CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD

Cambridgeshire County Council

Date:Thursday, 17 September 2015

10:00hr

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

Shire Hall
Castle Hill
Cambridge
CB3 0AP

Meeting Room 5, Bargroves Centre Cromwell Road, ST NEOTS, PE19 2EY

AGENDA

Open to Public and Press

CONSTITUTIONAL MATTERS

1	**Apologies and Declarations of Interest** *Guidance for Councillors on declaring interests is available at http://tinyurl.com/ccc-dec-of-interests*	
2	**150917 HWB minutes**	**5 - 14**
3	**150917-3 July minutes**	**15 - 28**
4	**150917-4 Action Log**	**29 - 32**
	THEME - PRIORITY 4 - Create a safe environment and help to build strong communities, wellbing and mental health	
5	**150917-5 Person's Story**	**33 - 34**

The Cambridgeshire Health and Wellbeing Board comprises the following members:

Councillor Tony Orgee (Chairman)

Councillor Margery Abbott Councillor Daryl Brown Councillor Mike Cornwell Councillor Sue Ellington Sylvia Knight Kate Lancaster Adrian Loades Chris Malyon Val Moore Dr Sripat Pai Liz Robin Councillor Joshua Schumann Aidan Thomas and Matthew Winn Councillor Paul Clapp Councillor Lucy Nethsingha Councillor Peter Topping and Councillor Joan Whitehead

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

Clerk Name: Ruth Yule

Clerk Telephone: 01223 699184

Clerk Email: ruth.yule@cambridgeshire.gov.uk

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

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

The Council does not guarantee the provision of car parking on the Shire Hall site and you will need to use nearby public car parks http://tinyurl.com/ccc-carpark or public transport

CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD: MINUTES

Date: **17th September 2015**

Time: **10.00 to 13.30**

Place: **Meeting Room 5, Bargroves Centre, Cromwell Road, St Neots**

Present:

Cambridgeshire County Council (CCC)
Councillors P Clapp, L Nethsingha, T Orgee (Chairman) and J Whitehead
Dr Liz Robin, Director of Public Health (PH)
Adrian Loades, Executive Director: Children, Families and Adults Services (CFAS)

District Councils
S Ellington (South Cambridgeshire) and R Johnson (Cambridge City)

Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)
Dr John Jones
Dr Sripat Pai (substituting for Dr Neil Modha)

Healthwatch
Val Moore

Apologies: Councillors M Cornwell (Fenland), R Mathews (Huntingdonshire); C Malyon (Section 151 Officer), N Modha (CCG), M Berry (NHS Commissioning Board) and J Farrow (co-opted representative of Voluntary and Community Sector)

145. ELECTION OF VICE-CHAIRMAN/WOMAN

Councillor Ellington was elected Vice-Chairwoman for the municipal year 2015-16.

The Chairman welcomed Val Moore, Chair of Healthwatch Cambridgeshire, to her first meeting of the Board, and welcomed Dorothy Gregson, Chief Executive to the Police and Crime Commissioner, as the Board's honoured guest, representing the Commissioner, Sir Graham Bright, who apologised that he was unable to attend.

146. DECLARATIONS OF INTEREST

None

.

147. MINUTES AND ACTION LOG UPDATE

The minutes of the meeting of 2nd July 2015 were signed as a correct record, and the Action Log update was noted.

148. A PERSON'S STORY

The Board received a report and was read an account of the experiences of a person who had suffered several episodes of depression and made several suicide attempts. After several years of regular visits to the GP and intermittent involvement of crisis teams and hospital-based psychiatrists, the person had received 12 weeks of

cognitive behavioural therapy (CBT) and been placed on a clinical trial, and was currently free of depression. The person had nothing but praise for the emergency teams, but not for other professionals, and had been kept going through the years of depression by the help and support of a friend and the friend's partner.

Points raised and noted in the course of discussing the person's story included

- it would have been helpful to have a member of the Mental Health team present to respond
- the CCG had mental health as a priority, with resources being put into it, because of stories such as this
- the author had told the story to the Mental Health Crisis Care Concordat group, which included the leader of the crisis team and other senior staff, where a useful discussion of the experiences outlined had taken place
- GPs were of critical importance in mental health treatment; it was important that they be well trained
- 75% of those dying from suicide had not seen a psychiatrist in the year before their death
- other factors affecting the person's wellbeing had included housing, welfare benefits, employment and loneliness – it was important to look at mental health issues within the wider context
- poor communication was a feature in this story as in other patient stories
- the author's friend had been an important positive factor – to help the system be joined up to meet the needs of those who had no such friend, part of the Board's role was to ensure that services joined up round a person, including referral to voluntary agencies
- vulnerable patients needed to know what sources of help were available and how to access them
- the aim of telling the story to the Board had been to raise the level of attention mental health and the Crisis Care Concordat received at senior level.

The Chairman expressed the Board's gratitude to the person who had been brave enough to provide the story, which gave food for thought, particularly about communication, about whether people felt that they were being listened to, and how they were treated.

The Board noted the story as context for the remainder of the meeting.

149. PROGRESS REPORT ON HEALTH & WELL-BEING STRATEGY PRIORITY 4: CREATE A SAFE ENVIRONMENT AND HELP TO BUILD STRONG COMMUNITIES, WELLBEING AND MENTAL HEALTH

Received a report updating members on progress with the Health and Wellbeing Strategy Priority 4: 'Create a safe environment and help to build strong communities, wellbeing and mental health'. Members noted that themes from the person's story just heard could be found in each stream of work described in the report.

In the course of discussion, members

- enquired whether the work of the various agencies described in the report was

changing the system response – for example, were GPs aware of the changes. It was important that individual service users could see that co-ordination between agencies was happening

- from a District Council perspective, reported that, as part of Local Health Partnership work, it had become apparent that a lot of council staff (in for example housing and social care) were quite frightened of any mention of mental health, thinking that it was something for specialists, so would not touch it. A Leaders' Seminar was being arranged about this problem, and workshops set up for staff to help them feel more comfortable when approaching people with mental health issues; the hope was that confidence amongst grass roots staff would grow
- noted that monthly meetings were held between partner organisations (including CCG, Cambridgeshire and Peterborough NHS Foundation Trust [CPFT] and MIND) in order to align approaches, while recognising that each organisation had its own performance indicators and priorities; care should be taken to avoid setting up duplicate or overlapping forums in addition to the existing ones
- drawing attention to the importance of suicide prevention work, expressed concern at whether this had sufficient priority in GP training, and at the level of support that GPs received. Members were advised that GPs were much engaged in the work that was going on; there were limits on GP numbers and on capacity and space in primary care to do more. Work was being undertaken with the voluntary sector and recovery coaches to ensure that nobody was discharged from hospital without access to sources of help
- enquired about work being done on the possible effects of the introduction of universal credit, which meant that people would receive their money monthly in arrears. Those with mental health problems would perhaps be less able than others to deal with these changes.

  The Executive Director CFAS undertook to circulate a briefing to HWB members, before the Board's next meeting, on the work being done on universal credit and provision of support in benefits sanction cases in Children, Families and Adults Services and in the District Councils . **Action required**

The Board noted the update.

150. REPORT FROM THE POLICE AND CRIME COMMISSIONER

Received a report which introduced the Police and Crime Commissioner's strategic vision to reduce demand on public sector services through an effective prevention agenda and set out how this vision could support the work of the Health and Wellbeing Board. Dorothy Gregson, Chief Executive, Cambridgeshire Office of the Police and Crime Commissioner (PCC) presented the report.

Arising from the report, members

- asked what assistance was given to people with mental health issues who were victims of crime, and what training in this was available to frontline police. The Chief Executive advised that a victims' hub had been established, through which a victim could have access to community psychiatric nurses (CPNs) and through which police officers could also obtain support
- noted that the Crisis Care Concordat group was undertaking an analysis of police training; it was necessary to be mindful of support for police officers, a significant proportion of whose calls were mental health related, which could have an impact

on their own mental health. It was also important that police officers were in a position to refer people to sources of support – the handback into the community was very important, as evidenced in the person's story already heard

- noted that the Police and Crime Commissioner's office monitored police sickness absences and were very aware of the stresses on police staff; cuts were making their jobs very different from a few years ago, and it was important to ensure that staff were flourishing
- enquired whether GPs were involved in low-level diversion of alcohol. The Chief Executive undertook to feed this point back to the office; the attitude to diversion was to use it to help people change their behaviour.

The Board noted the role of the Police and Crime Commissioner as a key stakeholder within the mental health agenda specifically through his focus on prevention.

151. CHILD AND ADOLESCENT MENTAL HEALTH TRANSFORMATION BID

As an urgent item of business, with the Chairman's and the Board's agreement, the Director of Public Health explained that numerous requests were being received to approve bids for central government funding, most recently the Child and Adolescent Mental Health Transformation bid. The Chairman added that this bid had to be approved by mid-October. Members noted that the funding would support work already being undertaken.

It was resolved unanimously to delegate to the Director of Public Health, in consultation with the Chairman of the Health and Wellbeing Board, authority to sign off the bid for Child and Adolescent Mental Health Transformation funding on behalf of the Health and Wellbeing Board.

152. NEW COMMUNITIES: NEW HOUSING DEVELOPMENTS AND MIGRANT POPULATIONS JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) 2015

Received a report presenting the proposed scope of the New Communities: New Housing Developments and Migrant Populations JSNA. The Board noted that, while the impact of the Syrian refugee crisis on Cambridgeshire was not yet clear, it was likely that there would be a high proportion of people with mental health needs, and a high proportion of children. The Board's advice was being sought on whether the JSNA should include an annex on refugees.

Members drew attention to the report considered by the Council's General Purposes Committee on 15th September on the CCC Strategy for Supporting New Communities. It was also pointed out that the Local Plans for Cambridge City and for South Cambridgeshire were still being considered by the Planning Inspector; the question was asked how far the JSNA work on new communities could be slotted into the emerging local plan work, given that the Councils had proposed that the inspectors' examination of the local plans be suspended until February 2016, and it was intended to complete the JSNA by March 2016.

The point was made that a JSNA covering both new communities and migrant populations would be extremely large, particularly given the number and extent of housing developments in the county and the need to consider their effect on the pre-existing communities. Officers advised that two working groups were covering different aspects of the report, and when it had first been decided to develop this JSNA, it had been recognised that it would equate to about three smaller JSNAs.

The Chairman pointed out that the issue of migrant populations did not overlap completely with new communities work, and rather than having refugees as an annex, there should be two separate documents.

The Board supported the proposed scope of the New Communities: New Housing Developments and Migrant Populations JSNA as outlined in the report, but as two separate JSNAs, one on New Communities and New Housing, the other on Migrants and Refugees.

153. ACCELERATING ACHIEVEMENT – PROGRESS UPDATE

Received a report updating the Board on the delivery of the Accelerating Achievement Strategy 2014-16 and inviting it to consider activities across the Health and Wellbeing Partnership that supported this work. Members noted the achievement gap in Cambridgeshire between vulnerable groups of pupils and other pupils, with those children who were entitled to free school meals and also had a special educational needs or disabilities achieving least well. The strategy aimed to reduce the gap by three percentage points by 2016.

In response to their questions and comments, members noted that

- considerable work on Looked After Children (LAC) had been undertaken as part of the action plan. There was a legal requirement to produce a personal education plan every six months for LAC, but Cambridgeshire produced one each term, looking at how the additional funding could best be used for the child
- the School Improvement Service had regular Keeping in Touch visits with headteachers and chairs of governors, which now included questions about how the pupil premium was making a difference to pupils' achievement. Pupil premium Plus for LAC was funded and monitored by the Head of Virtual School
- of groups not listed in the report, including children with mental health issues and LGBT children, work with children who had English as an additional language (EAL) was focussing on Eastern European and asylum seekers. The role of the Cambridgeshire Race, Equality and Diversity Service (CREDS) included supporting the cultural identities of children who were the only ones in a community with that identity; Stonewall provided support to transgender children; and work was being done with Child and Adolescent Mental Health Services
- there were gypsy/traveller children in 46% of the county's primary schools. The CREDS team had been trying to bring some of the adults in these communities into engagement with primary schools, and the Head of Virtual School was happy to visit sites to help spread the message about what was available.

Members thanked the Head of Virtual School for a useful report and welcomed the emphasis on progression as well as on absolute levels of attainment.

The Board noted the report.

154. SAFEGUARDING ADULTS BOARD (SAB) ANNUAL REPORT 2014/15

Received a report presenting the 2014/15 Safeguarding Adults Board Annual Report. Members noted that the report had been supplied in draft because it had not yet been presented to the SAB for final approval. The report included key work being undertaken with partner organisations, which included Healthwatch Cambridgeshire.

Examining the report, members

- commented on the relatively poor take-up of adult safeguarding training opportunities in contrast to well-attended children's safeguarding course. It was pointed out that the statutory safeguarding children framework had a much longer history than the adult framework. Members noted that changing training to support the Making Safeguarding Personal approach (rather than process-led) had led to better take up; the hoarding course had filled on the first day it was advertised
- noted that, as a consequence of the Supreme Court judgement in relation to Deprivation of Liberty Safeguards (DoLS), Cambridgeshire, like other local authorities, was now operating with a significant DoLS waiting list and was trying to gather suitably qualified staff to tackle this
- asked what the network of engagement was with care homes. Members were advised that there were regular provider forums, well-attended, at which the safeguarding message was communicated and providers had the opportunity to ask questions. However, the forums did not cover providers with whom the local authority did not place people, and there was a question of how best to engage them in a proactive preventative relationship. Members noted that Helathwatch Cambridgeshire was in discussion with care homes
- in relation to pressures on care homes, including the forthcoming national living wage, noted that the Care Quality Commission would expect care homes to continue to maintain sufficient staff; local authorities and providers had already started to raise the issue with the comprehensive spending review
- offered congratulations on many aspects of the report, in particular the nomination for one of the National Learning Disability and Autism Awards.

Drawing attention to the Safeguarding Adults Board work with Cambridge University colleagues, the Chairman suggested that there was more that the HWB could do to inform its own practice. The Service Director: Adult Social Care offered to provide a report on work in relation to safeguarding being undertaken with the universities.

The Board noted the Cambridgeshire Safeguarding Adults Board 2014-15 Annual Report and resolved unanimously to receive an update report later in the financial year on work in relation to safeguarding being undertaken with the universities.

155. CAMBRIDGESHIRE LOCAL SAFEGUARDING CHILDREN BOARD (LSCB) ANNUAL REPORT 2014-15

Received a report presenting the Local Safeguarding Children Board Annual Report for 2014-15. Members noted that the report had been supplied in draft because it was still to be presented to the LSCB on 22nd September 2015. Andy Jarvis, Business Manager for LSCB, attended to represent the LSCB Chair, Felicity Schofield, who sent her apologies.

Members noted that there was a statutory duty on the LSCB to present its annual report to the HWB. The main events of 2014-15 had been the Ofsted inspection and three serious case reviews. The LSCB's main priorities had been domestic abuse, child sexual exploitation, and safeguarding disabled children.

In response to the report, members

- congratulated the Business Manager on the report, which was much pithier and

more accessible than its predecessors

- drew attention to the importance of children's mental health, particularly in relation to self-harm and suicide
- enquired whether every member of staff working with children was currently aware of child protection policies. Members were advised that the LSCB had gone out to every agency to ask that very question, and was seeking replies from those that had not yet responded
- commented that considerable work on child sexual exploitation was being carried out in Wisbech, but not reflected in the report; every member of staff was being encouraged to report suspicions of child sexual abuse
- encouraged work to improve the transition between children's and adult services. The Executive Director CFAS said that it would be possible to have initial discussions between the Safeguarding Adults Board and the LSCB and bring a report to the HWB. One of the serious case reviews had included a hiatus in transition, with the young person almost having to re-register for the adult version of the service they had received as a child. **Action required**

The Health and Wellbeing Board resolved unanimously to confirm that, including the Safeguarding Adults Board, all three statutory partnerships shared the Health and Wellbeing Board Strategic priority to:

> "Develop integrated services across education, health, social care and the voluntary sector which focus on the needs of the child in the community, including the growing numbers of children with the most complex needs, and where appropriate ensure an effective transition to adult services."

156. BETTER CARE FUND UPDATE

Received a report presenting a copy of the Quarterly Report on the Better Care Fund (BCF) in the first quarter of 2015/16, submitted on 28 August. Members noted that the target of a reduction of 1% in non-elective admissions had not quite been achieved. This was believed largely to be due to the period of setting up and mobilisation that had followed the start of the UnitingCare contract on 1st April; it would take time for UnitingCare's initiatives to take effect.

The Board noted that the CCG had started discussions with UnitingCare on metrics for the user experience, and Healthwatch had also started work with UnitingCare. Healthwatch and CCG agreed to share their work with each other.

Members commented that the report had not been easy to understand, and sought assurance that progress was being made in the right direction, remarking that only the CCG and UnitingCare could make the figures move. The Chairman thanked officers for their report; the Board would await the next report with interest.

The Board noted the Better Care Fund Quarterly Report.

157. CAMBRIDGESHIRE AND PETERBOROUGH HEALTH AND CARE SYSTEM TRANSFORMATION PROGRAMME

Received a report updating the Board on the Health and Care System Transformation Programme; the CCG was leading a process to plan changes to the health system to improve outcomes for people and enable financial sustainability. Members noted the

early engagement work and analytical work being undertaken. The CCG's application for 'Urgent and Emergency Care' Vanguard had been successful, bringing with it funding and support for work on the management of emergency and urgent care.

Discussing the report, members of the Board

- expressed concern at the lack of progress since the report to the Board at its July meeting. The present report set out a clear description of the challenge, but no indication of how to solve it; events had been overtaking progress. The CCG Director of Corporate Affairs, attending the meeting on behalf of the Programme Director System Transformation Programme, acknowledged that developments such as the Vanguard bid and recent pressures at Addenbrooke's Hospital were making it necessary to adapt the transformation programme to events
- noted that the CCG Board had looked at the increasing budget pressures at its meeting on 15th September; money was forcing conversations between organisations, as no single organisation could solve the financial challenge alone
- observed that there were signs of change, such as some GP practices federating or joining into super practices
- commented that there was a lack of urgency in the report; it had been known for the last 18 months that there would be a shortfall in funding in 2019. The Board noted that more detailed conversations were taking place than were reported in the present public paper.

The Director of Public Health reported that she had been asked to lead on the development of a Prevention Scoping Strategy for the Cambridgeshire and Peterborough workstream tripartite group, working with the Executive Director CFAS. The strategy arising from this scoping work would be brought to meetings of both the Cambridgeshire and the Peterborough HWB.

The Board noted the report.

158. FORWARD AGENDA PLAN

Considered the HWB agenda plan, noting that a Board development day was planned for the morning of 29th October.

As well as adding the Prevention Scoping Strategy (minute 156 refers) to the agenda plan for 19th November 2015, it was suggested that, in view of the forthcoming publication of the Care Quality Commission (CQC) report on Cambridge University Hospitals NHS Foundation Trust (CUHFT), an update on developments at CUHFT be added to the November agenda. The Board was advised that both CUHFT and CQC had been invited to attend a meeting of the Health Committee on 5th November.

Action required

The Director of Public Health (DPH) advised that a bid by Cambridgeshire and Peterborough for participation in the first wave of the NHS Diabetes Prevention Programme was being submitted; the submission deadline was 18th September, and the needed to be approved by the DPH and the Chair of the HWB. She offered to circulate the bid form to Board members. **Action required**

159. DATES OF NEXT MEETING

Noted dates of the Board's forthcoming meetings (all at 10am on Thursdays):

- 19th November, Shire Hall, Cambridge CB3 0AP
- 14th January 2016, South Cambridgeshire Hall, Cambourne CB23 6EA
- 17th March 2016, East Cambridgeshire District Council, The Grange, Nutholt Lane, Ely CB7 4EE

Chairman

CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD: MINUTES

Date: **2nd July 2015**

Time: **10.05 to 13.05**

Place: **Council Chamber, Fenland Hall, March**

Present: Cambridgeshire County Council (CCC)
Councillors P Clapp, T Orgee (Chairman) and P Topping (substituting for Cllr M Loynes),
Dr Liz Robin, Director of Public Health (PH)
Adrian Loades, Executive Director: Children, Families and Adults Services (CFAS)

District Councils
M Cornwell (Fenland), S Ellington (South Cambridgeshire) and R Johnson (Cambridge City)

Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)
Dr John Jones
Dr Sripat Pai (substituting for Dr Neil Modha)

Healthwatch
Ruth Rogers

Apologies: Councillors M Loynes, L Nethsingha and J Whitehead (CCC); Cllr R West (Huntingdonshire); M Berry (NHS Commissioning Board), C Malyon (Section 151 Officer), N Modha (CCG) and J Farrow (co-opted representative of Voluntary and Community Sector)

127. NOTIFICATION OF CHAIRMAN

Noted that the County Council had appointed Councillor Tony Orgee as Chairman for the municipal year 2015-16.

128. ELECTION OF VICE-CHAIRMAN/WOMAN

The election of the Vice-Chairman was postponed to later in the meeting, as several members of the Board were not present.

129. DECLARATIONS OF INTEREST

Ruth Rogers declared an interest as Chief Executive of Red2Green.

130. MINUTES AND ACTION LOG UPDATE

The minutes of the meeting of 30th April 2015 were signed as a correct record.

The Action Log update was noted, including that:

- the question of one overall mental health strategy document was being discussed with the Service Director for Older People's Services and Mental Health, and with CCG officers and officers from other organisations.
- the addition of 'JSNA implications' as a section to all corporate papers had been agreed with the County Council's Strategic Management Team and Democratic Services
- the letter to the Department of Health highlighting the frustrations imposed by the current data protection limitation on information sharing had been signed
- the terms of reference for CEPB were being developed and placed on the agenda plan for a future Health and Wellbeing Board meeting

131. A PERSON'S STORY

The Board received a report and watched a short film of a daughter describing the last few years of her mother's life; the mother in her 90s had become increasingly frail and required more care from the daughter and care workers. Difficulties encountered had included poor communication between A&E and fracture clinic of the same hospital on how a broken ankle had been stabilised, and, later on, the tendency of inexperienced carers to assume that the mother was either deaf or not paying attention when she displayed silence as a defence mechanism when hearing unwelcome news. The last real smile that the daughter had seen from her mother had been in response to having her hair washed and blow-dried as a result of a carer's efforts.

Discussing the film and the lessons to be learned from the person's story, members of the Board commented on

- the importance of the linkages between services so that accurate and appropriate information was conveyed
- the need to acknowledge that family carers and the person being cared for were often the real experts on what was needed
- the difference that one individual carer's initiative, and something as simple as a hairdo, could make to the wellbeing of the person cared for – ideally, all health workers should be displaying this can-do attitude.

The Board noted the story as context for the remainder of the meeting.

132. PROGRESS REPORT ON HEALTH & WELL-BEING STRATEGY PRIORITY 2: SUPPORT OLDER PEOPLE TO BE INDEPENDENT, SAFE AND WELL

Received a report updating members on progress with the Health and Wellbeing Strategy Priority 2: Support Older People to be independent, safe and well. Members noted that there were two main elements being pursued by the CCG, Local Authorities and other stakeholders, namely the Older People and Adult Community Service Contract with UnitingCare, which offered a new model of integrated services and integrated teams; and the Better Care Fund (BCF).

From a CCC perspective, progress was being made towards the Transforming Lives programme, which included activity round getting advice to people when it was needed, achieving rapid crisis resolution, and developing on-going support. Work was being done around job descriptions for staff in Social Care to reflect this model, and around the structure of care teams on a geographical basis; this work was all being done in conjunction with UnitingCare, not as an individual organisation.

In the course of discussion, members

- in relation to delivery of UnitingCare's new service model of integrated teams, noted that the joint emergency team now covered the whole of Cambridgeshire and Peterborough, and had moved on 1 July 2015 to providing 24/7 coverage; neighbourhood teams were due to be implemented in September 2015, following the current formal consultation with staff on the new roles and how the teams would operate. The Executive Director: CFAS undertook to share the consultation with the Board **Action required**

- noted that existing services, such as district nursing, were continuing to operate meanwhile, and would be incorporated into the new neighbourhood teams in September

- enquired whether there were target dates for the expansion of OneCall beyond the initial phase of taking GP referrals. The Assistant Director, Improving Outcomes, Older People Programme Lead undertook to provide this information

- drew attention to the updates provided by UnitingCare for circulation to the Board. The Democratic Services Officer was asked to ensure that these were circulated consistently **Action required**

- asked how it was possible to reconcile preserving the confidentiality of records with the sharing of patient information with voluntary and community organisations involved in providing care. Members noted that this was a long-standing challenge; efforts were being made to join up different elements of NHS and social care records. UnitingCare were working on north and south voluntary sector collaborations, but this was dependent on patient consent. The CCG had contracts with non-NHS organisations, which were bound by the same regulations as NHS organisations with regard to confidentiality

- suggested that robust protocols were required to address the question in advance of how to reconcile family wishes with clinical intervention in a crisis situation. The Executive Director said that the approach described conformed to good social work practice, involving the individual and the family, and working to reconcile any differences between them; timeliness of intervention was key. The Assistant Director added that UnitingCare wanted to ensure good care plans were in place, ideally agreed with patient, family and carers, so that all knew what to do in a crisis

- noted that UnitingCare had looked at levels of deprivation and health care needs in each area when putting together the 17 integrated teams, and had checked with local GPs and others with local knowledge to see whether their plans for an area made sense for that area. Projected population growth had also been taken into account, but the number of teams could be changed if it proved necessary

- reflecting on the Person's Story, in which communication difficulties within one hospital had been described, suggested that people's views should be sought in a year's time on how well UnitingCare's efforts to improve connectivity were working.

The Director of Public Health reminded members that the Board had statutory duties to assess need and promote integration, and to consider if a Section 75 agreement was appropriate; there was such an agreement for the BCF, but Priority 2 was much larger than that. It was reassuring that Transforming Lives was working with

UnitingCare; the Board needed to assure itself that integration was being maximised to achieve the best outcomes for people.

The Board noted the update.

133. JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) ON LONG TERM CONDITIONS ACROSS THE LIFECOURSE

Received a report introducing the Cambridgeshire JSNA on Long Term Conditions (LTCs) across the Lifecourse. Members noted that this was the result of the efforts of a dedicated working group across a large number of organisations, and that stakeholders and voluntary and community sector organisations had been involved in its development throughout.

The focus of the JSNA was on people with adult-onset LTCs at high risk of poor health outcomes. It was accompanied by data supplements which were intended to be presented online; members were invited to give feedback on these [available at www.cambridgeshireinsight.org.uk/JSNA/LTCs-across-the-lifecourse-2015]. Rather than focussing on a single disease, this JSNA had taken a person-centred lifecourse approach to identifying and improving outcomes for people with LTCs.

Discussing the JSNA, members

- commended the document as excellent, thought-provoking and practical; it stressed the importance of self-management, targeted many important issues and demonstrated the extent to which mental health intertwined with almost all issues

- noted that the JSNA, which was a more technical document, was accompanied on the website by a set of ten slides summarising it, and a plain document in plain language for carers and service users

- drew attention to the high impact of deprivation on health, and stressed the importance of including economic factors in the Board's deliberations, such as wage levels and where business was being generated in Cambridgeshire; income was an important indicator of health

- noted that the importance of support at the point of diagnosis had emerged in the local views workshop; carers throughout the workshop had highlighted issues relating to the person cared for, not carer burden and stress

- in response to a question about the inclusion of the various types of immobility, such as of knees and hips, noted that the predictive modelling tool used on the limitation element had included pain and immobility

- described the JSNA as the most important piece of work the Board had seen for a long time, helping to explain what wellbeing was and how it crossed all services

- said that because of the scope for the strategic use of the JSNA, all providing services across the county should acknowledge its importance; a delivery plan should be developed so that use of the JSNA could be monitored

- in answer to a question about delivery routes for taking the JSNA forward, noted that UnitingCare had asked Public Health to identify high-risk populations, that another element was to support the Cambridgeshire Public Service Board's work

on the Healthy Lives JSNA, and that other options included reducing hospital admissions. Board members were invited to contribute further suggestions, and suggested that it might be appropriate to give presentations of the JSNA to various other groups, such as the CCG Governing Body and Local Health Partnerships.

In conclusion, the Chairman asked that members report any typographical errors they happened to notice to the Consultant in Public Health Medicine. He also asked that the Board receive updates at a future meeting on actions arising from the JSNA, He described the Long Term Conditions JSNA as a helpful and excellent report, which drew attention to the influence of deprivation, and treated Mental Health as a long-term condition of equal importance to physical conditions.

It was resolved unanimously:

- to approve the Joint Strategic Needs Assessment
- to note the findings and the areas highlighted for further work.

134. BETTER CARE FUND UPDATE

Received a report updating the Board on Cambridgeshire's Better Care Fund (BCF) plan, on national monitoring of the BCF, and on the associated projects; the BCF had also been covered under agenda item 7 (minute 132 above). Members further noted that in Cambridgeshire, the Fund was being used to support existing work and to promote targeted work. Attention was drawn to the first of the quarterly returns submitted to central government, which covered the last quarter of 2014/15, so related to the period before BCF had come into effect. The Chairman advised that, because the return had to be made by a certain date, he had given his approval to its submission, prior to reporting it to the Board at the present meeting.

Discussing the update, members

- welcomed the fact that the agreed target for reducing non-elective admissions had been accepted; the 1% reduction had been made against rising admission figures
- commented that data sharing had been an issue for some time, and noted that CCC was working with the UnitingCare model of a single view of a patient record; it was important to accelerate what UnitingCare was doing, and bring in more data from the social care system as it came online
- pointed out that, from personal experience, data sharing was not always functioning well at present, and sought assurance that this would improve. Officers advised that there were measures in place about data sharing in the UnitingCare contract which would be pursued through UnitingCare work on assurance; there were both factual measures of information sharing, and also proposed measures of how patients felt the information sharing was working, for example whether care team members are talking to each other.

The Board noted the update on the Better Care Fund monitoring and non-elective admissions targets.

135. UPDATING THE JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) SUMMARY REPORT

Received a report introducing an updated JSNA Summary Report. This summary had been developed by Wendy Quarry, the JSNA Programme Manager, and Helen Whyman, a public health information analyst. The Director of Public Health congratulated them both on producing the summary, which could be used as a map of JSNAs, and would be helpful to officers when they needed to produce a summary of a JSNA to a deadline, for example when putting together a funding bid,

Commenting on the summary report, members

- drew attention to the link given in the introduction; anybody interested in a particular JSNA could find details at www.cambridgeshireinsight.org.uk/jsna

- pointed out that percentage figures in table of Key Population and Health Statistics added up to rather more than 100%; the Programme Manager apologised and undertook to correct the error **Action required**

- noted that the summary report might be useful to the CCG Governing Body, as the summary brought together a number of reports that it had not received

- enquired whether there was any way in which the public could see what progress had been made in implementing key findings, and asked how new data was factored in to past JSNAs. Officers advised that a review of how the findings of JSNAs were being addressed had only recently been carried out; it formed an important part of JSNA work.

The Chairman thanked officers for the Summary Report.

The Board noted the updated JSNA Summary Report.

136. ADDRESSING THE FINDINGS OF THE TRANSPORT AND HEALTH JOINT STRATEGIC NEEDS ASSESSMENT

Received a report updating the Board on the proposed actions to take forward the findings of the Transport and Health Joint Strategic Needs Assessment 2015 (JSNA). Members noted that Appendix A set out opportunities to maximise the use and influence of the JSNA; the appendix was focussed on South Cambridgeshire at this stage, as this was the District that the author knew best.

The report invited members to suggest where each partner represented at the board could address the findings of the JSNA, and to suggest other opportunities for the JSNA not currently addressed within Appendix A.

In discussion, members

- pointed out that the JSNA had implications for authorities as they were developing their local plans; the current suspension of the Cambridge City and South Cambridgeshire local plan hearing provided an opportunity for those authorities to consider the implications

- stressed the relevance of the JSNA to the City Deal; as City Deal priorities were being set, it was important to see how the JSNA's priorities fitted in to various

projects being completed over the next few years. Members noted that officers had already brought this to the City Deal's attention

- commented that one of the reasons people were not adopting healthy commuting was infrastructure problems, and drew attention to the poor condition of some roads for example in the Wisbech area

- advised that Cambridge City now had its own Air Quality Action Plan, not a joint one

- noted that the CCG Director of Corporate Affairs had already shared the JSNA with the transformation team in the context of where and how to locate services; she also sat on the Cambridgeshire and Peterborough Workforce Partnership with Health Education East of England.

The Chairman recommended reading the JSNA, and asked whether it had been sent to the three leaders of the County Council, the City Council and South Cambridgeshire District Council as the three local authorities in the City Deal area. The Senior Health Improvement Specialist undertook to do this. **Action required**

The Board noted the progress to date on implementing the findings of the JSNA.

137. ALCOHOL AND DRUGS JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)

Received a report updating the Board on the proposed scope of the Alcohol and Drugs Joint Strategic Needs Assessment (JSNA). Members noted that it was planned that this JSNA would have a broad scope because of the wide impact of drug and alcohol issues. There were four priority areas being recommended for inclusion in the JSNA, with four shared themes in each area; this wide remit would involve a great deal of work with stakeholders in the county.

The Executive Director: CFAS expressed admiration for the ambitious scope of this far-reaching JSNA, and asked that it be made clearer that children and young people were included in its remit. The report author undertook to do so. **Action required**

Welcoming the proposed inclusion of the issue of legal highs, one member asked whether there might be value in the Chairman writing to the Secretary of State to ask for guidance. The Chairman said that he was willing to do so, but it would perhaps be better to wait until the JSNA had been completed and the relevant data was to hand. He pointed out that, while he too welcomed in the inclusion of legal highs, other activity was legal, such as the use of tobacco and alcohol. He stressed the importance of a whole lifecourse approach to the JSNA.

It was resolved unanimously:

to agree the proposed scope of the Alcohol and Drugs JSNA as outlined in Section 4 of the report before the Board.

