ADULTS COMMITTEE

Date:Thursday, 15 November 2018

Democratic and Members' Services
Fiona McMillan
Monitoring Officer

14:00hr

Shire Hall
Castle Hill
Cambridge
CB3 0AP

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

AGENDA

Open to Public and Press

CONSTITUTIONAL MATTERS

1. Apologies for absence and declarations of interest

Guidance on declaring interests is available at
http://tinyurl.com/ccc-conduct-code

2. Minutes - 18th October 2018 and Action Log

Minutes_181018_FINAL_ NON CONFIDENTIAL	**5 - 16**
Adults Committee Actions_November 2018	**17 - 20**

3. Petitions and Public Questions

DECISIONS

4	**Cambridgeshire & Peterborough Health & Social Care System Peer Review and CQC Area Review Preparations**	**21 - 38**

Date of Next Meeting

The next meeting will be held on Thursday 13 December at 2pm in the Kries Viersen Room, Shire Hall, Cambridge, CB3 0AP.

The Adults Committee comprises the following members:

Councillor Anna Bailey (Chairwoman) Councillor Mark Howell (Vice-Chairman)

Councillor Adela Costello Councillor Sandra Crawford Councillor Janet French Councillor Derek Giles Councillor Mark Goldsack Councillor Nichola Harrison Councillor David Wells and Councillor Graham Wilson

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

Clerk Name: Tamar Oviatt-Ham

Clerk Telephone: 01223 715668

Clerk Email: tamar.oviatt-ham@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 Constitutionhttps://tinyurl.com/ProcedureRules.

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.

ADULTS COMMITTEE: MINUTES

Date: Thursday 18th October 2018

Time: 2.00pm to 5.00pm

Present: Councillors A Bailey (Chairwoman), A Costello, J French, N Harrison, K Cuffley D Giles and M Howell (Vice-Chairman), D Wells and G Wilson

Apologies: Cllr D Wells

114. APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST

Apologies received from Councillor Wells. No declarations of interest received.

115. MINUTES FROM THE MEETING HELD ON 6TH SEPTEMBER AND ACTION LOG

It was resolved to approve the minutes of the 6th September 2018 as a correct record, and to note the action log and updates at the meeting.

116. PETITIONS AND PUBLIC QUESTIONS

No petitions were received. One question was received from a member of the public. The question and written answer can be found at appendix 1 of these minutes.

117. ALIGNMENT OF EXTRA CARE CONTRACT

The Committee considered a report on the alignment of extra care contracts.

Cambridgeshire County Council and Peterborough City Council worked collaboratively to review 16 extra care schemes in Cambridgeshire and 5 in Peterborough. Tendering multiple contracts was resource intensive. In recent years a number of contracts had been tendered together, thereby reducing overall procurement costs.

Both Authorities had different approaches to the type of service that they tendered so had reviewed the services across the piece and developed a visioning strategy, incorporating the learning from both authorities.

The work explored opportunities to co-locate other services that supported older people including day services. Developing the schemes as two-way local hubs, helped to embed extra care schemes as part of the community and demystified ‘extra care’ and promoted it as a natural choice for those who need additional care and support to live independently.

Work had been carried out to improve the information available on the Council website and a video was being developed in conjunction with other organisations.

Discussions were held with landlords on how they could work more collaboratively. Extensive consultation would be carried out with communities to understand their

perception of extra care and how it could be improved for future generations. The work would also focus on future population growth.

In order to facilitate the work it was necessary to seek extensions for a number of extra care contracts with the aim being to align the Cambridgeshire County Council contract end dates into three groups, as set out in appendix A of the report.

During discussion members:

- Sought clarification on the definition of extra care to aid the discussion.
- Commented on the benefits of sharing the workload for both authorities and making the process more efficient.
- Highlighted that officers should keep the process of block retendering under review to ensure it was the most efficient process in the future.
- Sought clarification on the percentage of schemes that were rental and leasehold – The majority of current schemes were rental. There was one new scheme, two-thirds were leasehold and one-third rental which was a possible model for the future.
- Sought clarification that people could choose to take a personal budget and were not just required to use the on-site facilities, this was confirmed.
- Recommended that those on the Committee that had not been to an extra care facility visit one. Poppyfields was recommended as a good example of integration.
- Sought clarification that procurement were happy with the approach and that it had been checked for value for money. It was confirmed that the proposal had been approved by the Council's Procurement and Legal teams as set out on page 21 of the agenda papers.

The Committee requested that an update on the timings for the visioning strategy should come back to Committee, along with the project plan. **ACTION**

It was resolved unanimously to:

a) agree the development of the joint extra care visioning strategy.

b) to facilitate this work, agree the request for exemptions to align with Peterborough City Council (PCC) contract end dates.

118. MENTAL HEALTH RECOVERY AND INCLUSION SERVICE

The Committee considered a report on the outcome of the tender process for the Mental Health Recovery and Community Inclusion Service and the proposed re-procurement exercise. The service was jointly commissioned with Peterborough City Council and the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG).

The procurement process was undertaken between March and July 2018 and 7 bids were received and evaluated. An award recommendation was made to Committee on 19th July 2018, which was approved and an Intention to Award notice was issued to the successful bidder.

Following the notice further feedback was requested by an unsuccessful bidder. A formal legal challenge to the outcome of the Contract Award was received on 31st July 2018. The standstill period between the Intention to Award Notice and Contract Award was extended in order for the challenge to be considered.

LGSS Law, LGSS Procurement and Cambridgeshire County Council Officers in consultation with its commissioning partners (the Cambridgeshire and Peterborough CCG and Peterborough City Council) considered the content of the challenge and concluded that it would be in the best interests of the Council to abandon the tender process. The legal challenge was withdrawn and disposed of giving the Council the opportunity to re-run the procurement exercise.

A formal notice of the abandonment of the tender was issued to all parties who had expressed an interest via Pro-Contract on 22nd August 2018.

All commissioning authorities (Cambridgeshire County Council, Peterborough City Council and Cambridgeshire and Peterborough CCG) were satisfied that the service specification to be procured would still fulfil the needs of Cambridgeshire residents, would meet long term demand and provide effective preventative services for people with mental health needs.

The recommendation was that the tender process be re-run with a different evaluation format to reduce, as far as possible, any further challenge.

It was recommended that the tender process be re-issued to the market in November 2018 with an anticipated contract start date of 1st July 2019.

A contract extension would be required for the Richmond Fellowship – Wellbeing, Prevention and Recovery Service, by way of an exemption in order to maintain current delivery prior to the new service contract start date.

Councillors sought clarity on the element of the process that had been challenged.

It was noted that one small part of the pricing element of the tender had been challenged but that as this was a confidential process this could not be discussed in the meeting.

Members sought further information regarding the successful challenge to the procurement process in order that they could be satisfied with the process. Assurance was sought by Members regarding how the Council could ensure it did not happen again. Officers undertook to provide a confidential briefing note regarding the process and the challenge received. **ACTION**

It was noted that a full debrief around all of the aspects of the process had taken place.

It was also clarified that the costs for this process had been borne by Cambridgeshire County Council.

Councillor Harrison proposed, seconded by Councillor Wilson that the recommendations be considered separately. On being put to the vote, the proposal was lost, 3 in favour, 5 against and 1 abstention.

The recommendations were put to the vote in block.

It was resolved by majority to:

a) note the outcome of the current tender process for the Mental Health Recovery and Community Inclusion Service and the proposal for re-procurement.

b) agree a further extension of up to 12 months by way of exemption for the current Recovery and Wellbeing service.

c) delegate the approval of the Award of Tender to the Executive Director, People and Communities Directorate following outcome of the procurement process.

119. FINANCE AND PERFORMANCE REPORT – AUGUST 2018

The Committee received the August 2018 iteration of the Finance and Performance report. In presenting the report it was noted that People and Communities at the end of August forecasted an overall overspend of £6,240K. This was a worsening position from the previous month when the forecast overspend had been £4,690k.

Specifically for the lines relating to the Adults Committee, the forecast overspend was £331k.

As previously discussed at Adults Committee the major savings agenda continued with £99.2m of savings required across the Council between 2017 and 2022. The total planned savings for P&C in the 2018/19 financial year total £21,287k.

Although significant savings are expected to be made in 2018/19 across the directorate, Adults services continue to face demand and price pressures, particularly:

- In Older People's services where capacity demand for domiciliary and residential care was affecting prices.

- Through increased demand in the NHS and improved performance in reducing delays in transfers of care.

- In Learning Disability services, where the needs of a relatively static number of service-users was increasing.

Of the performance indicators linked to Adults Committee there was one red indicator in

relation to the proportion of adults with primary support reason of learning disability in paid employment (year to date). It was noted that item 11 on the agenda covered the review of the Learning Disability Employment Strategy and resulting action plan.

During discussion members:

- Sought clarification regarding Grant Funding and the level of funding that would be available. It was noted that the money in the current budget related to the Better Care Fund and had been relatively unchanged over the last few months. The Better Care Fund was a grant over three years targeted for investing in hospital discharge, adult social care pressures and working with the market to build sustainable capacity. The Council had used some of it to support Adult Social Care pressures. The funding expired at the end of 2021. Alternative ways to manage the pressures needed to be sought.

- Sought further information on the Hancock funding. It was noted that Cambridgeshire County Council had just received notification of a one-off payment of £2.32m from Government designed to help alleviate pressures on the NHS this winter through speedier patient discharges and therefore freeing up hospital beds. The letter had only just been received and no guidance had been received regarding timescales for use of the funding.

It was resolved unanimously to review and comment on the report.

120. ADULTS COMMITTEE REVENUE PAPER – OCTOBER 2018

The Committee considered a report outlining the overview of the draft Business Plan Revenue Proposals for services that were in the remit of the Adults Committee.

The presenting officer provided an overview of the detailed proposals contained at pages 94 and 95 of the agenda papers.

During discussion members:

- Queried whether the proposed savings were realistic in relation to responding to the challenge. It was noted that all of the proposals were about providing better public services and achieving results for communities.

- Noted the table on page 91 of the agenda papers that showed that Cambridgeshire has the lowest spend on Adult Social Care for 2018/19, to its statistical neighbours. Attention was drawn to the level of spend per capita that demonstrated efficiency of the back office function in supporting front line services.

- Noted that the Council had lobbied Central Government regarding the Fairer Funding Formula and the outcome on this was due in September 2019.

It was resolved unanimously to:

a) note the overview and context provided for the 2019-20 to 2023-24 Business Plan revenue proposals for the Service.

b) comment on the draft revenue proposals that are within the remit of the Adults Committee for 2019-20 to 2023-24.

121. SERVICE COMMITTEE REVIEW OF ADULTS CAPITAL PROGRAMME – OCTOBER 2018

The Committee considered a report on the overview of the draft Business Plan Capital Programme for Adults Services.

It was noted that the plans remained unchanged from last year.

It was resolved unanimously to:

a) note the overview and context provided for the 2019-20 Capital Programme for Adults Services.

b) comment on the draft proposals for Adults' 2019-20 Capital Programme and endorse their development.

122. CAMBRIDGESHIRE AND PETERBOROUGH JOINT ADULT SOCIAL CARE MARKET POSITION STATEMENT

The Committee considered a report on the Cambridgeshire and Peterborough Adult Social Care Market Positon Statement. The statement was a statutory requirement as set out in the Care Act 2014. The purpose of the statement was to provide information to social care providers (both existing and new) and stakeholders about the needs of adults, both now and future projected needs and to highlight the authority's direction of travel in how care and support would be commissioned and provided.

The statement highlighted key messages which included;

- An aging population required increased support
- Substantial budget pressures
- Building capacity in communities
- Supporting people as early as possible.

Once approved a launch event would be held in mid-November and the statement would be reviewed annually. The next version of the statement would be published on Cambridgeshire Insight and would be interactive.

The Committee in its discussion of the document:

- Highlighted the good work that had gone into producing the statement.

- Noted that the authority spent as much on adults with learning disabilities as it does on older people. It was noted that this was the case with other authorities

and illustrated the particularly complex needs of people with learning disabilities.

- Queried the meaning of the number of packages with no offer. It was noted that this related to receiving no offers the first time the packages were distributed.

- Noted that further details on timescales for retendering would be provided in additional information available on the website.

- Requested an example of what was meant by building localised capacity. It was noted that one example of this was exploring micro enterprises, supporting people in communities to set up as a care provider in their own right. The Care Network had been granted funding from the Council's Innovate and Cultivate fund to take this forward. These individuals would have a professional status and salary and would receive the relevant training.

It was resolved unanimously to:

approve the Cambridgeshire and Peterborough Adult Social Care Market Position Statement.

123. LEARNING DISABILITY EMPLOYMENT STRATEGY UPDATE

The Committee received a report that provided an update regarding the Cambridgeshire Employment Strategy and Action Plan for people with learning disabilities and/or autism.

The report updated the Committee on the work to date and plans to meet the actions set out in the strategy, which focussed on increasing the number of adults with a learning disability and/or autism in employment.

The Strategy was developed as a result of adults with a learning disability and/or autism informing the authority that they wanted to secure employment as well as the need to improve Cambridgeshire performance in this area. Paid employment was beneficial for people in terms of a higher income, better health outcomes and improved self-esteem and social interaction. The Strategy considered the barriers to employment and proposed ways to overcome these.

The target number of adults with a learning disability and/or autism to be in employment was 6% and was expected, with the investment set out in the report, to be achieved.

Work had been ongoing with local employers to seek paid employment for individuals.

In discussing the report members;

- Highlighted the design hack as a good piece of work and noted that a co-creation group had been created as a result of the work.

- Queried why the statistics did not include the number of individuals in voluntary positions. It was noted that this was a statutory return and that it had been recognised that workplace learning should be recorded.

- Noted that the Switch Project in relation to a garden centre had been offered and was being investigated. Issues around transport had been looked into.

- Noted that there were barriers in relation to engagement with employers that needed to be overcome and that referrals needed to be made correctly.

- Noted the authority's work with FACET and Eddies in March and the service level agreement with March Community Centre and Café.

- Queried the ESIF bid as this was European Funding. It was noted that transformation funding could be used as an alternative option

- Requested that the action plan be updated as many of the actions had been completed. **ACTION**

- Highlighted the need to do further work with FE Colleges and strengthen relationships further. **ACTION**

- Requested more case studies with a particular focus on smaller communities be included within future reports. It was noted that case studies were provided frequently in a monthly update on progress. Members requested to be included in the updates. **ACTION**

- Noted that work was ongoing with HR regarding recruitment, including communication and support in completing application forms.

- Highlighted that as a 'Double Tick' employer the Council should promote it further. **ACTION**

- Noted that the Adult Learning Skills team were offering traineeships.

- Requested for information to be added to the Finance and Performance report in relation to progress in this area in relation to the numbers not yet reviewed. **ACTION**

- Requested more information on how this would affect peoples' care package costs. **ACTION**

- Highlighted the need to do more work on transitioning from voluntary to paid employment. It was noted that the authority were keen to work with the Department of Work and Pensions on this and were looking to hold workshops to explain what could happen in terms of benefits. It was noted that this would be included in the action plan. **ACTION**

- Requested that discussions took place across People and Communities and with Communities and Partnerships Committee and Children and Young People's Committee regarding how barriers to employment be addressed and include the outcomes of the discussions in the action plan. **ACTION**

It was resolved unanimously to:

note the contents of the update, progress made and plans for the future.

124. CARE HOME DEVELOPMENT

The Committee considered a report that provided an update relating to the commissioning strategy to address the shortfall in care home beds within Cambridgeshire and sought approval to extend two contracts for short term, respite and interim bed capacity.

The Council commenced a review of care home provision in Cambridgeshire in November 2017 which aimed to increase the capacity of affordable, sustainable high quality care home provision across the county. Through this review, a shortfall of 150 quality, affordable beds which could be directly commissioned by the Council was identified.

Since November 2017, commissioning sought to address the shortfall identified through:

- Extending the current block contract by 39 beds which had addressed the shortfall of Residential Dementia Care Home Beds within the Cambridge City area for the remainder of the contract.

- Developed a medium term approach to tender an additional block contract for long term beds within East Cambridgeshire, Huntingdonshire and South Cambridgeshire that would aim to target the ongoing shortfall of 111 beds by May 2019.

- Made significant progress with the competitive dialogue process aimed at procuring a strategic partner to design, build and run a number of Care Homes on Council owned land under a lease arrangement. This programme would target both the current and future shortfall of beds as well as introduce a number of high quality beds to the self-funder market through an ongoing build programme. The contract would be awarded to a strategic partner in May 2019, with an initial build site identified as part of the procurement process.

New models of care were being explored in partnership with District Councils through incorporating the use of ‘care suites’ into commissioning arrangements wherever it was appropriate to do so. This would include engaging with existing providers to convert current provision into care suites where appropriate to do so and in consultation with residents.

The Committee in discussion of the report:

- Queried the statutory risk implications and noted that these contracts were historically low risk and that there was only a slight risk to the Council.

- Queried whether 'Virtual Care Homes' had been considered and noted that this had been explored with an existing provider but was not considered to be value for money. Members, noted that the Council had offered to work with the provider to develop the model further.

- Noted that the extensions to the contracts had been discussed at the Commercial Board on 6th September 2018.

It was resolved unanimously to:

1) approve an extension of 12 months for two short term, respite and interim contracts.

2) approve current commissioning approaches to addressing the remaining shortfall of care home beds within Cambridgeshire.

3) approve the incorporation of care suites into existing models of commissioning where appropriate.

125. APPOINTMENTS TO OUTSIDE BODIES, PARTNERSHIP LIAISON AND ADVISORY GROUPS, AND INTERNAL ADVISORY GROUPS AND PANELS

None.

126. ADULTS COMMITTEE TRAINING PLAN 18/19

In discussion of the training plan members noted the quality of the Mental Health training session and that the subsequent on line training for prevention of suicides was very good. The training was recommended by Committee for Council staff.

It was resolved to note the training plan.

127. ADULTS COMMITTEE AGENDA PLAN

It was resolved to note the Agenda Plan.

Appendix B

Questions for Adults Committee 18th October 2018

Question: "As our local hospital has one of the highest numbers of Delayed Transfers of Care in the country, what is the county council doing to address this as it already takes months to source permanent care for the elderly in Cambridge, there is a shortage of carers and an inability to recruit them, and also one of the company's you are using is CQC rated as Inadequate and needs improvement and is causing safeguarding issues.
And finally as winter is coming do you have any extra provision for care in the community."

1. **Actions to address current levels of Delayed Transfers of Care and challenges in sourcing permanent care for the elderly in Cambridge**

Increasing levels of hospital admission and the need to reduce current numbers of delayed transfers of care is a national issue, and one which Cambridge is working as a system to address. The health and social care system is hugely reliant on the provision of homecare given that it enables people to remain safely in their own homes for as long as possible, and supports the facilitation of timely hospital discharge. Growing demand for homecare support has placed significant pressure on capacity within the independent homecare market within Cambridgeshire.

Since April 2017, there has been a 12.5% increase in the number of homecare hours delivered, totalling 450,000 per month. The Council also funds the second highest hourly rate in the region. Despite this, a shortfall in capacity remains. Building capacity within the home care sector is a long term challenge, but to date the Council has undertaken the following:

- **Implementation of a new approach to contracting homecare** which aimed to attract an increased number of providers to work with the Council through development of a more flexible contract arrangement, and provides the market with the opportunity to the work with the Council every three months. It also allows for a combination of smaller and larger providers to operate within the County. This has been successful in increasing the existing provider base by 53 providers.
- **Investment in an Occupational Therapy Team** to introduce moving and handling techniques and technology which enables packages delivered by two carers to be delivered by one, thereby maximising an individual's independence and ensuring best use of available homecare capacity.
- **Investment in an urgent, short term homecare service** for up to 6 weeks where capacity cannot be found within the mainstream market. This enables individuals to return home from hospital with the support required thereby preventing delay due to homecare capacity pressures.
- **Development of the brokerage function** to support not only those with a funded care package but also individuals who may be self-funding their care and support requirements. The brokerage team take a proactive approach to managing available capacity in a timely manner both within the community and on discharge from hospital.

Current operational practice and provision is also being transformed to ensure the Council is working with health partners to achieve maximum efficiency in order to avoid delays on discharge from hospital. This has included:

- Integrated Discharge Team- multi disciplinary health and social care team in each hospital working together to ensure timely discharge
- Admission avoidance work- making sure that if we can prevent a hospital admission we do so with our partners
- Significant investment in expanding the Council's in house Reablement Service to enable it to deliver homecare packages as 'provider of last resort' when this cannot be sourced from the independent sector. This is particularly important in avoiding delays on discharge from hospital.

However, there are also longer term challenges which the Council are also working to address. These mainly relate to recruitment and retention challenges in which the impact of Brexit must be considered; the high cost of living and low unemployment rates within Cambridgeshire and market competition within the retail and restaurant sector. The Council are working with our local health partners and regional networks, the Combined Authority, and ADASS to develop robust workforce development initiatives that aim to encourage growth in capacity within the homecare sector. Alternative approaches to delivering homecare are also being explored.

2. Quality of Homecare Provision

The Council has a statutory responsibility to manage the quality and sustainability of the social care market. Recently, following CQC inspection, a homecare provider currently commissioned by the Council has received a rating of 'Requires Improvement.' The Council, along with the CCG, are working in close partnership with the provider in question to address key shortfalls in quality through provision and implementation of a robust improvement plan. The improvement plan not only focuses on delivering the changes required, but also aims to ensure these changes are sustained and embedded as standard organisational practice in order to safeguard the needs of individuals receiving this service on an ongoing basis.

3. Extra provision to support care in the community this winter

Additional provision to support care in the community this winter is also being explored, and approaches centred on the following areas are currently under review:

- Additional short term, urgent domiciliary care capacity to expand on the service outlined above for a temporary period of time to support an increase in demand over winter
- Increased involvement of the third and voluntary sector to support delivery of 'non-registered' support activities. This could be anything from house clearances and deep cleaning of property to enable someone to return home safely to financial support and advice.
- Further investment in Reablement as 'provider of last resort'

Chairwoman

Agenda Item No: 2a

ADULTS COMMITTEE

Minutes Action Log

Cambridgeshire County Council

Introduction:

This log captures the actions arising from the Adults Committee up to the meeting on **18 October 2018** and updates Members on progress in delivering the necessary actions.

This is the updated action log as at 6 November 2018

Meeting of 6 September 2018

Minute No.	Report Title	Action to be taken by	Action	Comments	Status
108.	**Willow Court Bassenhally, Whittlesey - Tender for Contract**	**Lynne O'Brien**	Brief Committee on the outcome of the tender process once completed via email.	Currently liaising with Procurement regarding the tender process.	**Ongoing**
110.	**Cambridgeshire and Peterborough Foundation Trust Mid-Year Report 2017/18**	**Julie Frake-Harris**	Give feedback to Committee on the remaining number of mental health cases still in the backlog being worked through, as detailed in page 75 of the report.	This is currently being looked into	**Ongoing**

Meeting of 18 October 2018

Minute No.	Report Title	Action to be taken by	Action	Comments	Status
117.	**Alignment of Extra Care Contract**	**Lynne O'Brien**	The Committee requested that an update on the timings for the visioning strategy should come back to Committee, along with the project plan.	A meeting with colleagues from Peterborough City Council has taken place and some preparatory work on the project plan has been developed. Further work is ongoing in order to come back to Committee	**Ongoing**
118.	**Mental Health Recovery and Inclusion Service**	**Sarah Bye**	Members sought further information regarding the successful challenge to the procurement process in order that they could be satisfied with the process. Assurance was sought by Members regarding how the Council could ensure it did not happen again. Officers undertook to provide a confidential briefing note regarding the process and the challenge received.	Confidential briefing currently being prepared	**Ongoing**
123.	**Learning Disability Employment Strategy Update**	**Amanda Roach**	Requested that the action plan be updated as many of the actions had been completed.	In progress	**Ongoing**
		Amanda Roach	Highlighted the need to do further work with FE Colleges and strengthen relationships further.	In progress	**Ongoing**

Minute No.	Report Title	Action to be taken by	Action	Comments	Status
		Amanda Roach	Requested more case studies with a particular focus on smaller communities be included within future reports. It was noted that case studies were provided frequently in a monthly update on progress. Members requested to be included in the updates.	In progress	**Ongoing**
		Charlotte Black	Highlighted that as a 'Double Tick' employer the Council should promote it further.	CCC is signed up to the Disability Confident scheme which is a government standard. It aims to encourage employers to be positive about recruiting and retaining people with disabilities. This scheme replaced the Positive about Disability scheme that was often referred to as the 'Two Ticks' scheme. CCC has been accredited as a **Level 2 - Disability Confident Employer**	**Completed**
		Amanda Roach	Requested for information to be added to the Finance and Performance report in relation to progress in this area.	In progress	**Ongoing**
		Amanda Roach	Requested more information on how this would affect peoples' care package costs.	In progress	**Ongoing**

Minute No.	Report Title	Action to be taken by	Action	Comments	Status
		Amanda Roach	Highlighted the need to do more work on transitioning from voluntary to paid employment. It was noted that the authority were keen to work with the Department of Work and Pensions on this and were looking to hold workshops to explain what could happen in terms of benefits. It was noted that this would be included in the action plan.	In progress	**Ongoing**
		Amanda Roach	Requested that discussions took place across People and Communities and with Communities and Partnerships Committee and Children and Young People's Committee regarding how barriers to employment be addressed and include the outcomes of the discussions in the action plan.	In progress	**Ongoing**
129.	**Carers Strategy Refresh and Recommissioning of Carers Service**	**Lee McManus**	Requested that social needs for younger carers were added as a priority to the report.	Social needs of young carers have been incorporated into the strategy	**Completed**
		Lee McManus	Highlighted the need to link the strategy refresh into the Adults Positive Challenge Programme, emphasising the importance of carers' assessments.	The outcomes from the Adults Positive Challenge Programme will be incorporated into the specification for the new carers service	**Completed**

Agenda Item No: 4

CAMBRIDGESHIRE & PETERBOROUGH HEALTH & SOCIAL CARE SYSTEM PEER REVIEW AND CQC AREA REVIEW PREPARATIONS

To: **Adults Committee**

Meeting Date: **15 November 2018**

From: **Wendi Ogle-Welbourn, Executive Director: People and Communities**

Electoral division(s): **ALL**

Forward Plan ref: **N/A** *Key Decision:* **No**

Purpose: **The purpose of this paper is to update Adults Committee members on the delivery of the Local Government Association Health & Social Care System Peer Review, in preparation for a Care Quality Commission Area Review.**

Recommendation: **It is recommended that the Adults Committee consider the content of the report and raise any questions.**

	Officer contact:		***Member contacts:***
Name:	**Charlotte Black**	Names:	Cllr Bailey/Cllr Howell
Post:	Service Directors Adults & Safeguarding	Post:	Chair/Vice-Chair
Email:	Charlotte.black@cambridgeshire.gov.uk	Email:	annabailey@hotmail.co.uk; mark.howell@cambridgeshire.gov.uk;
Tel:	01223 727993	Tel:	01223 706398

1. BACKGROUND

1.1 Please refer to the Health & Social Care System Peer Review Briefing (Appendix 1) which includes background information to the Care Quality Commission (CQC) Local System Area Reviews, a link to CQC's Beyond Barriers Report (which details their findings from the 20 area reviews carried out), the scope and key lines of enquiry for the peer review and details on the peer review team members.

1.2 From the 20 areas reviewed, CQC found individual organisations working to meet the needs of their local populations. But they did not find that any had yet matured into joined-up, integrated systems. Health and care services can achieve better outcomes for people when they work together.

1.3 CQC looked for effective system-working and found examples of the ingredients that are needed. These included:

- A common vision and purpose, shared between leaders in a system, to work together to meet the needs of people who use services, their families and carers
- Effective and robust leadership, underpinned by clear governance arrangements and clear accountability for how organisations contribute to the overall performance of the whole system
- Strong relationships, at all levels, characterised by aligned vision and values, open communication, trust and common purpose
- Joint funding and commissioning
- The right staff with the right skills
- The right communication and information sharing channels
- A learning culture

1.4 Health and social care organisations should work together to deliver positive outcomes for people and ensure that they receive the right care, in the right place and at the right time.

1.5 In the local systems reviewed, people were not always receiving high-quality person-centred care to meet their needs, or getting their care in the right place.

1.6 In light of the findings CQC have made the following four recommendations to local and national leaders including government:

- An agreed joint plan that sets out how older people are to be supported and helped which in turn, guides joint commissioning decisions over a multi-year period
- A single framework for measuring the performance of how agencies collectively deliver improved outcomes for older people
- The development of joint workforce plans with more flexible and collaborative approaches to staff recruitment, retention and development
- New legislation to allow CQC to regulate systems and hold them to account for how they work together to support and care for older people.

2. MAIN ISSUES

2.1 The purpose of the peer review was to help prepare the 'system', for a CQC local system area review. The onsite programme took place between 24 and 27 September 2018 and involved Cambridgeshire County Council, Peterborough City Council, Cambridge University Hospital (CUH)/Addenbrookes, North West Anglian Foundation Trust, Cambridgeshire & Peterborough Foundation Trust, Cambridgeshire & Peterborough Clinical Commissioning Group, Healthwatch and number of other voluntary organisations.

2.2 The scope of the review was:

2.2.1 **Is there a shared vision and system wide strategy developed and agreed by system leaders, understood by the workforce and co-produced with people who use services?**

Key Lines of Enquiry (KLOEs):

- Is there clear leadership, vision and ambition demonstrated by the CEOs across the system
- Is there a strategic approach to commissioning across health and social care interface informed by the identified needs of local people (through the JSNA)
- How do system partners assure themselves that there is effective use of cost and quality information to identify priority areas and focus for improvement across the health and social care interface including delayed transfers of care

2.2.2 **The people's journey: how does the system practically deliver support to people to stay at home, support when in crisis and support to get them back home?**

Key Lines of Enquiry (KLOEs):

- How does the system ensure that people are moving through the health and social care system are seen in the right place, at the right time, by the right person and achieve positive outcomes (will cover how people are supported to stay well in own homes - community focus, what happens at the point of crisis and returning people home which will include a look at reablement, rehabilitation and enabling people to regain independence)
- How do systems, processes and practices in place across the health and social care interface safeguard people from avoidable harm
- Does the workforce have the right skills and capacity to deliver the best outcomes for people and support the effective transition of people between health and social care services?

2.3 The peer review team were:

- **Cathy Kerr, Lead reviewer** Local Government Association (LGA) Associate
- **Katherine Foreman Lead Reviewer** LGA Associate
- **Avril Mayhew**, Senior Adviser, LGA
- **Rose O'Keeffe**, Discharge Team Manager, Kings Hospital, London
- **Sharon Stewar**t, Assistant Director, Southampton City Council
- **Tanya Miles,** Assistant Director Adult Social Care, Shropshire

- **Lisa Christensen,** Improvement Manager, ECIST

2.4 During the onsite programme, peers visited the CUH (Addenbrookes) in Cambridge and the City Care Centre in Peterborough, during which they looked at live patient records, visited wards and observed a range of meetings. The peer team also undertook a case file audit before they arrived onsite.

2.5 The peer review team fed back two key messages:

- *'From everything we read and from everyone we met and spoke to, we think you are in a really strong position and have all the right ingredients to move forward – we saw energy and commitment at all levels, from executive leaders through to front line staff and wider stakeholders – everyone wants to do the right thing for the people of Cambridgeshire and Peterborough*
- *Outcomes for people in Cambridgeshire and Peterborough – we have heard about some excellent services and approaches to prevention, keeping people well, supporting independence and avoiding hospital admission* ***but*** *this isn't consistent and when they do go in to hospital, you have a real problem getting people out'*

2.6 Plus the following key recommendations:

- A single vision that is person focused and co-produced with people and stakeholders
- Ensure strategic partnerships include Primary Care, Voluntary Sector and Social Care providers
- Governance – Strengthen the system leadership role of Health & Wellbeing Boards and clarify supporting governance
- Establish Homefirst as a default position for the whole system
- Simplify processes and pathways – make it easier for staff to do the right thing
- Data – build on the recently developed DTOC data report

2.7 Joint Commissioning

- Understand your collective pound and agree whether your resources are in the right place ahead of winter and in the longer term
- Develop and implement a system wide commissioning strategy to deliver your vision.
- Look creatively at opportunities to shift or invest in community capacity to fully support a home first model.
- Be brave and jointly commit resources in the right place
- Homecare – work together with providers to review current arrangements/new ideas/solutions
- Don't compete with each other as commissioners – recommend a fully integrated brokerage team
- Ensure any commissioning for winter/surge periods is joined up
- A significant piece of work to be done together to put Primary Care centre stage
- Voluntary and community sector – work with the sector as strategic and operational partners to capitalize on their resource and ideas
- Build on strong relationship with Healthwatch to add more depth to co-production

2.8 Workforce

- Develop a cross system organisational development programme that reflects the whole system vision and supports staff in new ways of working
- Provide greater clinical leadership to support new processes and new ways of working across the system

2.9 The Cambridgeshire and Peterborough Health & Wellbeing Boards will be the governing boards which will monitor the 'system's' progress in action taken against the above recommendations and further preparations for a CQC Local Area Review.

2.10 A draft action plan will be presented to the Health Care Executive on 31 October for consultation. Once finalised, the action plan will be presented to the Cambridgeshire and Peterborough Health & Wellbeing Boards and Adults Committees.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

There are no significant implications for this priority.

3.2 Helping people live healthy and independent lives

The report above sets out the implications for this priority

3.3 Supporting and protecting vulnerable people

The report above sets out the implications for this priority

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

There are no significant implications within this category.

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

There are no significant implications within this category.

4.3 Statutory, Legal and Risk Implications

There are no significant implications within this category

4.4 Equality and Diversity Implications

There are no significant implications within this category

4.5 **Engagement and Communications Implications**

Following the peer review, there will be a need for further engagement and communications with key organisations across the system to monitor progress on the recommendations in preparation for a CQC Area Review.

4.6 **Localism and Local Member Involvement**

There are no significant implications within this category.

4.7 **Public Health Implications**

There are no significant implications within this category.

Source Documents	Location
Beyond Barriers https://www.cqc.org.uk/publications/themed-work/beyond-barriers-how-older-people-move-between-health-care-england **Appendix 1** HSC Peer Review Briefing	

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

HEALTH & SOCIAL CARE PEER REVIEW

DATES: 24-27 SEPTEMBER 2018

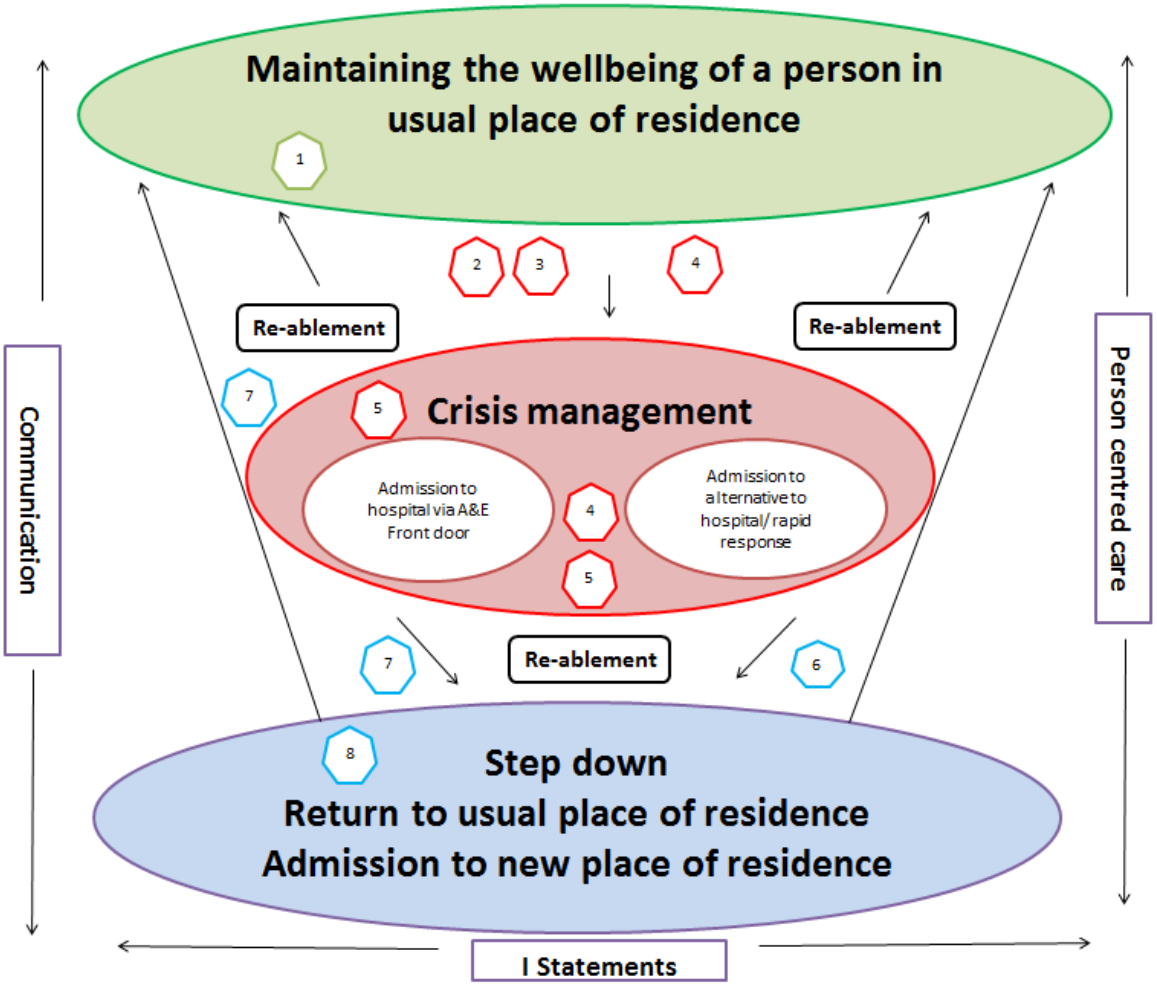
BACKGROUND

Following the budget announcement of additional funding for adult social care in 2017, the Care Quality Care Commission (CQC) was requested by the Secretary of State for Health to undertake a programme of local system area reviews.

20 area reviews were undertaken in 2017/18. The reviews were system wide and looked at the quality of the interface between health and social care and the arrangements and commitments in place to use the Better Care Fund to reduce delays in transfer of care. The scope also considered:

- How do people move through the system and what are the outcomes for people?
- What is the maturity of the local area to manage the interface between health and social care?
- How can this improve and what is the improvement offer?

Below is a diagram showing the main operational themes:



The reviews looked specifically at how people move between health and social care with a particular focus on people over 65 years old and what improvements could be made. They included services such as:

- NHS Hospitals
- NHS community services
- Ambulance services
- GP practices
- Care homes
- Residential care services

The reviews also considered pressure points such as:

- Maintenance of people's health and wellbeing in their usual place of residence
- Multiple confusing points to navigate in the system
- Varied access to GP / urgent care centres / community health services / social care
- Varied access to alternative hospital admission
- Ambulance interface
- Voluntary sector interface
- Discharge planning delays and varied access to ongoing health and social care
- Varied access to and transfer from reablement and intermediate care tier services

CQC have now published their final report: Beyond Barriers. The report identifies the following common themes:

https://www.cqc.org.uk/publications/themed-work/beyond-barriers-how-older-people-move-between-health-care-england

In the systems reviewed, CQC found individual organisations working to meet the needs of their local populations. But they did not find that any had yet matured into joined-up, integrated systems. Health and care services can achieve better outcomes for people when they work together. Joint working is not always easy.

The health and social care system is fragmented and organisations are not always encouraged or supported to collaborate.

An effective system which supports older people to move between health and care services depends on having the right culture, capability and capacity.

CQC looked for effective system-working and found examples of the ingredients that are needed. These include:

- A common vision and purpose, shared between leaders in a system, to work together to meet the needs of people who use services, their families and carers
- Effective and robust leadership, underpinned by clear governance arrangements and clear accountability for how organisations contribute to the overall performance of the whole system
- Strong relationships, at all levels, characterised by aligned vision and values, open communication, trust and common purpose
- Joint funding and commissioning
- The right staff with the right skills
- The right communication and information sharing channels
- A learning culture

Health and social care organisations should work together to deliver positive outcomes for people and ensure that they receive the right care, in the right place and at the right time.

In the local systems reviewed, people were not always receiving high-quality person-centred care to meet their needs, or getting their care in the right place.

Peer Review
Peer reviews are a constructive and supportive process with the central aim of helping areas to improve. They are not an inspection nor award any form of rating judgement or score. Reviews are delivered from the position of a 'critical friend' to promote sector led improvement.

The peer challenge process is a learning process and will help the health and social care system to assess its current achievements and to identify those areas where it could improve.

Following a scoping discussion with the Local Government Association (LGA), the following two questions and supporting key lines of enquiry have been agreed by the Health Care Executive:

1. Is there a shared vision and system wide strategy developed and agreed by system leaders, understood by the workforce and co-produced with people who use services?

KLOEs

- Is there clear leadership, vision and ambition demonstrated by the CEOs across the system
- Is there a strategic approach to commissioning across health and social care interface informed by the identified needs of local people (through the JSNA)
- How do system partners assure themselves that there is effective use of cost and quality information to identify priority areas and focus for improvement across the health and social care interface including delayed transfers of care

2. The people's journey: how does the system practically deliver support to people to stay at home, support when in crisis and support to get them back home?

KLOEs

- How does the system ensure that people are moving through the health and social care system are seen in the right place, at the right time, by the right person and achieve positive outcomes (will cover how people are supported to stay well in own homes - community focus, what happens at the point of crisis and returning people home which will include a look at reablement, rehabilitation and enabling people to regain independence)
- How do systems, processes and practices in place across the health and social care interface safeguard people from avoidable harm
- Does the workforce have the right skills and capacity to deliver the best outcomes for people and support the effective transition of people between health and social care services?

Programme
The peer review dates are 24-27 September 2018. The peer team will interview system leaders, commissioners, service leads, operational staff, service users and carers. The peers will also review written documents from strategic plans to randomly selected case files regarding service users.

PEER REVIEW TEAM

CATHY KERR -CO-TEAM LEADER

A Director with over 8 years' experience as statutory Director of Adult Social Services (DASS) and extensive work in both the NHS and local government over a career of 35+ years. I have managed significant operational services and budgets, and led major change programmes; hospital resettlement, health and social care integration, and most recently establishing a single Adult Social Services 'shared service' to serve two local authorities. I describe myself as outward looking, with a readiness to try new ways of working, and a commitment to high quality support, and delivery.

I trained many years ago as a social worker, and gained front line experience in 2 London boroughs, before moving into more senior roles outside London, initially in NHS provider services, then as senior NHS commissioner, before moving back into local government as Assistant Director with responsibility for establishing and managing integrated services. I was DASS for 2 London Boroughs until April 2017, where again the integration of health and care – and wider partnerships- was a key part of my role.

Since leaving my recent role as DASS, I have worked as a Care and Health consultant choosing assignments which allow me to use my expertise – particularly around integration – to support care and health systems. Key assignments in the last year:

- Special Advisor on the Care Quality Commission (CQC) Area Reviews. I supported CQC in developing the review methodology and acted as Special Advisor on 11 out of the 20 reviews. The reviews focus on the 'patient journey' and how services work together to support people to stay in their own homes; to 'step up' at time of crisis; and 'step down' following hospital admission. I have taken particular responsibility for 'well led' aspects of the reviews, interviewing and engaging with front line staff and senior leaders, including elected members and chief officer staff from local government, the NHS and partner organisations. Feedback, from both CQC and local systems, has confirmed that my supportive and open approach has been instrumental in ensuring positive outcomes for local systems.
- Association of Directors of Adult Social Services (ADASS). I have undertaken a number of assignments including; developing a new leadership programme with partner Newton; I ensured ADASS needs were met and the first programme was implemented to plan in Spring 2018; representing ADASS in national NHSE led programme on DTOC / BCF – supporting the continued development of joint working at a national level; providing specialist support on behalf of ADASS in recent high risk case of major care provider failure; currently leading review of ADASS policy function.

KATHERINE FOREMAN-CO-TEAM LEADER

An experienced board level clinician with an extensive knowledge of acute, community, primary care, mental health and social care. Hands on experience of undertaking CQC, Local System Reviews across England. Strong track record of focusing on improving safety, quality and ensuring robust governance of organisations. Politically aware of the challenges of supporting complex transformational change across health and social care to improve patient care.

Career history

Care Quality Commission - Specialist Advisor (Local System Reviews)

- Participated in 10/20 LSRs, in the capacity as a health adviser, in recognition of my understanding of whole system approach to integrating services.
- Working collaboratively with other Specialist Advisers including Local Authority Chief Executives and DASSs focusing on governance, leadership, capability to deliver services, looking for

innovative solutions, financial awareness, understanding local need and partnership working to deliver solutions.
- Understanding of complex whole system working and using High Impact Change Model, DTOCs, and other improvement approaches

Faculty of Medical Leaders and Managers -Executive Coach
- Led a team of coaches who delivered a national NHS England coaching programme for doctors.
- Supported CCGs and STP leaders by coaching senior staff.

Healthskills – Leadership and Organisational Development Consultancy- Lead Consultant
- Led a team of 6 consultants focused on strengthening the frailty pathways across 3 London CCG's.
- Facilitated several large and small -scale events focusing on dementia and care planning in primary care.
- Wrote a London CCG's, Primary Care Educational and Development Strategy.
- Facilitated NHS England events focusing on improving care in care homes.

Topeka Healthcare Ltd – owner of independent consultancy -Managing Director
- Facilitated strategic discussions across health and social care focused on dementia and frail older people.
- Organisational development lead for a CCG, supporting clinical leaders to make transitions to strategic roles.
- Designed and facilitated board development programme for a Foundation Trust in Lincolnshire.
- Designed and delivered leadership development, using action learning for clinicians in a Community Trust.

Medway Clinical Commissioning Group -Independent Registered Nurse – Governing Body
- Chaired Safeguarding & Quality Committee across 3 CCGs in North Kent for 2 years.
- Chaired Quality, Finance and Performance Committee since 2015 involving Local Authority.
- Participated in strategic meetings including, STP, Board to Board, and NHSE Assurance meetings.
- Member of Primary Care Commissioning Committee, Conflicts of Interest Group and Audit Committee
- Focus on robust challenge regarding governance, integrating services and improving the quality and safety of services for local people.

NHS South of England Head of Improvement
- Member of National Improvement Advisory Board. Led a regional clinical change programme and coached Directors of Nursing.
- Member of team supporting the development of the NHS Change Model and NHS Change Day, published research on 'Delivering Change the NHS' with University of Sussex.

Care Services Improvement Partnership - South East Director of Service Improvement and Relationship Management
- Designed and led executive development programmes for clinical leaders and non-clinical directors resulting in delegates having a greater understanding of innovative models of care, focusing on how to integrate services and drive improvement and transformation,
- Developed a strategic joint commissioning programme to develop organisational competencies.
- Improvement Advisor to a Cabinet Office programme. Resulting in £1.8m savings.

Colchester PCT -Director of Service Improvement

Advisory roles -**NICE**

LISA CHRISTENSON
I have worked in the public sector for 39 years in local government, the voluntary sector and in the NHS. Since 1986, I have worked exclusively in the field of health and social care delivery, management and as a leader across the health and social care sectors. Most of my work has been in areas and systems that have challenging characteristics in terms of need, capacity, performance and impact on outcomes for service users. My roles have included:

- Manager of a voluntary organization providing supported housing to adults with learning difficulties in Haringey. (HAIL).
- Director of older people's services in Bradford Community Health NHS Trust
- Director of community health services in Bradford Community Health NHS Trust;
- Executive Director in Hackney Council (with responsibility for health partnerships and social services);
- Director of Social services and Health Improvement at Lambeth Council;
- Director of Social Services at Norfolk County Council;
- Director of Children's Services at Norfolk County Council.

In all my roles, I have worked across boundaries between health, social care and the voluntary and independent sectors to try to ensure the citizen is kept at the centre of things and that services take responsibility for fitting themselves together to meet the whole needs of the individual.

When I took early retirement in July 2013, I worked in the health and social care sectors as an independent consultant doing short term pieces of work.

In July 2016 I started working as a consultant social care lead in the Emergency Care Improvement Programme (ECIP) which is part of NHSI. The focus of this team is to work with hospitals and their partners to improve the journey and outcomes for patients who need to use acute hospital services in an emergency, by improving flow and reducing delays in treatment and discharge when acute treatment is complete.

Delay creates harm for those in the hospital and increases risk for those who may need acute care but struggle to get access because the system is over-heating with pressure due to delays in various parts of the system. I have found that my skills and experience in working in challenged, complex, health and social care systems to lead improvement and create a culture of partnership and trust, has been put to good use in my work in the ECIP team.

Since 2018 I have been directly employed by NHSI as an Improvement Manager (social care) in the Emergency Care Improvement Support Team (previously known as ECIP) working largely with systems in the Midlands & East.

ROSE O'KEEFE
I am employed to manage the discharge team at Kings who work across an average of 500 beds in an acute hospital trust based in inner London. I am the lead for the Trust in relation to the weekly DTOC meetings that take place with our local social care providers and for any escalations/discussion with the respective CCG's (Lambeth/Southwark). A large part of my role is working jointly with health and social care across the interface of discharge pathways in particular representing the Trusts position in relation to Discharge to Assess initiatives. I am a nurse by background with 29 years of experience in various acute hospitals in London.

Career achievements
I previously worked as a Risk and Governance manager which I found to be hugely rewarding and insightful. It ensures that I can look and process, pathways and policy in a variety of ways. I have worked on many joint initiatives with Lambeth/Southwark health and social care (SLIC) including a project on a designated elderly care ward which resulted in improving the quality of the discharge experience whilst reducing length of stay. I am proud of the twice yearly discharge market place events where I lead on ensuring internal teams and external partners are brought together to update the hospital staff about discharge pathways, referrals, and process to meet the individuals who make this happen for our patients. I have a swathe of nursing experience which I utilise in most aspects of the role and service that I deliver for the Trust. Discharge to Assess has been particularly successful with 95% of CHC assessments taking place outside of the hospital setting and has also delivered a length of stay reduction on average of 10 days. I have made a big contribution to making this work at the Denmark Hill site. I have been the joint lead in the development of an educational framework (levels 1, 2 & 3) for the ward multidisciplinary teams, to deliver discharge planning pathways training and including clarity on roles and responsibilities. We are about to commence Trusted Assessor with some of our local care homes and this will be an exciting initiative which will further demonstrate how integration works for patients.

