only gives the option of a binary gender distinction but the service has recorded clients who

identify as transgender, a notable achievement given the cultural barriers and difficulties around this issue. In terms of sexual identity the services sees a similar proportion of people identifying as heterosexual but has higher rates of people declining to answer which suggest they is more work to be done in the area, see later for a fuller description. Similarly religion is not well recorded.

The Health Trainers see more people in the 35-59 age range compared to their proportion in the community, this is important as people who develop long term conditions do so after age 35 so increasing physical activity and improving diet is important in these age ranges. The service also attracts people disproportionally from the most disadvantaged areas, who statistically are likely to suffer poorer health outcomes.

Section 3: Equality Impact Assessment

With reference to the analysis above, for each of the equality strands in the table below please record and evidence your conclusions around equality impact in relation to the savings proposal.

Please list in the table below any adverse impact identified and, where appropriate, steps that could be taken to mitigate this impact. This analysis will inform the decision making process

If you consider it likely that your proposal will have an adverse impact on a particular group (s) and you cannot identify steps which would mitigate or reduce this impact, you will need to demonstrate that you have considered at least one alternative way of delivering the change which has less of an adverse impact.

If an adverse impact cannot be mitigated please describe an alternative option, its costs and the equality impact.

Target Groups What impact will the proposal have on specific groups of service users and staff?	**Impact – Positive or Adverse**	**Reason(s)** • Please add a narrative to justify your claims around impacts and, • Please describe the analysis and interpretation of evidence to support your conclusion as this will inform members decision making
Race	Adverse	The health trainers have disproportionately more people of Bangladeshi ethnicity as clients, a group which has higher levels of deprivation and children in poverty.

Ethnicity	**Service Data 15/16**	**% (excluding not stated)**	**Tower Hamlets ***
A: White - British	604	14.1%	31.2%
B: White - Irish	33	0.8%	1.6%
C: Other White Background	165	3.8%	12.4%
D: Mixed - White and Black Caribbean	63	1.5%	1.1%
E: Mixed - White and Black African	47	1.1%	0.6%
F: Mixed - White and Asian	14	0.3%	1.2%
G: Mixed - Any Other Mixed Background	40	0.9%	1.2%
H: Asian or Asian British - Indian	64	1.5%	2.7%
I: Asian or Asian British - Pakistani	64	1.5%	1.0%
J: Asian or Asian British - Bangladeshi	2487	58.0%	32.0%
K: Any Other Asian Background	25	0.6%	2.3%
L: Black or Black British - Caribbean	189	4.4%	3.7%
M: Black or Black British - African	271	6.3%	2.3%
N: Any Other Black Background	39	0.9%	1.5%
O: Chinese	31	0.7%	3.2%

<table>
<tr><td></td><td></td><td>
<table>
<tr><td>P: Any Other Ethnic Group</td><td>151</td><td>3.5%</td><td>2.3%</td></tr>
<tr><td>Z: Not Stated</td><td>677</td><td></td><td></td></tr>
<tr><td></td><td>4964</td><td></td><td></td></tr>
</table>
*Census 2011
</td></tr>
<tr><td>Disability</td><td>Neutral</td><td>
They see a lower proportion of people with disabilities although this is not entirely surprising as many of their sessions relate to physical activity and there is a disability targeted service Ability Bow that deals with this group.
<table>
<tr><th>Disability</th><th>Service Data 15/16</th><th>% (excluding not stated)</th><th>Tower Hamlets*</th></tr>
<tr><td>Not recorded</td><td>3467</td><td></td><td></td></tr>
<tr><td>Disabled</td><td>110</td><td>7.3%</td><td>13.5%</td></tr>
<tr><td>Not disabled</td><td>1387</td><td>92.7%</td><td>86.5%</td></tr>
<tr><td></td><td>4964</td><td>100.0%</td><td>100.0%</td></tr>
</table>
*Census 2011 – Day to Day activities limited a little (6.8%) or a lot (6.3%)
</td></tr>
<tr><td>Gender</td><td>Adverse</td><td>
The service sees a higher proportion of women than men.
<table>
<tr><th>Gender</th><th>Count</th><th>Percent</th><th>Tower Hamlets</th></tr>
<tr><td>Female</td><td>3684</td><td>74.21%</td><td>48.5%</td></tr>
<tr><td>Male</td><td>1268</td><td>25.54%</td><td>51.5%</td></tr>
<tr><td>Other</td><td>12</td><td>0.24%</td><td></td></tr>
<tr><td></td><td>4964</td><td>100.00%</td><td></td></tr>
</table>
*Census 2011 – note only allowed male or female
</td></tr>
<tr><td>Gender Reassignment</td><td>Neutral</td><td>
The main census only gives the option of a binary gender distinction but the service has recorded clients who identify as transgender, a notable achievement given the cultural barriers and difficulties around this issue. There is no evidence to suggest that there is disproportionate need for these services among the gender reassignment population.
<table>
<tr><th>Gender Reassignment</th><th>Service Data 15/16</th><th>Percent</th></tr>
<tr><td>Not recorded</td><td>4077</td><td>82.13%</td></tr>
<tr><td>No</td><td>875</td><td>17.63%</td></tr>
<tr><td>Yes</td><td>12</td><td>0.24%</td></tr>
<tr><td></td><td>4964</td><td>100.00%</td></tr>
</table>
No ONS estimate of transgender - Reed, B., Rhodes, S., Schofield, P. and Wylie, K (2009) Gender Variance in the UK: Prevalence, Incidence, Growth and Geographic Distribution Gender Identity Research in Education Society estimate 0.6% prevalence
</td></tr>
<tr><td>Sexual Orientation</td><td>Neutral</td><td>
In terms of sexual identity the services sees a similar proportion of people identifying as heterosexual but has higher rates of people declining to answer which suggest they is more work to be done in the area There is no evidence to suggest that there is disproportionate need for these services among the LGBT population.
<table>
<tr><th>Sexuality</th><th>Service Data 15/16</th><th>% (excluding not recorded)</th><th>Tower Hamlets*</th></tr>
</table>
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</table>

Not recorded	3761		
Bisexual	1	0.1%	0.7%
Did not wish to disclose	160	13.3%	6.1%
Gay & Lesbian	6	0.5%	1.9%
Heterosexual	1036	86.1%	89.0%
	4964	**100.00%**	

*ONS – Integrated Household Survey 2014

Religion or Belief	Neutral	There is no evidence to suggest that there is disproportionate need for these services among any religious groups in the borough.

Religion	Service Data 15/16	% (excluding not recorded)	Tower Hamlets*
Not recorded	3667	73.87	
B: Buddhist	3	0.06%	1.1%
C: Christian	118	2.38%	27.1%
D: Hindu	9	0.18%	1.7%
F: Jewish	2	0.04%	0.5%
G: Muslim	942	18.98%	34.5%
I: Sikh	7	0.14%	0.3%
K: Other	20	0.52%	0.3%
L: None	80	1.61%	19.1%
M: Declines to Disclose	71	1.43%	
N: Client Religion Unknown	39	0.79%	15.4%
	4964	**100.00%**	

*Census 2011

Age	Adverse	The health trainers see more people in the 35-59 age range compared to their proportion in the community, this is important as people who develop long term conditions do so after age 35 so increasing physical activity and improving diet is important in these age ranges.

Age

Age-band (DH)	Service Data 15/16	Percent	Tower Hamlets*
Not recorded	1	0.02%	
Declined	680	13.70%	
18 - 34	1334	26.87%	55.8%
35 - 44	1225	24.68%	18.7%
45 - 59	1140	22.97%	14.7%
60 and over	584	11.76%	10.8%
	4964	**100.00%**	

*Census 2011

Socio-economic	Adverse	The service also attracts people disproportionally from the most disadvantaged areas, who statistically are likely to suffer poorer health outcomes.

Deprivation Quintiles	Service Data 15/16	Percent	Tower Hamlets*

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<tr>
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<table>
<tr><td>No fixed abode</td><td>15</td><td>0.30%</td><td></td></tr>
<tr><td>Not recognised</td><td>431</td><td>8.68%</td><td></td></tr>
<tr><td>Q1 - Most deprived</td><td>3756</td><td>75.66%</td><td>69.7%</td></tr>
<tr><td>Q2</td><td>502</td><td>10.11%</td><td></td></tr>
<tr><td>Q3</td><td>223</td><td>4.49%</td><td></td></tr>
<tr><td>Q4</td><td>27</td><td>0.54%</td><td></td></tr>
<tr><td>Q5 - Least deprived</td><td>10</td><td>0.20%</td><td></td></tr>
<tr><td></td><td>4964</td><td>100.00%</td><td></td></tr>
</table>
*IMD 2010 – extend of deprivation % population in most deprived 20% of LSOAs
</td>
</tr>
<tr>
<td>Marriage and Civil Partnerships.</td>
<td>Neutral</td>
<td>
There is no evidence to suggest that there is disproportionate need for these services among any relationship groups in the borough.
<table>
<tr><th>Relationship Status</th><th>Service Data 15/16</th><th>% (excluding not recorded)</th><th>Tower Hamlets*</th></tr>
<tr><td>Not recorded</td><td>3671</td><td></td><td></td></tr>
<tr><td>Divorced / Person whose Civil Partnership has been</td><td>18</td><td>1.39%</td><td>4.86%</td></tr>
<tr><td>Married / Civil Partner</td><td>636</td><td>49.19%</td><td>30.27%</td></tr>
<tr><td>Not disclosed</td><td>386</td><td>29.85%</td><td></td></tr>
<tr><td>Separated</td><td>11</td><td>0.85%</td><td>6.22%</td></tr>
<tr><td>Single</td><td>224</td><td>17.32%</td><td>44.70%</td></tr>
<tr><td>Widowed / Surviving Civil Partner</td><td>18</td><td>1.39%</td><td>3.64%</td></tr>
<tr><td></td><td>4964</td><td>100.00%</td><td></td></tr>
</table>
*Census 2011
</td>
</tr>
<tr>
<td>Pregnancy and Maternity</td>
<td>Neutral</td>
<td>There is no evidence to suggest that there is disproportionate need for these services among pregnant and new mothers groups in the borough.</td>
</tr>
<tr>
<td>Other</td>
<td></td>
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</table>

Section 4: Equality Impact Assessment Action Plan

Adverse impact	Please describe the actions that will be taken to mitigate this impact
Race, gender, age and Socio-economic	The service is a universal access service and the impact comes from the reduction in activity which will affect these groups that use the service disproportionately more. Explore the possibilities of the emerging social prescribing and volunteering initiatives of the Tower Hamlets Together programme to mitigate this loss of activity.

Section 5: Future Review and Monitoring

Please explain how and when the actual equality impact of these changes will be reviewed and monitored. Services will continue to be monitored as part of contract monitoring.

OPP TITLE:	PH 002/2016-17 PUBLIC HEALTH GRANT - Maternity & Early Years Programme					
DIRECTORATE	ADULTS					
SERVICE:	PUBLIC HEALTH				LEAD OFFICER: Simon Twite	
Associate Director - Public health	Esther Trenchard-Mabere		THEME:	Healthy & Supportive Community		
SAVINGS OPPORTUNITY	BASE BUDGET £000	Savings 16/17 £000	Additional Savings 17/18 £000	Total Saving		Is an EA Req?
Administrative Efficiencies	8,720,856	169,300	540,202	709,502		Yes
FTE Reductions						

DETAILS OF SAVINGS OPPORTUNITY

1. Background

The public health aspirations for healthy early years are that 0-5 year olds have:

- Secure social and emotional attachment
- Good cognitive development
- Healthy eating habits
- Good oral health
- Good levels of social and physical activity and development
- Protection from infectious diseases
- Good health outcomes through early identification of need and access to early help
- Freedom from abuse or neglect
- Parents or carers with life skills for health and wellbeing through critical early years life stages e.g. pregnancy, infanthood, weaning, bonding, transitioning to school age

2. Current investment

Developing the foundations for health and wellbeing in early years is a particularly high priority due to the strong evidence that good health in early years has a lifelong impact. The total investment in this area each year is £8.7m covering the following:

- Health Visiting - a workforce of specialist community public health nurses who provide expert advice, support and interventions to families with children in the first years of life (£6.8m)
- Health Visiting Growth Fund (£400k)
- Children`s Centres (£1m)
- Family Nurse Partnership - a licensed service of specially trained family nurses who provide extra support to vulnerable, first time mothers aged 19 years and under (£550k)
- Breast Feeding Support a borough-wide breastfeeding support service that complements the Royal London Hospital maternity service (£328k)
- Unicef Baby Friendly – a programme to maintain UNICEF Baby Friendly accreditation in hospital and community settings (£143k)
- Locality Parent and Infant Wellbeing Coordinators – supports a team of peer supporters / volunteers to provide support for local parents and carers during pregnancy and the first year of the baby's life (£160k)
- Healthy Start Vitamins - a programme to increase distribution and uptake of Healthy Start Vitamins for all pregnant women and children under 4 (£55k)
- Healthy Eating and Physical Activity – enables enable parents and carers to provide healthy food for their families and provides exploratory physical activity for their children (£54k)
- Healthy Early Years supports the accreditation of children`s centres as Healthy Early Years centres (£50k)
- Healthy Teeth in Schools – a fluoride varnish programme in schools to reduce tooth decay (£160k)
- Brushing for Life (£60k) – provides free toothbrushes and fluoride toothpaste for families with children in nurseries and children's centres

3. Proposed budget reductions 16/17 and 17/18

- Health Visiting Growth Funding (£400k) - reduce by £69.6k (16/17) and a further £330.1k (17/18)
- Breast Feeding Support (£328k) - reduce by £32.8k (16/17)and a further £32.8k (17/18
- Unicef Baby Friendly (£143k) - reduce by £19.0k (16-17) and a further £9.6k (17/18)
- Locality Parent /Infant Wellbeing Coordinators (£160k) - reduce by £160k (17/18)
- Healthy Start Vitamins (£55k) - reduce by £8.0k (16/17) and a further £8.0k (17/18)
- Brushing for Life(£60k) reduced by £40k from 16-17

4. For review in phase 2

- Children`s Centres (£1m) - review in phase 2
- Family Nurse Partnership (£550k) - review in phase 2
- Healthy Eating and Physical Activity (£54k) - review in phase 2
- Healthy Early Years (Children`s Centre Accreditation) - (£50k) - review in phase 2

IMPLICATIONS
(Summarise impact on services provided, service users and health outcomes. Outline any risks to achievement of the saving.)

The proposed savings are to a group of services commissioned by Public Health to ensure the health of expectant mothers and their infants is protected and improved in line with National Institute for Clinical Excellence (NICE) guidance. This highlights the importance of maternal and child nutrition and the positive impact of health and development reviews, health promotion, parenting support, screening and immunisation programmes upon the health of children and families as set out in the national Healthy Child Programme 0-5.

Health Visiting Growth Funding (£400k) - reduce by £69.6k and further £330,1k in 17/18

This is the funding allocated to increase the numbers of health visitors from its current baseline (£6.76m) towards target and in 16/17 most of it will be required to enable the smooth transition of the Health Visiting Team into the new service starting April 2016..

The implications of reducing the funding in 17/18 are that the Health Visitor workforce will not increase significantly above the current 83 qualified health visitors which have already been recruited. However,83 qualified health visitors is a significant increase on the number that have been available in previous years and an improved service is anticipated from the new contract that started on 1st April 2016.

Breast Feeding Support (£328) - reduce by £32.8k in 16/17 and further £32.8k in 17/18

This service aims to increase the number of Tower Hamlets mothers who have a meaningful antenatal/postnatal contact with a member of the Tower Hamlets breastfeeding service or UNICEF Baby Friendly Coordinator at the Royal London Hospital or in community/home settings and to build the capacity of the breastfeeding volunteer peer support service. It is anticipated that staff numbers would reduce by approximately 2 whole time equivalent posts from the current 8 to 6 support workers.

The implications are that the number of mothers that can be supported with breast-feeding would be reduced by up to 660 in 2017-18 out of a total of 3,300 supported each year. Support will be targeted particularly on mothers in the most vulnerable groups in order to reduce the adverse health inequality impact.

UNICEF Baby Friendly (£143k) - reduce by £26.0k in 16/17 and further £2.4k in 17/18

The service supports UNICEF Baby Friendly Accreditation to ensure that hospital and community- based services such as primary care clinics provide an environment that actively supports and promotes breastfeeding. The proposed savings are to the training budget.

This service supports maternity services, health visitors and children`s centres to provide a baby friendly service that is accredited in line with the UNICEF standard and no significant impact is anticipated on the provision of this support.

Locality Parent/Infant Wellbeing Coordinators (£160k) reduce by £26.6k in 16/17 and by a further £133.2k in 17/18

The aim of the services to train and support four locality networks of peer supporters (volunteers) to support the emotional health and wellbeing of parents/carers and their babies up to the first year of life. This is a pathfinder

project running for 2 years; the contract end date is January 2017 meaning that whilst this will be funded in 2015/16 – 2016/17 this will not continue into 2017-18.

The implications are that the pilot will not continue but the learning from the programme will feed into other volunteer projects and the pool of volunteer peer supporters that has been established will continue to have a positive impact within the community and be supported through the Health Visitor locality teams.

Healthy Start Vitamins (£55k) reduce by £8k in 16/17 and further £8k in 17/18

The aim of the service is to improve the nutritional status and in particular prevent Vitamin D deficiency in pregnant women and children under 4 years. Provision of the service through community pharmacies has not worked as well as hoped and review indicates that it could be delivered at lower cost in house.