138. LIBRARY SERVICES IN CAMBRIDGESHIRE: DEVELOPING OUR APPROACH FOR THE FUTURE

In preparation for this item, a paper from Councillor Jocelynne Scutt was circulated and time taken to read it [attached as Appendix A]. The Chairman confirmed that he would have allowed her to speak had she been able to attend; she had indicated that would have liked to attend but apologised that she had another commitment.

Received a report seeking the Board's views on key areas of collaboration in achieving the transformation of the Library Service. Members noted that the intention was to develop a library service that supported Cambridgeshire's communities by building community resilience; enabling more than delivering; maximising use of assets; and digital first. The Board's views were being sought on

1. Developing shared objectives and outcomes
2. Identifying opportunities for joint service delivery
3. Engaging with communities and helping to support vulnerable people
4. Working together to help deliver skills, employment and enterprise opportunities
5. Who in your organisation can we work with to develop and take this forward?

The Service Director: Infrastructure Management & Operations explained that the paper set out the transformation of the library services in the context of saving 40% on the current library budget; libraries were much valued local assets, and everybody involved was keen to see this as an opportunity to transform and work with partners across traditional organisational boundaries. Councillor Scutt's paper referred to the decision to rescind the earlier decision on the Enterprise Centre at the Central Library; officers had been asked to look at alternative solutions, but it was important to recognise that non-delivery of the Enterprise Centre proposals would result in the need for savings to be made elsewhere. Although initial consultation on the strategy had closed on 10 May, the dialogue continued, and the Board's comments on the transformation of the Library Service would be welcomed.

In the course of discussion, members

- reported feedback that it had been difficult to engage with the consultation because it was on a general and generic level

- pointed out that not all initiatives referred to in the report were new – the GP surgery in Cambourne had been established about ten years ago, for example, and the children's centre there had been opened in 2008

- in the context of libraries and their relationship with Health and Wellbeing, and bearing in mind Councillor Scutt's point that libraries were a very trusted brand, commented that one of the opportunities to reach people was when they visited a library. Libraries were well-placed to deliver information, and computer literacy, and help with completing forms to access services – the relationship between libraries and Health and Wellbeing was important and significant

- reminded the Board that, as part of the Making Assets Count programme, services had been combined at County and District level, both in Chatteris and more recently in Whittlesey; it was necessary to understand that unless libraries became an all-embracing information point, service providers would have to put their own personnel in at times in order to provide specialist advice

- suggested that any attempt to use libraries to deliver wider services would have to be carefully marketed, as some sectors of the population would immediately be put off at any mention of attending a library; in some more deprived parts of the county it would be necessary to provide points of contact more locally

- pointed out that it would be necessary to have people available to give advice, or some ready means of accessing advice; not everybody would be happy to use a help screen, for example

- expressed interest in the idea of libraries acting as signposts to help people get access to health services, commenting that digital inclusion now opened up more possibilities and access to the next tier of support in a way that would have been impossible ten years ago

- reported seeing skype-style screens in use in libraries elsewhere some years ago; people could have face-to-face contact remotely when seeking advice, and were also able to complete forms over the system. Adding the human dimension was likely to encourage older people to use a remote system

- in relation to Councillor Scutt's comments on dementia services, cautioned that what was being proposed for libraries was a dementia-friendly approach, not a treatment service but a place where people who were vulnerable by reason of dementia would be able to engage, which in itself was preventative

- sought assurance that Wisbech library would remain open delivering literacy and numeracy education with the long-term aim of helping people to find employment

- endorsed the ned to keep community facilities open for people, as many library users did not have ready access to information via the internet at home; this would also help remedy the divide in digital literacy.

In response, the Service Director said that
- he noted and understood the point about the vagueness of the consultation
- the intention was not to take a uniform approach across the county but to tailor services to local need and local governance, as for example at Clay Farm
- he would pick up the suggestion around the skype-style screen
- he could not give reassurance that any specific library would not close, but it was probably unthinkable to close a key library such as Wisbech.

The Board noted the report.

139. CAMBRIDGESHIRE AND PETERBOROUGH HEALTH AND CARE SYSTEM TRANSFORMATION PROGRAMME

Received a report updating the Board on the strategic aims and values of the Cambridgeshire and Peterborough Health and Care System Transformation Programme; on the strategic planning process; and on the NHS England second wave Vanguard applications for acute hospitals.

Members noted that the programme was currently in phase 2. Key elements of this phase were detailed analysis of the issues facing the health system; engagement with the public around key challenges; and getting feedback from the public. A series of engagement events was planned, including Saturday Cafes and Public Involvement Assemblies. In relation to becoming a Vanguard site for new models of acute care collaboration, it was reported that, following an unsuccessful application in January, the System Transformation Programme would be considering whether to apply for inclusion in the second stage, for which the application deadline was 31 July 2015.

In the course of discussion, members

- commented that the update did not make it clear whether the programme was on track, and that it ought to be known by now whether a second phase Vanguard application was to be made, as the deadline was so soon.

  The Chair of Healthwatch explained that she and the Executive Director: CFAS both sat on the system transformation board. A considerable number of its discussions, which included trying to identify potential funding gaps in the health and social care system, were held in confidence to avoid giving rise to widespread premature speculation; the result was that the update document was not very transparent, but for a reasonable reason. To help provide reassurance, the Executive Director offered to share the project plan with members

  Action required

- noted that there were a number of workstreams involved in implementing the transformation programme. Progress had been made, but it was a huge piece of work, and a great deal of research was required because some of what was being proposed were major system changes The programme did not hinge on the Vanguard application, and if it were unsuccessful, ways of delivering the work from the transformation programme's own resources would be explored.

- pointed out that local government, as well as the NHS, was being required to make extensive savings

- commented that people needed a level of understanding to participate effectively in public engagement sessions; a few examples would aid understanding. It was important to get the first stages right, as the proposals when they emerged were likely to be far-reaching

- suggested that it would be sensible to hold a public engagement session in St Neots, as it was a large conurbation. Members were assured that a Public Involvement Assembly was planned for St Neots as part of the extensive programme of engagement.

The CCG Director of Corporate Affairs offered to circulate the workstreams and public engagement documents; quite a lot of ideas were still coming forward, and ever suggestion led to more ideas. **Action required**

The Director of Public Health advised members that she had now joined the System Transformation Board to help with the focus on preventative work. For example, the Health and Wellbeing Board's Public Health Reference Group had developed a paper on evidence-based ways of reducing the impact of obesity.

The Board noted the contents of the report.

140. NHS CAMBRIDGESHIRE AND PETERBOROUGH CLINICAL COMMISSIONING GROUP (CCG) – CHOICE OF LOCAL QUALITY PREMIUM INDICATORS FOR 2015/16

Received a report asking the Board to signal agreement to two of the proposed local indicators which would form part of the Quality Premium for 2015/16. Members noted that national planning guidance required CCGs to submit two local indicators, which in

combination with the national set of indicators would form the basis of payment of the 2015/16 Quality Premium. The three local indicators proposed by the CCG were

- Antenatal assessment <13 weeks (i.e. by 12 weeks and 6 days of pregnancy)
- Prevalence of breast feeding at 6-8 weeks from birth
- Stroke patients admitted to stroke unit within 4 hours (of arrival at hospital).

Of these three, the CCG recommended the second and third to the Board.

Discussing the choice, members

- expressed the view that the stroke-related indicator should definitely be one of those chosen, as the other two both related to childbirth

- asked why stroke patients were being encouraged to go to hospital, when the general aim was to keep people out of hospital. It was explained that attendance at a specialist unit was for initial diagnosis and treatment, and did not necessarily mean that the patient was being admitted to stay in hospital. Outcomes for all strokes, including mild ones, were far better if treated quickly

- suggested that it would have been appropriate to include a target relating to Child and Adolescent Mental Health (CAMH) services, which were under great pressure. Members noted that the choice of local indicators had to be made from a prescribed list of options, which probably did not include CAMH

- expressed support for antenatal assessment as contributing to the reduction of health inequalities, because those who did not present for assessment within 13 weeks tended to have chaotic lifestyles, to be young, or to be newly-arrived in the country; this antenatal appointment could include promotion of breastfeeding. It was pointed out however that breast-feeding had long-term importance, including being associated with less obesity and fewer hospital admissions; that levels of breastfeeding were below in the national average in some parts of the county; and that antenatal assessments would take place with or without the target

- noted that three other Health and Wellbeing Boards covered by Cambridgeshire and Peterborough CCG had opted for stroke and breastfeeding, but commented that the choice could not be determined by the chance order in which boards met.

It was resolved unanimously

to agree

- Antenatal assessment <13 weeks
- Stroke patients admitted to stroke unit within 4 hours

as the Health and Wellbeing Board's recommendation for the local indicators which would form part of the Quality Premium for 2015/16.

141. ANNUAL PUBLIC HEALTH REPORT

Received a report inviting the Board to consider the information and opportunities for action outlined in the Annual Public Health Report, and the Board's potential role in supporting delivery against these. The Chairman described it as a very helpful report, and advised that it had been sent to all County Councillors.

Members of the Board noted that the report was an independent report of the Director of Public Health, a surveillance report looking at trends and inequalities in public health outcomes across the county.

Asked whether the report was discussed at local health partnerships, the Director of Public Health said that the report should have been sent to the partnerships' chairs. She would be happy to attend these and other forums to present the report on request. Members commented that the information in the report should be brought to the attention of a wider audience.

142. FORWARD AGENDA PLAN: THEMED MEETINGS

Received a report presenting the proposed structure of themed Health and Wellbeing Board meetings for 2015/16 for comment. The Chairman asked that Board members send any comments on this agenda plan to the Democratic Services Officer.

It was agreed to defer the election of the Vice-Chairman/woman to the next meeting, as several members had already left.

143. DATES OF NEXT MEETING

Noted dates of the Board's forthcoming meetings (all at 10am on Thursdays):

- 17th September, Bargroves Centre, St Neots PE19 2EY
- 19th November, Shire Hall, Cambridge CB3 0AP
- 14th January 2016, South Cambridgeshire Hall, Cambourne CB23 6EA
- 17th March 2016, East Cambridgeshire District Council, The Grange, Nutholt Lane, Ely CB7 4EE

144. FAREWELL TO RUTH ROGERS

Ruth Rogers, Chair of Healthwatch, said that this was her last Health and Wellbeing Board meeting, as she was retiring in July and moving out of the area. The Chairman thanked her for her constructive comments over very many meetings.

Chairman

Item 13. Library Services in Cambridgeshire: Developing our Approach for the Future

1. The Cambridgeshire community has a strong commitment to libraries. That much is clear from the level of concern generated by the recent 'Enterprise Centre' debacle. As a Cambridgeshire County Councillor, I received more e-mails, phone calls, and other communications on this matter than on any other since being elected in May 2013. Residents spoke with me in the street, on the doorstep and on buses. Bus travellers missed their stop in order to emphasise their concerns and raise points of importance. Cyclists halted on their bicycles to raise the matter. Cars stopped. Phones rang – often all this happening at once, and whilst I was accessing e-mails or text messages on the subject.

2. Clearly, the savage funding cuts (not 'efficiency savings') imposed from central government mean the County Council must look to ways of providing current services at the necessary level by deploying resources in ways that enable this to happen. The County Council also needs to look to ways of generating income.

3. However, it is difficult to discern from the paper presented to the Health & Wellbeing Board precisely what is being suggested for library services. No clear proposals are put forward. No clear strategy for implementing any proposals is stated. Anyone agreeing to this paper is agreeing to 'anything' that might in the future be put forward with a claim that it has been supported by the Health & Wellbeing Board. Councillors need to be both aware and wary of this.

4. The paper does refer to a 'new Enterprise Centre at Central Library'. There is no indication of what this means – the flawed proposal originally endorsed by a slim majority of the Highways & Community Infrastructure Committee has been recognised since by all members of that Committee as misguided. It is clear that there is no need for private sector invasion of libraries for libraries to continue providing services and generating income. Central Cambridge Library already generates some £38,000 annually through hire of meeting rooms and all indications are that this sum can be readily increased without detracting from existing services. Wit, energy and commitment are most decidedly present in the library sector including the Central Library – all this needs to be valued and valorised, so that it can operate to maximise revenue raising opportunities on top of the already solid work undertaken by staff in all Cambridgeshire libraries.

5. If the private sector is to be involved, the Council needs to ensure that processes are transparent, private sector parties are properly subjected to due diligence, no confidentiality agreements are to be signed by anyone involved without proper oversight by the relevant Committee and, in any event, always with a Chair and Deputy Chair of the relevant Committee to be the signatories – so as to take responsibility and to report back to the fellow Councillors on that Committee. Furthermore, the Council needs to be aware that interminable meetings between Council officers and private sector parties projecting themselves as capable of running profitable enterprises within public sector institutions are an indicator that the private sector parties are surely not capable of undertaking any enterprise. A business person intent on promoting a private sector enterprise and actually making it work is unlikely to linger in interminable meetings: doing so would seem to indicate a propensity for 'talk-festing' rather than seriousness as to business enterprise. In any event, most importantly, as above, the talent, capacity, capability, expertise and experience of

those in the public sector must be recognised substantively, rather than 'private sector' being wrongly promoted as the 'only' means of sustaining operational capacity.

6. The reason libraries 'bring a highly trusted "brand"' is because of their present services, professional and trained staff, and well-lit, welcoming buildings and atmosphere. Losing any of these attributes would lead to a diminution of trust and debasing of the 'brand'.

7. As to the present position. On the one hand, the understandable anxiety generated by savage funding cuts that appear designed to destroy local government or at least render it operative has led to the notion that the only way out is to involve the private sector, turning the Central Library into a business operation. On the other, the proposal seems to be that libraries as a whole should be reframed as welfare centres. This is all to be done, as it appears, through the employment of 'generic staff'.

8. Yet professional librarians are essential to library provision – and that is why people are attracted to libraries, why libraries do fulfil an important role in education, training, entertainment and positive wellbeing for all in the community, and why libraries are a 'trusted "brand"'. Services for those suffering from high-level health problems such as dementia require professional services directed toward the alleviation or at least addressing the issues in a trained manner. These services need to be provided by professionals with appropriate training. Librarians cannot work as health or welfare workers. Health and welfare workers cannot work as librarians. Skills and professionalism are inherent in these jobs and those skills and professionalism are specific to them. Generic staff cannot fulfil the role of trained, skilled professionals. Trained, skilled professionals are able to work in a multi-tasked manner: this is a part of their training, skill and professionalism. However, to suggest that 'generic staff' can straddle the worlds of libraries and hospitals or care homes might be described by some as fanciful.

9. As proposed at the recent Highways & Community Infrastructure meeting of 26 June, the County Council needs to establish urgently a small working group comprising County Councillors, Library staff (particularly incorporating the expertise of the Central Library Events Team), County officers and members of the community to devise a forward-looking plan and strategy for the future of the libraries of Cambridgeshire so that they can continue to play their present role and build on it so as to (a) serve community needs to the optimal degree possible bearing in mind the function and purpose of libraries and their important role as libraries; and (b) where relevant incorporate income generating programmes including meeting room hire (inside and outside opening hours), performance and speakers, discussion groups and other events – this is already being done and requires support with additional staffing so that these programmes are able to meet their potential and exceed expectations.

10. Any plan or programme generated by this working group must identify clear goals and strategies, with clear, readily understood proposals in plain language, focused and direct so that those reading the plan or programme can understand precisely what is proposed and County Councillors can adopt the plan or programme knowing precisely what it is they are adopting.

HEALTH & WELLBEING BOARD MINUTES ACTION LOG AND UPDATES FROM 2nd JULY 2015

MINUTE & ITEM TITLE	ACTION REQUIRED / UPDATE	STATUS
99. Review of the Joint Health and Wellbeing Strategy	Request for information on how the different Mental Health Strategies are being brought together. **Action: C Bruin / E de Zoete / L Robin** **UPDATE**: Report on Priority 4 (agenda item 6, 17.09.15) includes an update on integrating mental health strategies.	**COMPLETED**
120. Better Care Fund	Updated Terms of Reference document for Cambridgeshire Executive Partnership Board to be brought to a future Health and Wellbeing Board meeting. **Action: G Hinkins / R Yule** **UPDATE:** Work on CEPB governance arrangements continues; the Terms of Reference document will be placed on the HWB's forward agenda plan as soon as possible.	**ONGOING**
124. Membership of HWB	Provision of regular update reports on the work of Cambridgeshire Health and Wellbeing Board to the Cambridgeshire Public Service Board (CPSB). **Action: A Lyne** **UPDATE:** An update on the work of the HWB Board was presented to CPSB on 14 August and CPSB requested further regular updates when there was substantive information to be discussed.	**COMPLETED**
	Invite the Police and Crime Commissioner (PCC) to a themed meeting of the HWB Board focussing on Priority 4 of the Health and Wellbeing Strategy. **Action: L Robin / A Lyne** **UPDATE:** The Police and Crime Commissioner and/or the Chief Executive is due to attend the HWB on 17 September and 19 November.	**COMPLETED**
	Explore the potential for a 'whole system' event, to further build relationships between HWB Board members and other key groups in the health and care system. **Action: A Lyne / L Robin / A Parr** **UPDATE:** Plans for a joint event have been discussed with the CCG Chief Strategy Officer in the context of system transformation work, which is not yet at the right stage for a joint event. A Health and Wellbeing Board development day is now being planned at which the need to further develop 'whole system' relationships will be discussed.	**ONGOING**
128. Election of Vice-Chairman/woman	Add to agenda plan for HWB on 17th September 2015 **Action: R Yule** **UPDATE:** On agenda for 17th September.	**COMPLETED**

MINUTE & ITEM TITLE	ACTION REQUIRED / UPDATE	STATUS
132. Progress Report on HWB Priority 2	Formal consultation with staff on roles within and operation of UnitingCare's neighbourhood teams, and target dates for the roll-out of the various stages of OneCall, both to be shared with HWB **Action: A Loades / R Yule** **UPDATE:** Consultation has concluded; document to be obtained from UnitingCare.	**ONGOING**
	Ensure UnitingCare Bulletins are being regularly received by HWB members **Action: R Yule** **UPDATE:** Most recent bulletin circulated to members of HWB and CCC Health Committee, and web link supplied for previous bulletins. R Yule already on circulation list for these bulletins.	**COMPLETED**
133. JSNA on Long-Term Conditions	Update on the actions arising from the JSNA to be placed on the HWB forward agenda plan **Action: A Lyne / R Yule** **UPDATE:** Advice is being sought on when an update report would be most appropriate.	**ONGOING**
	Develop a delivery plan to enable monitoring of how the JSNA document is being used **Action: A Mavrodaris** **UPDATE:** A delivery plan has been created identifying the relevant actions corresponding to the key findings from the JSNA process. Many actions relate to dissemination of the key findings among key stakeholders to inform commissioning and service development decisions and are addressed through the communications plan. Monitoring will be continued by Public Health.	**ONGOING**
	Correct typographical errors **Action: A Mavrodaris** **UPDATE:** A final, fully checked version of the report has been posted on Cambridgeshire Insight, along with a full set of data supplements and summary presentations; see http://www.cambridgeshireinsight.org.uk/JSNA/LTCs-across-the-lifecourse-2015.	**COMPLETED**
	Arrange for presentations of the JSNA to other groups, including CCG Governing Body and Local Health Partnerships, and share report with CCG Governing Body **Action: A Mavrodaris** **UPDATE:** A communications plan has been written to raise awareness with key stakeholders. JSNA findings will be presented at CCG Governing Body on 03.11.015. The JSNA has been requested as an agenda item for the local health partnership meetings; dates are currently being finalised. Letters and other correspondence will be used to raise awareness of the JSNA report among other stakeholders including Uniting Care	**ONGOING**

MINUTE & ITEM TITLE	ACTION REQUIRED / UPDATE	STATUS
	Partnership and other partners of the CEPB. A plain language summary is in development with colleagues at NHS Citizen Senate East of England for wider dissemination and feedback among local people living with long term conditions, particularly among those who contributed to the qualitative intelligence gathered.	
135. Updating the JSNA Summary Report	Correct error whereby percentage figures in table of Key Population and Health Statistics added up to rather more than 100% **Action: W Quarry** **UPDATE:** The percentage figure error has now been corrected.	**COMPLETED**
136. Addressing the Findings of the Transport and Health JSNA	This JSNA to be sent to the Leaders of the County Council, Cambridge City Council, and South Cambridgeshire District Council **Action: I Green** **UPDATE:** The JSNA has been raised at CPSB; officers are working with District Councils to arrange briefings to their management teams and/or members.	**ONGOING**
	Iain Green to liaise with Jess Bawden about other partnership groups this JSNA should be shared with. **Action: J Bawden / I Green** **UPDATE:** Arrangements are being made to present the JSNA to the CCG's Clinical and Management Executive Team (CMET)	**ONGOING**
137. Alcohol and Drugs JSNA	Make it clearer that children and young people were included in the JSNA's remit. **Action: V Thomas** **UPDATE:** The scope of the JSNA has been revisited and the specific areas of the JSNA relating to children and young people have been described, this includes prevention, treatment services and pathways for children and young people whose parents/carers misuse substances.	**COMPLETED**
139. Cambridgeshire and Peterborough Health and Care System Transformation Programme	Project plan, workstreams and public engagement documents to be circulated to HWB members **Action: J Bawden / A Loades / R Yule** **UPDATE:** A further report on the Transformation Programme (agenda item 13, 17.09.15) includes a summary report of feedback from engagement events, and links to System Transformation Programme documents.	

Agenda Item No. 5

A PERSON'S STORY

To: Health and Wellbeing Board

Date: 17th September 2015

From: Sarah Hughes, CEO, Mind in Cambridgeshire

1.0 PURPOSE

1.1 To introduce the story being presented to the Health and Wellbeing Board.

2.0 BACKGROUND

2.1 The Cambridgeshire Health and Wellbeing Board have requested that a person's story be presented at the start of each meeting. The story being presented at this meeting will set out an individual's experience of trying to access help when in the midst of a mental health crisis and supports the theme of mental wellbeing.

2.2 The story is an illustration of how people experience health and social care services. A discussion regarding the specifics of this person's experiences is not envisaged; the generalised learning and insight that can be taken from the experience being more pertinent.

3.0 SUPPORTING PARAGRAPHS

3.1 The story being told offers the Board an opportunity to consider the experiences of people with mental health problems and the difficulty in navigating the system in crisis linking to the work currently being undertaken via the Crisis Concordat across services.

3.2 The story will be anonymised.

4.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

4.1 This story relates to Priority Four of the Health and Wellbeing Board; to create a safe environment and help build string communities wellbeing and mental health.

5.0 IMPLICATIONS

5.1 There are no direct implications arising from this report.

6.0 RECOMMENDATION/DECISION REQUIRED

6.1 The Person's Story is being told as context for the remainder of the meeting.

Source Documents	Location
Health and Wellbeing Strategy	http://www.cambridgeshire.gov.uk/info/20004/health_and_keeping_well/548/cambridgeshire_health_and_wellbeing_board

Agenda Item No: 6

PROGRESS REPORT ON HEALTH & WELLBEING STRATEGY PRIORITY 4: Create a safe environment and help to build strong communities, wellbeing and mental health

To: Health and Wellbeing Board

Date: 17th September 2015

From: Emma de Zoete (Cambridgeshire County Council [CCC], Public Health)
Holly Gilbert (CCC, Public Health)
Kim Dodd (CCC, Children Families and Adults)
John Ellis (Cambridgeshire and Peterborough Clinical Commissioning Group [CCG])
Sarah Ferguson (CCC, Enhanced and Preventative Services)
Simon Kerss (CCC, Cambridgeshire Safer Communities Partnership Team)
Val Thomas (CCC, Public Health)
Susie Talbot (CCC, Drugs and Alcohol Action Team)
Lisa Faulkner (CCC, Strategy, Performance and Partnership)
Alison Smith (CCC, Children's Enhanced and Preventative Services)

1.0 PURPOSE

The purpose of this report is to update members on progress with the Health & Wellbeing (HWB) Strategy Priority 4: Create a safe environment and help to build strong communities, wellbeing and mental health.

2.0 BACKGROUND

Background information is provided in the associated HWB themed meeting template, which is attached as Appendix A to this paper.

3.0 INTRODUCTION TO PRIORITY 4

For ease of reference, the aims set out in Priority 4 were as follows:

- Implement early interventions and accessible, appropriate services to support mental health, particularly for people in deprived areas and in vulnerable or marginalised groups.
- Work with partners to prevent domestic violence, raise public awareness especially amongst vulnerable groups, and provide appropriate support and services for victims of domestic abuse.
- Minimise the negative impacts of alcohol and illegal drugs and associated antisocial behaviour on individual and community health and wellbeing.
- Work with local partners to prevent and tackle homelessness and address the effects of changes in housing and welfare benefits on vulnerable groups.

There are four main elements which the CCG, Local Authorities and other stakeholders are pursuing to deliver on the HWB Strategy Priority 4 aims:

a) Mental health strategic co-ordination
b) Clinical Commissioning Group (CCG) and Local Authority commissioning
c) Domestic abuse
d) Alcohol and illegal drug use

The work that contributes to achieving priority 4 of the health and wellbeing strategy takes place across a wide range of council directorates and partner organisations. This paper reflects the multi-agency nature of these issues and highlights the key areas of work that are currently contributing to achieving the 4 aims set out above.

4. MENTAL HEALTH STRATEGIC CO-ORDINATION

It is increasingly clear that to deliver mental health system transformation there is a need to work across organisations on the cross cutting themes that feature in the majority of the existing mental health strategies. It is recognised that aligning these strategies and organisations will result in better outcomes for service users, particularly through better communication and joint decision making in areas where commissioning and service delivery remits overlap.

In June 2015 the System Transformation Programme Board agreed to the development of a collaboration statement based on these key cross-cutting strategic themes. A set of shared principles and behaviours will support the implementation of this agreement by organisations signed up. A multi-agency Mental Health Forum is proposed to identify, align and co-ordinate this work. The forum would span beyond the health system and have a role in shaping the mental health transformation programme; building on current work already underway or planned for 2015/16 in individual organisations, or through existing groups such as the Crisis Care Concordat.

Additionally, some of the discussions within the forum are likely to be related to shorter term issues than those the system transformation programme is considering. In the longer term the forum would continue taking forward the delivery of transformation, which would by then be part of business as usual.

4.1 Crisis Care Concordat

The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis. The Concordat was signed locally by partners in 2014 and the local action plan is currently being refreshed in light of the CQC Right Here Right Now Report.

5. CCG COMMISSIONING

The CCG has been able to increase its investment in mental health services this year by approximately 5.6% due to the receipt of “parity of esteem” monies. The priorities within NHS services were agreed by CCG GP leads and Cambridgeshire and Peterborough Foundation Trust (CPFT) clinicians to be the following (totalling £1.7M):

- 24/7 staffing of the Section 136 suite at Fulbourn hospital
- an expansion of the capacity of the community teams
- some additional out-of-hours capacity in the crisis team
- additional staff on in-patient wards to meet “safer staffing” guidelines
- meeting new access targets for early intervention services.

In addition to this, the CCG committed last August to a substantial investment in Increased Access to Psychological Therapies (IAPT) services to meet the access targets (over £2M

for 2015/16). The CCG also set aside some of the "parity of esteem" monies received this year (approximately £800k) to support progress towards a more resilient and more equitable service model for mental health. The service model will be focused on "recovery", and better equipped to face the demand and financial challenges anticipated during the next five years. The three key work streams this year to achieve this objective are:

(i) **Enhanced and more Equitable Third Sector Provision throughout the CCG**. The CCG are addressing significant inequalities across the CCG in our third sector commissioning, this is particularly evident in the north of the county.
(ii) **A small team of "Recovery Coaches"** to support those patients who are struggling with the next stage of their "recovery" to access effective support, either via the third sector providers that the CCG commission or elsewhere within the local community. The model will be focussed on a strengths-based approach, utilising coaching techniques to enable people to move appropriately and confidently through the system.
(iii) **An Enhanced Primary Care Service.** The aim of this work stream is to create an Enhanced Primary Care Service that will resource primary care to provide an enhanced level of post discharge support for patients with severe and enduring mental illness who fall in "the gap" between primary and secondary mental health service thresholds.

The key objectives are to improve patient mental and physical health outcomes, reduce high morbidity/mortality rates in the mental health patient population, and reduce the demand on secondary and acute mental health services. This work is still in the design phase and a series of consultation events are scheduled for the next three months.

6. 6. LOCAL AUTHORITY COMMISSIONING & STRATEGIES – MENTAL HEALTH

Following work with service user's carers, public health mental health colleagues and other partners the final draft of the Social Care Strategy for Adults with Mental Health Needs was presented at the Adults Committee on 1st September for final sign off. The response to the strategy during the consultation period has been very positive, particular areas that received approval were the family approach, transitions for young people and the priorities around carers. The Strategy is based on the Care 2014 concept of wellbeing and the council's Transforming Lives strategy. Both of these have a particular focus on prevention and enabling people to retain their independence and wellbeing through help to help themselves. Following approval by the Adults Committee, the strategy will be launched with partners and an implementation group established to ensure and track implementation.

The strategy lists 15 priorities including:

- A three year project in collaboration with public mental health colleagues with Mind Cambridgeshire focusing on developing resilience within communities which will be independently evaluated and will go live this October.
- Developing the community navigator service to enable people with mental health needs to access support within their communities to increase their mental wellbeing and prevent, for example, social isolation and support increased and earlier access to resources.

Additionally, the strategy captures the challenges now being experienced with recruitment and retention of mental health social workers and sustaining the Approved Mental Health Practitioner service which is a vital service within the mental health crisis pathway. Several actions have been taken to address this within a broader recruitment and retention strategy. This includes the recent successful application to become a pilot site for the national 'Think

Ahead' programme, aiming to increase recruitment into mental health social work and establish a clear leadership structure for social workers. Work is also being completed as part of the local Mental Health Crisis Concordat Delivery Group in partnership with police and health colleagues.

Although not explicitly mentioned in the strategy, a project is currently being run collaboratively with the Fire Safety Service on developing a multi-agency protocol for working with people who have hoarding behaviours, this is underpinned by the strategy principles. It is known locally that people who have hoarding behaviours are at significant risk of death through fire, particularly if they are over the age of 65 years. The group was established to develop this protocol and includes representatives from public health, the police, district councils and mental health service. Completion of the draft protocol is planned for the end of this year.

The Public Mental Health Strategy was approved as a final version by Health Committee in May 2015. The strategy focuses on promotion of mental health and the prevention of mental illness. Key features of the strategy are promoting mental health across the life course, the impact of the wider environment on mental health, and the link between physical and mental health. This is a multi-agency strategy that is being implemented largely through existing governance structures. Key areas of work include:

- Funding an anti-stigma post with Peterborough City Council that sits within Mind to focus on campaigns work and coordinating mental health training.
- Additional support is being provided to schools to improve emotional wellbeing of children and young people, recognising the importance of mental health at a young age and the impact this can have in later life. This work contributes to wider work across the council focusing on addressing the high levels of self-harm in Cambridgeshire's young people.
- Continuing to promote and provide mental health first aid training and supporting employers with mental health training needs.
- Establishing a group to develop an action plan and drive forward work to improve the physical health of those with severe mental illness.

An update on strategy progress will be presented at Health Committee in December 2015.

Implementation of the 3 year Cambridgeshire and Peterborough Suicide Prevention strategy begun in 2014, the strategy focuses on key areas of suicide prevention as identified in the national suicide prevention strategy. Key areas of recent work for the implementation group have included the completion of the annual suicide audit and considerable input to improve the quality and variety of data we receive on suicide deaths to improve our understanding and target our work better. The multi-agency Pathfinder project has also formed a large part of the suicide prevention work with a campaign promoting the stop suicide pledge sharing the message that suicide is preventable. This campaign is supported by delivery of ASIST suicide prevention training that public mental health funding is helping to roll out further. The Pathfinder Stop Suicide work is being led by the charities Mind in Cambridgeshire, Peterborough & Fenland Mind and Lifecraft, supported by local NHS and Public Health teams. The work has been recognised nationally through an award and has been cited in national publications.

7. HOMELESSNESS AND THE EFFECTS OF CHANGES IN HOUSING AND WELFARE BENEFITS ON VULNERABLE GROUPS

District Councils have statutory functions in relation to social housing, housing benefit, and Council Tax support. As such, district councils have taken the lead on homelessness prevention and the impact of welfare benefit changes. The districts have established a range of partnerships to plan and deliver local action. Among the partnership priorities for the Child Poverty Champions Group for 2014/15 are:

1. **To address the incidence and impact of benefit sanctions on vulnerable families** – this has been led through the Together for Families programme, with systems established to support better partnership working between Job Centre Plus and support workers so that vulnerable clients are not sanctioned inappropriately, including improved use of shared IT systems.
2. **Improved early identification and support for families at risk of homelessness** – this too has mainly fallen within the remit of the Together for Families programme, with the following steps taken:

- Ensure the risk factors that identify potential homelessness are explicitly identified within the Together for Families programme. Risk factors include rent arrears and anti-social behaviour.
- Ensure that there are processes in place for agencies to refer families at risk of homelessness into the Together for Families programme.
- Ensure that the right support is offered to families identified at risk of homelessness within the Together for Families programme.

There is already evidence of successful homelessness prevention from Phase 1 of the Together for Families programme, and Phase 2 will build upon and extend this successful approach.

Sound mechanisms have been established to share information about benefit entitlements between district and County Councils. This has been facilitated by the Welfare Reform Act 2012. This enables identification of those families affected by the benefit cap and removal of the Spare Room Subsidy who were already known to county council teams, so that frontline practitioners could help to provide any additional support families might need.

8. DOMESTIC ABUSE

8.1 Domestic Abuse Governance Board

A multi-agency Domestic Abuse Governance Board was re-established in November 2013 following a peer review of the existing Partnership from Standing Together as part of a Home Office funded programme of support for local partnerships.

The initial plans for the Governance Board were as follows:

- the name would be the Domestic Abuse Governance Board
- sexual violence would remain a remit of the Partnership but would not be in the title of the governance group (this has since been revised)
- to review the (then) strategy (2011–15) and action plan of the Partnership.

The Strategy was revised, taking into account the Domestic Abuse Needs Assessment carried out in 2013-14, and the new Strategy was formally approved in November 2014.