Experience
I have experience of working jointly with health and social care to reduce the blockages to patient discharge- for example ensuring there is a 'choice' policy in relation to care home placements. I am the lead for this policy (having been part of the working group to produce it) in the hospital setting and ensure coordination with the local authority or CCG to work together to deliver a safe discharge destination. I have participated in audit exercises in relation to discharge, the quality being delivered and identifying some of the blockages to discharge pathways. Highlighting to LAs CCGs from the audit work the possible service changes required. I regularly attend site huddles and ward morning board reviews to ensure patient flow in the wider and assist with unblocking discharge pathways- using my external network to help assist and facilitate more timely discharges. I have experience of working closely with the Homeless team, Overseas visitor team and No Recourse teams to help expedite patient discharges that are particularly complex and often difficult to navigate. I remain curious and interested in the current role I deliver and would look forward to the opportunity to participate in peer review as I feel I have a lot of operational experience to draw on and as well would learn a great deal that I could bring back to my organisation.

TANYA MILES
I am a qualified Social Worker registered with the Health and Social Care Council and a qualified Nurse. I have worked in ASC for over 20 years, including 11 years as a practising Social worker. I have undertaken leadership roles for the past 12 years which have included Team leader for an Integrated Health and Social Care Learning Disability team, Service Manager for Community Operational teams and now Head of Adult Social Care for the last 2 years. I am acutely aware of the pressures in Health and Social care and understand the importance of working collaboratively to achieve the best outcomes for individuals.

I have a proven track record of leading Shropshire Adult Social Care through radical and unprecedented transformation in the delivery of ASC. We created a new vision and strategy which resulted in the 'Shropshire Operating Model' and we have been cited as leaders in the transformation of ASC. It was a bold and radical strategy based on experience and a strong commitment to do something different in response to the unprecedented demands on ASC and reducing budgets. We are now 4 years on and achieving better outcomes for Shropshire residents, improved performance results and have made Shropshire one of the top ASC services nationally.

Shropshire Council has recently been identified as one of the most improved Local Authorities for DTOC targets and we have been invited to a roundtable discussion with the Secretary of State for Health and Social Care to discuss how we have achieved over 91% reduction in delayed transfers of care from April 2017 to March 018 by using a similar approach as with the operating model (collaboration, creativity, innovation, trying things out). The central reason that has created the difference and necessary change is strong, effective leadership. Communication, empowerment, direction and are the central themes that have enabled an approach which has become embedded throughout Adult Social Care (ASC). I have also led on a radical approach to IBCF, providing innovative solutions and collaborative approach. Ideas from the teams resulted in exciting, untried initiatives such as 2 Carers in a Care and generated enthusiasm in staff, encouraging team identity and working towards a common purpose and goal to enable dramatic improvements in DTOC. As Head of ASC, I am very proud of our achievements and welcome the opportunity to share my knowledge and experience

AVRIL MAYHEW
Avril Mayhew is a Senior Adviser within the Care and Health Improvement Programme and has the lead for DTOC improvement. She is currently works with national partners to coordinate and deliver a programme of support to councils and system partners that helps improve patient flow and reduce delayed transfers of care. As part of her role she has delivered on site support to approximately 25 systems in the last 18 months.

Her previous role was as Head of Service at Royal Borough of Kingston upon Thames where she reported to the Executive Head of Adult Social Care and was responsible for the development and delivery of a wide portfolio of services for Older and Disabled Adults.

This included:

- Head of Learning Disability services with operational responsibility for Community Learning Disability social work team; brokerage service; user involvement facilitators; service development; and lead responsibility for learning disability commissioning and quality assurance. She had budgetary responsibility of £17 million. Avril also significantly developed her project management and service resdesign skills with a leading role in the transfer of Learning Disability provider services to a Social Enterprise.

- Older People's services: head of service for short and medium term support, assessment, urgent duty work and all new referrals to the Service, hospital discharge, safeguarding enquiries and investigations, homecare and reablement services, occupational therapy and equipment provision, mobile meals and telecare equipment.
- Other key achievements include the successful set up and operations of new teams and services in 2011, following major service redesign in the Council. This involved a review of internal management and governance structures and processes to create more effective service delivery, and the successful delivery of key national and local indicators including promotion of self-directed support and increase in personal budgets, reablement support and reductions in delayed transfers of care from hospital.

Current Position(s) Start Date – June 2015
Senior Adviser, Adult Social Care - Local Government Association (LGA)

Previous Position(s)
Service Manager - Adult Learning Disability Services - Royal Borough of Kingston upon Thames Feb-11 to Jun-15

Project Manager - Transforming Adult Social Care - Royal Borough of Kingston upon Thames Nov-08 to Feb-11
Principal Officer - assessment and care management - Royal Borough of Kingston upon Thames Jan-08 to Nov-08
Senior Practitioner (Adult Social Care) - Royal Borough of Kingston upon Thames Nov-06 to Jan-08
Team Manager - Older People's team - London Borough of Camden Jan-01 to Nov-06

Peer Challenge Experience: Project Dates
London Borough of Sutton – Peer Review Commissioning September 2014
London Borough of Hillingdon – Transition/Preparing for Adulthood March 2015
Manchester City Council – whole system review ASC April 2015
Rotherham MBC - Bespoke Adult Commissioning Feb 2017
Northumberland Council- Rapid Adults Peer Review 1 Sept 2016
Sheffield City-Adult Social Care CBO Peer Challenge-28 June-01 July
Berkshire West – DTOC peer review January 2018
Hospital to Home programme – Executive Peer visits June to September 2017
CQC Local Area Review – Hampshire, Specialist Advisor

LIZ GREER- REVIEW MANAGER
Liz is an Adviser, Adult Social Care with the LGA, and leads on the management and mitigation of risk in ASC and supports Avril on improving patient flow and reducing delayed discharge. Liz recently completed an evaluation of all national partners' DTOC support offers.

Liz has worked in human services in the public/not for profit sector at local, national & regional level for more than thirty years. Liz has substantial Programme and Project Management experience requiring coordination and management of multiple, simultaneous activities and projects in various locations on time, to plan and within budget. Liz is an experienced trainer, facilitator and action researcher, with membership of the Chartered Institute of Personnel and Development and professional qualifications in teaching, training, performance coaching and psychology with research methods.

Prior to joining the LGA, Liz was Care Act Programme Manager for North East ADASS, and has recent employment experience with the CQC, Healthwatch, Voluntary Organisations Network North East and Health Education England for the Northern Deanery. Liz has excellent verbal and written communication skills with a track record of designing and delivering original evaluations, reports, practice guidance and policy briefings as well as articles for publication and conference presentations on key social care and policy issues

Agenda Item No:5

JOINT WORKING WITH HEALTH - PRIORITIES

To:	**Adults Committee**
Meeting Date:	**15th November 2018**
From:	**Will Patten, Director of Commissioning**
Electoral division(s):	***all***
Forward Plan ref:	**N/A** *Key decision:* **No**
Purpose:	**The report provides an overview and approach to joint working with health and the current priorities.**
Recommendation:	**To note and comment on the report.**

	Officer contact:		***Member contacts:***
Name:	**Caroline Townsend**	Names:	Councillor Anna Bailey
Post:	Head of Commissioning Partnerships and Programmes	Post:	Chair
Email:	Caroline.townsend@peterborough.gov.uk	Email:	Anna.bailey@cambridgeshire.gov.uk
Tel:	07976 832188	Tel:	01223 706398

1. BACKGROUND

1.1 This paper provides a deep dive on joint working with health and the current priorities.

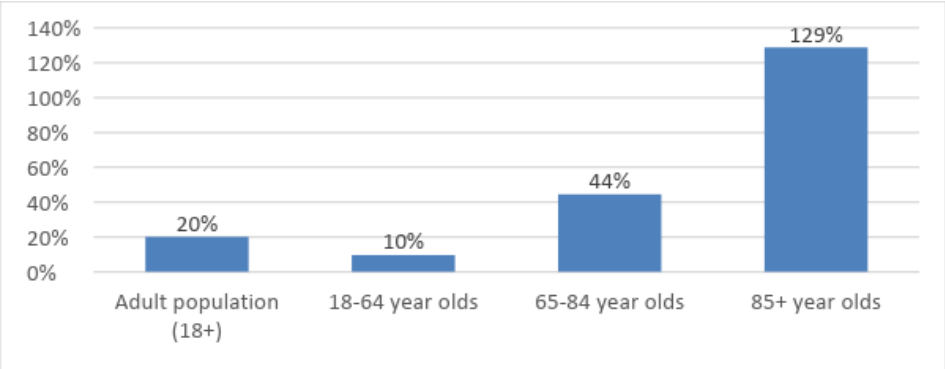
2. MAIN ISSUES

2.1 System Challenges

2.1.1 Population Growth

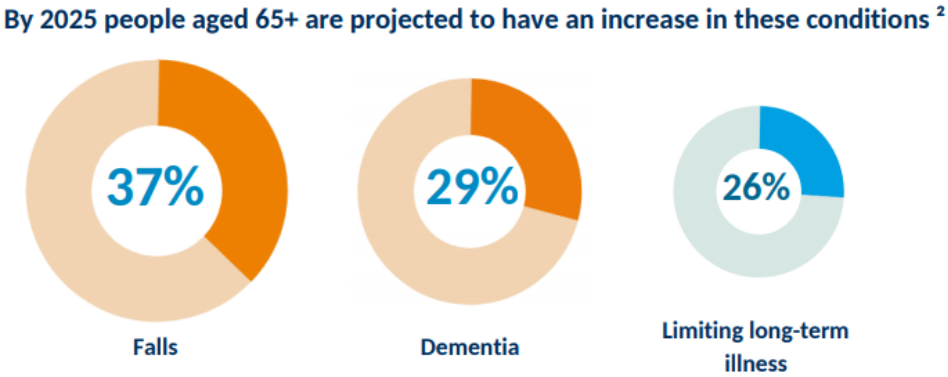
Cambridgeshire's population is growing significantly, with an increasing older population. Cambridgeshire and Peterborough's population of people aged 18+ is estimated at 690,000. Local forecasts suggest this will increase to approximately 827,000 by 2036, equating to a 20% increase. Forecasts suggest significant and disproportionate growth is expected, with those aged 65-84 expected to increase by around 44% and those aged 85+ expected to grow by nearly 130% by 2036, as can be seen in the chart below.

Cambridgeshire and Peterborough projected population growth 2018-2036



(Source: Cambridgeshire Business Intelligence Team)

The majority of adult social care service users within older people's services are aged 85+, so the expected population growth is likely to lead to a significant increase in demand. And by 2025, it is forecast that there will be a significant increase in the following conditions.



2.1.2 Financial Pressures

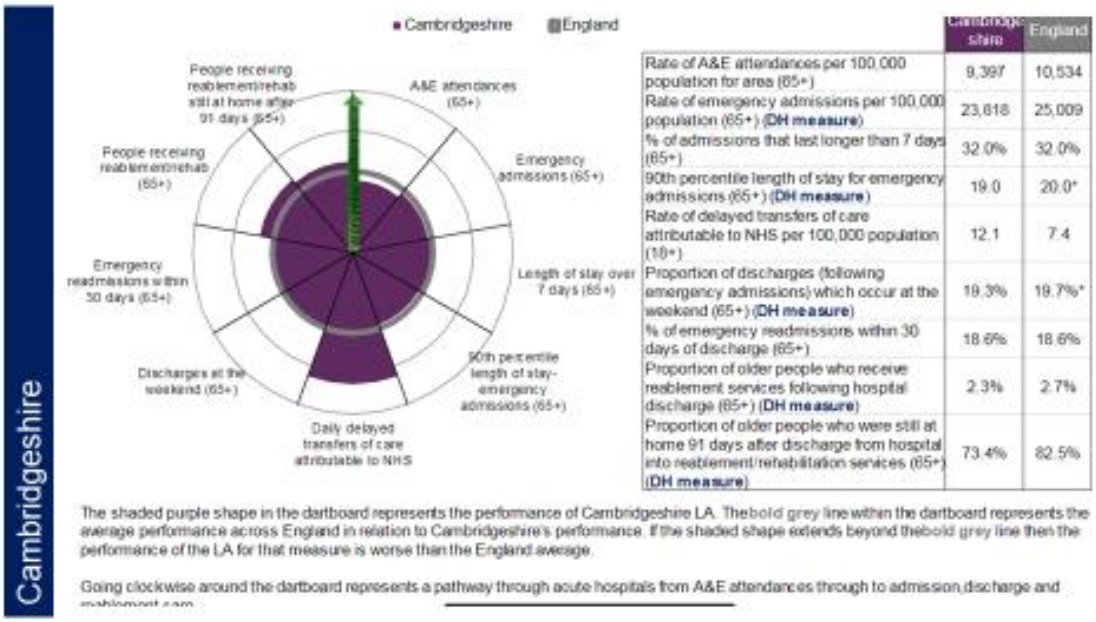
Underfunded system which means we have to address increasing demand with decreasi budgets. Cambridgeshire and Peterborough is one of the most financially challenged hea economies nationally. Cambridgeshire County Council is facing a £12 million budget gap 2019/20, and a further £16 million gap for 2020/21.

In addition, we are seeing financial pressures as a result of increasing costs of care, whic symptom of a market where demand outstrips supply and where providers face cost pres that they seek to pass onto the Council. The supply of market capacity is a result of a nur of factors linked to attracting and retaining staff, the complex nature of care requiring dou packages and the rurality of parts of Cambridgeshire. Although the Council is working ha mitigate pressures, additional provider pressures have resulted from legislative changes as automatic enrolment into pension schemes, national living wage increases and inflatio

To ensure we have financial sustainability for the future, we are working jointly with healt develop community capacity and capability to meet the needs of local communities in the cost effective way, supporting people to maintain their independence and wellbeing. In tu preventing the unnecessary escalation of needs and the provision of more expensive ser (e.g. domiciliary care, residential and nursing care, acute hospital intervention).

2.1.3 System Performance

The below diagram shows how Cambridgeshire is performing comparatively across a key range of health and social indicators.



	Cambridgeshire	England
Rate of A&E attendances per 100,000 population for area (65+)	9,397	10,534
Rate of emergency admissions per 100,000 population (65+) (**DH measure**)	23,618	25,009
% of admissions that last longer than 7 days (65+)	32.0%	32.0%
90th percentile length of stay for emergency admissions (65+) (**DH measure**)	19.0	20.0*
Rate of delayed transfers of care attributable to NHS per 100,000 population (18+)	12.1	7.4
Proportion of discharges (following emergency admissions) which occur at the weekend (65+) (**DH measure**)	19.3%	19.7%*
% of emergency readmissions within 30 days of discharge (65+)	18.6%	18.6%
Proportion of older people who receive reablement services following hospital discharge (65+) (**DH measure**)	2.3%	2.7%
Proportion of older people who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (65+) (**DH measure**)	73.4%	82.5%

The shaded purple shape in the dartboard represents the performance of Cambridgeshire LA. The bold grey line within the dartboard represents the average performance across England in relation to Cambridgeshire's performance. If the shaded shape extends beyond the bold grey line then the performance of the LA for that measure is worse than the England average.

Going clockwise around the dartboard represents a pathway through acute hospitals from A&E attendances through to admission,discharge and

Key features highlighted from this data profile are:

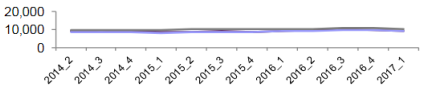
- Cambridgeshire has high rates of delayed transfers of care from hospital
- Cambridgeshire has high levels of GP referrals to A&E (see below graph);
- Attendance at A&E and avoidable admissions to hospital from care homes are lower than the national rate for Cambridgeshire (see below graph), as are avoidable admission rates.

Cambridgeshire Comparator England Significantly worse Significantly better

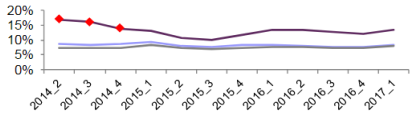
Activity – A&E Attendance aged 65+

CareQuality Commission

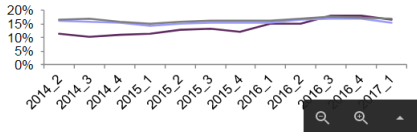
Rate of A&E attendances per 100,000 population aged 65+



Percentage of A&E attendance that were referred by GP aged 65+



Percentage of A&E attendances referred by GP that are discharged without follow-up aged 65+



16 / 52

This slide provides data to highlight if there are high rates of A&E attendance for people aged 65+ that may be putting pressure on the system or potentially indicating problems with primary or community care.

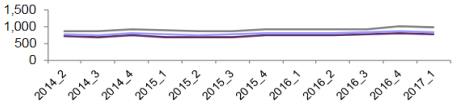
It also identifies whether there are high volumes of people aged 65+ attending A&E as a result of a referral from their GP and whether or not these people were subsequently discharged without follow-up (i.e. not admitted to hospital). The measures are intended to identify potential issues in primary care, including inappropriate referrals from GPs to A&E.

Area	Time period – calendar quarter			
	2016_2	2016_3	2016_4	2017_1
Cambridgeshire LA	9,638	10,320	9,825	9,397
Comparator average	9,375	9,889	9,713	9,192
England average	10,613	11,017	10,969	10,534
Cambridgeshire LA	13%	13%	12%	14%
Comparator average	8%	8%	8%	8%
England average	8%	7%	7%	8%
Cambridgeshire LA	15%	18%	18%	17%
Comparator average	16%	17%	17%	16%
England average	17%	18%	17%	17%

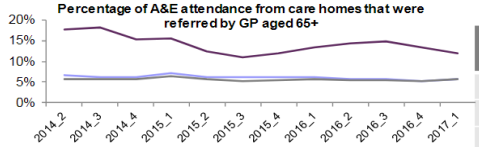
Activity – A&E Attendance from care homes

CareQuality Commission

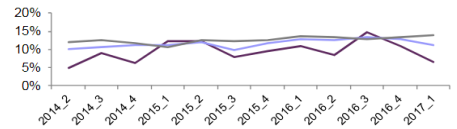
Rate of A&E attendances from care homes per 100,000 population aged 65+



Percentage of A&E attendance from care homes that were referred by GP aged 65+



Percentage of A&E attendances from care homes referred by GP that are discharged without follow-up

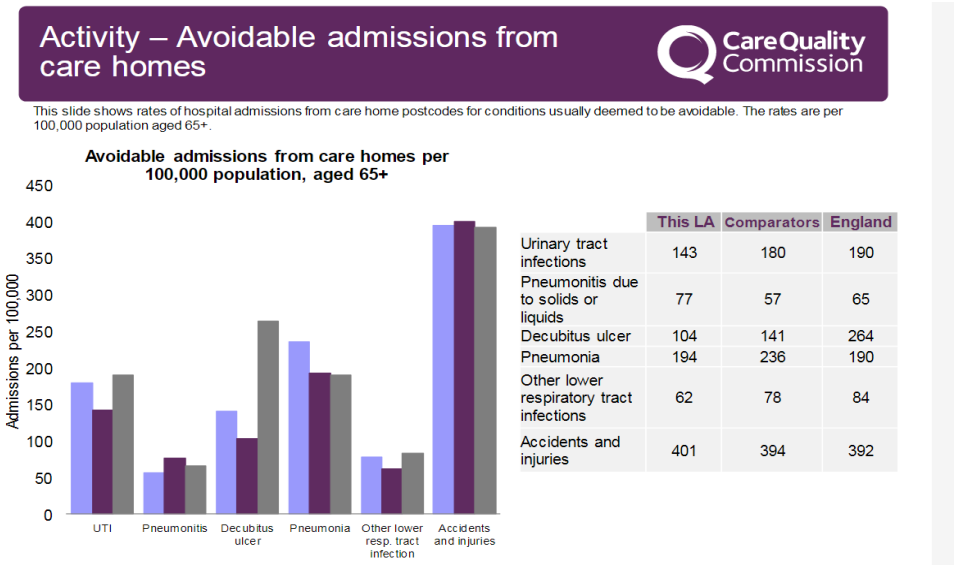


This slide provides data to highlight if there are high rates of A&E attendance from people aged 65+ coming from care homes that may be putting pressure on the system or indicate problems with primary care or community care

It also identifies whether there are high volumes of people aged 65+ living in care homes that are attending A&E as a result of a referral from their GP and whether or not these people were subsequently discharged without follow-up (i.e. not admitted to hospital). The measures are intended to identify potential issues in primary care, including inappropriate referrals from GPs to A&E.

Area	Time period – calendar quarter			
	2016_2	2016_3	2016_4	2017_1
Cambridgeshire LA	759	767	808	769
Comparator average	819	830	882	853
England average	918	922	1,006	979
Cambridgeshire LA	14%	15%	13%	12%
Comparator average	6%	6%	5%	6%
England average	6%	6%	5%	6%
Cambridgeshire LA	8%	15%	11%	6%
Comparator average	13%	13%	13%	11%
England average	13%	13%	13%	14%

Analysis based on attendances from postcodes containing a registered care home. Data could pertain to other addresses within the postcode. Due to low numbers the percentage of A&E attendances from care homes referred by GP that are discharged without follow-up has not been z-scored.

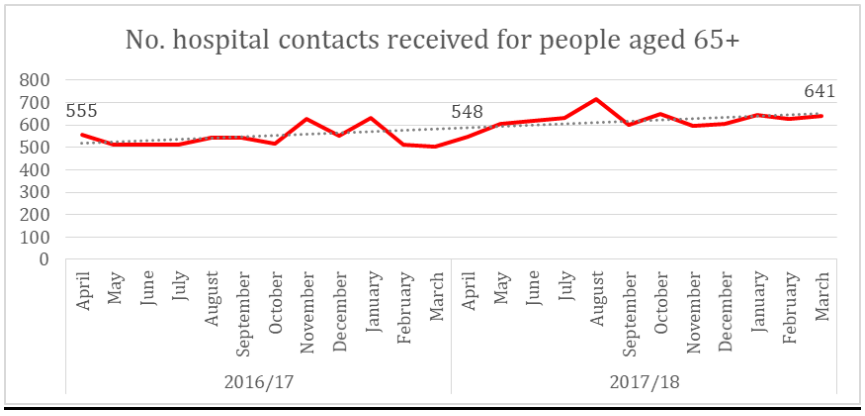


In addition, hospital admissions of over 80 year olds in 2017/18 has increased significantly since 2016/17 (see below table). This in turn has had a significant impact on social care and community services post discharge, as well as on the overall DTOC performance figures.

Admissions of over 80 year olds from April 2017 to August 2017 compared to the same period in the previous year

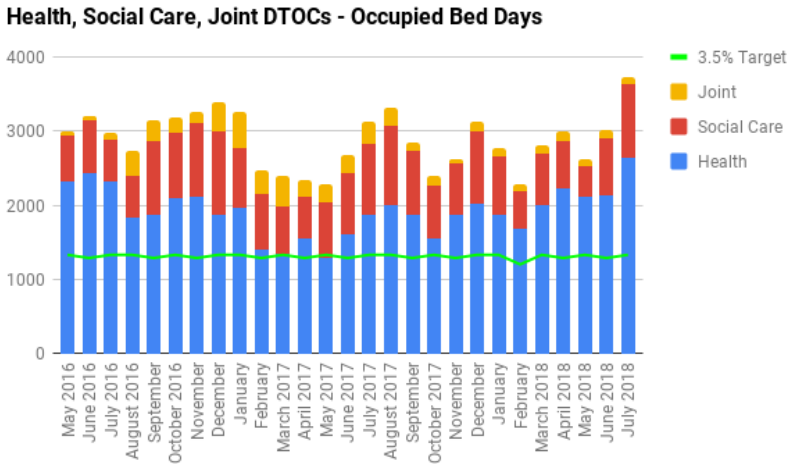
Hospital	Increase 2017/2018	% Change
Addenbrookes (CUHFT)	245	+7.9%
Hinchingbrooke	34	+2.2%
Peterborough City Hospital	-79	-3.4%
Queen Elizabeth Hospital (Kings Lynne)	119	+24%
TOTAL	335	+4.4%

More older people than ever are being discharged from hospital and referred into Adult Social Care Services (see below graph), which has led to increased demand and a pressure to find care places much quicker than in the past. This is combined with a greater complexity of care needs of these people. As hospitals respond to their pressures the average length of time older people are in hospital has reduced from 8.1 days in April to 5.6 days in October – older people are leaving hospital in higher numbers, more quickly and in a more fragile state.

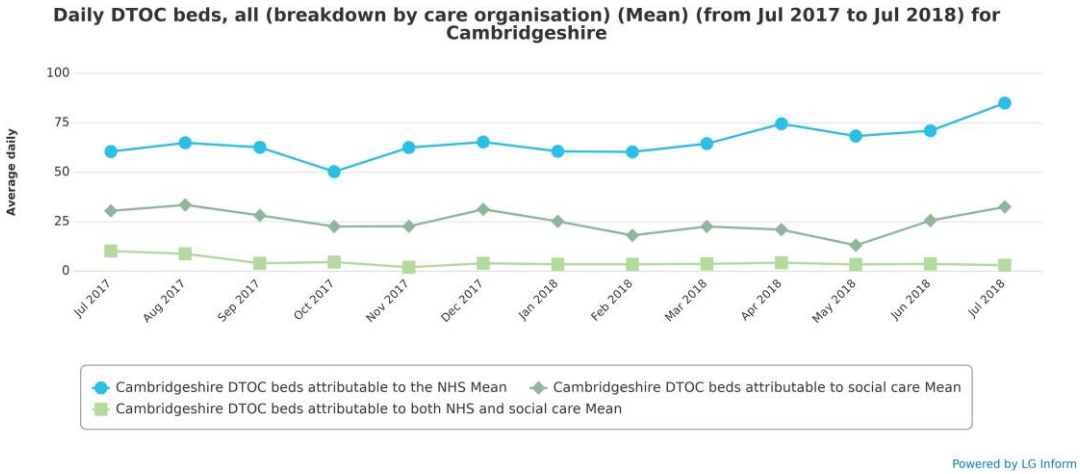


2.1.4 Delayed Transfers of Care (DTOCs)

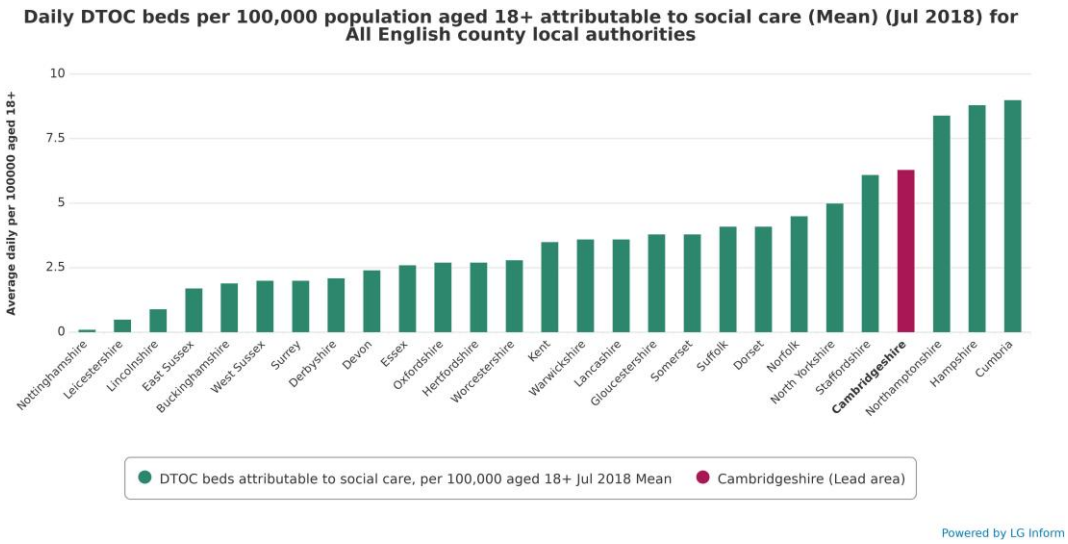
Despite continued effort, DTOCs continue to be a real pressure for the Cambridgeshire system. Based on the latest NHS England published DTOC statistics, the below graph shows month on month DTOC performance across Cambridgeshire against the 3.5% target, highlighting that performance is significantly underperforming against target.



During July, 81% of delayed days were within acute settings. 70.6% of all delayed days were attributable to the NHS, 26.9% were attributable to Social Care and the remaining 2.5% were attributable to both NHS and Social Care. The below graph shows the trend of DTOCs, by attributable organisation.



For July 2018 Cambridgeshire, compared to all single tier and county councils in England, is ranked 149 on the overall rate of delayed days per 100,000 population aged 18+, with a rank of 151 given to the area with the highest rate. It is ranked 148 on the rate of delayed days attributable to the NHS, and 136 on the rate of delayed days attributable to social care. The below graph shows how Cambridgeshire compares with other county local authorities.



2.2 Drivers and Strategic Priorities for Change

The Cambridgeshire and Peterborough Sustainability and Transformation Partnership (STP) key priorities, also illustrated below, mirror our system's principles around prevention, healthy lifestyles, early intervention, promoting independence, system sustainability and integration.

Priorities for change	10-point plan
At home is best	1. People powered health and wellbeing 2. Neighbourhood care hubs
Safe and effective hospital care, when needed	3. Responsive urgent and expert emergency care 4. Systematic and standardised care 5. Continued world-famous research and services
We're only sustainable together	6. Partnership working
Supported delivery	7. A culture of learning as a system 8. Workforce: growing our own 9. Using our land and buildings better 10. Using technology to modernise health

Peterborough and Cambridgeshire STP priorities for change

Our shared system vision for integration was articulated in the 2017-2019 Better Care Fund (BCF), as outlined below:

Our vision across Cambridgeshire & Peterborough

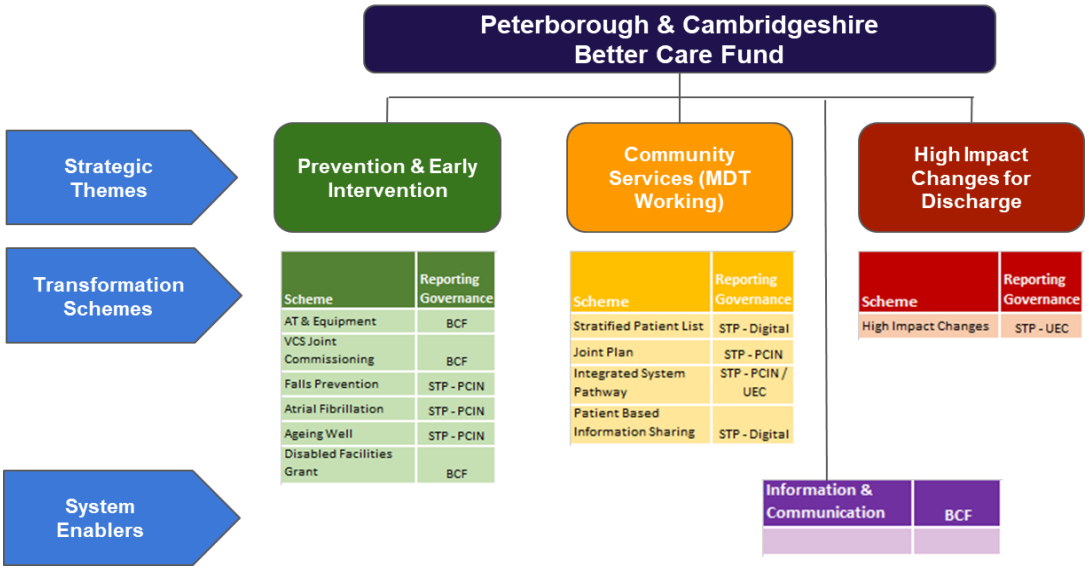
"Over the next five years in Cambridgeshire and Peterborough, we want to move to a system in which health and social care help people to help themselves, and the majority of people's needs are met through family and community support where appropriate. This support will focus on returning people to independence as far as possible with more intensive and longer-term support available to those that need it.

This vision is underpinned by seven core principles to make sure we make a long-term difference to health and wellbeing throughout the county and that we help those who need it most. We aim to:

1. Reduce inequalities by improving the health of the worst off fastest;
2. Focus on preventing ill health by promoting healthy lifestyles while respecting people's choices and for those who have an illness, preventing their condition from worsening;
3. Make decisions which are based on the best possible evidence;
4. Develop solutions which are cost-effective and efficient;
5. Recognise that different groups and communities have different needs;
6. Encourage communities to take responsibility for making healthy choices; and
7. Make sure services are sustainable.

Improved integration and joint working between health and social care has been a long-term strategic priority in Cambridgeshire. The Better Care Fund (BCF) 2017–2019 sets out four strategic themes as illustrated below.

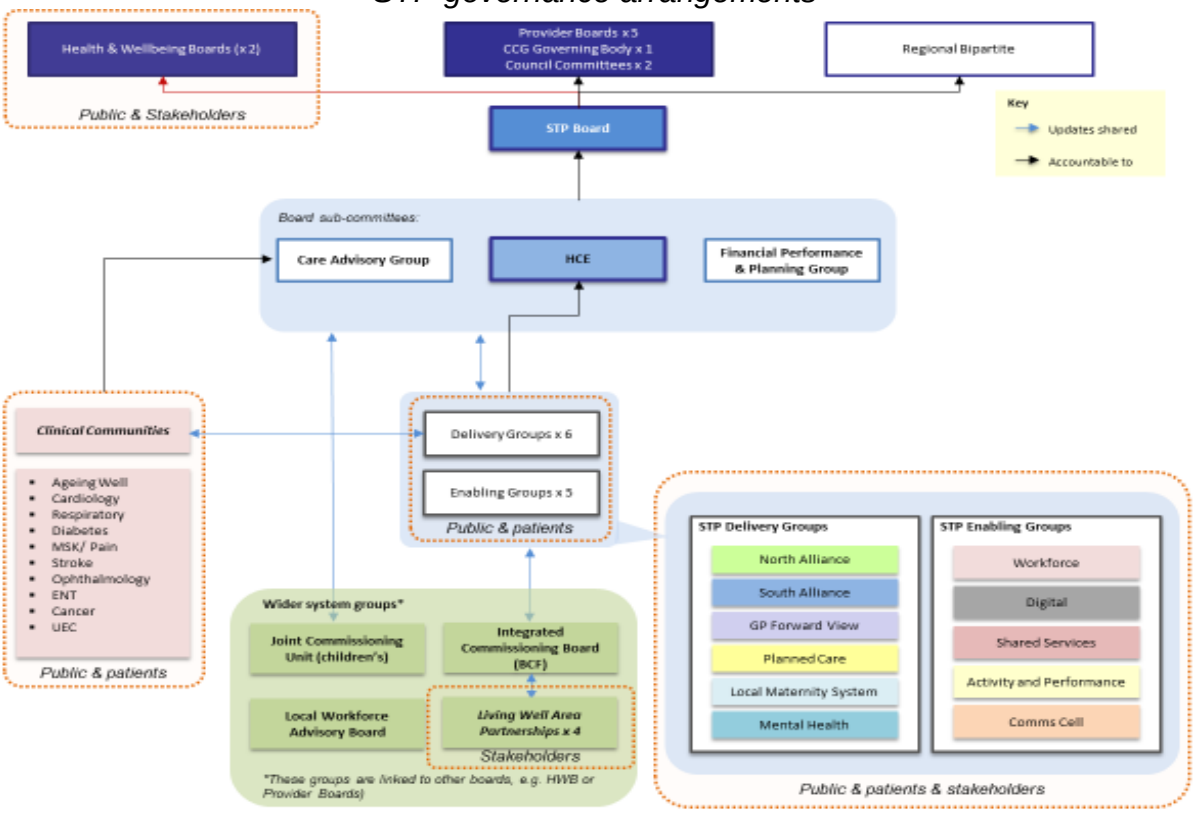
Peterborough and Cambridgeshire BCF strategic themes



2.3 Governance

Our shared strategic ambitions are delivered through longstanding and mature partnership arrangements. The Sustainability and Transformation Partnership (STP) has established a multi-agency multi-level governance structure to deliver our system priorities. The STP (please see governance diagram below) Board contains NHS partner Chairs and CEOs as well as elected members and directors of Cambridgeshire County Council and Peterborough City Council. STP governance also has the necessary structures and groups to ensure that senior executive leaders, operational directors, finance leaders, local clinicians and other stakeholders are driving forward the delivery of priorities.

STP governance arrangements



2.3.1 **Health and Well-being Boards (HWB):** Provide the formal strategic leadership for health and social care services through two Boards – one for Cambridgeshire and for Peterborough. HWBs routinely meet jointly and include County Council/Unitary Authority (elected and Lead Officers), District Council representation, NHS provider representation, the CCG, the Police and Crime Commissioner, Healthwatch, with the voluntary sector co-opted.

2.3.2 The **Health Scrutiny Committees** review key areas of priority, for example, Delayed Transfers of Care. In addition, Scrutiny can effectively drill down via its 'topic' process into key issues where Members require greater levels of assurance. Most recently, Scrutiny examined issues such as workforce, patient transport and pressures on primary care services. Cambridgeshire and Peterborough Councils have an Adults Committee and a Communities and Adults Committee respectively that provide oversight of adult social care and a lead Portfolio holder for adults.

2.3.3 **Living Well Area Partnerships:** Four geographical Partnerships have recently been developed to provide operational leadership of a "whole system" partnership approach to the local delivery and implementation of "living well" health and wellbeing improvements, care model designs, service improvements and savings opportunities identified at a local and system level in the Health & Wellbeing Strategies, Public Health Priorities, Sustainability & Transformation Plan, and Better Care Fund. The Partnerships represent

a wider community of stakeholders including patient representatives, Healthwatch, Local GP representatives, Primary Care Management Leads, NHS Trusts, District Councils, Public Health, the community & voluntary sector.

2.3.4 **Cambridgeshire and Peterborough Safeguarding Adults Board**: The Safeguarding Adults Board is made up of strategic leaders from a wide range of partner agencies whose activity is key in safeguarding adults. They have the responsibility for developing and authorising the strategic framework for safeguarding, including the policies and strategies needed to meet the core functions of the Board and the priorities in the Business Plan. The Board report to a Safeguarding Executive Group, made up of the three statutory partners (Local Authority, Police and CCG representing Health) at the highest Executive level. It holds the responsibility for ensuring there is an effective arrangement in place to safeguard children, young people and the adults who come under Section 42 of the Care Act. In doing so they are joined by senior leaders from Healthwatch and Public Health. They approve the Business Plan and ultimate accountability lies with them.

2.3.5 **North and South Alliances:** Two, recently developed, Alliance Delivery Groups ensure providers of services for health and social care work together in partnership to better plan and deliver a wider range of services across a geographical area that are more proactive, person-centred and holistic, sometimes pooling resources and budgets. By working together at a neighbourhood level, and around our acute hospital footprints, these Alliances aim to improve population health outcomes, manage demand for services, reduce the unacceptable delays and barriers to people's care and, in particular, reduce the number of days people spend in a hospital bed as an emergency.

2.3.6 **A&E Delivery Boards:** These two Boards compliment the above Alliances and address operational performance issues and ensure urgent care needs are dealt with in the most appropriate setting by the most appropriate services (which in many cases should not be in A&E departments or acute hospital beds). They deliver nationally mandated improvement initiatives and core responsibilities to lead to A&E recovery, as well as oversee improvement projects that require locality tailoring for successful implementation. Our A&E Delivery Boards also provide a vehicle for strong and visible front-line clinical leadership and resident/patient involvement, as well as promote a culture of continuous quality improvement.

2.3.7 **Integrated Commissioning Board:** The Board's primary focus is to provide oversight and governance of the Better Care Fund for Cambridgeshire and Peterborough.

2.4 Current Priorities for Joint Working with Health

There are a number of current key priorities for joint working with health, including:

- System working to address DTOCs
  - Improved Better Care Fund (iBCF) investment to support DTOCs
  - Joint Discharge Programme
  - Market management of capacity for home care, residential and nursing care
- Admission Avoidance initiatives
  - Neighbourhood Place Based Care
  - Supporting care homes to reduce avoidable hospital admissions
  - Joint Commissioning to support prevention and early intervention

2.4.1 *System Working to Address DTOCs*

NHS partners and both councils have worked in close partnership, at a strategic level through the Sustainability and Transformation Partnership (STP) and through our Joint Better Care Fund Plans, resulting in significant investment to reduce current challenges. A range of operational forums have been established to co-ordinate our system wide activities to enable timely hospital discharge. That said it needs to be recognised that there are a number of major challenges, including a growing older population, greater acuity of need, workforce recruitment and retention and significant funding issues across the health and care system.

2.4.2 <u>iBCF Investment to Support DTOC Pressures</u>

There was significant investment from the Improved Better Care Fund (iBCF) to support a range of initiatives to reduce DTOCs, as depicted below.

Key updates on these initiatives are outlined below:

- **Reablement Capacity:** Investment from the iBCF was made to increase reablement capacity by 20% and recruitment has established the teams at nearly full capacity.
- **Reablement Flats:** Additional capacity was commissioned across Eden Place, Ditchburn, Doddington Court and Clayburn Court to provide support to patients requiring a further period of recovery before returning home following hospital discharge.
- **Community Equipment:** additional investment to support the provision of equipment to enable people to manage as independently as possible in the home of their choice.
- **Dedicated Social Worker at Addenbrookes Hospital to support self-funders:** recruitment of a dedicated worker to support individuals who self-fund their care through the hospital discharge process.
- **Locality Review Backlog:** social worker capacity was recruited to address the backlog of reviews within the Cambridgeshire locality teams in order to avoid admission to hospital and ensure individuals are receiving the right level of care to meet their outcomes within the community.
- **Strategic Discharge Lead:** a coordinating social worker discharge lead has been established in Addenbrookes and Hinchingbrooke hospital. This has supported greater oversight of the system, including working with partner organisations to ensure the correct agencies are involved in discharge planning.
- **Trusted Assessor:** the service was commissioned from Lincolnshire Care Association (LINCA) and provides trusted assessments on behalf of care homes, to reduce unnecessary discharge delays in Addenbrookes.

A system-wide evaluation of iBCF funded DTOC initiatives is currently being undertaken to inform the future approach.

Joint Discharge Programme

2.4.2 A joint priority programme of work has been agreed with health and social care partners to support delivery of the 3.5% target. This comprises seven key enabling work streams of activity; Integrated discharge service (IDS), referral process for complex discharge support, robust operational management, discharge to assess, demand and capacity modelling, performance and reporting and effective partnership working. The key initiatives are set out below:

- An Integrated Discharge Service (IDS) has now been established in each acute site. The IDS is a team of health and social care discharge planning experts working together to support hospital wards with discharge planning for people with complex needs, and /or who need community support after discharge. In addition, a community hub has been established to manage capacity, demand and flow through key community pathways.
- Development of new Assessment and Discharge Notification forms that contain only information needed for the IDS to triage people effectively to the appropriate discharge pathway.

- Review and development of effective discharge to assess pathway to support hospital discharge and ensure people are getting the right care in the right setting:
    - Greater alignment of services offered under pathway 1 (services supporting people at home through an interim period of recovery);
    - Strengthening the commissioning arrangements for the community bed-based capacity required to support pathway 2 using evidence of need / demand for services;
    - Reviewing and simplifying the process for pathway 3 to ensure people with *not suitable for interim reabling care* are sent through the appropriate discharge pathway right out of hospital to plan their long-term care (including assessments for Continuing Health Care eligibility where appropriate);
- Understanding the growing needs for system- wide coordination of demand and capacity whilst fostering greater partnership working with independent sector providers; and
- Standardising data collection and reporting through joint health and social care governance structures in the system.

Market Management of Capacity

2.4.3 The Council is working intensively with the independent care home market to increase supply to home care provision. Homecare was recommissioned in Cambridgeshire, jointly with the CCG, by a Dynamic Purchasing Arrangement and came into effect in November 2017. The DPS framework re-opens every 3 months for new providers to apply. Since the launch of the new framework, home care providers have increased from 28 to 74. The Council engages with non-active providers on an ongoing basis to ensure available capacity is being maximised. In addition, a review of market capacity data and intelligence is being undertaken to address the geographical disparity of homecare provision across the county. Subsequent engagement with providers will inform the development of a strategy to increase capacity in areas of low supply in a sustainable way.

An integrated brokerage function is being developed across health and social care, providing a single point of managed access to the market across Cambridgeshire and Peterborough for Adults, including older people and physical disabilities. This will enable a managed response to demand, removing competitive agency behaviours, ensuring better control of market fees and maximising opportunities for optimising provider capacity through a dedicated route to market.

Admissions Avoidance Initiatives

A number of admission avoidance interventions have been implemented, including joint iBCF/STP investment in falls prevention and stroke prevention projects. Both Councils have established Adult Early Help services and continue to work with primary care and CPFT's neighbourhood Teams to identify people whose needs may be escalating or may be vulnerable to hospital admission.

Neighbourhood Place Based Care

CCC is currently piloting two pilot 'Neighbourhood Care Teams' in Soham and St Ives, where new ways of working with system partners are being developed to prevent needs escalating and enable timely discharge. The pilots are based on the principles of the Buurtzorg model of care and aims to test a community model that supports customised care. The new model will be driven by a neighbourhood, 'place based' approach, and success will mean that citizens have greater independence and better outcomes with reduced state intervention by:

- addressing needs early to prevent them from escalating - working in partnership with communities and health partners, to share information, act as one care workforce & be proactive;
- empowering individuals to do more for themselves - providing them with the resources, tools and local support network to make it a reality; and
- building self-sufficient and resilient communities - devolving more preventative care & support resources at a neighbourhood level and enabling individuals to spend their long term care budget within their community.

An external evaluator, York Consulting Ltd, has been appointed to provide ongoing evaluation of the pilot and the findings will support system partners in defining and developing an agreed model of neighbourhood delivery.

Supporting Care Homes to Reduce Avoidable Admissions
The need to improve the quality of life, healthcare and planning for people living in care homes is essential as we move from reactive models of care delivery towards proactive care that is centred on the needs of residents, their families and staff working in care homes. It is recognised that many people living in care homes do not have their needs appropriately assessed and acted on in a holistic manner. This frequently leads to people experiencing unnecessary, unplanned and avoidable admissions to hospital, and inappropriate prescribing of medication which can lead to adverse health outcomes. Key system priorities are focused on co-producing solutions to support implementation of the Enhanced Health in Care Home model and maximise opportunities for aligning health and social care resources to improve the support offer to care homes. This includes how we support discharge planning through coordinated multi-disciplinary support to care homes, closer alignment of quality assurance, contract management and care home support resources to maximise impact and upskilling the care home workforce to support effective management of residents, preventing unnecessary hospital admissions.

Joint Commissioning to Support Prevention and Early Intervention
Integrated commissioning approaches support us to increase consistency in service provision and enable better engagement and market management. The following are a number of existing integrated commissioning arrangements that we already have in place:

- BCF pooled budget: commissions a range of integrated initiatives, including: community multidisciplinary neighbourhood teams, prevention and early intervention initiatives such as falls prevention, interventions to support the management of DTOCs;
- Support for people with mental health issues;

- Learning Disability Partnership;
- Community Occupational Therapy Services; and
- Community Equipment Services and Technology Enabled Care Services.

As a system, we continue to work across Adult Social Care and health to develop joint up commissioning strategies, for example the development of our local Dementia Strategy.

Commissioning intentions are focused on supporting people across the following key areas:

- Early Intervention;
- Medium level, reablement and rehabilitative support; and
- High level, ongoing support.

Early Intervention and Prevention: There is a focus on services to support people to remain independent and healthy for longer. Our, system-wide, Ageing Well Strategy Board, led by Public Health, is focusing on approaches to address falls prevention, dementia, social isolation and multi-morbidity and frailty. Other areas include information, advice and guidance, technology enabled care, dementia support, day opportunities and employment opportunities. Through our Better Care Fund programme of work we are developing ways of strengthening integrated approaches to commissioning from the voluntary sector. We have a jointly commissioned 'Wellbeing Network', which is a single access and coordination point to the voluntary sector. Additionally, we have developed system-wide agreed principles to joint commissioning which will continue to inform our approach for greater integration of voluntary sector commissioning and developing community resilience.

Medium level support: It is our intention to increase medium level, reablement and rehabilitation type provision to support more people to remain as independent for as long as possible. We continue to expand current and quality reablement support that promotes safer and quicker hospital discharge. Additionally, we will review and commission an appropriate supply of extra care housing, supported living, mental health support and interim bedded provision.

High Level, Ongoing Support: Support to live at home, care home provision for older people and residential care for people with learning disabilities are a continued focus to build the provision we need locally. Currently, across Cambridgeshire, the local authority and CCG have a jointly commissioned dynamic purchasing system in place for home care provision and we are procuring a new joint commissioned framework for home care in Peterborough. This is supported in Cambridgeshire by an integrated brokerage team that places home care and care home packages for both social care and Continuing HealthCare. We are planning to expand this integrated brokerage approach across Peterborough later this year.

Local Government Association (LGA) Peer Review

Following the budget announcement of additional funding for adult social care in 2017, the Care Quality Care Commission (CQC) was requested by the Secretary of State for Health to undertake a programme of local system area reviews. Twenty area reviews

were undertaken in 2017/18. The reviews were system wide and looked at the quality of the interface between health and social care and the arrangements and commitments in place to use the Better Care Fund to reduce delays in transfer of care. The scope also considered:

- How do people move through the system and what are the outcomes for people?
- What is the maturity of the local area to manage the interface between health and social care?
- How can this improve and what is the improvement offer?

Following local system wide discussion, support was sought from the LGA to undertake a peer review for the Cambridgeshire and Peterborough health and care system. Peer reviews are a constructive process with the central aim of helping areas to improve and also proved a valuable opportunity to prepare the system for a future CQC inspection if we are selected.

Following a scoping discussion with the Local Government Association (LGA), the following two questions and supporting key lines of enquiry were agreed by the Health Care Executive:

1. Is there a shared vision and system wide strategy developed and agreed by system leaders, understood by the workforce and co-produced with people who use services?

2. The people's journey: how does the system practically deliver support to people to stay at home, support when in crisis and support to get them back home?

The peer review was undertaken during 24-27 September 2018. The peer team interviewed system leaders, commissioners, service leads, operational staff, service users and carers. The peers will also reviewed written documents from strategic plans to randomly selected case files regarding service users.