The implications are therefore minimal as transferring the service in house will maintain the numbers reached at lower cost.

Brushing for Life (60k) reduced by £40k in 2016-17

Brushing for Life is a programme aimed at preventing tooth decay in children under five. Brushing for Life provides tubes of fluoride toothpaste and a child's toothbrush in a pack which also contains educational material for the child, parents and carers. Our priority is to maintain the Healthy Teeth in Schools programme (fluoride varnish), which has been achieving increasing coverage of the cohort in Reception and Year 1 and has a stronger evidence base.

The reduction to the Brushing for Life programme can be absorbed without a major impact on the outcomes as it is intended to secure the supplies at lower cost and there are also other funding streams that children's centres can access to purchase the supplies in some cases, so a very limited overall impact is anticipated.

EQUALITIES SCREENING		
TRIGGER QUESTIONS	**YES/NO**	IF YES - please provide further details on how this impacts on each equalities groups
Does the change affect who provides the service?	Yes	Healthy Start Vitamins - service brought in house and potentially delivered through Children`s Centres. There is potential for the service to be more responsive to community and locality needs as well as reducing the cost.
Does the change reduce resources available to address inequality?	Yes	There is a potential reduction in staff delivering support for key early year's primary prevention (such as increasing in breast feeding rates). It is hoped to minimise the impact on face to face support through efficiencies in service delivery. There is also a reduced *future* staff capacity for universal support for expectant mothers and mothers of children aged 0-5 (Health Visiting) which may have a small impact on women of childbearing age and children aged 0-5. Targeted support to the more vulnerable families will be maintained or increased.
Does the change impact on local suppliers?	Yes	In some affected services shown above there is a need to reduce the contract value. The change is being phased over two years and we will seek to mitigate the impact where possible.
Does the change impact on the Third Sector?	Yes	The proposed savings from the mainstream programmes have explicitly avoided impacting on the local voluntary sector. However, three voluntary sector providers are currently delivering the Parent and Infant Support Coordinators pilot programme and if, as recommended this does not continue beyond the end of the current contract they would be affected. Public Health intends to take forward the learning from the pilot through other contracts.
Does the change reduce resources available to support vulnerable residents?	Yes	Loss of future staffing potential within the Health Visiting Service may impact on women of childbearing age and children aged 0-5 but an increase in the numbers of Health Visitors from the current position is still anticipated. There is a strong concern from the public consultation that support for breast feeding mothers would be impacted but it is hoped to minimise this through efficiencies within the service that enable the focus on face to face contact with mothers to be maintained.

CHANGES TO A SERVICE		
Does the change alter who is eligible for the service?	No	
Does the change alter access to the service?	Yes	Not substantially but where resources are reduced this may lead to a reduction in access.
Does the change involve revenue raising?	No	
Does the change involve a reduction or removal of income transfers to service users?	No	
Does the change affect who provides the service, i.e. outside organisations?	Yes	The proposed savings to the Universal Healthy Start Vitamins Scheme will affect who provides the service with the service being brought in house from the current provider (Barts Health).
Does the change involve direct impact on front line services?	Yes	Proposed savings to the UNICEF Baby Friendly/breast feeding support service will potentially impact on front line services but this will be minimised through a reduction of administrative tasks. Loss of funding will prevent the continuation of the Locality Parent & Infant Wellbeing pathfinder.
Does the change involve a reduction in staff?	Yes	The proposed savings to the breast feeding support service have the potential to lead to a staff reduction (or role redesign), although it is ultimately the responsibility of the provider (Barts Health) to decide how savings are made.
Does the change involve a redesign of the roles of staff?	Yes	The proposed savings to the breast feeding support service have the potential to lead to role redesign (or a staff reduction), although it is ultimately the responsibility of the service provider (Barts Health) to decide how to maintain service delivery within a reduced budget.

Budget Savings Proposals
Full Equality Analysis – Maternity and Early Years Programme

Section 1: General Information

1a) Name of the savings proposal
Public Health Maternity and Early Years Programme

1b)Service area
Public Health

1c) Service manager
Esther Trenchard-Mabere

1d) Name and role of the officer/s completing the analysis

Sumaira Tayyab, Public Health Advisor;
Simon Twite, Senior Public Health Strategist

Section 2: Information about changes to services

2a) In brief please explain the savings proposals and the reasons for this change

In the first phase of savings plans, LBTH Public Health has been required to make £2.3million savings from the public health grant. Overall, the principle has to been to preserve investment in early years as far as possible as this is where the strongest evidence is around long term health impact. In prioritising the £2.3m savings proposed the aim has been to identify those areas where public health investment has the greatest impact on population health and addressing health inequalities, and those where the impacts are least, to ensure proposals for savings are based on a robust and consistent set of criteria.

Developing the foundations for health and wellbeing in early years is a particularly high priority due to the strong evidence that good health in early years has a lifelong impact. The total investment in this area each year is £8.7m. From that base budget we are proposing a saving of £176,393 in 2016/17 and a full year saving of £549,657 in 2017/18:

- Health Visiting Growth Funding (£400k) - reduce by £69.6k (16/17) and a further £330.1k (17/18)
- Breast Feeding Support (£328k) - reduce by £32.8k (16/17) and a further £32.8k (17/18)
- UNICEF Baby Friendly (£143k) - reduce by £19.0k (16-17) and a further £2.4k (17/18)
- Healthy Start Vitamins (£55k) - reduce by £8.0k (16/17) and a further £8.0k (17/18)
- Brushing for Life(£60k) reduced by £40k from 16-17

Public Health have historically set aside non-recurrent funding for pilots. One pilot project within this programme area is due to end in 16/17 and the same level of non-recurrent funding can no longer be set aside to continue pilot programmes due to the significant cost pressures on the reduced public health grant. The cost of delivering the pilot is £159,845 (2016/17).

2b) What are the equality implications of your proposal?

All savings proposals have been screened for equalities relevance using the test of relevance questionnaire attached (Appendix A).

TRIGGER QUESTIONS	YES/NO	IF YES - please provide further details on how this impacts on each equalities groups
Does the change affect who provides the service?	Yes	Healthy Start Vitamins - service brought in house and potentially delivered through Children`s Centres. There is potential for the service to be more responsive to community and locality needs as well as reducing the cost.
Does the change reduce	Yes	There is a potential reduction in staff delivering support

resources available to address inequality?		for key early year's primary prevention (such as increasing in breast feeding rates). It is hoped to minimise the impact on face to face support through efficiencies in service delivery. There is also a reduced *future* staff capacity for universal support for expectant mothers and mothers of children aged 0-5 (Health Visiting) which may have a small impact on women of childbearing age and children aged 0-5. Targeted support to the more vulnerable families will be maintained or increased.
Does the change impact on local suppliers?	Yes	In some affected services shown above there is a need to reduce the contract value. The change is being phased over two years and we will seek to mitigate the impact where possible.
Does the change impact on the Third Sector?	Yes	The proposed savings from the mainstream programmes have explicitly avoided impacting on the local voluntary sector. However, three voluntary sector providers are currently delivering the Parent and Infant Support Coordinators pilot programme and if, as recommended this does not continue beyond the end of the current contract they would be affected. Public Health intends to take forward the learning from the pilot through other contracts.
Does the change reduce resources available to support vulnerable residents?	Yes	Loss of future staffing potential within the Health Visiting Service may impact on women of childbearing age and children aged 0-5 but an increase in the numbers of Health Visitors from the current position is still anticipated. There is a strong concern from the public consultation that support for breast feeding mothers would be impacted but it is hoped to minimise this through efficiencies within the service that enable the focus on face to face contact with mothers to be maintained.

Health Visiting Growth Fund: The implications of reducing the funding in 17/18 are that the Health Visitor workforce will not increase significantly above the current 83 qualified health visitors which have already been recruited. However, 83 qualified health visitors is a significant increase on the number that have been available in previous years and an improved service is anticipated from the new contract that started on 1st April 2016.

Breastfeeding Service: Performance data shows that on average, support is provided to 942 women by the service annually. The service was introduced to promote breastfeeding and its long term benefits for both mother and child and to help reduce bottle feeding and the associated negative impacts on the long term health of a child. Quarterly reporting shows the service is highly regarded by all users and fellow healthcare professionals. The service works to inform choice of feeding from the antenatal period through to one year postnatal and the groups are always oversubscribed. The current budget has allowed the service to run new groups in areas where rates of breastfeeding are low and groups targeted at key influences on a mother's likelihood to exclusively breastfeed (such mothers, mother in laws and grandmothers) and the reduction in budget will lead to a loss of groups where need is high. The figures below indicate the ethnicity of service users for Q3 (2015/2016).

Bangladeshi	39%
White-British	13%
European, Other, Mixed (not Eastern)	11%
Asian	4%
African	7.5%
Caribbean	2%
Eastern European	3%
Chinese	2%
Unknown	11%

Unicef Baby Friendly: This is a non-public facing service, delivering training to healthcare professionals and working towards maintaining the Unicef BFI standards in the acute and community setting.

Universal Healthy Start Vitamin programme: The purpose of this programme is to increase uptake of Healthy Start vitamins by the relevant population by providing free Healthy Start vitamins to those of the whole population of women (pregnant and 1 year post natal) and children (0-4 years) who are NOT

eligible for the national scheme.

Data from the provider suggests that introduction of the universal vitamins has resulted in higher than anticipated local uptake and a fall in the national programme uptake (i.e. people eligible for the national scheme (funded by central Government) are applying for the local universal scheme rather than going through the application process for the national scheme). This has local financial implications because the local provision of vitamins for women/children not eligible for the national scheme is funded through the Public Health grant. In addition, families eligible for the national scheme (those in greatest financial need) are missing out on the fruit and vegetable coupons component of the Healthy Start programme (worth £3.10/week per child). The proposed changes will enable greater oversight and linkage of data to ensure that resources are targeted more effectively.

Brushing for Life: Brushing for Life is a programme aimed at preventing tooth decay in children under five. Brushing for Life provides tubes of fluoride toothpaste and a child's toothbrush in a pack which also contains educational material for the child, parents and carers. Our priority is to maintain the Healthy Teeth in Schools programme (fluoride varnish), which has been achieving increasing coverage of the cohort in Reception and Year 1 and has a stronger evidence base for impacting upon oral health.

The reduction to the Brushing for Life programme can be absorbed without a major impact on the outcomes as it is intended to secure the supplies at lower cost and there are also other funding streams that children's centres can access to purchase the supplies in some cases, so a very limited overall impact is anticipated.

Section 3: Equality Impact Assessment

Target Groups What impact will the proposal have on specific groups of service users and staff?	**Impact – Positive or Adverse**	**Reason(s)** • Please add a narrative to justify your claims around impacts and, • Please describe the analysis and interpretation of evidence to support your conclusion as this will inform members decision making
Race	Neutral Adverse Neutral Positive Neutral	*Health Visiting Growth Funding*: Impact is on future growth, not on currently commissioned activity. *Breastfeeding Service*: Local evidence suggests that rates of mixed feeding are high in Tower Hamlets and continued targeted work is needed to address this. Proposal will potentially lead to a reduction in capacity which will have an impact. *UNICEF Baby Friendly*: Not public facing, no impact. *Universal Healthy Start Vitamins*: Targeted promotion is needed to raise awareness and increase uptake within BME communities in Tower Hamlets. Delivering the service from Children's Centres will allow significantly more awareness raising and support for expectant eligible mothers/mothers of both the importance of vitamin supplementation in pregnancy and of the national Healthy Start scheme. *Brushing for Life*: Provision of toothbrush and promotional material. Weak evidence of impact, alternative funding sources exist.
Disability	Neutral	There is no evidence to suggest that there is disproportionate need for these services among people who are disabled.
Gender	Neutral Adverse Neutral Positive Neutral	*Health Visiting Growth Funding:* impact is on future growth, not on currently commissioned activity. *Breastfeeding Service*: Primarily aimed at women as primary care giver. Service volunteers tend to be mothers who have used the service and this may be under threat as women may feel there are fewer opportunities for them to become breastfeeding support workers, as staff reduction may be inevitable. *UNICEF Baby Friendly*: Not public facing, no direct impact. *Universal Healthy Start Vitamins*: Women are the primary beneficiaries. Delivering the service from Children's Centres will allow significantly more awareness raising and support for eligible expectant mothers/ mothers of both the importance of vitamin supplementation in pregnancy and of the national Healthy Start scheme. *Brushing for Life*: Provision of toothbrush and promotional material. Weak evidence of impact, alternative funding sources exist.
Gender Reassignment	Neutral	There is no evidence to suggest that there is disproportionate need for these services among the population who have undertaken or are seeking gender reassignment
Sexual Orientation	Neutral	There is no evidence to suggest that there is disproportionate need for these services among the LGBTQ population.

Religion or Belief	Neutral Adverse Neutral Positive Neutral	*Health Visiting Growth Funding*: impact is on future growth, not on currently commissioned activity. *Breastfeeding Service*: Local evidence has suggested that in some extended families where living space is restricted, new mothers are choosing to opt for bottle feeding for lack of privacy and family duties. Current groups and the one to one support provided address these issues and help women to breastfeed with practical solutions and raising awareness of the importance of breastfeeding amongst extended families. Proposal will potentially lead to a reduction in capacity which will have an impact. *UNICEF Baby Friendly*: Not public facing, no direct impact. *Universal Healthy Start Vitamins*: Local evidence has shown that Muslim families may be reluctant to take nutritional supplements due to the makeup of the tablets. Targeted intervention is necessary as the risk of vitamin D deficiency is higher in this population due to cultural reasons. Locating the service within a community setting will enable better targeting of promotion activity. *Brushing for Life*: Provision of toothbrush and promotional material. Weak evidence of impact, alternative funding sources exist.
Age	Neutral Adverse Neutral Positive Neutral	*Health Visiting Growth Funding*: impact is on future growth, not on currently commissioned activity. *Breastfeeding Service*: Some evidence that young women are less likely to breastfeed due to social factors and require extra support. Proposal will potentially lead to a reduction in capacity which will have an impact. *UNICEF Baby Friendly:* Not public facing, no direct impact. *Universal Healthy Start Vitamins*: Children up to the age of 5 are the primary beneficiaries. Delivering the service from Children's Centres will allow significantly more awareness raising and support for eligible expectant mothers/mothers of both the importance of vitamin supplementation in pregnancy and of the national Healthy Start scheme. *Brushing for Life*: Provision of toothbrush and promotional material is to 0-5 year olds. Weak evidence of impact, alternative funding sources exist.
Socio-economic	Neutral Adverse Neutral Positive Neutral	*Health Visiting Growth Funding*: impact is on future growth, not on currently commissioned activity. *Breastfeeding Service*: Some evidence that White British people from lower socio-economic groups are less likely to breastfeed and require extra support. Proposal will potentially lead to a reduction in capacity which will have an impact. *UNICEF Baby Friendly:* Not public facing, no direct impact. *Universal Healthy Start Vitamins*: National Healthy Start programme includes fruit/veg/milk voucher component, those in receipt of welfare benefits are eligible for national scheme. Delivering the service from Children's Centres will allow significantly more awareness raising and support for eligible expectant mothers/ mothers for the national Healthy Start scheme. *Brushing for Life*: Provision of toothbrush and promotional material. Weak evidence of impact, alternative funding sources exist.
Marriage and Civil Partnerships.	Neutral	There is no evidence to suggest that there is disproportionate need for these services among people who are single, married, in civil partnerships, widowed or other groups.
Pregnancy and Maternity	Neutral Adverse Neutral Positive Neutral	Programme is directed at maternity/early years life course so impact will potentially disproportionately affect this characteristic. *Health Visiting Growth Funding*: impact is on future growth, not on currently commissioned activity. *Breastfeeding Service*: Antenatal and perinatal period is the key opportunity to support mothers to make infant feeding choices and support them to breastfeed. Proposal is likely to lead to loss of capacity within the service. On a pro-rata basis, if a 10% reduction is made to 2015/16 activity then there will be 330 fewer women supported by the service in 2016/17 and 660 fewer supported in 2017/18. *UNICEF Baby Friendly:* Not public facing, no direct impact. *Universal Healthy Start Vitamins*: Women antenatal and for 1 year post birth are eligible for local scheme. Reduction in funding may impact upon outreach/awareness raising of the importance of vitamin supplementation for all pregnant women. Delivering the service from Children's Centres will allow significantly more awareness raising and support for eligible expectant mothers/ mothers. *Brushing for Life*: No impact.
Other	Neutral	None

Section 4: Equality Impact Assessment Action Plan

Please describe the actions that will be taken to mitigate this impact	Adverse impact
We will ensure that quarterly monitoring and an annual review takes account of equality dimensions and recommendations are made to ensure targeted support is aligned to groups with greatest need.	The breastfeeding service aims to increase rates of exclusive breastfeeding through community engagement, one to one support, in a borough where mixed feeding is the norm.

Section 5: Future Review and Monitoring

Please explain how and when the actual equality impact of these changes will be reviewed and monitored.

The Infant Feeding (Breastfeeding) Service and the Universal Healthy Start Vitamins Programme will continue and activity will continue to be monitored quarterly in the usual way; we will continue to monitor delivery and uptake of the services across equality dimensions and the impact at a population level will continue to be monitored through the public health screening quality assurance processes and the JSNA programme.