The strategic aims of the Partnership are now to:

- prevent people from becoming perpetrators and victims of domestic abuse
- protect victims of domestic abuse and their families, whether or not they choose to report crimes to the police
- pursue perpetrators of domestic abuse through the criminal justice system and ensure that they face the consequences of their actions
- support victims to recover from the impact of domestic abuse.

An action plan, building on key areas from the Strategy, has been developed with key partners and is being implemented across the county via thematic sub-groups (Training and Awareness, Families and Young People and the countywide strategy Implementation Group).

A management information 'dashboard' has been developed to monitor the activities of the Partnership in terms of meeting its aims. Current membership of the partnership can be found in the Appendix.

8.2 Public awareness

A communications group, reporting to the operational Implementation Group, is in place to drive awareness-raising, and a range of communication activities have taken place in the last twelve months including:

- Creation of a leaflet 'Opening Closed Doors' aimed at people who are concerned that a friend or family member may be experiencing abuse
- Developing an Easy Read version of the above leaflet for adults with learning disabilities
- A poster campaign around the World Cup aimed at disrupting perpetrators
- An awareness raising campaign on Heart FM
- Input into police campaigns including stalking, domestic abuse and sexual violence
- Creation of social media accounts on Facebook and Twitter to form national links and increase awareness raising
- Continued monthly publication of Violence Against Women & Girls Newsletter
- Development of a new website for the partnership which has sections for the public and professionals
- The commissioning (via a grant provided by the Office of the Police and Crime Commissioner) of 'Health Relationships' programmes in some Cambridgeshire schools, to raise awareness of unsafe and risky relationships.

The Easy Read materials were developed with VoiceAbility and reached the finals in the 'Breaking Down Barriers' category at the 2015 Learning Disability and Autism Awards. The materials have also been shared nationally in electronic format and have received praise from across the UK.

Work is currently in progress for an awareness campaign aimed at older people which is being done in collaboration with the Adult Safeguarding team at the County Council. Age UK and Action on Elder Abuse have both pledged support nationally and locally, and will assist with sharing this campaign across their networks.

8.3 Provide appropriate support and services for victims of domestic abuse

The Cambridgeshire Safer Communities Partnerships Team (Cambridgeshire County Council) commissions two specialist providers of domestic abuse services in Cambridgeshire. Cambridge Women's Aid and Refuge both provide refuge and outreach support to victims and survivors.

In the year ending March 2015, outreach support was provided to nearly 900 victims of domestic abuse in Cambridgeshire.

The Independent Domestic Violence Advisory Service (Cambridgeshire County Council), based at the Multi-Agency Safeguarding Hub, works with high risk victims of domestic abuse. In the year ending March 2015, the service received 942 high risk referrals, 749 of which engaged with the service for support. The IDVAS also offer specialist support, at any level of risk, to the following groups:

- Victims from A8 Nations
- Victims aged 13-19 (funded by the Office of the Police and Crime Commissioner)
- Victims accessing 'health' provision as a consequence of domestic abuse

Cambridgeshire's Multi-Agency Risk Assessment Conference (MARAC), which develops and implements safety plans to prevent domestic abuse-related homicide, heard 591 cases (involving 745 children) during the period 2014/15. The chairing, coordination, management and information sharing systems of Cambridgeshire's MARACs are resourced via Cambridgeshire County Council.

Working alongside the IDVAS at the Multi-Agency Safeguarding Hub are Community Psychiatrist Nurses (funded via a grant from the Office of the Police and Crime Commissioner) and specialist Drug and Alcohol Workers (funded via the Safer Communities Partnership Team at Cambridgeshire County Council). These posts are integral to addressing the specific needs of some victims of domestic abuse.

In 2014, a comprehensive countywide domestic abuse 'offer' was developed along with a linked training strategy setting out four levels of intervention based on the NICE Domestic Abuse Guidance. This work includes developing practitioner guidance in collaboration with the Cambridgeshire Local Safeguarding Children Board. Additional training has been developed and commissioned for practitioners working at the higher levels and this is being delivered and assessed during 2015.

The Partnership, working alongside the Constabulary, has developed and implemented a new (2015) referral pathway to Cambridgeshire's Victims' Hub to provide additional support to those victims of domestic abuse-related crimes.

The Partnership is currently working with the National Institute of Health Research to pilot and evaluate a concurrent intervention programme to support children and their protective parent.

The Safer Communities Partnership Team at Cambridgeshire County Council has also commissioned the provision of two community-based perpetrator programmes which have been shown to increase the safety of victims of abuse and violence, and are also working in partnership with the Constabulary to develop further activities to disrupt those who perpetrate domestic abuse.

Supporting children and young people as victims of domestic abuse is a priority for the Local Safeguarding Children's Board and a task group has been established to take forward specific priorities in relation to this work:

- Work in schools and communities to raise awareness of what constitutes abuse and promote understanding of healthy relationships and sexual violence

- Consult with young people in Cambridgeshire about services for children and young people affected by domestic abuse
- Ensure that workers across public services are able to identify victims and potential victims and signpost or refer to appropriate services
- Provide new specialist interventions for children and young people and their families
- Develop clear policies on best approach for all partners to take when working with families where domestic abuse is occurring.

9. ALCOHOL AND ILLEGAL DRUG USE

The misuse of alcohol and drugs affects the health and wellbeing of individuals, families and communities. Both can have a serious effect on health leading to hospitalization and premature death. There were, in England in 2012/13, 13,917[1] admissions to hospital with a primary diagnosis of poisoning by illicit drugs and 6,490[2] alcohol-related deaths in 2012. Mental health issues are strongly associated with both alcohol and drug misuse. In England in 2014 there were 7,104[3] admissions to hospital with a primary diagnosis of a drug-related mental health and behavioural disorder.

Alcohol and drug misuse has a strong relationship with violence, almost half of all violent assaults nationally are linked with alcohol misuse[4]. It is a factor in marital/relationship breakdown and domestic violence with 27%[5] of social care serious case reviews mentioning alcohol misuse. There is an increasing concern about children who have physical, psychological, and behavioural problems that are associated with having parents/carers who misuse alcohol and drugs.

In Cambridgeshire alcohol and illegal drug misuse is addressed through a network of partnerships that work to the following three strategic priorities (2015-18) that were agreed by the overarching Cambridgeshire Drug and Alcohol Team (DAAT) Executive Board;

- **Prevention and protection from harm:** Preventing harm to individuals, children, young people, and families affected by drug and alcohol misuse.
- **Recovery:** Delivering effective partnership recovery based approaches to drug and alcohol treatment.
- **Enforcement:** Protecting communities through robust enforcement to tackle drug supply, drug and alcohol related crime, and anti-social behaviour.

Historically drugs and alcohol work has been funded through pooled budgets and shared resourcing from members of the partnership. Currently the majority of the funding for specific drug and alcohol services comes from the Public Health Grant. This is held by the Local Authority with small contributions from Cambridgeshire County Council Adult Social Care, Office of the Police and Crime Commissioner (PCC), and Cambridgeshire City Council. There is also wider partnership work that supports work to address the wider health and wellbeing issues created by alcohol and drug misuse.

9.1 Prevention and Protection from Harm

A programme of population wide and targeted campaigns that provide information about the harms associated with alcohol and drug misuse are ongoing in Cambridgeshire. These

[1] Health and Social Care Information Centre, Statistics on Drug Misuse:2014
[2] Health and Social Care Information Centre, Statistics on Alcohol England: 2014
[3] Health and Social Care Information Centre, Statistics on Drug Misuse:2014
[4] Public Health England; Alcohol and drugs prevention, treatment and recovery :why invest: 2014
[5] Public Health England; Alcohol and drugs prevention, treatment and recovery :why invest: 2014

campaigns have included drink driving harm reduction, and a workplace campaign in Fenland where high levels of alcohol misuse amongst the migrant workforce population is associated with community safety issues. Young people are targeted with specific information interventions. Recently a theatre company was commissioned to provide an educational play that highlighted risk taking activities to all year 9s in schools across Cambridgeshire and focused upon the links between child sexual exploitation and substance misuse. Bespoke information for people with learning difficulties is being developed in partnership with relevant organisations.

There is considerable concern about the growing misuse and harmful impact of Novel Psychoactive Substances (NPS). A local Strategy has been developed that is targeting different settings and population groups. A local Campaign 'Keep Calm and Party Safer' is underway and Cambridgeshire Constabulary Drugs Experts and Cambridge Business Against Crime (CAMBAC) have targeted the night time economy to promote harm reduction messages.

Other prevention activities are the provision of Identification and Brief Advice (IBA) training to a wide range of organisations and businesses focusing upon those that work with high risk individuals and communities. This evidence based intervention enables practitioners to effectively raise the issue of substance misuse, providing appropriate information and advice to stimulate any necessary behaviour change along with signposting to appropriate support.

The partnership is developing with key partners, new pathways, and mechanisms to improve the poor uptake of vaccination and testing for blood borne viruses (BBV's). Naloxone kits, which reverse the effects of a heroin overdose, are now routinely distributed in Cambridgeshire to users known to be at risk of overdose and this has saved the lives of a number of local drug misusers. A RAG rated Drug Alert system has been established where information about any substance related incident is rapidly disseminated across partner agencies and user groups.

9.2 Treatment and Recovery

Treatment and recovery services for those who misuse substances are critical to mitigating the impact that their behaviour can have on their families and communities.

The DAAT partnership commissions a range of treatment services for young people and adults who misuse alcohol and drugs. Inclusion (specialist directorate of South Staffordshire and Shropshire NHS Foundation Trust SSSFT) deliver both the specialist drug and alcohol treatment contracts for adults over 18 years of age. The treatment service model is focused on overcoming dependence to achieve sustainable recovery enabling integration back into families, local communities, and a return to work and education. Its services range from education programmes, needle and syringe services to structured treatment programmes. Alcohol services also include a GP commissioned detoxification service, provided in collaboration with Inclusion and detoxification in-patient beds commissioned from Cambridgeshire and Peterborough Foundation Trust (CPFT). The DAAT Partnership has recently commissioned a Substance Misuse GP Clinical Lead who is advising the team on strengthening shared care work with GP's.

Support for recovery is increasingly important and aims to reduce the number of patients who have repeat admissions to the treatment services. Volunteer "recovery champions" provide peer support to individuals and groups on discharge and also support the services.

Cambridgeshire Adolescent Substance Misuse Service (CASUS) delivers the combined drugs and alcohol service for young people between 12 and 21 years of age. A growing role for this service is to provide support to young people who are affected by parental substance misuse. The Partnership has focused on working with commissioned services to ensure that the impact of parental/carer drug and alcohol misuse on children is assessed and managed effectively in the delivery of services to families and children. This has resulted in improvements, which includes the design and implementation of a robust data system for recording children's information and a safeguarding manual for all staff. The DAAT partnership is also working closely with Children's Services, including Together for Families, to jointly implement support packages for families, focusing on the prevention of children and young people affected by parental/carer substance misuse becoming services users themselves.

The DAAT has a small budget from Cambridgeshire County Council Adult Social Care to spot purchase places for those requiring residential rehabilitation placements. The DAAT partnership also commissions a range of housing related support projects helping offenders and those with chronic alcohol use to gain accommodation and work towards independent living.

The Partnership has also invested in a pilot project to provide recovery and accommodation support for those who have a history of homelessness and are seeking change. The three bed Alcohol Abstinence House supports individuals post-detoxification, moving them out of the hostel system and into a house with wrap around support from key agencies. The house opened in February 2015 and the outcomes are being closely monitored.

The DAAT Partnership works closely with the criminal justice system which reflects high level of substance misuse amongst offenders. Offenders who access prison substance misuse services are offered support from the commissioned service Inclusion on their release into the community. The proportion of these picked up by services has increased recently from 34% to 80%.

The Drug Intervention Programme (DIP) that was launched as a national initiative is provided by Inclusion and aimed at engaging substance misusing offenders in drug treatment through a variety of methods. This has had some success and is securing a 95% retention rate in effective treatment for this cohort.

A representative from the DAAT Partnership sits on all of the local Community Safety Partnerships (CSPs) and on the countywide Community Safety Board to ensure that drug and alcohol work is driven at both a local and countywide level. Good partnership working ensures that agencies work closely with District Councils to respond to local issues such as street drinking, alcohol related violent crime, anti-social behaviour, and night time economy issues. As an example Fenland District Council is leading on a project to target and reduce street drinking in the Fenland area. The action plan is approved and overseen by Fenland Community Safety Partnership and Health and Wellbeing Partnership.

Reducing access to alcohol is also being addressed. The DAAT, Cambridgeshire County Council Public Health Team, and Trading Standards recently made a successful representation to the Fenland Licensing Committee. This led to the Licencing Committee refusing a license application in the Cumulative Impact Zone in Wisbech based on the evidence provided by the DAAT, Cambridgeshire County Council Public Health, and Trading Standards.

The DAAT Partnership is looking at new and innovative opportunities for supporting the recovery of substance misusers. The Cambridgeshire DAAT has successfully secured funding from Public Health England to develop a new recovery project in Cambridge City. This project will establish a community based resource which will include a café. It will be run by volunteers who will provide peer support and provide 'step down' support for those seeking long term abstinence as a move on from specialist services and avoid future admission to services.

The Partnership recognizes that one of its biggest challenges is the strong link between substance misuse and mental health difficulties. Dual Diagnosis is linked to poor outcomes for service users ranging from worsening psychiatric symptoms, increased admission to hospital services, homelessness, and significant levels of engagement with the criminal justice system. The Partnership has been heavily involved in the development and implementation of the countywide 'dual diagnosis' strategy which endeavours to ensure that those with a dual diagnosis can readily access coordinated inter-agency assessment, treatment, and support. This includes the introduction of the Dual Diagnosis Capability Framework which defines the required capabilities for staff and locality groups to strengthen local networks in support of the development of collaborative working around dual diagnosis. The Dual Diagnosis Protocol is another initiative which focuses upon developing pathways for those with early onset dementia related to alcohol misuse.

9.3 Engagement

The role of user and community engagement in both prevention and especially in treatment and recovery is well established. All the commissioned services have strong service user engagement groups in place. Inclusion holds monthly service user forums which are attended periodically by members of the Partnership and also offer comprehensive support and opportunities to individuals in recovery.

Sun Network is commissioned to provide the independent service user contract. This Service engages with service users independently of the treatment service to gain feedback on local provision and encourage those who are not currently in services to seek specialist support. The service runs regular 'Recovery cafés' across the county and provides advocacy work. The Service also provides service user input and feedback to the Drug and Alcohol Commissioning Group assisting in the monitoring and development of local quality services.

10. ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

This is an update on Priority 4 of the HWB strategy.

11. IMPLICATIONS

This is an update paper for members, so there are no new proposals contained within it.

12. RECOMMENDATION/DECISION REQUIRED

Members are asked to note this update.

Source Documents	Location
Please see report footnotes and Appendix A for background information and source documents.	

Appendix A: Health and Wellbeing Board themed meeting template

	Meeting theme: ***Priority 4 – Create a safe environment and help to build strong communities, wellbeing and mental health***	
	Focus areas: • Implement early interventions and accessible, appropriate services to support mental health, particularly for people in deprived areas and in vulnerable or marginalised groups. • Work with partners to prevent domestic violence, raise public awareness especially amongst vulnerable groups, and provide appropriate support and services for victims of domestic abuse. • Minimise the negative impacts of alcohol and illegal drugs and associated antisocial behaviour on individual and community health and wellbeing. • Work with local partners to prevent and tackle homelessness and address the effects of changes in housing and welfare benefits on vulnerable groups.	
1.	**Overarching partnership delivering against this priority and how this links to the Health and Wellbeing Board**	There is a proposal for a Mental Health Forum which will work to link all the key mental health strategies together. This is also strongly linked to the CCG System Transformation Mental Health Workstream and commissioning across local authorities and the CCG to avoid duplication. **Alcohol and Drugs - Governance** Partnership work is central to addressing and responding to substance misuse in Cambridgeshire in a coordinated approach, influencing and initiating a range of work streams that focus upon reducing harms to individuals, families, organisations and communities. The Drug and Alcohol Action Team (DAAT) is the multi-agency strategic partnership working to implement National and local Drug and Alcohol priorities. The functions of the DAAT sit within the 'Cambridgeshire Safer Communities Partnership Team' which is hosted within Cambridgeshire County Council. The DAAT Partnership Board leads on strategic development and oversight of prevention and treatment interventions and related commissioning. The Partnership includes a range of key partners which includes the Cambridgeshire Constabulary, Cambridgeshire and Peterborough Clinical Commissioning Group (CCG), Cambridgeshire County Council, Office of the Police and Crime Commissioner (PCC), District Councils, Probation services, service user representation and voluntary agencies.

		The Drugs and Alcohol Commissioning Group (DACG) has a wide ranging partner membership, is accountable to the DAAT Board and has clinical, financial and operational oversight for strategic and commissioning work. The DAAT is supported by an officer Team that facilitates and undertakes work across the county. Historically drugs and alcohol work was funded through pooled budgets and shared resourcing from members of the Partnership. The majority of the funding is now from the Public Health Grant, held by the Local Authority with small contributions from Adult Social Care (CCC), Office of the Police and Crime Commissioner (PCC) and Cambridgeshire City Council. The Director of Public Health has a mandatory responsibility for ensuing that there are effective substance misuse services and for providing assurance to Public Health England that the use of the Public Health Grant meets the terms and conditions of the Grant. A representative from the DAAT Partnership also sits on all of the local Community Safety Partnerships (CSPs) and on the countywide Community Safety Board to ensure that drug and alcohol work is driven at both a local and countywide level. Good partnership working ensures that agencies work closely with District Councils to respond to local issues such as street drinking, alcohol related violent crime, anti-social behaviour, and night time economy issues. A representative from Public Health also sits on the countywide Community Safety board. **Abuse and Sexual Violence** A multi-agency Domestic Abuse Governance Board was re-established in November 2013 following a peer review of the existing Partnership from Standing Together as part of a Home Office funded programme of support for local partnerships. The work of the Domestic Abuse and Sexual Violence Partnership can be found at: http://www.cambsdasv.org.uk Current membership of the Partnership is: • Cambridgeshire County Council Children, Families and Adults Services - Children's Social Care • Cambridgeshire County Council Children, Families and Adults Services - Adult Social Care

		• Cambridgeshire County Council Children, Families and Adults Services – Enhanced and Preventative Services (including the Safer Communities Partnership Team) • Cambridgeshire County Council Public Health Team • Cambridge and Peterborough Foundation Trust • Cambridgeshire Local Safeguarding Children Board (LSCB) • Cambridgeshire Clinical Commissioning Group • Cambridgeshire Constabulary • Office of the Police and Crime Commissioner • National Probation Service • Community Safety Partnership Representative • District Housing Representative • Specialist Domestic Abuse Service Representative (Cambridge Women's Aid/Refuge/Cambridge Rape Crisis Centre) • Service User Representation.
2.	**Recent Joint Strategic Needs Assessments (JSNAs)**	Older People'sMental Health JSNA 2014 http://www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/older-peoples-mental-health-2014 Autism, personality disorder and dual diagnosis JSNA 2014 http://www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/autism-personality-disorders-and-dual The mental health of children and young people in Cambridgeshire JSNA 2013 http://www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/mental-health-children-and-young-people Mental Health (working age adults) JSNA2010 http://www.cambridgeshireinsight.org.uk/currentreports/mental-health-adults-working-age Housing and health JSNA 2013 http://www.cambridgeshireinsight.org.uk/housing-jsna-2013

		Homelessness and At Risk of Homelessness JSNA 2010 http://www.cambridgeshireinsight.org.uk/currentreports/homelessness-and-at-risk-of-homelessness Other Needs Assessments: Victim and Offender Needs Assessment 2014 http://www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/other-assessments/victim-and-offender-needs-assessment Domestic Abuse health needs assessment http://www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/other-assessments/domestic-abuse-needs-assessment Alcohol and Drugs JSNA is currently in development and scheduled to be presented to the Health and Wellbeing Board in May 2016.
3	**a) Integrated partnership strategy or strategies in the health and care system delivering on this priority** **b) Has this been formally adopted as an annex to the Health and Wellbeing Strategy?**	a) 1. Suicide Prevention Strategy 2014 2. Public Mental health strategy 2015 3. Crisis Care Concordat 2014 4. Emotional Wellbeing and Mental Health of Children& Young People 2014 5. Social Care Strategy for Adults with Mental Health Needs (in development) 6. Older people's mental health – outcomes framework for the Uniting Care contract. 7. Together for Families (TFF) Phase II Strategy 8. Cambridgeshire 2014–18 Cambridgeshire Domestic Abuse Strategy b) The Emotional Wellbeing and Mental Health of Children and Young People's Strategy, and the Crisis Care Concordat 2014 have been adopted as Annexes to the Cambridgeshire Health and Wellbeing Strategy.
4.	**Joint commissioning and Section 75 arrangements**	The Section 75 Agreement between CCC and CPFT was signed of November 2014. The first Annual Report by CPFT will be taken to the Adults Committee in September by Deborah Cohen Director of Integrated Services CPFT.

		A joint commissioning arrangement for mental health is planned across Cambridgeshire County Council and Peterborough City Council. This will be supported by joint work with the CCG mental health commissioning team.
5.	**Alignment of NHS Cambridgeshire and Peterborough Clinical Commissioning Group's (CCG) commissioning plans with this priority**	The CCG mental health commissioning team have outlined their short term priorities and are working through the System Transformation Mental Health workstream on the longer term (five year) picture in terms of mental health services. The CCG commissioning priorities align well with this priority and the focus is on developing a more resilient and more equitable service model for mental health, even more focussed on "recovery", and better equipped to face the demand and financial challenges anticipated during the next five years. Parity of Esteem will begin to be rebalanced in 2015/16. **Key Measures of Success include:** • An enhanced role for primary care in the management of stable Serious Mental Illness patients (this will also improve physical health outcomes) • An expanded role for the voluntary sector both as an alternative to secondary mental health services and providing support to people post-discharge from these services • An expanded role for the Recovery College, more peer support and more help for carers • An increased locality focus to mental health services, better integrating mental and physical health and the use of local community resources • Easier access to secondary mental health services, including streamlined processes for referral to the single-point-of-access and from there to local community teams • Improved crisis care for patients across the health, social care, criminal justice system • Provision of psychological therapies on a "whole-system" basis, including self-referral and direct access for people with long-term conditions • Enhanced specialist mental health input to the rest of the local health system

Agenda Item No. 7

REPORT FROM THE POLICE AND CRIME COMMISIONER

To: Health and Wellbeing Board

Date: 17th September 2015

From: Dorothy Gregson, Chief Executive, Cambridgeshire Office of the Police and Crime Commissioner

1.0 PURPOSE

1.1 To share the Police and Crime Commissioner's strategic vision to reduce demand on public sector services through an effective prevention agenda and show how this vision can support the work of the Health and Wellbeing Board.

2.0 BACKGROUND

2.1 The first Police and Crime Commissioner elections took place in November 2012. They have a statutory responsibility, set out in the Police Reform and Social Responsibility Act 2011, to 'deliver an effective and efficient police force', 'work with partners to tackle crime and disorder' and 'ensure the efficiency and effectiveness of the criminal justice system'. Commissioners are required to publish a Police and Crime Plan setting out the Police and Crime Objectives for their area.

2.2 Cambridgeshire's Commissioner Sir Graham Bright shares many of the Health and Wellbeing Board's agendas and is committed to focusing on prevention and partnership working.

2.3 Within Sir Graham's Police and Crime Plan he sets out this commitment to 'improve the partnership response to mental health'. This was clearly demonstrated through the role he took in driving forward the local Cambridgeshire and Peterborough Mental Health Crisis Care Concordat declaration. This sets out the shared aspiration to 'prevent mental health crisis happening whenever possible through prevention and early intervention'. Sir Graham has also stepped in to jointly fund an identified gap in provision for victims of crime to support them into commissioned mental health services.

3.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

3.1 The Cambridgeshire Police and Crime Plan very much supports the Health and Wellbeing Strategy. We share the same communities and desire to work in partnership. In 2013 Sir Graham shared with the panel how his work supported the delivery across all priority areas of the Health and Wellbeing Strategy. For example:

- **Priority 1 - Ensure a positive start to life for children, young people and their families**
  - The Commissioner must hold the Chief Constable to account for "safeguarding of children and the promotion of child welfare".
- **Priority 2 - Support older people to be independent, safe and well**
  - The Commissioner funds the 'Bobby scheme' which provides practical support for elderly victims of burglary to enable them to feel safe and remain independent.

    - The Constabulary's response to calls for service prioritises the most vulnerable people.
- **Priority 3 - Encourage healthy lifestyles and behaviours in all actions and activities while respecting people's personal choices**
    - The Commissioner makes a contribution to drugs and alcohol treatment services and has taken responsibility for highlighting the alcohol agenda both locally and nationally.
    - Drugs/alcohol issues are seen in up to a third of all offenders.
- **Priority 4 - Create a safe environment and help to build strong communities, wellbeing and mental health**
    - Multiple shared agendas and shared delivery models such as Multi-Agency Referral Unit (MARU) and working arrangements such as Multi-Agency Risk Assessment Conferences (MARAC).
    - People with mental health issues are over represented within both victim and offender cohorts.
    - The Commissioner funds services to support victims of crime to cope and recover from their experience – this includes the provision of Mental Health Pathfinders to guide victims of crime into existing commissioned services.
    - The Commissioner also awards Police and Crime Reduction Grants to Community Safety Partnerships to allow them to fund grass roots work to tackle the issues which affect their community the most.
- **Priority 5 - Create a sustainable environment in which communities can flourish**
    - The Commissioner's commitment to 'divert young people away from a life of crime' has seen him set up a Youth Fund, Volunteer Police Cadet Schemes across the county and he contributes to the funding of the county's Youth Offending Services.
- **Priority 6 - Work together effectively**
    - Partnership working is at the heart of all of the Commissioner's work.

3.2 The police can be at the sharp end with respect to the management of vulnerable people. It is the police who are called when a person publically tips into crisis in order to safeguard them and the people around them; the frontline officers and staff then rely on colleagues in partner agencies to ensure the person receives the support they need towards recovery.

3.3 Over that past three years it is encouraging to see in how partners are working in a co-ordinated way to deal effectively with safeguarding issues. The police are often a key partners in this. The development of the Multi-Agency Safeguarding Hub which brings staff from a range of agencies together to effectively safeguard the most vulnerable people in our community, is just one example of this.

3.4 Progress has not only been made with respect to the partnership work to prevent people tipping into crisis or meeting safeguarding thresholds; there are many other examples of effective partnership working which meet both the Board and the Commissioner's agendas.

- Making Every Adult Matter project – working with chronically excluded adults
- Integrated Offender Management
- Integrated support services for victims of crime through the Victims' Hub
- Troubled Families project and through the gate support for offenders – although we see some overlap between them when reducing offending is the outcome.

3.5 While we all acknowledge there is work to be done we also need to celebrate what has been achieved in the past three years building on the assets of our communities. For example the continued increase in the number of people volunteering as Special Constables, to support victims of crime, for Neighbourhood Watch and as Volunteer Police Cadet Leaders and the Cadets themselves.

3.6 The Commissioner wholeheartedly welcomes the proposed work by Cambridgeshire County Council to develop a community resilience strategy. This work supports the view that communities need to be encouraged to become self-supporting – much of Sir Graham's allocation of Police and Crime Reduction Grants is in this same vein.

3.7 However even in supportive communities the Victim and Offender Needs Assessment (2012) identified that people with mental health illness are more vulnerable to becoming a victim of crime and as one of the main offender groups. Mental Health has emerged as a key local and national partnership agenda and we need to effectively commission services at all levels from high risk, high need to developing people's capacity to maintain good mental health themselves.

4.0 PARTNERSHIP WORK TO IMPROVE MENTAL HEALTH OUTCOMES

4.1 The Commissioner's commitment to bring partners together to start the conversation on the provision of mental health services is clear. At the first Mental Health Crisis Care Concordat roundtable (July 2014), which was jointly hosted by Sir Graham and the Chair of the Clinical Commissioning Group (CCG) Maureen Donnelly, partners heard from NHS England's National Clinical Lead for Mental Health Geraldine Strathdee on how transformation can ensure greater access to mental health services.

4.2 A consensus that service transformation was needed was reached at the second roundtable (November 2014) and the CCG pledged to link with all agencies on their agenda.

4.3 By the third meeting, a year after the first, the CCG reported their launch of this work and their commitment to consult with partnership agencies as this progresses. It was also acknowledged that risk areas remain, e.g. sustainable access to 24/7 provision of the Section 136 suite and the provision of mental health services for children and young people. The issue of information sharing to effectively safeguard people with mental issues has also yet to be fully resolved.

4.4 At the first round table Geraldine Strathdee shared a vision on how mental health services can be transformed building on the assets within communities to promote good mental health and allowing easy access to mental health services for those who can benefit from them. As set out in para 4.3 the transformation work programme has been initiated and partners look forward to this coming to fruition. In the meantime for policing there are risks which are important to be resolved through the Mental Health Crisis Care Concordat work.

5.0 IMPLICATIONS & NEXT STEPS

5.1 Working together to build 'Safer, Stronger Communities' in partnership is the right thing to do. But there is much work to be done to give the work stream the momentum to drive the strategic direction of partner agencies at a pace which matches the reduction in funding streams.

5.2 The Board must champion new and planned upstream preventative work across all of the interdependent priorities to manage the increasing demand on public sector services. The troubled families approach, through the gate support for offenders and health interventions will all play their part, but this is unlikely to be enough to tackle the scale of the demand.

6.0 RECOMMENDATION/DECISION REQUIRED

6.1 The Health and Wellbeing Board are requested to note the role of the Police and Crime Commissioner as a key stakeholder within the mental health agenda specifically through his focus on prevention. Clearly promoting good mental health, and helping those achieve and maintain good health, will reap rewards across the whole sector and in turn manage the increasing demand on public sector services.

Source Documents	Location
Police Reform and Social Responsibility Act 2012	www.legislation.gov.uk
Cambridgeshire and Peterborough Crisis Care Concordat Mental Health Declaration	www.crisiscareconcordat.org.uk
Cambridgeshire Police and Crime Plan – revised June 2015	www.cambs-pcc.gov.uk
Cambridgeshire Victim and Offender Needs Assessment	www.cambridgeshireinsight.org.uk

Agenda Item No: 8

NEW COMMUNITIES: NEW HOUSING DEVELOPMENTS AND MIGRANT POPULATIONS JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) 2015

To: **Health and Wellbeing Board**

From: **Fay Haffenden, Consultant in Public Health Medicine**
Iain Green, Senior Health Improvement Specialist
Sara Dunling-Hall, Public Health Registrar

Date: **17th September 2015**

1. PURPOSE

The purpose of this paper is to present the proposed scope of the New Communities: New Housing Developments and Migrant Populations JSNA.

The paper describes the context of the JSNA and the scoping process that led to the identification of the areas to be included in the JSNA. The proposed areas for inclusion are described along with the process for its development. The Board is asked to consider the proposed scope and approach for the development of the JSNA.

2. CONTEXT

2.1 Joint Strategic Needs Assessments (JSNAs) describe the future health, care and well-being needs of the local populations, the strategic direction of service delivery and the commissioning requirements to meet those needs. The reason for doing a JSNA is to develop the evidence base for the health and social care response so that it more closely meets the prioritised needs of local people and to inform the Joint Health and Wellbeing Strategy.

2.2 What is a Joint Strategic Needs Assessment?

- Provides analyses of data to demonstrate the health and wellbeing status of local communities.
- Defines where inequalities exist.
- Provides information on local community views.
- Provides the evidence of effectiveness of interventions.
- Provides information to help shape the planning and commissioning ofservices.
- Highlights key findings based on the information and evidence collected.

The Cambridgeshire JSNA has adopted a client based model that has a phased approach. Consequently each phase focuses upon the development or updating of a JSNA for a specific client group.

2.3 Why undertakea Joint Strategic Needs Assessment?

A JSNA includes analysis of the range of factors that influence health and wellbeing. It recognises that while health services make a contribution to health, most of the key determinants of health, for example, education, employment, housing, and environment, lie outside the direct influence of healthcare.

2.4 Who is involved in producing the JSNA?

Upper tier local authorities and Clinical Commissioning Groups (CCGs) have an equal and joint duty to prepare JSNAs, through the Health and Wellbeing Board. In Cambridgeshirethere is a strong commitment to involveas many organizationsas possible which provide services or advocacy in the collection of information and formulation of recommendations.

Community views are collected and included in the JSNA and inform the recommendations. Steering groups with memberships that reflect the organizations and communities oversee the development of the JSNA. This approach facilitates a joint understanding of needs and priorities that supports future collaborative work to address them.

3. THE JSNA PROGRAMME OF WORK 2015-16

3.1 The Cambridgeshire Health and Wellbeing Board has selected the following topics for the JSNA program of work for 2015-16.

- **New Communities** – Feedback from district and other colleagues at a recent HWB Board development day emphasised the importance ofassessing the health needs of new communities, given the scale of housing development in Cambridgeshire, and current levels of population mobility and migration. It was felt that this JSNA could also include a focus on Migrant Health in addition to new development areas as there is cross-over regarding community cohesion issues.

- **Alcohol misuse**– as a cross cutting issue for NHS, public health, social care and criminal justice services, where there were significant opportunities for prevention.

4. NEW COMMUNITIES: NEW HOUSING DEVELOPMENTS AND MIGRANT POPULATIONS JSNA

4.1 Issues in defining the Scope

4.1.1 Unlike other JSNAs the new development part of this workfocuses on communities and population groups that do not yet exist, although it draws on the experience and evidence from existing new communities. While all JSNAs must rely on assumptions about the changes in size and needs of populations groups to plan future health and wellbeing needs, these extrapolations are generally based on fairly stable estimates in existing populations.

4.1.2 Every new community is different and while lessons learnt from experiences in one community can inform planning for another there must necessarily be caution in transferring these lessons from one setting to another.