The initial feedback from the peer review team has indicated that as a system we are in a strong position, with synergy and commitment at all levels of management and front line staff. There was a recognition that there were some excellent services and approaches already in place to support prevention, keeping people well, supporting independence and avoiding hospital admission, but there is a lack of consistency. In addition, when people do go into hospital, as a system we have a real issue getting them out.

Key recommendations from the initial peer review feedback are outlined below. A full report will be developed and fed back to system partners imminently, which will then inform a more detailed action plan for how we take the recommendations forward to improve as a system.

- Development of a single vision that is person focused and co-produced with people and stakeholders. With simple, visual, clear branding and communications strategy.
- Ensure strategic partnerships include Primary Care, voluntary sector and Social Care providers
- Establish Home first as a default position for the whole system

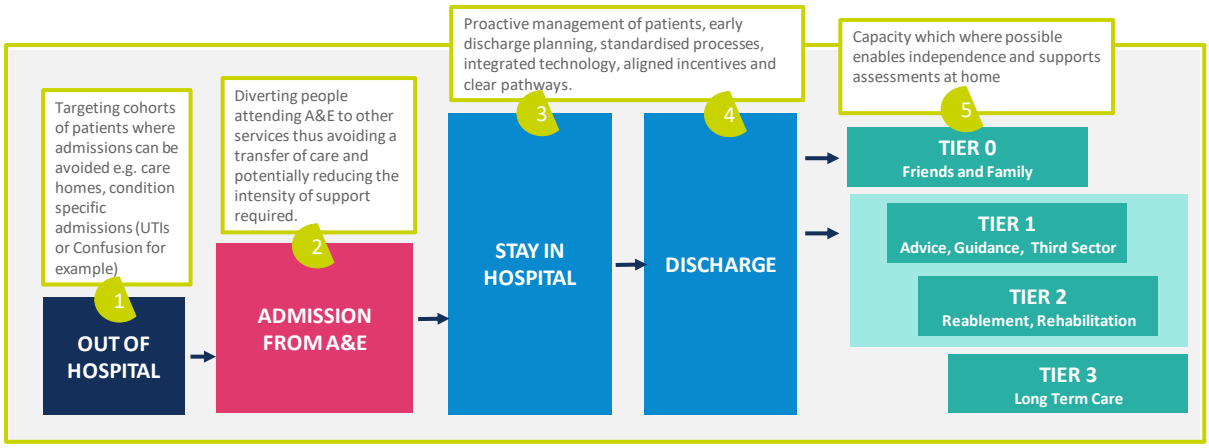
- Simplify processes and pathways – making it easier for staff to do the right thing
- Develop and implement a system wide commissioning strategy to deliver your vision. Look creatively at opportunities to shift or invest in community capacity to fully support a home first model.
- A significant piece of work to be done together to put Primary Care in the centre of models of care
- Build on strong relationship with Healthwatch to add more depth to co-production
- Develop a cross system workforce organisational development programme that reflects the whole system vision and supports staff in new ways of working
- Provide greater clinical leadership to support new processes and new ways of working across the system

2.5 Looking Ahead

Current schemes are focused on meeting demand at the 'back door' of the hospital and not managing demand across the system. Despite regional increases in NEL a sample of local authorities, showed:

- Only 8% of Improved Better Care Fund (iBCF) spend is currently focused on admission avoidance.
- Only 8.5% of schemes reviewed had an impact on admission avoidance.
- There are limited examples of schemes addressing cultural and behavioural issues across health and social care
- Very few examples of Discharge to Assess models are fully integrated

A more integrated approach to managing demand is needed to sustainably address system pressures, as outlined in the below model.



The key recommendations that will enable us as a system to deliver sustainable solutions to managing demand are:

- Widen the lens beyond the iBCF
- Invest in admissions avoidance
- Invest in disruptive innovation that tackles behaviours
- Address workforce issues jointly
- Change the narrative from coping with demand to maximising independence

3. ALIGNMENT WITH CORPORATE PRIORITIES

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

3.1 Developing the local economy for the benefit of all

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

- Improved provision of health and social care services that are more joined up, personalised and deliver care in the right setting at the right time.

3.2 Helping people live healthy and independent lives

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

- Increased focus on prevention and early intervention to support people to remain as independent as possible for as long as possible.

3.3 Supporting and protecting vulnerable people

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

- Better coordination of health and care support to prevent unnecessary escalations of need and enable services to be easier to navigate.

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

There are no significant implications within this category.

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

There are no significant implications within this category.

4.3 Statutory, Legal and Risk Implications

There are no significant implications within this category.

4.4 Equality and Diversity Implications

There are no significant implications within this category.

4.5 Engagement and Communications Implications

There are no significant implications within this category.

4.6 Localism and Local Member Involvement

There are no significant implications within this category.

4.7 **Public Health Implications**

There are no significant implications within this category.

Implications	Officer Clearance
Have the resource implications been cleared by Finance?	Yes or No Name of Financial Officer:
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	Yes or No Name of Officer:
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	Yes or No Name of Legal Officer:
Have the equality and diversity implications been cleared by your Service Contact?	Yes Name of Officer: Will Patten
Have any engagement and communication implications been cleared by Communications?	Yes or No Name of Officer:
Have any localism and Local Member involvement issues been cleared by your Service Contact?	Yes Name of Officer: Will Patten
Have any Public Health implications been cleared by Public Health	Yes or No Name of Officer:

Source Documents	Location
Cambridgeshire and Peterborough Sustainability and Transformation Plan	***https://www.fitforfuture.org.uk/what-were-doing/publications/***
Cambridgeshire Better Care Fund Plan 2017-19	***https://www.cambridgeshire.gov.uk/residents/working-together-children-families-and-adults/working-with-partners/cambridgeshire-better-care-fund-bcf/***

Agenda Item No: 6

NHS CONTINUING HEALTHCARE (CHC) 'DEEP DIVE'

To:	**Adults Committee**
Meeting Date:	**15 November 2018**
From:	**Charlotte Black** **Service Director: Adults and Safeguarding**
Electoral division(s):	**All**
Forward Plan ref:	**N/A** *Key decision:* **No**
Purpose:	**To provide an overview of NHS Continuing Healthcare (CHC) and the County Councils responsibilities in relation to this process.** **To summarise plans to improve performance and customer experience.**
Recommendation:	**To consider the report and provide comments on the proposed developments.**

Officer contact:		***Member contacts:***	
Name:	Kimberley O'Leary	Names:	Cllr Anna Bailey
Post:	Strategic Continuing Healthcare Manager	Post:	Chair
Email:	kimberley.o'leary@cambridgeshireshire.gov.uk	Email:	annabailey@hotmail.co.uk
Tel:	01223 703550	Tel:	01223 706398

1.0 BACKGROUND

1.1 The purpose of this report is to provide 'a deep dive' into NHS Continuing Healthcare (NHS CHC) in Cambridgeshire.

1.2 What is NHS Continuing Healthcare and how is eligibility determined?

1.2.1 *'NHS Continuing Healthcare means a package of ongoing care that is arranged and funded solely by the National Health Service (NHS) where the individual has been assessed and found to have a primary health need as set out in the National Framework. Such care is provided to an individual aged 18 or over, to meet health and associated care needs that have arisen as a result of disability, accident or illness' (DH, 2018).*

1.2.2 The process to determine eligibility for NHS CHC has two parts, which should be completed within 28 days, from the point when a Clinical Commissioning Group (CCG) receives a positive NHS CHC Checklist.

1.2.3 **Part 1:** The NHS CHC Checklist is completed (Appendix 1). If the outcome is positive, determined by the levels agreed in the 11 domains, the individual will proceed to stage 2 of the process. If the outcome is negative the process ends. Where an individual is entering a nursing home, this should be recorded on the checklist so that the financial contribution for the nursing care (Funded Nursing Care. FNC) can be recovered from the NHS.

1.2.4 **Part 2:** A multidisciplinary team (MDT) will complete the decision support tool (DST) (Appendix 2) and make a recommendation to the CCG on whether the individual is eligible for NHS CHC Funding. Once the recommendation is made, if the person is not recommended as eligible, but is entering a nursing home, this should be recorded to enable access to the FNC.

1.2.5 The minimum composition of the MDT, is two professionals from different health backgrounds or one professional who is from a healthcare profession and one person who is responsible for assessing persons who may have needs for care and support under part 1 of the Care Act 2014.

1.2.6 In Cambridgeshire only social workers and adult support co-coordinators who have been trained to complete NHS CHC checklists and participate in the MDT can be involved in this process.

2.0 NATIONAL AND LOCAL PERFORMANCE

2.1 Eligibility per 50,000 population

2.1.1 In Quarter 4 2017/18, the CCG's ranking improved to 73 out of 209 as the number of people being awarded NHS CHC increased to 48.2 per 50,000. This improvement reflects the efforts that have been made by the CCG and the Council to improve compliance with the National Framework and achieve better outcomes for local people.

2.2 Assessments exceeding 28 day time frame.

2.2.1 Approximately 50% of the 209 CCGs in England have a backlog of assessments exceeding the 28 day time limit. Nationally statistics show that as of the last day of Quarter 1 2018/2019 there were 4,910 assessments exceeding the 28 day timeframe.

Of these:

- 790 exceeded by up to 2 weeks
- 510 exceeded by more than 2 weeks and up to 4 weeks
- 1,012 exceeded by more than 4 weeks and up to 12 weeks
- 893 exceeded by more than 12 weeks and up to 26 weeks
- 1,705 exceeded by more than 26 weeks

2.2.2 At the end of September 2018, Cambridgeshire and Peterborough CCG had a backlog of 348 assessment of cases exceeding the 28 day time limit, with three cases waiting over three years. This is a significant improvement on the position in January 2018 when the backlog stood at 928 with longest wait dating back to July 2015.

2.2.3 The County Council's contribution to clearing the backlog was to employ two social workers with considerable experience NHS CHC. The funding for these posts came from the Better Care Fund.

2.2.4 The Council is paying the care costs of 67 Cambridgeshire residents who are waiting to have their eligibility for NHS CHC determined. The full-year effect of this on the Council is dependent on the outcome of the assessment and the level of care being funded. There are 196 people who has passed away before their assessment was completed. These cases will be resolved as part of the backlog programme. While there will be no in-year financial consequence for the Council from these cases, we will ensure that, where the deceased is eligible for NHS CHC, the client contribution will be reimbursed to the person's estate.

3.0 Performance against the 28 day timeframe

3.1 80% of NHS CHC cases with a positive NHS CHC Checklist, must have a decision on eligibility made within 28 days.

3.2 In August 2018, 71% of people with a NHS CHC Checklist had a decision on eligibility made within 28 days. Performance has deteriorated from 91% in May 2018.

3.3 The barriers to achieving the target include:

- Family refused to continue with multidisciplinary meeting as the professionals they were familiar with could not attend.
- CCG did not verify recommendations on time- various reasons
- Decision Support tool was not written up on time- various reasons
- Social worker did not sign/return signature to meet 28-day timeframe
- Staff sickness resulting in cancellation of appointment (nurses and social worker)
- Multidisciplinary team cannot agree the recommendation to the CCG

- Person with Lasting Power of Attorney could not attend appointment until outside 28 days.

3.4 The recurring themes are operational capacity in the CCG and the Council.

3.5 In April 2018 officers introduced a referral tracking system to enable the monitoring of requests for assistance from the CCG in determining a person's eligibility for NHS CHC. This has enabled us to monitor performance against the 80% target and understand the barriers to achieving it. It has been agreed locally that County Council staff will aim to respond to requests to attend MDTs in 2 days. Current performance is 2.5 days. The County Council has also agreed that we will aim to attend MDT and contribute to making a recommendation on eligibility if we are given seven days' notice.

3.6 The benefits of the tracker are:

- To monitor whether the response times are being achieved
- Mitigate the risk of the backlog increasing

To enable us to understand the workforce capacity needed to achieve the national targets.

4.0 Outcome of the NHS CHC process

4.1 National data indicates that 30% of people with a positive NHS CHC checklist are determined to be eligible NHS CHC funding. Analysis of the backlog cases that have been assessed indicates that approximately 27% of Cambridgeshire cases with a positive checklist received NHS CHC funding.

5.0 ACTIONS TAKEN BY THE COUNCIL TO IMPROVE THE NHS CHC PROCESS

5.1 The following actions have been taken to improve practice and customer experience:

- Recruited a strategic Lead for NHS CHC
- Employed dedicated social workers to support with clearing backlog and act as mentors for less experienced staff
- CHC clinics within the teams to assist staff with CHC queries
- Internal training programme to support social care staff and improve understanding of the process, practice the customer experience
- Reflective practice learning and development sessions for managers and senior practitioners
- Development of practitioner fact sheets and sharing examples of good practice
- Developed system to improve financial control and monitoring
- Participation in Complex Case Panels across all adult client groups and Children's Services.
- Systems in place to track the workflow which will be embedded in MOSAIC
- Working to improve relationships with partners in the CCG

6.0 NATIONAL PROGRAMME TO IMPROVE PERFORMANCE AND INDIVIDUAL EXPERIENCE

6.1 In April 2017, NHS England commenced a two year programme at how NHS CHC could be improved. The programme incorporates 23 projects ranging from commissioning, to workforce training and competency frameworks. The Council's Strategic Lead for NHS CHC is participating in the workshops.

6.2 NHS England, also now has a weekly conversation with the CCG to monitor local performance against clearing the backlog and achieving the 28 day standard.

6.3 Roles and responsibilities of the Local Authority

6.3.1 For Local Authorities, there are six requirements set out in the National Framework For NHS Continuing Healthcare and Funded Nursing Care (2018).

1. Where it appears that a person may be eligible for NHS Continuing Healthcare, the local authority must refer the individual to the relevant CCG.

2. Local authorities must, as far as is reasonably practicable, provide advice and assistance when consulted by the CCG in relation to an assessment of eligibility for NHS Continuing Healthcare. This duty applies regardless of whether an assessment of needs for care and support under section 9 of the Care Act 2014 is required. Where the local authority has carried out such an assessment of needs it must (as far as it is relevant) use information from this assessment to assist the CCG in carrying out its responsibilities.

3. A local authority must, when requested to do so by the CCG, co-operate with the CCG in arranging for a person or persons to participate in a multidisciplinary team. Local authorities should:
   - respond within a reasonable timeframe when consulted by a CCG prior to an eligibility decision being made:
   - Respond within a reasonable timeframe to requests for information when the CCG has received a referral for NHS Continuing Healthcare.

4. It is also good practice for local authorities to work jointly with CCGs in the planning and commissioning of care or support for individuals found eligible for NHS Continuing Healthcare wherever appropriate, sharing expertise and local knowledge (whilst recognising that CCGs retain formal commissioning and care planning responsibility for those eligible for NHS Continuing Healthcare).

5. Regulations state that local authorities must nominate individuals to be appointed as local authority members of independent review panels where requested to do so by NHS England. This duty includes both nominating such individuals as soon as is reasonably practicable and ensuring that they are, so far as is reasonably practicable, available to participate in independent review panels.

6.3.2 Nationally and locally there is an emphasis on partnership working and a joint commitment to improve the NHS CHC process for individuals.

7.0 Shared priorities and actions with the CCG

7.1 A joint CCG Complex Case Team and Local Authority Working Group was established July 2018 as a forum to agree joint priorities and areas of development. The ambition of this group is to clear the backlog and ensure that reviews are completed on time with active case management in the community. It is recognised that having a co-located team would significantly improve communication and build effective relationships between the partners and this is being explored

7.2 Both organisations agree that current processes and practice with regard to dispute resolution and joint funding tools require improvement. The aim is to complete these tasks by December 2018 and January 2019 respectively.

7.3 Since October 2017, the Council's CHC workers have worked with the CCG to resolve 116 disputes. There has been a reduction in disputes from August to October 2018 due to partnership working.

7.4 A joint approach will be developed to enhance knowledge and competence of practitioners across the system about NHS CHC. The current priority is the joint delivery of briefings on the updated National Framework which came into operation on the 1 October 2018.

7.5 In 2017, the CCG introduced a discharge to assess approach, known as 4Q, to reduce the number of NHS CHC cases being completed in acute hospitals. Results from the pilot indicate that this is achieving the national target (less than 15% being completed in acute hospitals). The CCG is leading a review of the 4Q process and developing a business case, jointly with the Council and Peterborough City Council to resource the revised model.

7.6 A priority of the Working Group is to improve communication about the NHS CHC process and what people can expect from it. The Working Group also want to ensure that the outcome of the process is communicated clearly in a timely way. The CCG has revised its website in consultation with Health Watch. The Council is reviewing information on the CCC website to compliment information provided the CCG. Officers have also worked with the CCG on two articles for the Carer's magazine on NHS CHC and have attended the Carer's Board to help answer questions in response to concerns raised by the Carers' Trust.

7.7 The CCG is currently re-organising the Complex Cases Team to improve stability, improve communication, accountability and increase capacity. The Council, with Peterborough City Council, will be considering options to compliment the capacity building by the CCG to enable the ambition of the Working Group to be realised. In the next phase of Adult Services re-organisation we will consider our organisational arrangements and the option of creating a small team, with Peterborough City Council, to focus solely on NHS CHC to be collated with health colleagues. The Commissioning Directorate is developing a joint brokerage function with the CHC Complex Cases Team which will result in a single point of contact and purchasing for all residential and nursing placements which will include placement made by the CCG for NHS CHC.

8.0 LEARNING DISABILITIES

8.1 In Cambridgeshire there is a Section 75 pooled budget for individuals supported by the Learning Disabilities Partnership (LDP). The County Council has delegated authority for managing the LDP budget. This budget included funding for people eligible for NHS CHC. Currently 39 people are in receipt of NHS CHC funding. Where an individual is not eligible for NHS CHC, but has needs that are of a nature and type that exceed the limit set out in Section 22 of the Care Act 2014, they are eligible for joint funding (which may include needs outside Funded Nursing Care (FNC). Currently 635 individuals are in receipt of joint funding.

8.2 A recent review of the budget indicated that the existing funding arrangements are not adequate to cover the needs of people with learning disabilities and the budget requires revision. As part of this work, an audit is being planned to begin in October 2018.

9.0 CONCLUSION

9.1 In a financially challenged health and social system determining how the costs of care and support for people with the most complex needs are met should be subjected to a high level of scrutiny. In this system partners are collaborating to address a shared understanding of the challenges and risks that impact on our ability to deliver the requirements of the National Framework for NHS CHC in an open, fair and competent way that also offers a person centred experience.

10.0 ALIGNMENT WITH CORPORATE PRIORITIES

10.1 Developing the local economy for the benefit of all

10.1.1 There are no significant implications for this priority.

10.2 Helping people live healthy and independent lives

10.2.1 The report above sets out the implications for this priority in **sections 1-5.**

10.3 Supporting and protecting vulnerable people

10.3.1 There are no significant implications for this priority.

11.0 SIGNIFICANT IMPLICATIONS

11.1 Resource Implications

11.1.1 The report above sets out details of significant implications in **section 1 and 4.**

11.2 Procurement/Contractual/Council Contract Procedure Rules Implications

11.2.1 There are no significant implications within this category.

11.3 Statutory, Legal and Risk Implications

11.3.1 The report above sets out details of significant implications in

11.4 Equality and Diversity Implications

11.4.1 There are no significant implications within this category.

11.5 Engagement and Communications Implications

11.5.1 There are no significant implications within this category.

11.6 Localism and Local Member Involvement

11.6.1 There are no significant implications within this category.

11.7 Public Health Implications

11.7.1 There are no significant implications within this category.

Source Documents	Location
None	

Implications	Officer Clearance
Have the resource implications been cleared by Finance?	Yes Name of Financial Officer: Tom Kelly
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	Yes or No Name of Officer: **N/A**
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	Yes or No Name of Legal Officer: **N/A**
Have the equality and diversity implications been cleared by your Service Contact?	Yes or No Name of Officer: **N/A**
Have any engagement and communication implications been cleared by Communications?	Yes or No Name of Officer: **N/A**

Have any localism and Local Member involvement issues been cleared by your Service Contact?	Yes or No Name of Officer: **N/A**
Have any Public Health implications been cleared by Public Health	Yes or No Name of Officer: **N/A**

Name:		D.O.B		NHS No:	

NHS Continuing Healthcare Needs Checklist

Date of completion of Checklist

Name

D.O.B.

NHS number

GP Practice and GP Address

Permanent address and location (e.g. name of hospital ward etc.)

Gender

Please ensure that the equality monitoring form at the end of the Checklist is completed.

Was the individual involved in the completion of the Checklist? Yes (please delete as appropriate)

Was the individual offered the opportunity to have a representative such as a family member or other advocate present when the Checklist was completed? Yes (please delete as appropriate)

If yes, did the representative attend the completion of the Checklist? Yes (please delete as appropriate)

Please give the contact details of the representative (name, address and telephone number).

Did you explain to the individual how their personal information will be shared with the different organisations involved in their care, and did they consent to this information sharing? Yes (please delete as appropriate)

Name:		D.O.B		NHS No:	

Capacity Assessment Guidance:

The Mental Capacity Bill (2005) states:

- All adults are presumed to be competent to consent unless proved otherwise.
- Any assessment of capacity to consent is decision specific.
- A person's capacity may be in doubt if they are seen to be cognitively impaired. Standard tests of cognition e.g. Mini Mental State Examination do not assess capacity.

Doubt about capacity

↓

What is the decision the individual is being asked to make?

↓

What are the identified risks / benefits to the individual?

↓

Ensure any assessments or information form the MDT are made available

↓

Discuss risk assessments with the patient

Can the patient: - (Tick for yes)

Understand the information relevant to the decision?	☐
Retain that information during the assessment?	☐
Use or weight that information as part of the process of making the decision?	☐
Communicate the decision (verbally or by any other means)?	☐
All of the above without coercion?	☐

↓

Have all five boxes been ticked?

YES	NO
Patient has the capacity to make this specific decision	Patient lacks capacity to make this specific decision
Patient makes informed treatment choice. The choice must be respected even if unconventional or unwise.	• Decision can be made under common law under principle of the patient best interest • Relatives can inform this process but cannot make decision for the individual • Take into account any relevant advance directives, spiritual or cultural factors. • Patients should be consistently informed and supported by the team member about this decision. • The Mental Health Act is only relevant in exceptional cases

Name:		D.O.B		NHS No:	

Where the individual has capacity to consent to the completion of the assessment and /or the sharing of information please complete this section
I understand that NHS Cambridgeshire and Peterborough CCG **and those acting on its behalf** will hold my information securely on paper and on computer in accordance with the Data Protection Act 1998 **I agree** that the information provided in this assessment may be shared with health and social care staff, service providers who contribute to my care and any agencies acting on behalf of these organisations. **I understand** that this information will be used for the purpose of providing a service, or care to me. I also **understand** that agencies may use anonymised information for statistical purposes and that the law may allow in some circumstances for other agencies to be provided with information about me. **I understand** that I may withdraw my consent to share information at any time, and this may result in a reduction of services being available. **I understand** that I have the right to restrict what information may be shared and with whom, but this may affect the provision of care to me. **I have made the following restrictions**: (if applicable)
Signature: Date:
Print Name:

This assessment will be shared with other professionals under the best Interest Principles (If Applicable)

Assessment of Capacity

Does the patient have an impairment of, or a disturbance in the functioning of their mind or brain?
Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?
A person unable to make a decision if they cannot:

- Understand information about the decision to be made
- Retain that information in their mind
- Use or weigh the information as part of the decision-making process or
- Communicate their decision (see Mental Capacity Act 2005)

(where incapacity is likely to be temporary, for example if the patient is unconscious or where the patient has fluctuating capacity please document: (please continue on another page if required)

Lead Coordinator met with X Prior to the Multi-disciplinary Meeting (MDT) and they were happy for the meeting to go ahead in their absence. X demonstrated understanding of the importance of the meeting but did not appear to retain the information. X also did not appear to understand the importance of their participation or contribution to the meeting. Lead Coordinator agreed that would not be able to understand some of the information discussed during the MDT thereby making it difficult for them to make decisions.

Assessment of patients best interests

To the best of my knowledge, the patient has not refused this procedure in a valid advance directive. Where possible and appropriate, I have consulted with colleagues and those close to the patient, and I believe the assessment to be in the patient's best interest. (please refer to best interest principles Mental Capacity Act 2005)

Name of Assessor:	**Signature:**	**Date:** **11-5-18**

Please submit the original of this signed page with your application

Name:		D.O.B		NHS No:	

Name of patient		Date of completion		
Please circle statement A, B or C in each domain	**C**	**B**	**A**	**Evidence in records to support this level**
Behaviour*	No evidence of 'challenging' behaviour. **OR** Some incidents of 'challenging' behaviour. A risk assessment indicates that the behaviour does not pose a risk to self, others or property or a barrier to intervention. The person is compliant with all aspects of their care.	'Challenging' behaviour that follows a predictable pattern. The risk assessment indicates a pattern of behaviour that can be managed by skilled carers or care workers who are able to maintain a level of behaviour that does not pose a risk to self, others or property. The person is nearly always compliant with care.	'Challenging' behaviour that poses a predictable risk to self, others or property. The risk assessment indicates that planned interventions are effective in minimising but not always eliminating risks. Compliance is variable but usually responsive to planned interventions.	A X presents with physical and verbally challenging behaviour. They have no insight into their needs around their diabetes control and how to manage it. They present with behaviours that are challenging and they will not comply with treatment resulting in a serious risk to her health. Evidence in GP records Live-in Nurse care records Diabetes specialist LDP records MCA records DoLS- in process

Name:		D.O.B		NHS No:	

Cognition	No evidence of impairment, confusion or disorientation. **OR** Cognitive impairment which requires some supervision, prompting or assistance with more complex activities of daily living, such as finance and medication, but awareness of basic risks that affect their safety is evident. **OR** Occasional difficulty with memory and decisions/choices requiring support, prompting or assistance. However, the individual has insight into their impairment.	Cognitive impairment (which may include some memory issues) that requires some supervision, prompting and/or assistance with basic care needs and daily living activities. Some awareness of needs and basic risks is evident. The individual is usually able to make choices appropriate to needs with assistance. However, the individual has limited ability even with supervision, prompting or assistance to make decisions about some aspects of their lives, which consequently puts them at some risk of harm, neglect or health deterioration.	Cognitive impairment that could include frequent short-term memory issues and maybe disorientation to time and place. The individual has awareness of only a limited range of needs and basic risks. Although they may be able to make some choices appropriate to need on a limited range of issues, they are unable to do so on most issues, even with supervision, prompting or assistance. The individual finds it difficult, even with supervision, prompting or assistance, to make decisions about key aspects of their lives, which consequently puts them at high risk of harm, neglect or health deterioration	A X has a learning disability. There are several MCA's in place in relation to their diabetes, finances, they is forgetful and has some difficulty remembering people. X lacks understanding re their diabetes management which has led to numerous hospital admissions and failed placements. X is also vulnerable to exploitation from others. Evidenced in Hospital and GP records Diabetes Specialist records LDP records- including social care. Several MCA assessments available Current request for DoLS in relation to diabetes.

Psychological/ Emotional	Psychological and emotional needs are not having an impact on their health and well-being. **OR** Mood disturbance or anxiety or periods of distress, which are having an impact on their health and/or well-being but respond to prompts and reassurance. **OR** Requires prompts to motivate self towards activity and to engage in care planning, support and/or daily activities.	Mood disturbance or anxiety symptoms or periods of distress which do not readily respond to prompts and reassurance and have an increasing impact on the individual's health and/or well-being. **OR** Due to their psychological or emotional state the individual has withdrawn from most attempts to engage them in support, care planning and/or daily activities.	Mood disturbance or anxiety symptoms or periods of distress that have a severe impact on the individual's health and/or well-being. **OR** Due to their psychological or emotional state the individual has withdrawn from any attempts to engage them in care planning, support and daily activities.	C X presents with anxiety around her diabetes. They are not able to understand the need for support and so becomes distressed when others support this. This affects their mood and can lead to challenging behaviour and putting themselves at risk. Evidence in Health records LDP records Social Care records Live-in support evidence.
Communication	Able to communicate clearly, verbally or non-verbally. Has a good understanding of their primary language. May require translation if English is not their first language. **OR** Needs assistance to communicate their needs. Special effort may be needed to ensure accurate interpretation of needs or additional support may be needed either visually, through touch or with hearing.	Communication about needs is difficult to understand or interpret or the individual is sometimes unable to reliably communicate, even when assisted. Carers or care workers may be able to anticipate needs through non-verbal signs due to familiarity with the individual.	Unable to reliably communicate their needs at any time and in any way, even when all practicable steps to assist them have been taken. The person has to have most of their needs anticipated because of their inability to communicate them.	B X has good verbal skills, however carers need to be able to anticipate Xs needs re their diabetes as X does not understand symptoms which puts them at high risk of harm without support. Evidence in Health records LDP records including Social Care records Live-in Nursing supporting evidence. Several MCA assessments available

Mobility	Independently mobile. **OR** Able to weight bear but needs some assistance and/or requires mobility equipment for daily living.	Not able to consistently weight bear. **OR** Completely unable to weight bear but is able to assist or cooperate with transfers and/or repositioning. **OR** In one position (bed or chair) for majority of the time but is able to cooperate and assist carers or care workers. OR At moderate risk of falls (as evidenced in a falls history or risk assessment)	Completely unable to weight bear and is unable to assist or cooperate with transfers and/or repositioning. **OR** Due to risk of physical harm or loss of muscle tone or pain on movement needs careful positioning and is unable to cooperate. **OR** At a high risk of falls (as evidenced in a falls history and risk assessment). **OR** Involuntary spasms or contractures placing the individual or others at risk.	C X is independently mobile
Nutrition	Able to take adequate food and drink by mouth to meet all nutritional requirements. **OR** Needs supervision, prompting with meals, or may need feeding and/or a special diet. **OR** Able to take food and drink by mouth but requires additional/supplementary feeding.	Needs feeding to ensure adequate intake of food and takes a long time (half an hour or more), including liquidised feed. **OR** Unable to take any food and drink by mouth, but all nutritional requirements are being adequately maintained by artificial means, for example via a non-problematic PEG.	Dysphagia requiring skilled intervention to ensure adequate nutrition/hydration and minimise the risk of choking and aspiration to maintain airway. **OR** Subcutaneous fluids that are managed by the individual or specifically trained carers or care workers. **OR** Nutritional status 'at risk' and may be associated with unintended, significant weight loss. **OR**	C X is able to feed themselves. Evidenced in Support plan and live in Nurse records

			Significant weight loss or gain due to an identified eating disorder. **OR** Problems relating to a feeding device (e.g. PEG) that require skilled assessment and review.	
Continence	Continent of urine and faeces. **OR** Continence care is routine on a day-to-day basis. **OR** Incontinence of urine managed through, for example, medication, regular toileting, use of penile Sheaths, etc. **AND** Is able to maintain full control over bowel movements or has a stable stoma, or may have occasional faecal incontinence/constipation.	Continence care is routine but requires monitoring to minimise risks, for example those associated with urinary catheters, double incontinence, chronic urinary tract infections and/or the management of constipation.	Continence care is problematic and requires timely and skilled intervention, beyond routine care. (For example frequent bladder wash outs, manual evacuations, frequent re-catheterisation).	C X is fully continent.

Name:		D.O.B		NHS No:	

Skin integrity	No risk of pressure damage or skin condition. **OR** Risk of skin breakdown which requires preventative intervention once a day or less than daily, without which skin integrity would break down. **OR** Evidence of pressure damage and/or pressure ulcer(s) either with 'discolouration of intact skin' or a minor wound. **Or** A skin condition that requires monitoring or reassessment less than daily and that is responding to treatment or does not currently require treatment.	Risk of skin breakdown which requires preventative intervention several times each day, without which skin integrity would break down. **OR** Pressure damage or open wound(s), pressure ulcer(s) with 'partial thickness skin loss involving epidermis and/or dermis, which is responding to treatment. **OR** A skin condition that requires a minimum of daily treatment, or daily monitoring/reassessment to ensure that it is responding to treatment.	Pressure damage or open wound(s), pressure ulcer(s) with 'partial thickness skin loss involving epidermis and/or dermis, which is not responding to treatment. **OR** Pressure damage or open wound(s), pressure ulcer(s) with 'full thickness skin loss involving damage or necrosis to subcutaneous tissue, but not extending to underlying bone, tendon or joint capsule', which is responding to treatment. **OR** Specialist dressing regime in place which is responding to treatment.	.C X's skin needs monitoring as they have diabetes.

Name:		D.O.B		NHS No:	

Breathing*	Normal breathing, no issues with shortness of breath. **OR** Shortness of breath, which may require the use of inhalers or a nebuliser and has no impact on daily living activities. **OR** Episodes of breathlessness that readily respond to management and have no impact on daily living activities.	Shortness of breath, which may require the use of inhalers or a nebuliser and limit some daily living activities. **OR** Episodes of breathlessness that do not respond to management and limit some daily activities. **OR** Requires any of the following: • low level oxygen therapy (24%); • room air ventilators via a facial or nasal mask; other therapeutic appliances to maintain airflow where individual can still spontaneously breathe e.g. CPAP (Continuous Positive Airways Pressure) to manage obstructive apnoea during sleep.	Is able to breathe independently through a tracheotomy that they can manage themselves, or with the support of carers or care workers. **OR** Breathlessness due to a condition which is not responding to therapeutic treatment and limits all daily living activities. **OR** A condition that requires management by a non-invasive device to both stimulate and maintain breathing (non-invasive positive airway pressure, or non-invasive ventilation)	C No issues with breathing.

Name:		D.O.B		NHS No:	

Drug therapies and medication: symptom control*	Symptoms are managed effectively and without any problems, and medication is not resulting in any unmanageable side-effects. **OR** Requires supervision/administration of and/or prompting with medication but shows compliance with medication regime. **OR** Mild pain that is predictable and/or is associated with certain activities of daily living; pain and other symptoms do not have an impact on the provision of care.	Requires the administration of medication (by a registered nurse, carer or care worker) due to: – non-concordance or non-compliance, or – type of medication (for example insulin); or – route of medication (for example PEG). **OR** Moderate pain which follows a predictable pattern; or other symptoms which are having a moderate effect on other domains or on the provision of care.	Requires administration and monitoring of medication regime by a registered nurse, carer or care worker specifically trained for this task because there are risks associated with the potential fluctuation of the medical condition or mental state, or risks regarding the effectiveness of the medication or the potential nature or severity of side-effects. However, with such monitoring the condition is usually non-problematic to manage. **OR** Moderate pain or other symptoms which is/are having a significant effect on other domains or on the provision of care.	A X needs specially trained workers due to Unstable diabetes which requires 24/7. As well as X's behavioural presentation around managing the diabetes. Requires administration of insulin, Ketone testing and someone able to identify and respond to hypo/hyperglycaemic and high ketone episdoes. Use of sliding scale insulin Novorapid. Responding to low blood glucose that may require emergency injection of glucagen. Monitoring of BG and diet and making adjustments to insulin when required. Evidences in GP records, Diabetes specialist records- LDP and social care records Live-in nurse records and Support plan

Altered states of consciousness*	No evidence of altered states of consciousness (ASC). **OR** History of ASC but effectively managed and there is a low risk of harm.	Occasional (monthly or less frequently) episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm.	Frequent episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm. **OR** Occasional ASCs that require skilled intervention to reduce the risk of harm.	A Previous placements have resulted in the X being admitted to hospital due to altered or loss of consciousness due to poor management of diabetes. In their current home X has experienced loss of consciousness on one occasion, this was responded to by the trained nurse using an emergency hypokit and no hospital admission was required. Due to managed need. Evidenced in GP records, Diabetes Specialist records- LDP and Social Care records Live-in nurse records and current Support plan
Total from all pages	6	1	4	

Name:	«Name»	D.O.B	«birthdate»	NHS No:	«nhsnumber»

Please highlight the outcome indicated by the checklist:

1. Referral for full assessment for NHS continuing healthcare is necessary.

or

2. No referral for full assessment for NHS continuing healthcare is necessary.

(There may be circumstances where you consider that a full assessment for NHS continuing healthcare is necessary, even though the individual does not apparently meet the indicated threshold. If so, a full explanation should be given.)

Rationale for decision

Social care review triggered Checklist: 4 A's in Behaviour, cognition, Drug therapies and medication control and ASC, including three asterisk domains.

Name(s) and signature(s) of assessor(s) **Date:**

Contact details of assessors (name, role, organisation, telephone number, email address)

Social Worker Cambridgeshire County Council

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

About you – equality monitoring

Please provide us with some information about yourself. This will help us to understand whether everyone is receiving fair and equal access to NHS continuing healthcare. All the information you provide will be kept completely confidential by the Clinical Commissioning Group. No identifiable information about you will be passed on to any other bodies, members of the public or press.

1 What is your sex?
Tick one box only.

Male	
Female	/
Transgender	

2 Which age group applies to you?
Tick one box only.

0-15	
16-24	
25-34	
35-44	
45-54	
55-64	/
65-74	
75-84	
85+	

3 Do you have a disability as defined by the Disability Discrimination Act (DDA)?
Tick one box only.

The Disability Discrimination Act (DDA) defines a person with a disability as someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day to day activities.

Yes	/
No	

4 What is your ethnic group?
Tick one box only.

A White

British	/
Irish	

Any other White background, write below

B Mixed

White and Black Caribbean	
White and Black African	
White and Asian	

Any other Mixed background, write below

C Asian, or Asian British

Indian	
Pakistani	
Bangladeshi	

Any other Asian background, write below

D Black, or Black British

Caribbean	
African	

Any other Black background, write below

E Chinese, or other ethnic group

Chinese	

Any other, write below

NHS Cambridgeshire and Peterborough Clinical Commissioning Group

5 What is your religion or belief?
Tick one box only.

Christian includes Church of Wales, Catholic, Protestant and all other Christian denominations.

None	☐
Christian	☐
Buddhist	☐
Hindu	☐
Jewish	☐
Muslim	☐
Sikh	☐

Other, write below

Not discussed ☐

6 Which of the following best describes your sexual orientation?

Tick one box only.

Only answer this question if you are aged **16** years or over.

Heterosexual / Straight	☐
Lesbian / Gay Woman	☐
Gay Man	☐
Bisexual	☐
Prefer not to answer	☐

Other, write below

Not discussed ☐

Please return the completed proforma to the appropriate NHS Continuing Health Team:

Complex Case Management Team (covering Cambridge & Huntingdon areas)
NHS Cambridgeshire and Peterborough Clinical Commissioning Group
Lockton House, Clarendon Road
Cambridge CB2 8FH
Tel: 01223 725429 - Email: capccg.chc@nhs.net

Continuing Healthcare Team (covering Peterborough, East Cambridgeshire & Fenland areas)
NHS Cambridgeshire and Peterborough Clinical Commissioning Group
Zone B – Floor 1, City Care Centre
Thorpe Road
Peterborough PE3 6DB
Tel: 01733 847328 - Email: capccg.peterboroughcontinuingcareteam@nhs.net

Good Example of a Decision Support Tool with a Primary Health Needs Test

Decision Support Tool for NHS Continuing Healthcare
Section 1 – Personal Details

Date of completion of Decision Support Tool to reflect claim period retrospectively for 27.02.2012 to 12.11.2012 (Excluding hospitalisation 10.03.2012 to 26.03.2012)

Name		**D.O.B.**	

NHS number and GP/Practice:	

Permanent Address and Telephone Number	**Current Residence (if not permanent address)**

Gender:

Please ensure that the equality monitoring form at the end of the DST is completed

Was the individual involved in the completion of the DST? ~~Yes~~/No (please delete as appropriate)

Was the individual offered the opportunity to have a representative such as a family member or other advocate present when the DST was completed? Yes/No (please delete as appropriate) This DST report was carried out reviewing relevant documentation for a NHS Continuing Care Retrospective Review. A NHS Retrospective Review Claimant Questionnaire was taken into consideration.

If yes, did the representative attend the completion of the DST? ~~Yes~~/No (please delete as appropriate)

Please give the contact details of the representative (name, address and telephone number)

A NHS Continuing Care Claimant Questionnaire was completed (next of kin) on [redacted]

Decision Support Tool for NHS Continuing Healthcare
Section 1 – Personal Details

Summary

Summary pen portrait of the individual's situation, relevant history and current needs, including clinical summary and identified significant risks, drawn from the multidisciplinary assessment:

[redacted] was a qualified electrical engineer. [redacted] was initially employed as an electrical engineer and subsequently as an editor for financial and engineering magazines. [redacted] lived in London before moving to Norfolk in 1991.

In 2004 [redacted] was diagnosed with Multiple System Atrophy (MSA), a progressive neurological disorder. Prior to this diagnosis [redacted] was thought to have Parkinson's Disease but a diagnosis of MSA was subsequently made. [redacted] was regularly reviewed by a Neurologist and supported by a Neurology Specialist Nurse. Symptoms of MSA reflect the three different areas of the brain – basal ganglia causing problems with movement, cerebellum causing poor balance and coordination and the brain stem causing autonomic problems such as poor bladder and blood pressure control.

[redacted] lived at home with [redacted] wife who was [redacted] main carer. [redacted] had further support from carers from [redacted] Care Agency. The carers visited [redacted] three times a day to deliver personal care such as hygiene needs, transfer, prepare a meal, get into bed at night.

On 04.01.2012 [redacted] was admitted to the [redacted] Hospital with a fractured right neck of femur. Following treatment for the fractured neck of femur [redacted] was discharged on 23.01.2012 to [redacted] Ward, [redacted] Hospital for rehabilitation.

Following a period of rehabilitation at [redacted] Hospital [redacted] was discharged back to [redacted] home on 27.02.2012.

On 10.03.2012 [redacted] was admitted to [redacted] Hospital with pneumonia. [redacted] was discharged back to [redacted] home on 26.03.2012.

Past Medical History
Multiple System Atrophy (MSA) - progressive neurological disorder (2004)
Parkinson's Disease (2003) – symptoms later transpired to be MSA and not Parkinson's
Meniere Syndrome (1971)
History of urinary tract infections (UTIs)
Fractured right neck of femur (January 2012)

Individual's view of their care needs and whether they consider that the multidisciplinary assessment accurately reflects these:

Not applicable

Decision Support Tool for NHS Continuing Healthcare
Section 1 – Personal Details

Please note below whether and how the individual (or their representative) contributed to the assessment of their needs. If they were not involved, please record whether they were not invited or whether they declined to participate.

The NHS Continuing Care Retrospective Review was carried out with the knowledge and permission of the patient and next of kin. [redacted] had difficulty writing therefore was unable to sign any relevant consent forms or the fill in the Claimant Questionnaire. [redacted] and next of kin signed or completed any relevant forms on behalf of [redacted].

A NHS Continuing Care Retrospective Review Claimant Questionnaire was completed by the next of kin on 29.01.2013.

Please list the assessments and other key evidence that were taken into account in completing the DST, including the dates of the assessments:

The following documentation was reviewed for the NHS Continuing Care Retrospective Assessment Review:

- NHS Continuing Care Checklist completed on 27.02.2014
- GP Records
- Hospital Records - [redacted] Hospital
- Hospital Records – [redacted] Hospital
- [redacted] Care Agency - carer records
- NHS Retrospective Review Claimant Questionnaire – completed by next of kin on 29.01.2013

A NHS Continuing Care Checklist was completed on 27.02.2014 which indicated the need for a full assessment for the period January 2012 to October 2012.

[redacted] was an inpatient in [redacted] Hospital from 04.01.2012 to 23.01.2012. Following treatment for the fractured neck of femur [redacted] was discharged on 23.01.2012 to [redacted] Ward, [redacted] Hospital for rehabilitation.

Following a period of rehabilitation at [redacted] Hospital [redacted] was discharged back to [redacted] home on 27.02.2012.

On 10.03.2012 [redacted] was admitted to [redacted] Hospital with pneumonia. [redacted] was discharged back to [redacted] home on 26.03.2012.

[redacted] was receiving NHS care while an inpatient at [redacted] Hospital, [redacted] Hospital and [redacted] Hospital. Therefore the periods of hospitalisation would not be considered for NHS Continuing Care for the following periods - 04.01.2012 to 26.01.2012 and 10.03.2012 to 25.03.2102. (The day of discharge back to home from [redacted] Hospital on 27.02.2012 and discharge from [redacted] Hospital on 26.03.2012 would be considered for NHS Continuing Care).

Decision Support Tool for NHS Continuing Healthcare
Section 1 – Personal Details

Assessors' (including MDT members) name/address/contact details noting lead coordinator:

Name
CHC Retrospective Team
[redacted]

Contact details of GP and other key professionals involved in the care of the individual:

The following professionals were involved in the care of [redacted]

- GP
- District Nursing Team
- Consultant Neurologist
- Neurology Specialist Nurse
- Podiatrist
- Speech and Language Therapist
- Physiotherapist
- Occupational Therapist
- Wheelchair Technician
- Carers from [redacted] Care Agency

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains

Please refer to the user notes

1. Behaviour: Human behaviour is complex, hard to categorise, and may be difficult to manage. Challenging behaviour in this domain includes but is not limited to:

- aggression, violence or passive non-aggressive behaviour
- severe disinhibition
- intractable noisiness or restlessness
- resistance to necessary care and treatment (this may therefore include non-concordance and non-compliance, but see note below)
- severe fluctuations in mental state
- extreme frustration associated with communication difficulties
- inappropriate interference with others
- identified high risk of suicide

The assessment of needs of an individual with serious behavioural issues should include specific consideration of the risk(s) **to themselves, others or property** with particular attention to aggression, self-harm and self-neglect and any other behaviour(s), irrespective of their living environment.

1. Describe the actual needs of the individual, including any episodic needs. Provide the evidence that informs the decision overleaf on which level is appropriate, such as the times and situations when the behaviour to likely to be performed across a range of typical daily routines and the frequency, duration and impact of the behaviour.
2. Note any overlap with other domains.
3. Circle the assessed level overleaf.

[redacted] was usually compliant with care. There were occasions when advice was not followed. For example [redacted] was advised to have a hospital bed by the Occupational Therapist, however this was initially refused but a hospital bed was agreed to at a later date. Although [redacted] did not always comply to advice this was [redacted] decision and [redacted] expressed [redacted] choice.

Frustration with the symptoms of [redacted] condition appeared to be a concern. [redacted] could sometimes become frustrated due to communication difficulties. [redacted] speech could be quiet making it difficult for some people to hear or understand. [redacted] found it difficult to communicate by telephone. The Speech and Language Therapist trialled an Echovoice with [redacted] which enables speech to be heard more clearly. However, [redacted] found this intrusive and found it difficult to use because [redacted] got the wires mixed up. In addition [redacted] felt the headset did not fit properly. [redacted] did not think it worth continuing with the Echovoice.

When [redacted] was delivered an electric wheelchair there was frustration at not being able to use it as [redacted] kept bumping into furniture.

On reviewing the documentation there was no evidence of aggressive behaviour.

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains
Please refer to the user notes

1. Behaviour

Description	Level of need
No evidence of 'challenging' behaviour.	No needs
Some incidents of 'challenging' behaviour. A risk assessment indicates that the behaviour does not pose a risk to self, others or property or a barrier to intervention. The person is compliant with all aspects of their care.	Low
'Challenging' behaviour that follows a predictable pattern. The risk assessment indicates a pattern of behaviour that can be managed by skilled carers or care workers who are able to maintain a level of behaviour that does not pose a risk to self, others or property. The person is nearly always compliant with care.	**Moderate**
'Challenging' behaviour that poses a predictable risk to self, others or property. The risk assessment indicates that planned interventions are effective in minimising but not always eliminating risks. Compliance is variable but usually responsive to planned interventions.	High
'Challenging' behaviour of severity and/or frequency that poses a significant risk to self, others or property. The risk assessment identifies that the behaviour(s) require(s) a prompt and skilled response that might be outside the range of planned interventions.	Severe
'Challenging' behaviour of a severity and/or frequency and/or unpredictability that presents an immediate and serious risk to self, others or property. The risks are so serious that they require access to an immediate and skilled response at all times for safe care.	Priority

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains

Please refer to the user notes

2. Cognition: This may apply to, but is not limited to, individuals with learning disability and/or acquired and degenerative disorders. Where cognitive impairment is identified in the assessment of need, active consideration should be given to referral to an appropriate specialist if one is not already involved. A key consideration in determining the level of need under this domain is making a professional judgement about the degree of risk to the individual.

Please refer to the National Framework guidance about the need to apply the principles of the Mental Capacity Act in every case where there is a question about a person's capacity. The principles of the Act should also be applied to all considerations of the individual's ability to make decisions and choices.

1. Describe the actual needs of the individual (including episodic and fluctuating needs), providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.
2. Where cognitive impairment has an impact on behaviour, take this into account in the behaviour domain, so that the interaction between the two domains is clear.
3. Circle the assessed level overleaf.

[redacted] had MSA a progressive neurological condition.

[redacted] was able to make decisions about his care. [redacted] was unable to write and relied on [redacted] to sign any necessary forms for [redacted] also dealt with [redacted] finances for which [redacted] had an Enduring Power of Attorney. [redacted] was responsible for administering [redacted] medication.

As a result of the progressive MSA [redacted] would sometimes have periods of confusion or become forgetful. [redacted] would sometimes become anxious which at times may have impacted on [redacted] cognition.

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains
Please refer to the user notes

2. Cognition

Description	Level of need
No evidence of impairment, confusion or disorientation.	No needs
Cognitive impairment which requires some supervision, prompting or assistance with more complex activities of daily living, such as finance and medication, but awareness of basic risks that affect their safety is evident. **OR** Occasional difficulty with memory and decisions/choices requiring support, prompting or assistance. However, the individual has insight into their impairment.	Low
Cognitive impairment (which may include some memory issues) that requires some supervision, prompting and/or assistance with basic care needs and daily living activities. Some awareness of needs and basic risks is evident. The individual is usually able to make choices appropriate to needs with assistance. However, the individual has limited ability even with supervision, prompting or assistance to make decisions about some aspects of their lives, which consequently puts them at some risk of harm, neglect or health deterioration.	Moderate
Cognitive impairment that could include frequent short-term memory issues and maybe disorientation to time and place. The individual has awareness of only a limited range of needs and basic risks. Although they may be able to make some choices appropriate to need on a limited range of issues they are unable to consistently do so on most issues, even with supervision, prompting or assistance. The individual finds it difficult even with supervision, prompting or assistance to make decisions about key aspects of their lives, which consequently puts them at high risk of harm, neglect or health deterioration.	High
Cognitive impairment that may, for example, include, marked short-term memory issues, problems with long-term memory or severe disorientation to time, place or person. The individual is unable to assess basic risks even with supervision, prompting or assistance, and is dependent on others to anticipate their basic needs and to protect them from harm, neglect or health deterioration.	Severe

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains

Please refer to the user notes

3. Psychological and Emotional Needs: There should be evidence of considering psychological needs and their impact on the individual's health and well-being, irrespective of their underlying condition. Use this domain to record the individual's psychological and emotional needs and how they contribute to the overall care needs, noting the underlying causes. Where the individual is unable to express their psychological/emotional needs (even with appropriate support) due to the nature of their overall needs (which may include cognitive impairment), this should be recorded and a professional judgement made based on the overall evidence and knowledge of the individual.