OPP TITLE:	PH 003/2016-17 PUBLIC HEALTH GRANT - Children`s Public Health Programme					
DIRECTORATE	ADULTS					
SERVICE:	PUBLIC HEALTH				LEAD OFFICER: Simon Twite	
Associate Director - Public Health	Esther Trenchard-Mabere		THEME:	Children`s Health		
SAVINGS OPPORTUNITY	BASE BUDGET £000	Savings 16/17 £000	Additional Savings 17/18 £000	Total Saving		Is an EA Req?
Administrative Efficiencies	2,634,764	121,696	72,284	193,980		Yes
FTE Reductions						

DETAILS OF SAVINGS OPPORTUNITY

1. Background

The public health aspirations for healthy children and adolescent are that they have:

- Good emotional health and foundations for lifelong mental wellbeing
- Sustainable habits building physical activity, healthy eating and good oral health into everyday life
- Freedom from behaviours harmful to health and resilience to adopting these in future life
- Good health outcomes through early identification of need and access to early help
- Freedom from abuse or neglect
- Life skills for health and wellbeing through critical life stages e.g. puberty, developing identity, starting relationships, transitioning to adulthood

2. Current investment

Childhood and adolescence is an important life stage for embedding lifelong habits. The school and family are critical settings for embedding lifelong habits for health and this explains the significant investments in public health interventions in these settings.

- School Health (School Nursing)- aims to ensure that school aged children and young people (5-19 years) are supported to live healthy lives and have the appropriate access to healthcare £1.6m
- Child and Family Weight Management 12 week multi component (healthy eating, physical activity and behaviour change) programmes aimed at children and families £431k
- Healthy Schools Team helping to ensure that school aged children and young people (aged 5-19 years) are supported to live healthy lives, integrating health and well-being within the ethos, culture, routine life and core business of the school/setting - £276k
- Active Cycling in Schools - Works with participating schools to create a 'whole school' cycling culture and to generate increases in regular cycling to school £80.2k
- Active Play 5-13 – provides an estate-based outreach programme of active play sessions to address low participation in active play £64.5k

- Healthy Families – works with schools, children's centres and community centres to embed healthy eating and physical activity ideas into a range of parent initiatives and programmes through practical workshops and community activities - £60k
- Public Health Dietitian (Child) - helping to ensure that school aged children and young people (aged 5-19 years) are supported to live healthy lives- £60k
- Healthy Minds in Schools - a pilot programme of mindfulness delivered to teachers/teaching assistants and other relevant staff in order for teachers to be equipped to deliver sessions to students.£43k
- Educational Psychology £40k – provides additional therapeutic support to school children and parents experiencing mental health or emotional difficulties.

3. Proposed budget reductions 16/17 and 17/18

- Child and Family Weight Management (£431k) reduce by £21.5k in 16/17 and further reduction £21.5k (17/18)
- Active Cycling in Schools - Bike It (£80.2k) reduce by £40.2k in 16/17 and further reduction £40k (17/18)
- Healthy Families (£60k) reduce by £20k from 16/17
- Educational Psychology (£40k) reduce by £40k from 16/17
- Healthy Minds in School (£43k) reduce by £10.8k in 17/18 only

4. Review in phase 2

- School health (School Nursing) £1.6m
- Healthy Schools Team £276k
- Active Play 5-13 £64.5k

IMPLICATIONS **(Summarise impact on services provided, service users and health outcomes. Outline any risks to achievement of the saving.)**

The proposed savings are to services that are currently commissioned by Public Health to increase the opportunities for children and young people and their families to benefit from a healthier diet and/or physical activity, and in the case of the educational psychology service to provide additional counselling for vulnerable children where clinical level problems exist. Proposed savings are lower in this area as the investment in children`s and young people`s health is a high priority which we aim to protect as far as possible. Consequently several of the most high priority services are being maintained at current levels including the School Health Service, the Healthy Schools Team in the Council and the Active Play programme.

Child and Family Weight Management (£431k) reduce £21.5k and further reduction £21.5k (17/18)

The aim of this service is to improve the health and quality of life of overweight and obese children and their families by enabling them to make sustainable improvement to their diet. A number of efficiency savings have been identified in the service, e.g. in the referral process from schools, and the modest reduction proposed is not expected to have an impact on the numbers participating in this programme.

Active Cycling in Schools - Bike It (£80.2k) reduce by £40.2k and further reduction £40k (17/18)

The aim of this programme is to create a cycling culture across the whole school community that brings about increases in regular cycling to school. The programme is an addition to other cycling training provided within schools. The proposed savings will end the funding of this programme from 2016/17.

Tower Hamlets is the only London borough to fund the programme through the Public Health grant (funding usually coming from Transport for London - TfL). Alternative funding sources are being explored. Delivery to the end of the current academic year will be funded.

The implications are reduced capacity for cycling training in the borough although the core training in schools funded by TfL remains.

Healthy Families (£60k) reduce by £20k

The aim of this programme is to empower parents and carers of nursery and primary school aged children and children of all ages with special needs to make it easier for the family to eat healthier food, enjoy a more active lifestyle and maintain emotional and mental wellbeing. The programme integrates health issues into parenting programmes.

Implications of the reduction are minimal as the success of the programme means savings can be achieved through integrating the health component into other parent and family support programmes.

Educational Psychology (£40k) reduce by £40k

This service provides extra support for pupils in schools in excess of the core offer for families and children. The service is therapeutic rather than being preventative and does not fully meet the criteria for public health funding. Delivery will continue until end of academic year, active case load managed down and alternative funding sources are being identified by Educational Psychology Service

Implications for reduction are minimal as the case load is being absorbed into the core service and the availability of specialist support is not affected.

EQUALITIES SCREENING

TRIGGER QUESTIONS	YES/NO	IF YES - please provide further details on how this impacts on each equalities groups
Does the change affect who provides the service?	No	

Does the change reduce resources available to address inequality?	Yes	There is a risk of reduction in resources available to address inequalities for vulnerable families and children through the potential reduction in staff delivering family support programmes. However, the health support will be integrated into other parent and family programmes.
Does the change impact on local suppliers?	No	
Does the change impact on the Third Sector?	Yes	Active Cycling in Schools is delivered by a national voluntary sector organisation (Sustrans). Alternative funding sources are being explored by Sustrans.
Does the change reduce resources available to support vulnerable residents?	Yes	The potential impact on vulnerable children of savings to the Educational Psychology project will be mitigated by provision of care through the core educational psychology provision. The impact on the Healthy Families programme is reduced by the integration of health support into other parent and family programmes.
CHANGES TO A SERVICE		
Does the change alter who is eligible for the service?	No	
Does the change alter access to the service?	No	
Does the change involve revenue raising?	No	
Does the change involve a reduction or removal of income transfers to service users?	No	
Does the change affect who provides the service, i.e. outside organisations?	No	
Does the change involve direct impact on front line services?	Yes	The proposed savings to the Healthy Families programme could impact on front line services but the impact is mitigated as stated above.
CHANGES TO STAFFING		
Does the change involve a reduction in staff?	Yes	The proposed savings to the Healthy Families programme have the potential to lead to a staff reduction (or role redesign). This would be treated in accordance with the Councils corporate change management procedure.
Does the change involve a redesign of the roles of staff?	Yes	The proposed savings to the Healthy Families programme have the potential to lead to a role redesign (or staff reduction). This would be treated in accordance with the Councils corporate change management procedure.

Budget Savings Proposals
Full Equality Analysis – Children and Young People

Section 1: General Information

1a) Name of the savings proposal
Public Health Children's Programme

1b)Service area
Public Health

1c) Service manager
Esther Trenchard-Mabere

1d) Name and role of the officer/s completing the analysis

Simon Twite, Senior Public Health Strategist

Section 2: Information about changes to services

2a) In brief please explain the savings proposals and the reasons for this change

In the first phase of savings plans, public health has been required to make £2.3million savings from the public health grant. Overall, the principle has to been to preserve investment in early years as far as possible as this is where the strongest evidence is around long term health impact. In prioritising the £2.3m savings proposed has been to identify those areas where public health investment has the greatest impact on population health and addressing health inequalities, and those where the impacts are least, to ensure proposals for savings are based on a robust and consistent set of criteria.

Childhood and adolescence is an important life stage for embedding lifelong habits. The school and family are critical settings for embedding lifelong habits for health and this explains the significant investments in public health interventions in these settings.
From a base budget of £2,634,764 we are proposing a saving of £121,696 in 2016-17 and a full year saving of £183,230 in 2017-18.

- Child and Family Weight Management (£431k) reduce by £21.5k in 16/17 and further reduction £21.5k (17/18)
- Active Cycling in Schools - Bike It (£80.2k) reduce by £40.2k in 16/17 and further reduction £40k (17/18)
- Healthy Families (£60k) reduce by £20k from 16/17
- Educational Psychology (£40k) reduce by £40k from 16/17

The proposed savings are to services that are currently commissioned by Public Health to increase the opportunities for children and young people and their families to benefit from a healthier diet and/or physical activity, and in the case of the educational psychology service to provide additional counselling for vulnerable children where clinical level problems exist. Proposed savings are lower in this area as the investment in children`s and young people`s health is a high priority which we aim to protect as far as possible. Consequently several of the most high priority services are being maintained at current levels including the School Health Service, the Healthy Schools Team in the Council and the Active Play programme.

2b) What are the equality implications of your proposal?
All savings proposals have been screened for equalities relevance using the test of relevance questionnaire attached (Appendix A).

Please go back to each of the test of relevance questions and ***using evidence*** please provide a more detailed analysis of the equality impact of your proposal.

TRIGGER QUESTIONS	YES/NO	IF YES - please provide further details on how this impacts on each equalities groups
Does the change affect who provides the service?	No	
Does the change reduce resources available to address	Yes	There is a risk of reduction in resources available to address inequalities for vulnerable families and

inequality?		children through the potential reduction in staff delivering family support programmes and the additional funding for Educational Psychology.
Does the change impact on local suppliers?	No	
Does the change impact on the Third Sector?	Yes	Active Cycling in Schools is delivered by a national voluntary sector organisation (Sustrans).
Does the change reduce resources available to support vulnerable residents?	Yes	The potential impact on vulnerable children of savings to the Educational Psychology project will be mitigated by provision of care through the core educational psychology provision. The impact on the Healthy Families programme is reduced by the integration of health support into other parent and family programmes.

Child and Family Weight Management:
MEND is a child and family weight management service delivered by MyTimeActive. Its aims are to improve the health and quality of life of overweight and obese children and young people and their families in Tower Hamlets by enabling them to make sustainable improvements to their diet, physical activity and weight. Additionally it provides a range of free workforce training available to staff who work closely with children and their families.
They provide a range of free healthy lifestyle programmes in community and school settings across the borough. These programmes provide nutritional advice and guidelines alongside fun exercise games and activities. They are tailored to different age groups, levels of need and capabilities.

The service currently employs the minimum number of staff required to deliver the full commissioned programme, there are limited opportunities to make savings at expense of staff numbers. Savings can be made by reducing the flexibility of the offer, and reducing Saturday sessions. There is a risk that this will reduce the opportunity for Moslem boys to attend who tend to have other extra-curricular education activities after school on weekdays. This will risk impacting upon a priority group in terms of need – Bangladeshi boys. The protected characteristics of those using the service (2015/16) are set out below.

Active Cycling in Schools - Bike It: Sustrans has been commissioned to deliver Bike It in Tower Hamlets' schools since 2008/09 by Tower Hamlets Public Health in order to increase participation in physical activity by creating social, cultural and physical environments that supports cycling to and from schools. Bike It has been delivered in 40% of Secondary schools and 80% of primary schools in Tower Hamlets. There are a number of barriers within deprived inner city areas with diverse ethnic populations, the two key ones that are most amenable to change being cultural perceptions of cycling and perceptions of road danger. Alternative funding opportunities are being sought by LBTH and Sustrans in order to continue the LBTH funded part of this programme. A .5 wte Bike It officer is also funded to work in Tower Hamlets by Transport for London (Public Health funding served as match funding in order to achieve this additional support).

Healthy Families: The aims of this programme are to utilise the skills and knowledge of parents through local networks, 'hubs' and peer support and build community capacity to support the Public Health Team and other partners and providers to co-design public health approaches and interventions which best meet local needs, influence long term behaviour change, empower whole communities and reduce health inequalities, in particular with parents and carers of nursery and primary school aged children (under 11) and children and young people with special needs (all ages) to make it easier for the family to eat healthier food, enjoy a more active lifestyle, develop self-confidence and maintain emotional and mental well-being.

Component/output	Current	Proposed
6 x 5 week Healthy Families programmes delivered to early years settings, CC's and vulnerable families living in the refuge	12	6
Parents/carers participating	150	60
Children birth – 11 benefiting from programme	175	80
Children 12 -16 benefiting from programme	40	10
Number of Healthy Family Parent Ambassadors sustained / maintained	20	25

The savings proposal will reduce the capacity of the Parent and Family Support team in LBTH to deliver Healthy Families Programmes and reduce the capacity to engage as many parents and children.

Educational Psychology: The Public Health Educational Psychology provided additional capacity over 3 areas:

PRU: Project aimed to engage with between 6-8 young people each year;
Schools: Project aims to deliver targeted support to 12-18 families will be provided with enhanced educational psychology support over the year;
Disabled Adolescents: Up to 6 counselling sessions for 10 young people.

Funding for this additional activity was ended in February 2016. The activity has been mainstreamed into the Educational Psychology 'main offer' and alternative sources of funding are being explored by the service in order to increase offered activity. The impact of savings proposal on this programme has therefore not been considered in the EIA below.

Section 3: Equality Impact Assessment

Target Groups What impact will the proposal have on specific groups of service users and staff?	**Impact – Positive or Adverse**	**Reason(s)** • Please add a narrative to justify your claims around impacts and, • Please describe the analysis and interpretation of evidence to support your conclusion as this will inform members decision making
Race	Adverse	*Child and Family Weight Management*: By virtue of the proportion of population in this age group being of Asian ethnicity this group may be disproportionately affected by reduction in capacity of service. Reduced flexibility of the offer (reduction of Saturday sessions) may generate a risk that this will reduce the opportunity for Moslem boys to attend (tend to have other extra-curricular education activities after school on weekdays). This will risk impacting upon a priority group in terms of need – Bangladeshi boys.
Disability	Adverse	*Healthy Families*: One of the areas of focus of the Healthy Families programme is children and young people with special needs (all ages) and a reduction of service capacity risks impacting upon these children.
Gender	Adverse	*Child and Family Weight Management*: Reduced flexibility of the offer (reduction of Saturday sessions) may generate a risk that this will reduce the opportunity for Moslem boys to attend (tend to have other extra-curricular education activities after school on weekdays). This will risk impacting upon a priority group in terms of need – Bangladeshi boys.
Gender Reassignment	Neutral	There is no evidence to suggest that there is disproportionate need for these services among the population who have undertaken or are seeking gender reassignment
Sexual Orientation	Neutral	There is no evidence to suggest that there is disproportionate need for these services among the LGBT+ population.
Religion or Belief	Adverse	*Child and Family Weight Management*: Reduced flexibility of the offer (reduction of Saturday sessions) may generate a risk that this will reduce the opportunity for children with other extra-curricular religious education activities after school on weekdays.
Age	Adverse	Programme is directed at childhood stage of life course so impact will potentially disproportionately affect this characteristic.
Socio-economic	Adverse	*Child and Family Weight Management:* Population prevalence of obesity in childhood is strongly correlated with socio-economic disadvantage. There is a potential risk that service reduction in service capacity will impact on families who are socio-economically disadvantaged. Current savings proposals under consideration by provider will not disproportionately affect this group.
Marriage and Civil Partnerships.	Neutral	There is no evidence to suggest that there is disproportionate need for these services among people who are single, married, in civil partnerships, widowed or other groups.
Pregnancy and Maternity	Neutral	Programme is directed at childhood stage of life course so impact will not disproportionately affect this characteristic.
Other	Neutral	None

Section 4: Equality Impact Assessment Action Plan

Adverse impact	Please describe the actions that will be taken to mitigate this impact
Sustrans' Bike It programme seeks to increase participation in physical activity by delivering work to support cycling to and from schools in a borough with low levels of cycling to school, and with social/cultural norms that discourage cycling/active travel.	Alternative funding opportunities are being sought by LBTH and Sustrans in order to continue the LBTH funded part of this programme. A .5 wte Bike It officer is also funded to work in Tower Hamlets by Transport for London (Public Health funding served as match funding in order to achieve this additional support). This post will remain (currently).
My Time Active Child & Family Weight Management - aims to improve the health and quality of life of overweight and obese children and young people and their families in Tower Hamlets in a borough that has amongst the highest levels of obesity in London and has previously seen a rapid increase in prevalence of obesity & overweight in Bangladeshi boys.	Weight management programmes will not alone impact significantly upon prevalence of excess weight in children and a range of other primary prevention activities are ongoing. When considering provision of treatment services there is a risk that reducing the flexibility of offer (e.g. ceasing delivery of programmes on Saturdays) will impact on those children and families who are unable to attend after school on weekdays (e.g. Moslem boys, who are a priority group in terms of need).
Healthy Families Parent Ambassador programme utilises the skills and knowledge of parents through local networks, 'hubs' and peer support and build community capacity to support PH and partners to co-design public health approaches and interventions which best meet local needs, influence long term behaviour change, empower whole communities and reduce health inequalities.	Reduction in funding will inevitably result in a reduction in activity. The service will mitigate against the potential equality risks by focussing on supporting an increased number of Healthy Family Parent Ambassadors to be supported and sustained in delivering their work.