4.1.3 A particular challenge of this JSNA is that each new development poses very different challenges. The largest and most complex such as Northstowe will be built over relatively long periods of time (15+ years). This prolonged period will likely have unpredictable impacts on community identity and cohesion, and in turn on mental health and wellbeing, the "needs" of a new community in year one of occupation are likely to be different from the "needs" at the end of the construction many years later.

4.1.4 In addition smaller developments also have impacts on existing communities and infrastructure. It is not always possible to ensure that the relevant infrastructure and services will be available when needed. Health services and facilities must be commissioned at the optimal point. Too early and the facilities are underused and uneconomical; too late and health needs are not adequately met and waiting times increase. In addition with the pressures on public sector finances there is a need to plan and provide services differently, the model of service provision now may not be "fit for purpose" in 20 years' time.

4.1.5 In planning for the Cambridgeshire JSNA on new communities it was agreed that one area of focus would be migrant health. As migrant populations are likely to have different and distinct needs from new community developments this will form a separate section of this JSNA.

4.1.6 Peterborough public health team also plan to complete a JSNA on Eastern European Economic Migrants by March 2016. This crossover forms an opportunity for joint working across the two public health teams and prevents duplication of work. However Migrants are not a homogenous group. International migrants in Cambridgeshire and Peterborough come from all over the world and have different socio-economic backgrounds. These include temporary labour migrants, highly skilled migrants, irregular or undocumented/illegal migrants, family reunion or reunification migrants, return migrants and forced migrants, which include refugees and asylum seekers.

4.1.7 Terminology – For the purpose of this briefing paper the term "Social Cohesion[1]" is used. There are other similar terms such as social capital, resilient communities, connectivity, community development, etc. These will be defined and explored where relevant in the finished JSNA. For the purpose of the scope the term social cohesion is used as the concept which enables a community to work towards the well-being of all its members.

4.2 Stakeholder engagement

The first stakeholder engagement event for the 'new housing developments' part of this work has been held and the results have informed the scope of the JSNA. Four broad topics can be distilled from the conversations, namely:

- Demography
- Environment

[1] Cohesive community is one where: there is a common vision and a sense of belonging; diversity of people's different backgrounds and circumstances are appreciated and positively valued; people from different backgrounds have similar life opportunities; strong and positive relationships are being developed between people from different backgrounds in the workplaces, schools and within neighbourhoods. (Guidance on Community Cohesion LGA/Home Office 2002: 6)

- Social Cohesion and Social connectivity[2]
- Assets and services

A stakeholder engagement event for the Migrant health part of the JSNA will take place in October 2015, although initial 1:1 meetings have already commenced. Early indications from these meetings suggest that broad topics will be:

- Demography
- Health Status & Health Service Usage
- Education
- Housing
- Employment
- Wellbeing & Lifestyle

4.3 The New CommunitiesJSNA 2015

4.3.1 New Housing Developments: The Aim

The first aim of the JSNA is to gather data and information on the health and wellbeing needs of populations in new developments with a view to informing service provision and commissioning for existing and future development sites within Cambridgeshire.

The second aim of the JSNA is to review the evidence on "designing and building in" opportunities for improving and maintaining health and wellbeing as part of the design of the new developments.

4.3.2 New Housing Developments: The Scope

The scope of this part of theJSNA will cover the following areas and questions:

- Demography and Health & Wellbeing Needs
  - What are the demographic profiles and health and wellbeing needs[3] of existing new developments and can they be applied to proposed new communities, and are these health and wellbeing needs likely to be different depending on the development?
  - Where do people who move into new communities move from and how long do they stay?
  - What are the variables that are most sensitive to changes in the housing market and how are these changes reflected in New Community populations?

- Environment
  - What factors contribute to "health and wellbeing" in new communities?
  - What can we learn from other new developments in terms of communities that are healthy and resilient[4]?

[2]Social Connectivity – "The relationships people have with others and the benefits these relationships can bring to the individual as and to society".

[3] An assessment of "need" can be inferred from the use of services data e.g. hospital data and social care data. In addition this can be supplemented through qualitative work to ascertain what the needs have been and through the literature review.

[4] Social Resilience – "The ability of groups or communities to cope with external stresses and disturbances"

- How do we “design and build in” opportunities for improved health and wellbeing as part of the design of the new developments, e.g. access and active travel, mental wellbeing, nutrition, opportunities to be physically active etc.?

- Social Cohesion and Social Connectivity
  - What are the most effective models of community development for building healthy and resilient communities and when should they be deployed?
  - How can a community development approach be sustained through the long periods required for communities to mature?
  - What do existing new community residents value? – learning from other developments

- Assets and services
  - What do we know about Health & Social Care utilisation in new communities, and can an analysis of the data show any patterns?
  - What assets are currently available in new communities (a Needs and Assets Assessment), and how can we replicate good practice in new and developing communities?

- Implications for Commissioning
  - What is the current NHS commissioning landscape, and how does this “fit in” with the Local Authority Planning system? To include but not limited to
    - pharmacy provision
    - Primary Care
    - Secondary care
    - Dentistry
    - Ophthalmology.
  - What type of Health and Social Care services (including non “health and social care services” which contribute to health and wellbeing e.g. Community Development) need to be provided in New Communities and what models of finance are available?

The JSNA will be underpinned with evidence on the value and “need” for the social infrastructure. The JSNA will also contain case studies of new communities both locally and further afield.

4.3.3 **Migrant Populations: The Aim**

The second aim of the JSNA is to gather data, information and evidence on the health and wellbeing needs of international migrants across Cambridgeshire. This will be completed with a view to inform future service provision and provide information on how best to utilise current assets in order to improve health outcomes for this population.

4.3.4 **Migrant Populations: The Scope**

The scope of this part of the JSNA will cover the following areas and questions:

- Demography
    - Where are international migrants currently living within Cambridgeshire, and what are the demographics of these populationsand are there any particular health issues that are of relatively greater concern in these populations[5]?
    - What are past and predicted future trends in patterns of migration in Cambridgeshire?
    - How long do international migrants tend to stay within the Cambridgeshire area?

- Health Status and Health Service Usage
    - How does the health status of these individuals compare to that of the UK born population?
    - Is this population registering/accessing appropriate health services? And if not what are the barriers/issues in doing so?

- Education
    - What is the distribution of migrant children across Cambridgeshire?
    - How does the attendance and educational attainment of migrant children compare to UK born children?

- Housing
    - What is the housing tenure of international migrants living within Cambridgeshire?
    - Are there any inequalities between migrants and UK born citizens with regards to homelessness?

- Employment
    - What is the employment status of international migrants living within Cambridgeshire?
    - Is there evidence of exploitation issues amongst the migrant worker population in Cambridgeshire and what is the level of this?

- Wellbeing and Lifestyle
    - Are there issues with social cohesion between local migrant and indigenous populations?
    - What are the levels of smoking/alcohol consumption amongst migrant populations?

4.4 Target Group

The first part of the JSNA will include analysis of the health and wellbeing needs of residents in new communities. It will take a phased approach, looking at needs across a new community as the community grows and ages.

The second part of the JSNA will focus on the health and wellbeing needs of migrant populations. It will also identify assets and services that are effective in meeting these needs.

[5] These populations have many of the same health issues as non-migrant populations but they may also have some specific issues attributable to their situation and history as migrants.

4.5 Focus and Aims

Given the broad scope of the JSNA, the aim will be to identify and summarise key issues for the target groups to support commissioning and planning priorities. Where necessary recommendations for further work will be made. Links will be made to other relevant JSNAs e.g. Housing and Health, Transport and Health. Areas of particular focus of the JSNAwill be:

- Needs and Assets
- Social Cohesion
- Commissioning services

4.6 Who is Involved

A steering group has been set up which includes representation from:

- Cambridgeshire County Council (Public Health; Environment, Transport & Economy; Children, Families & Adults)
- Cambridge Sub-regional Housing Board
- Cambridgeshire and Peterborough CCG
- Cambridge City, South Cambridgeshire, Huntingdonshire, Fenland, East Cambridgeshire District Councils
- Cambridgeshire Clinical Commissioning Group

The Steering Group has its own Terms of Reference which describes its key purpose giving strategic direction and overall programme management of the JSNA. It has another critical role in undertaking the initial interpretation of the data and formulating the recommendations for discussion more widely with stakeholders. The steering group will seek input from a wider range of stakeholders, including the voluntary sector to ensure engagement and future support for the adoption of the JSNA.

4.7 Populating the JSNA - Content

The JSNAwill collect a range of information and data from national and local datasets, including:

- Demographic data – either local data or survey/national data applied to Cambridgeshire's situation
- Data on existing services where available or the use of survey / national data to estimate health need and service use in Cambridgeshire
- Results of local consultations
- Evidence, best practice and cost-effectiveness

The stakeholders are critical to these information processes, both in contributing data and also facilitating opportunities to engage with communities. These sources of information will build a picture of the key needs, assets and evidence of effective interventions and good practice.

4.8 Timeframe

TheNew CommunitiesJSNA 2015 is scheduled for completion by March 2016 and will be presented to the Board at its 17th March 2016 meeting

5.0 RECOMMENDATIONS

The Health and Wellbeing Board is asked to agree the proposed scope of the New Communities: New Housing Developments and Migrant Populations JSNAas outlined in Section 4.3 above and to make suggestions for improvements.

Source Documents	Location
Reports and minutes of Health and Wellbeing Board	http://www2.cambridgeshire.gov.uk/CommitteeMinutes/Committees/Committee.aspx?committeeID=70

Agenda Item No. 9

ACCELERATIING ACHIEVEMENT – PROGRESS UPDATE

To: Health and Wellbeing Board

Date: 17 September 2015

From: Jo Pallett, Head of Virtual School for Cambridgeshire, Children, Families and Adult Services

1.0 PURPOSE

1.1 To provide the Health and Wellbeing Board with an update on the delivery of the Accelerating Achievement Strategy 2014-16.

2.0 BACKGROUND

2.1 The Accelerating Achievement strategy - *Accelerating the achievement of vulnerable groups of children and young people within Cambridgeshire 2014-16* sets out our ambition to improve the educational achievement of vulnerable groups of children and young people. These include (but are not limited to) children entitled to Free School Meals (FSM), children who have Special Educational Needs or Disabilities (SEND), or are Looked After (LAC). A link to the Accelerating Achievement strategy is provided below at section 8.1. The Vulnerable Children and Families JSNA 2015 analysis supports the continued work of the strategy. A link to the JSNA is provided below at section 8.2.

2.2 The Accelerating Achievement strategy is closely aligned to Cambridgeshire's School Improvement Strategy, with the ambition that by 2016, Key Stage 2 and Key Stage 4 attainment gaps will have improved by three percentage points above the rate of improvement by non-FSM pupils year on year.

2.3 To achieve this aim, the strategy describes two sets of objectives. One set focuses on how the Council will work across Directorates, and with schools, settings, professionals and families to improve the achievement of children in vulnerable groups in general. The other set focuses on specific vulnerable groups, identifying the actions the Council will take in order to improve the achievement of children in those groups.

2.4 In June 2015 the Accelerating Achievement 2014-16 Annual Report was published to provide a progress report on the delivery of the Accelerating Achievement Strategy plus an analysis of the 2014 assessment and examination results. A link to the Annual Report is provided below at section 8.3.

3.0 PROGRESS IN DELIVERING THE ACCELERATING ACHIEVEMENT ACTION PLAN

3.1 The Accelerating Achievement Annual Report is in two parts. The first part is an analysis of the most recent set of assessment results, to test against the overall ambition and the specific targets as described above. The second part is a description of the actions that have been undertaken as part of the delivery of our strategy, and an assessment of their output.

3.2 Performance overall (based upon 2014 assessment data)

3.2.1 At Key Stage 2 we are seeing absolute performance improve in nearly all of our target groups. A larger proportion of children eligible for free school meals, with special educational needs, speaking a Central or Eastern European language at home or from Gypsy / Roma ethnic backgrounds, achieved the required benchmark at the end of Key Stage 2. But we are still falling slightly short of our overall aim of 3ppts more than non-disadvantaged children. Unfortunately, the performance of Looked after Children in Cambridgeshire schools deteriorated in 2014, and the gap between LAC attending school in Cambridgeshire and the national level of achievement by LAC generally widened.

3.2.2 At Key Stage 4 we do not know how we compared to last year. However, the general trend has been that the gap is reducing in FSM and SEN statement, but not in SEN non-statement.

3.2.3 At the Early Years Foundation Stage all targets have already been achieved. This is a real strength. Key Stage 1 and Key Stage 2 are not achieved, and not on target broadly speaking. Key Stage 4 targets have not been achieved but are on target to achieve by the end of the strategy.

3.3 **Action plan**

3.3.1 Key actions undertaken in 2014-15 to support the delivery of the strategy include:

- The re-organisation of early help services to focus on families, and on educational achievement within the family plan.
- Bringing together specialist SEND services so that children with SEND get the right support from the Council.
- Focusing on Pupil Premium and the performance of disadvantaged pupils in summer term monitoring visits with schools.
- An analysis of the characteristics of children who did not achieve the benchmark in 2013 at KS2, which found that the combination of FSM and SEND was particularly challenging.
- Publishing guidance documents including pathways for SEND (the pathway on autism received national recognition from a charity), information about good practice in Pupil Premium, and good practice in interventions for children with SEND.
- Ensuring the largest possible proportion of children in vulnerable groups are registered to receive all of the education welfare and free childcare they are entitled to.
- Piloting a new Family Common Assessment Framework process, which supports better planning around the parental role in supporting educational achievement, in 3 areas and due to roll out countywide in autumn 2015.
- Set out clear expectations of parental engagement in the learning of children with SEND as part of the Local Offer.
- Organised conferences for school staff on the best use of Pupil Premium.
- Continued to campaign under the ‘Count Me In’ banner for registration for FSM and Pupil Premium, with a 38% increase in applications in January 2015.
- Linked together information about Funded 2s places with information about children in early years to ensure maximum take up of EY Pupil Premium.

- Improved the 'Risk of Non-Participation Indicator' to include more variables, so as to target pupils leaving school who are most likely to not be in education, employment or training post-16.
- Engaged with the Learning and Skills Board to improve the support offered to help vulnerable post-16 into good education, employment or training opportunities.

4.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

4.1 The Accelerating Achievement Strategy sets out how Cambridgeshire County Council will marshal its resources to support and challenge schools, settings and professionals working with families to accelerate the achievement of those vulnerable to underachievement. The strategy aligns with the Cambridgeshire Health and Wellbeing Strategy in terms of Priority 1: Ensure a positive start to life for children, young people and their families, Priority 4: Create a safe environment and help to build strong communities, wellbeing and mental health and Priority 6: Work together effectively.

5.0 OFSTED

5.1 During the 2015 summer term a thematic inspection by Ofsted on the impact of the Accelerating Achievement strategy was expected. The inspection did not take place. However, Ofsted will be evaluating the impact of the strategy as part of their school inspection visits over the course of the coming school year.

6.0 NEXT STEPS

6.1 The Accelerating Achievement Steering Group has agreed the following actions to progress delivery of the strategy:

- A review of the Accelerating Achievement action plan will be undertaken during October 2015 following publication of the 2015 key stage results.

- The Steering Group will set absolute targets by September 2015 for EYFSP, KS1, KS2 and KS4 targets based on the ambition of ensuring that by 2016 all children in Cambridgeshire have similar chances of success compared to their peers in similar areas.

7.0 RECOMMENDATION/DECISION REQUIRED

7.1 The Health and Wellbeing Board is invited to:

a.) Consider the Accelerating Achievement Annual Report.

b.) Consider activities across the Health and Wellbeing Partnership that support this work and provide comment on the future delivery of the strategy.

Source Documents	Location
8.1 Accelerating the achievement of vulnerable groups of children and young people within Cambridgeshire 2014-15	http://www.cambridgeshire.gov.uk/downloads/file/3322/accelerating_achievement_strategy
8.2 Vulnerable Children and Families JSNA 2015	http://www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/vulnerable-children-and-families-2015
8.3 Accelerating the achievement of vulnerable groups of children and young people within Cambridgeshire 2014-15 Annual Report June 2015	http://www.cambridgeshire.gov.uk/downloads/file/3810/accelerating_achievement_annual_report_june_2015

Agenda Item No: 10

SAFEGUARDING ADULTS BOARD (SAB) ANNUAL REPORT 2014/15

To Health and Wellbeing Board

Date 17 September 2015

From: Claire Bruin, Service Director, Adult Social Care, Children, Families and Adults

1.0 PURPOSE

1.1 Presentation of the 2014/15 Safeguarding Adults Board (SAB) Annual Report.

2.0 BACKGROUND

2.1 The Annual Report provides a background to adult safeguarding work in Cambridgeshire and a summary of the work undertaken by the Safeguarding Adults Board (SAB) and Adult Safeguarding Team within the period April 2014 to March 2015. The Annual Report (attached as Apppendix A) is presented as a draft report because this report had to be submitted for the Health and Wellbeing Board a week before it was presented to the Safeguarding Adults Board for final approval.

2.2 In the coming year the Care Act will make significant changes that will have an effect on all Safeguarding Boards across the Country. Cambridgeshire's SAB is proactive and forward thinking in its approach to these changes. Through its strong partnership working the Board is committed to having the processes and systems to ensure that the SAB's remit and function match the requirements set out in the new legislation.

2.3 For example:

- The SAB has agreed its guidance for Multi Agency Safeguarding Reviews of Serious Cases (SARs)
- Guidance has been agreed on the new role of the Designated Adult Safeguarding Manager (DASM) ensuring that all allegations against staff working with adults in Cambridgeshire are managed consistently.

2.4 This year the SAB has reviewed its current working arrangements and identified the need to consider having an Independent Chair as this would ensure that the Board is well placed both to hold each partner to account for its own safeguarding arrangements and ensure partners are working together to promote the wellbeing of those adults at risk of abuse and neglect.

2.5 The report also highlights the achievements made by our partners represented on the Board, for example:

- Healthwatch Cambridgeshire: are fully involved with the Safeguarding Adults Board and with the network group (representatives for service users, carers and the wider public) attending the Board and working with us to devise ways in which service users and the wider general public can have a voice in safeguarding;

including how the process works, but much more importantly about how we can understand and learn from people's experiences and what helps them stay safe.

- The Fire Service: having identified residents that have hoarding behaviours and are at risk of being injured or dying as a result of fire is working closely with the SAB and housing partners to produce a Multi-Agency Hoarding Protocol.

2.6 Whilst the Board is not complacent about the need to continue the development of our approach and responses to safeguarding adult issues, this report evidences the commitment and strength of the partnership working in Cambridgeshire.

2.7 Finally thanks must go to all staff (including volunteers) across Cambridgeshire, through their hard work, skillful intervention, commitment and courage that has resulted in positive outcomes for a large number of adults at risk, their families and carers.

3.0 SUPPORTING INFORMATION

3.1 This has been a significant year for safeguarding adults. The Care Act 2014 received royal assent in 2014 placing safeguarding adults on a statutory framework for the first time from 1 April 2015.

3.2 The Care Act now requires all local authorities to review their guidance to ensure that it is linked to the principles of Making Safeguarding Personal (MSP) and linking this to changes being made across the adult social care sector at both regional and national level, ensuring that appropriate responses are made when a concern is raised which may not need to be dealt with under the safeguarding process. Information would still need to be collected, but the response may be different as we focus more on what the service user wants as an outcome.

3.3 The most commonly reported type of abuse continues to be physical abuse (48%) which has been consistently high over the past three years. This is one of the easiest forms of abuse to identify and is commonly the type of abuse in situations where one service user has hit out at another service user.

3.4 The Board will continue to monitor these figures and other management information as we develop the new guidance ensuring that Making Safeguarding Personal is enshrined throughout the safeguarding process and the establishment of the Multi Agency Safeguarding Hub (MASH) that will triage referrals.

4.0 LOOKING FORWARD TO 2015/16

4.1 The SAB will focus on a number of key areas during the year including:

- A training strategy for safeguarding and mental capacity work which meets the needs of the social care and health workforce, enabling a better understanding of the decision making process in safeguarding whilst taking into account the legal requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards.

- Introduce changes to practice, procedures and training to support the implementation of the Making Safeguarding Personal approach

- Working with colleagues from Cambridge University to evaluate how Making Safeguarding Personal is embedded within our day to day safeguarding work

- Developing understanding about how to respond to people who self-neglect

- Closer collaboration with the LSCB with regard to:
  - Safer recruitment
  - Working collaboratively to support young people who may need to be safeguarded as they reach 18.

5.0 RECOMMENDATION

5.1 Members of the Board are invited to:

(i) comment on the Cambrisgeshire Safeguarding Adults Board 2014-15 Annual Report

(ii) consider an area(s) of work for 2015/16, set out in section 4 above, that the Board Members would like further information about through an update report later in the financial year.

Source Documents	Location
Terms of reference and annual reports for Cambridgeshire Safeguarding Adults Board	http://www.cambridgeshire.gov.uk/downloads/download/147/cambridgeshire_safeguarding_adults_board

DRAFT

Cambridgeshire Safeguarding Adults Board

making a difference together

Annual Report

April 2014 – March 2015

Contents

Members of the Cambridgeshire Safeguarding Adults Board

Chairperson: Executive Director - Children, Families and Adults Services Cambridgeshire County Council (CCC)

Representatives from:

Addenbrookes Hospital, Cambridge University Hospital NHS Foundation Trust
Adult Safeguarding Team, CCC
Adult Social Care, CCC
Age UK Cambridgeshire
Anglia Ruskin University
Cambridge Regional College
Cambridgeshire and Peterborough NHS Foundation Trust
Cambridgeshire Community Services NHS Trust
Cambridgeshire Constabulary
Cambridgeshire Fire Service
Cambridgeshire Healthwatch
Cambridgeshire Learning Disability Partnership, CCC
Care Quality Commission
Children Safeguarding and Standards Unit, CCC
County Councillor, CCC
Drug and Alcohol Action Team (DAAT), CCC
East of England Ambulance NHS Trust
Hinchingbrooke Health Care NHS Trust
NHS Cambridgeshire and Peterborough Clinical Commissioning Group
NHS England
Papworth Hospital NHS Foundation Trust
Papworth Trust
Procurement (Social Care), CCC
South Cambridgeshire District Council representing District Councils across Cambridgeshire

Welcome from the Chair

As Chair of the Cambridgeshire Safeguarding Adults Board I am delighted to commend this annual report to you. The Board has continued to be productive with a focus this year on preparing for the Care Act and ensuring the Board is well placed to meet its new duties.

In the coming year there will be significant changes that will have an effect on all Safeguarding Boards across the Country. Cambridgeshire's Safeguarding Adults Board is proactive and forward thinking in its approach on understanding the changes and promoting the Board's transformation. Through strong partnership working and transparency the Board is committed to having the processes and systems to ensure that our remit and function match the requirements set out in the new legislation.

With this purpose in mind the Board has reviewed its current working arrangements and identified the need to consider having an Independent Chair as this would ensure that the Board is well placed both to hold each partner to account for its own safeguarding arrangements and ensure partners are working together to promote the wellbeing of those adults at risk of abuse and neglect.

Through the Board's strategic vision and planned development the changes that need to be made locally will allow the Board to adapt and to build on this year's work by:

- continuing to work closely with relevant Boards e.g. Local Safeguarding Children's Board, the Health and Wellbeing Board and partners including the Cambridgeshire and Peterborough Clinical Commissioning Group and Cambridgeshire and Peterborough Constabulary who now also have a statutory role in safeguarding adults
- strengthening communications around safeguarding

This report also highlights the achievements made by our partners represented on the Board.

For example:

Healthwatch Cambridgeshire has worked closely with the Safeguarding Adults Board to devise ways in which service users and the wider general public can have a voice in safeguarding and how the processes work, but much more importantly, about how we can understand and learn from people's experiences and what helps them stay safe.

The Fire Service has identified people who have hoarding tendencies and are at risk of being injured or dying as a result of fire and is working closely with the Safeguarding Adults Board and housing partners to produce a Multi-agency Hoarding Protocol.

Whilst the Board is not complacent about the need to continue the development of our approach and responses to safeguarding adult issues, this report evidences the commitment and strength of the partnership working in Cambridgeshire.

I hope you find this report useful, either by raising awareness or identifying issues you can take forward in your own organisation as it is important that this is a "working document". We would also welcome any feedback on how we can improve the presentation of this information in the future.

Finally I would like to thank staff across all agencies for their commitment to safeguarding adults in Cambridgeshire.

Adrian Loades
Executive Director
Children, Families and Adults Services

Executive Summary

This report highlights the work of the Cambridgeshire Safeguarding Adults Board (CSAB) and its partners. The Board has spent much of the year working towards the implementation of the Care Act 2014.

The Department of Health guidance developed to support Local Authorities and partners to deliver the requirements of the Care Act reinforces the importance of the Making Safeguarding Personal approach to safeguarding adults. Work started on identifying how the approach in Cambridgeshire could be redesigned to respond in a more personalised way and this is being used to inform a revision of practice, procedures and training.

This report shows that there has been a very slight decrease in the number of safeguarding referrals made this year as compared to 2013-14. The upward trend of the previous three years has not been reflected in 2014-15. This will need to be monitored in 2015-16 and the focus on raising awareness will need to continue.

The highest number of alleged perpetrators continues to be "other vulnerable adults" and informed by discussions with Regional colleagues, alternative approaches to responding to these situations will be introduced when the Multi-Agency Safeguarding Hub is established in 2015-16.

Cambridgeshire County Council has seen a significant increase in the number of Deprivation of Liberty Safeguards (DoLS) applications, which has been due to the landmark Supreme Court ruling regarding what constitutes a Deprivation of Liberty.

At the end of 2014-15 the Board had been operational for almost twelve years and currently 29 partners are represented.

The Board meets on a quarterly basis and had two development events strategically timed to enhance annual planning.

Safeguarding Nationally

2014 was a significant year for safeguarding adults. The Care Bill received royal assent in May 2014 placing safeguarding adults on a statutory framework under the Care Act 2014 from 1 April 2015.

The Care Act 2014 set out a clear legal framework for how local authorities and other statutory agencies should protect adults with care and support needs, at risk of abuse or neglect.

The new duties include:

- The Local Authority's duty to make enquiries or cause them to be made.
- Establish a Safeguarding Adults Board (SAB), with the local authority, Clinical Commissioning Groups and the Constabulary as statutory partners.
- Undertaking Safeguarding Adults Reviews (SARs) where someone dies or the SAB knows or suspects that they have experienced serious abuse or neglect and there is a concern about how relevant organisations acted, so that lessons can be learnt.
- Publish an annual report and strategic plan.

All these initiatives are designed to ensure greater multi-agency collaboration as a means of transforming adult social care.

The Care Act has also extended the Local Authority's safeguarding responsibilities to all people with care and support needs where those needs mean that they cannot protect themselves, not just those who have needs that meet the eligibility for access to social care support. It has also explicitly included neglect alongside abuse under the safeguarding responsibilities. The guidance has also extended the list of types of abuse and neglect to cover:
Physical abuse
Domestic violence
Sexual abuse
Psychological abuse
Financial or material abuse
\modern slavery
Discriminatory abuse
Organisational abuse
Neglects and acts of omission
Self-neglect.

During 2014-15 the Local Government Association (LGA) and Association of Directors of Adult Social Services (ADASS) Making Safeguarding Personal programme continued with significantly more Local Authorities adopting the approach. This approach focuses on the wishes of the person who is being safeguarded rather than the processes. It sets the expectation that the outcome that the person wants will be clarified and that a flexible approach will be taken to safeguarding enquiries that keep the person and their wishes at the centre of the process. This expectation has been included within the guidance supporting the implementation of the Care Act 2014.

At the start of 2014 the Department of Health, following consultation, published "Positive and Proactive Care: reducing the need for restrictive interventions" - Guidance for all those working in health and social care settings: commissioners of services, executive directors, frontline staff and all those who care for and support people.

This guidance was developed as concerns about the inappropriate use of restrictive interventions across health and care settings were identified by Winterbourne View Hospital (DH 2012), Mental Health Crisis Care: Physical Restraint in Crisis in June 2013 by MIND, and a recent inspection of inpatient learning disability services by the Care Quality Commission (CQC). The guidance provides a framework within which adult health and social care services can develop a culture where restrictive interventions are only ever used as a last resort and only then for the shortest possible time.

The Supreme Court Judgement at the end of 2013-14 in relation to Deprivation of Liberty Safeguards (DoLS) widened and clarified the definition of deprivation of liberty. This has resulted in a significant increase in DoLS cases from hospitals and care homes nationally and locally. The judgement also widened the scope of DoLS to include adults living in the community requiring such cases to be put to the Court of Protection.

In October 2014 the Care Quality Commission (CQC) announced their new regulatory model that has people right at its heart. They will ask the questions that matter most to people who use services, listen to their views, take action to protect them and provide them with clear, reliable and accessible information about the quality of their services.

Andrea Sutcliffe, CQC's Chief Inspector of Adult Social Care, introduced the "Mums Test" which requires inspections and inspection teams to consider whether the service is one that they would be happy for someone they love and care for to use.

Following each inspection, each service will be rated: Outstanding, Good, Requires Improvement or Inadequate.

What this means in practice for Cambridgeshire

The Cambridgeshire Safeguarding Adults Board has been in place since 2003 so is well placed to make this transition and has considered some of the wider implications for Board Members and their organisations for example the Board has already reviewed its membership and consolidated its links with the Clinical Commissioning Group and the Constabulary.

The Board has agreed its guidance for multi agency safeguarding adult's review of serious cases (SARs). The aim of a review is to ensure that lessons are learnt from cases and to improve future practice and partnership working, thus minimising the possibility of it happening again.

Guidance has also been agreed on the new role of Designated Adult Safeguarding Manager (DASM) a role required of the Local Authority, Clinical Commissioning Group and Constabulary to oversee safeguarding processes in accordance with the Care Act guidance. Other partners from the SAB have also agreed to identify a lead to fulfil the DASM role within their organisation.

Partnership effectiveness

The Cambridgeshire Safeguarding Adults Board Business Plan 2014/17 is linked directly to both the Standards for Adult Safeguarding (produced jointly by the Local Government Association, Association of Directors of Adult Social Services, NHS Confederation and Social Care Institute for Excellence) and the six principles included within the Government Statement on Adult Safeguarding, May 2013.

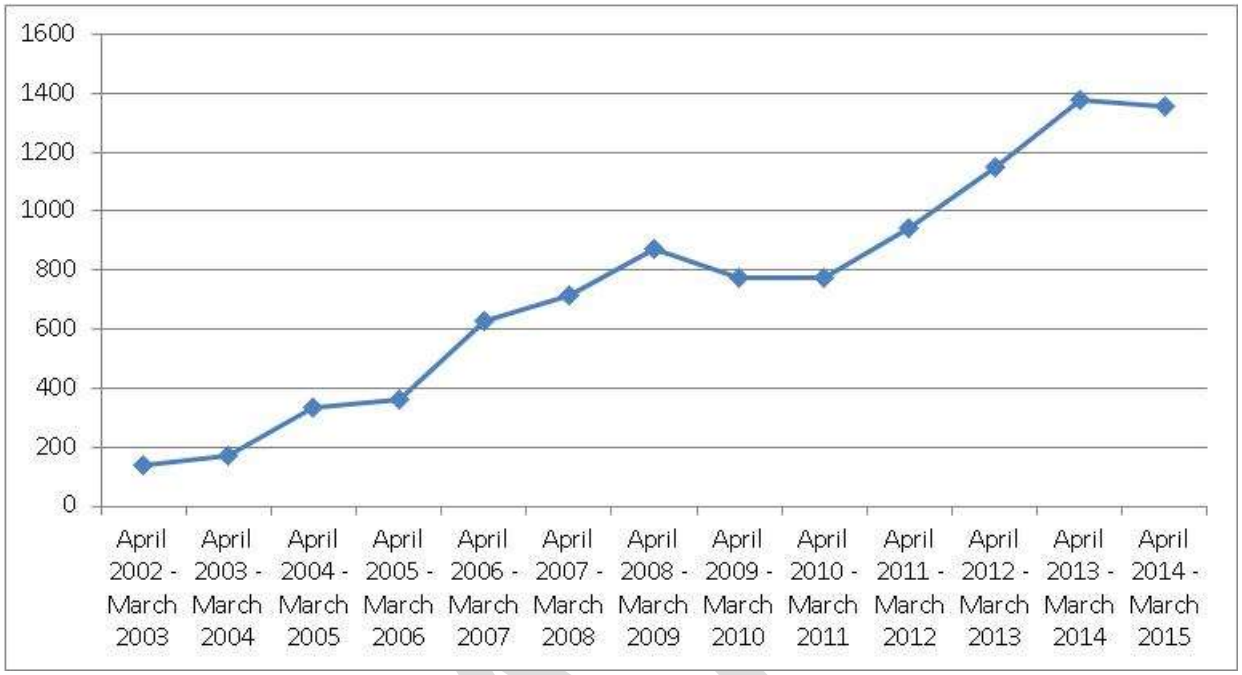
Standards for Adult Safeguarding	Government Statement on Adult Safeguarding
Outcomes	Empowerment
People's experiences of safeguarding	Protection
Leadership, strategy and commissioning	Prevention
Service delivery and effective practice	Proportionality
Performance and resource management	Partnership
Local safeguarding board	Accountability

Partners share organisational changes or risks which may impact upon safeguarding adult's arrangements at the Cambridgeshire Safeguarding Adults Board.

The Cambridgeshire Safeguarding Adults Board has an up to date Information Sharing and Partnership Agreement in place to ensure robust governance.

Analysis of Adult Safeguarding Referrals

Number of incidents received per year



The above chart shows the number of safeguarding referrals made each year in Cambridgeshire since 2002 (139). The number of referrals has increased year on year although in 2014/15 there has been a very slight reduction (1.6%) from 1377 to 1355.

Referrals are monitored by the Board on a regular basis to determine what areas the Board will need to prioritise. The chart above shows that there have been two periods of increasing referrals (2005-6 to 2008-9 and 2010-11 to 2013-14) with slight reductions in the intervening years. This needs further investigation to better understand if there is a common reason for this pattern.