1. Describe the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.
2. Circle the assessed level overleaf.

[redacted] had MSA which is a progressive neurological condition. [redacted] had worked as a electrical engineer and an editor for financial and engineering magazines. The progression of the MSA and deterioration following two admissions to hospital would have impacted emotionally on [redacted] and [redacted]. [redacted] would get anxious. Some of the anxiety may have been due to the impact the progression of the MSA and the impact on [redacted] decreasing independence and reliance on [redacted] and carers. [redacted] bed was in the dining room because [redacted] was unable to get up or down the stairs safely.

In January 2012 [redacted] was admitted to hospital for a fractured neck of femur and in March 2012 for pneumonia. Post discharge from hospital deterioration in [redacted] abilities was having an impact on [redacted] activities of daily living. [redacted] wanted to be independent but had to depend on [redacted] and carers for aspects such as hygiene needs, support and observation of feeding and toileting needs.

When [redacted] was discharged from hospital in February 2012 following treatment for a fractured neck of femur a deterioration in [redacted] mobility had been noted. [redacted] was initially isolated at home because a ramp had not been built to enable [redacted] to get out in [redacted] wheelchair. The ramp was eventually built. [redacted] trialled an electrical wheelchair as [redacted] was unable to move around in a manual wheelchair by [redacted]. The trial was not successful due to [redacted] poor coordination as he kept bumping into furniture. This was frustrating for [redacted] as the electric wheelchair would have allowed some independence. [redacted] continued with the manual wheelchair having to rely on other people to wheel [redacted] about.

[redacted] was spending long periods in bed. This was detrimental to [redacted] psychological and emotional wellbeing.

[redacted] sometimes had difficulty in making [redacted] understood to other people due to quiet speech. [redacted] also found it difficult to use the telephone because people could not hear or understand what

[redacted] was saying. This could lead to frustration.

The Neurologist had suggested the insertion of Percutaneous endoscopic gastrostomy (PEG) for feeding which [redacted] did not want at that time. This further demonstrates the progressive nature of MSA and the decisions that [redacted] was faced with.

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains
Please refer to the user notes

3. Psychological and Emotional Needs

Description	Level of need
Psychological and emotional needs are not having an impact on their health and well-being.	No needs
Mood disturbance, hallucinations or anxiety symptoms, or periods of distress, which are having an impact on their health and/or well-being but respond to prompts and reassurance. **OR** Requires prompts to motivate self towards activity and to engage them in care planning, support, and/or daily activities.	**Low**
Mood disturbance, hallucinations or anxiety symptoms, or periods of distress, which do not readily respond to prompts and reassurance and have an increasing impact on the individual's health and/or well-being. **OR** Due to their psychological or emotional state the individual has withdrawn from most attempts to engage them in care planning, support and/or daily activities.	Moderate
Mood disturbance, hallucinations or anxiety symptoms, or periods of distress, that have a severe impact on the individual's health and/or well-being. **OR** Due to their psychological or emotional state the individual has withdrawn from any attempts to engage them in care planning, support and/or daily activities.	High

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains

Please refer to the user notes

4. Communication: This section relates to difficulties with expression and understanding, in particular with regard to communicating needs. An individual's ability or otherwise to communicate their needs may well have an impact both on the overall assessment and on the provision of care. Consideration should always be given to whether the individual requires assistance with communication, for example through an interpreter, use of pictures, sign language, use of Braille, hearing aids, or other communication technology.

1. Describe the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.
2. Circle the assessed level overleaf.

[redacted] was deaf, completely deaf in [redacted] right ear and wore a hearing aid in his left ear (the deafness was caused by Meniere's disease).

[redacted] had dysphonia and dysarthria due to MSA. [redacted] speech was sometimes weak, quiet and difficult to understand. [redacted] was sometimes slow to make sentences. [redacted] was regularly assessed by the Speech and Language Therapist. Assessment found [redacted] to have a fast rate of speech and reduced lip movement. Strategies were advised including to swallow excess saliva and take a deep breath before speaking, pause for breath often, ensuring a good position for breath support, reducing background noise and distractions, exaggerate articulation and to speak at slow rate. Strategies for individuals communicating with [redacted] included making sure to stand on [redacted] left side, speaking clearly and slowly and ensuring able to see [redacted] mouth. A further strategy included [redacted] giving feedback on what [redacted] understood when asking for repetition. [redacted] found it difficult with some of the strategies. For example [redacted] found it hard to remember to over articulate. [redacted] tried abdominal breathing exercises a few times.

The Speech and Language Therapist trialled an Echovoice with [redacted] The Echovoice would enable speech to be amplified at times when speech was poor. However, despite the Echovoice being effective at amplifying voice, [redacted] found it intrusive. [redacted] agreed to trial the Echovoice for a month but found it difficult to use because [redacted] got the wires mixed up. In addition [redacted] felt the headset did not fit properly. [redacted] did not think it was worth continuing with the Echovoice.

Due to the MSA [redacted] had poor coordination. [redacted] was unable to write therefore had to rely on [redacted] to sign forms or write letters on [redacted] behalf. [redacted] was able at times to use a laptop computer.

[redacted] found it difficult to use the telephone. [redacted] was hard of hearing and despite wearing a hearing aid in [redacted] left ear there was some difficulty in hearing people talk on the telephone. Due to [redacted] speech problems people found it difficult if talking to [redacted] on the telephone to understand what [redacted] was saying.

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains
Please refer to the user notes

4. Communication

Description	Level of need
Able to communicate clearly, verbally or non-verbally. Has a good understanding of their primary language. May require translation if English is not their first language.	No needs
Needs assistance to communicate their needs. Special effort may be needed to ensure accurate interpretation of needs or additional support may be needed either visually, through touch or with hearing.	**Low**
Communication about needs is difficult to understand or interpret or the individual is sometimes unable to reliably communicate, even when assisted. Carers or care workers may be able to anticipate needs through non-verbal signs due to familiarity with the individual.	Moderate
Unable to reliably communicate their needs at any time and in any way, even when all practicable steps to assist them have been taken. The person has to have most of their needs anticipated because of their inability to communicate them.	High

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains

Please refer to the user notes

5. Mobility: This section considers individuals with impaired mobility. Please take other mobility issues such as wanderinginto account in the behaviour domain where relevant. Where mobility problems are indicated, an up-to-date Moving and Handling and Falls Risk Assessment should exist or have been undertaken as part of the assessment process (in line with section 6.14 of the National Service Framework for Older People, 2001), and the impact and likelihood of any risk factors considered. It is important to note that the use of the word 'high' in any particular falls risk assessment tool does not necessarily equate to a high level need in this domain.

1. Describe the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, with reference to movement and handling and falls risk assessments where relevant. Describe the frequency and intensity of need, unpredictability, deterioration and any instability.
2. Circle the assessed level overleaf.

In January 2012 [redacted] was admitted to hospital with a fractured neck of right femur as a result of sustaining a fall. [redacted] was discharged from [redacted] Hospital for a period of rehabilitation at [redacted] Hospital.

Prior to the fractured neck of femur [redacted] was able to mobilise with assistance. However, on return to [redacted] home following rehabilitation at [redacted] hospital [redacted] mobility had deteriorated. Subsequently [redacted] was admitted to [redacted] Hospital with pneumonia and on discharge [redacted] mobility had deteriorated. A district nurse visiting [redacted] noted that [redacted] appeared to have reduced body strength.

[redacted] had MSA in which [redacted] presented with parkinsonism symptoms including poor balance and coordination and poor movement which impacted on his overall mobility. [redacted] was at risk of falls. A neurology review identified that [redacted] was unable to walk because of unequal leg length.

[redacted] had [redacted] bed in the dining room, [redacted] was unable to mobilise safely up or downstairs. On discharge from hospital [redacted] had been spending long periods in bed. This would have impacted on [redacted] psychological and emotional needs and put [redacted] at risk of developing pressure ulcers.

Carers who visited [redacted] three times a day and [redacted] had to transfer using a stand aid hoist or a Ross turntable.

[redacted] was assessed at home by an Occupational Therapist and physiotherapist. The physiotherapist worked with [redacted] and [redacted] to enable safe transfer using a Ross turntable. [redacted] gradually managed to stand [redacted] for longer periods using the turntable. The physiotherapist assessed [redacted] as being safe to be transferred using the Ross turntable. However, carers would not do so until they received written assurance from the physiotherapist. Which was subsequently supplied.

[redacted] used a manual wheelchair but [redacted] was unable to manoeuvre [redacted] around in the

wheelchair. [redacted] had an assessment by a wheelchair technician. As a result of the assessment an electric wheelchair was ordered. Unfortunately [redacted] was unable to use the wheelchair safely due to [redacted] lack of coordination. [redacted] kept bumping into furniture which was frustrating for [redacted]. [redacted] stopped using the electric wheelchair and preferred the use of the manual wheelchair. The wheelchair technician suggested the use of a battery pack for use with the wheelchair so that [redacted] would find it easier to manoeuvre when out. On initial discharge from [redacted] hospital [redacted] was confined to the house because there was no ramp for the wheelchair. A ramp was eventually built to enable [redacted] to get out of the house in the wheelchair.

In addition to lack of mobility as a result of the MSA [redacted] experienced poor posture and would often lean to one side. This required careful positioning in [redacted] chair or bed to ensure [redacted] was supported and comfortable. [redacted] was unable to do this [redacted] and was dependent on [redacted] or carers. The physiotherapist assessed [redacted] for aids to support his posture. A foam wedge proved to be unreliable not offering much support. Cushions were found to be more appropriate. [redacted] was unable to position the cushions [redacted] and relied on the carers or [redacted] to do so.

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains
Please refer to the user notes

5. Mobility

Description	Level of need
Independently mobile	No needs
Able to weight bear but needs some assistance and/or requires mobility equipment for daily living.	Low
Not able to consistently weight bear. **OR** Completely unable to weight bear but is able to assist or cooperate with transfers and/or repositioning. **OR** In one position (bed or chair) for the majority of time but is able to cooperate and assist carers or care workers. **OR** At moderate risk of falls (as evidenced in a falls history or risk assessment)	Moderate
Completely unable to weight bear and is unable to assist or cooperate with transfers and/or repositioning. **OR** **Due to risk of physical harm or loss of muscle tone or pain on movement needs careful positioning and is unable to cooperate.** **OR** **At a high risk of falls (as evidenced in a falls history and risk assessment).** **OR** Involuntary spasms or contractures placing the individual or others at risk.	**High**
Completely immobile and/or clinical condition such that, in either case, on movement or transfer there is a high risk of serious physical harm and where the positioning is critical.	Severe

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains

Please refer to the user notes

6. Nutrition – Food and Drink: Individuals at risk of malnutrition, dehydration and/or aspiration should either have an existing assessment of these needs or have had one carried out as part of the assessment process with any management and risk factors supported by a management plan. Where an individual has significant weight loss or gain, professional judgement should be used to consider what the trajectory of weight loss or gain is telling us about the individual's nutritional status.

1. Describe the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.
2. Circle the assessed level overleaf.

Due to the MSA [redacted] was at risk of aspiration pneumonia due to dysphagia (swallowing difficulties). [redacted] was assessed by the Speech and Language Therapist (SALT). Following a SALT assessment while [redacted] was in hospital, recommendations included one to one supervision for meals to be alert, to be sat upright, supported feeding and use a valve straw when drinking. Food was pureed and [redacted] had normal fluids.

[redacted] was prescribed Glycopyrronium bromide 2mg tabs one twice a day to dry out excessive saliva. Excessive saliva would impact on his speech and swallowing.

[redacted] was assessed by home visits from the SALT and telephone review. An assessment at home by the SALT in April 2012 (following a referral by the Neurology Specialist Nurse) noted that [redacted] swallow was effective but due to recurrent chest infections a videofluroscopy was required to identify risk of silent aspiration. Recommendations included to puree food (fork mashed), normal fluids, encourage slow intake of food one mouthful at a time and to ensure upright to 90 degrees for all food intake. The SALT advised to try red grape juice for saliva control. At a further review by the SALT the advice regarding the grape juice had not been implemented. The SALT advised that if [redacted] was coughing on oral intake or [redacted] chest deteriorated then the SALT was to be contacted as soon as possible.

A review in Neurology clinic had commented on the possibility of [redacted] to be considered for a Percutaneous endoscopic gastrostomy (PEG). [redacted] was not keen on having a PEG.

There was a delay with an appointment for the videofluroscopy. However, in September 2012 following a report from the videofluroscopy the SALT recommended that [redacted] continued with normal fluids taken via a straw, to trial soft/normal diet avoiding foods that [redacted] finds difficult.

Further assessment of [redacted] swallowing by the SALT in October 2012 noted that [redacted] was managing more normal solid food. No clinical signs of aspiration had been reported. Recommendations included to continue on soft/normal diet, normal fluids via a straw, 90 degree angle for all oral intake, to trial bread and salad. The SALT would regularly review [redacted]

[redacted] tended to lean to one side and [redacted] or carers had to ensure that [redacted] was upright for feeding and not leaning to the side.

[redacted] was prescribed nutritional supplements. The district nurse noted that [redacted] ate well and had an above average BMI 25-29.9 and weight loss score 0.5-5kg. However, in October 2012 the SALT noted that [redacted] had mild weight loss with [redacted] weight being 15-16 stone. It was recommended to monitor weight loss (judging by how clothing fits and whether more loose).

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains
Please refer to the user notes

6. Nutrition – Food and Drink

Description	Level of need
Able to take adequate food and drink by mouth to meet all nutritional requirements.	No needs
Needs supervision, prompting with meals, or may need feeding and/or a special diet. **OR** Able to take food and drink by mouth but requires additional/supplementary feeding.	Low
Needs feeding to ensure adequate intake of food and takes a long time (half an hour or more), including liquidised feed. **OR** Unable to take any food and drink by mouth, but all nutritional requirements are being adequately maintained by artificial means, for example via a non-problematic PEG.	Moderate
Dysphagia requiring skilled intervention to ensure adequate nutrition/hydration and minimise the risk of choking and aspiration to maintain airway. **OR** Subcutaneous fluids that are managed by the individual or specifically trained carers or care workers. **OR** Nutritional status "at risk" and may be associated with unintended, significant weight loss. **OR** Significant weight loss or gain due to identified eating disorder. **OR** Problems relating to a feeding device (for example PEG.) that require skilled assessment and review.	**High**
Unable to take food and drink by mouth. All nutritional requirements taken by artificial means requiring ongoing skilled professional intervention or monitoring over a 24 hour period to ensure nutrition/hydration, for example I.V. fluids. **OR** Unable to take food and drink by mouth, intervention inappropriate or impossible.	Severe

7. Continence: Where continence problems are identified, a full continence assessment exists or has been undertaken as part of the assessment process, any underlying conditions identified, and the impact and likelihood of any risk factors evaluated.

1. Describe the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.
2. Take into account any aspect of continence care associated with behaviour in the Behaviour domain.
3. Circle the assessed level overleaf.

Due to [redacted] MSA and autonomic problems, this resulted in reduced bladder control. [redacted] was catheterised which was regularly changed by the district nurse. However, the catheter would become blocked requiring bladder washouts. The washouts were carried out by [redacted] [redacted] or the district nurse. There were occasions when the catheter had to be changed earlier than the planned change due to problems with blockage and overflow. The problems of the catheter blockage were unpredictable but required prompt management to prevent any further complications.

[redacted] was prone to urinary tract infections requiring monitoring and referring to the GP as appropriate to ensure timely treatment such as antibiotics.

[redacted] experienced faecal incontinence and constipation. Monitoring and management of the faecal incontinence and constipation was on-going. There is evidence in the documentation of the district nurse having to perform a rectal examination due to [redacted] not having [redacted] bowels open for six days. [redacted] was prescribed Lactulose for constipation.

[redacted] developed blisters on [redacted] thigh which the district nurse queried whether due to a latex allergy from the catheter. The district nurse monitored and reviewed regularly. The blisters eventually healed.

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains
Please refer to the user notes

7. Continence

Description	Level of need
Continent of urine and faeces.	No needs
Continence care is routine on a day-to-day basis; Incontinence of urine managed through, for example, medication, regular toileting, use of penile sheaths, etc. **AND** is able to maintain full control over bowel movements or has a stable stoma, or may have occasional faecal incontinence/constipation.	Low
Continence care is routine but requires monitoring to minimise risks, for example those associated with urinary catheters, double incontinence, chronic urinary tract infections and/or the management of constipation.	Moderate
Continence care is problematic and requires timely and skilled intervention, beyond routine care (for example frequent bladder wash outs, manual evacuations, frequent re-catheterisation).	**High**

8. Skin (including tissue viability): Evidence of wounds should derive from a wound assessment chart or tissue viability assessment completed by an appropriate professional. Here, a skin condition is taken to mean any condition which affects or has the potential to affect the integrity of the skin.

1. Describe the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.
2. Circle the assessed level overleaf.

[redacted] required full assistance for [redacted] personal and hygiene needs. [redacted] had poor and fluctuating mobility. [redacted] was unable to move [redacted] independently in bed or in [redacted] chair to change [redacted] position. [redacted] tended to lean to one side which could have put pressure on that side if [redacted] was not positioned appropriately. The Waterlow score assessed by the district nurse was 20 very high risk. At a later date the Waterlow score was assessed as 15 high risk.

On discharge from hospital [redacted] had a small broken area 1cm x 2mm to [redacted] inner buttock crease. It was noted to be 100% granular with good surrounding skin. Further reviews by the district nurse evidenced that the broken area was healing. For example at one visit it was noted to be a slight scuff to buttocks and was covered with Tegaderm dressing for protection. A further visit noted that [redacted] had some discoloration on [redacted] buttocks but a dressing was not required.

There were times when [redacted] spent long periods in bed. When [redacted] was not in bed [redacted] would spend long periods in in chair or wheelchair. [redacted] sat out in a recliner chair, there was a risk of slipping and potential for developing pressure ulcers due to friction or sheering. It was difficult for [redacted] to use a pressure relieving cushion due to [redacted] posture and difficulty in positioning. This made **** at risk of developing pressure ulcers. [redacted] was transferred using a stand aid hoist or Ross turntable. The physiotherapist advised [redacted] to stand [redacted] on the Ross turntable, gradually lengthening the time. This would have given some relief, but there was an inevitable risk to developing pressure ulcers due to long periods sitting or lying down. Cavilon cream (Cavilon is a barrier cream) was regularly applied.

[redacted] developed blisters on his thigh requiring assessment, on-going monitoring and dressings being applied by the district nurse. The district nurse considered the blisters could be a latex allergy from the latex catheters. An alternate catheter such as a silicone catheter was advised and tried but [redacted] was concerned that previous use of a silicone catheter caused too much trauma due to how hard it is and caused bladder damage. Use of the latex catheter continued and there was regular monitoring and dressings by the district nurse. The blisters eventually healed but gauze was used to protect the thigh from the catheter.

[redacted] was catheterised which would overflow requiring bed linen and clothes to be changed promptly to prevent pressure ulcers and moisture lesions. In addition [redacted] had occasional faecal incontinence which would require appropriate management.

[redacted] had dry skin which required the application of an emollient by the carers or [redacted]. Support hosiery is worn by [redacted] on a daily basis which requires [redacted] or carers to put on and remove.

[redacted] was regularly visited by the podiatrist and appropriate assessment and treatment given.

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains
Please refer to the user notes

8. Skin (including tissue viability)

Description	Level of need
No risk of pressure damage or skin condition.	No needs
Risk of skin breakdown which requires preventative intervention once a day or less than daily without which skin integrity would break down. **OR** Evidence of pressure damage and/or pressure ulcer(s) either with 'discolouration of intact skin' or a minor wound. **OR** A skin condition that requires monitoring or reassessment less than daily and that is responding to treatment or does not currently require treatment.	Low
Risk of skin breakdown which requires preventative intervention several times each day, without which skin integrity would break down. **OR** Pressure damage or open wound(s), pressure ulcer(s) with 'partial thickness skin loss involving epidermis and/or dermis', which is responding to treatment. **OR** A skin condition that requires a minimum of daily treatment, or daily monitoring/reassessment to ensure that it is responding to treatment.	**Moderate**
Pressure damage or open wound(s), pressure ulcer(s) with 'partial thickness skin loss involving epidermis and/or dermis', which is not responding to treatment **OR** Pressure damage or open wound(s), pressure ulcer(s) with 'full thickness skin loss involving damage or necrosis to subcutaneous tissue, but not extending to underlying bone, tendon or joint capsule', which is/are responding to treatment. **OR** Specialist dressing regime in place; responding to treatment	High
Open wound(s), pressure ulcer(s) with 'full thickness skin loss involving damage or necrosis to subcutaneous tissue, but not extending to underlying bone, tendon or joint capsule' which are not responding to treatment and require regular monitoring/reassessment. **OR** Open wound(s), pressure ulcer(s) with 'full thickness skin loss with extensive destruction and tissue necrosis extending to underlying bone, tendon or joint capsule' or above **OR** Multiple wounds which are not responding to treatment.	Severe

9. Breathing As with all other domains, the breathing domain should be used to record needs rather than the underlying condition that may give rise to the needs For example, an individual may have Chronic Obstructive Pulmonary Disease (COPD), emphysema or recurrent chest infections or another condition giving rise to breathing difficulties, and it is the needs arising from such conditions which should be recorded.

1. Describe below the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.
2. Circle the assessed level overleaf.

[redacted] was prone to chest infections and in March 2012 [redacted] was admitted to [redacted] Hospital with pneumonia from which [redacted] made a recovery.

[redacted] had impaired swallowing ability which if not managed appropriately could result in choking and possible aspiration pneumonia. The Speech and Language Therapist had advised on strategies to prevent complications such as one to one support and sitting upright for feeding.

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains
Please refer to the user notes

9. Breathing

Description	Level of need
Normal breathing, no issues with shortness of breath.	No needs
Shortness of breath which may require the use of inhalers or a nebuliser and has no impact on daily living activities. **OR** **Episodes of breathlessness that readily respond to management and have no impact on daily living activities.**	**Low**
Shortness of breath which may require the use of inhalers or a nebuliser and limit some daily living activities. **OR** Episodes of breathlessness that do not respond to management and limit some daily living activities. **OR** Requires any of the following: • low level oxygen therapy (24%). • room air ventilators via a facial or nasal mask. • other therapeutic appliances to maintain airflow where individual can still spontaneously breathe e.g. CPAP (Continuous Positive Airways Pressure) to manage obstructive apnoea during sleep.. •	Moderate
Is able to breathe independently through a tracheotomy that they can manage themselves, or with the support of carers or care workers. **OR** Breathlessness due to a condition which is not responding to treatment and limits all daily living activities	High
Difficulty in breathing, even through a tracheotomy, which requires suction to maintain airway. **OR** Demonstrates severe breathing difficulties at rest, in spite of maximum medical therapy Or A condition that requires management by a non-invasive device to both stimulate and maintain breathing (bilevel positive airway pressure, or non-invasive ventilation)	Severe
Unable to breathe independently, requires invasive mechanical ventilation.	Priority

10. Drug Therapies and Medication: Symptom Control: The individual's experience of how their symptoms are managed and the intensity of those symptoms is an important factor in determining the level of need in this area. Where this affects other aspects of their life, please refer to the other domains, especially the psychological and emotional domain. The location of care will influence who gives the medication. In determining the level of need, it is the knowledge and skill required to manage the clinical need and the interaction of the medication in relation to the need that is the determining factor. In some situations, an individual or their carer will be managing their own medication and this can require a high level of skill. References below to medication being required to be administered by a registered nurse do not include where such administration is purely a registration or practice requirement of the care setting (such as a care home requiring all medication to be administered by a registered nurse).

1. Describe below the actual needs of the individual and provide the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.
2. Circle the assessed level overleaf.

All prescribed medication was administered by [redacted]. [redacted] was unable to self medicate due to difficulty with coordination and poor dexterity. Medication was in soluble from due to risk of choking.

[redacted] was prescribed the following medication:

- Glycopyrronium bromide 2mg tabs one twice a day,
- Ensure plus nutrition supplement
- Amantadine 50mg/5ml 2x5ml spoon twice daily
- Lactulose 10-15mls twice daily
- Lansoprazole 30mg once daily
- ABIDEC multivitamin drops
- Cavilon barrier cream

In addition when [redacted] had a urinary tract infection or chest infection antibiotics were prescribed by the GP.

Medication required monitoring and referral to the GP as required for further review. Medication was also reviewed by the Consultant Neurologist.

10. Drug Therapies and Medication: Symptom Control

Description	Level of need
Symptoms are managed effectively and without any problems, and medication is not resulting in any unmanageable side-effects.	No needs
Requires supervision/administration of and/or prompting with medication but shows compliance with medication regime. **OR** Mild pain that is predictable and/or is associated with certain activities of daily living. Pain and other symptoms do not have an impact on the provision of care.	Low
Requires the administration of medication (by a registered nurse, carer or care worker) due to: non-concordance or non-compliance, or type of medication (for example insulin), or route of medication (for example PEG,). **OR** Moderate pain which follows a predictable pattern; or other symptoms which are having a moderate effect on other domains or on the provision of care.	Moderate
Requires administration and monitoring of medication regime by a registered nurse, carer or care worker specifically trained for the task because there are risks associated with the potential fluctuation of the medical condition or mental state, or risks regarding the effectiveness of the medication or the potential nature or severity of side-effects. However, with such monitoring the condition is usually non-problematic to manage. **OR** Moderate pain or other symptoms which is/are having a significant effect on other domains or on the provision of care.	High
Requires administration and monitoring of medication regime by a registered nurse, carer or care worker specifically trained for this task because there are risks associated with the potential fluctuation of the medical condition or mental state, or risks regarding the effectiveness of the medication or the potential nature or severity of side-effects. Even with such monitoring the condition is usually problematic to manage. **OR** Severe recurrent or constant pain which is not responding to treatment. **OR** Risk of non-concordance with medication, placing them at risk of relapse.	Severe
Has a drug regime that requires daily monitoring by a registered nurse to ensure effective symptom and pain management associated with a rapidly changing and/or deteriorating condition. **OR** Unremitting and overwhelming pain despite all efforts to control pain effectively.	Priority

11. Altered States of Consciousness (ASC): ASCs can include a range of conditions that affect consciousness including Transient Ischemic Attacks (TIAs), Epilepsy and Vasovagal Syncope

1.Describe below the actual needs of the individual providing the evidence that informs the decision overleaf on which level is appropriate (referring to appropriate risk assessments), including the frequency and intensity of need, unpredictability, deterioration and any instability.
2. Circle the assessed level overleaf.

[redacted] had MSA which could lead to autonomic problems such as low blood pressure. [redacted] experienced some dizzy spells. However, it is noted from review of the documentation that [redacted] had no episodes of altered states of consciousness.

11. Altered States of Consciousness (ASC)

Description	Level of need
No evidence of altered states of consciousness (ASC).	No needs
History of ASC but it is effectively managed and there is a low risk of harm.	**Low**
Occasional (monthly or less frequently) episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm.	Moderate
Frequent episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm. **OR** Occasional ASCs that require skilled intervention to reduce the risk of harm.	High
Coma. **OR** ASC that occur on most days, do not respond to preventative treatment, and result in a severe risk of harm.	Priority

12. Other significant care needs to be taken into consideration: There may be circumstances, on a case-by-case basis, where an individual may have particular needs which do not fall into the care domains described above or cannot be adequately reflected in these domains. If the boxes within each domain that give space for explanatory notes are not sufficient to document all needs, it is the responsibility of the assessors to determine and record the extent and type of these needs here. The severity of this need and its impact on the individual need to be weighted, using the professional judgement of the assessors, in a similar way to the other domains. This weighting also needs to be used in the final decision. It is important that the agreed level is consistent with the levels set out in the other domains. The availability of this domain should not be used to inappropriately affect the overall decision on eligibility.

1. Enter below a brief description of the actual needs of the individual, including providing the evidence why the level in the table overleaf has been chosen (referring to appropriate risk assessments), and referring to the frequency and intensity of need, unpredictability, deterioration and any instability.
2. Circle the assessed level overleaf.

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains
Please refer to the user notes

12: Other significant care needs to be taken into consideration

Description	Level of need
	Low
	Moderate
	High
	Severe

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains

Please refer to the user notes

Assessed Levels of Need

Care Domain	P	S	H	M	L	N
Behaviour				X		
Cognition	[redacted]				X	
Psychological Needs	[redacted]	[redacted]			X	
Communication	[redacted]	[redacted]			X	
Mobility	[redacted]		X			
Nutrition – Food and Drink	[redacted]		X			
Continence	[redacted]	[redacted]	X			
Skin (including tissue viability)	[redacted]			X		
Breathing					X	
Drug Therapies and Medication			X			
Altered States of Consciousness		[redacted]			X	
Other significant care needs	[redacted]					
Totals			4	2	5	

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains

Please refer to the user notes

Please note below any views of the individual on the completion of the DST that have not been recorded above, including whether they agree with the domain levels selected. Where they disagree, this should be recorded below, including the reasons for their disagreement. Where the individual is represented or supported by a carer or advocate, their understanding of the individual's views should be recorded.

Decision Support Tool for NHS Continuing Healthcare
Section 3 – Recommendation

Please refer to the user notes

Recommendation of the multidisciplinary team filling in the DST

Please give a recommendation on the next page as to whether or not the individual is eligible for NHS continuing healthcare. This should take into account the range and levels of need recorded in the Decision Support Tool and what this tells you about whether the individual has a primary health need. Any disagreement on levels used or areas where needs have been counted against more than one domain should be highlighted here. Reaching a recommendation on whether the individual's primary needs are health needs should include consideration of:

- **Nature:** This describes the particular characteristics of an individual's needs (which can include physical, mental health, or psychological needs), and the type of those needs. This also describes the overall effect of those needs on the individual, including the type ('quality') of interventions required to manage them.
- **Intensity:** This relates to both the extent ('quantity') and severity (degree) of the needs and the support required to meet them, including the need for sustained/ongoing care ('continuity').
- **Complexity:** This is concerned with how the needs present and interact to increase the skill needed to monitor the symptoms, treat the condition(s) and/or anage the care. This can arise with a single condition or can also include the presence of multiple conditions or the interactions between two or more conditions.
- **Unpredictability:** This describes the degree to which needs fluctuate, creating challenges in managing them. It also relates to the level of risk to the person's health if adequate and timely care is not provided. Someone with an unpredictable healthcare need is likely to have either a fluctuating, or unstable or rapidly deteriorating condition.

Each of these characteristics may, in combination or alone, demonstrate a primary health need, because of the quality and/or quantity of care required to meet the individual's needs.

Also please indicate whether needs are expected to change (in terms of deterioration or improvement) before the case is next reviewed. If so, please state why and what needs you think will be different and therefore whether you are recommending that eligibility should be agreed now or that an early review date should be set.

Where there is no eligibility for NHS continuing healthcare and the assessment and care plan, as agreed with the individual, indicates the need for support in a care home setting, the team should indicate whether there is the need for registered nursing care in the care home, giving a clear rationale based on the evidence above.

Decision Support Tool for NHS Continuing Healthcare
Section 3 – Recommendation

Please refer to the user notes

Recommendation on eligibility for NHS continuing healthcare detailing the conclusions on the issues outlined on the previous page:

Nature

In 2004 [redacted] was diagnosed with Multiple System Atrophy (MSA), a progressive neurological disorder. Symptoms of MSA reflect the three different areas of the brain – basal ganglia causing problems with movement, cerebellum causing poor balance and coordination and the brain stem causing autonomic problems such as poor bladder and blood pressure control.

Following a fall in January 2012 [redacted] was admitted to hospital with a fractured neck of femur. Subsequently [redacted] was discharged to a community hospital and had a period of rehabilitation. On discharge back home it was noted that [redacted] condition had deteriorated. [redacted] had a further hospital admission in March 2012 for pneumonia.

[redacted] was regularly assessed by the physiotherapist, Speech and Language Therapist and the District Nurse. [redacted] was regularly reviewed by a Neurologist and supported by a Neurology Specialist Nurse.

[redacted] was the main carer. Further support consisted of carers visiting [redacted] home three times a day to deliver care. [redacted] required support with activities of daily living such as to transfer from bed to chair or wheelchair, hygiene, observation and assistance with feeding, continence care and administration of medication. [redacted] was transferred using a stand aid hoist or Ross turntable. [redacted] was at risk of falls.

[redacted] had an indwelling catheter which was changed by the district nurse. The catheter would often block requiring bladder washouts delivered by [redacted] or the district nurse. There were occasions when [redacted] catheter had to be changed earlier that the planned change date.

[redacted] spent long periods in bed or [redacted] chair or wheelchair and was at risk of developing pressure ulcers. [redacted] sat out in a recliner chair, there was a risk of slipping and potential for developing pressure ulcers due to friction or sheering. It was difficult for [redacted] to use a pressure relieving cushion due to [redacted] posture and difficulty in positioning. On discharge from hospital [redacted] had a small broken area 1cm x 2mm to [redacted] inner buttock which was assessed, treated and monitored by the district nurse. The wound healed, however, at a further visit it was noted that [redacted] had some discoloration on [redacted] buttocks but a dressing was not required. Pressure ulcer risk was reviewed regularly.

[redacted] developed blisters on his thigh requiring assessment, on-going monitoring and dressings being applied by the district nurse. The district nurse considered the blisters could be a latex allergy from the latex catheters. It was advised that alternative catheter considered but [redacted] and [redacted] were reluctant to try an alternative because of previous experience. The blisters eventually healed following intervention and treatment by the district nurse but regular monitoring of the area was on-going.

[redacted] had dysphagia and was at risk of choking and aspiration pneumonia. [redacted] required observation, one to one support and assistance with feeding.

[redacted] would become frustrated and anxious. [redacted] was unable to be fully independent and the deterioration of his condition impacted on his emotional state.

[redacted] was unable to self medicate and medication was administered by [redacted].

Intensity

[redacted] required input and on-going assessment and monitoring from various health professionals. [redacted] was [redacted] main carer and was supported by agency carers visiting three times a day to deliver care and to get up and put to bed. [redacted] as main carer liaised on a regular basis with health professionals to communicate concerns and progress. Prescribed medication was administered by [redacted] and [redacted] would report any concerns regarding effectiveness of the medication.

Following a fall [redacted] had an admission to hospital with a fractured neck of femur and was at risk of further falls. Although [redacted] spent long periods in bed or [redacted] chair there was a risk when being transferred. [redacted] would also slide down his recliner chair which if not regularly observed could result in an injury.

[redacted] was at risk of choking and aspiration pneumonia. Recommendations had been made by the Speech and Language Therapist to ensure [redacted] was able to eat safely and prevent complications. For example he required one to one support at mealtimes.

[redacted] had dysarthria and [redacted] voice often went quiet making it difficult for people to understand what [redacted] was saying. Advice and coping strategies were given by the Speech and Language Therapist some of which were implemented by [redacted]

[redacted] had an indwelling urinary catheter which often became blocked and required frequent bladder washouts which were carried out by [redacted]. On occasions the blockages would be problematic requiring an earlier change in catheter by the district nurse earlier than the planned change date. [redacted] was prone to urinary tract infections which required monitoring and prescribed treatment.

[redacted] was at risk of developing pressure ulcers. [redacted] would often spend long periods in bed. There were other occasions when [redacted] would spend long periods in a chair or wheelchair. [redacted] sat out in a recliner chair and on occasions [redacted] would slip down the chair with a potential for developing pressure ulcers due to friction or sheering. It was difficult for [redacted] to use a pressure relieving cushion due to [redacted] posture and difficulty in positioning.

Complexity

The progressive nature of MSA meant deterioration in [redacted] condition. A Consultant Neurologist, Neurology Specialist Nurse and other health professionals were involved in the care of [redacted]

Symptoms of MSA reflect the three different areas of the brain – basal ganglia causing problems with movement, cerebellum causing poor balance and coordination and the brain stem causing

autonomic problems such as poor bladder and blood pressure control. [redacted] was experiencing symptoms and affected by the three different areas of the brain. For example [redacted] was catheterised due to poor bladder control and [redacted] mobility was limited.

[redacted] MSA resulted in interrelating concerns. For example [redacted] was at risk of developing pressure ulcers. This required on-going monitoring and appropriate management. [redacted] spent long periods in a chair or in bed, [redacted] leaned to one side which made positioning difficult, [redacted] had occasional faecal incontinence and [redacted] catheter would occasionally overflow. These factors required appropriate and prompt management to decrease the risk.

[redacted] was at risk of choking and aspiration pneumonia. In March 2012 [redacted] had an admission to hospital with pneumonia. The Speech and Language Therapist made recommendations to lessen the risk of choking such as one to one support, sitting up at 90 degrees when feeding. [redacted] would lean to one side and appropriate methods of support had to be considered to enable [redacted] to sit more upright. The physiotherapist trialled and advised [redacted] on appropriate support such as cushions.

[redacted] was not a trained nurse but [redacted] was delivering care with the skills that a trained nurse would do. For example carrying out bladder washouts for a blocked catheter. In addition [redacted] was monitoring [redacted] for any concerns or complications and ensuring prompt communication to prevent escalation to more serious complications. For example liaising with the GP or district nurse regarding UTIs to enable prompt treatment to prevent sepsis. [redacted] administered [redacted] [redacted] medication and would monitor for effectiveness and any concerns with escalation to the district nurse or GP as appropriate.

Unpredictability

Due to the symptoms experienced by [redacted] and the progressive deterioration of his condition such as poor mobility and risk of aspiration pneumonia [redacted] care needs could often result in unplanned intervention.

[redacted] had an indwelling catheter. The catheter would often block requiring bladder washouts delivered by [redacted] or the district nurse. There were occasions when the bladder washouts were not successful and [redacted] catheter had to be changed earlier than the planned change date. [redacted] was prone to UTIs requiring monitoring and treatment. The problems with the catheter blocking and UTIs were unpredictable.

[redacted] was at risk of developing pressure ulcers and this required monitoring. On discharge from hospital [redacted] had a small broken area to his inner buttock crease. There were times when [redacted] spent long periods in bed or in [redacted] chair and wheelchair. [redacted] sat out in a recliner chair, there was a risk of slipping and potential for developing pressure ulcers due to friction or sheering. There was an unpredictable risk to developing pressure ulcers due to long periods sitting or lying down.

[redacted] also developed blisters on [redacted] thigh requiring assessment, treatment and on-going monitoring. The district nurse considered this to be a latex allergy and alternative catheters were advised which [redacted] refused due to a difficult previous experience of using a silicone catheter. The blisters healed but there was an unpredictable risk that they would occur again.

[redacted] would regularly liaise with health professionals regarding his condition. Due to the progressive nature of MSA it was difficult to predict when symptoms would deteriorate and require further review or intervention.

Recommendation:
The clinical retrospective assessor has scrutinised all available evidence and considers that the quantity and quality of [redacted] needs in totality are indicative of a primary health need. Therefore considers [redacted] was eligible for NHS Continuing Healthcare retrospectively from 27.02.2012 to 12.11.2012. (Excluding hospitalisation 10.03.2012 to 26.03.2012). From January 2012 [redacted] was in [redacted] Hospital prior to 27.02.2012 therefore would not be considered for NHS Continuing Healthcare until discharge back to his home on 27.02.2012.

From 12.11.2012 [redacted] was found to be eligible for NHS Continuing Healthcare.

Signatures of MDT making above recommendation:

Health professionals

Printed Name	Designation	Professional Qualification	Signature	Date
[redacted]	CHC Retrospective Practitioner	RGN		[redacted]

Social care/other professionals

Printed Name	Designation	Signature	Date

Agenda Item No: 7

NEIGHBOURHOOD CARES PILOT 'Deep Dive'

To:	**Adults Committee**
Meeting Date:	**15 November 2018**
From:	**Wendi Ogle-Welbourn: Executive Director: People and Communities**
Electoral division(s):	***All***
Forward Plan ref:	**N/A** *Key decision:* **No**
Purpose:	**To provide an update on progress of the Neighbourhood Cares Pilot to date and share the findings from the interim external evaluation report.**
Recommendation:	**To consider the report and provide comments on progress, proposed developments and issues raised by the interim external evaluation report.**

Officer contact:		***Member contacts:***	
Name:	Louise Tranham	Names:	Cllr Anna Bailey
Post:	Neighbourhood Cares Manager	Post:	Chair
Email:	louise.tranham@cambridgeshireshire.gov.uk	Email:	annabailey@hotmail.co.uk
Tel:	01223 729139	Tel:	01223 706398

1. BACKGROUND

1.1 On the 24th May 2018 The Adults Committee received a deep dive paper on the Neighbourhood Cares Pilot (NCP). This report provides an update on the progress of the NCP and shares the findings from the interim external evaluation report from York Consulting.

1.2 The Neighbourhood Cares Project (NCP) is testing a radically different model of social care work and social work with funding approved by the General Purpose Committee (GPC) and Strategic Management Team (SMT) in November 2017.

1.3 Buurtzorg Model

The Neighbourhood Cares pilot is based upon the principles of the Buurtzorg model of care that involves the creation of self-managing nursing teams to meet the short term health and care needs for people living in their own homes. This model of care is offered by over 10,000 nurses and care staff in Holland. The success of Buurtzorg is a natural fit with the direction of travel we have for adult social care and we want to apply the Buurtzorg principles to accelerate our transformation of the care and support to older people and people with physical disabilities.

1.4 The principles we are testing are:

- Workers involved with each vulnerable adult kept to a minimum
- Personalised approach
- Reduced cost to the system
- Reduced demand on professional systems and minimum bureaucracy
- Shift as much resource as possible to the front line
- Self-managed local teams, focused on local delivery and solutions
- Maximise opportunities to collaborate with partners and develop an integrated response
- Devolved budget and decision making with teams empowered to solve problems
- Creative solutions developed locally. The care and support is determined by the team according to the needs and strengths of each person using community assets.
- Acceptance of a level of risk
- Reduced dependency on care agencies and try to move away from traditional models of care
- Responsibility for the whole population
- Increasing community resilience and building on social capital
- Delivery of statutory responsibilities and safeguarding duties in a person centred community connected, outcome focussed way.

1.5 The key outcomes are:

- Improve outcomes for service users.
- Manage costs by achieving the same or better outcomes in a more cost effective way.
- Improve job satisfaction for social care staff because they can see the difference they make as they have more direct contact with people enabling them to do the right thing, at the right time in the right place.
- Increase Community capacity where we currently have capacity gaps, particularly in home care.

- Use the learning from the pilot sites to inform the evolution of placed based models of social care for the wider transformation of the whole system.

1.6 York Consulting is carrying out an external evaluation of the NCP the key points from their interim report is provided in **section 3** of this paper.

2 NEIGHBOURHOOD CARES PILOT UPDATE SINCE MAY 2018

2.1 The number of people supported by NCP continues to grow.

The number of people having contact with both NC teams continues to grow each month.

	New referrals St Ives	Total number of people supported by St Ives	New referrals Soham	Total number of people supported by Soham
June	16	200	20	260
July	36	216	29	289
August	28	252	17	306
September	9	261	16	322

2.1.1 Of the 261 people known to the St Ives team, 120 have eligible needs and of those, 47 people receive a contribution to their personal budget from the council. The remaining 73 are not eligible for funding by the local authority.

From these 47, 32 have had a review and the remaining 15 have had Carers assessments.

2.1.2 In Soham 175 of the 322 people known to the team have eligible needs, 153 reviews and assessments have been completed (53, adult social care assessment, 14 Carers assessments and 100 reviews).

2.1.3 Therefore in St Ives 46% of the people known to the team have an eligible need and 28% of those people are not eligible for financial support from the Council. In Soham 54% of the people known to the team have an eligible need and in the region of 5% of those people are not eligible for financial support from the Council.

2.1.4 The difference in the number of people who have had contact with NCP in the 2 sites could be related to a number of factors.
The main ones are :

- While demographics are similar the needs of each community are different.
- The Soham team is able to interact and prompt itself with the whole community. Whereas the St Ives Team is linked to a population registered with one GP practice.
- The Soham Library provides a physical access point that the residents of Soham find welcoming and easy to access and the Neighbourhood Cares Workers (NCWs) can use the building as their work base and a venue to hold a range of events and activities that prompt the NCP.

2.2 **Mosaic**

Members will be aware that in October the implementation of the new adult social care information system, Mosaic went live. This system can accommodate self-managed teams and enables peer to peer authorisation.

2.3 **Devolved budgets to NCP**

Since July 2018 the care budgets for all older and physical disabled service users in the pilot have been transferred to the relevant Neighbourhood Cares Team. This gives the teams' ownership and accountability, resulting in them being even more focussed on individual and creative outcomes. It is too early to give a confident assessment for the spending trends of these budgets.

2.4 **Reablement workers integrated with the Neighbourhood Cares Teams**

2.4.1 Both teams now have reablement staff in the teams. This enables getting the right support to be offered to people when they need it particularly if they have a crisis or sudden change in need.

2.4.2 The reablement workers are also being used by the NCWs to assess the capabilities of people who are due a planned review, to see if there is scope to increase independence by using new types of equipment or technology, thereby reducing or avoiding the cost on long term care.

2.4.3 For example:
A gentleman receiving daily support from carers for his shower following a stroke. When reviewed by the NCW, it was felt it would be possible for him to manage his personal care needs with just his wife's supervision. This is something he wanted to achieve but both he and his wife were anxious about how he could manage without the support of a carer. The NCW arranged for a reablement worker to visit and support the couple so that he could shower independently and safely. The outcome was that within 4 weeks of having the initial contact with the NC team he was able to achieve this goal. The annual avoided cost is £5,987.

2.4.4 It is also important to acknowledge that this couple felt supported knowing if they had any queries they could easily contact the team for advice.

2.4.5 Mary is an 89 year old woman who has memory loss, lives alone and no family living locally. She was referred by her GP who felt she needed regular input from a paid carer to help her maintain her daily living routine. The NCW met with her and discussed the best way to help her remain independent. The NCW also supported her to claim her benefit entitlement which she used to employ a local company to clean her home, do her laundry, shopping and paperwork and support her to maintain her daily routine. The NCW arranged for the team's reablement worker to visit and assess that Mary had all the technology and equipment to meet her daily needs.

2.5 **Reviewing the skills set in the Neighbourhood Care Teams**

The initial composition of each of the NC teams was the equivalent of four fulltime senior social workers. This proved to be beneficial in the setup and initial roll out of testing social care self- managed teams. As we have gained an insight and knowledge into the needs of each local community we have followed the Buurtzorg model and introduced different bands of NCWs into the two teams.

The Buurtzorg teams successfully operate with 3 bands of staff, the NCP is testing a similar approach. This will bring a wider range of skills to the teams and reduce costs.

2.6 **Having accommodation that is meaningful to the community and effective for staff.**

2.6.1 Having been operational for a year the importance of the team base has become more evident. The Soham library provides easy access to the community and access to a range of meeting spaces.

2.6.2 The St Ives NCP is based in the Broad Leas Centre in St Ives. It is in the right location but is not particularly accessible for people with disabilities or those who need space to have a private conversation. The team therefore have to use other community buildings in St Ives. Having the use of a room in the Spinney surgery each week has partially compensated for the limitations of Broadleas.

2.7 **Working with primary care and community health services**

2.7.1 As both teams have become more established we have seen professional relationships develop with colleagues across primary care and community health services.
This good relationship has replaced the need for formal referral processes, achieving the best outcomes for the person and ensuring both health and social care staff time is used appropriately and productively. Our health partners now recognise the benefits NCWs can bring to the management of people with complex health needs.

2.7.2 For example :
A man with complex health needs including alcohol dependence, epilepsy and Type one diabetes was not compliant with his medication. Consequently he had repeated hospital admissions. The NCW had a conversation with him to understand why he required emergency care on a regular basis. They then worked with colleagues in housing, health, reablement and Technology enabled Care to support him to manage daily living tasks and maintain a healthier lifestyle. He was also encouraged to attend health appointments and get involved in local community activities. The outcome is that in the weeks that the NCWs have been providing support he has not required any emergency support from health services.

2.8 **Developing social capital**

2.8.1 NCP is working in partnership with Care Network's Connected Community project, funded by the Council's Innovate and Cultivate grant, to increase the number of social enterprises and personal assistants in St Ives and Soham.

2.8.2 At the time of writing the Connected Community project is actively promoting the support it can offer and has started conversations with people (4 in St Ives and 3 in Soham) who have shown an interest in starting a social enterprise or becoming a personal assistant.

2.8.3 Since May an additional 4 volunteers are now regularly supporting the NCP.
The roles and functions the volunteers perform have expanded and include:

- Running drop in and group sessions knowing they can call on NCWs if they are needed.
- Supporting people who need to make benefit applications to apply for a range of benefits including blue badges, bus passes and attendance allowance.
- Providing practical help to the team, for example, when a person needed their current bed dismantled and their new bed assembled to ensure they could be discharged from hospital that same day a volunteer went with a NCW to complete the task.

2.8.4 Both teams continue to develop their network and relationships with all other partners both voluntary, statutory and private. This has resulted in the teams having confidence in the appropriateness of the information and advice being given to people. It in turn means the NCWs are increasingly seen as a source of information by both people looking for advice and support and those people and organisations that provide services.

2.9 **Training with Public World and Buurtzorg Coach**

2.9.1 To ensure we are using the Buurtzorg principles in delivering the project outcomes we continue to work with Public World and link up with others in the UK using the Buurtzorg principles. In September Public World provided two days of training to NCP and concluded that :
"The Buurtzorg principles seemed to be in all the NCW's DNA and that their way of working demonstrated an exemplary way of delivering social care. What a positive experience it was to work with the NCP as the only local authority currently taking forward the model to deliver social work in the UK."

2.9.2 The NCWs felt that the training gave a detailed insight in to how Buurtzorg teams function and gave them further skills in how they deal with conflict in the team, and to organise and manage their team meetings to be as productive and effective as possible.

2.9.3 Public World will do a further session with the NCWs in December to improve their practice as self-managed teams and the Buurtzorg Coach is available by phone if specific issues need to be addressed.