Section 5: Future Review and Monitoring

The Children and Families Weight Management and Healthy Families programmes will continue to be subject to the standard quarterly performance monitoring process which will allow us to monitor any impact upon delivery across the equality dimensions to ensure impact on specific groups is not affected, or is minimised.

Public health funding for the Bike It programme will end, but the impact at a population level will continue to be monitored through the public health screening quality assurance processes and the JSNA programme.

OPP TITLE:	PH 004/2016-17 PUBLIC HEALTH GRANT - Smoking Cessation Programme					
DIRECTORATE	**ADULTS**					
SERVICE:	**PUBLIC HEALTH**				**LEAD OFFICER: Jane Stephenson-Glynn**	
Associate Director - Public Health	Chris Lovitt		**THEME:**	Healthy & Supportive Community		
SAVINGS OPPORTUNITY	**BASE BUDGET £000**	**Savings 16/17 £000**	**Additional Savings 17/18 £000**	**Total Saving**		**Is an EA Req?**
Administrative Efficiencies	1,367,940	399,000	107,000	506,000		Yes
FTE Reductions						

DETAILS OF SAVINGS OPPORTUNITY

1. Background

The public health aspiration is to continue to drive down the use of tobacco in the borough:

- Stopping people starting smoking
- Helping people quit smoking
- Protecting people from the harmful effects of second hand smoke

Stopping smoking is amongst the most important measures that an individual can take to improve their health. Within a year, an individual's chance of heart disease is halved and in five years the risk of lung cancer is halved. Tower Hamlets has amongst the highest level of premature death from smoking related diseases in the country and this is why offering universal smoking cessation services has been such a priority. Services support 1500-2000 to stop smoking each year in Tower Hamlets.

2. Current investment

- Smoking cessation services provided in pharmacies £330k
- Enforcement of no smoking legislation in pubs and restaurants and public areas £263k
- Specialised smoking cessation service - 1-1 and group intensive smoking cessation support for smokers with higher needs such as long term addiction, pregnant smokers, smokers with chest conditions £227k and Specialist service drug costs £45k

- Targeted smoking cessation for black and minority ethnic(BME) groups - 1-1 and group tobacco and smoking cessation support for tobacco chewers and smokers from BME groups £213k
- Smoking cessation in GP surgeries – support to quit smoking through GPs and GP practices £194k
- Peer education tobacco – educational programme for young people on the risks of smoking delivered in schools and youth centres £80k

3. Proposed budget reductions 16/17 and 17/18

- Smoking cessation in pharmacies (£330k) reduce by £117and a further reduction of £17k (17/18)
- Tobacco control (£263k) – reduce by £163k
- Specialist smoking cessation service (£226k) reduce by £5k and further reduction £5k (17/18)
- Targeted smoking cessation (£213k) BME groups reduce by £5k and further reduction £5k (17/18)
- GP practice smoking cessation services (£194k) reduce by £14k (16/17) and further reduction of £80k (17/18)
- Peer Education tobacco (£80k) reduce by £80k
- Specialised service drug costs (£45k) reduce by £15k

IMPLICATIONS
(Summarise impact on services provided, service users and health outcomes. Outline any risks to achievement of the saving.)

Tower Hamlets residents continue to have higher rates of smoking than the national or regional averages with smoking especially prevalent in particular demographic groups. Supporting people to stop smoking is

one of the most cost effective and health enhancing public health intervention that not only reduces mortality and morbidity but has a significant impact on reducing health inequalities.

As elsewhere, smoking prevalence has been falling steadily in Tower Hamlets over the past ten years. In 2005 prevalence was estimated at 29% and the most recent estimate is 10%. This fall is likely to have been driven by the smoking ban, e-cigarettes and changing societal attitudes. However, it is important to recognise that these falls have been less marked in more deprived groups and smoking therefore remains an important driver of heath inequalities. For these reasons, it has been the approach to reduce the provision of universal services (in line with the reduction in footfall) and to preserve the more specialised and targeted services.

Smoking cessation service in pharmacies (£330k) reduce by £117k and further reduction £17k (17/18)

We are proposing to make savings by reducing the length of the treatment programme provided by community pharmacies. Many smokers do not use the full amount of Nicotine Replacement Therapy (NRT) prescribed during a quit attempt either because four weeks combination supply is enough to last them six weeks, they quit but manage without using the full prescribed amount, or they chose to buy electronic cigarettes. This results in a surplus of NRT prescribed and therefore waste. The specialist services treatment programme will not be reduced for smokers who are more heavily addicted to nicotine e.g. smokers with mental health illness. The varenicline treatment programme (an alternative nicotine substitute product) also remains the same. This means that the same number of smokers can be helped but at lower cost. We are exploring a payment mechanism that will ensure that pharmacies are only paid fees if there is a successful quit at the end of the programme.

Specialist smoking cessation service (£226k) reduce by £5k and further reduction £5k (17/18)
Specialised service drug costs (£45k) reduce by £15k
Targeted smoking cessation (£213k) BME groups reduce by £5k and further reduction £5k (17/18)

The changes to the GP Network Improvement Service (NIS) will see an increased footfall, of approximately 2,000 smokers, into the specialist service stop smoking service and Black and Minority Ethnic (BME) tobacco project combined in 2016/17. 42% of these smokers will come from BME groups. As the service provides a more effective and specialised service than GPs can offer the quit rate will increase from 22% to over 50%. This will reduce the cost per quitter. In addition there will be a reduction in prescribing costs due to the following:

- Pick up of some prescribing costs for those patients supported by the specialist service or BME tobacco project within GP practice settings
- Reduction in specialist treatment programme of Nicotine Replacement Therapy (NRT) (with the exception of pregnant smokers)
- Increased use of electronic cigarettes leading to a reduction in smokers offered NRT and/or varenicline programmes

GP practice smoking cessation services (£200k) reduce by £20k in 16-17 and further reduction £80k (17-18)
As described above the smoking cessation support practice in GP practices in the borough will change so that smokers that need sustained support will be referred by GPs to the specialist services that will operate from the GP practices. This will reduce the cost per quitter and provide a higher quality level of support. The aim of the changed approach is to increase the number of smokers receiving support as some GP networks (not all) have not been very successful at providing support for smoking cessation.

Tobacco control – reduce by £163k
The funding that is provided to the Council`s Environmental Health Consumer Team to undertake checks on illegal counterfeit cigarette sales, underage sales, smoke free premises and public vehicles, etc, can be reduced because the evidence is that there is generally a good level of compliance compared to three years ago. Some funding will still be available for these activities and appropriate checks on commercial premises will continue to be undertaken.

Peer Education tobacco (£80k) reduce by £80k
It is proposed to discontinue the peer education smoking cessation programme that is funded by Public Health as smoking awareness education is still provided through school PSHE activity, the School Health programme and the Council`s Healthy Schools Team.

Public Health is working with Youth Services through the Youth Service Review to develop a health-promoting youth service and mainstream this throughout the borough youth provision in order to maintain and improve the outputs of peer education programmes. Tobacco will be included as a key theme in this.

Impact on key local or national targets

The changes proposed are not anticipated to have a detrimental impact on local or national stop smoking targets and the effectiveness of the services are likely to increase as both the specialist and BME services have a higher successful quit rates compared to the previous configuration of services in Primary Care. It is also expected that there will be a Commissioning for Quality and Innovation (CQUIN) target for referrals implemented at the Royal London Hospital. CQUINS are additional targets that are set to provide incentives for services to undertake extra work to meet challenging targets. The CQUIN should significantly improve the identification and referral of smokers from the acute hospital and so increase the access and referrals of patients to cessation services. It is also proposed to allocate some of the additional funding allocated to the borough`s Vanguard service integration programme (a government initiative) to put a stronger focus on smoking cessation in the whole range of services delivered by the borough`s main acute services provider, Barts Health.

EQUALITIES SCREENING

TRIGGER QUESTIONS	YES/NO	IF YES - please provide further details on how this impacts on each equalities groups
Does the change affect who provides the service?	**Yes**	GP practices will no longer provide smoking cessation support but will instead refer patients to the specialist stop smoking service or BME stop tobacco project. Minimal impact on equalities groups as the service will still be provided by the two aforementioned services and also community pharmacists.
Does the change reduce resources available to address inequality?	No	
Does the change impact on local suppliers?	Yes	May reduce some staff hours but the risks to provision for equalities groups are minimal. Small risk to outreach provision for minority groups but will be mitigated by the specialist and BME services accessing these client groups through GP practices
Does the change impact on the Third Sector?	No	
Does the change reduce resources available to support vulnerable residents?	Yes	External providers including GPs, the BME and specialist services will have funding reduced. Services for the most high risk smokers with multiple conditions are being maintained. Risks to provision for equalities groups minimal. Small risk to outreach provision for minority groups but may be mitigated by supplier accessing these client groups through GP practices. Also length of pharmaceutical treatment provision will be cut.
CHANGES TO A SERVICE		
Does the change alter who is eligible for the service?	No	
Does the change alter access to the service?	Yes	Smoking cessation support will be refocused into specialist services. However all residents will still be able to access cessation support through the wide variety of easy to access community pharmacies, and some specialist clinics will be hosted at GP practices by the specialist service and BME stop tobacco project. Numbers of quits are likely to increase, rather than decrease, due to the specialist support producing a

		superior quit rate (i.e. more people quitting successfully) to primary care smoking cessation provision in GP practices.
Does the change involve revenue raising?	No	
Does the change involve a reduction or removal of income transfers to service users?	No	
Does the change affect who provides the service, i.e. outside organisations?	No	The providers will remain the same.
Does the change involve direct impact on front line services?	Yes	Cessation services will now be provided by the specialist services in partnership with Primary care. However all residents will still be able to access cessation support through the wide variety of easy to access community pharmacies.
CHANGES TO STAFFING		
Does the change involve a reduction in staff?	No	
Does the change involve a redesign of the roles of staff?	No	

Budget Savings Proposals
Full Equality Analysis – Smoking Cessation

Section 1: General Information

1a) Name of the savings proposal
Public Health smoking cessation programme

1b)Service area
Public health

1c) Service manager
Chris Lovitt

1d) Name and role of the officer/s completing the analysis

Chris Lovitt, Associate Director of Public Health
Jane Stephenson-Glynn, Public Health Strategist

Section 2: Information about changes to services

2a) In brief please explain the savings proposals and the reasons for this change

In the first phase of savings plans, public health has been required to make £2.3million savings from the public health grant. Overall, the principle has to been to preserve investment in early years as far as possible as this is where the strongest evidence is around long term health impact. Preventative services among middle aged and older people, particularly where delivered at an individual level, are less cost effective and therefore have been subject to a number of proposed cuts.

There is a strong evidence base for structured support to stopping smoking. This service is performing in delivering high quit rates for the highest need groups (e.g. severe mental illness, long term conditions, routine and manual smokers) therefore minimum savings have been made to the smoking and tobacco cessation services. We are proposing to make savings by reducing the length of the treatment programme provided by community pharmacies. Many smokers do not use the full amount of Nicotine Replacement Therapy (NRT) prescribed during a quit attempt either because four weeks combination supply is enough to last them six weeks, they quit but manage without using the full prescribed amount, or they chose to buy electronic cigarettes. The savings proposed are:-

2016-17

- Specialised varenicline (specialist service treatment)– budget reduction of £15,000 (contract value 45,000)
- Tobacco Control – budget reduction of £163,000
- Pharmacy Smoking ES and prescribing – budget reduction of £117,000 (contract value 330,000)
- GP practice smoking cessation services - budget reduction of £14,000 (contract value 194,000)
- Peer Education (Tobacco) - budget reduction of £80,000 (contract value 80,000)
- Specialised Smoking Cessation Service - budget reduction of £5,000 (contract value 226,800) (6 months)
- Black and Minority Ethnic Communities Smoking Cessation - budget reduction of £5,000 (contract value 213,140) (6 months)

The proposed additional budget reductions in 2017-18 are:

- Pharmacy Smoking ES and prescribing – further budget reduction of £17,000
- Specialised Smoking Cessation Service – further budget reduction of £10,000 (contract value 226,800)
- Black and Minority Ethnic Communities Smoking Cessation – further budget reduction of £10,000 (contract value 213,140)

2b) What are the equality implications of your proposal?
All savings proposals have been screened for equalities relevance using the test of relevance questionnaire attached (Appendix A).

TRIGGER QUESTIONS	YES/NO	IF YES - please provide further details on how this impacts on each equalities groups
Does the change affect who provides the service?	Yes	Cessation services will now be provided by the specialist services in partnership with Primary care
Does the change reduce resources available to address inequality?	No	External providers including GPs, the BME and Specialist Services will have funding reduced. Risks to provision for equalities groups minimal. Small risk to outreach provision for minority groups but may be mitigated by supplier accessing these client groups through GP practices. Also length of pharmaceutical treatment provision will be cut.
Does the change impact on local suppliers?	Yes	May reduce some staff hours
Does the change impact on the Third Sector?	No	
Does the change reduce resources available to support vulnerable residents?	Yes	External providers including GPs, the BME and specialist services will have funding reduced. Services for the most high risk smokers with multiple conditions are being maintained. Risks to provision for equalities groups minimal. Small risk to outreach provision for minority groups but may be mitigated by supplier accessing these client groups through GP practices. Also length of pharmaceutical treatment provision will be cut.

Section 3: Equality Impact Assessment

Target Groups What impact will the proposal have on specific groups of service users and staff?	**Impact – Positive or Adverse**	**Reason(s)** • Please add a narrative to justify your claims around impacts and, • Please describe the analysis and interpretation of evidence to support your conclusion as this will inform members decision making
Race	Neutral	• There are higher levels of smoking prevalence in some ethnic minority groups in the borough. The BME stop tobacco group service specifically addresses the needs of people from different ethnic backgrounds. The proposed saving is small in order to maintain the service and no impact on numbers engaged is anticipated. • Peer Education- we will mainstream the peer education services within the youth service and ensure that people from ethnic groups continue to benefit from these services
Disability	Neutral	• Both the specialist stop smoking service and the BME Stop Tobacco Project comply with DDA regulations. Those living with severe mental health will still be supported to quit smoking.
Gender	Neutral	• All the services provide equal opportunity for all. • The BME Stop Tobacco Project continues to have separate help lines for male and female smokers and tailored support.
Gender Reassignment	Neutral	• There is no evidence to suggest that there is disproportionate need for these services among the gender reassignment population.
Sexual Orientation	Neutral	• There is no evidence to suggest that there is disproportionate need for these services among the LGBTQ population.
Religion or Belief	Neutral	• There is no evidence to suggest that there is disproportionate need for these services among any religious groups in the borough.

Age	Neutral	• All the commissioned smoking cessation services can support people of all ages and the savings will not impact on provision.
Socio-economic	Neutral	• The specialist stop smoking service and the BME stop tobacco project both support routine and manual, unemployed, carers and student's and this support will continue.
Marriage and Civil Partnerships.	Neutral	• There is no evidence to suggest that there is disproportionate need for these services among people who are single, married, in civil partnerships, widowed or other groups.
Pregnancy and Maternity	Neutral	• Pregnant women and new parents are supported by the specialist stop smoking service which is only subject to a small proposed reduction. The treatment programme the service provides for pregnant smokers is not reduced.
Other	Neutral	None

Section 4: Equality Impact Assessment Action Plan

Adverse impact	Please describe the actions that will be taken to mitigate this impact
None identified	

Section 5: Future Review and Monitoring

Both the prescribing pharmacy programme and the specialist varenicline prescribing programme will continue to be monitored and impact on both quit outcomes and budget evaluated at 6 months.