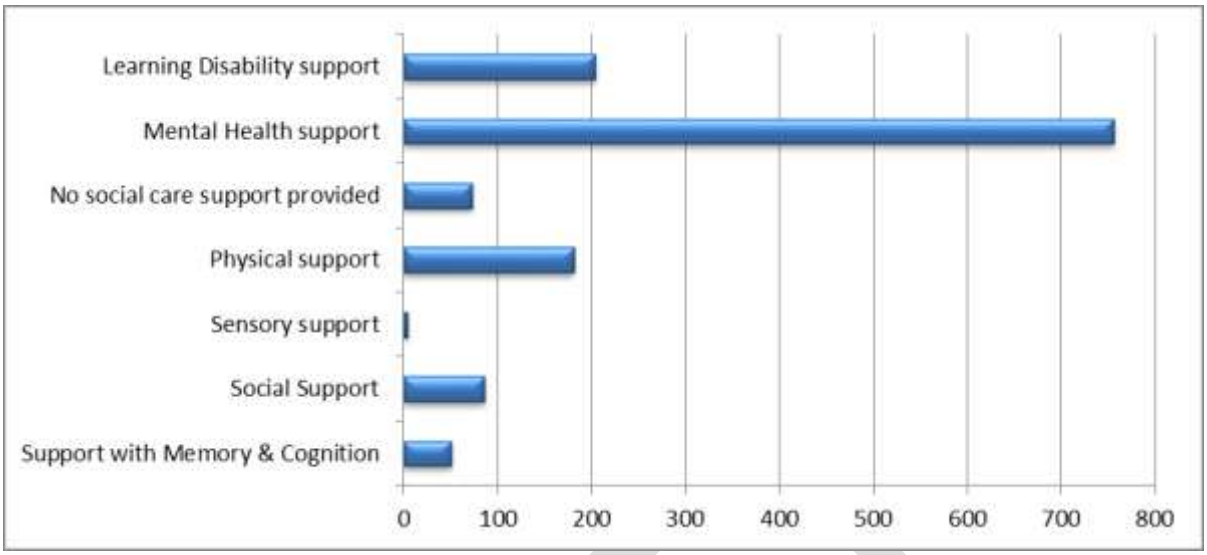
The interplay between compliance against contract standards, poor practice and safeguarding adults at risk of abuse will be addressed in the revision of the local safeguarding procedures and the development of the Multi Agency Safeguarding Hub (MASH). This will ensure that issues of contract compliance and poor practice are addressed through appropriate interventions such as contract monitoring and quality improvement mechanisms rather than safeguarding. The impact of these changes on the number of incidents of safeguarding reported in 2015/16 will need to be monitored.

Types of Abuse

	2012-2013	2013-2014	2014-2015	Trend
Discriminatory abuse	0%	1%	0%	⇩
Emotional/Psychological abuse	11%	11%	13%	⇧
Financial abuse	11%	10%	9%	⇩
Institutional abuse	4%	2%	2%	⇔
Neglect and/or acts of omission	21%	22%	22%	⇔
Physical abuse	46%	49%	48%	⇩
Sexual abuse	7%	5%	6%	⇧

The most commonly reported type of abuse continues to be physical abuse (48%) which has been consistently high over the past three years. This is one of the easiest forms of abuse to identify and is commonly the type of abuse in situations where one service user has hit out at another service user. Information set out in the tables below and information from operational staff, reinforces the links between physical abuse and some groups of service users. The second most commonly reported type of abuse has been neglect and acts of omission accounting for 22%.

Client category

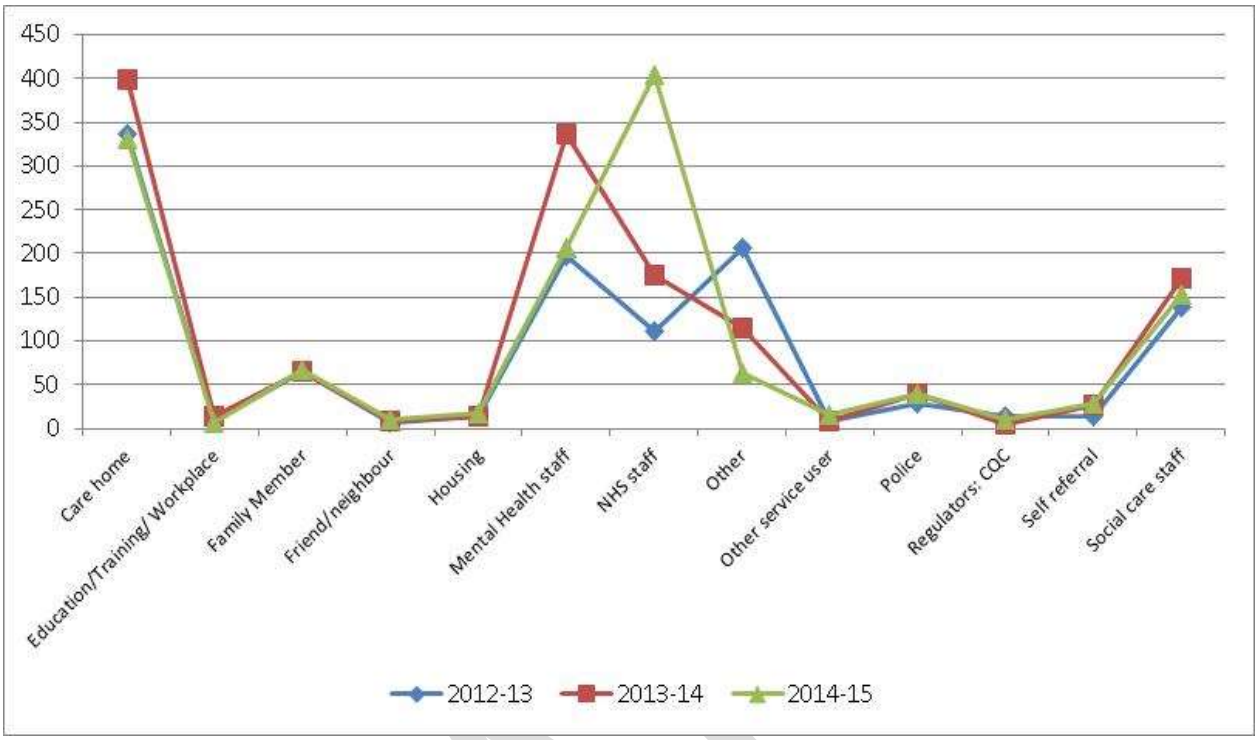


Due to a change in the way that safeguarding information has been collected in the client category this year we are only able to show one years' worth of data. However it is noticeable that Mental Health support has the highest number of alleged cases at (750), followed by Learning Disabilities (201). This includes the number of situations where a service user hits out at another service user and links to the incidence of physical abuse in the Table on page 10.

The revision of the local procedures will clarify how the incidents of alleged abuse between service users are dealt with in the future, ensuring that these situations are recognised and followed up, but only undertaking a safeguarding enquiry when the situation is abusive.

The SAB has also highlighted the areas where reporting is low. Training for service users and carers highlighting how to recognise abuse and make a safeguarding referral is high on the agenda.

Source of referral



This table shows us who made the safeguarding referrals. In 2012/13 the highest number of referrals made was by care home staff. With the overall increase in the number of referrals in 2013/14 the pattern of referrals is very similar, with the care home sector (399) and mental health staff (337) making the most referrals. This again reflects the number of incidents involving service users with dementia, mental health issues and learning disabilities within the overall figures.

For 2014/15 we have seen a real increase in the number of referral's from NHS staff from (176) in 2013/14 to (404) reflecting increased awareness. In 2014/15, the other notable area is a reduction in the "other" category from (114) to (63) which may suggest that people reporting abuse are more accurately recording their role, particularly those in the NHS.

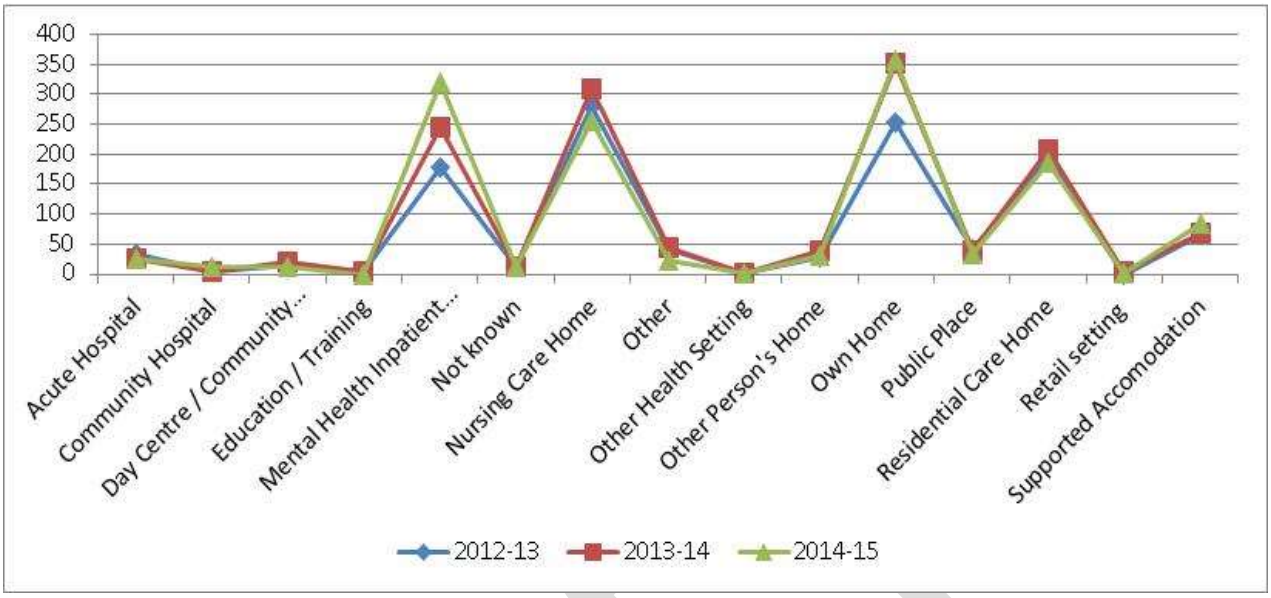
The Board will continue to monitor these figures as we develop the new guidance and establish the MASH that will triage referrals. Different approaches to referrals will have the potential to impact on the balance of different people reporting abuse or neglect.

A new Training and Development Manager has recently joined us and she is developing new training courses to meet the requirements of the Care Act and Making Safeguarding Personal. The team is working closely with the Network Group (representatives for service users, carers and the wider public) to raise awareness with the general public to recognise when an adult is at risk of abuse or neglect and how a referral can be made.

It is recognised that this approach needs to take into account the information needs of those who do not have English as a first language and those who cannot access

information from a website or may have visual impairments or be unable to read or comprehend information in a written form.

Number of incidents at each location



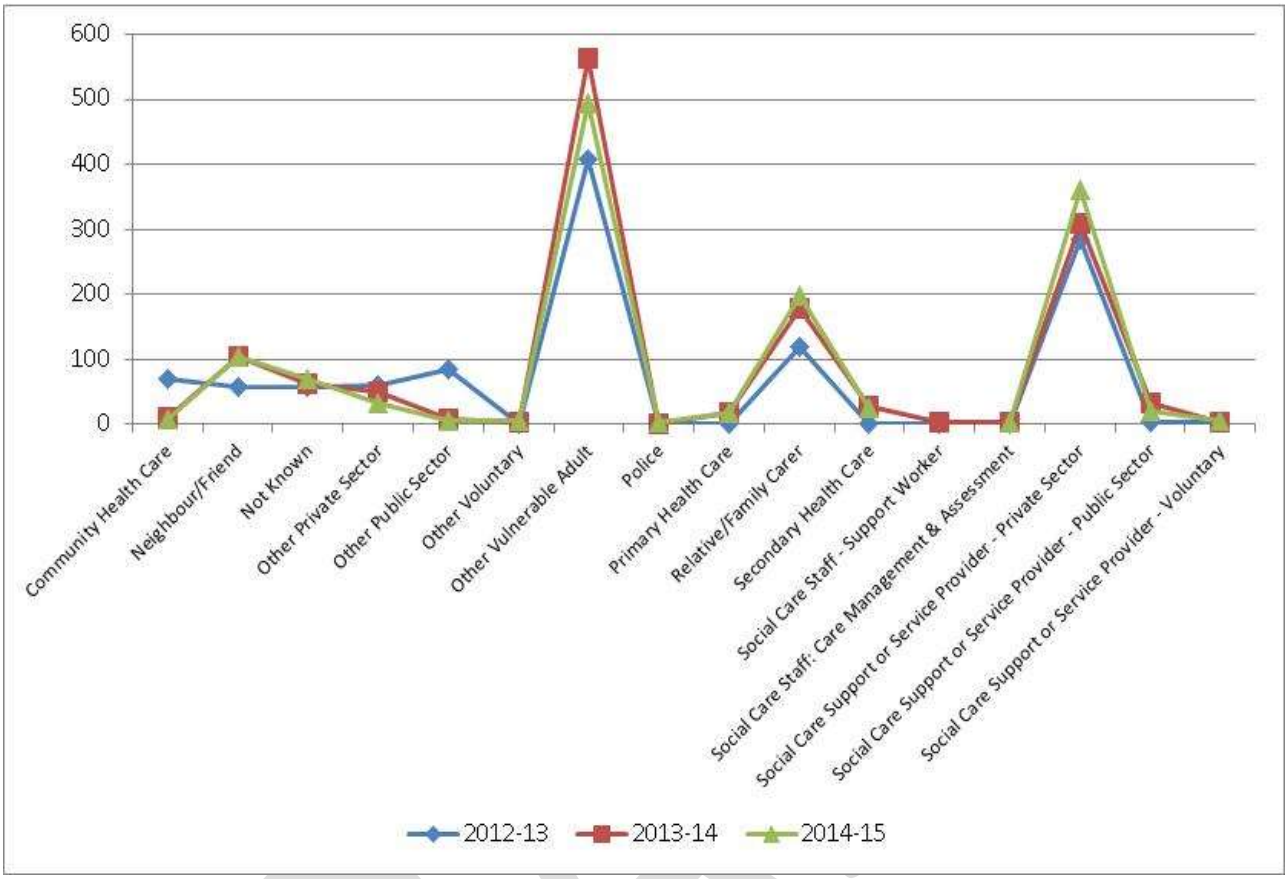
The most common location of reported abuse or neglect was the alleged victim's own home (357 of all referrals) closely followed by mental health inpatient settings (320) and nursing care homes (256 referrals).

The number of incidents reported in nursing care homes and inpatient mental health services reflects the number of incidents involving service users in both service groups, but this needs to be considered along with the information in the Table on page 12, Alleged Perpetrators.

The number of incidents in people's own homes represents potentially the greatest challenge to Safeguarding Adults at Risk of Abuse. It can be harder for statutory agencies to pick up concerns especially in situations where relatives or family members are the alleged perpetrator. This year has seen a focus on raising awareness of safeguarding and the Mental Capacity Act with GPs and Healthcare Professionals across Cambridgeshire and Peterborough. There has been a very good take up of this training which will help staff pick up signs of abuse when they see an adult at risk either in their surgery, clinic or in the person's own home. The requirement for training for home care agency staff has continued to be reinforced at providers meetings and through contract monitoring.

The SAB continues to raise awareness of the signs of potential abuse in the wider community by providing training to service users and service user groups within the community. The Network Group (representatives for service users, carers and the wider public) have been very supportive in helping with this area of work and it remains a key priority as we work to embed Making Safeguarding Personal.

Alleged perpetrators



This year the pattern of alleged perpetrators remains very similar with the number of referrals where other vulnerable adults are recorded as the alleged perpetrator being the highest (495). This again reinforces that incidents initiated by a service user against another service user are the highest single type of incident that is reported through the safeguarding process.

The next highest category is Social Care Support or Service Provider - Private Sector (362), followed by relative and family carer (197). The link between the alleged perpetrator being a relative or family carer and incidents reported as being in the person's own home is referred to on page 14.

There is a clear need to continue to find ways to address abuse where the alleged perpetrator is a member of staff particularly in the private sector. In Cambridgeshire the majority of the direct care provided in residential/nursing homes and by home care agencies is provided by the independent sector i.e. the private sector and the voluntary sector, with the private sector provision being significantly larger than the voluntary sector provision.

Where concerns are raised about poor performance against contract requirements or poor practice these are shared at a Bi-Monthly Information Sharing Meeting attended by the Council, the Care Quality Commission (CQC), Cambridgeshire Community Services NHS Trust, Cambridgeshire and Peterborough Clinical commissioning Group (CCG) and Cambridgeshire and Peterborough NHS

Foundation Trust. Information about concerns is shared and a multi-agency response agreed on how to address the concerns with the provider. The concerns may be raised through whistle blowing, or information gathered by any of the agencies attending the meeting through their visits to residential/nursing homes or appointments with people living in their own homes.

In a small number of cases (and where there are serious concerns), a Risk Summit has been held that includes all of the agencies previously mentioned along with representatives from the Police, Ambulance, Fire, Health and Safety and Environmental Health, if required. This allows the agencies to plan the best approach to ensuring compliance with all of the requirements (including legislative requirements) applicable in a care home or other care service.

Work to address the potential abuse of adults with care and support needs living in residential/nursing homes and receiving support in their own homes continues to be a high priority for the SAB and the training team will deliver tailored training courses for organisations following safeguarding concerns. The work to raise awareness within the wider community, described earlier, is an important part of this work – safeguarding adults is “everybody’s business” in the way that child protection has been promoted with the public.

The Health Sub Group which is Chaired by a representative from the CCG continues to focus on improving standards in nursing homes. This work is being informed by the issues that have been raised through the information sharing meetings.

Case conclusions

	2012-2013	2013-2014	2014-15	Trend
Investigation ceased at individual's request	-	2%	3%	⇧
Not determined/ inconclusive	16%	16%	17%	⇧
Not substantiated	20%	19%	21%	⇧
Partly substantiated	16%	14%	10%	⇩
Substantiated	48%	49%	49%	⇔

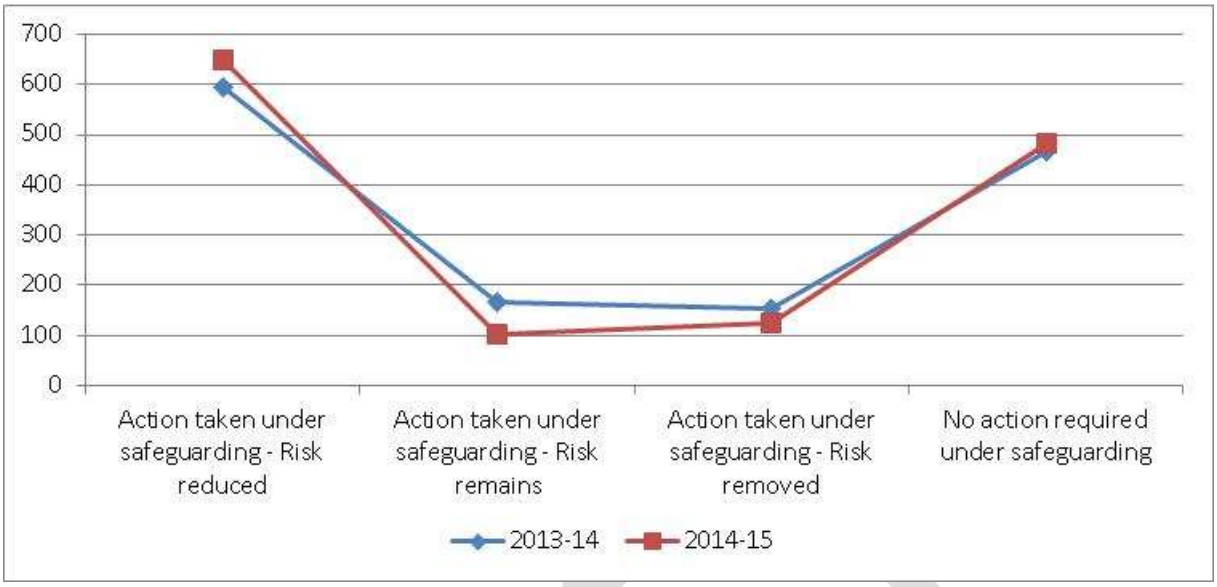
This table shows what the findings were at the end of the safeguarding process with a total of 59% being “substantiated” or “partly substantiated”. The safeguarding process uses decisions based on the balance of probabilities as opposed to beyond reasonable doubt as used by the Police.

The percentage of cases that were “not determined/inconclusive” has risen slightly for 2014/15. It can be difficult to prove an allegation of abuse one way or another, especially if the incident is un-witnessed and these cases would be described as “not determined/inconclusive”.

The percentage of “not substantiated” cases where the available evidence demonstrates that there was no abuse has increased, with partly substantiated having fallen which does reflect the difficulty when making decisions based on insufficient information.

The overall picture of case conclusions suggests that some of the referrals may have been better addressed through other interventions. Where the safeguarding approach is appropriate, changes to be introduced in the second half of 2015-16 will lead to more focused enquiries that will hopefully provide clearer evidence of what has happened in some situations, particularly in residential and nursing homes.

Outcomes for victims



This chart shows the recorded outcomes for victims of abuse, in terms of risk, for 2013-14 and 2014-15 as a result of the actions taken to respond to the safeguarding referral.

Where risks remain or are reduced rather than removed there will be a plan to monitor and review the situation, often with multi- agency input and information being shared to ensure that action can be taken quickly if there are further concerns.

Risks may remain, or be reduced rather than removed, where the person lives in their own home and does not want to move or be separated from a relative or family carer who may be the alleged perpetrator. Also, risk may not be removed where people continue to live in residential/nursing homes where other service users are instigating the aggression and it is not considered appropriate to move people to alternative services. This reinforces the importance of working with the providers of these homes to ensure that they have the skills and experience to manage behaviours that may be challenging.

It is important to note that there has been an increase in the number of cases where the risk has been reduced and a similar number of cases with no action required under safeguarding. The situations where no action was required under safeguarding reflect the types of situations that could be better addressed by other interventions as described earlier in the report.

The Making Safeguarding Personal approach will focus on the outcomes that people want from the response to the alleged abuse or neglect that they have suffered. A new approach to capturing the outcomes and the extent to which these are achieved will be developed during 2015-16.

Measuring the quality of the safeguarding process

A priority for the Board during the coming years will be to ensure that Making Safeguarding Personal is embedded into the work of safeguarding adults as outlined within the Care Act.

Work will continue to:

- Introduce changes to practice, procedures and training to support the implementation of the Making Safeguarding Personal approach
- Develop a way to capture the desired outcomes of people who have been abused or neglected and are involved in the safeguarding process
- Improve the outcomes for people who have been involved with the safeguarding process
- Ensure Safeguarding Adults Reviews (SARs) provide effective opportunities to learn and improve collaborative working
- Using the Network Group (representatives for service users, carers and the wider public) to ensure safeguarding is embedded within the community
- Stronger links with Peterborough Adult Safeguarding colleagues

Quarterly reports are produced for the SAB in relation to the safeguarding activity. Ensuring that the Board learns from individual experiences of the safeguarding process and guaranteeing that standards are maintained will be an ongoing priority and area of development for the coming years.

How have we worked together to safeguard adults from abuse?

Making Safeguarding Personal in practice is to ensure that the service user is consulted throughout the process as to what outcomes they want to achieve, in essence, to remain person centred and not to be process driven.

Case Study

A telephone call was made by neighbours to the police who were concerned about a group of people gathered in a garden of a derelict looking property in their street. They were concerned as there was a lot of noise and other anti-social behaviour.

The police attended and whilst they moved the people on they checked the property and found that someone was inside. As the property was in a derelict state they were concerned that someone was living in such conditions and made a safeguarding referral to Adult Social Care as they were concerned about self neglect of the individual.

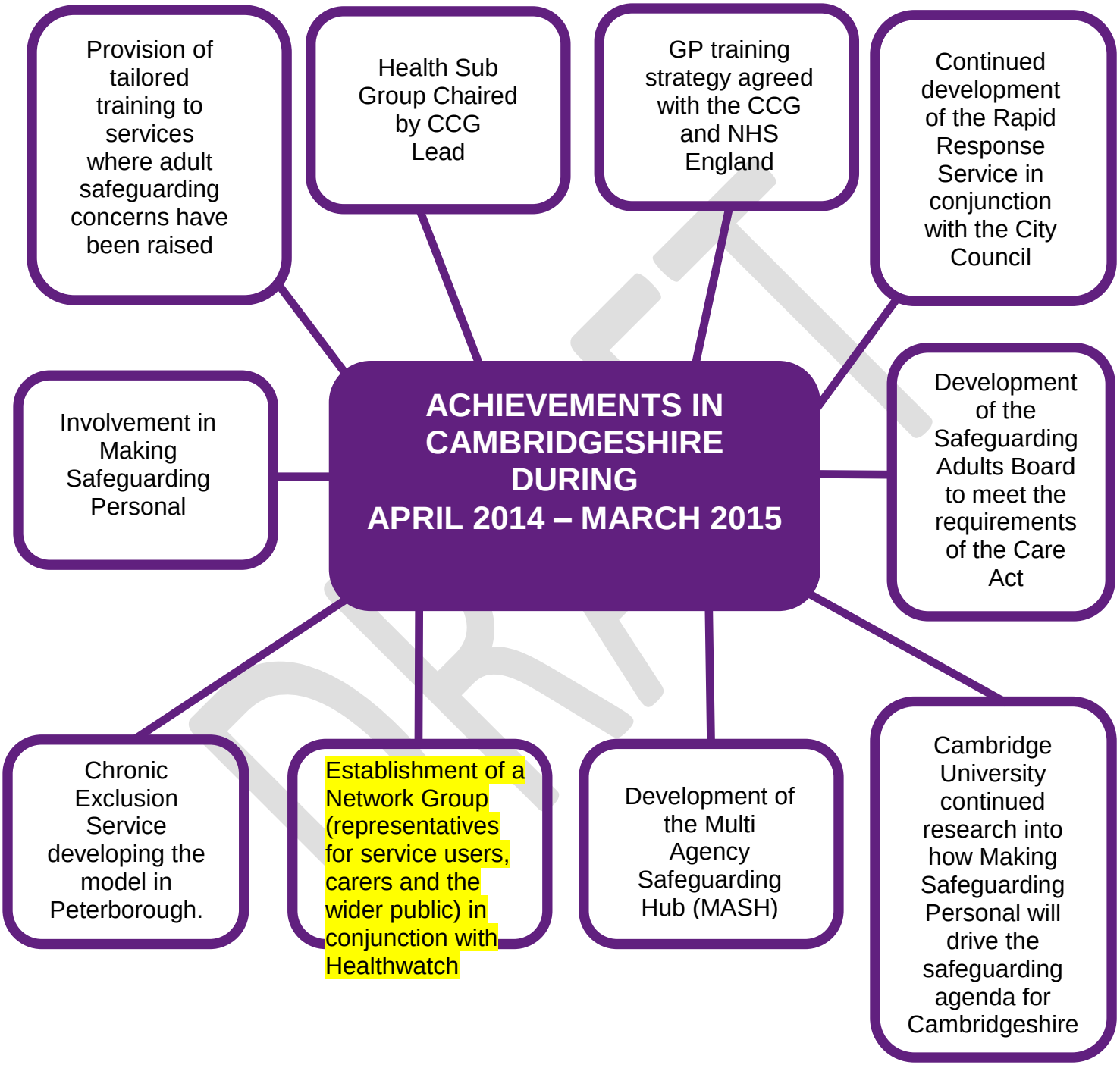
A joint visit with a Police Community Support Officer (PCSO) and a Social Worker was arranged and they discovered that Charmaine was living in the property and was locked in by her sister. Charmaine was in her 60's and said she was waiting for her sister to return as usual that day. She was not able to unlock the door as her sister had the key. Charmaine spoke through the door and explained that her sister visited her every day and brought food for her. The concerns were now about neglectful behaviour of her sister to her.

From the initial discussion with Charmaine there were concerns that she may not be making decisions about how she wanted to live and her sister was imposing this way of life on her. There was a concern that she may have a learning disability. A plan was made for the PCSO and the Social Worker to work on building a trusting relationship with Charmaine and keeping her at the centre of all decisions and establishing what she wanted to change in her life, if anything. This was achieved over a period of several weeks until she felt able to give contact details of her sister. Access was eventually gained and the living conditions of Charmaine were very poor. She was thin and had no means of cooking or washing. She was poorly clothed and not appropriately for the weather and was not able to keep herself warm. The condition of the property meant there were environmental concerns. The Social Worker was able to work with Charmaine to support her to make decisions about her life and worked at her pace to make positive changes she wanted to make. She still wanted a relationship with her sister and this was supported. She was also supported to move to another property which she settled into well.

The feedback from her has been positive and the outcomes she identified have been achieved.

A multi-agency approach supported Charmaine and the outcomes she achieved were those identified by her over time. She now lives amongst new friends she has made and reports she has been given a new life.

What have we achieved?



Safeguarding Adults Team Training and Development

Introduction

The County Council's Safeguarding Adults Training Team offers training to our statutory partners and independent, private, voluntary and charitable organisations across Cambridgeshire.

A commitment towards improving the lives of adults at risk remains central to the work of the team, which is reflected in the changes to be made to the training in the coming year, in light of the Care Act 2014.

Staffing

The Safeguarding Adults specialist training team is made up of three part-time trainers and a manager, supported by 1.5 administrators.

In April and May 2015, a Training Organiser and Training and Development Manager were recruited and further recruitment is taking place to maintain the team with three part time trainers.

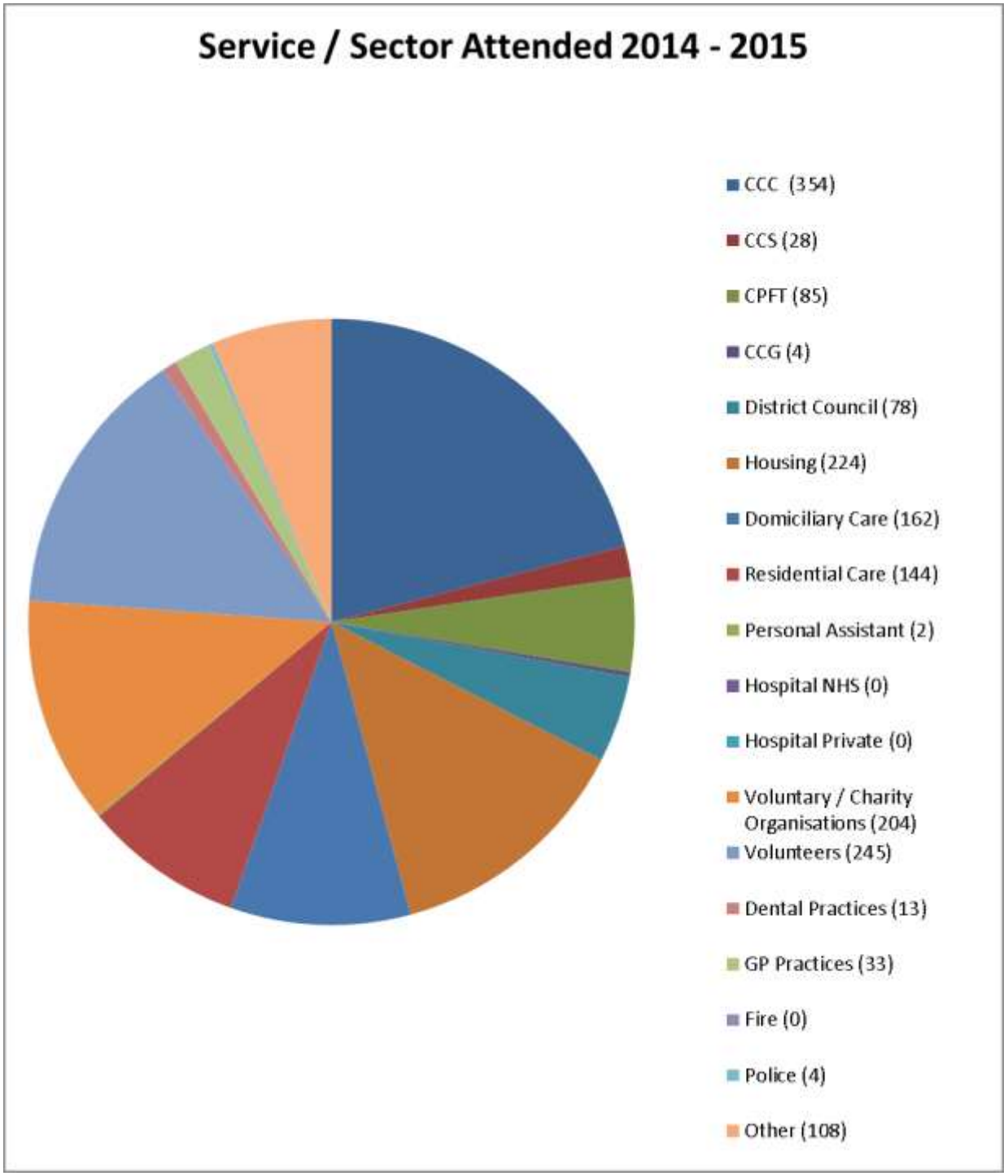
There is a wealth of knowledge within the new team structure, with experience and knowledge of safeguarding adults and professional further educational experience; with the result that we are able to ensure that training sessions are structured for the maximum learning benefit of the attendees.