2.9.4 The plan is to continue to work with Public World to both support the teams and support the Council in taking forward a placed base neighbourhood model beyond March 2019.

2.9.5 The NCP has shared its learning tools with others using Buurtzorg principles in the UK.

3 Interim External Evaluation Report

York Consulting has been commissioned by the Council to undertake an evaluation of the NCP. Their interim report presents early findings on the implementation of the NCP, the successes, challenges and outcomes evidence to date.

3.1 The key points outlined within the conclusion of the report are:

3.2 The final evaluation is seeking to provide evidence on:

- whether the service has prevented people's needs from escalating;
- the impact of the service on clients' quality of life;
- the benefit to community assets;
- the benefits to Neighbourhood Cares Team members;
- the cost benefit of the service;
- the cost of spend on support costs in each 10,000 population;
- the workforce needed to support populations of 10,000 to meet all the social care needs of that community and what that will cost.

1. At this interim reporting stage, we would suggest that the early signs are positive. Qualitative evidence suggests that the pilot has prevented the escalation of needs, impacted on clients' quality of life and had a positive impact on the development of community assets. However, these positive findings cannot be assessed to reflect the whole service cohort and we must wait for the final report to see whether these early indicators are evidenced across the board.
2. Evidence to date suggests that the teams have prevented crises by preventing hospital admissions or readmissions, preventing carer breakdown and preventing a deterioration in mental health issues. Teams have been able to identify issues before they escalate and helped clients and their families plan for the future. Hospital admissions have been prevented by ensuring better continuity of care and readmissions have been prevented by providing more appropriate care on discharge. Hospital admissions have been averted by the swift nature of the NCT response and the trusting relationships developed with workers which means that clients have been more willing to acknowledge the issues they are facing. Being community based the teams are accessible, responsive and seen as different to other services: clients know they can phone them up and they will receive a response.
3. The consultations undertaken so far have also highlighted the impact on clients' quality of life in terms of the teams' ability to provide a personalised response to clients' needs and supporting clients and their families to access more appropriate care to meet those needs. Workers have enabled clients to remain within their own homes, helped improve living conditions and addressed issues of social isolation. This in turn is reported to have had a positive impact on clients' mental health and wellbeing.
4. The teams have facilitated the development of community assets by identifying gaps in existing resources, galvanising existing activity and facilitating the development of groups which can become self-sustaining. Community assets have been developed in partnership with other providers and volunteers and there is evidence of the positive impact engagement in these activities is having on clients and volunteers. Community assets have been developed in St Ives, but the work undertaken has been constrained by capacity/workload issues and logistical challenges. There is a

need for protected time to allow the team to focus on developing this area of work further.

5. For team members, the main benefit of working in the pilot has been improved job satisfaction. This was linked to being in a role where they could provide preventative support, have the flexibility to respond to clients' needs and not be constrained by timeframes. Improved job satisfaction was also linked to the opportunity the pilot gave them to work in a new way, to shape service delivery and be autonomous decision makers within self-managed teams. They valued the learning opportunities presented by the role and the increased confidence linked to these opportunities.
6. At this stage, it is too early to draw any conclusions from the available data and therefore too early to comment with any authority on the cost benefit of the service. A longer analysis period is needed to be conclusive about cost savings, although the interim results allow for some cautious optimism.
7. The cost of spend on support costs in each 10,000 population and the workforce needed to support populations of 10,000 to meet all the social care needs of that community and what that will cost will be presented in the final report.

3.3 **Next steps**

- The evaluators and the County Council will agree on when the final assessment of cost savings will be undertaken. In doing this, the aim is to allow a sufficient analysis period for the findings to capture the impacts of NCP in a 'business as usual' state, whilst also recognising and adhering to the Council's planning cycles, Committee requirements etc. Regardless of what is agreed, further analysis of the comparison group data will be undertaken, and a clearer view formed on how similar the comparison group is to the NCP client group[1].
- Client-level assessments of cost savings will be incorporated within the qualitative case studies undertaken between now and the end of the evaluation. Within these, the aim is to showcase examples of where NCP has prevented or has delayed crises occurring for clients and to estimate the likely the cost savings of having done so.

4 A Case Study that demonstrates the key principles of the NCP being implemented:

4.1 By being a solution focused team that spends time getting to know people and their families the NCWs have been able to provide support to all the members of one family that are dealing with a number of complex health and social care issues**.**

4.2 The NCWs received a referral from the community matron in December 2017 about Mrs Cook, a 55-year-old woman who has a late-stage neurological condition. Mrs. Cook has had the disease for 12 years and had a period of respite care in March 2017 in a nursing home.

4.3 Mrs Cook struggles with her personal care needs, she has limited mobility and uses a mobility scooter outside of the home. Her 68 year old husband is her sole carer and

1 This first requires fewer NCP clients to be excluded from the analysis. This will happen in the final assessment as those excluded from the interim exercise because they have only recently engaged with the service will have been supported for a longer period.

struggles to cope at times. They are both reluctant to engage or accept support and feel that no one is listening or helping. No formal package of care is in place.
The Cooks have little confidence that support is available to help them and are reluctant to engage with services, but agreed to meet with the NCW.

4.4 The Cooks have a 20 year old son living at home who has learning difficulties and attends college and Mr Cook's 78 year old brother who has failing health.
Following this referral the team made contact and started working with the Cook family initially to build up trust and a relationship and to understand why this family haven't been engaging with services previously.

4.5 With lots of listening the NCWs were able to develop a relationship with each member of the family. This enabled the NCWs to introduce some support in the form of a volunteer who regularly spends times with Mrs Cook and gives Mr Cook the opportunity to go out. The NCWs started to discuss how things may change for Mrs Cook over the next few month/ years and did they know what to expect and how they would want to manage as those changes occurred.

4.6 They were at first reluctant to look to the future, saying that they will manage when the situation arises. A big step was Mr Cook realising that his wife's condition was deteriorating and that she was struggling to manage the stairs and that at some point soon they would need to move her bed downstairs.

4.7 The outcome was that an assessment was completed that introduced a wider range of equipment into the home and carers to assist with Mrs Cook's personal care needs. This ensured Mrs Cook received the care she needed and Mr Cook was supported in his role as her carer.

4.8 The NCWs were in continual contact with health services and on occasions attended health appointments with the Cooks so that they fully understood the consequences of what they were being told.

4.9 In June 2018 Mrs Cook's health deteriorated, resulting in an admission to hospital. During her hospital admission the NCWs liaised closely with the hospital to arrange her discharge home.

4.10 In discussions with the family regarding Mrs Cook's return home it became evident that her brother in law felt very uncomfortable living in the house with Mrs Cook and was aware that Mrs Cook now needed to use the lounge as her bedroom and as the only bathroom is downstairs he had to go through the bedroom/lounge to get into the bathroom. He asked the NCWs for help so he could have his own home. This was something he had always wanted but did not know or understand the process to make it happen.

4.11 Mrs Cook was discharge home in July with the appropriate equipment and care in place. The NCWs are continuing to work proactively with all the family. Mrs Cook is now dependent on her husband, son and the carers for all her needs. Mr and Mrs Cook are happy with the support and care being provided.

4.12 The NCWs were becoming aware that Mr Cook's own health was also deteriorating but he continued to say he was well and that he knew he could contact NCWs if he needed anything. The important thing for him was that his wife was at home receiving the care she needed.

4.13 In August Mr Cook was persuaded by a NCW to agree to a visit from his GP. This resulted in Mr Cook being admitted to hospital the same day as he required emergency surgery.

4.14 The NCWs arranged to put the carers "What if plan" into action to ensure Mrs Cook could receive the care she needed while her husband was in hospital. Staying with Mrs Cook so that Mr Cook was confident that she was safe. When it was realised 24 hours later that Mr Cook would be in hospital for at least 10 days Mrs Cook's care was reviewed and it was agreed that the most suitable way for Mrs Cook's needs to be met for that period of time would be in nursing respite care. Realising that Mrs Cook's son wouldn't be able to pack for his mum a NCW went round and helped pack her bags, medications and ensure that her DNR form went with her.

4.15 While in respite care Mrs Cook developed pneumonia that required hospital admission - unfortunately this was into a different hospital to the one her husband is in.
The NCWs contacted both hospitals, keeping everyone up to date on what is happening and planning for appropriate discharge home for both Mr and Mrs Cook.

4.16 The NCWs have also been in regular contact with their son checking he is getting to college and offering any support he might need.

4.17 The NCWs supported Mr Cook's brother to make an application for a sheltered bungalow very near to his brother's home. This was successful. The NCWs then helped him source the furniture and appliances he requires for his new home using the links with local charities to do this at minimal cost. They have also supported him with all the appropriate benefit applications he is eligible for. He is delighted with his new home and feels it would not have been possible without the team's intervention. However he is staying with his nephew while his parents are in hospital in order to support him.

4.18 At the time of writing this case study Mr Cook has returned home from hospital and is being supported by the NCWs both practically and emotionally as he has been informed that he has cancer and will require further treatment.

4.19 The Cook family's situation demonstrates the value of a solution focused team that is well networked in the local community that has developed a trusted relationship with each individual member of the family.

4.20 As a NCW in the team stated :
"By knowing all the family and what their needs are we have been able to support them all effectively and work together with other partner agencies to ensure the best and most appropriate care is in place. The family know that they can call us and we will get back to them and support them."

5 How we will continue to development in the Neighbourhood Cares Pilot from the learning to date.

5.1 Going forward for the remaining duration of the NCP both teams will continue to build on all their learning and deliver support to their respective communities in Soham and St Ives.

- Assessing the impact changing the skills of the NCWs has on the delivery of the outcomes of NCP.
- Apply the best practice from both teams e.g. recording of evidence of outcomes to ensure a consistent approach of practice across the NCP that will provide the required data for the evaluation of NCP.
- Minimise any duplication of resources by managing the interface between health and social care.
- Maximise the use of technology
- Continue to explore and develop using the reablement approach with existing service users. Currently reablement has only been used for new people.
- Work with local providers to deliver flexible solutions to fill the gaps in availability of services.
- Offer to trail the use of pre-paid cards for Direct Payments
- Look to apply the learning from the NCP to explore how a self-managed model of place based teams can be applied to the changing models of place based practise across Cambridgeshire. For example the Library Transformation Project.

6 ALIGNMENT WITH CORPORATE PRIORITIES

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

6.2 **Developing the local economy for the benefit of all**

The overall approach and purpose of the Neighbourhood Cares Pilot is to test and learn the benefits for both the local economy and the benefits for all living and working in the communities piloted.

6.3 **Helping people live healthy and independent lives**

The overall approach and purpose of the Neighbourhood Cares Pilot is to test and learn the best way to support people to live independent and health lives.

6.4 **Supporting and protecting vulnerable people**

The overall approach and purpose of the Neighbourhood Cares Pilot is to test and learn the best way to support and protect vulnerable people.

7 SIGNIFICANT IMPLICATIONS

7.1 Resource Implications

*The Neighbourhood Cares Pilot has an allocated budget**:***

7.2 Procurement/Contractual/Council Contract Procedure Rules Implications

There are no significant implications within this category

7.3 Statutory, Legal and Risk Implications

There are no significant implications within this category

7.4 Equality and Diversity Implications

There are no significant implications within this category

7.5 Engagement and Communications Implications

The neighbourhood Cares pilot is working with the council's communication team in order to provide updates on the pilot with in a communications plan.

7.6 Localism and Local Member Involvement

Local Members have been informed of the Neighbourhood Cares Pilot and their engagement and involvement in the pilot is welcomed at all times.

7.7 Public Health Implications

The aim of the Neighbourhood Cares pilot is to ensure a better coordination of health and social care service for the people in the communities the pilots are delivered in. To ensure that the right support and services are delivered at the right time in the right place to enable people to make the choices they need to make to live well and independently

Implications	**Officer Clearance**
Have the resource implications been cleared by Finance?	**Yes** or No Name of Financial Officer:
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by Finance?	**Yes** or No Name of Financial Officer:

Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	Yes or No Name of Legal Officer:
Have the equality and diversity implications been cleared by your Service Contact?	**Yes** or No Name of Officer:
Have any engagement and communication implications been cleared by Communications?	Yes or No Name of Officer:
Have any localism and Local Member involvement issues been cleared by your Service Contact?	**Yes** or No Name of Officer:
Have any Public Health implications been cleared by Public Health	Yes or No Name of Officer:

SOURCE DOCUMENTS GUIDANCE

Source Documents	Location
None	

Agenda Item No: 8

ADULT SOCIAL CARE SERVICE USER AND CARERS SURVEY - UPDATE REPORT

To:	**Adults Committee**
Meeting Date:	**14 November 2018**
From:	**Service Director: Adults and Safeguarding**
Electoral division(s):	**All**
Forward Plan ref:	**N/A** *Key decision:* **No**
Purpose:	**To provide the Committee with an update and actions undertaken following the results of the service user and carers surveys previously shared in March 2018.** **To provide the Committee with early sight of the results of the 2017/18 service user survey published on 3 October 2018.**
Recommendation:	**The Committee is being asked to review the actions undertaken in response to the findings of the 2016/17 service user and carers surveys.** **The Committee note the early results from the Service User Survey 2017/18, analysis for which will be provided in more detail in the new year.**

	Officer contact:		***Member contacts:***
Name:	**Tina Hornsby**	Names:	Councillor Bailey
Post:	Head of Service Integration	Post:	Chair
Email:	Tina.hornsby@cambridgeshrie.gov.uk	Email:	Anna.bailey@cambridgeshire.gov.uk
Tel:	01733 452547	Tel:	01223 706398

1. BACKGROUND

1.1 The committee received a report in March 2018 summarising the results of the annual statutory Adult Social Care User Experience Survey and the two yearly Carers Experience Surveys.

1.2 Overall the Carers Experience Survey results had been less positive than the Service User results, and officers were developing an action plan to respond to the issues raised. A number of key actions have been taken in relation to the support for carers into which the survey results have directly fed. This report provides the committee with an update on progress.

2. MAIN ISSUES

2.1 The carers survey undertaken during 2016/17 showed a decline in reported carer satisfaction. Two results also stood out as being below the national average. The proportion of carers who report that they have been included or consulted in discussion about the person they care for was 65.8% against the national average of 70.7%. The proportion of carers who find it easy to find information about support) was 59.2% against the national average of 64.2%.

2.2 As part of the wider Adult Positive Challenge Programme currently being undertaken with support from Impower, a dedicated carer's work stream has been put in place with the following as the identified outcomes for delivery:

1. Carers can balance their caring roles and maintain their desired quality of life
2. Staff have the knowledge and ability to have the right conversations with carers, and direct carers towards the right level of support to meet their needs
3. Carers have access to right tools and information to enable them to manage their health and wellbeing and support them to maintain their caring role
4. The right community-based support is available to carers across all client groups
   All carer reviews are in date

2.3 Key deliverables identified within the work stream to be undertaken during 2018/19 include.

- Delivery of focussed training for front line staff to encourage take up of carers services and increase awareness of the carers offer
- Specify the information and advice requirements for carers to inform the development and implementation of an improved online information and advice offer
- Roll out resources to successfully and effective complete all carer reviews.
- A review of the model for delivery of statutory assessments of carers.
- Learn from other Local Authorities what community based support provides best outcomes for carers, consult with carers and young carers and commence a process of procurement.

2.4 In addition to the dedicated carers' workstream, the following activity has already started within the Fast Forward work:

- 'Changing the conversation' initial training sessions with several of the social care practitioner teams which includes time focusing on the conversation with carers, their needs and preventing breakdown
- A review of good practice for carer support across the country has been undertaken

and is being discussed in terms of insight for Cambridgeshire CC and Peterborough CC on 30th October.

2.5 Update of the 2018 Service User and Care Surveys

2.5.1 The 2017/18 service user survey was carried out in February to March 2018 and the local results were submitted in May 2018. Initial local results from this survey indicate there has been an improvement in the overall reported quality of life, in the proportion of people feeling they control over their lives, feelings of safety and feeling that services provide made people feel safe but a slight reduction in overall levels of satisfaction among service users.

2.5.2 High level messages published by NHS Digital from the survey on the 3 October 2018 were as follows:

Overall satisfaction

- Overall nationally 65% of service users reported they were “Extremely” or “Very satisfied” with the care and support they received. 2% reported they were “Extremely” or “Very dissatisfied.
- For Cambridgeshire slightly less were satisfied or extremely satisfied at 63.2% but less 1.5% reporting being extremely or very dissatisfied.

Overall Quality of Life

- 62.6% of respondents nationally reported that their quality of life was good or better.
- In Cambridgeshire this was higher at 65.2%

Paying of additional care

- Nationally the proportion of service users who do not buy additional care or support decreased from 64.7% in 2016-17 to 63.3 per cent in 2017-18. The proportion who buy more support with their own money increased from 27.4 per cent to 28.6 per cent.
- In Cambridgeshire a higher percentage of respondents (66.5%) did not buy additional care with a smaller percentage (24.7%) paying for additional care from their own monies.

Feeling safe

- More than two thirds of national respondents (69.9%) of service users reported feeling as safe as they want, compared to 1.8 per cent who reported not feeling at all safe.
- In Cambridgeshire a higher percentage reported feeling as safe as they want (73.5%) and only 0.7% reported not feeling safe at all.

Pain or discomfort

- The proportion of service users who reported having moderate pain or discomfort decreased nationally from 51.1% in 2016-17 to 50.1% in 2017-18, with 13.2% reporting extreme pain and discomfort.
- In Cambridgeshire a lower percentage reported pain and discomfort at 48.7% with only 7.4% reporting extreme pain and discomfort.

Feeling clean and being able to spend time doing what they want

- 57.8% of respondents in England reported feeling clean and able to present themselves as they wished. Nationally 68.8% of respondents reported being able to spend enough of the time doing the things they wanted to. 52.7% of service users that feel clean also reported being able to spend their time doing as they want, compared to 7.9 per cent of service users who don't feel clean reported being able to spend their time as they want.
- In Cambridgeshire a higher percentage (62.1%) reported feeling as clean and able to present themselves as they wished. A higher percentage also reported being able to spend enough time doing the things they wanted, 75.6%

Social contact

- 46% of respondents across England reported having as much social contact as they would like.
- In Cambridgeshire this was higher with 47.6% reporting as much social contact as they wished.

2.5.3 Analysis of these results will be fed back into the Adult Positive Challenge Programme and reported back to the Adults Committee alongside the wider self-assessment in the new year.

2.5.4 The 2018/19 Carers survey is to be conducted during October and November 2018 and be submitted in March 2019 with results being published in June 2019.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

There are no significant implications for this priority.

3.2 Helping people live healthy and independent lives

This work is relevant to this priority area and any intelligence from this work will be used to support this priority, in particular, linking to Adult Positive Challenge programme, Transforming Lives and other transformational activity.

3.3 Supporting and protecting vulnerable people

This work is relevant to this priority area and the actions being undertaken to address the identified issues highlighted in terms of the experiences of service users and carers will contribute to this priority.

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

There are no significant implications within this category.

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

There are no significant implications within this category.

4.3 Statutory, Legal and Risk Implications

There are no significant implications within this category

4.4 Equality and Diversity Implications

There are no significant implications within this category

4.5 Engagement and Communications Implications

The annual survey provides us with valuable intelligence on the views of our service users. This information is shared with management to help support decision making and to help us shape our services to meet the needs of our service users and carers wherever possible.

4.6 Localism and Local Member Involvement

The surveys support us in building a picture of the issues facing our service users and carers and enables us to analyse trends in terms of issues effecting specific geographical areas of the communities we support. Findings from the most recent surveys have supported the intention from the Adult Positive Challenge Programme to increase the range of community based resources accessible by service users and carers.

4.7 Public Health Implications

Findings from the previous service user survey around the fear of falling were shared with the Falls Prevention group and have directly influenced the current Public Health campaign – Stay Stronger for Longer.

Implications	**Officer Clearance**
Have the resource implications been cleared by Finance?	Yes or No Name of Financial Officer:
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	Yes or No Name of Officer:
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	Yes or No Name of Legal Officer:
Have the equality and diversity implications been cleared by your Service Contact?	Yes or No Name of Officer:

Have any engagement and communication implications been cleared by Communications?	Yes or No Name of Officer:
Have any localism and Local Member involvement issues been cleared by your Service Contact?	Yes or No Name of Officer:
Have any Public Health implications been cleared by Public Health	Yes or No Name of Officer:

Source Documents	**Location**
Cambridgeshire County Council Adult Social Care User Experience Survey 2017-18 statutory submission	Business Intelligence Service 2nd Floor Octagon Shire Hall Cambridge CB3 0AP
Personal Social Services Adult Social Care Survey England 2018	***https://digital.nhs.uk/data-and-information/publications/statistical/personal-social-services-adult-social-care-survey/2017-18***

Agenda Item No: 9

SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2017-18)

To:	**Adults Committee**
Meeting Date:	**15 November 2018**
From:	**Russell Wate, SAB Chair**
Electoral division(s):	***All***
Forward Plan ref:	**No**
Purpose:	**Receive Safeguarding Adults Board Annual Report 2017-18**
Recommendation:	**Committee are asked to note the Safeguarding Adults Board Annual report 2017/18**

	Officer contact:		***Member contacts:***
Name:	**Russell Wate**	Names:	Councillor Bailey
Post:	Safeguarding Adults Board Chair	Post:	Chair/Vice-Chair
Email:	Russell.wate@peterborough.gov.uk	Email:	Anna.bailey@cambridgeshire.gov.uk
Tel:		Tel:	01223 706398

1. BACKGROUND

1.1 The Care Act 2014 states that
As soon as is feasible after the end of each financial year, an Safeguarding Adults Board (SAB) must publish a report on -

1. what it has done during that year to achieve its objective,
2. what it has done during that year to implement its strategy,
3. what each member has done during that year to implement the strategy,
4. the findings of the reviews arranged by it under section 44 (safeguarding adults reviews) which have concluded in that year (whether or not they began in that year),
5. the reviews arranged by it under that section which are ongoing at the end of that year (whether or not they began in that year),
6. what it has done during that year to implement the findings of reviews arranged by it under that section, and
7. where it decides during that year not to implement a finding of a review arranged by it under that section, the reasons for its decision.

The SAB must send a copy of the report to -

1. the Chief Executive and the Leader of the Local Authority which established the SAB,
2. the Local Policing Body the whole or part of whose area is in the Local Authority's area,
3. the Local Healthwatch organisation for the Local Authority's area, and
4. the Chair of the Health and Wellbeing Board for that area.
5. "Local Policing Body" has the meaning given by section 101 of the Police Act 1996.

2. MAIN ISSUES

2.1 The Report can be found as Appendix 1 to this report and at http://www.safeguardingpeterborough.org.uk/wp-content/uploads/2018/08/SAB-Annual-Report-2017-18.pdf

It is the first Annual Report from the Board since it combined with the Peterborough SAB. It demonstrates the progress made to date in creating an effective set of

arrangements across both Local Authorities.

Priorities remain:

1. Domestic Abuse, in particular where there are elderly victims
2. Neglect
3. Self-Neglect
4. Living with mental Health Issues

Making Safeguarding Personal remains the key “Golden Thread” woven through all the work of the Board, and it has a specific Action Plan designed to create the working culture required for services to deliver person centred outcome focussed work.

The main milestone this year was the agreement and promotion of the SAB Policy and process for multi-agency safeguarding, giving a framework for all agencies to address safeguarding concerns.

The Board now has an independent Chair and Business Unit which is the foundation for a proper partnership between the Local Authority, police and CCG in working with all the other agencies involved. This will support effective multi-agency working on the shared priorities and assist the Local Authority meet its statutory responsibilities for safeguarding under the Care Act.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

There are no significant implications for this priority.

3.2 Helping people live healthy and independent lives

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

- Making Safeguarding Personal prioritises ensuring adults remain in control of their lives and retain as much independence as is achievable.

3.3 Supporting and protecting vulnerable people

The SAB Annual Report is concerned with this issue directly.

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

There are no significant implications within this category.

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

There are no significant implications within this category.

4.3 **Statutory, Legal and Risk Implications**

There are no significant implications within this category.

4.4 **Equality and Diversity Implications**

There are no significant implications within this category.

4.5 **Engagement and Communications Implications**

There are no significant implications within this category.

4.6 **Localism and Local Member Involvement**

There are no significant implications within this category.

4.7 **Public Health Implications**

There are no significant implications within this category.

.

Source Documents	Location
Safeguarding Adults Board Annual Report 2017/18	***http://www.safeguardingpeterborough.org.uk/wp-content/uploads/2018/08/SAB-Annual-Report-2017-18.pdf***

Cambridgeshire and Peterborough Safeguarding Adults Board

Annual Report 2017/18

Foreword

By Dr Russell Wate QPM, Independent Chair Peterborough Safeguarding Children Board

It gives me great pleasure to present to you Cambridgeshire and Peterborough's Safeguarding Adults Board annual report for the period April 2017 – March 2018.

This has been a momentous year for those of us involved with safeguarding the most vulnerable in our society, its children and adults at risk. In response we have put in place new ways of working that mean we are better able to measure what is needed and then meet those needs.

The review of Local Safeguarding Children Boards and the Social Care Act 2017 have changed how agencies will work together to protect children. This Report describes how our response to this has meant a joining together of the Boards across Cambridgeshire and Peterborough into one Adult Board coinciding with the creation of one Children Board. We have merged the Teams that keeps the Boards functioning to support these changes. This has allowed us to increase the effectiveness of our efforts and reduce barriers to services across different parts of the County whilst saving money for front-line services.

This is therefore the first Safeguarding Adults Board Report for Cambridgeshire and Peterborough. It outlines the activities and achievements of the Board and its partners over the last year and how well we have delivered on our priorities and actions in the Business Plan. It is our account to the community of the work we have done to safeguard and enhance the wellbeing of adults with care and support needs.

Safeguarding is about people -their wishes, aspirations and needs. What we as a Board do has to be judged in terms of whether it has placed adults in need of safeguarding at the centre of its work. How well we hear and respond to what people want is the measure of our success. I am confident we have the right mechanisms in place to carry out our role, and look forward to Chairing the Board as it uses those mechanisms to ensure safeguarding in Cambridgeshire and Peterborough is sensitive to the needs of the people involved, effective and above all personal.

Dr Russell Wate QPM

MAKING SAFEGUARDING PERSONAL IN CAMBRIDGESHIRE AND PETERBOROUGH

Contents

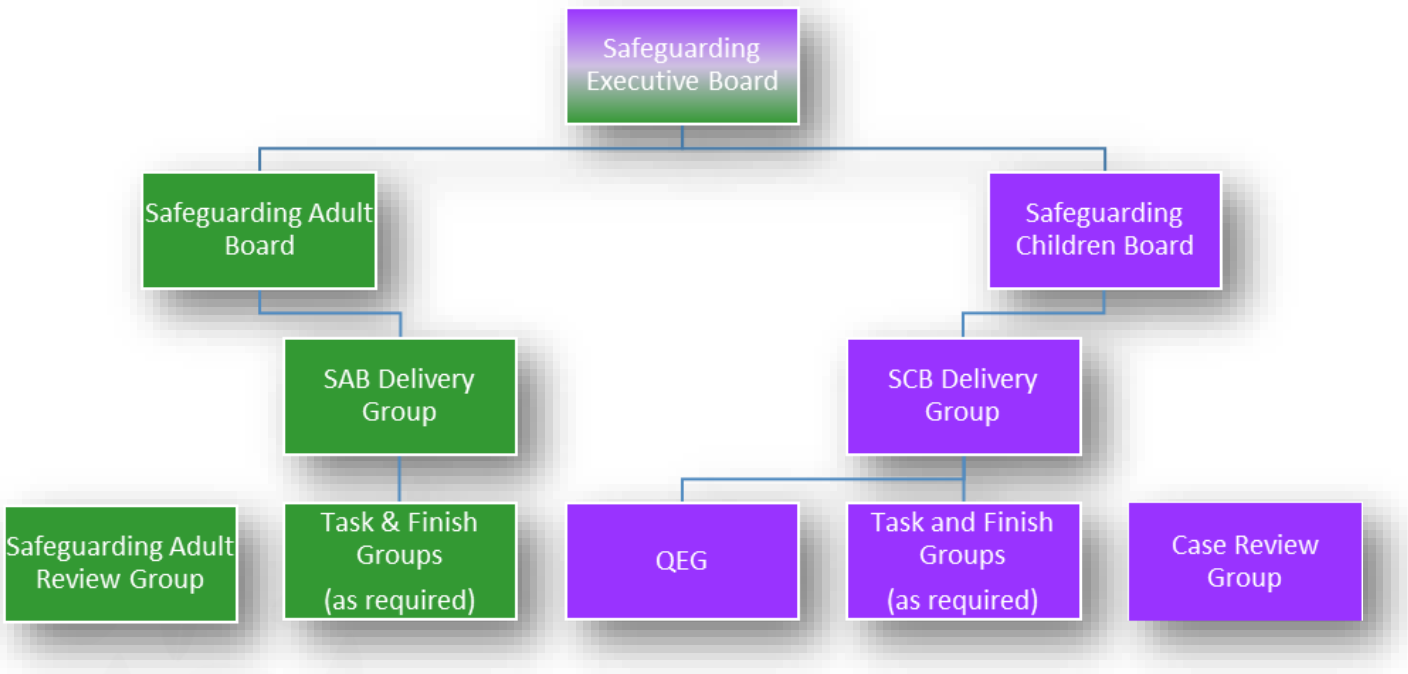
About the Board

The Safeguarding Adults Board

"14.133 Each local authority must set up a Safeguarding Adults Board (SAB). The main objective of a SAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who meet the criteria set out at paragraph 14.2.

14.134 The SAB has a strategic role that is greater than the sum of the operational duties of the core partners. It oversees and leads adult safeguarding across the locality and will be interested in a range of matters that contribute to the prevention of abuse and neglect. These will include the safety of patients in its local health services, quality of local care and support services, effectiveness of prisons and approved premises in safeguarding offenders and awareness and responsiveness of further education services. The SAB will need intelligence on safeguarding in all providers of health and social care in its locality (not just those with whom its members commission or contract). It is important that SAB partners feel able to challenge each other and other organisations where it believes that their actions or inactions are increasing the risk of abuse or neglect. This will include commissioners, as well as providers of services." (Care Act Statutory Guidance)

During the course of 2017 to 2018 Cambridgeshire and Peterborough Adults and Adult's Boards came together in one structure supported by a merged Business Unit.



The **Joint Safeguarding Executive Board** is the overarching countywide governance board for both the Safeguarding Adults Board and Safeguarding Children Board and will consider issues around both the adults and children safeguarding agendas. This is a high level strategic board which will primarily focus on safeguarding systems, performance and resourcing and has the statutory accountability for safeguarding in both local authority areas.

The **Safeguarding Adults Board** is responsible for progressing the Board's business priorities through its business plan and finalise the annual report. It will authorise the policy, process, strategy and guidance required to support Board priorities and effective safeguarding. It will

scrutinise, challenge and maintain an overview of the state of adult safeguarding in Cambridgeshire and Peterborough. This will be undertaken through quality assurance activity, learning and development programmes and commissioning and overseeing SAR's / learning reviews

The **Adult Board Delivery group** will implement the business plan, manage the preparation of detailed proposals and documents for SAB approval, coordinate the dataset, audits and other sources of information about safeguarding in the local authority areas and ensure that learning is used to inform and improve practice, including through the SAB training programme.

All existing sub groups, with the exception of the **Safeguarding Adults Review (SAR),** and **Quality and Effectiveness (QEG)** subgroups, were replaced with time limited task and finish groups.

Relationship with other Boards

For the Board to be influential in coordinating and ensuring the effectiveness of safeguarding arrangements, it is important that it has strong links with other groups and boards who impact on adult services. The Safeguarding Boards work very closely with the Health and Wellbeing boards in both local authority areas, the Countywide Community Safety Partnership, the Local Family Justice Board, and the MAPPA Strategic Management Board. This ensures that all aspects of safeguarding are taken into account by the other statutory boards and there is a co-ordinated and consistent approach.

The Board Chair is also a member of other strategic and statutory partnerships within Cambridgeshire and Peterborough which include the Health and Wellbeing Boards, the County Wide Community Safety Partnership, the Safer Peterborough Partnership and the Strategic MAPPA Board. These links mean that safeguarding adults remains on the agenda of these groups and is a continuing consideration for all members, widening the influence of the Safeguarding Adult Board across all services and activities in Cambridgeshire and Peterborough.

In addition, the Head of Service is a member of the Domestic Abuse Governance Board and the Adult and Families Joint Commissioning Board.

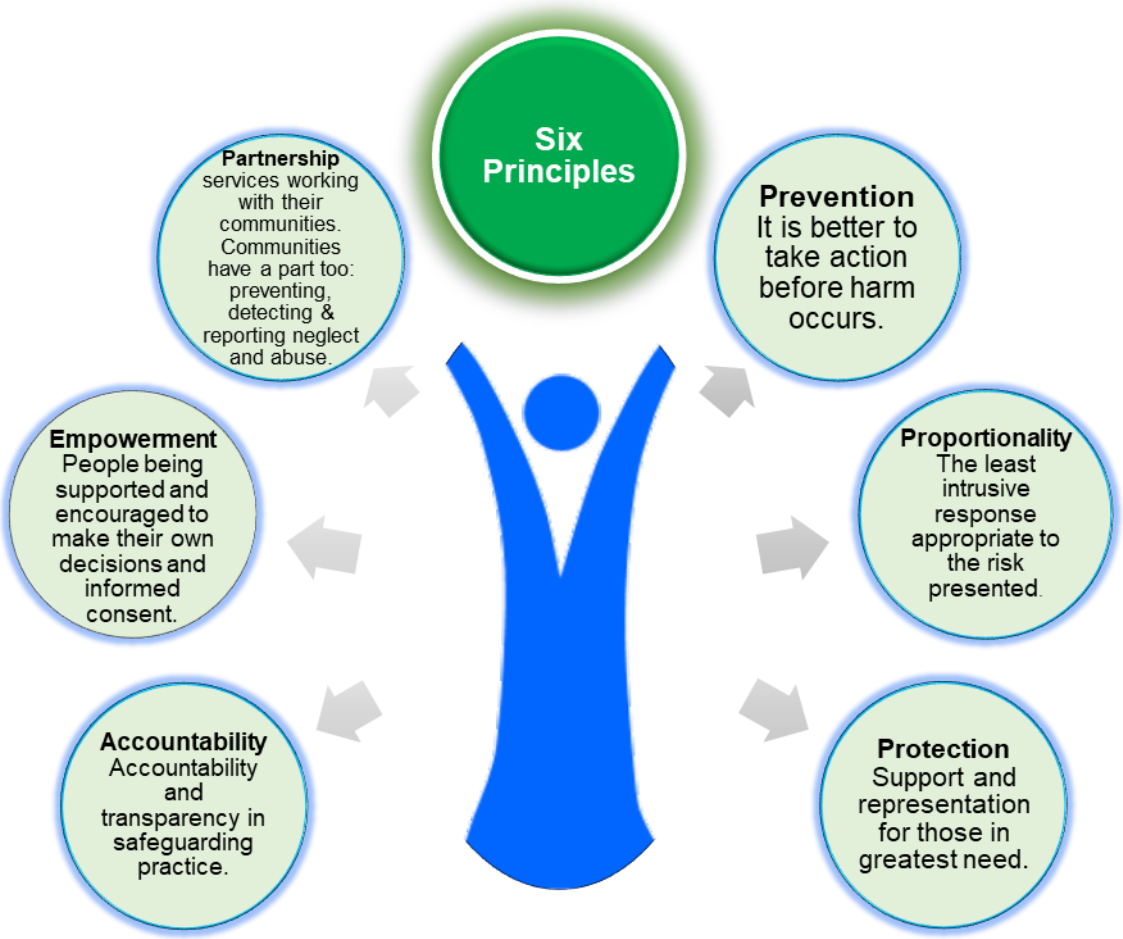
Our Aim

Our aim is clear:

> ***Safety, Enablement, Empowerment and Prevention will be at the centre of everything we do - by working with partner agencies to safeguard adults at risk of abuse and neglect. We also have a broader aim in promoting the wider understanding of what safeguarding is and our shared responsibility in this area.***

We have worked towards these aims by building on the firm foundation the two boards had developed, through shared values and beliefs, brought together by close partnership working, commitment and our mutual accountability

Our aim is developed around the six principles that underpin adult safeguarding:



Procedures and Guidance

One of the first priorities of the joint SAB was to establish new multi-agency procedures; the Practice and Procedures sub-group pulled this work together and in May 2017 the Executive Board approved the new Cambridgeshire and Peterborough Multi-agency Safeguarding Adults Policy and Procedures, and these were adopted across the county, and are available on our website. These will be reviewed in 2018.

Also reviewed and updated was the escalation procedure, and new Safer Recruitment guidance was introduced.

Making Safeguarding Personal

The Care Act 2014 defines safeguarding adults as protecting an adult's right to live in safety, free from abuse and neglect. Making Safeguarding Personal (MSP) aims to make safeguarding person-centred and outcome focussed and moves away from process-driven approaches to safeguarding. This continues to be a priority for the SAB and the inaugural meeting of the joint SAB reviewed progress in Cambridgeshire and Peterborough and pulled together the work on MSP in the two Local Authority Areas into a shared Action Plan, which is now being implemented.

MSP and the six principles are a "golden thread" that run through all we do. This includes:

- Multi-agency Procedures - What staff should be considering and doing to be in line with MSP is embedded into the procedures and guidance.
- The SAB Audit framework - Agency service delivery is measured against MSP principles.
- Our website and communications - The term and what it means is repeatedly emphasised and promoted on all of our materials
- The agency self-assessment process was structured around MSP principles
- All SAB training explicitly incorporates MSP
- MSP was a theme at the SAB Conference and across the March Awareness Month,

Communication and social engagement

The SAB has its own website which links with the LSCB website, making it more accessible for those working in both adult and children's services and for the general public. The website can be found at: www.safeguardingpeterborough.org.uk

Although the materials and resources on the site have been rebranded for Cambridgeshire and Peterborough, and it is accessible across the county, we are still waiting for the site to be allocated a new web address which will easily identify it as being for Cambridgeshire and Peterborough. This change is imminent

The first Cambridgeshire and Peterborough Safeguarding Adults newsletter was published in January 2018. This was sent out via email to a wide range of partners and interested parties, and is also available on the SAB website. It is aimed at anyone who has an interest in safeguarding adults at risk. The newsletter aims to be an important means to keep practitioners and professionals up to date, and to share good practice and important information, it includes updates on local and national policies and developments in Safeguarding, learning from Safeguarding Adult Reviews and upcoming multi-agency training events. Contributions to the newsletter are received from various partner agencies and other information is sourced from national publications and organisations (ADASS, LGA etc.).

Throughout the year we have rebranded all our leaflets with the new joint logo and these are available on the website.

Following on from last year's successful **Safeguarding Adults Awareness** month, which took place in Peterborough, the SAB decided to run another awareness month, this time across Cambridgeshire and Peterborough, and across childrens and adult services. Each member agency was asked to commit to either doing or being involved in at least one activity.

A wide range of agencies got involved in lots of different activities including:

- Using social media to spread key messages

- Drop in events
- Including reflection on safeguarding in supervision
- Weekly emails with safeguarding themes to all staff
- Awareness events with stalls and information
- Training events
- Conferences
- Roadshows

At the end of the month agencies were asked to evaluate how the month had gone. Those that responded showed that over 2000 staff were given the awareness message as were over 750 service users and members of the public. Cambridgeshire City Council also shared the "Chelsea's Choice" production with 918 pupils, and there were also 2 community performances for parents and community groups.

Many partners delivered a communication message highlighting safeguarding, including newsletters, email messages, and training bulletins which went out to over 4000 staff. Many partners also used the month to run specific training events.

Agency comments included:

"Excellent, well worthwhile" – Cambs Early Years Team

"It is important to keep sharing the story, so people remember, and refer when they have concerns" – Cross Key Homes

"Found it a helpful challenge to do something innovative, a useful exercise for us all" – NHS England

"*There was a recognition that safeguarding is everyone's responsibility, and how it effects the majority of services and staff*" – Cambridgeshire County Council.

"*It has been a useful opportunity to raise awareness of safeguarding and to offer targeted support and learning for our staff*" – CCS NHS Trust

Highlights

The East Anglia Ambulance Service embraced the month, with key personnel going out to raise awareness amongst their teams, meeting members of the public, and spreading awareness not just in Cambridgeshire and Peterborough, but across their whole area, including Norfolk, Essex and Bedford. In total they met with over 700 staff and 300 service users/public. In their evaluation they said the awareness month had been a very positive experience, and very beneficial to staff and service users. This is a good example that we can learn from for next year.

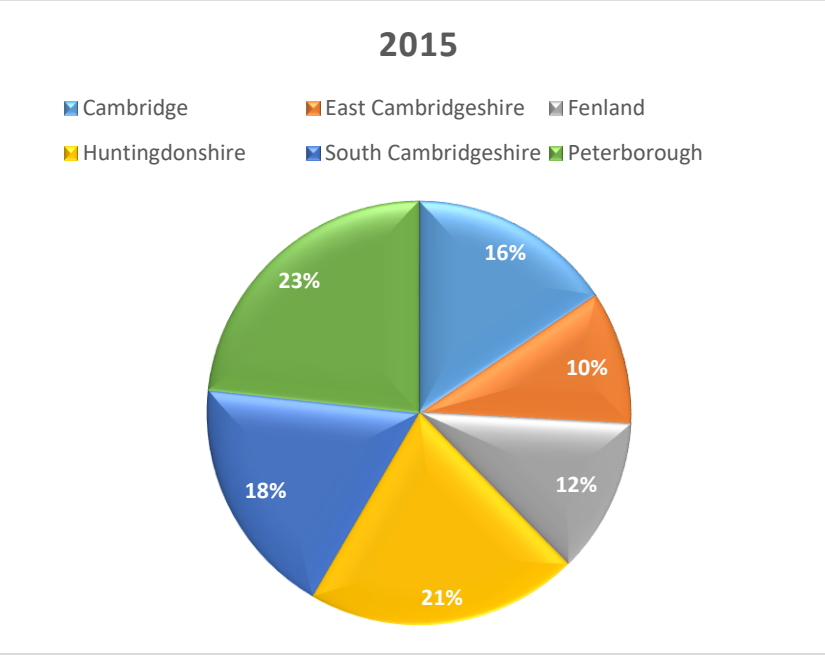
Cambridgeshire Constabulary also worked with partners to produce a short film highlighting different roles in Safeguarding, and why it's so important. This film can be found on their YouTube channel:

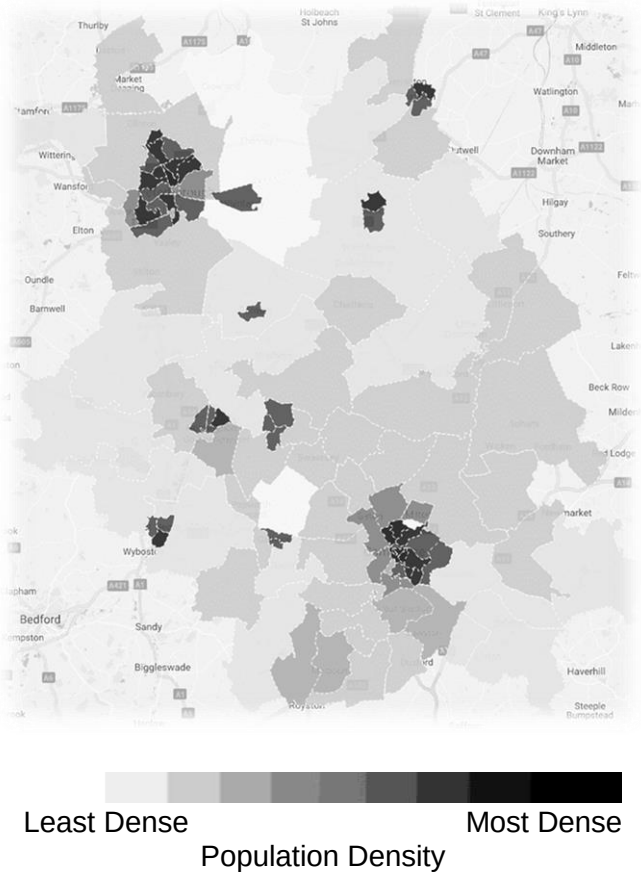
Safeguarding in Cambridgeshire and Peterborough

The Context of Cambridgeshire and Peterborough

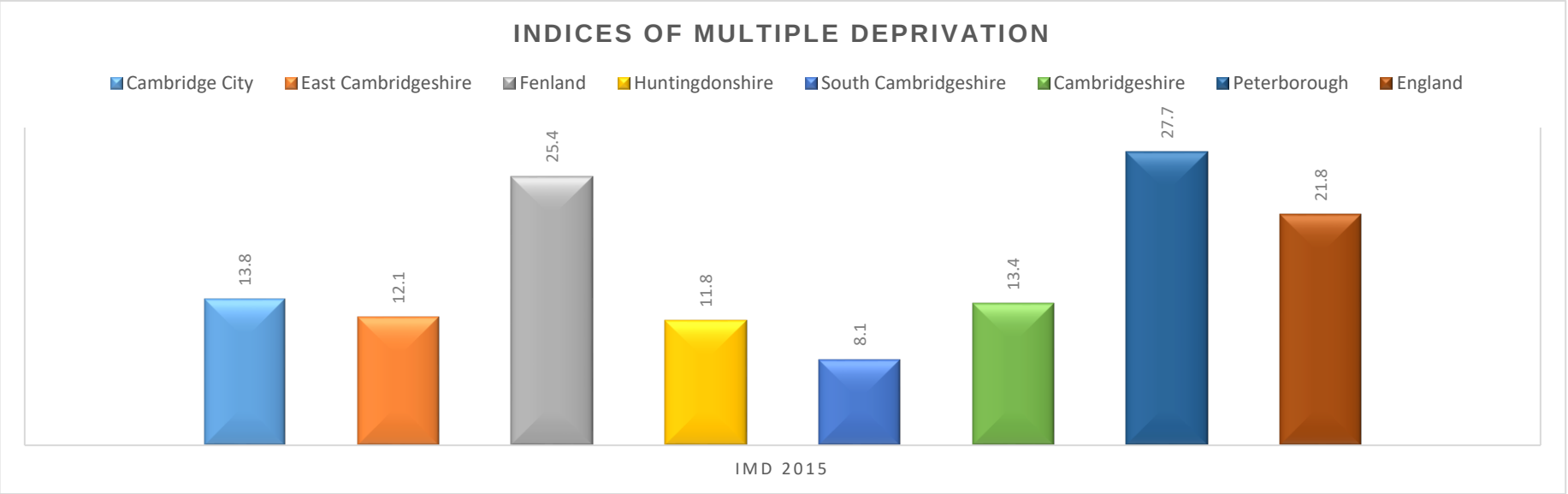
Population (Taken from Cambridgeshire Insight using 2011 census data)

	2015
Cambridge	132,130
East Cambridgeshire	86,300
Fenland	99,170
Huntingdonshire	176,050
South Cambridgeshire	154,660
Peterborough	196,640





Levels of Deprivation



Indices of Multiple Deprivation (IMD) measure relative deprivation between areas; the higher the IMD score, the greater the level of deprivation in the area. Scores reflect levels of deprivation but are not directly comparable, e.g. an area with an IMD score of 30.0 can be assessed as having a higher level of deprivation than an area with a score of 15.0 but it cannot be assumed that the area has twice the deprivation. Data show that Cambridgeshire is markedly less deprived that England, as are all of its districts with the exception of Fenland. The most deprived area within this analysis is Peterborough with an overall IMD score of 27.7.

Care and Support Needs in Cambridgeshire and Peterborough.

What do we know about how many people in our area would come under safeguarding, where are they what are their care needs?

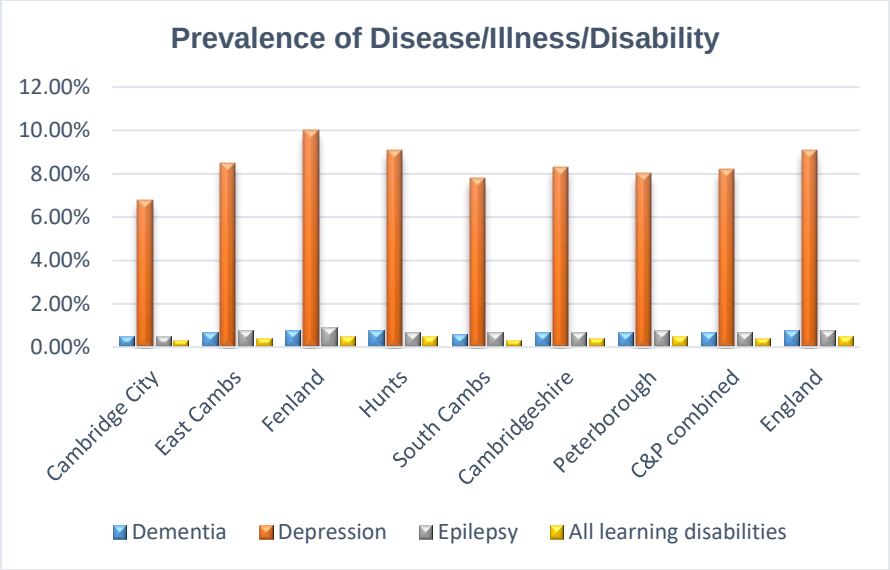
1. Disease/Illness/Disability Prevalence – Cambridgeshire Districts, Cambridgeshire, Peterborough & England, 2016/17

Indicator	Cambridge City	East Cambs	Fenland	Hunts	South Cambs	Cambridgeshire	Peterborough	C&P combined	England
Dementia	0.5%	0.7%	0.8%	0.8%	0.6%	0.7%	0.7%	0.7%	0.8%
Depression	6.8%	8.5%	10.0%	9.1%	7.8%	8.3%	8.0%	8.2%	9.1%
Epilepsy	0.5%	0.8%	0.9%	0.7%	0.7%	0.7%	0.8%	0.7%	0.8%
All learning disabilities	0.3%	0.4%	0.5%	0.5%	0.3%	0.4%	0.5%	0.4%	0.5%

Source: Quality Outcomes Framework

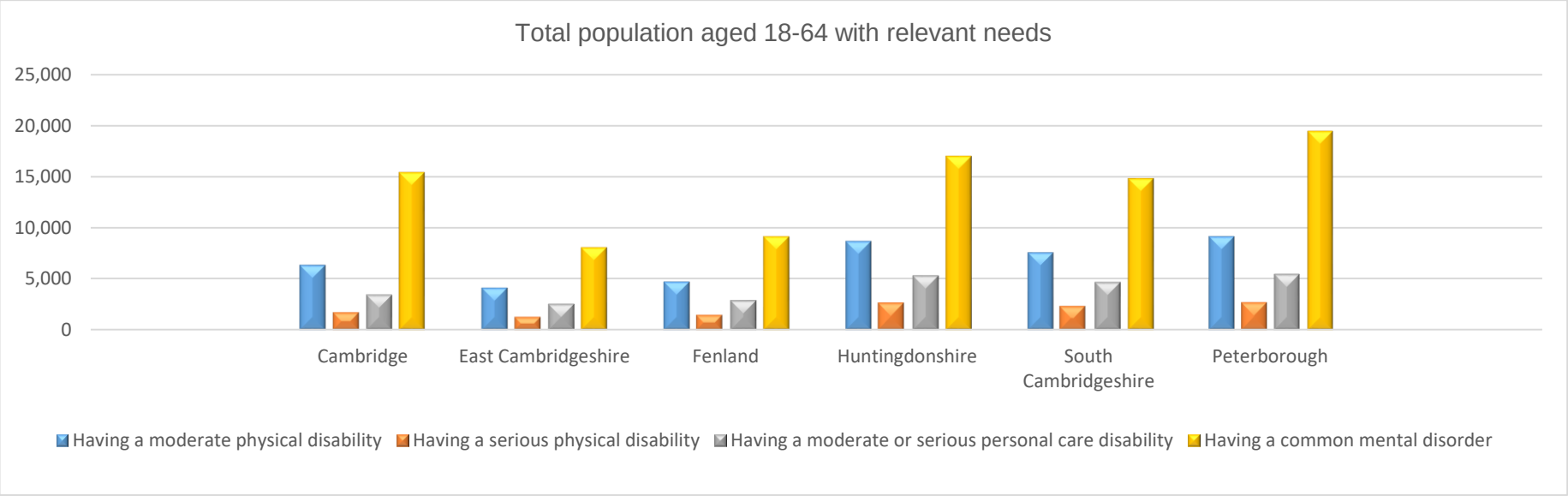
Key
Statistically significantly lower than England
Statistically similar to England
Statistically significantly worse than England

Cambridgeshire has a statistically significantly lower prevalence of dementia, depression, epilepsy and all learning disabilities combined than England. Peterborough is also statistically significantly lower than England for prevalence of dementia and depression. Fenland is the only area within the table above to have any statistically significantly high prevalence values in comparison to England, with significantly high prevalence of depression, epilepsy and all learning disabilities in comparison to the national average.