OPP TITLE:	PH 005/2016-17 PUBLIC HEALTH GRANT - Sexual Health Programme					
DIRECTORATE	ADULTS					
SERVICE:	PUBLIC HEALTH				LEAD OFFICER: Reha Begum	
Associate Director - Public Health	Chris Lovitt		**THEME:**	Healthy & Supportive Community		
SAVINGS OPPORTUNITY	**BASE BUDGET £000**	**Savings 16/17 £000**	**Additional Savings 17/18 £000**	**Total Saving**		**Is an EA Req?**
Cut in service duplication & move to more cost effective service provision	3,077,529	619,336	345,000	964,336		Yes
FTE Reductions						

DETAILS OF SAVINGS OPPORTUNITY

1. Background

The aspiration of the sexual health programme is to:

- Promote good sexual health in the population
- Promote safe sex practices
- Identify sexually transmitted infections and HIV in the population as early as possible
- Provide high quality access to contraception and widen access in primary care
- Improve access to online and other testing facilities e.g. community pharmacies, primary care and to target acute services at complex patients requiring treatment

2. Current investment

- Acute Genito-Urinary Medicine (GUM) Provision of contraceptive services, STI screening & treatment & psychosexual counselling, chlamydia screening £5.5m
- Integrated sexual health (Contraception and Sexual Health Services - CASH) Provision of contraceptive services STI screening & treatment, chlamydia screening co-ordination, psychosexual counselling and work with high need groups £1.4m
- Integrated sexual health young people - Provision of contraceptive services, STI screening & treatment, chlamydia screening co-ordination, SRE and targeted prevention work with young people £601k
- Sexual health services in general practice - Provision of contraceptive services, STI screening & uncomplicated treatment, chlamydia screening £280k
- Sexual health services in pharmacies Provision of Emergency Contraception, Chlamydia and Gonorrhoea screening & uncomplicated treatment, condom distribution - £190k
- Peer education sexual health – sex and relationship education programmes that are offered in schools and youth centres £178k
- Enhanced sexual health promotion in high risk groups - Targeted outreach, community mobilisation and resource development to support testing, treatment and behaviour change to reduce STIs, HIV transmission and increase sexual health £170k
- Commissioning support for sexual health – specialist commissioning support for GUM services £50k
- Sexual health promotion in commercial sex workers - through outreach, community mobilisation and health promotion to encourage street based commercial sex workers to test, treat and vaccinate to reduce STIOs and BBVs £50k
- Living well with HIV - health promotions with people living with HIV to encourage treatment uptake, behaviour change and adoption of healthy lifestyles £50k
- Pan London sexual health -
  London wide HIV prevention programme targeting MSM and people from African Communities £47k

- Health promotion in undiagnosed HIV - through outreach, community mobilisation and health promotion to encourage people from high need communities to test for HIV £40k
- London DPH programme - £22k
- North East London Sexual Health Network (NELNET) - provision of a clinical commissioners network for HIV and sexual health services across North East London £10k

3. Proposed budget reductions 16/17 and 17/18

- Acute GUM (£5.5m) reduce by £200k
- TH CASH (£1.4m) reduce by £250k in 16/17 and a further reduction of £250k in 17/18
- Integrated sexual health young people (£601k) reduce by £15k
- Peer education sexual health (£178k) reduce by £108k and further reduction of £70k in 17/18
- Enhanced sexual health promotion for high risk (£170k) reduce by £6k
- Sexual health promotion in commercial sex workers (£50k) reduce by £25k and further reduction of £25k 17/18
- Living well with HIV (£50k) reduce by £3k
- Health promotion in undiagnosed HIV (£40k) reduce by £3k
- North East London Sexual Health Network (NELNET) (£10k) reduce by £10k

IMPLICATIONS
(Summarise impact on services provided, service users and health outcomes. Outline any risks to achievement of the saving.)

Improving sexual health is a high priority for public health in Tower hamlets and there is an ambition to shift the focus of the investment towards prevention rather than the treatment of infections. To that end there is a strong commitment to protecting the prevention services as far as possible. There is also commitment to ensuring that wherever possible services are provided at the appropriate level, for example, making better use of the primary care services that are provided rather than a continued increase in take up of high cost services in hospital-based clinics. Services such as the Young People`s Service and the prevention services working with the high risk groups are seen as important to maintain.

At the same time the cost of meeting the needs of local residents sexual health needs has significantly increased over the last two years. A major initiative is being made through the London and East London Sexual Health transformation programme to ease and reduce the cost of accessing services by greater use of, online services, enhanced partner notification services and replacing the current national payment structures for providers with a more appropriate integrated sexual health tariff. The transformation programmes will start to commission services in 2017 and 2018.

Acute GUM (£5.5m) reduce by £200k and in16/17

GUM services that can be accessed anywhere by Tower Hamlets residents are one of the major costs for the public health grant and in recent years the growth in expenditure has been very significant. There are a number of initiatives to control cost levels in this area and in the interim a reduced cost of £200k per year is anticipated.

The implications of this are that some users of acute sexual health services would be encouraged to attend at primary care settings and in borough acute services where the requirement is a straightforward contraception requirement, testing or simple treatment rather than a more acute need. This would result in a better use of the available resources without having an adverse impact on any sexual health service user.

TH CASH (£1.4m) reduce by £250k and further reduction of £250k in 17/18

In advance of the transformation programme we will work with the current providers of services to reduce duplication of services provided by the current configuration of sexual health services provided by the TH CASH service at Mile End Hospital and the Ambrose King Centre at the Royal London Hospital by co-locating the level 3 services (CASH and GUM) at Ambrose King. This will improve the efficiency of the services by reducing overheads, enabling less complex activity to be provided by community based services and encourage lower urgency resident access (e.g. supply of condoms only) to access services in a lower cost setting or change how services are provided to reduce the costs of delivery.

The implication would be a reduction in the duplication of services and the referral of users to more appropriate service levels. No significant impact on the accessibility of services is anticipated as needs can be met from other services such as those offered in primary care.

Integrated sexual health young people (£601k) reduce by £15k

The Young People Services provides a high quality, accessible, comprehensive contraception and sexual health service for young people aged 24 years and under with a particular focus on those aged 19 years and under. Clinic based clinical services and community outreach services offer information, advice and guidance, provision of contraception, diagnosis and treatment of sexually transmitted infections including partner notification as set out in this service specification and onward referral where appropriate.

This is a high priority service to maintain and the small reduction in the budget is likely to be achievable through reducing duplication of services between primary care and this service so there will be no or very limited impact on the numbers of young people supported

Peer education sexual health (£178k) reduce by £108k and further reduction of £70k in 17/18

The aim of this programme is to work with adolescents and young adults in schools and community settings to deliver targeted Sex and Relationship Education. This is an important area of pastoral education but is also supported through other sources of funding such as school PHSE programmes. In addition it has frequently proved difficult to engage schools positively and the programme has struggled to reach the numbers anticipated.

The review of the Youth Service has highlighted this as an area that will be prioritised for development as part of a health-promoting Youth Service, including sexual health as one of its core themes

Enhanced sexual health promotion for high risk groups (£170k) reduce by £6k

This service provides enhanced sexual health promotion and HIV prevention, targeting high need communities in the London Borough of Tower Hamlets. This work is in addition and builds on the general population sexual health promotions undertaken by both public health and other providers. The small reduction in the budget can be absorbed without significant impact on the levels of engagement.

Sexual health promotion in commercial sex workers (£50k) reduce by £25k and further reduction of £25k 17/18

The commercial sex workers health promotion project targets street-based sex workers to encourage regular testing and take up of treatment services for sexually transmitted infections. However, the project has not engaged the numbers anticipated and will be brought in house and provided through a Drugs Intervention Programme (DIP) project that already works with this client group.

The implications are minimal as the service is failing to add value and there is duplication of services that will still be provided through the DIP project.

Living well with HIV (£50k) reduce by £3k

This project aims to improve the health and well-being of people with HIV using a peer led and peer-supported approach. A small reduction in the budget is proposed and this should be absorbed without significant impact on the numbers engaged.

Health promotion in undiagnosed HIV (£40k) reduce by £3k

The service delivers enhanced health promotions to reduce undiagnosed HIV, targeting high need communities in Tower Hamlets – men who have sex with men, some ethnic minority groups and at risk young people under age 35. A small reduction in the budget is proposed and this should be absorbed without significant impact on the numbers engaged.

North East London Sexual Health Network (NELNET) – (£10k) – reduce by £10k
This is a support group for clinical commissioners which will continue with other funding through the sexual health service providers.

Impact on key local or national targets

The changes proposed are not anticipated to have a detrimental impact on local or national sexual health indicators which include teenage pregnancy rates, chlamydia screening and late HIV diagnosis. Services will remain open access and access points have increased following the extension of sexual health services to nearly all community pharmacists for provision of Emergency Contraception, HIV testing and chlamydia and gonorrhoea screening. The savings proposed are based on increasing efficiency, reducing duplication and directing users to lower cost services where appropriate to their needs.

Health promotions and health improvement programmes targeted to the most at risk groups for sexual ill health will continue and work will continue to mainstream the promotion of good sexual health throughout the wider education, youth, and social care and NHS services.

EQUALITIES SCREENING

TRIGGER QUESTIONS	YES/NO	IF YES - please provide further details on how this impacts on each equalities groups
Does the change affect who provides the service?	Yes	The commercial sex workers project will be brought in house from the current provider the Homerton Hospital and provided by the DIP team
Does the change reduce resources available to address inequality?	Yes	There is a small potential impact on the high risk groups such as MSM, however the services commissioned will continue to target resources at the most vulnerable. The reductions proposed are likely to be able to be met by reducing duplication of services and/ or increasing efficiency of provision and so are not expected to lead to a significant increase in inequalities.
Does the change impact on local suppliers?	Yes	Current service providers are Barts Health, sub-contractors Step Forward, Positive East and the Homerton Hospital. The Council will work with the providers to manage the impact as sensitively as possible.
Does the change impact on the Third Sector?	Yes	Step Forward and Positive East are both Third Sector providers The Council will work with the voluntary sector providers to manage the impact as sensitively as possible.
Does the change reduce resources available to support vulnerable residents?	Yes	There is a small potential impact on the high risk groups such as MSM, however the services commissioned will continue to target resources at the most vulnerable. The reductions proposed are likely to be able to be met by reducing duplication of services and/ or increasing efficiency of provision and so are not expected to lead to a significant increase in inequalities.
CHANGES TO A SERVICE		
Does the change alter who is eligible for the service?	No	
Does the change alter access to the service?	No	
Does the change involve revenue raising?	No	

Does the change involve a reduction or removal of income transfers to service users?	No	
Does the change affect who provides the service, i.e. outside organisations?	No	
Does the change involve direct impact on front line services?	Yes	It is likely that some low risk clients who currently access the hospital based services and outreach services will be re-prioritised to attend community based services.
CHANGES TO STAFFING		
Does the change involve a reduction in staff?	Yes	It is likely that that the budget reduction will require the providers to deliver a small reduction in staffing numbers by reducing duplication of services.
Does the change involve a redesign of the roles of staff?	Yes	It is likely that that the budget reduction will require the providers to redesign roles of staff.

Budget Savings Proposals
Full Equality Analysis – Sexual Health Programme

Section 1: General Information

1a) Name of the savings proposal
Public Health sexual health programme

1b)Service area
Public health

1c) Service manager
Chris Lovitt

1d) Name and role of the officer/s completing the analysis

Chris Lovitt, Associate Director of Public Health
Reha Begum, Senior Public Health Strategist

Section 2: Information about changes to services

2a) In brief please explain the savings proposals and the reasons for this change

In the first phase of savings plans, public health has been required to make £2.3million savings from the public health grant. Overall, the principle has to been to preserve investment in early years as far as possible as this is where the strongest evidence is around long term health impact. Preventative services among middle aged and older people, particularly where delivered at an individual level, are less cost effective and therefore have been subject to a number of proposed cuts.

We currently have a duplication of sexual services provided from acute settings and feel that fully integrating these services and ensuring that residents with non-complex sexual health needs are seen in primary care settings will enable the same level of service to be provided but at lower cost. Other savings are proposed from prevention services through increased efficiencies and/or mainstreaming services into core universal services e.g. the Youth Service and we would anticipate that these would not have major impact on service delivery. The savings proposed are:-

- Acute GUM (£5.5m) reduce by £200k
- TH CASH (£1.4m) reduce by £250k in 16/17 and a further reduction of £250k in 17/18
- Integrated sexual health young people (£601k) reduce by £15k
- Peer education sexual health (£178k) reduce by £108k and further reduction of £70k in 17/18
- Enhanced sexual health promotion for high risk (£170k) reduce by £6k
- Sexual health promotion in commercial sex workers (£50k) reduce by £25k and further reduction of £25k 17/18
- Living well with HIV (£50k) reduce by £3k
- Health promotion in undiagnosed HIV (£40k) reduce by £3k
- North East London Sexual Health Network (NELNET) (£10k) reduce by £10k

2b) What are the equality implications of your proposal?
Sexual health services will remain open access and provided from a wide variety of locations serving the needs of residents of Tower Hamlets. All service provision is actively monitored against the nine protected characteristics and this monitoring will continue to ensure that services are both accessible and meet local needs.

The reduction in acute GUM is expected to be met by increased provider efficiencies and is not expected to have an impact on any of the nine protected characteristics. The reduction in the THCASH service will lead to two services being co-located in a single site and will be supported by a review of satellite services to ensure that the needs of clients currently accessing services are met through either transfer to the new site or met through satellite services.

The reduction in the integrated sexual health services for young people is expected to be met by increased provider efficiency. The reduction in peer education spending is expected to be mitigated by

the mainstreaming of these services in universal services including the youth service.

The reduction in funding for sexual health promotion for commercial sex workers follows a reduction in the number of street based sex workers operating in the borough and a review of service provision has identified that the needs of these clients can be mainstreamed as part of the DIP programme.

The reduction in health promotions programme is expected to be met by increased provider efficiency. The cessation of funding of the NELNET programme is expected to have no impact as clinical providers can continue to operate a network with the resourcing of this from existing resources.

Section 3: Equality Impact Assessment

Target Groups What impact will the proposal have on specific groups of service users and staff?	**Impact – Positive or Adverse**	**Reason(s)** • Please add a narrative to justify your claims around impacts and, • Please describe the analysis and interpretation of evidence to support your conclusion as this will inform members decision making
Race	Neutral	• Sexual ill health is over represented in specific ethnic groups especially people from black ethnic backgrounds. The savings proposed could potentially widen health inequalities if services were restricted or reduced access to people from black ethnic backgrounds. Therefore all services will remain open access and free for local residents and performance management of services will continue to ensure that services address the needs of people from different ethnic backgrounds • GUM- the savings identified will be met through contract negotiations with NHS providers to reduce the cost per person seen. All services will remain open access. • THCASH- there is currently a duplication of services provided by THCASH and GUM. We will work with the provider to identify how savings can be made through integration of services with GUM and encouraging patients who are currently using hospital based services for non-complex services such as accessing condoms only can have services provided from the most cost effective locations e.g. community pharmacists or on line • Integrated sexual health young people- All services will remain open access and free for local residents and performance management of services will continue to ensure that services address the needs of people from different ethnic backgrounds • Peer Education- we will mainstream the peer education services within the youth service and ensure that people from ethnic groups with higher sexual ill health continue to benefit from these services • Sex Workers- there has been a reduction in on street sex workers and we will integrate the promotion of sexual health into other services who work with this client group • Enhanced sexual health promotion for high risk- we will ensure that the services continue to prioritise services to ethnic groups with higher sexual health needs • Living well with HIV- we will ensure that the services continue to prioritise services to ethnic groups with higher sexual health needs • Health Promotion undiagnosed HIV- we will ensure that the services continue to prioritise services to ethnic groups with higher sexual health needs • NELNET- this service will be mainstreamed by the providers
Disability	Neutral	• People with disabilities can have increased sexual health needs and there is some evidence that people with learning disabilities can have poorer sexual health. People living with HIV are a key group with a disability who often have higher rates of STIs. Contract management with services will continue to ensure that services remain open, accessible and that services continue to promote services to people with disabilities • GUM- the savings identified will be met through contract negotiations with NHS providers to reduce the cost per person seen. All services will remain open access. • THCASH- there is currently a duplication of services provided by THCASH

		and GUM. We will work with the provider to identify how savings can be made through integration of services with GUM and encouraging patients who are currently using hospital based services for uncomplex services such as accessing condoms only can have services provided from most cost effective locations e.g. community pharmacists or on line • Integrated sexual health young people- All services will remain open access and free for local residents and performance management of services will continue to ensure that services address the needs of people with disabilities • Peer Education- we will mainstream the peer education services within the youth service and ensure that people with disabilities with higher sexual ill health continue to benefit from these services • Sex Workers- there has been a reduction in on street sex workers and we will integrate the promotion of sexual health into other services who work with this client group • Enhanced sexual health promotion for high risk- we will ensure that the services continue to prioritise services to people with disabilities who have higher sexual health needs • Living well with HIV- we will ensure that the services continue to prioritise services to people with disabilities with higher sexual health needs • Health Promotion undiagnosed HIV- we will ensure that the services continue to prioritise services to people with disabilities with higher sexual health needs • NELNET- this service will be mainstreamed by the providers.
Gender	Neutral	• There are differing sexual health needs according to gender. Services will continue to be open and accessible and all contracts are performance managed by gender to ensure services continue to address gender based sexual health inequalities
Gender Reassignment	Neutral	There is some evidence that residents who have undertaken or are seeing gender reassignment can have worse sexual health with elevated rates of STIs. All services will remain open and accessible and gender identity is recorded to enable ongoing performance monitoring of contracts to ensure services continue to address identified need.
Sexual Orientation	Neutral	There are significant sexual health inequalities in the LGBTQ population. Services will continue to be open and accessible and all contracts are performance managed by sexual orientation to ensure services continue to address LGBTQ based sexual health inequalities.
Religion or Belief	Neutral	There is evidence to suggest that there is disproportionate need for some sexual health services among some religious groups in the borough e.g. FGM. FGM counselling and deinfubulation services are commissioned by the CCG and we will work with them to ensure that the services remain open and accessible throughout any service reconfiguration.
Age	Neutral	Rates of sexual ill health vary with different age groups, young people are disproportionately affected by poor sexual health and the highest rates of STIs is in people it the mid to late 20's age group. There is therefore a risk that reducing service hours could impact on this age group.
Socio-economic	Neutral	There is evidence to suggest that people with lower socio-economic status are disproportionately affected by poor sexual health and higher rates of STIs. All services will remain open and accessible and it is not expected that there will be any impact on this protected characteristic.
Marriage and Civil Partnerships.	Neutral	There is no evidence to suggest that there is disproportionate need for these services among people who are single, married, in civil partnerships, widowed or other groups.
Pregnancy and Maternity	Neutral	There is no evidence to suggest that there is disproportionate need for these services among people who are single, married, in civil partnerships, widowed or other groups.
Other	Neutral	None

Section 4: Equality Impact Assessment Action Plan

Adverse impact	Please describe the actions that will be taken to mitigate this impact
Reduction in access or uptake of services	All services are regularly monitored against the nine protected characteristics and any reduction in access or uptake of services will lead to remedial plans agreed between providers and commissioners.
Failure to mainstream services	In the event that services that have been identified for mainstreaming as part of universal services are not provided then additional commissioning will be considered to meet any identified priority need.
Expected provider efficiencies significantly reduce service provision and adversely impact on services provided to 9 protected characteristics	In the event that reductions in funding to providers lead to a significant reduction in service provision then this will be monitored through regular commissioner meetings. If provider efficiencies cannot be found then services will be reviewed and reprioritised to ensure the most vulnerable users are prioritised.