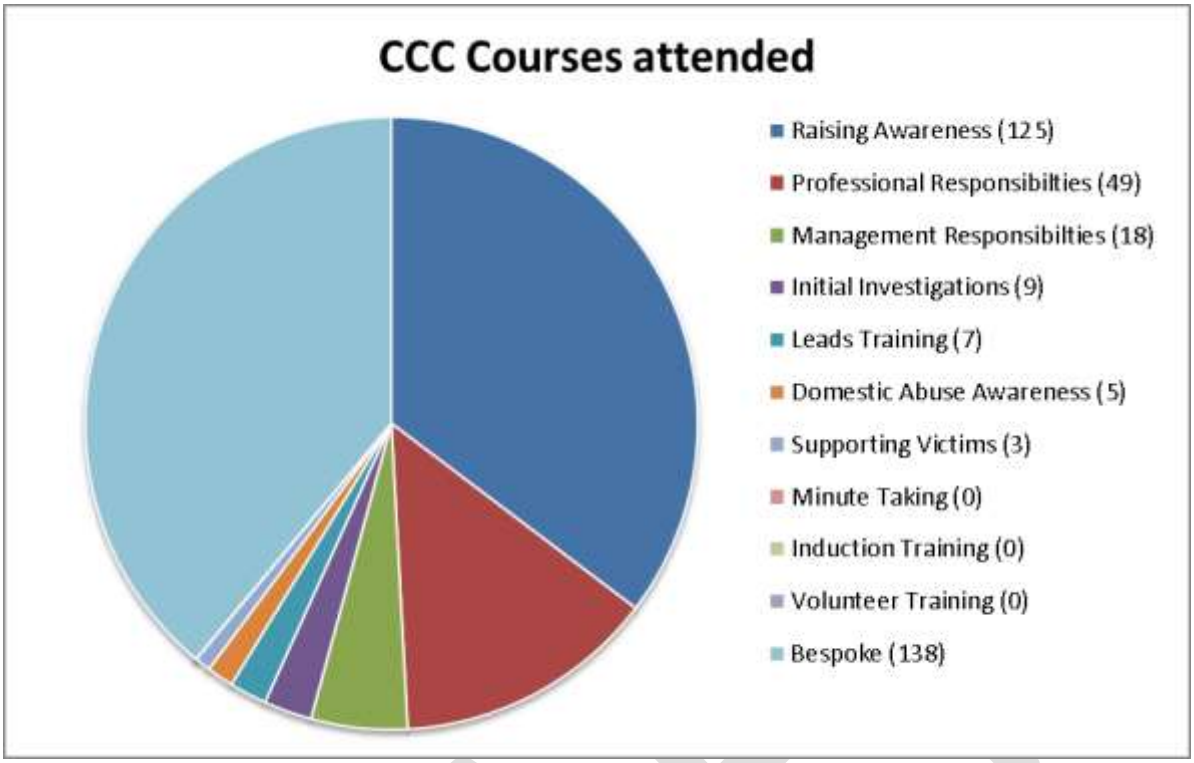
Training Figures

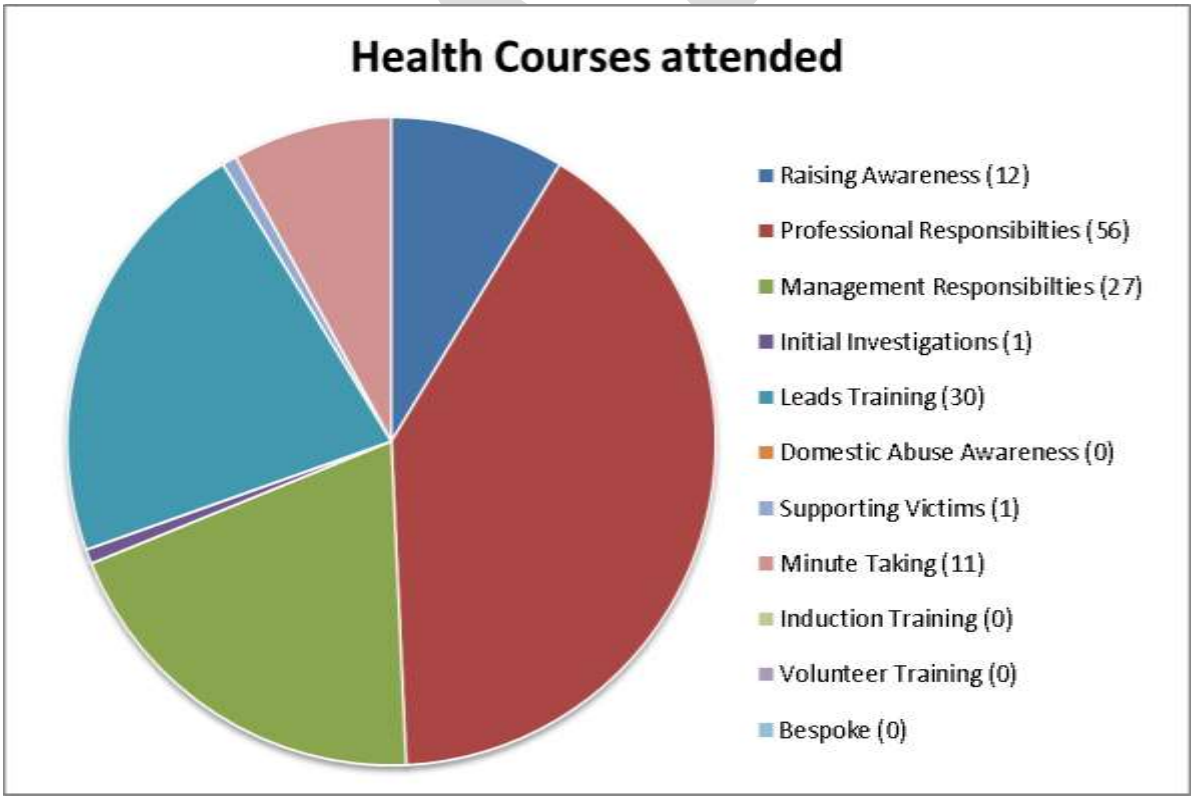
- We have noticed a decrease of attendees at courses of 11% from the previous year 2013-2014 – a substantial factor that relates to this figure is that the majority of courses were cancelled in February and March 2015, due to the forthcoming changes in national guidance and pre-empting the changes required to be made to the Council's Safeguarding Adults Procedures.
- 12 different set courses were provided – these range from basic awareness courses to more in-depth training for safeguarding leads. Awareness raising courses were the most to be provided, with other courses delivered based on the learning needs of attendees and the depth of information required, such as training on the responsibilities of provider managers. These courses do not include the many in-service (bespoke) courses we provide, or e-learning.
- There was a 10% cancellation rate by attendees.
- 20% of CCC staff failed to turn up to booked courses, compared to a 15% non-attendance of PVI sector attendees. Costs are incurred for failure of attendance and charges are made to recoup costs.
- There was an increase of numbers allowed on courses for more capacity.
- 15 provider agencies (care homes and domiciliary care agencies) have received bespoke (in-service) training.
- In total, there were 126 sessions provided during the year, with 1688 attendees.

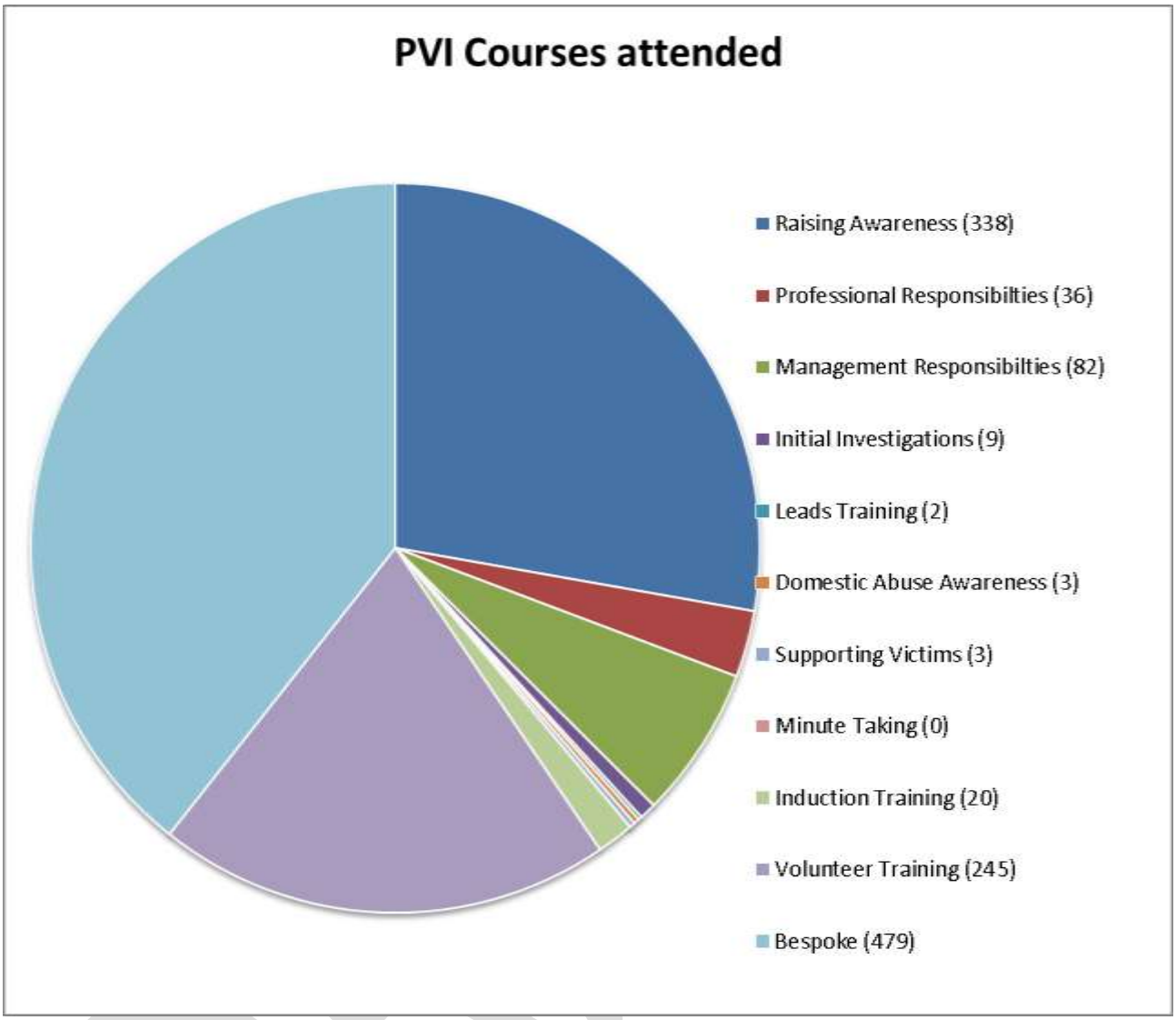
The team administrators also support the Mental Capacity Act and Deprivation of Liberty Safeguards Team with their training programme. These figures are not included in these statistics.

People trained




CCC Courses attended
Raising Awareness (125)
Professional Responsibilties (49)
Management Responsibilties (18)
Initial Investigations (9)
Leads Training (7)
Domestic Abuse Awareness (5)
Supporting Victims (3)
Minute Taking (0)
Induction Training (0)
Volunteer Training (0)
Bespoke (138)


Health Courses attended
Raising Awareness (12)
Professional Responsibilties (56)
Management Responsibilties (27)
Initial Investigations (1)
Leads Training (30)
Domestic Abuse Awareness (0)
Supporting Victims (1)
Minute Taking (11)
Induction Training (0)
Volunteer Training (0)
Bespoke (0)



The private, voluntary and independent sector continues to represent the largest percentage of overall course attendees with people attending our Raising Awareness course and in-service (bespoke) training being arranged for providers.

Course and Resource Development during 2014 to 2015

Many changes were planned in light of the Care Act, which was outlined in a Training Team Care Act Action Plan, which considered reviewing the content and structure of courses, linking to national guidance and the new Safeguarding Adults Policy and Procedures.

An Adult Safeguarding and Mental Capacity Act Training Strategy for GP Practices was written in consultation with the CCG and Peterborough City Council. Bespoke training sessions have begun and will run throughout 2015/2016.

A joint training programme between the Safeguarding Adults Team and the Education Child Protection Service continues to be developed, in light of the changes from the Care Act.

An effective working relationship has continued with the Diocesan of Ely Safeguarding Officer to review their training and contribute towards updating knowledge of internal trainers on adult safeguarding.

The e-learning package has been replaced to reflect the implementation of the Care Act 2014, with a huge increase in people accessing it – these figures will show in next year's report. E-learning continues to be a free resource and available to all organisations and members of the public, including informal carers and people who use services.

Future work plan

The Adult Safeguarding Training Team and the Adult Safeguarding Training & Development Sub Group, will work towards the objectives laid out in the Safeguarding Adults Board's Business Plan for the next year – Priority Area Three - updated to reflect the changes required by the Care Act.

Core objectives for the team for the next year include targets set in the Training Teams Care Act Action Plan. The Action Plan was updated in June this year (2015) to now have a clear definition of tasks required and SMART targets, which include a complete review of all courses and redesign of the range of courses and content of those courses, to ensure they are Care Act and Cambridgeshire County Council Safeguarding Procedure compliant. A central theme for the proposed courses will be Making Safeguarding Personal, with outcomes of courses aimed at meeting the learning needs of course attendees and ultimately adults who may be at risk. The Action Plan will be taken to the Safeguarding Adults Training & Development Sub Group.

To be able to take a systematic approach to updating courses, as identified in the Action Plan, a framework, with SMART targets, is being developed by the team, whereby, every course will be scrutinised and either radically updated, or broken down, with relevant information used, where appropriate, in future training. Main drivers for training courses in the future will be to meet the requirements of the Care Act, provide practical guidance relating to the different types of abuse (including domestic abuse, self-neglect and modern slavery) and guidance on how to respond to concerns and how to evidence decisions made – with a central theme of making safeguarding personal – the adult at risk should be central and involved in any safeguarding activity or decision made.

Cambridgeshire Chronically Excluded Adults (CEA) Service

Cambridgeshire County Council is partnered with other statutory and social sector organisations and is the lead organisation for this service for specific individuals with severe and complex, multiple needs often leading chaotic lifestyles. The success of the service lies in achieving strategic buy-in and bringing the right people and agencies to the table. It also provides a single point of contact for service users to help them navigate access to services, co-ordinate provision and follow and support them through the journey to increased stability and safety with the goal of providing the space to rebuild their lives.

The CEA service has been in operation since 2011 and has worked with 60 complex needs clients over the period primarily to achieve an increase in client well-being, a reduction in costs to public services through reduced arrests and court appearances, planned treatment interventions rather than emergency responses and improved engagement with existing services.

2014/15 Update

The CEA Team has worked hard in 2014/15 to continue to ensure that the co-ordinated approach is supported by relevant services. The Operational Group that oversees the work has expanded to include regular attendance from Probation, Adult Social Care and the IDVA service, reflecting the nature of the complex needs client group. The group also welcomes representation from Huntingdonshire and East Cambridgeshire District Councils to add to its knowledge and experience base, therefore providing a better service to clients in those parts of the county.

In November 2014, the district authorities were successful in a bid for extra funding from the Department of Communities and Local Government. Some of this funding was allocated to enable Cambridgeshire County Council to team up with Peterborough City Council to develop the CEA approach in Peterborough. Peterborough is keen to embed the CEA approach to address the issues facing their complex needs population and the CEA team have been working with the colleagues in Peterborough since the funding was allocated. 2015/16 promises to be an exciting venture in this partnership.

Voices from the frontline

The CEA Team and service users have taken part in the Voices from the Frontline Project hosted by the MEAM Team. One of our service users took part in the project aimed at giving service users a wider voice when influencing policy at a National level. Paul (front, second left) and CEA Co-ordinator Marie (rear, far right) met with other service users and stakeholders in Nottingham.

Paul and Marie were invited to sit on a panel of expert contributors at the project launch in November at Westminster. The panel, Chaired by Baroness Tyler, set out the vision for the project to a large and varied audience of interested participants. The Solutions from the Frontline Report was published in June. A link to the full report can be found below

http://meam.org.uk/wp-content/uploads/2013/04/Solutions-from-the-Frontline-WEB.pdf

The CEA Approach

Since 2011, the CEA Team has used the MEAM methodology to drive its work. The team have spent time this year producing information on the approach locally to demonstrate why the Cambridgeshire service has been one of the most successful in the country. This has become particularly relevant this year following the publishing of the MEAM year two analysis of the work (link below), in February 2014.

http://meam.org.uk/wp-content/uploads/2014/02/MEAM-evaluation-FTI-update-17-Feb-2014.pdf

The analysis showed that the Cambridgeshire service saved an average of £958 per client per month. This once again drew national attention and during 2014/15, the CEA Team have been invited to seminars and workshops to share good and innovative practice in Norfolk, Newcastle, London and Blackburn. CEA also hosted services from across the country who came to see the work and what they could learn.

Trans-Atlantic Practice Exchange

Early in 2014, Homelesslink, the body that represents over 500 organisations working with the Homeless client group, approached the CEA Team to host a visit from the United States to exchange good practice. In June 2014, Aubrey Patiño from Avalon Housing in Ann Arbor, Michigan touched down in the UK. Aubrey spent two weeks with the CEA Team, meeting some of our partners and service users. Some of the cultural differences in the approach between the US and UK were stark and we all drew massively from the experiences. Aubrey's report of her experience can be found on page 44 of the paper below.

http://www.homeless.org.uk/sites/default/files/site-attachments/Homeless%20Link%20-%20Transatlantic%20Practice%20Exchange%202014.pdf

Rapid Response Service

The Rapid Response Service (RRS) has operated since October 2013 as part of the Single Homeless Service (SHS). The service comprises two full-time Rapid Response Workers (RRW) that sit within the Adult Safeguarding Team at Cambridgeshire County Council.

The SHS aims to reduce homelessness by providing a swift route in to appropriate accommodation for clients with low support needs. The primary issue for these clients is their housing difficulty and inability to find a route out of homelessness. They are clients where there is no statutory obligation to support but who may end up accessing supported accommodation schemes which they do not need other than to provide shelter. Both RRWs hold a caseload of clients and provide support, information and guidance to navigate individuals out of their homelessness. As well as supporting Housing Officers to provide a thorough assessment of each applicant's eligibility for the service, RRWs can offer support for up to 12 weeks after clients access accommodation during which time any longer term needs can be identified and a referral to appropriate services made.

Origins
In Cambridgeshire, the SHS was created using a sub-regional grant as part of the national governments' 'No Second Night Out' initiative. It had been raised at a number of partnerships meetings in Cambridgeshire, that accessing support and guidance was crucial at the set up stage of any new accommodation to give it the best chance of success. Given that the target group for the SHS was low needs homeless clients, an early, short, targeted intervention to enable this was felt to be crucial. The RRWs could also work with applicants to identify underlying issues which may have led to them becoming homeless and provide support or signposting to agencies that could help address these issues.

Methodology
The SHS is open to referrals from any of the Housing Advice departments within the Cambridgeshire sub-region. A client will present at their local authority and be assessed by a housing adviser. If they meet the initial criteria, an assessment form and information disclosure document is completed by the client and passed back to the housing adviser. The advisor creates an Inform page for the client allowing easy access to relevant information for supporting services. The advisor also creates a separate SHS page, linked to the client's main Inform record. This generates an automatic e-mail to the RRWs.

On receiving a referral email, the duty RRW will allocate the case and send the information disclosure document to the police for a background check. This is to adhere to the lone working policy. The RRWs contact the client to arrange a more in-depth assessment. As a service we aim to contact the client within two working days. This contact however, is normally made on the same day as receiving the referral. The RRWs arrange to meet the client at a time and place which is convenient for them. First appointments are typically at the local authority offices. This can be flexible to meet the need of the client. As a service we aim to see client within five working days.

The RRWs carry out a further in depth assessment using the information provided by the housing advisor as a starting point. If the client is eligible and accepted onto the service, the RRWs look at options available to them. This may be placing them on our waiting list for our Town Hall Lettings properties, looking into private rented accommodation or making referrals to youth or adult services. If, after assessment, the client is ineligible the RRW would signpost to relevant services or refer back to the Housing Adviser.

Referrals and Outcomes

- There were 183 referrals to the SHS in the first year 1/11/13 – 31/10/14. These clients were all assessed by the RRS.
- 91% of referrals were seen by a RRW within seven working days of the referral. Initial contact with all clients was attempted within two working days, a majority of times on the same day. RRWs were able to set up appointments with all clients who were able to respond.
- Referral quality and quantity increased in the third and fourth quarters as the service smoothed out teething problems with the method and understanding of the process.
- The RRS has supported 72 clients into accommodation in the first year of operation.
- 22 clients have found their own accommodation after initial support from the RRS.
- Following assessment by a RRW, 24 clients were found to be ineligible for the scheme, their support needs being too high.

Budget

The RRWs have access to a solutions budget that can make the difference in successfully taking someone from homelessness to independent accommodation. The budget does not replace existing funding streams and is only used where no alternative can be found.

The use of the budget has been entirely within the year 2014/15 which coincides with the majority of private rented accommodation sourced by Town Hall Lettings. Approximately 90% of the budget is spent providing the client with furnishings or appliances to make unfurnished properties habitable. Funds have also been used to support clients with food or households goods in the first stages of set up when moving costs have proved prohibitive and with transport to enable clients to access appointments, work or training until they have been paid.

Case Study

The positive impact that the RRS can have on lives is best demonstrated with a case study.

<u>Amir</u>

Amir approached our service in January 2014. He is now living in self-contained accommodation in Cambridge.

“I moved to England 15 years ago as a refugee, fleeing Iran. I’ve lived in Cambridge for the majority of this time, living in shared houses and spare rooms whilst my immigration status was sorted out. I’m now able to look for work.

I did have a settled place to live through a lettings agency. However, with average rent prices rising, the landlord decided that he was not making enough money from the property. He re-let the whole house to students and I was served notice to leave.

At this point, I didn't know where to go. I had no job, was relying on benefits and I couldn't find another place. In desperation, I slept on the floor of the letting agency office (I had obtained a key) until they found out.

I then spent two years living in a garage of a friend's house. The garage had no heating or light. It was so cold – I can still feel the cold to this day. My health deteriorated – my heart condition worsened, my back pain increased, my eyesight was damaged from the low light, my ear canal was damaged from the effect of the wind and now I have problems with balance and dizziness. I showered at the local mosque; I used the customer toilets at the local supermarkets. I kept praying for a way out of my situation as I just couldn't cope. Eventually, a friend recommended I contact the Council.

My housing adviser helped me obtain a bed space at Jimmy's and from there I obtained a room at The Springs. My support worker helped me with bidding and after a few months I was offered my own place. I just couldn't believe it – I just cried. Things are looking up for me. I'm applying for a passport, which will enable me to see my family, who I haven't seen in nearly 20 years. I'm looking to get work – I'm a trained welder and gas engineer.

I'm still scarred though. The effects of homelessness – the physical pain, the painful memories – will be with me forever. But at least I can start looking to the future."

Future Planning

The Rapid Response Service as part of The Single Homeless Service has proved to add an additional support mechanism that allows Housing Advisers an option for low needs clients that did not previously exist. The service currently receives on average between one and two referrals per day, demonstrating that a need for this option is required.

Anecdotal information suggests that there are also a reduced number of low support needs clients using supported accommodation options, freeing up space for those who need this type of housing. The effectiveness and need for this type of service to not only provide an option for low needs homelessness but also to free up resource for higher need clients is tangible.

The Rapid Response Service is currently reviewing its procedures and processes using learning gained from the first year of the project and also feedback gained from clients. By doing this, we hope to consolidate the good work achieved to date and improve the service that we offer. The service also will seek to be part of a wider project group to explore the longevity of this essential service and capitalise on innovative collaboration between voluntary sector and local government within a two tier authority.

Local Authority Responsibilities under the Counter Terrorism and Security Bill

The Counter Terrorism and Security Bill ("the Bill") was introduced into the Commons on 26 November 2014.

The Government asked Parliament to fast track the Bill because of the increased threat posed by terrorists, in particular as the result of the involvement of Britons in the Islamic State of Iraq and the Levant (ISIL) Insurgency In Syria. The Bill received Royal Assent in March 2015.

Chapter 1 – Preventing people being drawn into terrorism

This part of the Bill is intended to put the existing Prevent programme on a statutory footing. The Notes say that this programme relies on the co-operation of many organisations to be effective and that currently such cooperation is not consistent across the country.

Clause 21

This clause imposes a duty on specified authorities in the exercise of their functions to have due regard to the need to prevent people being drawn into terrorism.

The authorities are those specified in Schedule 3. The list includes local authorities, educational institutions, penal institutions, health bodies such as NHS trusts and police forces.

The list of educational institutions includes: higher education institutions eligible for public funding and universities with the power to award UK degrees, regardless of whether they are publicly funded; further education institutions funded by the Secretary of State (this would include sixth form colleges funded by the EFA) or by the SFA (i.e. further education colleges); state maintained and independent schools and academies; institutions preparing more than 250 students for qualifications regulated by Ofqual. This will cover most privately funded schools and colleges**.**

Clause 25

This gives the Secretary of State power to issue directions to a specified authority that she is satisfied has failed to discharge the cl.21 duty. Such a direction can be enforced by an application to the courts for a mandatory order.

Chapter 2 – Support for people vulnerable to being drawn into terrorism

This will be of concern to local authorities and other specified authorities who are treated as the partners of the panels already established. This part of the Bill is intended to put the existing voluntary Channel Programme on a statutory footing. The aim is to underpin the Programme and improve co-operation between authorities.

Clause 28

This requires local authorities to establish panels of persons to assess the extent to which identified individuals are vulnerable to being drawn into terrorism. "Identified individual" means an individual who is referred to the panel, on reasonable grounds, by a chief police officer, for an assessment of their vulnerability. Once an individual is identified as so vulnerable, the panel's functions are to prepare a plan to support them to reduce their vulnerability, arrange that support, review the plan and revise support, or withdraw support.

Clause 30

This clause requires that the partners of a panel must, so far as appropriate and reasonably practicable, co-operate with the panel and the police in the carrying out of their respective functions.

Co-operation includes the giving of information, but not if disclosure would contravene the Data Protection Act or result in the disclosure of information about or obtained through or held by the intelligence services.

Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) have been subject to considerable criticism ever since their introduction in 2009. However in March 2014, two events inflicted further damage to its already tarnished reputation. First, we have the House of Lords' post legislative scrutiny committee on the Mental Capacity Act publishing a report that concluded the DoLS were not "fit for purpose" and proposed their complete replacement. A few days later, a Supreme Court judgment not only widened the definition of the deprivation of liberty through the "acid test" but also the settings where it could occur to include supported, shared lives accommodations and even people living in their own homes if the state is found to be imputable. The fact that the living arrangements were comfortable and made life enjoyable, made no difference as according to Lady Hale – "a gilded cage is still a cage".

The "acid test" as revealed basically determines whether the person concerned was under continuous supervision and control, and not free to leave. Both conditions must be satisfied in order to amount to a deprivation of liberty. Whilst the "acid test" has clarified the factors in determining what constitutes a deprivation of liberty, it also meant that anyone meeting this definition would be deemed to be deprived of their liberty. Hence, potentially it will affect thousands of people across England and Wales that do not have the mental capacity to give valid consent to their placements in hospitals or care homes. This will include many older people with dementia or people with severe learning disabilities or acquired brain injuries.

Since March 2014, we have seen a significant increase in the number of applications for DoLS' authorisations from care home providers and hospitals across the County. For example, for the whole of 2013/14 we have had only 62 applications but for the same period in 2014/15, applications have gone up tenfold to 614 in keeping with national trends.

The Department of Health has accepted that there are difficulties with the DoLS and has asked the Law Commission to consider re-writing the legislation as to how deprivation of liberty should be authorised and supervised in settings other than hospital and care homes where it is possible that Article 5 and Article 8 rights would otherwise be infringed. The Law Commission has now published their consultation document on the proposals for law reform of the DOLS and we will be submitting our responses and views before the close of the consultation period in early November.

The financial implications of implementing the judgment and putting in place the necessary safeguards to protect a greater number of vulnerable adults are significant. Under the DoLS' procedure, these costs include:

- fees payable to section 12 Doctors who assesses a person's mental health
- independently employed Best interest assessors
- Court and legal fees for cases that need to go to the Court of Protection for authorisation.
- general administrative costs

It is a real possibility that significant financial and human resources may have to be diverted from elsewhere in order to meet our legal responsibilities under the MCA DoLS' regime.

In psychiatric inpatient settings, clinical staff will need to review the situation of all their informal patients who are incapable of giving their valid consent to their admissions and consider whether they are being deprived of their liberty. If so, they must then decide whether to use the Mental Health Act or the MCA DoLS to protect the person's rights. Potentially, this may result in more people being detained under Section 3 of the Mental Health Act and in turn, will have financial implications on the S117 aftercare budget. (S117 relates to some people who have been detained in hospital under the Mental Health Act 1983) i.e. "sectioned people" are entitled to free aftercare when they are discharged from hospital.

Children's services and especially the Fostering and Transition teams will also be affected by these changes as there are some young people who are unable to give valid consent to their placements. The MCA principles apply to people over the age of 16, hence issues relating to lack of capacity (as it would be in regards to DoL) must be addressed accordingly.

What we already know from case law is that those with parental responsibility cannot consent to their child's deprivation of liberty. This judgment is significant for Section 20 placements in general. In this regard, authorisation for a deprivation of liberty can only be obtained from the Courts, be it the Family Court or the Court of Protection.

In response to the ADASS' advice note, we have formulated an action plan to address the implications of the judgment and this will be taken forward through our MCA Management and Practice Group.

The Council has raised these issues at national and local level with colleagues to advocate for a central government response to acknowledge the challenging legal position that each local authority is facing. In particular, the scale of increased resources that may be needed to comply with the law and also to provide practical suggestions on how to meet the challenges to protect this vulnerable group of people as a consequence of the ruling.

A word from some of our Partners

Addenbrookes Hospital, Cambridge University Hospital NHS Foundation Trust

Cambridge University Hospital NHS Foundation Trust is a large teaching and academic health science centre providing services for the local community alongside a significant volume of regional and national work for specific conditions. The adult series are delivered within Addenbrookes Hospital; women's and maternity services are delivered within the Rosie Hospital.

Governance and Accountability

The Chief Nurse is the Executive Director with Board responsibility for Safeguarding across CUHFT. Safeguarding matters are reported through the Trust's quarterly Combined Adult and Children's Safeguarding Committee, which is chaired by the Chief Nurse. Information is taken forward to a sub-committee of the Board, the Quality Committee. The Trust Board receives biannual reports on safeguarding via the quarterly Quality Committee.

Attendance at the Adult Safeguarding Board meetings is prioritised. The Adult Safeguarding Lead attends those meetings of SAB Sub Groups concerning Health, MCA/DoLS and Practice and Training.

The Trust's presence at the NHS England regional adult safeguarding forum also ensures access to current information delivered by expert practitioners along with the benefit of discussion and collaboration with peer safeguarding leads across the local health economy.

These platforms provide timely access to new developments and contribute to an equity of approach across the region in this dynamic and evolving area of practice.

Reorganisation of local services has resulted in the supervisory body, Cambridgeshire County Council, taking the lead role in adult safeguarding enquiries, or causing enquiries to be made at CUHFT in cases where criminal action does not feature. The Adult Safeguarding Lead at the Trust continues to provide clinical reports and to take responsibility for the progression of enquiries so that they may fit appropriately within the delivery of acute clinical services.

2014-15 Achievements

- The Adult Safeguarding Steering group meets quarterly, attended by senior staff members from across the Trust. The group reports to the Joint Safeguarding Committee and then into a sub-committee of the Board. A Safeguarding Board report is submitted annually.
- The implementation of an electronic patient record system across the Trust was achieved in October 2014.
- Delivery of our safeguarding training plan continues. A clinically developed e-learning package providing adult safeguarding information is being installed to augment the basic awareness of adult safeguarding currently provided at the Trust's corporate induction sessions. The more in-depth face-to-face training to newly employed clinical staff, nursing students, overseas nurses and specialist teams such as the emergency department continues, with focus on MCA/DoLS and information regarding PREVENT.
- Materials including posters and booklets containing safeguarding information continue to be distributed across the Trust. Awareness and interest is further encouraged via the safeguarding forum, a Trust-wide group of 'link professionals' who meet quarterly for discussion and to hear presentations from subject matter experts. Recent talks from the

Local Authority Designated Officer, Multi Agency Risk Assessment Conference and from the operational adult safeguarding lead at CCC were well attended and received.

2015-16 Action Focus

- Consolidation of planned integration of the three strands of safeguarding across the Trust, and co-location of wider team – to include added services such as Learning Disability/Mental Health and Dementia.
- Further liaison and cooperation on cases with partner agencies, using newly implemented internal ASG policy.
- Continue to pursue better and timelier feedback on case enquiries raised for patients within the Trust.
- In light of newly implemented Care Act 2014 and the Making Safeguarding Personal agenda, to update our processes and policies in line with those of our supervisory body CCC once those guidelines are fully available.
- Continued emphasis on training, particularly for MCA/DoLS and the associated duties such as Best Interests process and engagement of advocates.

Age UK Cambridgeshire

Age UK Cambridgeshire is a local, independent organisation, often the first point of contact for older people or others concerned for the well-being of an older person, who may be suffering abuse. Worried friends and neighbours also turn to us at times when an older friend may not be caring for themselves as well as in the past. Our skilled staff offer information, advice, advocacy and support to older people and their carers and friends.

All Age UK Cambridgeshire staff and volunteers undertake specific safeguarding training, the Senior Operations Manager is the safeguarding lead and the Chief Executive is a member of the Safeguarding Adults Board. Reports on safeguarding matters are made regularly to our board of directors.

An important part of our role is to bring the views and opinions of local people to the Safeguarding Board so as to inform practice and policy development.

We work closely with our colleagues at Age UK Peterborough – with whom we are discussing the potential to merge our organisations – and this closer working will allow us to share information and intelligence across the wider Cambridgeshire & Peterborough area.

Cambridgeshire Community Services NHS Trust

The Trust has a full time Named Nurse for Adult Safeguarding in Luton, showing its commitment to the safeguarding agenda.

Senior Trust representatives are members of the multi-agency Safeguarding Adult Boards in Cambridgeshire, Peterborough and Luton and as such are integral decision makers in the development and implementation of the local safeguarding agendas. The Trust is also well represented on a number of Partnership Safeguarding Adult Board sub-groups; including Mental Capacity Act/Deprivation of Liberty Safeguards and Training and Development, Policy, protocols and procedures, Communication and Community Engagement and Audit, Information Sharing Provider CQC meetings and Best Practice Groups.