2. **Total population aged 18-64 with relevant needs** (Based on 2015 figures and with a high level of reliability)**:**

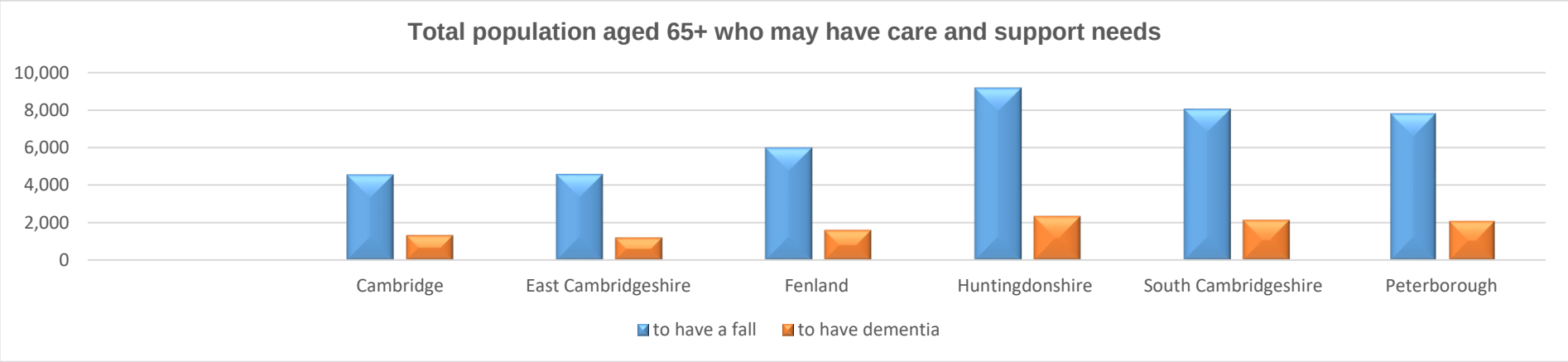
Area	Having a moderate physical disability	Having a serious physical disability	Having a moderate or serious personal care disability	Having a common mental disorder
Cambridge	6,332	1,679	3,435	15,435
East Cambridgeshire	4,116	1,245	2,530	8,128
Fenland	4,721	1,429	2,886	9,211
Huntingdonshire	8,638	2,598	5,282	17,030
South Cambridgeshire	7,531	2,274	4,626	14,859
Cambridgeshire	31,338	9,224	18,759	64,663
Peterborough	9,101	2,618	5,411	19,458



Total population aged 65+ who may have care and support needs:

Falls are the most common cause of emergency hospital admissions for older people and significantly impact on long term outcomes, e.g. being a major cause of people moving from their own home to long-term nursing or residential care. The table above outlines predicted numbers of falls in residents aged 65+, who may still be susceptible to hospital admission/minor injury and potentially lose resilience as a result of falls. The second set of data is the numbers of people suffering from dementia

Area	to have a fall	to have dementia
Cambridge	4,552	1,316
East Cambridgeshire	4,581	1,183
Fenland	5,987	1,579
Huntingdonshire	9,161	2,311
South Cambridgeshire	8,045	2,113
Cambridgeshire	32,326	8,502
Peterborough	7,792	2,051



Safeguarding in Cambridgeshire

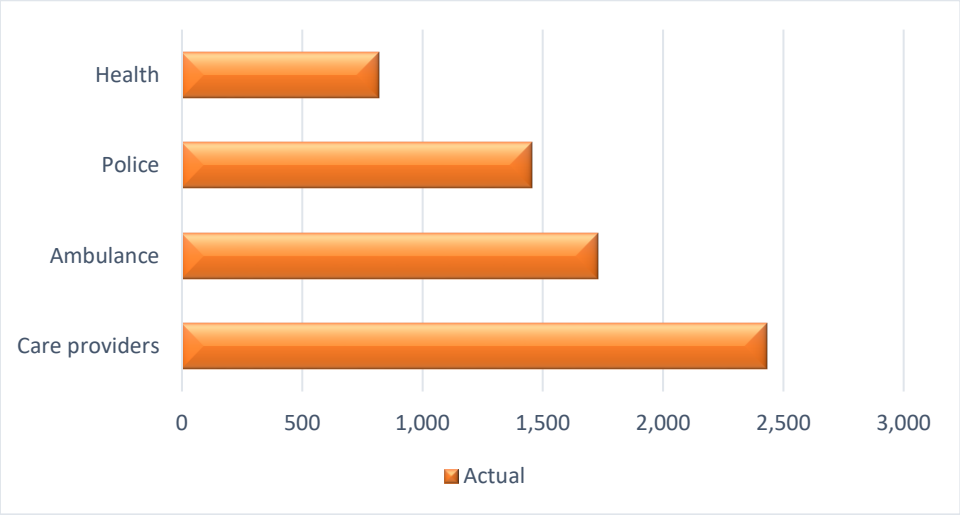
MULTI-AGENCY SAFEGUARDING HUB (MASH) DATA

How much abuse was reported?

CCC Adult MASH received 9,805 concerns in 2017/18, this was an increase on the previous year of 1,061 (12.1%). The Adult MASH carried out 391 enquiries themselves and asked adult social care teams and others to carry out a further 1,130 enquiries

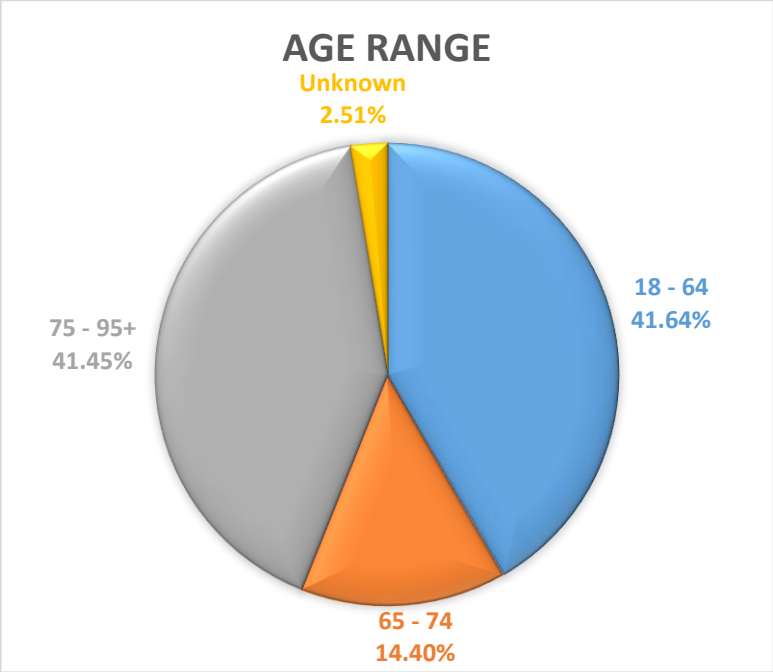
Who reported the abuse?

The four main sources for safeguarding concerns received by the adult MASH are;

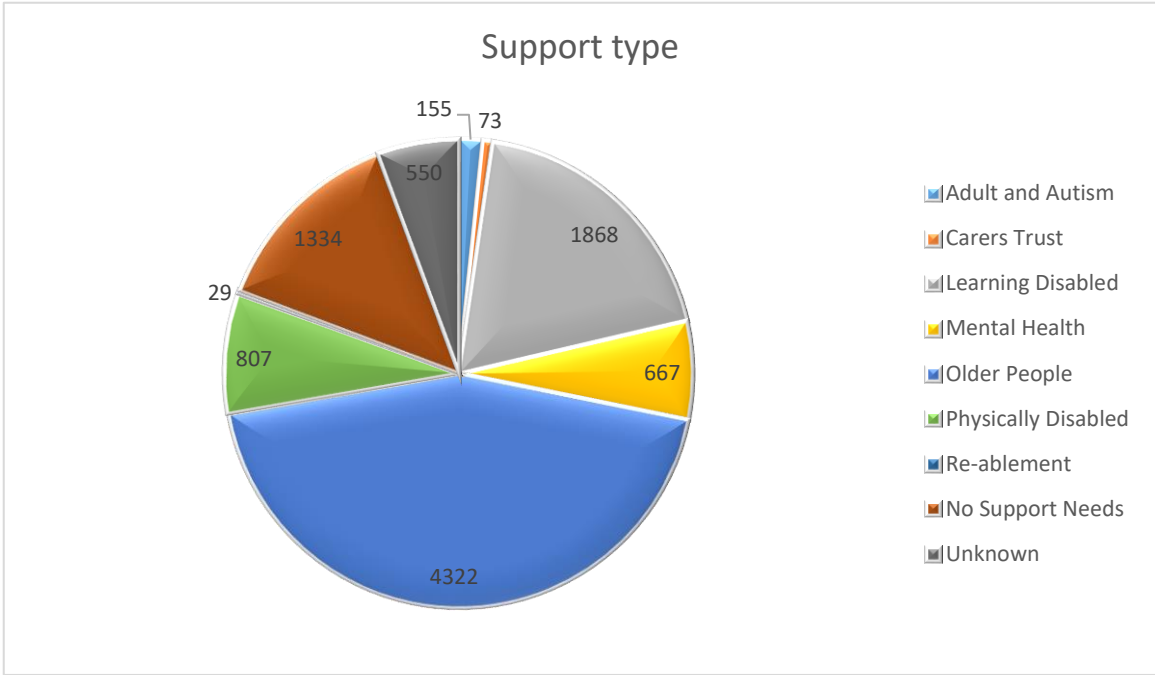


Source	Actual	% split
Care providers	2,431	27.80%
Ambulance	1,727	19.80%
Police	1,455	16.60%
Health	816	9.30%

Who was abused? By their age:



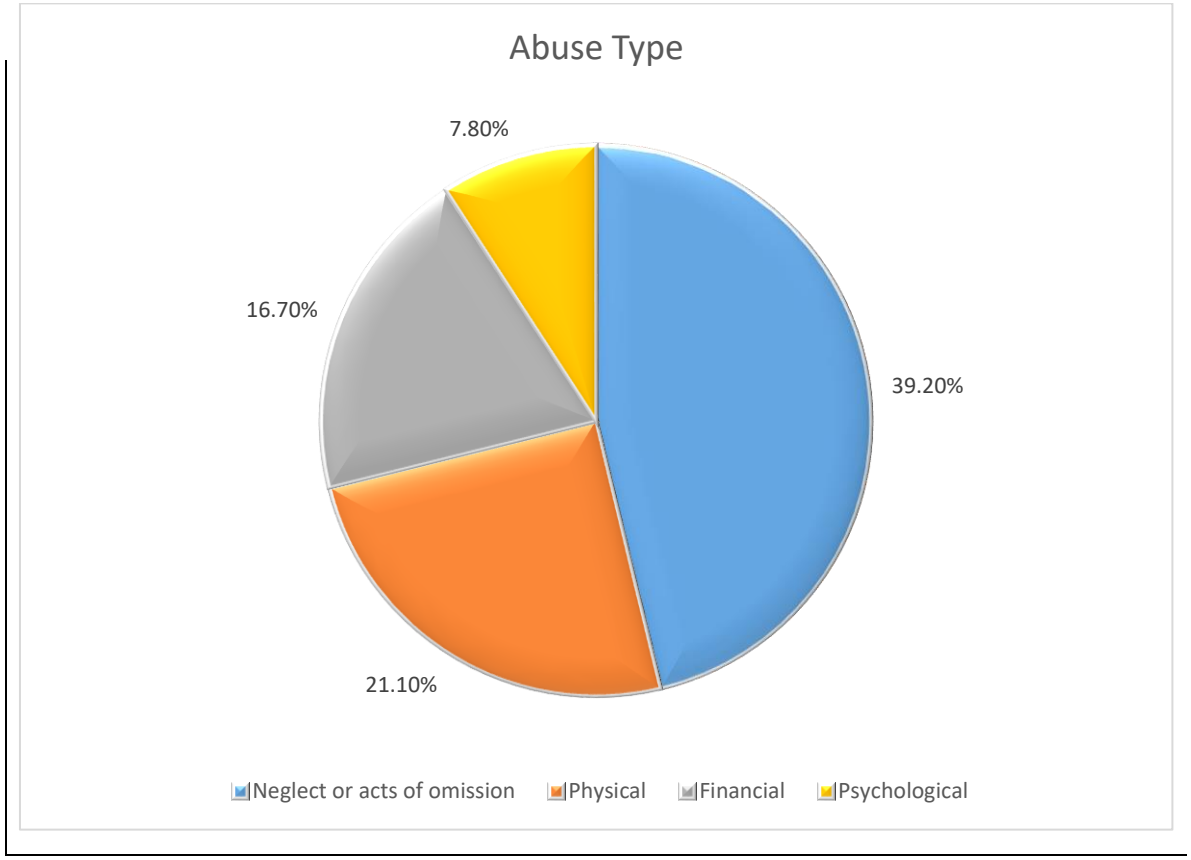
Age range	Actual	% split
Total for age range 18-64	4,083	41.6%
Total for age range 65-74	1,412	14.4%
Total for age range 75-95+	4,064	41.5%
Unknown	246	2.5%



Support type	Actual	% split	Support type	Actual	% split
Adult & Autism	155	1.6%	Physically Disabled	807	8.2%
Carers Trust	73	0.7%	Re-ablement	29	0.3%
Learning Disabled	1,868	19.1%	No Support Needs	1,334	13.6%
Mental Health	667	6.8%	Unknown	550	5.6%
Older People	4,322	44.1%			

What sort of abuse was reported?

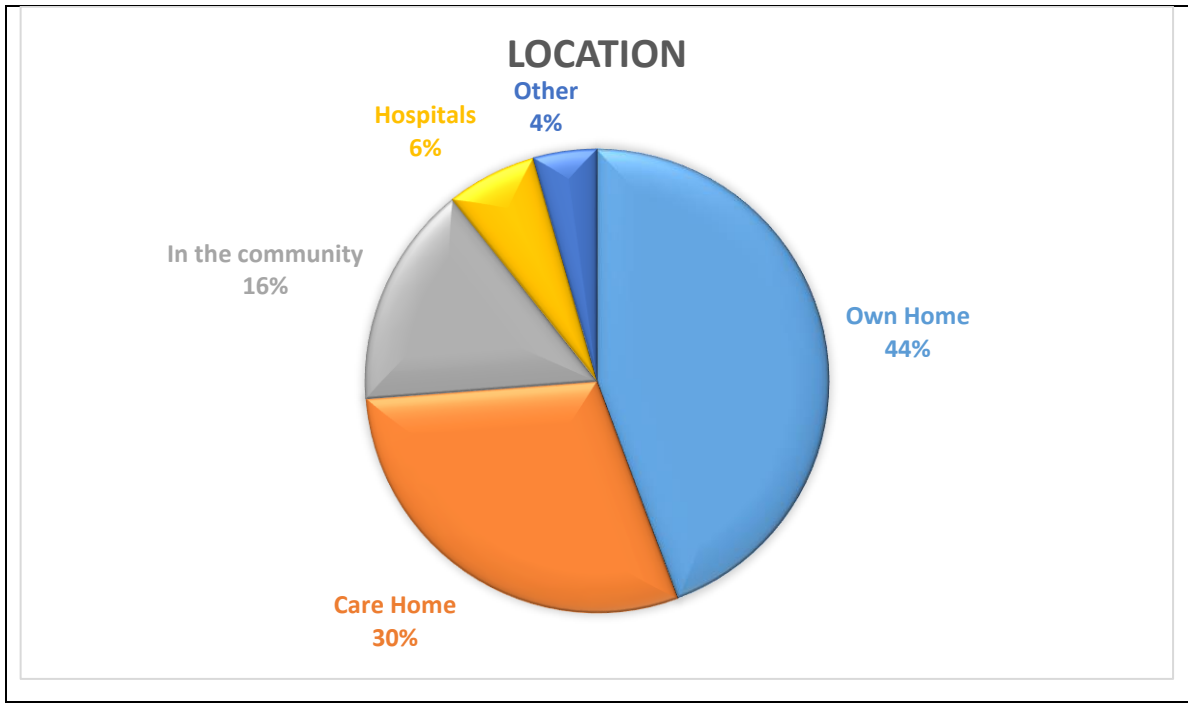
For the CCC enquiries recorded the most common abuse types were;



Abuse type	% split
Neglect or acts of omission	39.2%
Physical	21.1%
Financial	16.7%
Psychological	7.8%

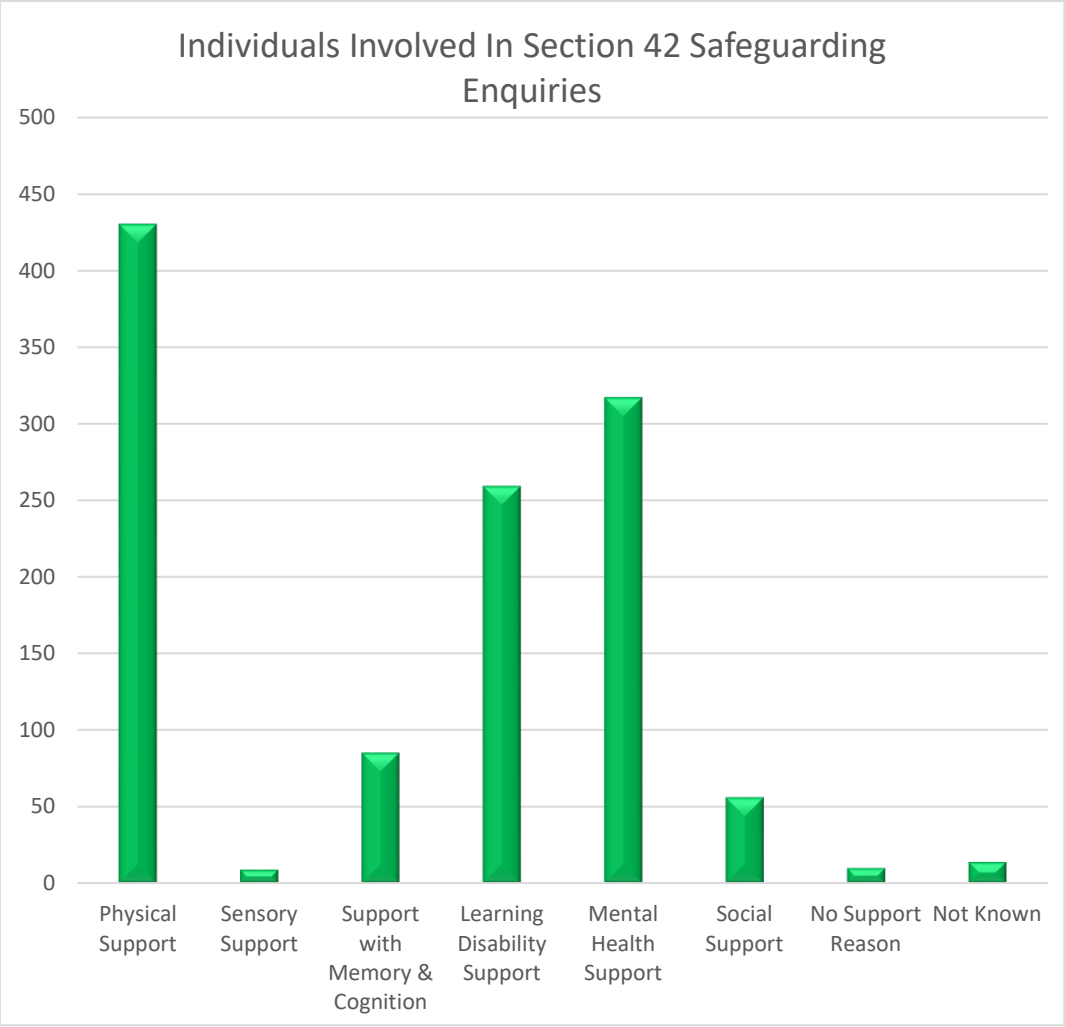
Where did it occur?

Of the CCC enquiries recorded the main locations where the abuse occurred was in;

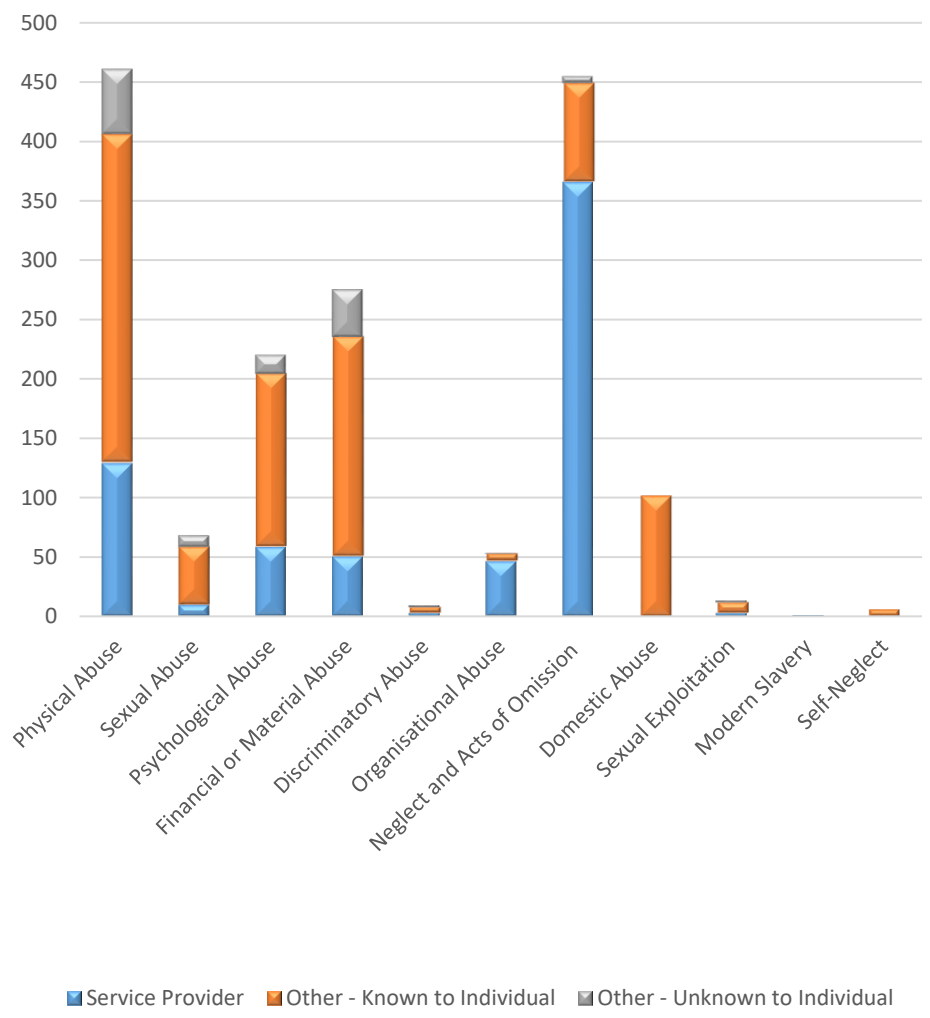


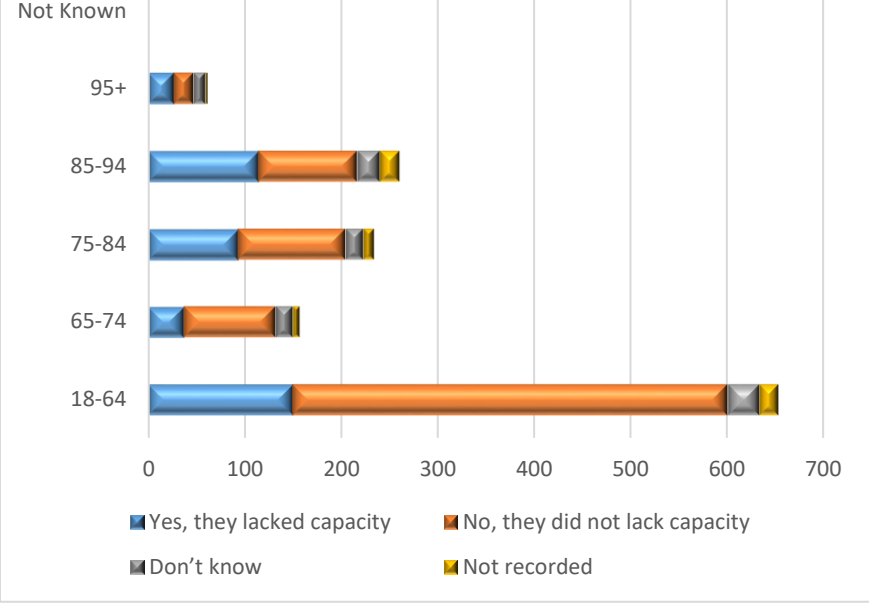
Location	% split
Own Home	44.3%
Care homes	29.5%
In the community	15.5%
Hospitals	6.3%
Other	4.4%

ENQUIRIES INTO ABUSE AND NEGLECT



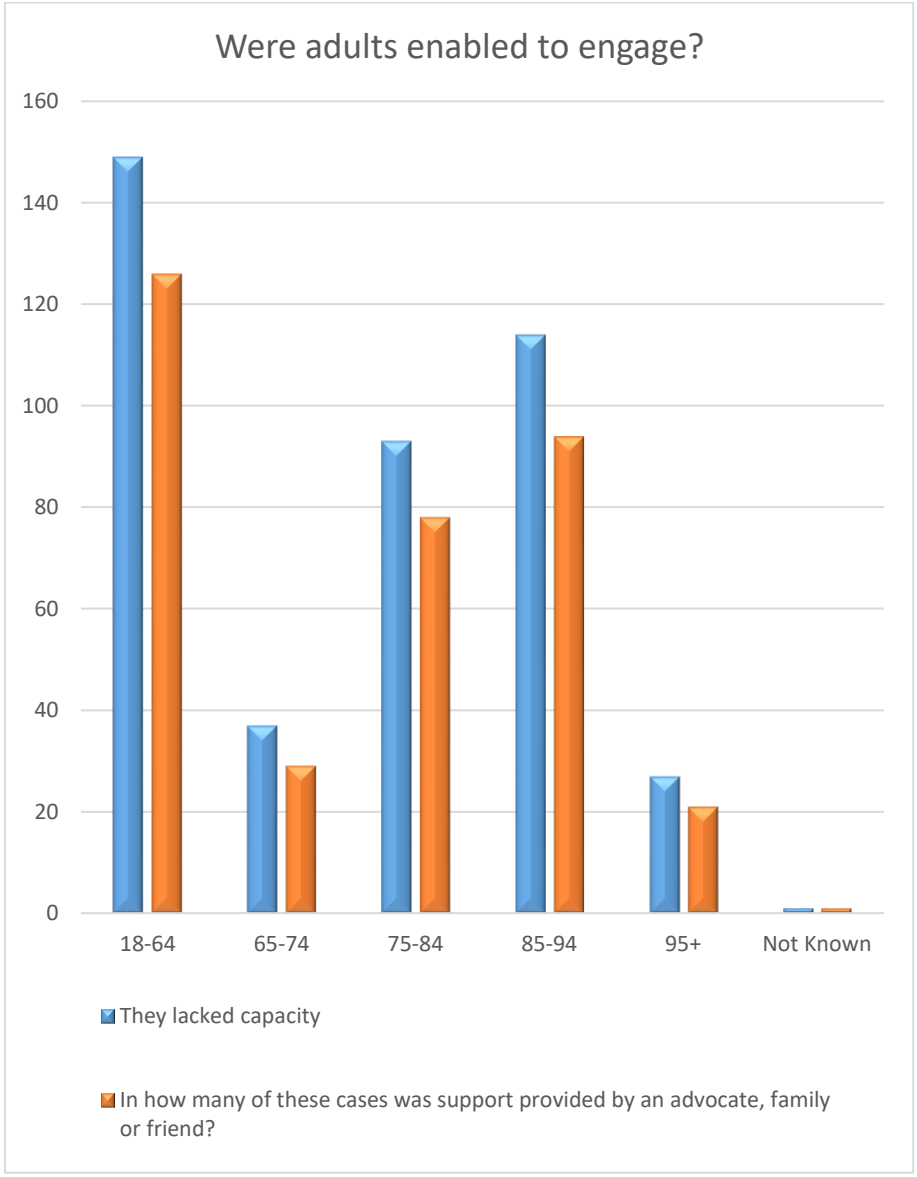
- A significant number of enquiries involved people with physical support, Learning Disability and Mental Health needs.
- Risk was most frequently coming from someone known to the adult at risk, except in cases of Neglect where the service provider was more often the cause of the concern



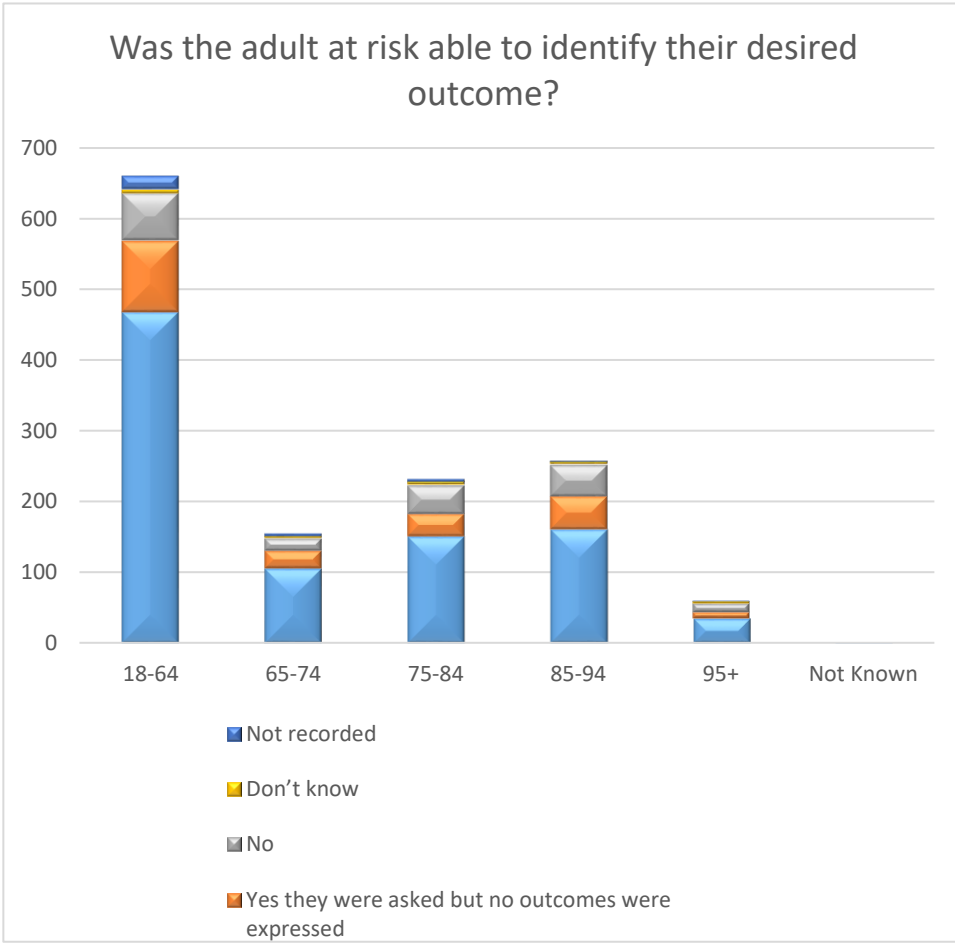


It is critically important to know if the adult at risk is able to make decisions for themselves and as far as possible enable them to do so if they can. A higher proportion of people over 75 were assessed as not being able to make specific decisions compared to younger people.

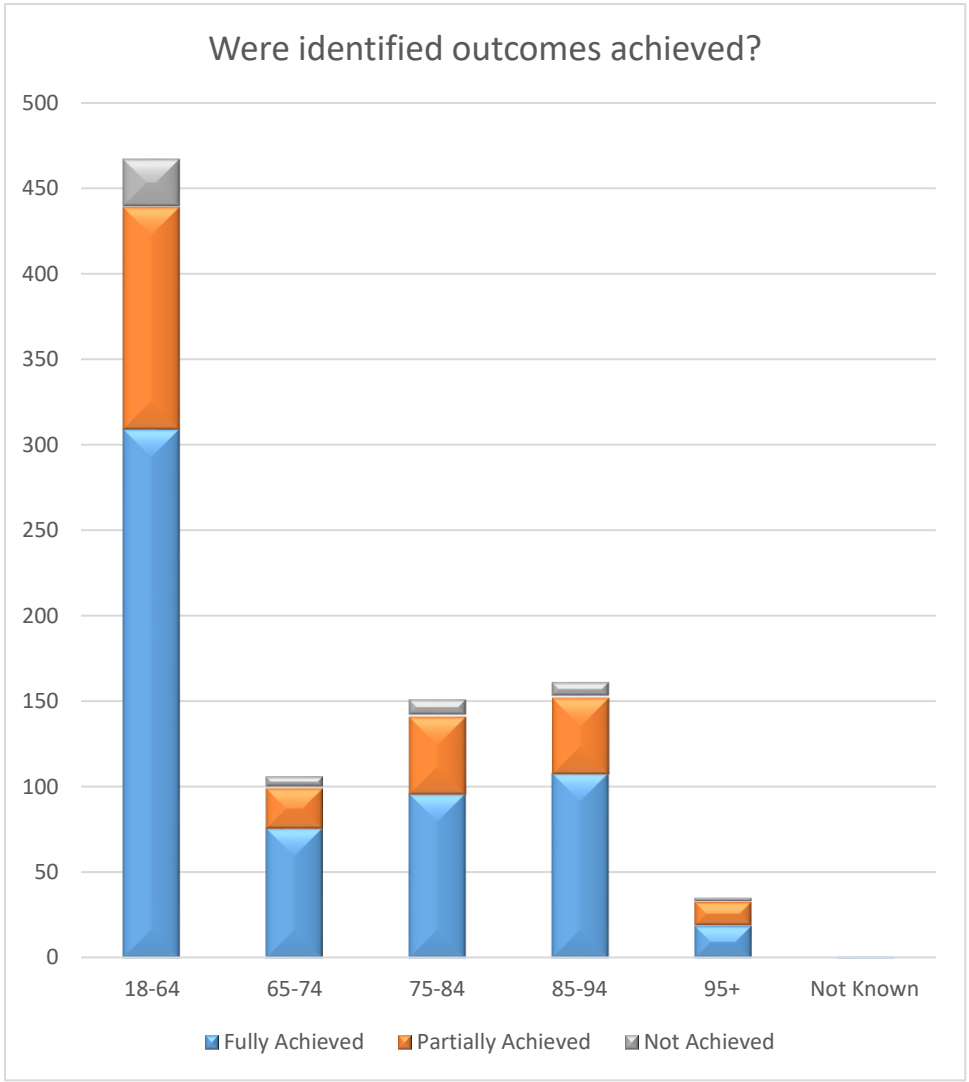
Where this is the case, work should be done to ensure the adults perspective can be heard by using a family member, friend or professional advocate.

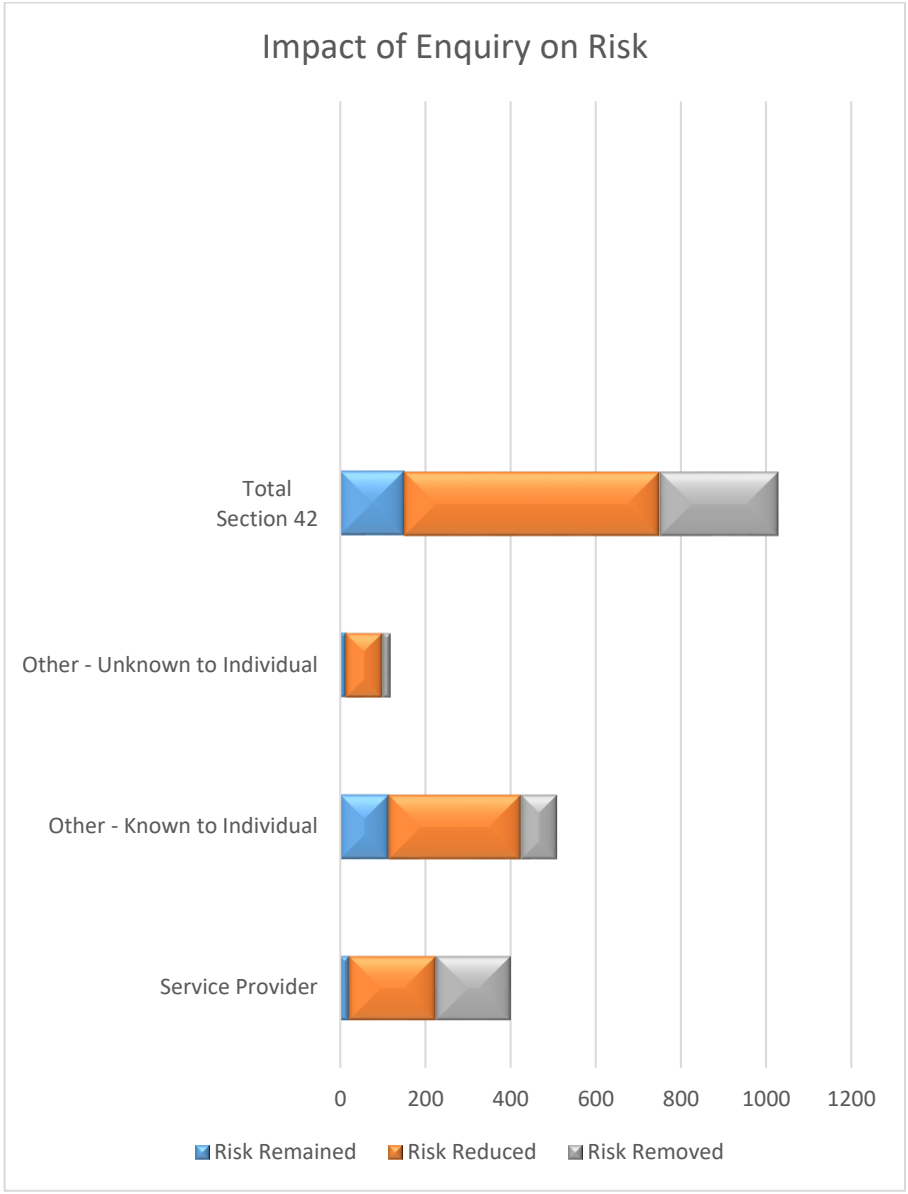


The adult at risk should be involved in agreeing the outcome that they want from the Enquiry



And then that outcome should be achieved as far as possible and the risk reduced if not removed.





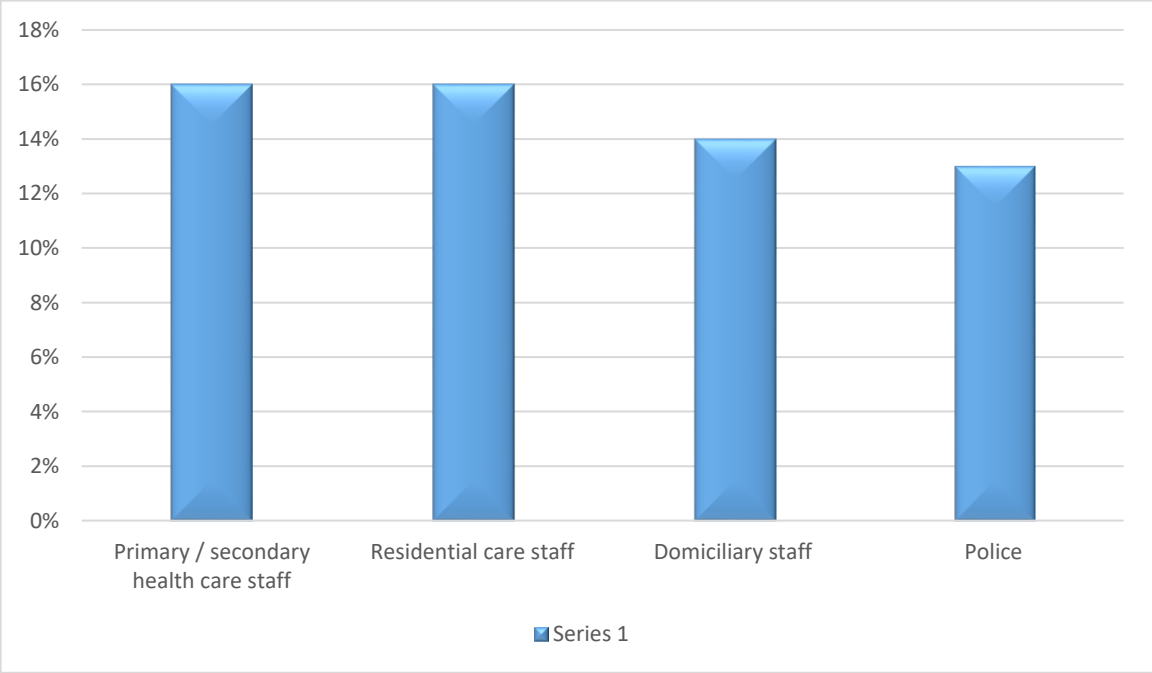
Safeguarding in Peterborough

MULTI-AGENCY SAFEGUARDING HUB (MASH) DATA

How much abuse was reported?

ASC/CPFT dealt with 1915 new safeguarding concerns (cases that progressed as far as triage) and 227 new enquiries

Who reported the abuse?



Primary/secondary health care staff 16% of concerns

Residential care staff 16%

Domiciliary staff 14%

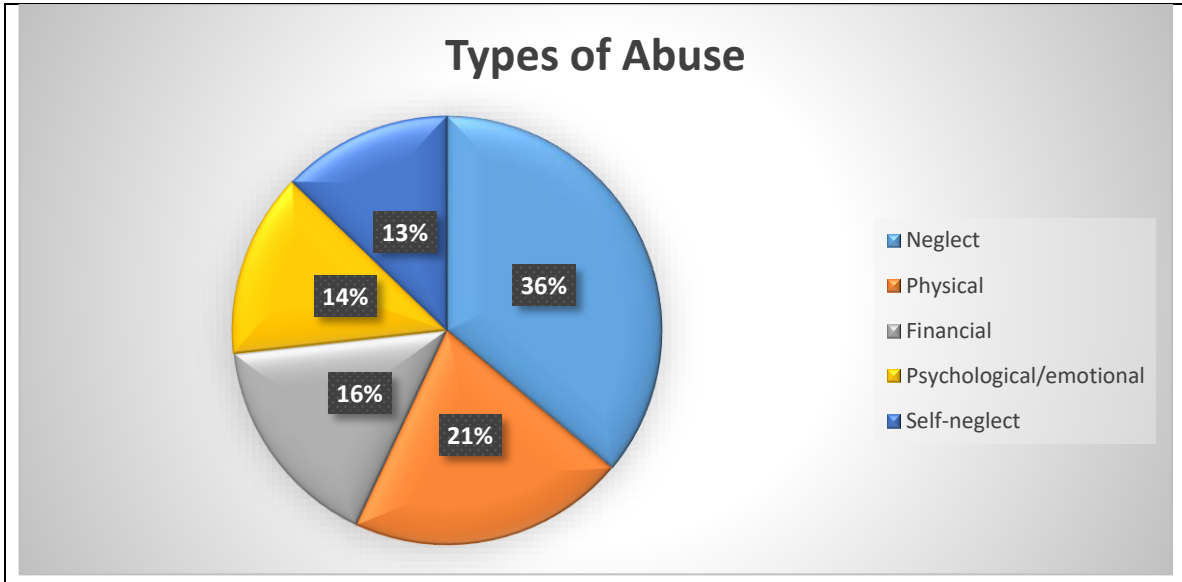
Police 13%

Who was abused?

Of the individuals involved in new safeguarding concerns

- 22% were aged under 65
- 55% were aged 65+
- 23% were aged 85+
- 60% were women
- 40% were men
- 52.6% had a physical support need (and were responsible for 54% of the safeguarding concerns)
- 12% had a learning disability (and were responsible for 14% of the safeguarding concerns)
- 10% a mental health need (and were responsible for 10% of the safeguarding concerns)

What sort of abuse was reported?



Neglect 31%

Physical 18%

Financial 14%

Psychological/emotional 12%

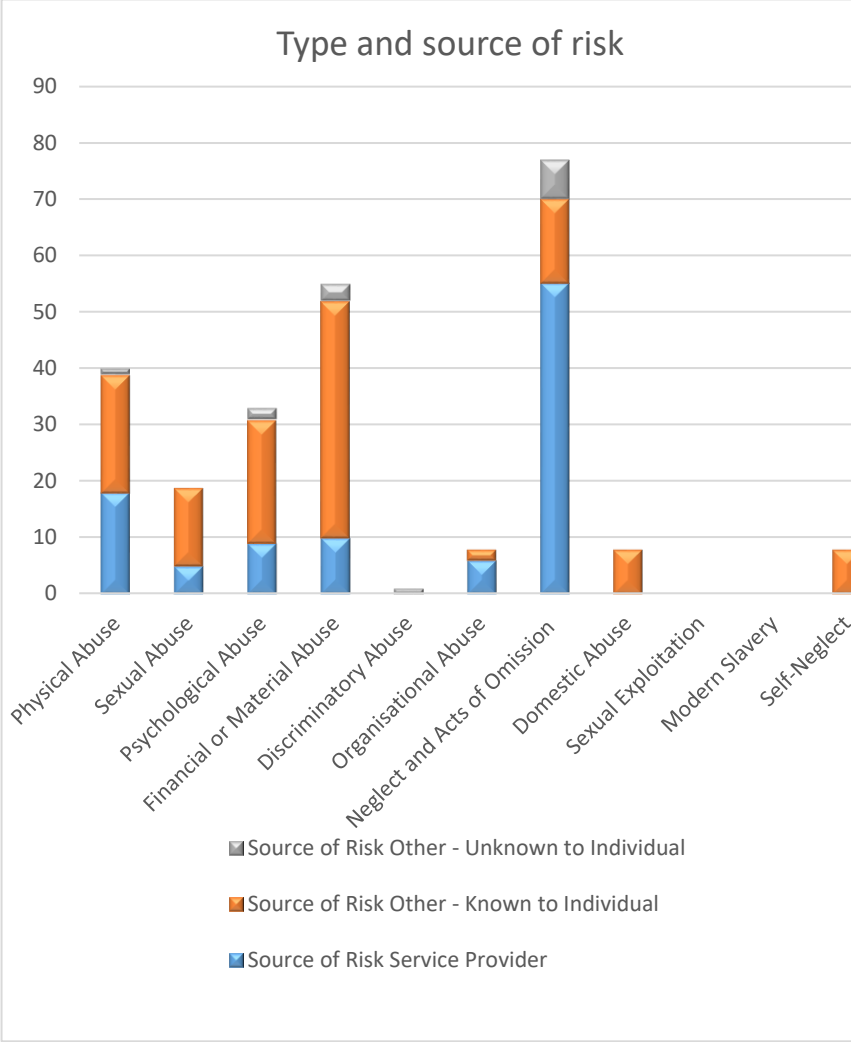
Self-neglect 11%

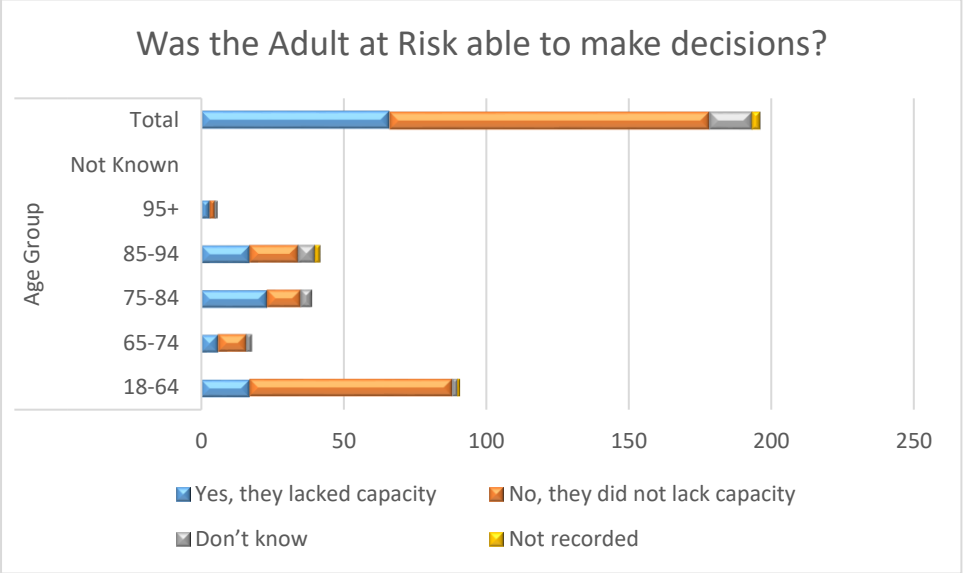
Where did it occur?