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Section 5: Future Review and Monitoring

It is not anticipated that there will be any significant impact or that any impact that is subsequently identified will not be able to be mitigated.

OPP TITLE:	**PH 006/2016-17 PUBLIC HEALTH GRANT - Long Term Conditions**					
DIRECTORATE	**ADULTS**					
SERVICE:	**PUBLIC HEALTH**				**LEAD OFFICER: Judith Shankleman/Luise Dawson**	
Associate Director of Public Health	Abigail Knight		**THEME:**	Healthy & Supportive Community		
SAVINGS OPPORTUNITY	**BASE BUDGET £000**	**Savings 16/17 £000**	**Additional Savings 17/18 £000**	**Total Saving**		**Is an EA Req?**
Administrative Efficiencies	1,387,728	296,258	152,2565	448,514		Yes
FTE Reductions						

DETAILS OF SAVINGS OPPORTUNITY

1. Background

The public health aspirations for the long term conditions programme are:

- Good emotional health and foundations for lifelong mental wellbeing
- Positive health habits built into daily life
- Freedom from behaviours harmful to health
- Good outcomes through early identification of need and access to early help to reduce or reverse progression of health conditions and maintain a good quality of life
- Freedom from abuse or neglect
- Dignity and a sense of control in the last years of life

2. Current investments

Tower Hamlets has amongst the highest levels of premature deaths from cardiovascular disease and cancer. This is linked to deprivation and high prevalence of behavioural risk factors (e.g. unhealthy diet,

sedentary behaviour, smoking high alcohol use in those who drink). There is a strong evidence base for intervention to prevent disease or reduce progression (lifestyle change, cholesterol and blood pressure control) The priority in these programmes is to provide prevention and early identification services to those at highest risk of long term conditions (e.g. cardiovascular disease, diabetes and cancer)

- Fit4Life Centre (adult obesity) - takes all referrals, sets goals and signposts to 12 week Fit 4 Life programmes healthy eating, physical activity weight loss and behaviour management £332k
- Fit4Life Group (adult obesity) - 12 week multi component* groups for adults with (or at high risk of) type 2 diabetes and CVD and other long term conditions £270k
- Fit4Life Tier 3 (adult obesity) - specialist 12 week multi component*programme for adults with severe obesity and/or related conditions that require clinical management £208k
- Fit4Life Disability (adult obesity) - specialist 12 week multi component programme for adults with mental ill -health, physical and learning disabilities. £50k
- Health lives data support (EMIS Web) – data to support referrals into the Fit 4 Life programme £25k

- Health checks in primary care - national programme delivering the NHS Health Check for heart disease risks between the ages of 40 – 74yrs £207k
- Cancer public engagement – outreach project increase knowledge of common symptoms and the importance of early diagnosis £55k
- Bower cancer screening promotion in primary care - to improve public awareness and early presentation of cancer symptoms and to reduce delays in referral and diagnosis of cancer in the Tower Hamlets residents at highest risk of developing cancer and of late diagnosis £40k
- Making Every Contact Count (supporting frontline provider to promote healthy lives) £10k
- TB outreach - outreach activities targeting at-risk groups who have complex health and social needs £85k
- Loneliness in Neighbourhoods (pilot)- non-recurrent programme ending in 16/17 £60k
- Loneliness in Care Homes (pilot) – non-recurrent programme ending in 16-17 £60k
- Flourishing Minds (pilot) – non-recurrent programme ending in 16-17 £85k
- Digital Mental Health – non recurrent programme ending in 16-17

3. Proposed budget reductions for 16/17 and 17/18

- Overall funding to Fit4Life Centre, Group and Tier 3 (£810) reduced by £125k and further reduction of £125k in 17/18
- Health lives data support (EMIS Web) (£25k) reduced to £9k
- Cancer public engagement (£55k) reduced by £27k and further £28k in 17/18
- Bowel cancer screening promotion in primary care £40k
- TB Outreach (£85k) reduced by £85k
- Making Every Contact Count (£10k) reduced by £10k

IMPLICATIONS
(Summarise impact on services provided, service users and health outcomes. Outline any risks to achievement of the saving.)

There is a commitment to maintaining services that help adults to manage their weight in order to avoid or reduce the risk of the serious health impacts from long term conditions. However, there is evidence that costs per head are significantly higher in Tower Hamlets than in other areas so it is prudent to look at how costs can be managed so that they are cost effective and proportionate.

An overall reduction of funding to Fit4Life Centre, Groups and Adult Weight Management (£810k funding total) reduced by £125k and further reduction of £125k in 17/18

Fit4Life Centre receives referrals for people eligible for adult weight management and obesity reduction programmes. They undertake an assessment and referral to the appropriate service within the borough, including the full range of activities that are provided in community settings such as healthy walks, exercise programmes in community centres, activities available in leisure centres and other physical exercise and nutritional support programmes. They also follow up people who have been through the Fit4Life programme to encourage maintenance and continued lifestyle change.
Fit4Life Groups is a 12 week structure lifestyle support programme for people who are obese and at high risk of developing long term conditions.
Fit4Life Adult Weight Management is a tier 3 service, designed to provide intensive lifestyle and psychological support over a 12 month period for people with a BMI>35. From April 2016 CCGs will be taking on commissioning responsibilities for bariatric surgery (surgery to reduce the size of the stomach with a band or by removing a section so that appetite is reduced) and are recommended to commission tier 3 services as part of an integrated adult obesity pathway.

The implications are:

15% reduced activity across all contracts in 16/17, equating to:

- Fit4Life Centre: 300 fewer assessments, and 33 fewer people setting an action plan(out of 2,000 assessments and 1,400 plans)
- Fit4Life Groups: 135 fewer people starting the programme (out of 900 starts)
- Tier3 weight management: 33 fewer people starting the programme (out of proposed 220 starts)

30% reduced activity across all contracts in 17/18, equating to:

- Fit4Life Centre: 600 fewer assessments, and 66 fewer people setting an action plan (out of 2,000 assessments and 1,400 plans)
- Fit4Life Groups: 270 fewer people starting the programme (out of 900 starts)
- Tier 3 weight management: 66 fewer people starting the programme (out of proposed 220 starts)

We will work with the service providers for the Fit 4Life programme and with GPs to reduce the impact through more efficient administration and improved use of technology (the unit costs of the service are high compared to areas with similar need) and will ensure that the service to the most vulnerable users (those with the greatest imminent health risk) is not reduced or impacted.

Health lives data support (EMIS Web) (£25k) reduced to £9k

EMIS Web is the IT system used by GPs in the borough, and we have therefore purchased our own licenses to simplify referral pathways into adult weight management services, and thereby improve referral rates. We are able to take out set up costs from the original budget.

There are no ongoing implications as the start-up costs have already been met.

Cancer public engagement reduced by £27k and further £27k in 17/18

Cancer Public Engagement is a grass roots health education programme with two voluntary sector partners. Local community groups are trained in the signs and symptoms of cancer to be alert to, with the intention that they will act as community champions to share this information within their local communities. This has shown to be effective at improving awareness of cancer signs and symptoms, and we are confident that there is a sufficient evidence base to use to apply for alternative sources of funding. LBTH staff will retain involvement by supporting these funding applications.

The implications are that there will be a potential impact on stage of diagnosis of some cancers in the borough, which itself has a significant impact on prognosis. We propose this is mitigated through supporting the organisations to secure other sources of funding that are currently available for work to improve the early detection of cancer such as from national cancer charities.

Bowel cancer screening promotion in primary care reduced by £40k in 16/17

GP Bowel Cancer NIS has been a programme through which we incentivise GP practices to contact patients to encourage uptake of the national bowel cancer screening programme. A local evaluation of this initiative has demonstrated that this has not had an impact on bowel cancer screening uptake. It is therefore not an effective use of public health funds given the restrictions on the overall budget. This remains, however, a priority area for Tower Hamlets as we have relatively low rates of screening uptake. We are working with NHS England – lead commissioners for national cancer screening programmes - to identify alternative interventions to increase screening uptake;

Making Every Contact Count (£10k) reduced by £10k in 16/17

Making Every Contact Count (MECC) – is a training programme for front line social care staff across adults and children`s services to encourage informed and appropriate conversations about healthy lifestyle changes and signposting into supporting services. This programme is being taken on by the Tower Hamlets Integrated Provider Partnership through the Vanguard programme which is funded separately. It will include funding for training programmes across these same staff groups, and wider staff groups within the partnership, ultimately achieving broader reach.

The implications are that this will embed Making Every Contact Count within frontline services more effectively through the Vanguard programme. We will ensure that learning from the LBTH programme is shared and built on.

TB Outreach (£85k) reduced by £85k

The CCG are the lead commissioners of the TB pathway. London-wide services include a peripatetic “find

and treat" service and there are other existing services such as Tower Hamlets Street Outreach and Response Team. The implications of ending the public health funded service are therefore not anticipated to be very significant as the current service duplicates existing provision locally.

EQUALITIES SCREENING		
TRIGGER QUESTIONS	**YES/NO**	**IF YES - please provide further details on how this impacts on each equalities groups**
Does the change affect who provides the service?	Yes	Some contracts are being safely decommissioned. Some pilot projects will not be continued beyond the original end date.
Does the change reduce resources available to address inequality?	Yes	Reducing the contract size of Fit4Life contracts will reduce the number of people going through the service. This potentially has a greater impact on some equality groups, e.g. people with mental or physical disabilities.
Does the change impact on local suppliers?	Yes	Some small organisations are contracted and this will affect their income. There are plans to support the organisations to access other sources of funding.
Does the change impact on the Third Sector?	Yes	Some small organisations are contracted to deliver some services and the change will affect their income stream.
Does the change reduce resources available to support vulnerable residents?	Yes	Reducing the contract size of Fit4Life will reduce the number of people able to use the service. There are plans for the services to secure funding from other sources.
CHANGES TO A SERVICE		
Does the change alter who is eligible for the service?	No	
Does the change alter access to the service?	No	
Does the change involve revenue raising?	No	
Does the change involve a reduction or removal of income transfers to service users?	No	
Does the change affect who provides the service, i.e. outside organisations?	No	
Does the change involve direct impact on front line services?	Yes	Reducing the contract size of Fit4Life will reduce the number of people able to use the service. There are plans for the services to secure funding from other sources.
CHANGES TO STAFFING		
Does the change involve a reduction in staff?	Yes	It is likely that that the budget reduction will require the providers to deliver a small reduction in staffing numbers by reducing duplication of services.
Does the change involve a redesign of the roles of staff?	Yes	It is likely that that the budget reduction will require the providers to redesign roles of staff.

Budget Savings Proposals
Full Equality Analysis – Long Term Conditions

Section 1: General Information

1a) Name of the savings proposal
Public Health long term conditions programme

1b)Service area
Public health

1c) Service manager
Abigail Knight

1d) Name and role of the officer/s completing the analysis

Abigail Knight, Associate Director of Public Health
Sukhjit Sanghera, Senior Public Health Strategist
Judith Shankleman, Senior Public Health Strategist
Luise Dawson, Senior Public Health Strategist

Section 2: Information about changes to services

2a) In brief please explain the savings proposals and the reasons for this change

In the first phase of savings plans, public health has been required to make £2.3million savings from the public health grant. Overall, the principle has to been to preserve investment in early years as far as possible as this is where the strongest evidence is around long term health impact. Preventative services among middle aged and older people, particularly where delivered at an individual level, are less cost effective and therefore have been subject to a number of proposed cuts. In addition, Tower Hamlets has high benchmarked unit costs of obesity services and also the possibility of the CCG funding the higher end elements of the service (under discussion at time of writing paper). Other programmes had weaker evidence for long term impact on health or there were opportunities for funding to be picked up elsewhere.

- Overall funding to Fit4Life Centre, Group and Tier 3 (£810) reduced by £125k and further reduction of £125k in 17/18
- Health lives data support (EMIS Web) (£25k) reduced to £9k
- Cancer public engagement (£55k) reduced by £27k and further £28k in 17/18
- Bower cancer promotion in primary care £40k
- TB Outreach (£85k) reduced by £85k
- Making Every Contact Count (£10k) reduced by £10k

2b) What are the equality implications of your proposal?
All savings proposals have been screened for equalities relevance using the test of relevance questionnaire. (See above)

Fit4Life Programme – Centre, Group and Tier 3 Adult Weight Management. The service started in October 2015 and as this was a new type of service there has been a mobilisation period required of several months. This means that limited data is available as yet on service delivery. The target numbers are for the service to receive 2,000 referrals, primarily from GPs, each year. These would be people with co-morbidities, i.e. long term health conditions such as diabetes, heart disease or mental health issues, as well as being obese or seriously overweight.

The savings template suggests that the worst case scenario is that up to 1/3 of the activity could be lost in a full year. This equates to:

- Fit4Life Centre: 600 fewer assessments, and 66 fewer people setting an action plan (out of 2,000 assessments and 1,400 plans)
- Fit4Life Groups: 270 fewer people starting the programme (out of 900 starts)
- Adult weight management: 66 fewer people starting the programme (out of proposed 220 starts)

There is limited evidence yet on the background of Fit4Life users but evaluation of the previous adult weight management programme in 2013 reported that the service was accessed fairly evenly across

different adult age groups up to age 65. 80% of the participants were women and 66% were Bangladeshi which suggests a disproportionate use of the service by Bangladeshi women which is not in line with the rates of adult obesity in the borough which is higher amongst white adults. This may reflect the more self-referral nature of the previous programme whereas Fit4Life is based on GP referrals through the Fit 4 Life centre and to qualify people must have co-morbidities, so the pattern of referrals may be different.

Public health commissioners have been clear that the reduction in the Fit 4 Life programme will have some impact but there is a commitment from the providers to work with commissioners to aim to minimise the adverse impact. The Fit 4 Life Disability service is not subject to reductions as it is considered that the specialist service for people with the more severe levels of disability should be maintained.

In respect to the **Small c Cancer Public Engagement programme** the evidence is that Bangladeshi people are less likely to be aware of symptoms than white people and, for example, a lower proportion of black and Asian women regularly check their breasts for lumps than do white women. There are also higher perceived barriers such as embarrassment or language issues within some communities that reduce the likelihood of consulting a doctor at an early stage. The mitigation is that other engagement and outreach staff can promote cancer awareness in local communities and there are significant national programmes that will continue.

Bowel cancer screening take up pilot – people aged 60+ are encouraged to take part in the bowel cancer screening programme but rates of take up in Tower Hamlets are lower than in many areas. However, evaluation showed that the pilot was not having a positive impact on screening rates and Public Health is working with NHS England and GP networks to identify better ways of increasing take-up.

TB outreach service – poor completion rates for TB treatment has a stronger association with social risk factors such as homelessness, problem drug and alcohol use and imprisonment rather than with protected characteristics. Other services are available that focus more effectively on these issues.