The Named Nurse for Adult Safeguarding is also a representative at the East Anglia and Essex Adult Safeguarding Forum, which meet quarterly and have recently published Adult Safeguarding Best Practice Guidance for NHS Services in East Anglia, which should be used alongside CCS Adult Safeguarding Policies.

The Trust has an established Adult Safeguarding Group, which maintains responsibility for the strategic overview of adult safeguarding within the Trust with attendance by local council safeguarding leads to enable information sharing across the partners.

The Named Nurse is a member of the Integrated Patient Safety Group and Harm Free Care meetings.

The Named Nurse in Luton works with Partner Agencies on Tackling Serious Youth Crime, MARAC and Chanel Panel groups and is the Lead Nurse for local PREVENT, attending the CCS PREVENT forum.

The Trust's incident reporting database Datix has been re-modelled to provide data on Adult Safeguarding concerns, ranging from potential and suspected abuse, to confirmed and reported episodes of abuse that are escalated to full investigation by the local adult safeguarding teams. The data provides an overview of clusters and trends with both internal and external providers of care that can be shared with local council leads. An improved process has been introduced to alert our hospital partners of incidents that may have resulted in poor or failed discharges.

The Trust's safeguarding adult policy supports local Safeguarding Adult Board Multi-Agency policies, is currently under review in light of the Care Act 2014. Once it is complete it will be available to all staff on the Trust intranet.

All recommendations identified from the Clinical Commissioning Group Deep Dive review of Adult Safeguarding within the Trust have now been actioned and implemented.

The Care Act 2014

The Care Act 2014 has made a number of changes to Adult Safeguarding:

- Sets out a clear legal framework for the first time as to how Local Authorities and other parts of the Health and Social care system should protect adults at risk of abuse or neglect.
- Changed the term vulnerable adult to adult at risk of abuse or neglect.
- Included new categories of abuse including, self-neglect, modern slavery and trafficking and domestic violence.

- The Care Act places a duty on Local Authorities to make safeguarding enquiries or to ask others to make those enquiries. This will include health agencies.
- The Care Act requires Local Authorities to set up Safeguarding Adult Boards; these are currently well established within Luton, Cambridgeshire and Peterborough and are attended by senior Trust members.
- The Care Act requires that Safeguarding Adult Reviews are held to ensure that lessons are learnt to improve future practice.

The Named Nurse for Adult Safeguarding is currently working with their local authority partners to develop policies in line with the current guidance. These are to be implemented in April 2015. Changes will be reflected in all Adult Safeguarding teaching sessions.

Mental Capacity Act
In April 2014 NHS England published A Guide for Clinical Commissioning Groups and other commissioners of health care services on Commissioning for Compliance. This document ensures compliance with the Mental Capacity Act 2005 and sets out the duties that providers have in ensuring that the rights of those receiving care and treatment who lack capacity are made based on the 5 Principles of the Act.

CCS Named Nurse for Adult Safeguarding is currently working collaboratively with HPFT Named Nurse Adult Safeguarding to develop a template for recording mental capacity assessments on SystmOne.

Deprivation of Liberty Safeguards (DoLS)
Following the publication of the Supreme Court Judgement P v Cheshire West and Chester Council in March 2014, changes have been made to the Deprivation of Liberty Safeguards. There has been a large increase in the referrals to Local Safeguarding teams within local authorities for DoLS assessments.

Adult Safeguarding Training
The target for compliance for staff attending adult safeguarding training is 95%. Performance against this target is outlined below.

Cambs City & South	87%
Huntingdon	92%
Ely and Fens	92%
Corporate Services	93%
Peterborough	82%
Luton	96%
Luton Specialist Services Children's	95%
Cambs City & South Section 75	N/A
Overall Children and Young People	88%
Overall Specialist Services	93%
Luton Children and Young People	89%
Luton Specialist Services	100%
Overall Summary CCSNHST wide (figures in brackets are 2012/13 data)	92% (84%)

** Available by specialty only

E- learning packages are available on the intranet for Adult Safeguarding, MCA and DoLS.

Safeguarding Champions
A small cohort of staff within Luton attended a University of Bedfordshire run course sponsored by Luton CCG and Luton and Dunstable Hospital.

Champions attended one day of learning per month for seven months. Topics covered included domestic abuse, mental capacity, record keeping and deprivation of liberty safeguards. We now have 4 safeguarding champions within adult services in Luton, with a keen interest and increased knowledge of safeguarding issues. It is hoped that a further course will run over 2015 in order to increase Champions at operational level.

Lessons Learned
A programme is underway for all clinical staff to attend workshops to understand the governance process, discuss lessons learned and identify better ways of working. The scenarios were adopted from serious incidents, complaints and safeguarding investigations that have occurred over the previous year. The focus is on local issues, learning from other's experiences and translating learning into best practice in a supportive environment. Over a hundred staff have attended this quarter so far. The hope is to enable staff to attend one session per quarter on an on-going basis.

Adult safeguarding - key actions for 2015-16:

- Increased number of staff to complete higher levels of adult safeguarding training to provide a more in-depth knowledge of safeguarding and to support the investigation process.
- Safeguarding adult competencies are currently being reviewed in light of the Care Act 2014. The new competency framework will be rolled out to all staff once review is complete.
- Audit and review of safeguarding systems and processes, to ensure accurate collection of safeguarding information across the whole organisation.
- Ultimately, no reported cases of adult neglect attributed to CCS.
- Identify further staff to 'champion' safeguarding within CCS operational services.

- Engagement with regional Learning Disability work streams and enlist in-service champions.
- Multi-agency partnership work to focus on reporting mechanisms and thresholds.
- Integration of Care Act 2014 recommendations regarding adult safeguarding into both policy and practice within the Trust as soon as guidance has been completed.
- Ensure that all staff are updated with the new DoLS guidance.
- Increased awareness for staff in relation to emerging trends e.g. domestic abuse, sexual exploitation and modern slavery.
- Enable staff to attend a local lessons learned workshop.
- PREVENT is part of the government's anti-terrorism strategy CONTEST, that aims is to stop people being drawn into or supporting terrorism. The Trust has a cohort approved Workshop to Raise Awareness of Prevent (WRAP) Trainers who are rolling out a prioritised programme of awareness training to staff based on the NHS England guidelines published in January 2015 and will meet the stated requirement of 85% compliance with WRAP training within 3 years. We are also actively engaged with local and regional CONTEST meetings.

Training Delivery

- PREVENT Basic Awareness is delivered to all staff; as part of a proactive initiative, this has been delivered to staff as part of the Corporate Induction programme since August 2014.
- Basic Awareness training for staff that joined before August 2014 can be provided through local service based workshops.
- Knowledge, skills and compliance are reviewed annually as part of an individual's appraisal.
- WRAP3 training has been delivered in a number of ways:
    - Through in-house sessions delivered 8 weekly at various CCS NHS Trust venues with a maximum of 40 participants at each session.
    - Through external agencies who can deliver appropriate training; including Cambridgeshire & Bedfordshire Police and Luton Council. Both inter-agency and multi-agency training can be utilised for WRAP delivery.

WRAP3 Training Trajectory

- The Trust has 616 current members of staff that require WRAP3 training.
- The in-house training programme provides 240 places per year; this combined with the estimated 60 external training places per year will allow the Trust to become 85% compliant in fewer than 2 years.
- Currently the Trust has 17.9% of those requiring training trained.

Cambridgeshire Constabulary

A criminal investigation is but one outcome of effective safeguarding activity and the Constabulary is committed to delivering safeguarding primarily through a countywide Multi-Agency Safeguarding Hub which increases the opportunity for agencies to share information quickly and speedily. This enhances the opportunities for partnerships to ensure risk is identified and responded to in the most effective manner, leading to better outcomes for vulnerable people. A safeguarding approach is now embedded across the organisation from the moment of first call, with resources being prioritised based on an assessment of threat, risk and harm.

Cambridgeshire Constabulary is committed to working with partners to safeguard vulnerable adults and has a specialist Adult Abuse Investigation and Safeguarding Unit (AAISU) within the Public Protection Department. The unit works closely with the Multi-Agency Referral Unit with an established referral pathway, referring on to the AAISU where necessary.

Cambridgeshire County Council Drug and Alcohol Action Team (DAAT)

The drug & alcohol recovery service has appointed 5 Safeguarding Leads in all localities with expert support provided through 3 designated social workers.
The lead social worker and 2 service managers have also attended training to incorporate the new Care Act into the assessment process.

A recent survey of DAAT commissioned services SOVA training has highlighted all frontline staff in the drug and alcohol, offender accommodation and hostel services possessing current SOVA level 1 with this being a mandated training requirement for all new entrants.

Cambridgeshire Safer Communities Partnership team (CSCPT) is further committed to the development and deployment of safeguarding through attendance at the Adult Safeguarding Training Sub Group by a designated officer.

Domestic Abuse Update

A Domestic Abuse and Safeguarding of Vulnerable Adults Action Plan was implemented in 2013 and updated in early 2015 to capture work that overlaps or links the two areas. The actions continue to be delivered.

The number of adult safeguarding cases with a domestic abuse element in 2014-15 was 79, this is slightly less than the 84 recorded in 2013-14.

The Care Act came into force in April 2015, setting out for the first time legislation around adult safeguarding. Domestic abuse is now a national category of abuse for adults at risk from harm (the new term for vulnerable adults).

The Partnership have undertaken some work with VoiceAbility, a support and advocacy organisation for adults with learning disabilities, to raise awareness of domestic abuse amongst this client group. The Speak Out Council of service users at VoiceAbility approached the Partnership as a result of personal experience where a domestic abuse survivor with learning disabilities found it hard to find accessible information and support. The Partnership Officer worked with the Speak Out Council to develop accessible versions of posters which were distributed to specialist organisations throughout the county. VoiceAbility were also commissioned to create an Easy Read version of the Opening Closed Doors leaflet which they did in collaboration with the Speak Out Council. The resulting booklet was distributed both locally and nationally and received positive feedback from

professionals in learning disability services across the UK. This work was nominated and finalised under the Breaking Down Barriers category at the National Learning Disability and Autism Awards 2015.

Cambridgeshire Fire and Rescue Service

Cambridgeshire Fire and Rescue Services vision of a safe community where there are no preventable deaths or injuries in fires or other emergencies continues to be its ethos.

We have instigated multi-agency de-briefs should a fire death occur. Agencies involved with the individual work in partnership to ascertain if together we could have intervened to prevent this fire from occurring, as well as identifying any similarities in individuals' life style choices with incidents of a similar nature.

One finding identified residents that have hoarding tendencies are at a high risk of being injured or dying as a result of fire. CFRS has responded to emergency calls of this nature which has resulted in four fire fatalities in recent years. National research ratifies that people with this disorder fit the profile of having a fatal fire.

As a result of these findings CFRS has instigated hoarding awareness raising and guidance for front line staff to follow.

This includes:

- Home Fire Safety Check guidance for homes where hoarding is present
- Fitting specialist smoke alarms
- Providing carbon monoxide alarms
- How to identify and access the level of hoarding using the Clutter Image Rating scale (CIR)
- What actions to take following identification of hoarding
- How, when and where to record this information

The service is up skilling its front line staff to recognise these risks, enabling the resident to be sign posted to agencies that can offer support and guidance to be safe and stay in their own homes.

CFRS has recognised by tackling the issues that make individuals a high risk of fire we can reduce their risk of dying as a result of fire.

Safeguarding training has also been identified as high priority and to support this we have instigated on line learning for front line staff that can be monitored and reported on and in 2014/15 around 100 referrals were made into the MASH. To also support this work Human Resources have also received safe recruitment training.

Cambridgeshire and Peterborough NHS Foundation Trust

Statement of purpose
Cambridgeshire and Peterborough NHS Foundation Trust is committed to working with partner agencies to ensure the safeguarding of adults at risk of abuse or neglect.

Governance and Accountability
Safeguarding matters are reported to the Board via the Quality Safety and Governance Committee. The Director of Nursing is the Executive Director with Board responsibility for Safeguarding Adults, The Head of Adult Safeguarding is the lead officer for adult safeguarding with responsibility for developing processes and procedures within the Trust.

2014-15 Achievements

- **Health care services**

Following the successful tender for provision of integrated services for older people, CPFT now has from 1 April 2015 taken on responsibilities relating to community health care services.

- **CQC registration**

In 2014-15**,** CPFT declared compliance with CQC Outcome 7, safeguarding. A further CQC inspection was carried out during May 2015 and the report is due in August.

- **Activity**

Safeguarding activity continues to increase and there was a 5% increase in safeguarding referrals over the previous year.

- **Training**

Training in adult safeguarding reached 97% compliance at March 2015.

- **Partnership working**

Work has proceeded to develop a Multi Agency Safeguarding Hub (MASH) as a single point for referrals and triage of all adult safeguarding matters. It is anticipated that CPFT will be fully integrated into this partnership by autumn 2015.

- **Care Act 2014**

CPFT has worked closely with partner agencies to implement the requirements of the Care Act 2014 and Making Safeguarding Personal.

- **Deprivation of Liberty Safeguards**

The number of DoLS applications has increased substantially following the Supreme Court ruling in the Cheshire West case[1]. Amended guidance has been produced to reflect the changes.

[1] "P v Cheshire West and Chester Council and another" and "P and Q v Surrey County Council" Supreme Court Judgment 19 March 2014

- **Policy and Procedures**

The CPFT adult safeguarding policy has been updated to reflect the Care Act changes.

Priorities for the Coming Year

- Ensure all staff receive appropriate training and are able to identify and respond to safeguarding issues and that the target of 95% for staff training continues to be met.
- Ensure compliance with attendance at Mandatory PREVENT training.
- Develop a model for adult safeguarding appropriate to the Older Peoples Integrated Care and Neighbourhood teams.
- Ensure that each ward and community team in the adult services has a sufficient number of trained SOVA leads.
- Work with partners (including Local Authorities & Police to implement the Multi-Agency Safeguarding Hub (MASH).

Care Quality Commission

The Care Quality Commission is the independent regulator of health and adult social care in England.

Our purpose is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and to encourage care services to improve. We will develop our approach to inspection so we can respond to new models of care and new models of service which will develop over the next few years. We are clear that regulation will not act as a barrier to innovation.

Our role is to monitor, inspect and regulate services to ensure they meet fundamental standards of quality and safety and to publish what we find, including performance ratings to help people choose care.

CQC's underpinning priorities are to:

- focus on quality and act swiftly to eliminate poor quality care, and
- to make sure that care is centred on people's needs and protects their rights

Care that fails to meet the expected national standards of quality and safety against which we regulate will not be tolerated. We will use our enforcement powers necessary to stamp out poor practice wherever we find it. Any form of abuse, harm or neglect is unacceptable and should not be tolerated by the provider, its staff, the regulators or by members of the public who become aware of such incidents. Safeguarding is everybody's business and CQC is aware of the role it can play in striving to reduce the risk of abuse from occurring.

Safeguarding is a key priority that reflects both our focus on human rights and the requirement within the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to have regard to the need to protect and promote the rights of people who use health and social care services.

As the regulator of health and adult social care services, our primary role is to make sure that providers have appropriate systems in place to safeguard people who use the service and that those systems are implemented and followed in practice to ensure good outcomes for people who use the service. We will monitor how these roles are fulfilled through our regulatory processes by assessing their compliance with the national standards of quality and safety.

The CQC consists of three main inspection directorates of Hospitals, Adult Social Care (ASC) and Primary Medical Services (PMS). We now consider our inspection findings to answer five key questions which we will always ask: Is the service caring? Is the service responsive? Is the service safe? Is the service effective? Is the service well led?

We will continue to implement and improve the new approach to regulation. 2015/16 will be the first year that we will inspect using the new regulations approved by Parliament as a result of the Government's response to Sir Robert Francis QC's Report into Mid Staffordshire NHS Foundation Trust. The Care Act 2014 Guidance Chapter 14 replaces the https://www.gov.uk/government/publications/no-secrets-guidance-on-protecting-vulnerable-adults-in-care 'No secrets' guidance.

Healthwatch Cambridgeshire

Safeguarding is a key priority for Healthwatch Cambridgeshire and we are delighted to have become fully involved in the Cambridgeshire Safeguarding Adults Board during the past year. We have worked closely with the County Council to devise ways in which service users and the wider general public can have a voice in safeguarding; how the processes work, but much more importantly, about how we can understand and learn from people's experiences and what helps them stay safe.

Three people have come forward to act as representatives for service users, carers and the wider public to help us develop meaningful ways of talking to people and gathering their views. The three representatives attend all Board meetings together with the CEO of Healthwatch Cambridgeshire. Ann Robinson, the service user representative for mental health services, said 'I am impressed that the Safeguarding Adults Board understands the benefits of listening to people's voices and I look forward to helping make a difference'. In due course and with support from the County Council, we aim to develop a network of voices that will widen our listening.

Healthwatch Cambridgeshire continues to work closely with the Care Quality Commission and the County Council to ensure that there is a robust system for reporting safeguarding concerns. All Healthwatch Cambridgeshire staff and volunteers undertake safeguarding training, the CEO is the Safeguarding Lead and there is also a Safeguarding Adults Champion to make sure that safeguarding policies and procedures are current, practical and effective.

NHS Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)

The CCG is committed to safeguarding adults and attends multiagency meetings in order to achieve partnership working. There has been regular attendance at the Cambridgeshire Safeguarding Adults Board meeting and its sub groups.

Health Executive Safeguarding Board

The Health Executive Safeguarding Board is a sub group of the SAB and takes a strategic view of health issues within safeguarding adults across the health economy working collaboratively with members of Cambridgeshire and Peterborough Local Authority Safeguarding Adults Teams.

Safeguarding Adults Health Sub Group

The Safeguarding Adults Health Sub Group is a multi-agency forum, including representation from both Cambridgeshire and Peterborough safeguarding adults teams, reviewing operational issues which reports to the Health Executive Safeguarding Board and had a collective work plan of:

- Raising awareness of MCA/DoLS
- Monitoring of quality of care in care homes
- Developing a risk framework for referrals
- Sharing of information

The publication of the Care Act 2014 and the supporting guidance in October 2014 resulted in a review of procedures and training across agencies which is still ongoing.

Monitoring compliance of Commissioned providers of care with safeguarding adults requirements

The monitoring of Providers compliance with the safeguarding adults requirements in the quality schedule of the NHS contract was undertaken by the CCG on a quarterly basis as part of the Clinical Quality Review meetings (CQRs) held with providers using the quality dashboard with metrics and RAG rated thresholds.

There were issues with compliance with the training requirements particularly in relation to MCA/DoLS. Additional funding has been received from NHS England to facilitate this.

Work plan for 2015 - 2016

- Revise the CCG safeguarding adults policy and procedures.
- Revise CCG PREVENT policy.
- Agree the training needs analysis for types and levels of training for CCG staff and provide basic awareness training in safeguarding adults and PREVENT for all CCG staff.
- Revisit the commissioned Providers and review their safeguarding adults arrangements in light of the new Care Act requirements and the changing landscape within the NHS.
- Develop a plan for utilisation of NHS England monies for MCA/DOLS training for 2015/16.
- Monitor compliance with the quality standards in the NHS Care Home contracts.

NHS England: Midlands and East, East Locality

NHS England is committed to safeguarding and promoting the welfare of children and vulnerable adults. Engagement with the local safeguarding boards and building stronger partnership working arrangements has continued during 2014/15. One of the successes have been the Quality Surveillance Group meetings which continue to bring together a range of partners to address quality and safety issues at a strategic level across the health and social care arena.

Another success is the hosting and facilitation of the safeguarding forums which bring together adult safeguarding leads from health organisations and commissioning parties across both East Anglia and Essex. As part of the group, continuous professional development occurs with recent topics including Domestic Abuse and The Daisy Project in Essex. The forum also shares learning from Serious Case Reviews, Domestic Homicide Reviews and Serious Incidents (extending beyond the Cambridgeshire locality). Finally the forum provides a means of clinical supervision and support (supervision training commissioned from NSPCC).

Finally, in working with the CCG national funding has been utilised to enable a variety of training events covering MCA and DoLS.

Priorities for 2015/16:

- To complete and ensure distribution of the Best Practice Guidance developed by the forum.
- Continued close working arrangements with our CCG colleagues to improve adult safeguarding awareness, skills and expertise in our directly commissioned services specifically with regards to primary care services. This is not without difficulties as some national contracts (for example GP contracts) do not mandate adult safeguarding training.
- To continue to work at a strategic level to ensure that adult safeguarding issues are addressed within the health and social care arena. Specific areas include focussing on the Transforming Care agenda and concordant, addressing the quality of care in nursing and residential homes as well as private hospital care and raising quality and safety standards for vulnerable adults in acute hospitals.
- To remain aware and implement where necessary the requirements of the Care Bill and developments in DoLS legislation.

Work continues:

	Forecast completion
On the delivery of a comprehensive and bespoke Mental Capacity Act (MCA, 2005) learning and development programme for GPs and healthcare professionals across Cambridgeshire and Peterborough.	2015/16
To ensure that the local authority has in place a workforce that is aware and knowledgeable and have due regard to the need to prevent people being drawn into terrorism.	2015/16
With the network group (representatives for service users, carers and the wider public) in the development of Making Safeguarding Personal and the links to the revised guidance.	Ongoing
On the training strategy for safeguarding and MCA which meet the needs of the social care and health workforce, to enable a better understanding of the decision making process in safeguarding whilst taking into account the legal requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards.	2015 ongoing
To achieve a go live date in September/October for the Multi Agency Safeguarding Hub (MASH).	2015
With Cambridgeshire County Council's involvement at a regional and national level to influence national policy in relation to adult safeguarding.	Ongoing
To ensure the links to the Domestic Abuse and Sexual Violence Strategy meets the requirements of the Care Act.	Ongoing
With colleagues from Cambridge University to evaluate how Making Safeguarding Personal is embedded within our day to day safeguarding practice.	Ongoing

Further information

You can find out more information about safeguarding adults in Cambridgeshire on our website: www.cambridgeshire.gov.uk/safeguardingmca

On the webpage you will find additional information on Adult Safeguarding/Mental Capacity Act and the Deprivation of Liberty Safeguards.

If you are worried about a vulnerable adult who is being abused or who is at risk of abuse you should contact the following numbers:

Customer services

For reporting adult safeguarding or urgent contacts between
8am and 6pm Monday to Friday and between 9am and 1pm on Saturday

Telephone: 0345 045 5202
Fax: 01480 498066
Email: referral.centre-adults@cambridgeshire.gov.uk
Minicom: 01480 376743
Text: 07765 898732

If you urgently need to make contact outside of the above hours	**01733 234724**

Cambridgeshire Constabulary

Non-Emergency Contact Centre	**101**

Cambridgeshire and Peterborough NHS Foundation Trust

Huntingdon and Fenland	**01480 415177**
Cambridge and Ely	**01223 218695**
Action on Elder Abuse Response Line	**0808 808 8141**
Age UK Cambridgeshire	**0300 666 9860**

For further information contact:

Ivan Molyneux, Adult Safeguarding Manager by email
ivan.molyneux@cambridgeshire.gov.uk

For copies of this annual report or if you would like a copy of this annual report on audio cassette, CD, DVD or in Braille, large print or other languages, please call 0345 045 5202. Or write to Cambridgeshire County Council, Box No. SH1211, Shire Hall, Cambridge, CB3 0AP

We would like to thank everyone who has contributed to this annual report.

Agenda Item No: 11

CAMBRIDGESHIRE LOCAL SAFEGUARDING CHILDREN BOARD (LSCB) ANNUAL REPORT 2014-15

To: Health and Wellbeing Board

Date: 17th Sept 2015

From: Andy Jarvis. LSCB Business Manager on behalf of
Flick Schofield, LSCB Chair

1. PURPOSE

1. 1 The purpose of the Annual Report is:

- to provide an outline of the main activities of the Cambridgeshire LSCB and theachievements during 2014-15 against the objectives in the LSCB Business Plan;
- to comment on the effectiveness of safeguarding activity and of the LSCB insupporting this;
- to provide the public and partner agencies with an overview of LSCBsafeguarding activity;
- To identify gaps and challenges in service development in the year ahead.

1. 2 Working Together (2015) states:

1. 3 "The Chair must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area. The annual report should be published in relation to the preceding financial year and should fit with local agencies' planning, commissioning and budget cycles. The report should be submitted to the Chief Executive, Leader of the Council, the local police and crime commissioner and the Chair of the health and well-being board.

1. 4 The report should provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action. The report should include lessons from reviews undertaken within the reporting period…"

1. 5 It is the intention of the LSCB to share this report with all partner agencies and with those that have influence over the services provided to children and families in Cambridgeshire.

1. 6 In preparing this report, contributions were sought from Board members and the chairs of all sub-groups as well as from other partnerships. It summarises

the information contained in reports presented to the LSCB, either on a statutory basis or at the Board's request.

1. 7 In submitting the report to this meeting (see Appendix A), the LSCB is fulfilling this duty. Please note, this is a draft of the report as at the date of submission the report had not been presented yet to the LSCB on 22nd September 2015

1. 8 Once published it will be put on the website www.cambridgeshire.gov.uk/lscb/

2.0 BACKGROUND

2. 1 Since the beginning of 2014 OFSTED has been reviewing LSCBs, alongside the inspection of the Local Authority. One of the descriptors of a 'good' LSCB in the OFSTED framework is that "through its annual report, provides a rigorous and transparent assessment of the performance and effectiveness of local services. It identifies areas of weakness and the causes of those weaknesses, and evaluates and where necessary challenges the action being taken. The report includes lessons from management reviews, serious case reviews and child deaths within the reporting period"

2. 2 When the LSCB was reviewed by OFSTED in June 2014 a part of the Council's inspection of safeguarding and services for Looked after Children (LAC), the LSCB was judged to be 'good'.

2. 3 To meet its purpose the Report is lengthy. Half of the pages make up five appendices that provide more detailed information referred to within the body of the Report.

2. 4 The Report does have an executive summary that covers the most significant content of the full Report.

2. 5 Since April the LSCB has been working to the Action Plans attached to the Report. Significant progress has been made towards the year's targets.

2. 6 A further Serious Case review has been published, a multi-agency audit has been completed and a second one is in progress. The lessons from these activities are processed into changes in service delivery through a Learning and Improvement Framework, which is currently being refreshed.

2. 7 As part of a wider focus on protecting children from professionals who pose a risk, a well-attended and very positively received Conference "When it's one of us, professionals who abuse" took place in July.

2. 8 The capacity of the Board to support this work has been hampered by the absence of a Business Manager, but the new post holder has now started. It is also in the process of appointing a CSE Strategy Coordinator to increase the LSCBs capacity to support the development of multi-agency working in this critical area of concern.

3.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

3.1. The work of the LSCB detailed in its Annual Report is aligned to the following areas of the Health and Wellbeing strategy 2012-17:

- Priority One: Ensure a positive start to life for children,young people and their families – ensuring the basic safety to the child or young person is the fundamental aim of the LSCB partners
- Priority Four: Create a safe environment and help to build strong communities, wellbeing and mental health, especially around the focus areas of domestic abuse and alcohol misuse and their impact upon children
- Priority Six: Working Together Effective, especially in demonstrating the LSCB's effectiveness in achieving its objective of co-ordination of safeguarding children work and the ensuring the effectiveness of that work

4.0 IMPLICATIONS

4.1 The LSCB will continue to monitor and evaluate the effectiveness of services which safeguard children in Cambridgeshire and will identify any gaps in service provision and support the management of the risks to effective safeguarding.

5.0 RECOMMENDATION/DECISION REQUIRED

5.1 It is recommended that the Health and Wellbeing Board:

- offer feedback and comment on the work of the LSCB
- confirm that, including the Safeguarding Adults Board, all three statutory partnerships share the Health and Wellbeing Board Strategic priority to:

  "Develop integrated services across education, health, social care and the voluntary sector which focus on the needs of the child in the community, including the growing numbers of children with the most complex needs, and where appropriate ensure an effective transition to adult services"

Source Documents	Location
OFSTED framework for the Inspection for the Services for Children in Need of Help and Protection	http://www.ofsted.gov.uk/resources/framework-and-evaluation-schedule-for-inspection-of-services-for-children-need-of-help-and-protection
The full Ofsted Report	http://reports.ofsted.gov.uk/local-authorities/cambridgeshire

Agenda Item No: 12

BETTER CARE FUND UPDATE

To: Health and Wellbeing Board

Date: 17 September 2015

From: Adrian Loades, Executive Director: Children Families and Adults, Cambridgeshire County Council
Andy Vowles, Chief Strategy Officer, Cambridgeshire and Peterborough Clinical Commissioning Group

1.0 PURPOSE

1.1 To provide the Board with a copy of the Quarterly Report on the BCF in the first quarter of 2015/16, submitted on 28 August. The Quarterly Report is attached as appendices 1 and 2.

2.0 BETTER CARE FUND (BCF) QUARTERLY REPORT

2.1 In August 2015, NHS England and the Local Government Association issued quarterly report templates for the first quarter of 2015/16, for local areas to report on progress with their BCF plans. Cambridgeshire's response was developed by officers and shared with members of the Cambridgeshire Executive Partnership Board (CEPB) and the Chair of the Health and Wellbeing Board for consultation before submission.

2.2 The submission highlights progress in the various areas of work supported by the BCF in Cambridgeshire. The Board's attention is drawn in particular to the following:

- Some of the national BCF conditions are met and progress is being made in other areas towards delivery

- Non-elective admissions increased in the first quarter of 2015/16, against a target reduction of 1%. We believe that the reasons for underachieving in the non-elective admissions target are largely due to the fact that Q1 has been a period of setting up and mobilisation across the system. The initiatives launched by UnitingCare will take time to have an impact; and the BCF projects themselves are more focused on medium term transformation. However, it will be important to ensure that all organisations are aligned and working to support a reduction in non-elective admissions. A report will be developed for the new Cambridgeshire and Peterborough Partnership Board on the triggers of non-elective admissions; a review of the collective contribution to reducing non-elective admissions; and recommendations to support a reduction in future quarters.

- There has been an underspend in Q1, due to the projects still being in the set-up phase and the Transformation Team not being fully staffed. At present it is not anticipated that there will be a significant underspend at the end of the year.

- The narrative (section 8) highlights progress towards delivery of the projects and delivery of the UnitingCare model, which receives significant funding from the BCF.

2.3 Any feedback received from NHS England will be shared with the Health and Wellbeing Board at a future meeting.

3.0 RECOMMENDATIONS

The Cambridgeshire Health and Wellbeing Board is invited to comment on and note the Better Care Fund Quarterly Report.

Source Documents	Location
None	

Quarterly Reporting Template - Guidance

Notes for Completion

The data collection template requires the Health & Wellbeing Board to track through the high level metrics and deliverables from the Health & Wellbeing Board Better Care Fund plan.

The completed return will require sign off by the Health & Wellbeing Board.

A completed return must be submitted to the Better Care Support Team inbox (england.bettercaresupport@nhs.net) by midday on 28th August 2015

This Excel data collection template for Q1 2015-16 focuses on budget arrangements, the national conditions, payment for performance, income and expenditure to and from the fund, and performance on local metrics. It also presents an opportunity for Health and Wellbeing Boards to register interest in support. Details on future data collection requirements and mechanisms will be announced ahead of the Q2 2015/16 data collection.

To accompany the quarterly data collection Health & Wellbeing Boards are required to provide a written narrative into the final tab to contextualise the information provided in this report and build on comments included elsewhere in the submission. This should include an explanation of any material variances against planned performance trajectories as part of a wider overview of progress with the delivery of plans for better care.

Content

The data collection template consists of 9 sheets:

Validations - This contains a matrix of responses to questions within the data collection template.
1) Cover Sheet - this includes basic details and tracks question completion.
2) Budget arrangements- this tracks whether Section 75 agreements are in place for pooling funds.
3) National Conditions - checklist against the national conditions as set out in the Spending Review.
4) Non-Elective and Payment for Performance - this tracks performance against NEL ambitions and associated P4P payments.
5) Income and Expenditure - this tracks income into, and expenditure from, pooled budgets over the course of the year.
6) Local metrics - this tracks performance against the locally set metric and locally defined patient experience metric in BCF plans.
7) Understanding support needs - this asks what the key barrier to integration is locally and what support might be required.
8) Narrative - this allows space for the description of overall progress on plan delivery and performance against key indicators.

Validations

This sheet contains all the validations for each question in the relevant sections.
All validations have been coloured so that if a value does not pass the validation criteria the cell will be Red and contain the word "No" and if they pass validation they will be coloured Green and contain the word "Yes".

1) Cover Sheet

On the cover sheet please enter the following information:
The Health and Well Being Board
Who has completed the report, email and contact number in case any queries arise
Please detail who has signed off the report on behalf of the Health and Well Being Board.

Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 8 cells are green should the template be sent to england.bettercaresupport@nhs.net

2) Budget Arrangements

This plays back to you your response to the question regarding Section 75 agreements from the 2014-15 Q4 submission and requires 2 questions to be answered. Please answer as at the time of completion. If you answered 'Yes' previously you can selection 'Not Applicable' this time.
If your previous submission stated that the funds had not been pooled via a Section 75 agreement, can you now confirm that they have?
If the answer to the above is 'No' please indicate when this will happen

3) National Conditions

This section requires the Health & Wellbeing Board to confirm whether the six national conditions detailed in the Better Care Fund Planning Guidance are still on track to be met

It sets out the six conditions and requires the Health & Wellbeing Board to confirm 'Yes', 'No' and 'No - In Progress' that these are on track. If 'No' or 'No - In Progress' is selected please provide a target date when you expect the condition to be met. Please detail in the comments box what the issues are and the actions that are being taken to meet the condition.
'No - In Progress' should be used when a condition has not been fully met but work is underway to achieve it by 31 March 2016.
Full details of the conditions are detailed at the bottom of the page.

4) Non-Elective and Payment for Performance

This section tracks performance against NEL ambitions and associated P4P payments. The latest figures for planned activity and costs are provided along with a calculation of the payment for performance payment that should have been made for Q4. Three figures are required and one question needs to be answered:

Input actual Q1 2015-16 Non-Elective performance (i.e. number of NELs for that period) - Cell L12
Input actual value of P4P payment agreed locally - Cell D23
If the actual payment locally agreed is different from the quarterly payment taken from above please explain in the comments box
Input actual value of unreleased funds agreed locally

This section also requires indication of the area of spend that unreleased funds have been spent on for Q4 and Q1 using a drop-down list. If no funds were left unreleased then 'Not Applicable' should be selected.