- 52% in the adult's own home
- 20% in a care home
- 10% in hospital
- 10% in the community

ENQUIRIES INTO ABUSE AND NEGLECT

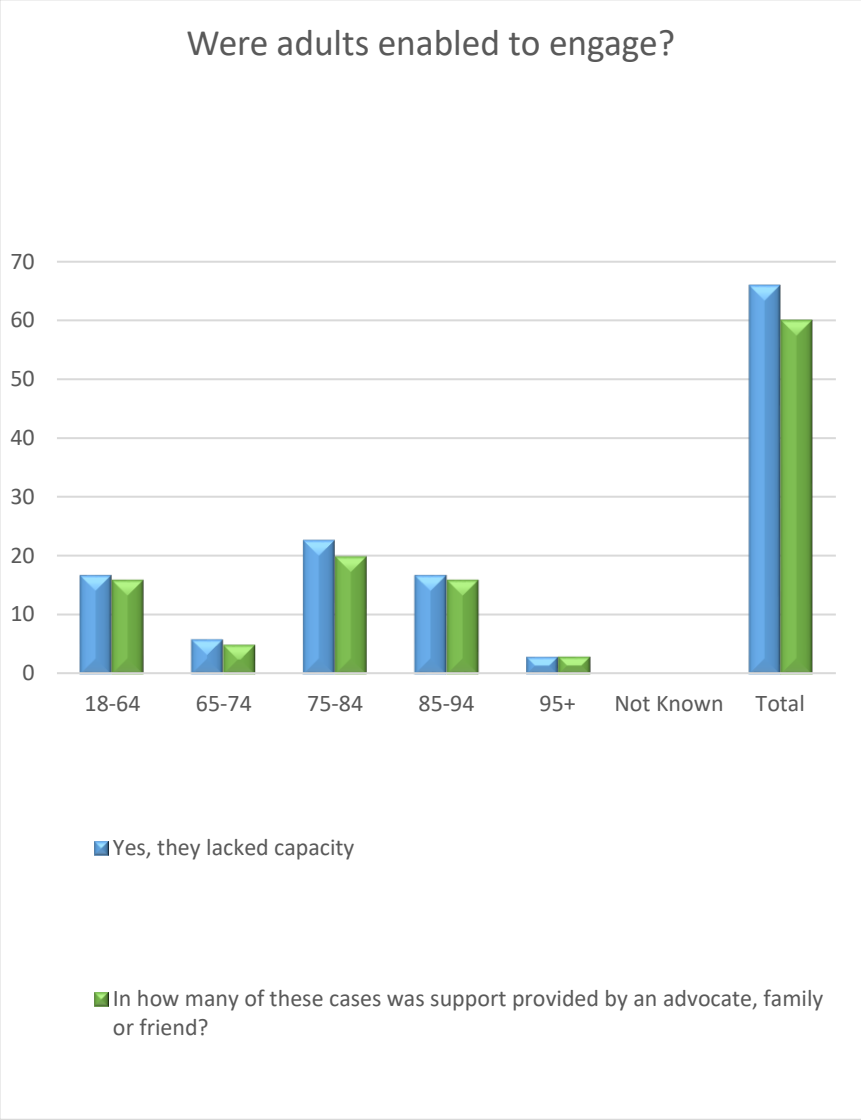
- **Over half the enquiries made were with adults who had physical support needs.**
- **Risk was most frequently coming from someone known to the adult at risk, except in cases of Neglect where the service provider was more often the cause of the concern**



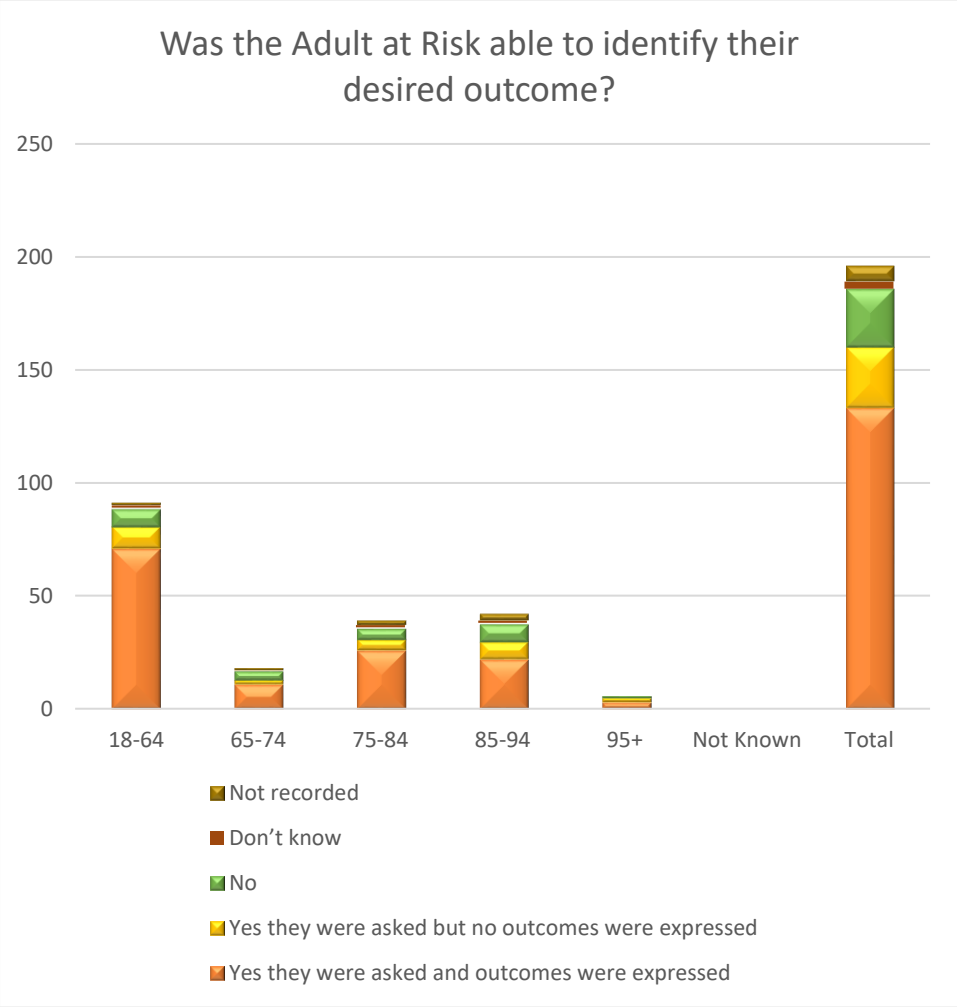


It is critically important to know if the adult at risk is able to make decisions for themselves and as far as possible enable them to do so if they can. A higher proportion of people over 75 were assessed as not being able to make specific decisions compared to younger people.

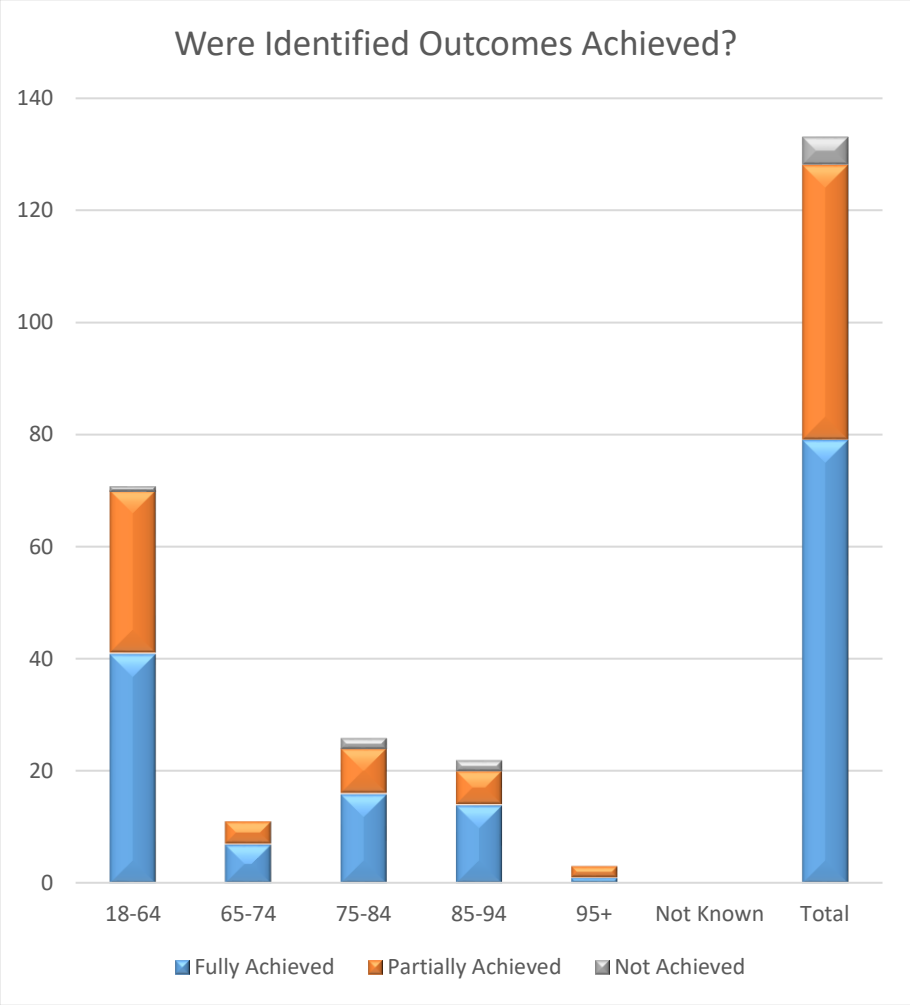
Where this is the case, work should be done to ensure the adults perspective can be heard by using a family member, friend or professional advocate.

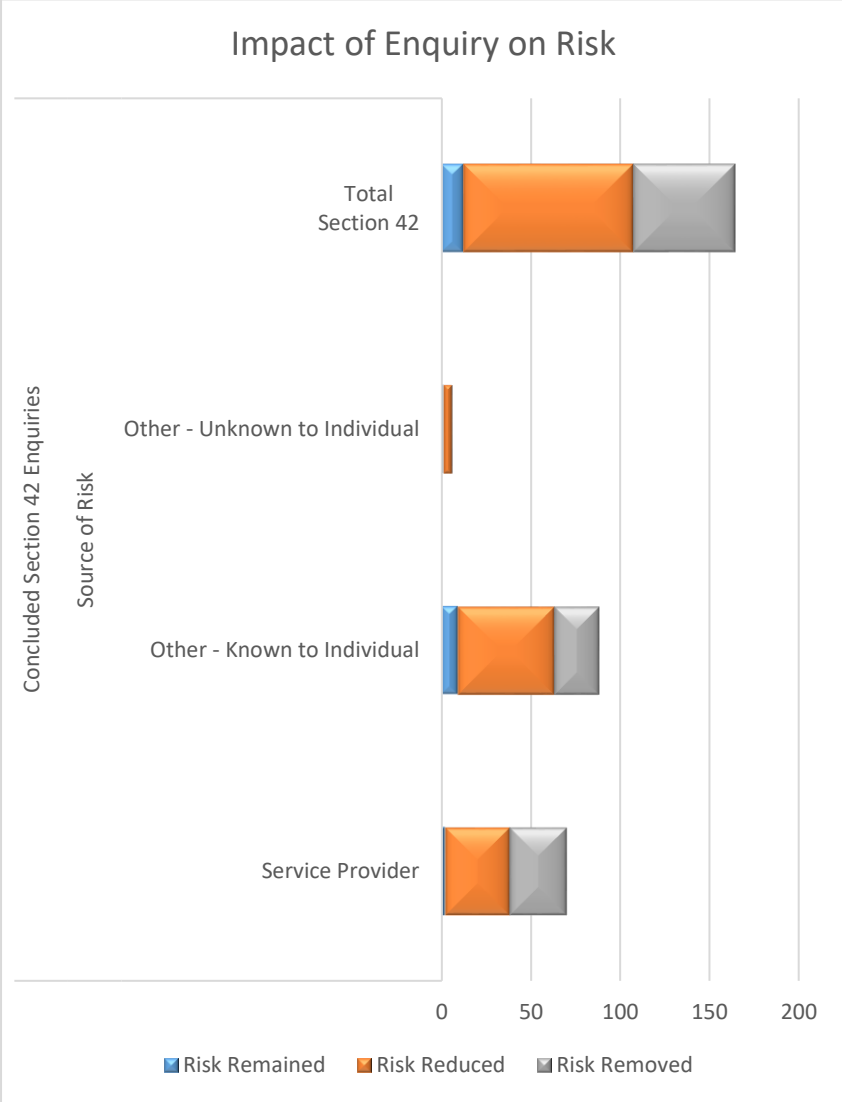


The adult at risk should be involved in agreeing the outcome that they want from the Enquiry



And then that outcome should be achieved as far as possible and the risk reduced if not removed.





Progress against the Board Priorities

Strategic Business Plan 2017-2019

Listening and responding to the voices of the people of Cambridgeshire and Peterborough:

We have:

- Worked with a small group of people who use services and/or have experience as carers and are willing to contribute to Board meetings. An additional member has been added to this group and we provide the facilities and support that this role needs.
- Attended Conferences, together with service user representative, launching the Association of Directors of Adult Social Care (ADASS) MSP Toolkit supporting SABs in making service user involvement real.
- Started an initiative to transform the way we do business to allow community feedback to be heard and used at the right time.
- Increase our contact with other community representation groups through meetings, awareness events, SAB communications, and building on existing networks. This includes organisations that work on prevention and early help.

Prevention - by anticipating and identifying issues before abuse and neglect can occur to prevent harm from taking place

We have:

- Made links with the agencies and voluntary groups that undertake preventative work and are looking to increase their understanding of safeguarding. We have delivered training to staff and volunteers.
- Provided information on the recorded outcomes of cases that do not meet the threshold for social work services in the MASH to improve planning.

Ensuring practitioners work within the principles of Making Safeguarding Personal (MSP)

We have:

- Ensured that MSP and the six principles are a "golden thread" that run through all we do. This includes:
  - The SAB Procedures. What staff should be considering and doing to be in line with MSP is embedded into the procedures and guidance.
  - The SAB Audit framework. Agency service delivery is measured against MSP principles.
  - Our website and communications. The term and what it means is repeatedly emphasised and promoted on all of our materials
  - An agency self-assessment process was structured around MSP principles
  - All our training explicitly incorporates MSP
  - MSP was a theme at the SAB Conference and across the March Awareness Month
- The inaugural meeting of the Board reviewed progress in Cambridgeshire and Peterborough and pulled together the work on MSP in the two Local Authority Areas into a shared Action Plan, which is now being implemented.

Ensuring the workforce is appropriately skilled and trained to identify and respond to issues of abuse and neglect.

We have:

- Appointed an experienced trainer to deliver multi-agency training for the SAB alongside a colleague from Peterborough.
- Developed a training offer that covers the Board priorities.
- Worked with other training providers to ensure there is a coherent offer to professionals across all agencies where we compliment rather than compete with each other's programmes.
- Issued a training timetable and run training. The programme is continually expanding its range. Self-Neglect programme running, as is

the joint Children and Adults DA programme. An adults' programmes focusing on elder abuse and Learning Disabilities will be launched within the next three months.
- Received consistent positive feedback about the quality and relevance of the training events
- Initiated the development of a set of standards, quality expectations and assurance criteria for all adult safeguarding training
- Ran a series of Awareness events for people who would not attend formal training sessions
- Ensured MSP is at the core of all training

Monitor, scrutinise and challenge safeguarding practice across the partnership.

We have:

- Conducted a multi-agency audit of cases involving Domestic Abuse, the first such audit to be completed in Cambridgeshire or Peterborough. There were many useful lessons from this audit in regards to working together. These audit findings were turned into SMART Actions, enabling learning to generate change.
- Prepared our next audit, on cases involving neglect within an adult's home.
- Coordinated a structured self-audit by Cambridgeshire County Council, Peterborough City Council, Cambridgeshire and Peterborough CCG and the Police that covered what agencies need to have in place to deliver high quality services in line with MSP. The judgements made were discussed at a multi-agency meeting and the themes were turned into actions for further development. This exercise provided a high level of assurance that agencies were effective in working towards the goal of MSP.
- Analysed information on the work of the Multi-Agency Safeguarding Hub (MASH), including outcomes for those situations that do not lead to social work safeguarding intervention.
- Agreed the main elements of a dataset that summarises the level of activity in safeguarding, the involvement of the adult at risk and the effectiveness of the work. Currently this is reliant on Social Care information that needs augmenting with relevant information from Health and the Police. This will over time provide evidence on the effectiveness of the safeguarding system.
- Created a picture of the prevalence of people with care and support needs in Cambridgeshire and Peterborough, and the trends in the level of needs, with the support from Public Health colleagues. This will support planning and inform judgements as to whether need is being identified and services are being delivered where it is most required.
- Presented information to the SAB on how safeguarding is working locally, including benchmark data, derived from national data and surveys of those using the services. This has enabled the SAB to have a proper understanding of the strengths and weaknesses of local safeguarding. This has included the low percentage of concerns that go to social work safeguarding and differences in the level of involvement by some providers.

Raising awareness of the role of the SAB's and safeguarding issues across communities

We have:
Coordinated the March Awareness Month. Agencies included

- Age UK
- Cambridgeshire County Council (CCC)
- Peterborough City College
- Domestic Abuse and Sexual Violence Partnership Board (DASV)
- Focus Care Agency
- Hunters Down Care Centre
- NHS England
- Peterborough City Council (PCC)
- Phillia Lodge
- Cambridgeshire Constabulary

- Cambridgeshire and Peterborough CCG – with NHS England
- Cambridgeshire and Peterborough Foundation Trust (NHS) (CPFT)
- East of England Ambulance Trust (NHS)
- Healthwatch
- National Association for Care and Resettlement of Offenders (NACRO)
- North West Anglia Foundation Trust (NHS) (NWAFT)
- Peterborough Diocese
- Vivacity – Library services
- Cambridgeshire Fire and Rescue Service
- Cambridgeshire Community Services (NHS) (CCS)
- Cross Keys Housing
- Hinchingbrooke Hospital
- National Probation Service
- Papworth Hospitals
- Peterborough Regional College
- Youth Offending Services (YOS)

Events and activities included:

- Using social media to spread key messages
- Holding drop in events
- Reflection on safeguarding in supervision
- Weekly emails with safeguarding themes to all staff
- Awareness events with stalls and information
- Training events and conferences
- Single agency training and communication events

Over 2000 staff were given awareness message and over 750 service users/members of the public.

- Newsletters, email messages, and training bulletins which went out to over 4000 staff.
- Issued the first joint SAB Newsletter
- The Website is now near completion and includes materials on SAB priority areas.
- Prepared and circulated briefings on priority topics
- Delivered an Awareness Roadshow
- Run the SAB Conference on the theme that Safeguarding is Everyone's Business
- Undertaken a presentation on learning from SCR and SARs to new social workers

Our Priorities:

Domestic Abuse –

To ensure that adults at risk of abuse and neglect are protected from all types of Domestic Abuse; and when victims are identified they are provided with appropriate support to recover and are safeguarded in line with the principles of Making Safeguarding Personal. In this priority there will be a particular focus on elder abuse (over 65)

We have:

- Undertaken a multi-agency audit and identified learning
- Coordinated our action plan within that of the Domestic Abuse and Sexual Violence (DASV) Board to maximise impact and avoid duplication.
- Worked within the DASV processes to effectively cover issues as they relate to adults at risk.
- Issued information, resources and training for staff
- Included the issue in our community awareness material
- Made the development of training covering Elder Domestic Abuse and the impact on those with learning disabilities a priority.

Neglect (including self-neglect and hoarding)

To ensure that adults, at risk of abuse and neglect, in all settings, are protected from neglect; and when victims are identified they are provided with appropriate support to recover and are safeguarded in line with the principles of Making Safeguarding Personal.

- Put in place preparation for a multi-agency audit of cases involving neglect

- Timetabled a multi-agency audit of self-neglect cases
- Initiated a Safeguarding Adults Review (SAR) on a self-neglect case that includes a review of policy and guidance on effective practice
- Completed the SAR on a case involving neglect and begun to apply the learning
- Reviewed materials on the website
- Designed and delivered training that focusses on self-neglect and hoarding
- Liaised with the Fire Service on learning from fatal fire reviews where hoarding was a factor.

Adults living with mental health issues

To ensure that adults at risk of abuse and neglect are protected`, and that practitioners are skilled and trained appropriately to recognise changes in symptoms and behaviours that may indicate a deterioration in their mental health and that a change in care management/planning is required; and when victims are identified they are provided with appropriate support to recover and are safeguarded in line with the principles of Making Safeguarding Personal.
We have:

- Joined the Zero Tolerance to Suicide strategic partnership to identify and support the development of its work with adults at risk.
- Identified the training need and made it a priority for the SAB Training
- Timetabled a multi-agency audit

Other areas of work

Suicide and Serious Self-Harm

The initial work on a county-wide strategy came from a need to address the numbers of people committing suicide who had been receiving secondary mental health services. This has been expanded to include all who may be at risk of suicide in the future. Many if not all of these would come under safeguarding if abuse, neglect or self-neglect were present and a contributory cause.

Human Trafficking and Modern Slavery

This is an emerging issue for the Board. Our work needs to be coordinated within the overall approach of the Community Safety Partnerships. Their joint Strategy is still in preparation. We have worked with the police in identifying where adult safeguarding fits within the overall response from agencies on this issue. We do know that this area has a high prevalence of agriculture based modern slavery and that Peterborough and Cambridge have a significant issue regarding sex worker trafficking. Not all victims would require care or support, but many will and safeguarding services need to be available to those that do.

Pressure Ulcers Protocol

Following the release of a national Pressure Ulcers protocol, the Board has a sub group in place to review local service compliance. To date they have conducted a survey of provider awareness and needs and contacted NHS specialist professionals to confirm compliance of policy and practice with protocol. Amended local guidance to follow by September.

Learning and Improvement

Learning Disabilities Mortality Review (LeDeR)

The Learning Disabilities Mortality Review (LeDeR) programme was established to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and take forward the learning into service improvement initiatives.

The programme has developed a review process for the deaths of people with learning disabilities. All deaths receive an initial review; those where there are any areas of concern in relation to the care of the person who has died, or if it is felt that further learning could be gained, receive a full multi-agency review of the death.

More information, including easy read material, can be found at: http://www.bristol.ac.uk/sps/leder

Training and Supporting Reviewers

Twenty local reviewers have been trained to undertake an LeDeR review since February 2017. All reviewers have the opportunity of securing a reviewer 'buddy' if they so wish. Cambridgeshire LDP have set up a 'peer support' group for LeDeR reviewers and reviewers across Cambridgeshire and Peterborough are encouraged to participate.

By 31/03/18 Cambridgeshire and Peterborough have received Twenty nine cases for LeDeR mortality review since 'going live' on 1st May 2017.

LeDeR Reviews

There has been six Reviews completed. Four completed reviews securing feedback and approval, one review awaiting this and one has been reallocated to another CCG at the LAC request.

Age range of reported deaths is from 9 years to 89 years.

14 of the LeDeR deaths took place in general hospital settings.

What has been learnt?

The relatively low number of completed reviews make generalisation difficult. However, nationally there have been a significant number of reviews and the lessons can be drawn out from them:

> "Overall themes identified as learning points or recommendations
>
> Of the 103 completed reviews, 67 identified a total of 189 learning points. Thirty-six reviews (35%) did not explicitly identify any learning, the remainder identified between 1 and 21. Overall, the average was 2.8 learning points in each review.
>
> The most commonly reported learning and recommendations were made in relation to the need for:
>
> a) Inter-agency collaboration, including communication
> b) Awareness of the needs of people with learning disabilities
> c) The understanding and application of the Mental Capacity Act (MCA)
> It should be noted that two learning points referred to evidence of good practice and the opportunity for others to learn from positive experiences, both in relation to inter-agency communication."

LeDer Annual Report December 2017

Easy Read LeDeR Annual Report 2016-2017 (PDF, 674kB)

https://www.youtube.com/watch?v=-fXylKY-jQs&feature=youtu.be

Future Developments

LeDeR is a new initiative and only a handful of reviews have been completed. More local support is planned to improve review uptake. The purpose is to learn from the reviews and make changes that will reduce the gap between the life expectancy of someone with a Learning Disability and the rest of the community. We need to increasingly focus on what we learn from the reviews and ensure this learning leads to positive changes.

Quality and Effectiveness Subgroup

What does it do?

It will "ensure that the Safeguarding Adults Board have a detailed overview of the quality and effectiveness of agencies' practice and performance in relation to the safeguarding of adults in Cambridgeshire and Peterborough."

How does it do this?

By:

- gathering and interpreting information on how safeguarding takes place
- auditing safeguarding cases,
- requiring agencies to assess their approach to safeguarding and whether it can be improved,
- asking service users and staff about their experiences

What happens then?

There is always room for improvement. The Board and individual agencies use what they learn to make improvements and then assess if the changes made have had the required effect. There needs to be a constant cycle of learning and improvement.

Who does this?

A multi-agency cross-disciplinary group of professionals and managers who understand and influence how their agency is safeguarding adults at risk.

What have we done this year?

- A multi-agency audit of cases where domestic abuse was present
- Commissioned a picture of who has care and support needs in the area and how this will look in years to come
- Regularly review information on cases being referred into safeguarding and what then happens for the adults concerned
- Support an agency self-assessment audit by CCG, Police and the local authorities
- Developed our ability to ask professionals and service users about their experience of safeguarding

This year has been about putting into place the foundations we need to be able to deliver this work. Looking ahead, the QEG will be judged by what is different because of what it has done, and this takes time to achieve. We have:

- Highlighted the number of cases referred that don't go on to have a full social work enquiry, and the importance of understanding the situation of these adults.
- Used learning gained to focus training and develop practice
- Adopted an approach that seeks information about the engagement and involvement of the adult at risk in their own safeguarding. This is to promote Making Safeguarding Personal

Safeguarding Adults Review Subgroup

Under the 2014 Care Act, Safeguarding Adults Boards (SABs) are responsible for Safeguarding Adults Reviews (SARs). The purpose of SARs in the statutory guidance is to 'promote effective learning and improvement action to prevent future deaths or serious harm occurring again'. The aim is that lessons can be learned from the case and for those lessons to be applied to future cases to prevent similar harm re-occurring.

To meet this responsibility, we have brought together the SAR Sub Groups from Cambridgeshire and Peterborough into one meeting. This is a multi-agency meeting of managers and senior professionals with expertise in safeguarding, able to identify when a SAR is required and then oversee its completion. We have maintained a good level of attendance and engagement which has allowed us to progress the work without any interruption.

Completed SARs

We have completed one SAR, Katherine.

This SAR was commissioned following the death in 2016 of a woman under 30. Services had been involved with her since early adolescence, and the SAB suspected that neglect, and possibly abuse, had contributed to her death. Katherine was immobile and lived as a young person and adult in an unsanitary environment that caused significant physical deterioration for her and acute sensory discomfort for staff.

Katherine suffered from Chronic Regional Pain Syndrome, a rare condition where after a physical injury there is pain and physical symptoms that are highly disproportionate to the injury. Affected limbs can physically look like they have had significant nerve damage and may show significant and obvious physical signs. It can lead to multiple medical investigations, most of which return normal results. This pattern means that it can be a considerable time before this diagnosis is reached, though for Katherine in this case the diagnosis was relatively quick.

The symptoms expressed were not purely 'psychosomatic'. However, a history of more complex psychological issues tends to indicate the likely complexity and presentation of pain symptoms. The psychological focus on physical symptoms and pain, and assuming the 'sick role', can prevent recovery.

The nature of the pain can be extremely severe such that people experience pain in response to trivial sensory changes e.g. slight changes in temperature, or a gentle breeze. Treatment for CRPS involves a complex multi-disciplinary approach, which may commonly include desensitisation. Treatment received earlier in the course of the illness is more likely to be successful.

A summary of the Review can be found at: http://www.safeguardingpeterborough.org.uk/adults-board/about-the-adults-board/sars/

Summary of Themes of Key Areas of Learning

1. CRPS is a highly complex condition requiring clinical treatment addressing both physical and psychological aspects. In Katherine's case, whilst clear recommendations for treatment were made by specialist services, local services did not or were not able to support a timely package which implemented these recommendations. Physical treatment provided to Katherine focused on treating the secondary symptoms of CRPS rather than addressing core maintaining factors
2. Agencies did not always work together effectively. Katherine's care was not coordinated by a health professional with specialist knowledge of CRPS. In the last few years of her life, the GP assumed much of this role but at a level that went above and beyond what is expected from a GP. Knowledge, awareness and understanding of CRPS was poor.
3. Katherine and her mother had a complex co-dependent relationship. This impacted on the way that services interacted with Katherine as an autonomous and independent individual. Professionals did not always make sufficient effort to determine Katherine's views in the absence of her mother.
4. There were deficits on the approach to assessment of Katherine's capacity. Specifically, in the assessment of mental capacity professionals depended disproportionately on the anticipated outcome of a formal assessment for an Autism Spectrum Condition.
5. In Katherine's childhood, a number of potential concerns that should have resulted in safeguarding interventions were missed. This lack of formal intervention during childhood was potentially a significant contributor to the escalation, development and maintenance of Katherine's problems as an adult. Further passage of time made her

situation more entrenched and difficult to extricate herself from.

6. The potential and actual harm being experienced by Katherine as a result of her situation, her lack of control, the potential elements of co-dependency in her relationship with her mother, her lack of ability to engage in appropriate treatment and the fact that professionals reached a wide range of conclusions about Katherine's capacity should, taken together, have acted as a trigger of the need to urgently gain a court's view of the situation.
7. Legal advice was not sought early enough, and when sought was not followed through in a timely manner. The process for dealing with different legal advice obtained by different agencies was not clear.

What has changed?

The learning from this Review has been communicated through training, presentations and written material to inform professionals about the issues and equip them to learn and respond differently when parallel situations arise. Specific training, such as that on Self-Neglect, now covers issues identified with a wide audience.

Agencies in Cambridgeshire and Peterborough have agreed to look at a new and innovative way to ensure that in highly complex cases there is scope to have a multi-agency approach led by someone able to break through the barriers and access resources and expertise.

Services for children are undertaking the work needed to address the issues raised about opportunities missed and the sharing of information and understanding when a child moves to adulthood.

SARS BEING UNDERTAKEN.

We are currently undertaking a review into the harm suffered by a vulnerable adult with limited mobility as a single amputee. Has suffered significant harm to his health by potential neglect to his wounds. Whilst the neglect was by his choice questions remain about the effectiveness of services in supporting him in taking appropriate care of himself. The SAR Overview author is a nationally recognised lead on self-neglect and the review will address the issues in this individual case and also the existing guidance we have in place for staff.

EXISTING COMPLETED SARS

Reviews completed by the Peterborough Board were some time in the past, but the current Group has ensured that the Action Plans in place were completed appropriately.

These actions were centred on

a) Better recording of prescriptions and medication for patients living in Care Homes; and

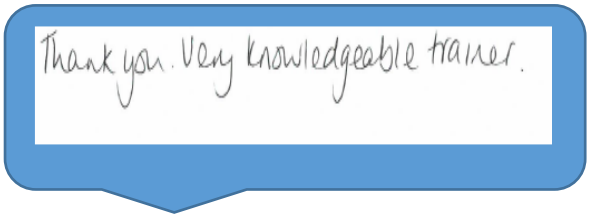
b) Effectively communicated and implemented discharge plans.

Training and Development

Training

Following the amalgamation of the Boards we have continued to deliver the existing programme but the focus has been on building for the future.

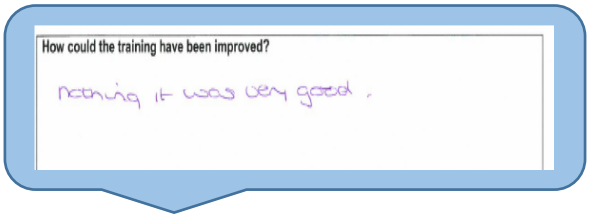
The Safeguarding Boards Unit appointed a dedicated Adult Safeguarding trainer at the end of 2017 to go complement the existing PCC trainer



We have a web based training programme and have successfully introduced an e-booking system to make access easier and streamline administrative tasks.

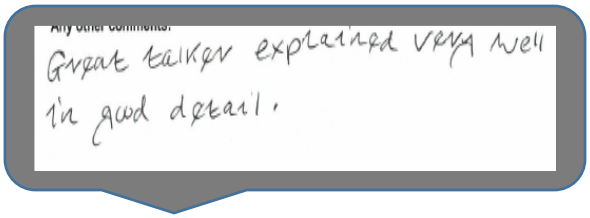
We delivered a joint Training Programme that covered children and adult safeguarding, some programmes addressing issues across children and adult safeguarding.

Matched current and future programme availability against Business Plan priorities.

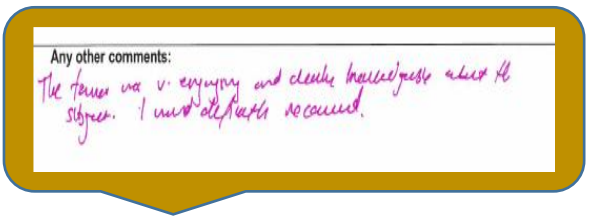


The Awareness Roadshow and Training Programme were used to obtain the perspective of staff on their current training needs.

Planned a comprehensive needs assessment for 2018-19



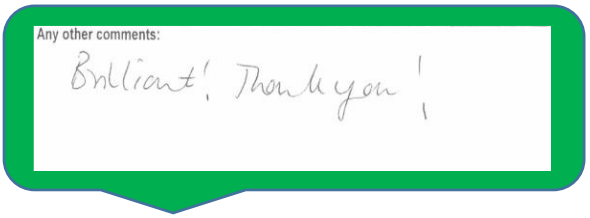
Delivered an "Awareness Roadshow" in March designed to promote a shared understanding of safeguarding. It was free to all and promoted to the "harder to reach" agencies such as Care Homes and Domiciliary Care providers.



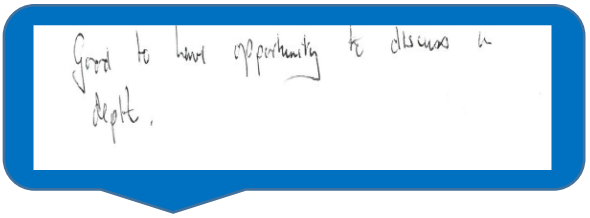
The existing training programme can be found at: http://www.safeguardingpeterborough.org.uk/availabletraining/.

This is a developing programme and it will continue to expand in the coming months.

73% of attendees at our courses said they were completely relevant.

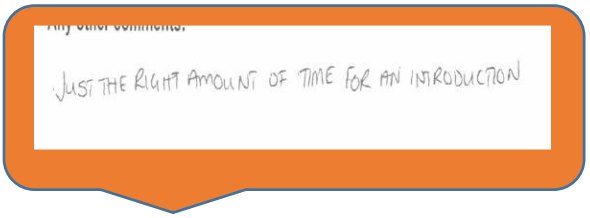


60% of attendees described the delivery at our training as Excellent, with a further 38% saying it was good/very good.



Annual Conference

Timed to coincide with the Awareness Month, the annual conference took place in March. This year's theme was "Safeguarding is Everyone's Business".



"A really good day - for learning and meeting people"

This was the first joint conference, and the aim was to introduce common topics and set a clear path for the way the SAB would work together in the future; there were presentations on Information Sharing and Making Safeguarding Personal as key areas where we must get it right and work together. Speakers included a local police officer who talked about a real case of elder abuse, and involved a member of the victim's family as part of the presentation. This made a real impact on delegates, and feedback received saying this was a powerful message. Similar feedback was also received for a presentation on the learning from a local SAR, where a key worker involved in the case gave a personal account of how it was for him.

"We need to know how we can share information"

A representative from CQC also spoke, and she told delegates about the good work that has been seen in our local services.

95 people attended the conference, with a good mix of delegates from across Cambridgeshire and Peterborough, and all key agencies were represented including CCG, CCC, PCC, Police, Residential and Domiciliary Care Providers, health, prison, probation and education.

At the end of the event delegations were asked to complete an evaluation; of the 95 delegates who attended, 79 completed the evaluation giving a completion rate of 83%.

Key points from the evaluation:

- Achievement of aims/outcomes – 90% rated this as good or excellent
- Delivery/Presentations – 79% rated as good or excellent
- Materials/Resources – 70% rated as good or excellent
- Organisation of event – 89% rated as good or excellent

Statutory Partners

The statutory members (Police, CCG and the Local Authorities) were asked to consider the following questions when outlining what they have done:

1. What has your agency done to embrace and embed the Safeguarding Principles?

- **Empowerment**
- **Prevention,**
- **Proportionality,**
- **Protection,**
- **Partnership**
- **Accountability**

2. What has your agency done to improve the safeguarding and welfare of adults in Cambridgeshire/Peterborough?

3. How does your agency evaluate its Safeguarding effectiveness and what evidence do you have?

4. How has your agency challenged itself and others to improve safeguarding arrangements?

5. What progress your agency has made against the Board priorities:

- **Domestic Abuse**
- **Neglect (including self-neglect and hoarding)**
- **Adults living with mental health issues**

Cambridgeshire Constabulary

Detective Superintendent Martin Brunning - Head of Public Protection

Cambridgeshire Constabulary is responsible for effective policing across the whole of Cambridgeshire, covering approximately 1,316 square miles of the East of England region. For policing purposes the county is divided into six districts, Peterborough, Huntingdonshire, Fenland, East Cambridgeshire, Cambridge City and South Cambridgeshire, each headed by a district commander with their own dedicated policing teams who know the local area inside out. Specialist officers and staff provide services such as major investigations, roads policing and public protection.

Primarily during 2017-18 there has been a drive within the Public Protection Department to continually develop awareness and expertise in the area of Adult Safeguarding. The Constabulary has maintained a dedicated Adult Abuse Investigations & Safeguarding Unit (AAISU). This is a specialist team comparison of 1 x Detective Sergeant, 4 x Detective Constables and 3 x Civilian Investigators. The team investigate offences where an offender is in a POT (Position of Trust). The offences are against Adults with care and support needs. They investigate offences ranging from Neglect/Rape or Serious Sexual Offences/Assaults/Fraud etc. They attend Professional's Meetings and conduct joint S42 visits with Social Workers. There is also a dedicated MASH resource to manage referrals relating to Adults at Risk. All these officers have completed training relating to Adult Safeguarding and to Making Safeguarding Personal.

1. What has your agency done to embrace and embed the Safeguarding Principles?

Evidence of the safeguarding principles can be found throughout AAISU investigations, in how our officers work with other agencies and in how we support victims. During the past 12 months there has been a drive to increase involvement in Section 42 Safeguarding enquiries even when no crime is immediately apparent, and we strive to ensure that MSP is at the heart of our investigations.

The development of co-location of the Cambridgeshire County Council Adults MASH alongside the investigation team has delivered benefits in terms of joint working, and continued visibility and contribution to SAB meetings and

sub-groups ensures that the Constabulary is engaged in actively working with partners at strategic and tactical level to improve safeguarding service delivery.

2. What has your agency done to improve the safeguarding and welfare of adults in Cambridgeshire/Peterborough?

In addition to the above, training events during autumn 2017 were dedicated to Adult Safeguarding. Under the heading "Recognising Vulnerability" over 100 officers from different teams received training relating to Mental Capacity, Deprivation of Liberty Safeguards, The Mental Capacity Act, and MSP principles and practice. These events were supported by cases studies and a panel of professionals who took part in a Q&A session.

An AAISU investigator also gave a presentation at the annual Safeguarding Adults Conference, talking about a local case where an elderly lady, who had Dementia was abused in her home by her paid carers. This case highlighted how we work with partners and support the victims and their families.

We have used internal and external media to promote the work of adult safeguarding and the ways in which we can support victims of abuse and neglect. We ensure appropriate referrals for ongoing support services are made and that information is shared correctly.

We have worked closer with our partners, for example doing joint visits with social workers where possible.

3. How does your agency evaluate its Safeguarding effectiveness and what evidence do you have?

We are developing our existing crime review methodology into regular monthly audits that will consider safeguarding across a range of disciplines including Adults. This is work in progress and includes:

- Op Sherlock – This is a Force Operation that was rolled out last year to improve the quality of crime investigations. Officers were given briefings on how to improve the initial investigation and also in relation to improved supervision of crimes. Safeguarding is an included part of the investigation. Crimes were dip sampled by a Detective Inspector / Detective Chief Inspector on a monthly basis and feedback given to Officers.
- Crime Reviews – The crime review is conducted by a Detective Sergeant and looks at the investigation as a whole, this includes actions completed and outstanding actions. It also looks at the Safeguarding aspect of the crime, this relates to the risks to the victim and also the risk that the suspect poses to the victim and other people. If the risk is high then this will make a difference to what safeguarding actions the Police decide (Marker on the victim's address/IDVA/Referral to MARAC/Arrest/Bail Conditions etc.)

4. How has your agency challenged itself and others to improve safeguarding arrangements?

As well as the measures outlined above the following training offered to police officers and partner agencies challenges us to improve our safeguarding arrangements:

- Recognising Vulnerability – PPD Training given by Adult Social Care in relation to the Mental Capacity Act and Safeguarding.
- Initial crime Investigators Development Programme (ICIDP) – 3 hour presentations given by an officer from the AAISU to the ICIDP course of newly qualified detectives, focused on offences of neglect. A similar course will soon be offered to probationers.
- Raising public awareness through promotion of court results to the media. TV and radio interviews done with Look East, Radio, Caught on Camera etc. Also national media coverage in papers to highlight cases where

adults at risk have been neglected by carers – to shows the consequences of actions for people who neglect/abuse adults at risk in their care.

5. What progress your agency has made against the Board priorities:

The work of the AAISU encompasses the priorities and aims to keep MSP at the heart of what we do, and in particular the following measures ensure we work towards the best outcomes:

- sharing of information through the MASH to Partner Agencies
- promoting more joint working with Social Workers from ASC/CPFT when a S42 investigation is commenced and a crime is identified, including joint visits to see the victim so each agency can work closely together, resulting in better joined up working and a better outcome for the victim.
- closer working with ASC MASH/CPFT to identify high risk cases and act immediately
- Victim Care Contracts completed with 100% compliance ensuring victims are updated in line with the Victim's Code.
- DVNA's completed and referrals made to the Victim's Hub for ongoing Support & signposting
- referral to MARAC if threshold met.
- referral to ISVA's for sexual offences

Cambridgeshire and Peterborough Clinical Commissioning Group (CAPCCG)

Carol Davies - Designated Nurse for Safeguarding Adults

Cambridgeshire and Peterborough Clinical Commissioning Group ('the CCG') is one of the largest CCGs in England (by patient population), with 102 GP practices as members. They cover all GP practices across Cambridgeshire and Peterborough as well as three practices in North Hertfordshire (Royston) and two in Northamptonshire (Oundle and Wansford). The CCG is responsible for planning and buying local NHS services for the local population, such as the care you receive at hospital and in the community, ensuring that the care and treatment delivered is of the best possible standards.

1. What has the CCG done to embrace and embed the safeguarding principles?

CAPCCG strives to prioritise the importance of safeguarding adults to the health and well-being of our population and continues to promote a culture of 'Making Safeguarding Personal'[1]. The safeguarding of adults is firmly embedded within the statutory duties of the CCG in order to promote well-being, prevent harm and respond effectively if concerns are raised. We are committed to working with partner agencies to identify all forms of abuse and maltreatment, ensuring that 'Safeguarding is everyone's business.'

In addition, services commissioned by the CCG are expected to comply with the Care Act 2014[2], Care and Support Statutory Guidance[3] and Care Quality Commission (CQC) regulations[4], as well as meeting the requirements of the NHS

[1] https://www.adass.org.uk/media/6137/msp-resources-2017-for-safeguarding-adults-boards.pdf

[2] http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

[3] https://www.gov.uk/guidance/care-and-support-statutory-guidance

[4] http://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-13-safeguarding-service-users-abuse-improper

Contract[5]. The CCG is robust in holding commissioned Providers to account for their performance around Safeguarding Adults. This activity in turn contributes to raising awareness and promoting excellent practice by staff around the safeguarding and welfare of adults at risk locally.

Empowerment – People being supported to and encouraged to make their own decisions and informed consent.

The broad principles of 'Making Safeguarding Personal'[6] are mirrored in the NHS Constitution[7] and it is therefore an expectation that all NHS organisations work to these principles. Similarly, NHS staff are required to address the requirements within the Mental Capacity Act 2005[8] which aims to empower people to make decisions for themselves as much as possible and to protect people who may not be able to take some decisions.

***Prevention – It is better to take action before harm occurs*.**

The CCG fully supports a proactive approach to the avoidance of harm. Learning from past incidents via Safeguarding Adult Board (SAB) processes (e.g. Safeguarding Adult Reviews) is key for both the CCG and commissioned Providers. Lessons learned as a result of Serious Incidents[9] (SIs) which have safeguarding implications are shared across the local Health economy. The CCG also takes a system leadership role around Fatal Fire Reviews[10] and Domestic Homicide Reviews[11] to contribute towards the prevention of future harm. Responses to 'Whistle blowing' and complaints that have a safeguarding context equally provide an opportunity for learning.

During March 2018 (Safeguarding Awareness Month) the CCG arranged GP training events with Norfolk and Suffolk CCG colleagues for General Practice staff, and supported the Community Education Provider Network training events for GPs in particular. The CCG also delivered training in partnership with the SAB to staff and residents of Cross Keys Housing.

Proportionality – The least intrusive response appropriate to the risk presented.

There is an expectation that CCG staff and commissioned Providers will apply the principles of Making Safeguarding Personal[12] and the Mental Capacity Act[13] to acknowledge an adult's right to choose whether they want to engage with safeguarding processes. This would include respecting the notion of 'unwise' decision making, whilst remaining alert to the need to intervene under certain circumstances.

Protection – support and representation for those in greatest need.

Mindful of the potential need for patient support and representation, awareness of Advocacy Services is flagged in CCG staff training and we expect commissioned Providers to do so similarly. The CCG and commissioned Providers have also adopted 'Safer' recruitment practices in line with standard NHS requirements to reduce the likelihood of unsuitable staff being recruited.

Partnership – Local solutions through services working with their communities.

The CCG takes its responsibilities to partnership working in the safeguarding adults' arena

[5] https://www.england.nhs.uk/wp-content/uploads/2018/05/2-nhs-standard-contract-2017-19-particulars-service-conditions-may-2018.pdf Service Condition 32
[6] See 1.
[7] https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england
[8] https://www.scie.org.uk/mca/introduction/mental-capacity-act-2005-at-a-glance
[9] https://improvement.nhs.uk/resources/serious-incident-framework/
[10] A fatal fire review considers all community safety information gathered regarding the person who died in the fire and the circumstances of the fire, in order to identify organisational learning points that can be implemented
[11] https://www.gov.uk/government/collections/domestic-homicide-review
[12] See 1.
[13] See 8.

seriously. The CCG actively participates in the work of the Safeguarding Adult Board, including membership of the Joint Executive Board, the Board, Delivery Group and a range of sub-groups. The Designated Nurse has developed strong working relationships with the local healthcare community as Chair of the Health Safeguarding Group which links to the SAB. Similarly, the Designated Nurse meets regularly with the Head of Safeguarding for Adult Social Care and the Head of the SAB Business Unit.

Accountability – Accountability and transparency in delivering safeguarding.

There are Safeguarding Adult requirements specified by NHS England which apply to all NHS organisations, including both Providers and the CCG[14]. The CCG is also required to fulfil safeguarding obligations as part of the CCG authorisation process[15].

Commissioned Providers are expected to demonstrate compliance with measures around accountability and transparency in the Quality Schedule of the NHS Contract, and fulfilment of these measures is monitored via the Clinical and Contract Quality Review (CCQR) process.

2. What has the CCG done to improve the safeguarding and welfare of adults across Cambridgeshire as a whole?

The CCG is conscientious in actively engaging with SAB and partners locally, and as described previously is proactive in seeking assurance that local healthcare Providers are meeting their responsibilities too.

3. How does the CCG evaluate its Safeguarding effectiveness and what evidence do you have?

The CCG completed the SAB Safeguarding Self-Assessment Toolkit and believe that the SAB was sufficiently assured of the CCG's effectiveness. The CCG also participated in a pilot of an electronic Safeguarding Assurance Tool[16] led by NHS England which resulted in an overall rating of 'Green'.

4. How has the CCG challenged itself and others to improve safeguarding arrangements?

This is broadly described in previous sections.

Regarding the SAB Priorities;

- Domestic Abuse - To ensure that adults at risk of abuse and neglect are protected from all types of Domestic Abuse; and when victims are identified they are provided with appropriate support to recover and are safeguarded in line with the principles of Making Safeguarding Personal. In this priority there will be a particular focus on elder abuse (over 65).

The Designated Nurse is a member of the Domestic Abuse and Sexual Violence Board, representing the Health economy, and is a Domestic Abuse Champion. The Health Safeguarding Group has begun a peer review exercise of their memberships' Domestic Abuse Policies.

- Neglect (including self-neglect and hoarding) - To ensure that adults, at risk of abuse and neglect, in all settings, are protected from neglect; and when victims are identified they are provided with appropriate support to recover and are safeguarded in line with the principles of Making Safeguarding Personal.

The Designated Nurse was involved in the review of the SAB Self-Neglect and Hoarding Protocol and frequently participates in multi-agency 'Complex Case' discussions to support more effective management of such cases.