Section 3: Equality Impact Assessment

Target Groups What impact will the proposal have on specific groups of service users and staff?	**Impact – Positive or Adverse**	**Reason(s)** • Please add a narrative to justify your claims around impacts and, • Please describe the analysis and interpretation of evidence to support your conclusion as this will inform members decision making
Race	Negative	• Fit4Life Centre, Group and Tier 3 – there is some evidence to suggest that the south Asian population is at higher risk of developing LTC and therefore may have greater need for these services. We do not currently have sufficient months' reporting data to comment on who is taking up these services. • Cancer public engagement - this programme has been delivered to Bangladeshi and Somali women's groups. • Bowel cancer promotion in primary care - access to bowel screening is determined by age rather than race. • TB Outreach – half of all people diagnosed with TB are Bangladeshi. However, poor completion of treatment, which this service aims to address, has stronger association with social risk factors than race. • Making Every Contact Count - this is a training programme for front-line staff who deliver services to general population. The MECC programme is being rolled out more widely with Department of Health service integration funding. No impact on race.
Disability	Negative	• Fit4Life Centre, Group and Tier 3 – people with a disability have higher rates of obesity and are at higher risk of developing LTC and therefore may have greater need for these services. The funding for the Fit 4 Life Disability service is not being reduced. • Cancer public engagement - people with disabilities experience worse cancer outcomes than the general population • Bowel cancer promotion in primary care - people with disabilities have lower screening uptake rates than the general population • TB Outreach – poor completion of treatment, which this service aims to

		address, has stronger association with social risk factors than disability. • Making Every Contact Count - this is a training programme for front-line staff who deliver services to general population. The MECC programme is being rolled out more widely with Department of Health service integration funding. No impact on disability.
Gender	Neutral	• Fit4Life Centre, Group and Tier 3 – it is too early to say in the delivery of these contracts whether there is a gender divide in the uptake of these services. However, this has not been the design of these services. We do not currently have sufficient months' reporting data to comment on who is taking up these services. • Cancer public engagement - this programme has been delivered to women's groups. However, the rationale for this is that they share learning and experience with male family members to affect their behaviour. Therefore neither men nor women would be disproportionately affected by the reduction to this service. • Bowel cancer promotion in primary care - access to bowel screening is determined by age rather than gender • TB Outreach – poor completion of treatment, which this service aims to address, has stronger association with social risk factors than gender. • Making Every Contact Count - this is a training programme for front-line staff who deliver services to general population. The MECC programme is being rolled out more widely with Department of Health service integration funding. No impact on gender.
Gender Reassignment	Neutral	There is no evidence to suggest that there is disproportionate need for these services among the gender reassignment population.
Sexual Orientation	Neutral	There is no evidence to suggest that there is disproportionate need for these services among the LGBTQ population.
Religion or Belief	Neutral	There is no evidence to suggest that there is disproportionate need for these services among any religious groups in the borough.
Age	Negative	• Fit4Life Centre, Group and Tier 3 – these services are expected to be predominantly used by people over 40 (according to the clinical criteria for referral). We do not currently have sufficient months' reporting data to comment on who is taking up these services. • Cancer public engagement - this programme has been delivered to community groups of adults from a range of age groups. • Bowel cancer promotion in primary care - access to bowel screening is determined by age (60-74 years). • TB Outreach – poor completion of treatment, which this service aims to address, has stronger association with social risk factors than age. • Making Every Contact Count - this is a training programme for front-line staff who deliver services to general population. The MECC programme is being rolled out more widely with Department of Health service integration funding. No impact on age.
Socio-economic	Negative	• Fit4Life Centre, Group and Tier 3 – people from lower socio-economic groups are more likely to have the clinical risk factors that make them eligible for these services. However, we do not currently have sufficient months' reporting data to comment on who is taking up these services. • Cancer public engagement - this programme has been reaching more socio-economically disadvantaged groups. We do not currently have sufficient evidence that it has influenced their behaviour to affect stage of cancer presentation. • Bowel cancer promotion in primary care - access to bowel screening is lower among the socio-economically disadvantaged. • TB Outreach – poor completion of treatment, which this service aims to address, has a strong association with social risk factors, such as homelessness, problem alcohol or drug use and imprisonment. • Making Every Contact Count - this is a training programme for front-line staff who deliver services to general population. The MECC programme is being rolled out more widely with Department of Health service integration funding. No impact on race.
Marriage and Civil Partnerships.	Neutral	There is no evidence to suggest that there is disproportionate need for these services among people who are single, married, in civil partnerships,

		widowed or other groups.
Pregnancy and Maternity	Neutral	These services are not delivered to pregnant women or new parents.
Other	Neutral	None

Section 4: Equality Impact Assessment Action Plan

Adverse impact	Please describe the actions that will be taken to mitigate this impact
The Fit4Life programme is likely to have greater take up from the south Asian population, people with a disability and people who are socio-economically disadvantaged due to clinical eligibility criteria**.**	Fit4Life contracts were mobilised from November 2015. We do not therefore have sufficient month's reporting data to confirm whether uptake is greatest among any of these communities so this is not a proven concern as yet. We will ensure that an annual review takes account of equality dimensions and recommendations are made to ensure targeted uptake is aligned to groups with greatest need. We have excluded our contract with Ability Bow, who work specifically with people with a disability or a severe mental illness, from these proposals to ensure these groups are not disadvantaged by these savings proposals.
The Cancer public engagement contracts have been delivered to socio-economically disadvantaged, Somali and Bangladeshi groups.	This programme is coming to the end of its contract and we propose not to renew this. Other engagement and outreach staff can promote cancer awareness in local communities and there are significant national programmes that will continue. We have undertaken a robust evaluation of the scheme that the third sector organisations can use, with support of public health staff, to apply for external funding should they wish to continue delivery.
The Bowel cancer screening programme in primary care targets people eligible for screening who are age 60-74 and there is greatest need for screening among people who are disabled or socio-economically disadvantaged.	There is mixed evidence as to the effectiveness of this programme in terms of its impact on uptake of screening programmes. NHS England are the commissioners of the bowel cancer screening service so we are working with them to ensure that appropriate commissioning activity takes place to follow up people who do not access screening, who are likely to be those who are disabled or socio-economically disadvantaged.
The TB outreach programmes is designed to target people with a number of social risk factors, such as homelessness, problem alcohol or drug use and imprisonment.	Local data suggests that this contract is not having the desired impact on these groups. Find and treat services, which are better designed to target people from these groups, are commissioned at a London regional level and may be duplicating these services.

Section 5: Future Review and Monitoring

The Fit4Life programme will continue to be monitored and following the first year of delivery we will be able to monitor uptake across equality dimensions to ensure impact on specific groups is not effected, or is minimised.

The other programmes will be coming to an end, but the impact at a population level will continue to be monitored through the public health screening quality assurance processes and the JSNA programme.

OPP TITLE:	PH 008/2016-17 PUBLIC HEALTH GRANT - PUBLIC HEALTH STAFF OUTREACH TEAM					
DIR: Adults Services				**REF: PH 009 2016-17**		
SERVICE:	**PUBLIC HEALTH STAFF (Health Outreach Worker Programme)**			**LEAD OFFICER: Somen Banerjee, DPH**		
Lead: Somen Banerjee, DPH	PUBLIC HEALTH	**THEMES:** Healthy & Supportive Community				
SAVINGS OPPORTUNITY	**BASE BUDGET £000**	**Net Savings 16/17 £000**	**Net Savings 17/18 £000**	**Total Saving**		**Is an EA Req?**
Administrative Efficiencies	570,000	440,000	0	440,000		Yes
FTE Reductions						

DETAILS OF SAVINGS OPPORTUNITY

1. Background

A sum of public health grant was allocated in 2014-15 to establish a pool of twelve public health outreach workers. Based in Ideas stores but working in other community settings the objectives of the programme are to

- Conduct individual health and wellbeing assessments
- Provide lifestyle advice and signpost to local services
- Provide health and care information and advice
- Gather and share insights on local services
- Implement a health programme in Ideas stores

2. Current investment

- £570k was allocated to this programme (12 outreach workers)
- 3 outreach workers have been recruited so far as the programme is being piloted in Whitechapel Idea Store

3. Proposed reduction in 16/17

- Health outreach worker programme (£570k) reduced by £440k in 16/17

IMPLICATIONS
(Summarise impact on services provided, service users and health outcomes. Outline any risks to achievement of the saving.)

Health outreach worker programme (£570k) reduced by £440k in 16/17

Three public health outreach works were recruited in 2014-15 and are now in post. It is proposed to recruit one further outreach workers making the total team of four outreach workers that will be deployed one in each of the four localities in the borough. The cost of the four workers team is £130,000 per year. This means that a saving of £440,000 in the budget can be realised by not recruiting further outreach workers. No recruitment has been carried out to any of the outreach worker posts that are being deleted through this saving and therefore no staff are affected by the change, which is, however a saving to the public health staff budget overall.
There are no implications on staff and it is considered that four health outreach workers are adequate to meet the objectives of the programme. Since the original funding proposal was agreed a mapping of the available health outreach staff has indicated that with the addition of one outreach worker per locality in addition to other existing services such as Health Trainers there is sufficient capacity.

EQUALITIES SCREENING

TRIGGER QUESTIONS	YES/NO	IF YES - please provide further details on how this impacts on each equalities groups
Does the change affect who provides the service?	No	
Does the change reduce	Yes	There will be a smaller team of outreach workers than was

resources available to address inequality?		proposed. However, public health continues to support a number of outreach programmes through Health Trainers and several other projects that will continue so the impact will not be significant.
Does the change impact on local suppliers?	No	
Does the change impact on the Third Sector?	No	
Does the change reduce resources available to support vulnerable residents?	No	
CHANGES TO A SERVICE		
Does the change alter who is eligible for the service?	No	
Does the change alter access to the service?	No	
Does the change involve revenue raising?	No	
Does the change involve a reduction or removal of income transfers to service users?	No	
Does the change affect who provides the service, i.e. outside organisations?	No	
Does the change involve direct impact on front line services?	No	
CHANGES TO STAFFING		
Does the change involve a reduction in staff?	Yes	It does not impact on current staff but does reduce the size of the staff team that would have been recruited if the full recruitment had gone ahead.
Does the change involve a redesign of the roles of staff?	No	

Budget Savings Proposals
Full Equality Analysis – Health Outreach Workers

Section 1: General Information

1a) Name of the savings proposal
Public health Grant Savings Proposal – Health Outreach Workers

1b)Service area
Public Health – Adults` Services

1c) Service manager
Tim Madelin

1d) Name and role of the officer/s completing the analysis

Keith Williams, Public Health Commissioning Programme Manager

Section 2: Information about changes to services

2a) In brief please explain the savings proposals and the reasons for this change

In the first phase of savings plans, public health has been required to make £2.3million savings from the public health grant in response to reductions in the level of grant by central government. Public Health has considered how to make the savings with the minimum impact on population health and least exacerbation of health inequalities using a priority-based approach. In respect to the public health staff team a reduction in the proposed numbers of Health Outreach Workers, based in Idea Stores, from 12 to 4 achieves an annual saving of £440,000, and as these proposed posts are not yet filled, there is no risk of compulsory redundancy of in-post staff involved.

2b) What are the equality implications of your proposal?
All savings proposals have been screened for equalities relevance using the test of relevance questionnaire attached (see above).

Since the original funding proposal was agreed a mapping of the available health outreach staff has indicated that with the addition of one outreach worker per locality in addition to other existing services such as Health Trainers there is sufficient capacity. There are no implications for staff and it is considered that four health outreach workers are adequate to meet the objectives of the programme.

There is a potential impact on Tower Hamlets residents in deprived communities who experience the poorest health of a reduced team of Outreach Workers. However, this is mitigated by the existence of other existing outreach activity which is not being reduced. In practice there will be no reduction in current levels of activity as the posts that are affected by this proposal are unfilled proposed posts that had not started to deliver any activity. So the impact is against the extra activity that could have been delivered had the original proposal for twelve workers been followed through. As stated above a review of outreach activity concluded that the additional Outreach Workers proposed would not add significant value for the level of investment required.

In respected to the protected characteristic groups, health inequalities impact more significantly on some of the characteristic groups, particularly ethnic groups, older people and disabled people, however, as there is no reduction in current activity there is no immediate impact. The current team of Health Outreach Workers works across the protected groups and no particular impact on any of the characteristic groups is identified.

Section 3: Equality Impact Assessment

With reference to the analysis above, for each of the equality strands in the table below please record and evidence your conclusions around equality impact in relation to the savings proposal.

Please list in the table below any adverse impact identified and, where appropriate, steps that could be taken to mitigate this impact. This analysis will inform the decision making process

If you consider it likely that your proposal will have an adverse impact on a particular group (s) and you cannot identify steps which would mitigate or reduce this impact, you will need to demonstrate that you have considered at least one alternative way of delivering the change which has less of an adverse impact.

If an adverse impact cannot be mitigated please describe an alternative option, its costs and the equality impact.

Target Groups What impact will the proposal have on specific groups of service users and staff?	**Impact – Positive or Adverse**	**Reason(s)** • Please add a narrative to justify your claims around impacts and, • Please describe the analysis and interpretation of evidence to support your conclusion as this will inform members decision making
Race	No impact	Reducing the number of outreach workers will not impact disproportionately on the race characteristic group.
Disability	No impact	Reducing the number of outreach workers will not impact disproportionately on the disability characteristic group.
Gender	No impact	Reducing the number of outreach workers will not impact disproportionately on the gender characteristic group.
Sexual Orientation	No impact	Reducing the number of outreach workers will not impact disproportionately on the sexual orientation characteristic group.
Religion or Belief	No impact	Reducing the number of outreach workers will not impact disproportionately on the religion/belief characteristic group.
Age	No impact	Reducing the number of outreach workers will not impact disproportionately on the age characteristic group.
Socio-economic	No impact	Reducing the number of outreach workers will not impact disproportionately on the socio-economic characteristic group.
Marriage and Civil Partnerships.	No impact	Reducing the number of outreach workers will not impact disproportionately on the marriage/civil partnership characteristic group.
Pregnancy and Maternity	No impact	Reducing the number of outreach workers will not impact disproportionately on the pregnancy/maternity characteristic group.
Other		

Section 4: Equality Impact Assessment Action Plan

Please list in the table below any adverse impact identified and, where appropriate, steps that could be taken to mitigate this impact.

If you consider it likely that your proposal will have an adverse impact on a particular group (s) and you cannot identify steps which would mitigate or reduce this impact, you will need to demonstrate that you have considered at least one alternative way of delivering the change which has less of an adverse impact.

Adverse impact	Please describe the actions that will be taken to mitigate this impact
None identified	

If an adverse impact cannot be mitigated please describe an alternative option, its costs and the equality impact.

Section 5: Future Review and Monitoring

Please explain how and when the actual equality impact of these changes will be reviewed and monitored. Resources for public health outreach will be reviewed again before the end of 2016 as part of an outcome-based review of all public health programmes. This will provide an opportunity to consider the impact of the proposed saving. It is likely that in light of continuing pressure on resources the programme will be reviewed regularly thereafter.

Public Health Savings Phase 1 2016-17

ANNEX B

PUBLIC CONSULTATION FEEDBACK

Your borough your voice public health savings consultation 20th May – 16th June 2016

1. Introduction

1.1 The Your Borough Your Voice – Public Health savings consultation gave users and other stakeholders the opportunity to comment on and feedback on the savings proposals being put forward to reduce public health expenditure by 2.3 million as a consequence of reductions in the level of Public Health Grant from the Department of Health. The reductions in public health grant were not confirmed by the government until early in 2016 so consultation on these proposed savings was not possible to include in the earlier Your Borough Your Voice public consultation in respect to the Council`s Medium Term Financial Strategy.

1.2 The consultation was designed to meet statutory and best practice consultation guidance by providing an opportunity for users and stakeholders to give their views on perceived impacts that the proposals could have, including identifying the groups that could be affected by the proposals and setting out any potential adverse impacts, risk or benefits to the proposals**.**

1.3 The consultation with users and stakeholders included:

- General consultation facilitated through the council website.
- Direct consultation through user group meetings, regular stakeholder meetings and open public sessions
- Presentation and discussion with the Overview and Scrutiny Committee

1.4 Council staff are not directly affected by the current public health savings other than in terms of a reduction of the new Health Outreach Worker team which will now be reduced in size. The three Health Outreach Workers currently in post were briefed on this and had the opportunity to respond. They were chiefly concerned about the impact of reduced capacity (see 3.8.2 below).

1.5 The consultations on the savings proposals ran from 20th May to 16th June 2016. A range of methods were used to capture feedback including web-based options, face to face discussions with stakeholder groups, open to the public sessions and specific interest groups. A full list of the consultation events is set out below.

1.6 The findings of the consultation have been used to further assess the equality impact of the savings proposals and full Equality Assessments are being presented with the draft programme savings proposals to inform final decisions.

2. Approach to consultation

2.1 The savings proposals were presented under the public health programme work areas as follows:

- Healthy Communities
- Maternity and Early Years

- Children and Young People
- Smoking Cessation
- Sexual Health
- Long Term Conditions
- Health outreach staff

2.2 Equality screening was undertaken for each savings proposal to identify possible impacts on groups with protected characteristics. These assessments identified the potential degree of impact and were published along with the detail of savings proposed and the rationale for each saving.

2.3 General public consultations on all the savings was undertaken through the council website. Detailed templates set out each proposed saving and explained the reasoning for each proposal along with equality screening information. The website also provided access to background information about the scope and role of the Council`s public health programme and access to a copy of the full report on savings proposals and the budgetary reasons that the savings are required. Responses could be made through a template.

2.4 There were 223 responses on the Council website during the consultation, including 152 responses on the proposed savings in the Maternity and Early Years programme, far more than for any other public health programme area. Most of the responses for the programme tended to focus on one proposal that attracted particular attention and comment. Summary details of the consultation responses are set out below in section 3.

2.5 Public health managers also presented details of the proposals in a range of regular stakeholder meetings including the following:

- Rainbow Hamlets LGBTQ Conference
- Healthwatch Board
- Clinical Commissioning and GP Forum
- Local Management Committee (LMC)
- CCG Long Term Conditions Group
- Sexual Health Advisory Board
- Older People`s Reference Group
- Integrated Care Board
- Children and Families Partnership Board
- DAAT Board
- Adults` Services, Children`s Services and CLC DMTs
- East London Cancer Board
- CCG Children and Young People Programme Board

2.6 User group meetings were held with the following groups

- Two sessions with users of sexual health health promotion services – a total of 20 users attended
- Two sessions were held with users of smoking cessation services (BME specialist service and specialist smoking cessation service) – a total of 17 users and service staff attended.

2.7 Public health managers have also met and discussed the proposals with managers of services funded from public health grant - both those where savings are proposed and those where no savings are currently proposed.

2.8 Services also engaged with their service users to encourage feedback.

2.9 To provide an additional opportunity for discussion and feedback four open sessions were arranged – two at Idea Stores and two at community venues. These were not especially well attended but did provide an opportunity for some constructive discussion between the public and the Director of Public Health and Lead Member.

2.10 Awareness of the consultation was raised through the issue of a press release at the start of the consultation period, news about the consultation on the council`s homepage, the use of social media and information about the consultation going out through local networks via the CVS networks and the Healthwatch mailing list.

2.11 In addition to the option to feedback though the council website feedback forms were issued in paper format at a number of the meetings and stakeholders were also offered the option to write in direct to the Director of Public Health.