5) Income and Expenditure

This tracks income into, and expenditure from, pooled budgets over the course of the year. This requires provision of the following information:

Planned and forecast income into the pooled fund for each quarter of the 2015-16 financial year

Confirmation of actual income into the pooled fund in Q1

Planned and forecast expenditure from the pooled fund for each quarter of the 2015-16 financial year

Confirmation of actual expenditure into the pooled fund in Q1

Figures should reflect the position by the end of each quarter. It is expected that planned income and planned expenditure figures for Q4 2015-16 should equal the total pooled budget for the Health and Wellbeing Board.

There is also an opportunity to provide a commentary on progress which should include reference to any deviation from plan.

6) Local metrics

This tab tracks performance against the locally set metric and locally defined patient experience metric submitted in approved BCF plans. In both cases the metric is set out as defined in the approved plan for the HWB and **the following information is required for each metric:**

Confirmation that this is the same metric that you wish to continue tracking locally

Confirmation of planned performance for each quarter of 2015-16 (against the metric being tracked locally - whether the same as within your plan or not)

Confirmation of actual performance for Q1 2015-16 (against the metric being tracked locally - whether the same as within your plan or not)

Commentary on progress against the metric and details of any changes to the metric including reference to reasons for changing

7) Understanding Support Needs

This asks what the key barrier to integration is locally and what support might be required in delivering the six key aspects of integration set out previously. This section builds upon the information collected through the BCF Readiness Survey in March 2015. HWBs are asked to:

Confirm which aspect of integration they consider the biggest barrier or challenge to delivering their BCF plan

Confirm against each of the six themes whether they would welcome any support and if so what form they would prefer support to take

There is also an opportunity to provide comments and detail any other support needs you may have which the Better Care Support Team may be able to help with.

8) Narrative

In this section HWBs are asked to provide a brief narrative on overall progress in delivering their Better Care Fund plans at the current point in time with reference to the information provided within this return.

Better Care Fund Template Q1 2015/16

Data collection Question Completion Validations

Cover

Health and Well Being Board	completed by:	e-mail:	contact number:	Who has signed off the report on behalf of the Health and Well Being Board:
Yes	Yes	Yes	Yes	Yes

Budget Arrangements

S.75 pooled budget in the Q4 data collection? and all dates needed
Yes

National Conditions

	1) Are the plans still jointly agreed?	2) Are Social Care Services (not spending) being protected?	3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	i) Is the NHS Number being used as the primary identifier for health and care services?	ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	6) Is an agreement on the consequential impact of changes in the acute sector in place?
Please Select (Yes, No or No - In Progress)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "No - In Progress" estimated date if not already in place (DD/MM/YYYY)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Comment	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Non-Elective and P4P

Actual Q1 15/16	Actual payment locally agreed	Comments	Any unreleased funds were used for: Q4 14/15	Any unreleased funds were used for: Q1 15/16
Yes	Yes	Yes	Yes	Yes

I&E (2 parts)

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Please comment if there is a difference between the total yearly plan and the pooled fund
Income to	Plan	Yes	Yes	Yes	Yes	Yes
	Plan					
	Forecast	Yes	Yes	Yes	Yes	
	Forecast					
	Actual	Yes				
	Actual					
Expenditure From	Plan	Yes	Yes	Yes	Yes	Yes
Expenditure From	Plan					
	Forecast	Yes	Yes	Yes	Yes	
	Forecast					
	Actual	Yes				
	Actual					
	Commentary	Yes				

Local Metrics

	Same local performance metric in plan?	If the answer is No details				
	Yes	Yes				
	Plan	Plan	Plan	Plan	Actual	Actual
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16
Local performance metric plan and actual	Yes	Yes	Yes	Yes	Yes	Yes
Commentary	Yes					

	Same local performance metric in plan?	If the answer is No details				
	Yes	Yes				
	Plan	Plan	Plan	Plan	Actual	Actual
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16
Local patient experience plan and actual	Yes	Yes	Yes	Yes	Yes	Yes
Commentary	Yes					

Understanding Support Needs

Area of integration greatest challenge
Yes

	Interested in support?	Preferred support medium
1. Leading and Managing successful better care implementation	Yes	Yes
2. Delivering excellent on the ground care centred around the individual	Yes	Yes
3. Developing underpinning integrated datasets and information systems	Yes	Yes
4. Aligning systems and sharing benefits and risks	Yes	Yes
5. Measuring success	Yes	Yes
6. Developing organisations to enable effective collaborative health and social care working relationships	Yes	Yes

Narrative

Brief Narrative
Yes

Cover and Basic Details

Q1 2015/16

Health and Well Being Board	Cambridgeshire

completed by:	Geoff Hinkins
E-Mail:	geoff.hinkins@cambridgeshire.gov.uk
Contact Number:	01223 699679
Who has signed off the report on behalf of the Health and Well Being Board:	TBC

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

	No. of questions answered
1. Cover	5
2. Budget Arrangements	1
3. National Conditions	24
4. Non-Elective and P4P	5
5. I&E	21
6. Local metrics	18
7. Understanding Support Needs	13
8. Narrative	1

Budget Arrangements

Selected Health and Well Being Board:

Cambridgeshire

Data Submission Period:

Q1 2015/16

Budget arrangements

Have the funds been pooled via a s.75 pooled budget?	Yes
If it has not been previously stated that the funds had been pooled can you now confirm that they have?	
If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	

Footnotes:

Source: For the S.75 pooled budget question which is pre-populated, the data is from the Q4 data collection previously filled in by the HWB.

National Conditions

Please select
Yes
No
No - In Progress

Selected Health and Well Being Board:

Cambridgeshire

Data Submission Period:

Q1 2015/16

National Conditions

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these are on track as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include a date **and** a comment in the box to the right

Condition	Please Select (Yes, No or No - In Progress)	If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	Comment			
1) Are the plans still jointly agreed?	Yes			1	1	1
2) Are Social Care Services (not spending) being protected?	Yes			1	1	1
3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	No - In Progress	31/03/2016	An HR Consultation is underway for affected County Council staff; it is expected that changes to affected County Council staff will come into effect no later than November 2015. Other seven day services referenced in our BCF Plan, including the new Joint Emergency Team, are now in place and delivering. Our ongoing seven day working project is progressing, with	1	1	1
4) In respect of data sharing - confirm that:						
i) Is the NHS Number being used as the primary identifier for health and care services?	No - In Progress	31/10/2016	The NHS Number is in place for the vast majority of social care users, and is to be used as the primary identifier for data sharing between health and social care. However it will not become the primary identifier for all social care users until procurement is complete for a new IT system, during the 2016/17 financial year.	1	1	1
ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	Yes			1	1	1
iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	No - In Progress	30/11/2015	This is being developed within each organisation as part of our data sharing work	1	1	1
5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	No - In Progress	31/03/2016	Some joint assessments and care planning are now taking place. Funding is not yet used for integrated packages of care. The number of joint assessments and care plans will increase with the expansion of care planning through Integrated Neighbourhoood Teams during this financial year, led by Cambridgeshire's Lead Provider, UnitingCare.	1	1	1
6) Is an agreement on the consequential impact of changes in the acute sector in place?	Yes		This was agreed during development of our BCF submission and continues to be discussed through our partnership board.	1	1	1

National conditions - Guidance

The Spending Round established six national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.

2) Protection for social care services (not spending)

Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013/14: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.

4) Better data sharing between health and social care, based on the NHS number

The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.
Local areas should:
• confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing open APIs (i.e. systems that speak to each other); and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place.
NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.

6) Agreement on the consequential impact of changes in the acute sector

Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

Better Care Fund Revised Non-Elective and Payment for Performance Calculations

Selected Health and Well Being Board: Cambridgeshire

	Baseline				Plan				Actual					
	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	% change [negative values indicate the plan is larger than the baseline]	Absolute reduction in non elective performance
D. REVALIDATED: HWB version of plans to be used for future monitoring	13,791	14,323	14,055	14,735	13,791	14,158	13,857	14,504	13,765	14,751			1.0%	594

Which data source are you using in section D? (MAR, SUS, Other)	MAR	If other please specify	
Cost per non-elective activity	£1,490		

	Total Payment Made			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Quarterly payment taken from above	£0	£0		
Actual payment locally agreed	£0	£0		

If the actual payment locally agreed is different from the quarterly payment taken from above please explain in the comments box (max 750 characters)	

	Total Payment Made			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Suggest amount of unreleased funds	£0	£245,850		
Actual amount of locally agreed unreleased funds	£0	£245,850		

	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Confirmation of what if any unreleased funds were used for (please use drop down to select):	not applicable	acute care		

Footnotes:

Source: For the Baselines, Plans, data sources, locally agreed payment and cost per non-elective activity which are pre-populated, the data is from the Better Care Fund Revised Non-Elective Targets - Q4 Playback and Final Re-Validation of Baseline and Plans Collection previously filled in by the HWB. This includes all data received from HWBs as at 10am on 6th August 2015. Please note that the data has not been cleaned and limited validation has been undertaken.

	Planned Absolute Reduction (cumulative) [negative values indicate the plan is larger than the baseline]				Maximum Quarterly Payment				Performance against baseline				Suggested Quarterly Payment						
Total Performance Fund Available	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Total Performance fund	Total Performance and ringfenced funds	Q4 Payment locally agreed
£885,060	0	165	363	594	£0	£245,850	£295,020	£344,190	26	-428			£0	£0			£885,060	£9,957,000	£0

Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in both cases the year-end figures should equal the total pooled fund)

Selected Health and Well Being Board: Cambridgeshire

Income

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Total Yearly Plan	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£11,621,750	£8,403,750	£8,403,750	£8,403,750	£36,833,000	£37,669,000
	Forecast	£11,621,750	£8,403,750	£8,403,750	£8,403,750		
	Actual*	£11,621,750					

Please comment if there is a difference between the total yearly plan and the pooled fund	Please note that the higher amount in the first quarter is due to the capital funding being received in one lump sum by the County Council from central Government. The discrepancy between the total yearly plan and the pooled fund is because we have not planned for use of the £836k performance related funding. This will only be released to the pooled fund if we are successful in meeting our target for non-elective admissions, and will then be used to support our transformation projects

Expenditure

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Total Yearly Plan	Pooled Fund
Please provide , plan , forecast, and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£10,651,250	£8,727,250	£8,727,250	£8,727,250	£36,833,000	£37,669,000
	Forecast	£10,651,250	£8,727,250	£8,727,250	£8,727,250		
	Actual*	£10,454,107					

Please comment if there is a difference between the total yearly plan and the pooled fund	As above, discrepancy between the total yearly plan and the pooled fund is because we have not planned for use of the £836k performance related funding. This will only be released to the pooled fund if we are successful in meeting our target for non-elective admissions, and will then be used to support our transformation projects

Commentary on progress against financial plan:	Not all posts are yet recruited to and projects have not yet been in a position to spend significantly and this has led to a spend below forecast in Q1. It is anticipated that the budget will be used or committed in subsequent quarters within this financial year; if any funds remain at the end of the financial year, these will be rolled forward in accordance with the Section 75 agreement

Footnote:

Actual figures should be based on the best available information held by Health and Wellbeing Boards.
Source: For the pooled fund which is pre-populated, the data is from a Q4 collection previously filled in by the HWB.

Local performance metric and local defined patient experience metric

Selected Health and Well Being Board:	Cambridgeshire
Local performance metric as described in your approved BCF plan	The proportion of adults (aged 18+) receiving long-term social care (per 100,000 of population)
Is this still the local performance metric that you wish to use to track the impact of your BCF plan?	Yes
If the answer is no to the above question please give details of the local performance metric being used (max 750 characters)	

	Plan				Actual			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Local performance metric plan and actual	1,881	1,724	1,724	1,724	1,744	1,428		

Please provide commentary on progress / changes:	The denominator and target for this indicator have been updated since our BCF submission to reflect 2014 population estimates. The denominator (Cambridgeshire popuplation 18+) is now 508,328. in the first quarter of 2015/16, 7,261 adults were in receipt of long-term social care services in total - representing a reduction from the previous quarter. This indicator is calculated quarterly based on year-to-date figures and the figure is likely to increase during the winter months (lower is better)

Local defined patient experience metric as described in your approved BCF plan	Friends and Family Test - Inpatient - % that would recommend NHS service received to friends and family
Is this still the local defined patient experience metric that you wish to use to track the impact of your BCF plan?	Yes
If the answer is no to the above question please give details of the local defined patient experience metric now being used (max 750 characters)	

	Plan				Actual			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Local defined patient experience metric plan and actual:	96	96	96	96	94	95		

Please provide commentary on progress / changes:	Performance is close to target although the target has been met. Discussions are ongoing about performance against this indicator in future quarters.

Source: For the local performance metric which is pre-populated, the data is from a local performance metric collection previously filled in by the HWB.
For the local defined patient experience metric which is pre-populated, the data is from a local patient experience previously filled in by the HWB.

Support r

Selected Health and Well Being Board: Cambridgeshire

Which area of integration do you see as the greatest challenge or barrier to the successful implementation of your Better Care plan (please select from dropdown)?	1.Leading and Managing successful better care implementatic

Please use the below form to indicate whether you would welcome support with any particular area of integration, and what format that support might take.

Theme	Interested in support?	Preferred support medium
1. Leading and Managing successful better care implementation	Yes	Case studies or examples of good practice
2. Delivering excellent on the ground care centred around the individual	Yes	Peers to peer learning / challenge opportunities
3. Developing underpinning integrated datasets and information systems	Yes	Central guidance or tools
4. Aligning systems and sharing benefits and risks	Yes	Case studies or examples of good practice
5. Measuring success	Yes	Central guidance or tools
6. Developing organisations to enable effective collaborative health and social care working relationships	Yes	Case studies or examples of good practice

equests

on

Comments - Please detail any other support needs you feel you have that you feel the Better Care Support Team may be able to help with.

BCF Quarterly return – section 8, narrative

Progress with the BCF in Cambridgeshire has been broadly in line with planned activity. However, we acknowledge that we did not meet our target for non-elective admissions in the first quarter of 2015/16. We believe that the reasons for underachieving in the non-elective admissions target are largely due to the fact that Q1 has been a period of setting up and mobilisation. For example, the UnitingCare (UC) contract commenced on 1 April 2015. The initiatives launched in Q1 will require time to make an impact – for example OneCall and JET were launched on 6 May, but were only expanded to full geographical coverage and 24/7 operation from 1 July. The impact of local CCG initiatives for under 65s also have had a similar lead in time. Further, the BCF transformation projects have been establishing themselves during this period, and given that they are more focused on medium term transformation were not expected to have a significant impact on non-elective admissions during the first quarter. The performance payment has been made to acute providers reimbursing them for the additional non elective activity as per the CCG's contractual obligations.

The most significant area of spend and activity has been on the Older People and Adult Community Services Contract let by the CCG to the new 'Lead Provider' in Cambridgeshire - UnitingCare.

UnitingCare has begun service delivery in this quarter and made progress towards establishing new services. The following key features of the UnitingCare care model are now being phased in across Cambridgeshire and Peterborough:

• Integrated teams: 17 neighbourhood teams across Cambridgeshire and Peterborough. Each team will support up to six GP practices, and will provide community-based healthcare centred around the patient. These teams will each include a combination of community nurses, psychiatric nurses, allied health professionals, and support workers, all working together providing planned and rapid response services to meet the needs of the patient. Neighbourhood teams will be supported by specialist health care professionals in four integrated care teams, based in Huntingdon, Peterborough, Cambridge and Fenland/Ely. These teams will include a housing co-ordinator to ensure any accommodation issues are addressed, alongside consultants, geriatricians, psychiatrists, cardiologists, respiratory physicians and palliative care consultants for advice and consultation. The configuration of the Neighbourhood Teams has been developed, engagement with staff is underway leading to consultation with staff and implementation of new arrangements from September 2015.

• OneCall- UnitingCare single point of co-ordination: the new OneCall Service was launched on 6th May 2015, taking referrals from GPs in its first phase. The aim is that services will be accessible via a single telephone number available to GPs, out of hours services, community and mental health teams, hospitals, social care teams, voluntary organisations, residential care homes as well as patients and carers. Staffed by professionals with access to expert

clinical advice, it will provide people with guidance and advice as well as signposting them to relevant services or support.

UnitingCare will work with GPs and their teams to identify the patients at greatest risk of deterioration or future hospital admission and then co-ordinate their care through regular reviews by a multidisciplinary team comprising health, social care and housing support professionals.

• Joint Emergency Team (JET): the new JET service was launched on 6th May 2015, taking referrals from GPs and operating during daytime hours only in its first phase. It is being rolled out as a 24/7 emergency service that will work alongside ambulances and out of hours GPs to undertake assessments and provide immediate treatment or care in the patients home, preventing unnecessary referrals to hospital and allowing more people to receive care in the comfort of their own home.

• Wellbeing and prevention: UnitingCare will work closely with voluntary organisations and social care to deliver services and support for adults and older people to help keep people well.

• Technology: Currently different organisations use different electronic patient record systems, which means for example GPs cannot see what hospital staff have added and vice-versa. The new technology will bring together summaries of all the different records for that one patient, creating a single view of the whole patient record. This will speed up some of the processes making it easier to make decisions. It will also enable patients to view their own records. The first phase will be the launch of a 'single view of the patient record' in July 2015.

Other transformation projects

The scope of the OPACS contract does not include social care, however to be successful it is essential that services are closely integrated between health, social care and other related services.

Our BCF Transformation Projects are also continuing to progress and are being jointly developed across Cambridgeshire and Peterborough. The first quarter has been a period of development for the projects, which aim to deliver transformation to the local system in the medium term.

• Data Sharing: To deliver an effective and secure joint approach to data sharing across the whole system, enabling improved co-ordination and integration of services for adults and older people.

The Data Sharing project is underway. A Board has been established and has agreed a comprehensive project plan and dashboard, which will steer the project going forward. Additional outcomes and statements were added to ensure there is a clear service user focus:

o Patients and service users will have a better experience of care and improved outcomes;

o Patients and service users will have access to their own data;

o "My privacy and wishes will be respected";

o "Professionals will be able to access my information when it is to my benefit, if and when they need to"; and

o "I won't have to keep telling my story to different professionals from different places".

The immediate focus is on expanding the UnitingCare 'OneView' to include social care teams, with a particular focus in the first instance on discharge planning and reablement teams. Each Council has consulted with practitioners to understand what health information would be valuable from a social care perspective and also what social care information may be available that would be useful to share with health. Technical discussions have started on how to enable the uploading of social care data into OneView.

In addition, a piece of work will be developed to ensure that patients and service users are consulted and their feedback collected on the development of data sharing models.

• 7-Day Working: To expand 7 day and out of hours working to ensure a safe, effective and caring response is available 24 hours a day, seven days a week, to prevent avoidable admissions and promote discharge from hospital.

There is an inclusive project plan and a dashboard established. This project is being led by each SRG in Cambridgeshire and Peterborough. SRGs are considering the priorities for each area to develop plans for seven day working. Priorities have been established and a plan developed by the Peterborough SRG, and the process is ongoing in other areas.

• Information, Communication and Advice: To develop and deliver high quality sources of information and advice based on individuals' needs as opposed to organisational boundaries. This will include an agreed principle of 'no wrong front door', building on good work already underway in Peterborough and Cambridgeshire.

Monthly core group meetings are now in place for this project workstream. Next steps have been agreed and a series of work has commenced to establish the priorities for a shared project across Cambridgeshire and Peterborough.

• Person Centred System - To enhance and improve person centred care across the entire system, ensuring that care and support is planned and co-ordinated by Integrated Care

Teams; establishing a process for joint assessments with an accountable lead professional; and that an integrated approach to identifying risk is established across different sectors.

This project is being led by UnitingCare as it is strongly linked to the development of the UnitingCare Service model – the scope includes Multi-Disciplinary Team working, approaches to risk assessment, and shared care plans. A monthly project steering group will provide governance and monitoring for this project.

• Ageing Healthily and Prevention - To develop community based preventative services to support and enable older people in particular to enjoy long and healthy lives and feel safe within their communities. This work is to be led by Public Health in Cambridgeshire and Peterborough. During the last quarter, priorities have been developed and a project team formed, which will meet for the first time towards the end of Q2. The project will include a series of targeted evidence-based health programmes and interventions for the following key priority areas:

- Falls
- Mental Health & Dementia
- Physical Activity & Nutrition
- Incontinence and urinary tract infections (UTI's)
- Multimorbidity
- Social isolation and loneliness

The project will also incorporate the development of the Voluntary Sector-led Wellbeing Service, which forms part of the new UnitingCare service model.

CAMBRIDGESHIRE AND PETERBOROUGH HEALTH AND CARE SYSTEM TRANSFORMATION PROGRAMME

To: Health and Wellbeing Board

Date: 17 September 2015

From: Dr Neil Modha, Chief Clinical Officer (Accountable Officer)
Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)

1.0 PURPOSE

1.1 Cambridgeshire and Peterborough Health and Care System Transformation Programme last presented information to the Health and Wellbeing Board on 2 July 2015. This paper updates the Health and Wellbeing Board on this planning process.

2.0 BACKGROUND

2.1 Strategic aims and values

The strategic aims and values of the programme remain:

- People at the centre of all that we do
- Empowering people to stay healthy
- Developing a sustainable health and care system
- Improving quality, improving outcomes

2.2 Update

Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) is leading a process to plan changes to the health system that will improve outcomes for people and enable financial sustainability. This process involves providers, partners and patients and has four phases.

The programme continues to work on the following areas:

- Detailed analysis of the issues facing the health system, working with key stakeholders about areas of challenge. The Change Document for the programme has been updated
- Engagement with the public around the key challenges facing the health system now and into the future
- Getting feedback from the public about current services and how they think things could change

2.3 Refreshed change document and technical appendices

The System Transformation Programme published a document in June 2014 which described the current state of the health system and aspirations for change including health outcomes that the programme aims to improve. It also provides benchmark information against which any change can be assessed.

This document has now been refreshed and a new set of technical appendices has been published. The link to this document is in the table of "Source Documents" below.

2.3.a Changes since the previous version of the Change Document:

The main document is shorter with more technical information appearing in the technical appendices

2.3.b Key messages in the Change Document

The key messages in the refreshed version focus on why the health system needs to change. They are:

- If we do not change our health system substantially then we face a deficit of at least £250 million by 2018/19 and this will make it harder to deliver good quality care. At the moment our hospitals have significant deficits
- The health services continue to increase
- Primary care is not sustainable in its current form
- We have a mismatch between capacity and demand which affects all parts of the system and is significantly affecting our hospitals
- There are gaps in some parts of the workforce across the Cambridge and Peterborough health system
- In addition we have service gaps in mental health and services for children

2.3.c Overview of changing context for the Transformation Programme:

There is a new section on expected changes in our health system which reviews the changes that are already anticipated in the following areas:

- Primary care
- Community care
- Acute settings
- Approaches to commissioning:
    - Outcomes focus
    - Primary care
    - Enhancing integration and joint commissioning through the Better Care Fund

2.3.d Developments in the analytical work

The information in the technical appendices has been updated with new information that has become available.

The 2014 version contained as assessment of the feasibility of forecasting health demand for our system and refreshed version contains the methodology that has been developed to do this for the acute sector of the health economy, the outputs and top level assumptions.

2.3.e Maximising wellbeing and reducing demand for services

Activity modelling undertaken as part of the programme has shown that conditions such as obesity are likely to be a cause of half of the increase in demand on health services.

The Director of Public Health is scoping a prevention workstream which aims to promote wellbeing and reduce the need for health and care services.

2.4 Wider engagement with the public

A themed report is available in Appendix 1, summarising by theme, feedback from the Public Involvement Assembly and Saturday Cafés.

2.4.a Public Involvement Assembly

As the “Fit for the Future” System Transformation Programme crosses organisational boundaries, it was felt that a single forum was needed to draw together existing networks and give local people not already involved in health engagement groups the chance to give their views and feedback on an ongoing basis.This forum is called the “Public Involvement Assembly” and is informing the forward work of the programme.

The Forum is made up of people from existing engagement networks, such as Patient Participation Groups (PPGs), community groups and Healthwatch, alongside members of the public who are new to discussing health services. The Assembly meets in several different sites with each site considering the same questions. Sessions have been held in Cambridge, Peterborough, Wisbech, Ely and Huntingdon. Around 80 people have taken part in the first round. On the whole the feedback from the sessions has been positive. The next round of the Public Involvement Assembly is planned for the autumn(commencing in October/November 2015).

2.4.b Saturday Cafés

These have been two-hour drop in sessions for members of the public to find out more about Fit for the Future and the System Transformation Programme, and give their views of the challenges our local health system is facing. These have been held in Cambridge, Peterborough, Wisbech, Ely and Huntingdon. Feedback gathered during the Saturday Cafés was used to generate discussion at the Assembly sessions.

2.4c Roadshows at clinical bases

Following on from the Saturday Cafes and first PIAs, engagement work is continuing with the team visiting hospital and community healthcare bases with an information stand and directing people online throughout August/September.

2.4.d Online engagement

Information shared at both the Assembly sessions and the Saturday Cafés is available on the System Transformation Programme’s webpages on the CCG’s website.
This includes an opportunity for people to give their feedback online. People can also get involved in the programme through the Fit for the Future NHS Cambridgeshire and Peterborough page on Facebook or by becoming a follower of @fitforfuturenhs on Twitter. Engagement will continue online throughout August.

2.5 Next steps for the programme

Following the Fit for the Future System Transformation Saturday Cafes and Public Involvement Assembly sessions over summer 2015, the Transformation Team will be holding a series of roadshows at clinical bases and developing possible ideas for change with clinicians across Cambridgeshire and Peterborough during autumn 2015.

Engagement with the public to develop the ideas for change is now expected to take place in the first half of 2016, followed by public consultation on any proposals for change.

2.6 Second wave of "Vanguard" site applications

The NHS England New Models of Care Programme aims to co-design different types of new care models for the NHS. More details of these models can be found in the "Five Year Forward View". The link is in the 'Source Documents' table below.

2.6.a Successful Urgent and Emergency Care Vanguard

The CCG applied for "Urgent and Emergency Care" Vanguard status and was successful. The proposal is to develop local urgent and emergency health services by supporting people to keep well, and by bringing home care, mental health, community and GP, ambulance, and hospital services closer together.

Currently there are four System Resilience Groups across Cambridgeshire and Peterborough. The vision is to create one overarching Super System Resilience Group with strong clinical leaders. This aims to accelerate improvements and develop a best practice model for urgent care services which helps address variations in access to services and health inequalities within the region.

The overarching Resilience Group will focus on:

- promoting self-care and management
- helping people with urgent care needs to get the right advice first time and to access the right service seven days a week
- providing highly responsive urgent care services outside of hospital
- developing a workforce to meet these needs
- reassessing service standards based on outcomes and redefine payment methods to improve outcomes

2.6.b Acute Care Collaboration Vanguard application

An application for the acute care collaboration Vanguard was made by Peterborough and Stamford Hospitals NHS Foundation Trust, Hinchingbrooke Health Care NHS Trust, Cambridgeshire and Peterborough NHS Foundation Trust, Papworth Hospital NHS Foundation Trust, Cambridgeshire Community Services NHS Trust and Cambridge University Hospitals NHS Foundation Trust. This bid proposes a Hospital Federation with increased sharing of medical expertise across sites, and greater efficiency from shared back office administration. This application was endorsed by the System Transformation Programme Board and was submitted on 30 July 2015.

We were advised on 20 August that we were not shortlisted for the Acute Care Collaboration Vanguard status – detailed feedback will be shared with the Board in September. Further work is planned to develop the elements described within the bid application. A proposal will be shared with the System Transformation Programme Board in October 2015, describing the key elements of a proposed high level plan and potential governance arrangements, building on the 'spread and replication' theme which is at the heart of the New Care Models Programme.

3 RECOMMENDATIONS

Health and Wellbeing Board members are asked to note this update.

Source Documents	Location
• Cambridgeshire and Peterborough health system Change Document/15 to 2018/19: Main text	http://www.cambridgeshireandpeterboroughccg.nhs.uk/five-year-plan.htm
• Cambridgeshire and Peterborough health system Blueprint 2014/15 to 2018/19: Appendices	http://www.cambridgeshireandpeterboroughccg.nhs.uk/five-year-plan.htm
• Cambridgeshire and Peterborough System Transformation Programme Frequently asked Questions	http://www.cambridgeshireandpeterboroughccg.nhs.uk/STP_FAQS_Feb_2015docx.pdf
• NHS England " Five Year Forward View"	http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
• NHS England " Acute Care Collaboration" web site	http://www.england.nhs.uk/ourwork/futurenhs/5yfv-ch3/new-care-models/acute-care-collaboration/
• NHS England " Urgent and Emergency Care Vanguard" site •	http://www.england.nhs.uk/ourwork/futurenhs/5yfv-ch3/new-care-models/uec/

Author
Dr Fiona Head
Programme Director
Cambridgeshire and Peterborough System Transformation Programme
4 August 2015

Appendix 1

High level summary report of feedback from engagement through PIAs and Saturday Cafés according to theme

Demand rising

Education-based approach should be adopted to combat rising demand for health services. Health services are fragmented – people need to know the most appropriate place to go.

Health needs changing

It's recognised that health needs are changing. There were multiple reports of experience of mental illnesses and diabetes. Feedback favoured support for prevention and people taking responsibility for their own health, where able to do so.

Best use of NHS spend

Focus on reducing waste in the system such as the prescription of 'unnecessary' medication and not collecting/or providing process for returning equipment such as crutches. Make people aware of the costs, charge for equipment, fine patients for missing appointments and review administration staff. Buy in bulk more.

GP surgeries

Generally people are complimentary about care received from local GPs but expressed difficulties with getting appointments. There is a recognised need for younger GPs. Views were expressed that making GPs into businesses was a bad idea and that GPs are not viewed as an integrated part of NHS.

Hospital beds

Feedback favoured the development of services at 'community hospitals' such as the Princess of Wales and North Cambs. Beds to support convalescence after discharge from the bigger hospitals are needed.

Staffing shortages

It was questioned how a local programme can influence national issues with NHS staffing. It was suggested that the local health system was promoted as place people want to come and work in, and to train and recruit locally.

Mental Health Services

There was a lot of feedback from people at Saturday Cafes with experience of local mental health services. Difficulties were expressed with accessing the right type of mental health care, particularly crisis care. There was less feedback from the Public Involvement Assembly sessions on mental health but reducing the stigma around mental health, increasing funding and giving more support via local GP practices was suggested.

Children's and maternity services

There was very limited feedback on Children's and Maternity Services and it was suggested that other ways were needed to engage with young families and young people. There was though an awareness of lack of 'joined-up services'.

Other

It was suggested the NHS should work more with non-NHS organisations to help improve health and support health services – i.e. sports clubs and voluntary organisations. More education to help the public use the NHS appropriately is needed.

HEALTH AND WELLBEING BOARD FORWARD AGENDA PLAN

MEETING DATE	ITEM	REPORT AUTHOR	TO DEMOCRATIC SERVICES RUTH YULE BY
19 Nov 2015	***Priority 1 – Ensure a positive start to life for children, young people and their families***		
	Person's story	Lenja Bell, pinpoint	**Thursday 5 November**
	Priority 1 (Children's Trust) update	Meredith Teasdale	
	General business		
	Reflections on Priority 4 meeting	Sir Graham Bright	
	Better Care Fund Update [standing item]	Adrian Loades / Andy Vowles/ Geoff Hinkins	
	Cambridgeshire and Peterborough Health and Care System Transformation Programme [standing item]	Andy Vowles / Dr Modha	
	CCG's Commissioning Intentions (TBC – probably in January)	Jessica Bawden	
14 Jan 2016	***Priority 3 – Encourage healthy lifestyles and behaviours in all actions and activities while respecting people's personal choices***		
	Person's story	TBC	**Wednesday 30 December**
	Priority 3 update	Val Thomas	
	Public Health Reference Group update	Liz Robin	

MEETING DATE	ITEM	REPORT AUTHOR	TO DEMOCRATIC SERVICES RUTH YULE BY
	General business		
	CCG's Operational Plan	Jessica Bawden	
	CCG's Commissioning Intentions (or already covered in November)	Jessica Bawden	
	Better Care Fund Update [standing item]	Adrian Loades / Andy Vowles/ Geoff Hinkins	
	Cambridgeshire and Peterborough Health and Care System Transformation Programme [standing item]	Andy Vowles / Dr Modha	
17 March 2016	***Priority 5 – Create a sustainable environment in which communities can flourish***		
	Person's story	TBC	**Thursday 3 March 2016**
	New Communities JSNA? (TBC)	TBC	
	Priority 5 update	Iain Green	
	General business		
	Better Care Fund Update [standing item]	Adrian Loades / Andy Vowles/ Geoff Hinkins	
	Cambridgeshire and Peterborough Health and Care System Transformation Programme [standing item]	Andy Vowles / Dr Modha	
26 May 2016	***No theme: first meeting of municipal year***		
	Person's story – TBC	Oral	**Thursday 12 May**
	Election of Vice-Chairman/woman	Oral	
	Alcohol and Drugs JSNA report	Val Thomas	
	CCG's Choice of Local Quality Premium Indicators	Jessica Bawden	

MEETING DATE	ITEM	REPORT AUTHOR	TO DEMOCRATIC SERVICES RUTH YULE BY
	Cambridgeshire and Peterborough Health and Care System Transformation Programme [standing item]	Andy Vowles / Dr Modha	
	Better Care Fund Update [standing item]	Adrian Loades / Andy Vowles/ Geoff Hinkins	

To be scheduled:

- Two further updates from the Safeguarding Adults Board – priority area/area of interest to be agreed by HWB as part of Annual Report discussion
- Two further updates from the Local Safeguarding Children Board – priority area/area of interest to be agreed by HWB as part of Annual Report discussion

Update: RY 2 September 2015