3. Summary of responses from stakeholders

3.1 General responses

A letter from the Local Medical Committee expressed concern about the likely impact of service reductions across the whole programme of savings proposed. The LMC wrote:

"we are horrified by these cuts. .. and are disappointed that our council, along with other Labour Councils, have not resisted more strongly. Austerity is having an appalling effect on the lives of large numbers of our patients many of whom are amongst the most deprived in the country. ... Why will those in charge of policy making not listen to the evidence?"

In response the Council has pointed out that alongside co-signers from 6 other London boroughs the Lead Member wrote to the Department of Health and the former Mayor of London in protest against the public health cuts which would 'cut funding to London's most deprived boroughs, whilst its wealthiest gain.' Further, in a letter to Jeremy Hunt, she stated that the cuts would 'have a direct impact, not only on our most vulnerable residents and communities but also on our local health services who inevitably bear the cost of treating preventable poor health.'

Tower Hamlets Council officers also responded to the Government's formal consultation to challenge the cuts.
The GP Care Forum pledged to work with the Council to identify where public money was not being well used and to reduce duplication and waste. They suggested that there could be significant cost benefits from working closely together, for example sharing premises to host services.

A number of responses from the public, service providers and other stakeholders such as the LMC made the point that the government`s public health savings were short-sighted and likely to undermine health improvement work leading to greater strains on the NHS in future.

The Geezer`s Club (older men's group) stated:
"By reducing the available funding to these Projects thereby making them less regular it will just push the money spent to another sector notably the NHS, because more people will fall in to the trap of being unfit or obese, therefore these people are more likely to be treated by GPs and Hospitals."

3.2 Programme Responses - Healthy Communities

3.2.1 Online Responses

Twenty-one online responses were received. Nineteen of these thought that the proposals would have an impact and the following groups were identified:

- Local communities
- Families and people over aged 55
- Regular users of Health Trainer services
- Service organisations

Two responses thought that there could be a positive impact from the proposals which they expressed as:

- Saving public money, and
- Money wasted on teaching people what they already know

Nineteen people thought there would be negative impacts such as:

- More health issues and demands on the NHS
- Health inequalities
- Less health trainer sessions available locally to people who cannot afford to pay elsewhere
- More isolation/depression and reduced self-esteem
- Long term health impacts
- Job losses

Other comments made were that the Council should help organisations to secure other sources of funding if Council funding was reducing.

3.2.2 Qualitative Comments from other engagement

Health Trainer services were mentioned in most of the open public meetings and their role as healthy lives promoters in local communities was strongly advocated, mirroring some of the online responses. It was suggested that Health Trainers were effective at engaging with the most vulnerable adults – Bangladeshi women, people with mental health issues and the Somali community – and that reducing the teams in size would have an impact on these groups. Much of the testimony came from Health Trainer Team members themselves. The Healthwatch Board thought that Health Trainers needed to be more visible to the wider community.

There was also regret expressed that the Can Do Community Development programme could not be continued as this had provided a genuinely bottom up approach to raising the local awareness of the small scale changes that could make a difference to community health outcomes. The Council was asked to support efforts to secure alternative funding.

3.2.3 Service response

Consultation has highlighted the extent to which Health Trainers is a valued service within local communities. It is acknowledged that outputs – numbers of local people engaged and supported – will reduce. The prioritisation undertaken by Public Health has been a difficult exercise and proposed savings for Health Trainers need to be seen in the context of the overall programme positon and the need to reduce costs. Mitigation of impact will be possible though targeting of the most vulnerable and better join up across public health and other services.

The added value the Can Do Community Development programme has delivered over a number of years is recognised and the Council will support the provider organisations to identify other sources of funding.

3.3 <u>Programme Responses - Maternity & Early Years</u>

3.3.1 Online Responses

One hundred and fifty-two responses were received on this programme which represents 68% of all responses. Almost all of the responses focused on the proposed saving in public health funding for the breast feeding support team. 148 of the responses considered that the proposals would have an impact, including on the following groups:

- Health of children (and families) as grow up
- Mothers and babies especially the most vulnerable e.g. ethnic minority, non-English-speaking, poorest
- Mothers who struggle to breastfeed due to complications e.g. tongue tied baby
- Other staff teams e.g. midwives
- Peer support workers, volunteers and peer supporters (Parent and Infant support Pilot)
  - Health visiting Teams

Nineteen responses considered that there were positive impacts. These were:

- Parent should be more responsible
- Increased cost efficiency e.g. healthy start vitamins – more efficient distribution achievable
- Deliver same outcomes at lower cost
- Balancing the budget
- Too much emphasis on breast-feeding
- Brushing for Life could be commercially sponsored

One hundred and forty-eight responses though that there would be negative responses:

- Reduction in critical support for mothers at a very vulnerable time – less 1:1 help available
- Less breast-feeding and more bottle feeding leading to health impact slater
- Impact on mothers self-esteem if breast feeding fails – post natal depression and psychological impacts
- Increased pressure on A and E and acute services
- More health problems not being recognised
- Adverse impact on service quality standards
- Impact on oral health (if Brushing for Life packs less available)
- Impacts on staff and volunteers in Parental Support team and families supported

Other comments included a great deal of individual and passionate testimony to the excellent work of the Breast Feeding Team and how this had a positive impact on parents, children and families. Also that the proposed saving is short term thinking leading to longer term health issues and that the Council should look at other savings instead.

3.3.2 Qualitative Comments from other engagement

The strategy of aiming to protect the public health investment in maternity and early years services was generally supported in the meetings, however, there were concerns that the Parent and Infant Wellbeing programme (known as Better Beginnings), a pilot project that runs until March 2017, was unlikely to continue due to lack of available funding. The programme trains volunteer peer supporters to work with families during pregnancy and the first year of life and the primary concern was around how the pool of volunteers that had been built up would be sustained and supported after the programme ended.

The chair of the Local Medical Committee (LMC) in a letter responding to the consultation expressed strong concern at any reduction in the Health Visitor programme, the breast feeding support service and the Brushing for Life programme.

The Older People`s Reference Group, whilst understanding the focus on protecting services for maternity and children, were concerned that this should not lead to a neglect of the vital services for older adults, some of which appeared to them to be under threat.

3.3.2 Service response

The high value which users place on the Breast-feeding support service comes through forcefully in the consultation responses and Public Health recognise this and agree that early years services are crucially important for lifetime health outcomes. In fact the overall spend on early years has been protected in the proposals and the level of reduction is lower than for other programmes. In addition discussions with Barts Health have identified scope to better manage the administrative burden on the breast feeding support team so that the support workers face to face time with breast-feeding mothers can be maximised in order to mitigate the impact of savings.

The Parent and Infant Wellbeing Programme was designed to be a pilot that ended after two years. An evaluation is being conducted and it is intended that the learning from this programme would be mainstreamed through other services, for example Health Visiting. The Council will also support the provider organisations to identify other sources of funding, including joint bids with Public Health.

Within the oral health programme the proposal is to prioritise maintaining the Healthy Teeth in Schools (fluoride varnish) programme which is strongly evidenced and supported by NICE guidance. Brushing for Life will be continued with a smaller budget but other sources of funding to provide free toothpaste and toothbrushes will also be explored.

The existing Health Visiting service has been protected from proposed savings and the increased number of Health Visitors that have recently been recruited will be maintained, but savings have been made to the funding available to further expand the service

3.4 Programme Responses - Children and Young People

3.4.1 Online Responses

Thirteen responses were received. Eleven of these thought there would be an impact and groups cited were:

- Children and families
- Primary Schools
- Families that don`t engage with health messages
- Children most vulnerable to poor health and health inequalities in life

Three people thought there could be positive outcomes. These were:

- Less waste
- Less cycling (too dangerous)

Twelve responses thought there were likely to be negative impacts:

- Negative impact on child health e.g. child obesity, oral health
- Loss of opportunities and enriching activities in school e.g. Bike It
- Several positive comments received on Bike it programme
- Impact on school travel plans and road safety
- Dental hygiene
- Need for more expensive interventions later in life

Other comments were:

- Why cut children`s health at all?
- Empower families and community nurses to do more
- Lets down the promised London Olympics legacy

3.4.2 Qualitative Comments from other engagement

The Local Medical Committee (LMC) were concerned about the impact on child obesity in particular of reducing the Child and Family Weight Management and Health Families programmes and also school cycling training.

The Healthwatch Board supported the idea that the Youth Service should do more on health promotion with young people and that the current review of the Youth Service is a good opportunity to take this forward.

3.4.3 Service response

Public health services for young people were also prioritised through the review and the impact of the relatively small level of proposed savings minimised. In respect to programmes where there are savings proposed Public Health will work with the providers to ensure that the mitigations reduce the impact. With respect to the cycling in schools programme, for example, the provider wishes to continue the delivery and there are other sources of funding that can be pursued.

In respect to services for young people/adolescents it is agreed that the review of the Youth Service is a very good opportunity to do much more on health through the main youth service curricula. Public Health and Children`s Services will bring forward a plan setting out how this can be achieved.

3.5 Programme Responses - Smoking Cessation

3.5.1 Online Responses

Nine responses were received. Seven responses thought there would be an impact on the following:
- Vulnerable smokers with multiple conditions
- People wanting to quit smoking – especially those who prefer 1:1 rather than group therapy

Five people thought that there could be a positive impact from the changes proposed:
- Saving public money
- Stop supporting smokers – the harm is self –inflicted

Eight responses thought there would be negative impacts:
- Reduction of easiest to access services in GPs and pharmacy
- More young people will start smoking if school intervention reduced
- Will impact significantly on other health services (NHS) if increases long term conditions

Other comments were that the proposed changed approach as outlined needs a more strategic rationale than given and a stronger needs assessment to target the support better.

3.5.2 Qualitative Comments from other engagement

Two meetings were held with users and staff of the Specialist Smoking service and the BME smoking service which are both delivered through Queen Mary University. Some concern was expressed about the reduction of the smoking cessation programmes from 12 weeks to 8 weeks and the need for patients to understand the shorter timeframe for NRT support. It was also suggested that longer treatment might be required for patients with serious mental illness or

long term conditions. There was also a request for more training on medicine management.

3.5.2 Service response

Public Health will work with schools and Children`s Services to ensure that smoking cessation work in schools with young people is maintained.

In respect to the adult smoking cessation services there will be greater focus on targeting the most vulnerable smokers for ongoing support; there will continue to be a range of accessible services to support people to quit smoking including community pharmacists.

3.6 Programme Responses - Sexual Health

3.6.1 Online Responses

Twenty-four responses were received. Twenty three people thought there would be an impact on groups including the following:

- Young people, especially Bangladeshi
- Bangladeshi women (contraception)
- People unwilling to go to GP for help
- People with /at risk of HIV
- Sex workers

Three people thought that there could be positive outcomes. The following were cited:

- More online support and testing could be made available
- Opportunity to move funding into the most effective services and for better integration

Twenty one responses though that there would be negative impacts:

- Merging Mile End clinic with Ambrose King risks fragmenting the patient pathway (Barts Health response)
- More STIs and teenage pregnancies
- Impact on specialist clinics – loss of skilled jobs and reduced patient satisfaction
- Some client groups were less likely to use pharmacy or GP services e.g. men who have sex with men
- Less prevention and reduction of early diagnosis for HIV and other STDs
- Reduced ability for very specialist work on child safeguarding and gang related
- Drug Intervention Programme (DIP) service not able to offer the same support on sexual health issues to sex workers who have rising rates of STIs due to increasing unsafe sex

Other comments were:

- That the cuts focus on patient-facing services,
- GP waiting times are off putting and GPs cannot take up the strain of reduced services in acute
- There is no mention of gay men or MSM in the proposals

- School PHSE is not capable of filling the sex education gap

3.6.2 Qualitative Comments from other engagement

At meeting with service users at Positive East there was strong support for the sexual health promotion services that were being provided through the voluntary sector organisation. There was a need for more testing to avoid late diagnosis of HIV and some support for increased focus on primary care and pharmacies. The merger of Mile End Hospital (MEH) clinic and Ambrose King Centre at the Royal London Hospital with MEH site still providing level 2 services was broadly supported.

The Executive Director of Positive East wrote to the Director of Public Health supporting the borough`s aim of protecting prevention services as far as possible and continuing to support work with high risk groups and those at risk of HIV and welcoming that only modest savings were proposed in this area.

The GP Forum thought that some services could be provided more efficiently and free condom distribution for example needed to be better targeted.

3.6.3 Service response

The consultation broadly confirmed the priority of maintaining support for sexual health promotion and prevention interventions.

Greater efficiency is required in the delivery of sexual health treatment services at an affordable cost as otherwise unacceptable levels of cost will fall upon other high priority areas of the programme such as early years and children`s public health. The Council will continue to work with providers and with other East London boroughs to accelerate the shift to more cost effective and sustainable commissioning in this service area.

The merger of the Mile End clinic and the Ambrose King clinic provides an opportunity to deliver a more accessible, higher quality and better integrated service in redeveloped facilities on the Royal London site. We are already working with Barts Health to deliver this.

The contraception and sexual health service for young people is being maintained with a small saving and as indicated above in other responses Public Health will work with the Youth Service to ensure that the focus on sex and relationship education, reducing teenage pregnancies and avoiding sexually transmitted infections is maintained.

The DIP provide a specialist outreach team that has better engagement with street-based sex workers and has an equivalent level of competence to refer workers into contraception and sexual health treatment services when required.

3.7 Programme Responses - Long Term Conditions

3.7.1 Online Responses

Four responses were received on long term conditions. All four thought there would be an impact on the following groups:

- Residents at risk of cancer
- Hard to reach and vulnerable communities
- Isolated people

No-one thought there would be positive outcomes. Three thought there would be negative impacts:

- Potential impact on levels of TB, cancer.
- Late diagnosis
- Increased NHS costs
- Inequalities in cancer outcomes

Other comment s referred to the risks on low screening rates and TB issues in Tower Hamlets, general concern about public health reductions and increasing health inequalities from multiple factors e.g. the impact of the new housing act. The East London Cancer Board asked how the Council intended to discharge its public health duties on cancer prevention.

3.7.2 Qualitative Comments from other engagement

At one of the open public sessions there was a discussion about loneliness, isolation and mental health issues in some communities and the need for greater engagement with these issues including some of the existing mainstream health services. The point was made at several of the meeting that the isolation older people could feel was compounded by the lack of access to the internet and web based communications which hindered their ability to respond to the service consultations that public sector like bodies like the Council increasingly relied on.

GPs expressed some concern about the proposed reductions in the Fit 4 Life adult obesity programme although it was also recognised that savings in then public health programme needed to be identified in challenging circumstances. GPs felt that social prescribing could potentially fill some of the gap and make up some of the funding that would be lost to the voluntary sector.

The Healthwatch Board and the older people`s reference Group were concerned about a reduction in the “small c” cancer community engagement programme as early identification of cancer remains a serious challenge in Tower Hamlets.

The Geezers Club (older men`s group) thought that there should be more focus on men’s health issues such as prostrate and testicular cancer.

3.7.3 Service response

The consultation on the long term conditions has been open that here is likely to be an impact from the proposed savings in terms of numbers engaged. This means that more precise targeting will be required. The Public Health commitment is to maintain the focus on risk factors such as smoking and being overweight and the most prevalent conditions such as Type 2 Diabetes, heart disease and cancer. We will work with the service providers and colleagues in

NHS services to identify how we can be more efficient and align better or integrate our approaches and budgets to ensure that we make best use of the resources we have available in Tower hamlets.

3.8 Programme Responses - Health Outreach Workers

3.8.1 Online Responses

There was only one response on this proposal. No negative impacts were perceived and it was suggested that it was preferable to reduce this service rather than some of the other services being proposed for savings such as Health Visiting.

3.8.2 Qualitative Comments from other engagement

The chair of the Local Medical Committee in a letter responding to the consultation commented that in the light of the shortage of advocacy for BME patients in the borough, the loss of the additional Health Outreach Workers could have a detrimental impact. Health Outreach Staff were concerned at the potential impact on capacity for community engagement on health issues.

3.8.3 Service response

The impact of the saving in Health Outreach posts can be mitigated by a better join up of existing outreach and engagement services so that we improve health literacy in the community and levels of health service access in the most vulnerable part of the community.

4. General Comments

4.1 Many of the respondents made the point that reducing the public health grant undermined the government`s stated commitment to maintaining health funding, was short-sighted and was likely to lead to an increase in levels of poor health and more especially greater health inequalities in the longer term. Many people commented on the potential adverse impact on the NHS. Some people suggested that the Council should "fight back" against the government cuts but many recognised that if the budget was reduced the savings had to be found somewhere from the programme and there were no easy choices.

4.2 The overall strategy of aiming to maintain preventative public health services and programmes for early years and children and young people was generally supported but many online responses though that the cuts proposed to early years and children's health services undermined this intention (although the overall level of reduction for early years and children`s services at 8% and 7% respectively is far lower than for long term conditions (37%), smoking cessation (35%), or non-acute sexual health (27%) .

4.3 There were also concerns about savings in the Health Trainers' budget, the Fit 4 Life programme and sexual health services. In short virtually none of the proposed savings were particularly well-received but there was understanding about the difficulty of the position and a welcome commitment from many of the key partner organisations such as the GP forums and the voluntary sector providers to work with the Council`s public health team to protect and continue

the public health improvements that had been achieved over the past few years.