- Adults living with mental health issues - To ensure that adults at risk of abuse and neglect

[14] https://www.england.nhs.uk/wp-content/uploads/2015/07/safeguarding-accountability-assurance-framework.pdf

[15] https://www.england.nhs.uk/wp-content/uploads/2012/04/ccg-auth-app-guide.pdf

[16] http://www.quiqsolutions.com/SAT.html

are protected`, and that practitioners are skilled and trained appropriately to recognise changes in symptoms and behaviours that may indicate a deterioration in their mental health and that a change in care management/planning is required; and when victims are identified they are provided with appropriate support to recover and are safeguarded in line with the principles of Making Safeguarding Personal.

The Designated Nurse works to influence best practice in this field as part of the working relationship with the primary provider of mental health services locally. Where required influencing CCG commissioning and contracting colleagues is undertaken.

Local Authority

Helen Duncan - Head of Adult Safeguarding/Principal Social Worker, (Cambridgeshire County Council and Peterborough City Council)

Debbie McQuade - Assistant Director Adult Operations, Adult Social Care, Peterborough City Council

1. What have you done to embrace and embed the Safeguarding Principles?

Cambridgeshire County Council

Initially there was a lack of clarity regarding process for dealing with Safeguarding for referrals that had complaint issues and complaints that had Safeguarding issues. The Safeguarding team has worked with the Customer Care Team to ensure that any complaint issues in safeguarding referral are properly addressed. Similarly there is now greater clarity regarding the process for ensuring that appropriate action is taken when a complaint that raises safeguarding issues is the received.

As part of Safeguarding Awareness Month presentations about Making Safeguarding Personal were given at:

- The Adult Social Care Forum,
- Learning Disability Partnership Board,
- Older People's Partnership Board
- Physical Disability & Sensory Impairment Partnership Board meetings.

The Care Act – "Making Safeguarding Personal" (MSP) Principles have been embedded as quality measure themes within both operational Case File and Thematic Audit frameworks; this has included:

- Core Format - Case File Recording Standards – self-audit implemented from 01/02/2018
- Reflective Professional Practice – management audit implemented from 01/02/2018
- Care & Support Planning – thematic audit undertaken during December 2017
- Carers Assessment & Support planning – thematic audit undertaken during January 2018
- Safeguarding Adults S42 Enquiries – thematic audit undertaken during February/March 2018
- Mental Capacity Act Assessment – thematic audit to be undertaken during 2018

The Adults Principal Social Worker attended IDVA Team meeting to discuss overlap between IDVA and Adult Safeguarding processes. DASV Adult SG Lead attended Adult SG refresher training to ensure any advice given to IDVAs embraces MSP and Safeguarding.

The Counting Every Adult (CEA) Service at Cambridgeshire County Council works with the most chaotic and excluded adults in the county to improve outcomes for individuals and for society as a whole. Individuals with multiple and complex needs have a disproportionally large impact across services such criminal justice, housing, mental health, substance misuse, domestic violence and tenancy support due to the chaotic lifestyles that they lead. The service is widely recognised as a national leader in the field of supporting multiple needs individuals, as an example of good practice, has featured at UK conferences and in the local and national press.

The six core safeguarding principles underpin and encapsulate all work undertaken by CEA; their

key priority of client-led support being “person 1st, service user 2nd”. This empowering approach to support has continued to be promoted during 2017/2018; with ongoing exploration of development opportunities. Additionally the six core principles are embedded in our cross partner operational work. Working closely with services such as the Police, CPFT, Housing and a wide number of voluntary sector organisations, CEA encourages frontline workers to embrace the principles in their work around multiple disadvantaged individuals as well as creating this culture within their own services.

Adult Principal Social Worker joint delivers both the Safeguarding Training and Mental Capacity Act training to further embed the MSP principles and support practitioners to have the confidence to challenge systems that may not support this.

Peterborough City Council

There continues to be a dedicated Safeguarding Team Manager who line manages the Safeguarding Lead Practitioners and Co-ordinator. This ensures a consistent response to concerns being raised at MASH. We had a provider shadow MASH for part of the day and the feedback from them was extremely positive and helped them understand the information required when referring concerns that enabled MASH to make appropriate decisions on risk and the need for S42 work. The team have links to MARAC, attend meetings with Channel, Quality Improvement Team and CQC. The leads organise and facilitate CPD sessions for staff .PCC & CCC MASH managers have met and shadowed each other to understand and share best practice.

All staff are required and supported to attend the safeguarding board awareness training. Awareness training is also provided on a bespoke basis to teams where identified as a need. All social workers are required and supported to attend leading safeguarding enquiries training which is scheduled twice a year. The content of which supports the safeguarding principles:

- The safeguarding process, current themes and approaches, messages from research and application to practice, including new safeguarding legislation
- Explore safeguarding concerns in the community and institutional care
- Further learning on consent, information sharing, mental capacity, etc.
- Practice risk assessment and outcome focused planning
- Application of procedures and guidance
- Evaluating and Recording safeguarding concerns

Evaluation of training:

100% of delegates rated the course as good or excellent overall.

Describe how you are going to apply the skills and knowledge gained from the training:

- Safeguarding - ensuring follow the Care Act law. Collaborative multi agency working.
- Triangle of evidence. HRA & interaction with safeguarding.
- Care act principles. Inform staff. Reflections/discussions with staff. Supervise safeguarding enquiries closely within the team.
- Involving the MDT in safeguarding enquiries - effective communication at all times. Empowering the service user & ensuring their safety at all times. Ensuring/share knowledge on safeguarding concerns to the team confidently.
- Use of the Care Act safeguarding principles when conducting my first enquiry under mentoring of our team. Be more aware of Human Rights relevant articles to guide my practice.
- Better evidence gathering. Overarching legislation.
- Use the balance of probability scales. Checks & balances for the low human rights being contravened.

- Applying human rights to audits. Weighing evidence. Burden of proof.
- Think about dignity and find a way of implementing this.
- Treating people with dignity & value under Human Rights. Understanding the frameworks to include when undertaking safeguarding e.g. Human Rights & MC.
- Using the safeguarding principles & applying to the situation. For example how has the service user been empowered? Using the evidence domains - observation, communication & writing during all visits. Also looking at the bigger picture.

These principles are embedded as standard in the operational practice of services. The Client Income Service supported 3 clients during 2017/18 to take back responsibility for managing their own financial affairs. This followed a period where the Local Authority managed these clients' finances as corporate appointee either because of a crisis, or because they were asked to do so because client felt unable to manage their own finances.

The PCC in-house Older People's Day Service has supported and assisted many clients to maintain their independence and health & wellbeing in a range of ways for example, recognizing self-neglect in terms of not eating well and making arrangements for food shopping / supporting with meal preparation / provision of a choice of hot meals at the day centre / giving general encouragement to eat, making appointments with GP's and supporting clients to take medication to help avoid hospitalisation, carrying out small remedial repair tasks in the home to help with security e.g. fitting coloured key fobs to help identify the right key, putting clients in touch with the Council's handyperson & Care & Repair teams to carry out other property adaptations e.g. grab rails, access ramps and rails etc.

The Client Income Service has also continued to offer support with daily living finances in the form of appointeeship to vulnerable adults who are struggling to manage, thus preventing build-up of debt / unpaid bills especially rent, utilities etc. and reducing the risk of financial abuse, self-neglect

Q2 - What have you done to improve the safeguarding and welfare of adults in Cambridgeshire and Peterborough?

Cambridgeshire County Council

Within in the Customer Care Team all team members have received refresher training in Safeguarding Awareness and are aware of who to contact should they become aware of that abuse may be taking place. For example a complaint was received stating that a terminally ill man had been discharged from hospital with no care and support arrangements. On receipt of the complaint the Principal Social Worker was made aware and the Complex Care team were made aware of the situation and made urgent arrangements to ensure that appropriate care was put in place

Each of the thematic audits undertaken from December 2017 to date is supported by an Action Plan designed to advance improvements in the safety, well-being and welfare experiences of adults in Cambridgeshire.

The suite of Practitioner Factsheets, available to all staff involved in Adult Social Care services in Cambridgeshire, is directly linked to statutory duties/responsibilities and is subject to an ongoing review and updating process, in order to promote and improve the safety, well-being and welfare of the people who use, or are in contact with, services and their carers.

The Partnership Support Officer (Domestic Violence/Abuse) participated in audit of Domestic Abuse/Adult Safeguarding/Adult Social Care cases – a multi-agency action plan is being taken forward from this audit. Developed a DA/AS/ASC Action Plan with specific actions related to safeguarding to feed into main VAWG Action Plan.

In the pursuit of ongoing development and improvements to the safety, welfare and well-being of local citizens with multiple and complex needs, the CEA service has, in partnership with Cambridge City Council, worked on the expansion of the existing local "Housing First" scheme which meets the needs of those individuals who have been refused accommodation based support – typically because they are deemed to pose a risk to other residents or because their needs are too high or too complex. This expansion is planned to commence during the summer of 2018 and is a 3 year funded programme designed to inform the creation of a "Homelessness Pathway" with/for single people.

In addition, the Cambridgeshire CEA service has been accepted to form part of the new national "Making Every Adult Matter" (MEAM) study which will look at 25 areas, rising to 40, over three years and provide a full impact assessment of work with adults with multiple needs. Taking part in this study will provide a valuable opportunity to share learning with other authorities, generate some robust evaluation data and help Cambridgeshire shape the future delivery model. CEA is also working with MEAM to improve client participation with a view to achieving true co-production of services.

CEA have ensured that a number of adults in Cambridgeshire have received vital services when they were at risk of exclusion or so peripheral to services that they were not engaged with any treatment or support. CEA do this routinely with individuals who they become aware of but do not work with on the basis that we cannot ignore and adult at risk just because they are not eligible for our service. In doing this we have, on occasion, had to challenge internal working practice as well as external.

The DOLS 'team has formulated an action plan to constructively address the back log of DOLS' applications and also reviewing systems within the Team. In particular, aiming to prioritise all of them in accordance to the ADASS' Priority Tool and ensuring the high priority cases will be assessed and responded to.

Peterborough City Council

By recognising that safeguarding is a core and key priority embedded across all areas of service that have contact with or relate to individuals, and by making sure that the profile of safeguarding is continually high by ensuring it is a feature of 1:1;s team meeting agendas, annual appraisals etc.

Q3 - How do you evaluate your Safeguarding effectiveness and what evidence do you have?

Cambridgeshire County Council

In 2016/17 5% (7 of 140) of complaints had some safeguarding concerns this increased in 2017/18 to 8% (13/163). This increase, in part indicates an increased staff awareness of what constitutes a safeguarding issue.

All audits undertaken (as recorded above) are designed to evaluate the effectiveness of current practice and processes in line with MSP Principles. Evaluation of the evidence gathered has directed the development of clear and time-scaled plans of action. All supporting evidence is available for review.

Quarterly performance data on the percentage of IDVA clients with a safety plan in place. DA victims with a safety plan are at less risk of homicide than those with no safety plan.

Internal audit is undertaking an audit of the DOLS' procedures and processes.

Peterborough City Council

Alert and aware to safeguarding concerns and effective in response to these - but not complacent. There have been a number of safeguarding alerts raised by staff in these service areas which have resulted in safeguarding investigations and good outcomes for service users e.g. PCC acting as corporate appointee/deputy in managing and safeguarding client finances, improvements in client

condition/wellbeing due to interventions at home or increased say service attendance.

The work of the Quality Assurance team, outlined below, also challenges our safeguarding effectiveness.

Q4 - How have you challenged itself and others to improve safeguarding arrangements?

Cambridgeshire County Council

Reviewing statistics and practice at weekly meetings and also on a quarterly basis

Peterborough City Council

Safeguarding is a constant theme in all areas of activity where direct contact/dealings with clients is had, and also is a regular theme at team meetings, in 1:1's, and at annual staff appraisals. Mandatory safeguarding training is also completed as necessary, and regular contributions are made to safeguarding investigations e.g. to provide advice/information/evidence on financial abuse, and asking for/contributing to care and support reviews.

Q5 - **What progress have you made against the Board priorities?**

Cambridgeshire County Council

Where practice issues are identified as part of a complaint investigation we work closely with CPFT. An example of this involved a complaint about the care and support provided to a man with Mental Health issues. The complaint went to the Local Government Ombudsman (LGO) and the investigation showed that there needed to be further training carried out with regard to assessments reviews and contingency planning. As a result a training day was subsequently delivered to CCC and CPFT staff.

Full participation in the SAB coordinated Domestic Abuse Multi-agency Thematic Audit.

Domestic Abuse Partnership have been fully involved in the DA Audit and work closely with CPFT to improve professional responses to DA and SV across the trust.

The thematic audits introduced in CCC are all in line with the SAB priorities and also follow the order of the MSP principles.

Peterborough City Council

Neglect

The need has been identified for reablement and other HSDM workers to develop an awareness of neglect and hoarding- bespoke training has now been planned (2018)

Adults living with mental health issues

Provision of mental health awareness training in 2017/18. Advanced training will be provided in 2018/19 including a focus on section 117 aftercare.

Quality Assurance Audit

The QA team continue to audit MASH contacts, S.42 safeguarding enquiries on a regular basis. Within the last six months two thematic audits and a contact dip sample were completed, which all involved part of the adult safeguarding process. A total of 100 cases were audited (20 from each audit and 60 from contact dips) and each were presented to Senior Management within Adult Social Care. A summary of each can be found below, along with common areas of good practice, and areas for development.

S.42 Enquiry Audit: The most recent s.42 audit showed improvement compared to the previous two audits, highlighting examples of good practice as well as areas for further development. Adult Social Care, including CPFT, appropriately identified and responded to risks and effectively safeguarded adults at risk. There was evidence of well-coordinated multi-agency working and cooperation although a more consistent approach to the consultation and involvement of the Quality Improvement Team is required.

There was good evidence of making safeguarding personal principles. Staff adopted a person-

centred and outcomes-based approach, ensuring adults at risk or their families were empowered and supported where necessary to express their preferred outcomes. They were consulted, fully involved, regularly updated on progress and given feedback on outcomes achieved.

There is a need to ensure that all information relevant to safeguarding enquiries is recorded on Framework. While acknowledging that there will be variation between cases, there is a need to ensure adherence, where possible, to the guideline timescales published in the Cambridgeshire and Peterborough Safeguarding Adults Board Procedures October 2017. There was evidence that Adult at Risk meetings contributed to positive outcomes for the adult at risk and their family as well as improving partnership working and enhancing organisational learning.

Self-Neglect Audit: This audit shows that organisationally, there is good knowledge of self-neglect and workers have confidence in their ability to identify its signs and symptoms. However, there appears to be a lack of awareness and knowledge of local guidance on multi-agency policy and procedures to support those who self-neglect and exhibit hoarding behaviour. The majority of those with previous involvement of self-neglect felt that they had sufficient prior training, found reflective practice valuable and had adequate supervision and management oversight.

There are concerns about the efficiency and effectiveness of safeguarding enquiries. Timescales from referral to MASH decision, including high risk cases, and from enquiry start to conclusion were not consistently within local guidance timescales. In addition, the audit indicated that not all safeguarding concerns were triaged via MASH, as two referrals were sent directly to the allocated CPFT worker for an adult already under their support. Potentially, some information relevant to safeguarding enquiries, including management discussion and oversight, is only recorded on the RiO recording system and not copied across to Frameworki recording system.

Staff consistently assessed capacity, considered all information relevant to the case and conducted a proportionate, person-centred enquiry in light of identified risk. Records should be clear, analytical and jargon-free. There is a need for broader analysis to help understand why some adults do not want to engage or accept care and support. While effective joint agency working is evident, better use of multi-agency risk management meetings and SMART planning would ensure a more holistic and coordinated approach to self-neglect cases.

Embedding organisational awareness and understanding of local safeguarding adults board procedures and multi-agency policy and procedures to support people who self-neglect and display hoarding behaviours will improve practice and service delivery enabling better health and wellbeing outcomes for adults at risk.

MASH Contact Dip: Action taken by the MASH in response to safeguarding concerns were consistent and proportionate to the initial concern. Work conducted was timely, and considerate of both adults and children involved in the concern. Risk assessments conducted by the MASH varied quality, and documentation of decision making did not always incorporate the completed risk assessment.

Work conducted was person centred and some adults were involved in the process and were empowered to express their desired outcomes in relation to the safeguarding concern. The use of advocates was considered where appropriate, however the independence and suitability of some family members acting as advocates should be considered at all times.

Where there is a requirement to question an adult's capacity and to conduct a Mental Capacity Assessment there should be clear documentation that this has been considered.

It is important that the MASH and QI Team work together in an effective way where safeguarding referrals are raised in relation to independent providers. NoCs were completed where required, but it is unclear if issues raised in safeguarding concerns that may affect other service users would be dealt with as part of a collaborative effort by QI and MASH.

Good Practice Areas: The following areas of good practice were identified:

- Mental capacity was considered in the majority of cases, and capacity assessments were completed when required.
- Enquiries were proportionate, comprehensive and person-centred.
- Decision making considered historical involvement.
- Evidence of consideration and response to diversity was found.
- Up to date protection plans were present.
- The adult at risk's family or representative were given appropriate feedback.
- Notifications of Concern (NOC) were raised where appropriate.
- Providers contributed to safeguarding enquiries where appropriate.

Areas for Further Development

The following areas for further development were identified:

- Where possible, safeguarding enquiries should adhere to the timescales suggested by local Safeguarding Adults Board guidance to ensure efficiency and effectiveness.
- All relevant and up to date information relating to safeguarding cases should be recorded on Framework and not just on RiO, CPFT's recording system.
- Ensuring the adult at risk's response is recorded where advocacy is offered.
- Ensuring a coordinated joint agency approach to self-neglect cases, holding multi-agency risk management meetings and producing SMART plans where appropriate.
- Ensuring better management oversight by the allocated worker's manager in both ASC and CPFT and all management discussions are recorded in Framework.
- Case recording should be clear, analytical and jargon-free.
- Increasing organisational awareness of the knowledge and practice hub on self-neglect on CC Inform across ASC and CPFT.
- Risk and Strengths Assessment in the MASH Safeguarding Triage Assessment requires consistency in its completion.
- Consent needs to be considered and discussed with all adults.
- When recording the adult's voice, the specific words used by the adult should be recorded in order to capture their direct voice.
- Safeguarding concerns relating to independent providers should consider the potential wider impact on other service users, as others may have been effected by a similar issue.
- Adult at risk meeting minutes should be uploaded to the record in FWi within a reasonable timescale.

Appendix 1 Glossary and Jargon Buster

GLOSSARY AND JARGON BUSTER

ADASS	Association of Directors of Adult Social Care
ASC	Adult Social Care
CCC	Cambridgeshire County Council
CCC	Cambridge City Council
CCG	Clinical Commissioning Group
CCS	Cambridgeshire Community Services
CPFT	Cambridgeshire and Peterborough Foundation Trust
CQC	Care Quality Commission
CRC	Community Rehabilitation Company
CUHT	Cambridge University Hospital Trust
DASV	Domestic Abuse and Sexual Violence
GP	General Practitioner
LeDeR	Learning Disabilities Mortality Review
LGA	Local Government Association
LGO	Local Government and Social Care Ombudsman
LSCB	Local Safeguarding Children Board
CPSCB	Cambridgeshire and Peterborough Safeguarding Children Board
MAPPA	Multi-Agency Public Protection Arrangements
MASH	Multi-Agency Safeguarding Hub
MSP	Making Safeguarding Personal
NACRO	National Association for the Care and Resettlement of Offenders
NHS	National Health Service
NOC	Notification of Concern
NPS	National probation Service
NWAFT	North West Anglia Foundation Trust
PCC	Peterborough City Council
QEG	Quality and Effectiveness Group
QI	Quality Improvement
SAB	Safeguarding Adults Board
CPSAB	Cambridgeshire and Peterborough Safeguarding Adults Board
SAR	Safeguarding Adult Review
SSAFA	Armed Forces Charity
YOS	Youth Offending Service

Adult at risk is a person aged 18 or over who is in need of care and support regardless of whether they are receiving them, and because of those needs are unable to protect themselves against abuse or neglect.

Adult safeguarding means protecting a person's right to live in safety, free from abuse and neglect.

Adult safeguarding lead is the title given to the member of staff in an organisation who is given the lead for Safeguarding Adults.

Advocacy taking action to help people who experience substantial difficulty contributing to the safeguarding process to say what they want, secure their rights, represent their interests and obtain the services they need.

Best Interest - the Mental Capacity Act 2005 (MCA) states that if a person lacks mental capacity to make a particular decision then whoever is making that decision or taking any action on that person's behalf must do so in the person's best interest. This is one of the principles of the MCA.

Appropriate individual within this document an 'appropriate individual' is a person who supports an adult at risk typically but not exclusively in an advocacy role, and is separate to an Appropriate Adult as described above.

Care Act 2014 - The Care Act 2014 introduces major reforms to the legal framework for adult social care, to the funding system and to the duties of local authorities and rights of those in need of social care

Care setting is where a person receives care and support from health and social care organisations. This includes hospitals, hospices, respite units, nursing homes, residential care homes, and day opportunities arrangements.

Carer someone who spends a significant proportion of their time providing unpaid support to a family member, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems.

Commissioning is the cyclical activity, to assess the needs of local populations for care and support services, determining what element of this, needs to be arranged by the respective organisations, then designing, delivering, monitoring and evaluating those services.

Concern is the term used to describe when there is or might be an incident of abuse or neglect.

Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. It replaces the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA).

Enquiry (Section 42 Enquiry) establishes whether any action needs to be taken to stop or prevent abuse or neglect, and if so, what action and by whom the action is taken. Previously this may have been referred to as a 'referral'

Enquiry Lead is the agency who leads the enquiry described above.

Enquiry Officer is the member of staff who undertakes and co-ordinates the actions under Section 42 (Care Act 2015) enquiries.

Independent Domestic Violence Advocate - Adults who are the subject of domestic violence may be supported by an Independent Domestic Violence Advocate (IDVA). IDVA's provide practical and emotional support to people who are at the highest levels of risk. Practitioners should consult with the adult at risk to consider if the IDVA is the most appropriate person to support them and ensure their eligibility for the service.

IMCA (independent mental capacity advocate) established by the Mental Capacity Act (MCA) 2005 IMCAs are mainly instructed to represent people where there is no one independent of services, such as family or friend, who is able to represent them. IMCAs are a legal safeguard for people who lack the mental capacity to make specific important decisions about where they live, serious medical treatment options, care reviews or adult safeguarding concerns.

Independent Sexual Violence Advocate (ISVA) - is trained to provide support to people in rape or sexual assault cases. They help victims to understand how the criminal justice process works and explain processes, for example, what will happen following a report to the police and the importance of forensic DNA retrieval.

LGBT (lesbian, gay, bisexual and transgender) is an acronym used to refer collectively to lesbian, gay, bisexual and transgender people.

Making Safeguarding Personal is about person centred and outcome focussed practice. It is how professionals are assured by adults at risk that they have made a difference to people by taking action on what matters to people, and is personal and meaningful to them.

Natural justice refers to the principles and procedures that govern the adjudication of an issue, which should be unbiased, without prejudice, and there is equal right to being heard.

Position of trust refers to a situation where one person holds a position of authority and uses that position to his or her advantage to commit a crime or to intentionally abuse or neglect someone who is vulnerable and unable to protect him or herself.

Procurement is the specific function to buy or acquire services which commissioners have duties to arrange to meet people's needs, to agreed quality standards, providing value for money to the public purse.

Public interest is a decision about what is in the public interest needs to be made by balancing the rights of the individual to privacy with the rights of others to protection.

Regulated Provider is an individual, organisation or partnership that carries on activities that are specified in Schedule 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Sexual Assault Referral Centres (SARC) is for people who have been raped or sexually assaulted.

Victim Support is a national charity, which provides support for victims and witnesses of crime in England and Wales. It provides free and confidential help to family, friends and anyone else affected by crime, which includes information, emotional and practical support. Help can be accessed either directly from local branches or through the Victim Support helpline.

Appendix 2
Board Administration and Budget Contributions

Key Roles and Relationships

Dr Russell Wate, QPM, is the Independent Chair of the CPSAB and is tasked with leading the Board and ensuring it fulfils its statutory objectives and functions.

The Chair is accountable to the **Chief Executive of Peterborough City Council and Cambridgeshire County Council** and they met frequently during 2017/18. **The Corporate Director of People and Communities** for both Local Authorities also continued to work closely with the Chair on related safeguarding challenges.

The Lead Member for Adult's Services in Peterborough and the **Chairman of Adult & Young People Committee** in Cambridgeshire are "participating observers" of the CPSAB; engaging in discussions but not part of the decision making process which provides the independence to challenge the Local Authority when necessary.

The CPSAB Business Unit

The Cambridgeshire and Peterborough Safeguarding Board Business Unit supports both the Adult and Children's Safeguarding Boards and is made up of the following members of staff;

- Head of Service (Children's Lead)
- Service Manager (Adults Lead)
- Safeguarding Board Officer – Adult's Lead 0.8 FTE
- Safeguarding Board Officer – Children's Lead
- Communication and Online Safeguarding Lead
- Exploitation Strategy Coordinator
- Practice Improvement and Development Lead x 1.5
- Safeguarding Adults Board Trainer 0.8 FTE
- Business Support Officer - Full-time x2
- Business Support Officer - Part-time x2

Board Finances

Historically, there have been two Safeguarding Adults Boards across Cambridgeshire and Peterborough. Each Board had a different funding formula and business unit structure to support and drive forward the work of the Boards, and safeguarding in the two local authority areas.

During 2017, the two SAB's were amalgamated to form a single countywide SAB and the two Local Safeguarding Children Boards were also amalgamated to form a single countywide LSCB. As part of the changes the existing business units for all of these boards were merged into a single Adults and Children's business unit.

Partner contributions towards the SAB budgets for 2017/18 are broken down as follows:

Adults Board	Cambridgeshire	Peterborough
Cambridgeshire County Council*	£20,000	-
Peterborough City Council	-	£37,992.00
Police (via the Office of Police and Crime Commissioner)	£35,000	£35,884.00
NWAFT	-	£4,750.00
CPFT	-	£4,750.00
CCG	-	£4,750.00
Total	**£55,000**	**£92,876.00**
** CCC contributes additional funds for a full time SAB trainer		

Board Membership & Attendance

This year has been unusual in that the re-structure of the Boards led to there being only two meetings each for the Board and Delivery Group.

Cambridgeshire and Peterborough Safeguarding Adults Board

Attendance of partner organisations. 2 meetings held between January 2018 and March 2018

	Number of seats allocated	Attendance	%
Safeguarding Boards Independent Chair	1	2	100.00%
Assistant Director Commissioning & Commercial Operations, Cambridgeshire & Peterborough Local Authorities	1	1	50.00%
Assistant Director, Children's Social Care (Cambridgeshire)	1	0	0.00%
Assistant Directors, Adult Social Care, Cambridgeshire & Peterborough Local Authorities	2	2	100.00%
Cambridge Regional College	1	1	50.00%
Chief Executive Officer, Healthwatch	1	1	50.00%
Chief Executive, Cambridgeshire Age UK (representing voluntary sector)	1	2	100.00%
Deputy Director and Head of Cambridgeshire Local Delivery Unit, BeNCH CRC	1	2	100.00%
Deputy Director Patient Quality & Safety, CCG	1	0	0.00%
Designated Nurse for Safeguarding Adults, CCG	1	2	100.00%
District Council Representatives	1	1	50.00%
Head of Cambridgeshire Local Delivery Unit, National Probation Service	1	2	100.00%
Head of Public Protection, Cambridgeshire Constabulary	1	2	100.00%
Head of Safeguarding, Cambridgeshire Fire & Rescue	1	2	100.00%
HM Prison representative	1	1	50.00%
Housing association representative (Axiom housing)	1	1	50.00%
Further Education	2	2	100.00%
Representatives of the Community Network Group	1	2	100.00%
Senior Locality Manager, East of England Ambulance Service	1	2	100.00%
Service Director, Adult's & Safeguarding, Cambridgeshire & Peterborough Local Authorities/Regional Housing Representative	1	1	50.00%

Cambridgeshire and Peterborough Safeguarding Adults Delivery Group

Attendance of partner organisations. 2 meetings held between January 2018 and March 2018

	Number of seats allocated	Attendance	%
Safeguarding Boards Independent Chair	1	2	100.00%
Adult Safeguarding Manager, Cambridgeshire County Council	1	2	100.00%
DCI representative, Public Protection Department, Cambridgeshire Constabulary	1	2	100.00%
Designated nurse for safeguarding adults, CCG	1	2	100.00%
District Council Representative	1	1	50.00%
Drugs and Alcohol Action Team	1	1	50.00%
East of England Ambulance Service	1	0	0.00%
Head of Commissioning, Social Care, Cambridgeshire & Peterborough Local Authority	1	1	50.00%
Head of Service, Assessment and Care Management, Peterborough Local Authority	1	2	100.00%
Head of Adult Safeguarding, Cambridgeshire County Council	1	2	100.00%
Healthwatch representative	1	1	50.00%
CCS (Cambridgeshire Community Service NHS)	*1*	*0*	0.00%
CPFT (Cambridgeshire & Peterborough NHS Foundation Trust)	*1*	*2*	100.00%
CUH (Cambridgeshire University Hospital)	*1*	*1*	50.00%
Hinchingbrooke Healthcare (North West Anglia NHS Foundation Trust)	*1*	*2*	100.00%
Papworth Hospital NHS Foundation Trust	*1*	*1*	50.00%
Peterborough City Hospital (North West Anglia NHS Foundation Trust)	*1*	*1*	50.00%
Cross Keys Homes	*1*	*0*	0.00%
Peterborough Care	*1*	*0*	0.00%
Representatives of Community Network Group	1	2	100.00%

Safeguarding Lead, Safeguarding and Quality Assurance, Peterborough City Council	1	0	0.00%
SSAFA representative	1	0	0.00%
Team Leader BeNCH CRC	1	2	100.00%
Team Leader, National Probation Service	1	2	100.00%
Peterborough Church of England Diocese	1	1	50.00%

Cambridgeshire and Peterborough Safeguarding Adults Board

1st Floor Bayard Place
Peterborough
Cambridgeshire
PE1 1FZ
01733 863744

5 George Street
Huntingdon
Cambridgeshire
PE29 3AD
01480 373522

safeguardingboards@cambridgeshire.gov.uk

Agenda Item No: 10

FINANCE AND PERFORMANCE REPORT – SEPTEMBER 2018

To:	**Adults Committee**
Meeting Date:	**15 November 2018**
From:	**Chief Finance Officer** **Executive Director: People and Communities**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable** *Key decision:* **No**
Purpose:	**To provide the Committee with the September 2018 Finance and Performance report for People And Communities Services (P&C).** **The report is presented to provide the Committee with the opportunity to comment on the financial and performance position as at the end of September 2018.**
Recommendations:	**The Committee is asked to review and comment on the report.**

	Officer contact:
Name:	Stephen Howarth
Post:	Strategic Finance Business Partner
Email:	stephen.howarth@cambridgeshire.gov.uk
Tel:	01223 714770

1.0 BACKGROUND

1.1 A Finance & Performance Report for People and Communities (P&C) is produced monthly and the most recent available report is presented to the Committee when it meets – the latest is provided in Appendix B.

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

1.3 This report is for the whole of the P&C Service, and as such, not all of the budgets contained within it are the responsibility of this Committee. Members are requested to restrict their attention to the budget lines for which this Committee is responsible, which are detailed in Appendix A, whilst the table below provides a summary of the budget totals relating to Adults Committee:

Forecast Variance Outturn (Previous) £000	Directorate	Budget 2018/19 £000	Actual Sep 2018 £000	Forecast Outturn Variance £000
-37	Adults & Safeguarding	153,997	60,200	-161
367	Adults Commissioning (including Local Assistance Scheme)	10,590	19,736	367
330	**Total Expenditure**	**164,587**	**79,936**	**206**
0	Grant Funding (including Better Care Fund, Social Care in Prisons Grant etc.)	-26,567	-12,167	0
330	**Total**	**138,020**	**67,770**	**206**

Please note: Strategic Management – Commissioning covers all of P&C and is therefore not included in the table above. The Executive Director and Central Financing budgets are now reported to CYP Committee as they contain items material to services under the oversight of that committee.

1.4 **Financial Context**

As previously discussed at Adults Committee the major savings agenda continues with £99.2m of savings required across the Council between 2017 and 2022. The total planned savings for P&C in the 2018/19 financial year total £21,287k.

Although significant savings are expected to be made in 2018/19 across the directorate, Adults services continue to face demand and price pressures, particularly:

- In Older People's services where lack of capacity in the domiciliary and residential care markets is driving up prices
- Through increased demand in the NHS and improved performance in reducing delays in transfers of care
- In Learning Disability services, where the needs of a relatively static number of service-users is increasing

Central government has recognised pressures in the social care system through a number of temporary ring-fenced grants given to local authorities and these are able to be used to offset

pressures, make investments into social work to bolster the social care market or reduce demand on health and social care services. Further funding has recently been announced and the Council is drawing up plans to spend this funding addressing the above pressures mainly with a focus on providing additional domiciliary care, but awaits formal notification of grant conditions before confirming plans.

2.0 MAIN ISSUES IN THE SEPTEMBER 2018 P&C FINANCE & PERFORMANCE REPORT

2.1 Revenue

At the end of September, People & Communities overall is forecasting an overspend of £2.7m, which is reduced from a forecast £6.2m overspend in August. This is mainly due to the agreement by General Purposes Committee to an allocation from the smoothing fund reserve to Children's Services, reflecting the extensive pressures faced by that service.

Specifically for lines relating to Adults Committee, the forecast for September is an overspend of £206k, which is an improvement from the £330k overspend forecast in August.

The causes of the forecast overspend position remain fundamentally unchanged from last month, principally being pressures on care spend within Learning Disability and Older People's services as well as slower than anticipated delivery of certain savings programmes with an expectation that work will continue into 2019/20 and deliver over a revised timescale. The forecast pressure in the Learning Disability Partnership has increased by around 150k in September. These pressures are partially mitigated by the application of grant funding mentioned above, which is unchanged from the previous month.

In September, further mitigations have been identified:

- Expenditure on direct payments to carers has continued at levels seen in 2017/18, resulting in an expected £150k underspend.
- Several expensive care packages were expected to become the responsibility of the Autism and Adult Support Team but have either not been transferred or been transferred later in the year than expected, resulting in a forecast underspend of around £70k. These were cases centred on whether a person was ordinarily resident in Cambridgeshire.

2.2 Performance

The performance information in the September F&PR relates to information up to the end of August.

Of the performance indicators linked to Adults Committee, two are showing as red:

1. Proportion of adults with a primary support reason of learning disability support in paid employment (year to date)
2. Average monthly number of bed day delays (social care attributable) per 100,000 18+ population

3.0 2018-19 SAVINGS TRACKER

3.1 The savings tracker for lines relating to Adults Committee is attached as Appendix C. It shows the position for delivery of savings to the end of September, including some commentary where savings plans are materially not on track to deliver at the level expected or within the original timescale.

For lines relating to Adults Committee, there were around £16.5m of savings in the business plan for 2018/19. Of these, around £14.3m is expected to be delivered, with three savings lines rated as 'red' and one as 'black' (a black rating means that work on the saving did not commence).

In addition to the planned lines shown in the tracker, a further £2m of savings have been identified in-year as part of the savings funnel process, mainly in these areas:

- Retendering of block car rounds for domiciliary care achieving more than the planned saving
- Additional occupational therapist resource funded through the Improved Better Care Fund making savings through reducing demand for higher-cost packages of care
- Further use of assistive technology for people with learning disabilities, reducing costs by, for example, facilitating the removal of overnight waking support
- Reviewing contracts to ensure budgets align with expected spend where potential activity related payments are not going to be triggered

4.0 ALIGNMENT WITH CORPORATE PRIORITIES

4.1 Developing the local economy for the benefit of all

4.1.1 There are no significant implications for this priority.

4.2 Helping people live healthy and independent lives

4.2.1 There are no significant implications for this priority

4.3 Supporting and protecting vulnerable people

4.3.1 There are no significant implications for this priority

5.0 SIGNIFICANT IMPLICATIONS

5.1 Resource Implications

5.1.1 This report sets out details of the overall financial position of the P&C Service.

5.2 Procurement/Contractual/Council Contract Procedure Rules Implications

5.2.1 There are no significant implications within this category.

5.3 Statutory, Risk and Legal Implications

5.3.1 There are no significant implications within this category.

5.4 Equality and Diversity Implications

5.4.1 There are no significant implications within this category.

5.5 Engagement and Consultation Implications

5.5.1 There are no significant implications within this category.

5.6 Localism and Local Member Involvement

5.6.1 There are no significant implications within this category.

5.7 Public Health Implications

6.7.1 There are no significant implications within this category.

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

Appendix A

Adults Committee Revenue Budgets within the Finance & Performance report

Adults & Safeguarding Directorate
Strategic Management – Adults
Principal Social Worker, Practice and Safeguarding
Autism and Adult Support
Carers

Learning Disability Services
LD Head of Services
LD - City, South and East Localities
LD - Hunts & Fenland Localities
LD – Young Adults
In House Provider Services
NHS Contribution to Pooled Budget

Older People and Physical Disability Services
OP - City & South Locality
OP - East Cambs Locality
OP - Fenland Locality
OP - Hunts Locality
Neighbourhood Cares
Discharge Planning Teams
Shorter Term Support and Maximising Independence
Physical Disabilities

Mental Health
Mental Health Central
Adult Mental Health Localities
Older People Mental Health

Commissioning Directorate
Strategic Management – Commissioning – *covers all of P&C*
Local Assistance Scheme

Adults Commissioning
Central Commissioning - Adults
Integrated Community Equipment Service
Mental Health Voluntary Organisations

Executive Director
Executive Director - *covers all of P&C*
Central Financing - *covers all of P&C*

Grant Funding
Non Baselined Grants - *covers all of P&C*

From: Martin Wade and Stephen Howarth
Tel.: 01223 699733 / 714770
Date: 10th October 2018

Agenda Item 10 – Appendix B

People & Communities (P&C) Service

Finance and Performance Report – September 2018

1. SUMMARY

1.1 Finance

Previous Status	Category	Target	Current Status	Section Ref.
Red	Income and Expenditure	Balanced year end position	Red	2.1
Green	Capital Programme	Remain within overall resources	Green	3.2

1.2. Performance Indicators – August 2018 Data (see sections 4&5)

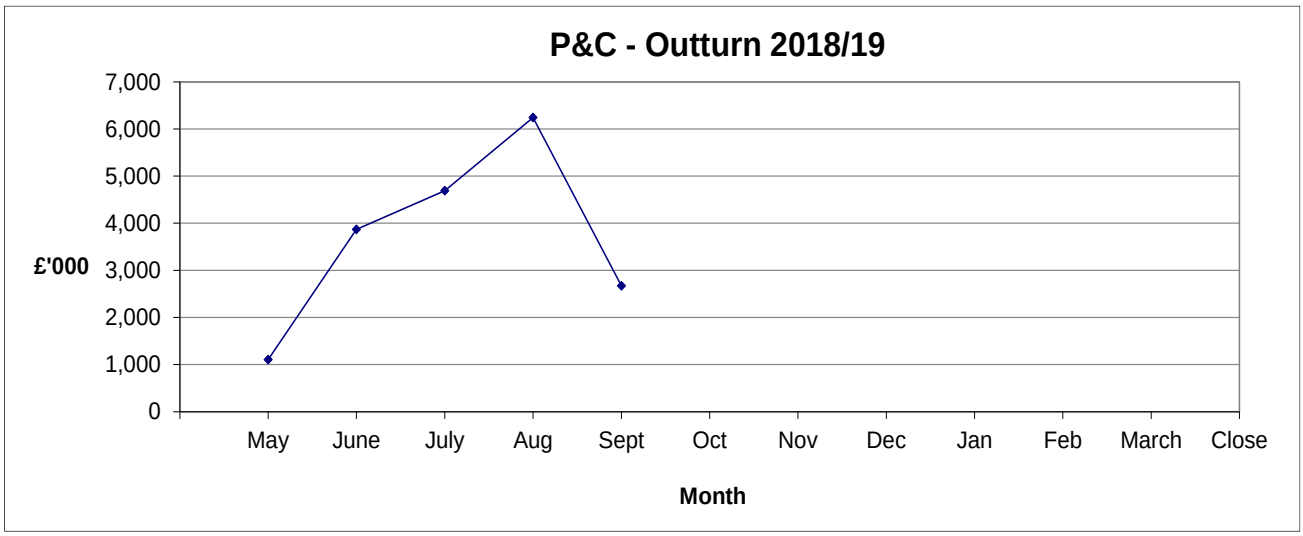
Monthly Indicators	Red	Amber	Green	No Target	Total
August 17/18 Performance (No. of indicators)	7	8	9	14	38

2. INCOME AND EXPENDITURE

2.1 Overall Position

Forecast Variance Outturn (Aug) £000	Directorate	Budget 2018/19 £000	Actual £000	Forecast Outturn Variance £000	Forecast Outturn Variance %
-37	Adults & Safeguarding	153,997	60,200	-161	-0.1%
4,117	Commissioning	44,102	33,870	4,117	9.3%
-50	Communities & Safety	6,693	3,039	-50	-0.7%
1,648	Children & Safeguarding	51,285	24,960	1,615	3.1%
2,367	Education	79,586	55,544	3,421	4.3%
504	Executive Director	4,336	376	-2,909	-67.1%
8,549	**Total Expenditure**	**339,999**	**177,989**	**6,033**	**1.8%**
-2,309	Grant Funding	-96,735	-47,605	-3,362	3.5%
6,240	**Total**	**243,263**	**130,384**	**2,671**	**1.1%**

The service level finance & performance report for 2018/19 can be found in appendix 1. Further analysis of the forecast position can be found in appendix 2.



2.2 Significant Issues

At the end of September 2018, the overall P&C position is an overspend of £2,671k.

Significant issues are detailed below:

Adults

- The Carers service are forecasting an underspend of -£150k due to lower levels of direct payments to carers than was expected over the first half of the year. Uptake of direct payments has continued at 2017/18 levels, reflecting continued good progress to increase direct payments compared to previous years.

Children

- A £1m overspend is currently being forecast against the funding allocated to Special Schools and High Needs Units. This is a result of increasing numbers of young people with Education Health and Care Plans (EHCP), and a corresponding increase of young people taking up a place at Special Schools and Units. This budget is funded from the Dedicated Schools Grant (DSG) High Needs Block and will be managed within the overall available DSG resources. Work is being undertaken across SEND Services 0-25 to reduce the pressure on this budget. This will comprise both short-term mitigations such as reviewing high-cost provision to ensure that the additional support being provided is still required, and longer term structural review looking at the role of all schools and units within the county's overall SEN provision.

- The underspend within the Central Financing policy line reflects the allocation of the £3.413m smoothing fund reserve to support Children's Services pressures, as recommended by CYP Committee and approved by General Purposes Committee.

2.3 Additional Income and Grant Budgeted this Period

(De Minimis reporting limit = £160,000)

A full list of additional grant income anticipated and reflected in this report can be found in appendix 3.

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

A list of virements made in the year to date can be found in appendix 4.

2.5 Key Activity Data

The Actual Weekly Costs for all clients shown in section 2.5.1-2 are calculated based on all clients who have received a service, are receiving a service, or we plan will receive a service. Some clients will have ceased receiving a service in previous months, or during this month, or we will have assumed an end date in the future.

2.5.1 Key activity data to September 2018 for **Looked After Children** (LAC) is shown below:

	BUDGET				ACTUAL (September)				VARIANCE		
Service Type	*No of placements Budgeted*	*Annual Budget*	*No. of weeks funded*	*Average weekly cost per head*	*Snapshot of No. of placements September 18*	*Yearly Average*	*Forecast Outturn*	*Average weekly cost per head*	*Yearly Average budgeted no. of placements*	*Net Variance to Budget*	*Average weekly cost diff +/-*
Residential - disability	1	£132k	52	2,544.66	2	1.84	£368k	3,537.43	0.84	£236k	992.77
Residential - secure accommodation	0	£k	52	0.00	1	0.52	£163k	5,908.00	0.52	£163k	5,908.00
Residential schools	16	£2,277k	52	2,716.14	19	17.25	£2,433k	2,858.99	1.25	£156k	142.85
Residential homes	39	£6,725k	52	3,207.70	37	35.29	£5,962k	3,368.65	-3.71	-£763k	160.95
Independent Fostering	199	£9,761k	52	807.73	285	283.44	£11,608k	797.01	84.44	£1,847k	-10.72
Supported Accommodation	31	£2,355k	52	1,466.70	22	21.26	£1,478k	1,187.04	-9.74	-£876k	-279.66
16+	8	£89k	52	214.17	7	4.70	£72k	270.34	-3.3	-£17k	56.17
Growth/Replacement	-	£k	-	-	-	-	£729k	-	-	£729k	-
Pressure funded within directorate	-	-£1,526k	-	-	-	-	£k	-	-	£1,526k	-
TOTAL	294	£19,813k			373	364.30	£22,813k		70.3	£3,000K	
In-house fostering - Basic	191	£1,998k	56	181.30	182	179.18	£1,914k	179.79	-11.82	-£83k	-1.51
In-house fostering - Skills	191	£1,760k	52	177.17	190	187.46	£1,742k	179.17	-3.54	-£18k	2.00
Kinship - Basic	40	£418k	56	186.72	31	38.56	£387k	195.91	-1.44	-£31k	9.19
Kinship - Skills	11	£39k	52	68.78	10	9.62	£34k	67.42	-1.38	-£6k	-1.36
In-house residential	5	£603k	52	2,319.99	0	1.33	£431k	6,234.79	-3.67	-£172k	3,914.80
Growth	0	£k	-	0.00	0	0.00	£k	0.00	-	£k	-
TOTAL	236	£4,818k			213	219.07	£4,508k		-16.93	-£310k	
Adoption Allowances	105	£1,073k	52	196.40	106	106.28	£1,141k	194.59	1.28	£69k	-1.81
Special Guardianship Orders	246	£1,850k	52	144.64	248	247.69	£1,831k	142.14	1.69	-£19k	-2.50
Child Arrangement Orders	91	£736k	52	157.37	89	90.37	£727k	153.57	-0.63	-£10k	-3.80
Concurrent Adoption	5	£91k	52	350.00	5	4.93	£90k	350.00	-0.07	-£1k	0.00
TOTAL	447	£3,750k			448	449.27	£3,789k		1.28	£39k	
OVERALL TOTAL	977	£28,382k			1034	1,032.64	£31,110k		54.65	£2,729k	

NOTE: In house Fostering and Kinship basic payments fund 56 weeks as carers receive two additional weeks payment during the Summer holidays, one additional week payment at Christmas and a birthday payment.

2.5.2 Key activity data to the end of September for **SEN Placements** is shown below:

	BUDGET			ACTUAL (September 18)				VARIANCE			
Ofsted Code	*No. of Placements Budgeted*	*Total Cost to SEN Placements Budget*	*Average annual cost*	*No. of Placements September 18*	*Yearly Average*	*Total Cost to SEN Placements Budget*	*Average Annual Cost*	*No of Placements*	*Yearly Average*	*Total Cost to SEN Placements Budget*	*Average Annual Cost*
Autistic Spectrum Disorder (ASD)	98	£6,165k	£63k	95	97.15	£6,289k	£65k	-3	-0.85	£123k	£2k
Hearing Impairment (HI)	3	£100k	£33k	2	2.00	£74k	£37k	-1	-1.00	-£26k	£4k
Moderate Learning Difficulty (MLD)	3	£109k	£36k	8	9.07	£131k	£14k	5	6.07	£21k	-£22k
Multi-Sensory Impairment (MSI)	1	£75k	£75k	0	0.00	£0k	-	-1	-1.00	-£75k	£k
Physical Disability (PD)	1	£19k	£19k	5	5.00	£91k	£18k	4	4.00	£72k	-£1k
Profound and Multiple Learning Difficulty (PMLD)	1	£41k	£41k	1	0.99	£67k	£68k	0	-0.01	£26k	£26k
Social Emotional and Mental Health (SEMH)	35	£1,490k	£43k	43	41.47	£2,063k	£50k	8	6.47	£572k	£7k
Speech, Language and Communication Needs (SLCN)	3	£163k	£54k	2	2.00	£88k	£44k	-1	-1.00	-£76k	-£11k
Severe Learning Difficulty (SLD)	2	£180k	£90k	4	3.73	£388k	£104k	2	1.73	£207k	£14k
Specific Learning Difficulty (SPLD)	8	£164k	£20k	9	7.66	£232k	£30k	1	-0.34	£68k	£10k
Visual Impairment (VI)	2	£64k	£32k	2	2.00	£57k	£29k	0	0.00	-£7k	-£4k
Growth / (Saving Requirement)	-	£1,000k	-	-	-	£612k	-	-	-	-£388k	-
TOTAL	157	£9,573k	£61k	171	171.07	£10,091k	£55k	14	14.07	£518k	-£6k

In the following key activity data for Adults & Safeguarding, the information given in each column is as follows:

- Budgeted number of clients: this is the number of full-time equivalent (52 weeks) service users anticipated at budget setting, given budget available
- Budgeted average unit cost: this is the planned unit cost per service user per week, given the budget available
- Actual service users and cost: these figures are derived from a snapshot of the commitment record at the end of the month and reflect current numbers of service users and average cost

The forecasts presented in Appendix 1 reflect the estimated impact of savings measures to take effect later in the year. The "further savings within forecast" lines within these tables reflect the remaining distance from achieving this position based on current activity levels.

2.5.3 Key activity data to end of September for **Learning Disability** Services is shown below:

		BUDGET			ACTUAL (September 18)				Year End		
Service Type		*Expected No. of Service Users 2018/19*	*Budgeted Average Unit Cost (per week) £*	*Annual Budget £000*	*Current Service Users*	*DoT*	*Current Average Unit Cost (per week) £*	*DoT*	*Forecast Actual £000*	*DoT*	*Variance £000*
Learning Disability Services	Residential	299	£1,379	£21,440k	281	↓	£1,471	↑	£22,605k	↓	£1,165k
	Nursing	8	£1,678	£698k	8	↔	£1,694	↔	£729k	↓	£31k
	Community	1,285	£666	£44,527k	1,308	↔	£686	↑	£48,048k	↓	£3,521k
Learning Disability Service Total		**1,592**		**£66,665k**	**1,597**				**£71,382k**		**£4,717k**
Income				-£2,814k					-£3,306k	↓	-£493k
Further savings assumed within forecast as shown in Appendix 1											-£1,295k
Net Total				**£63,851k**							**£2,929k**

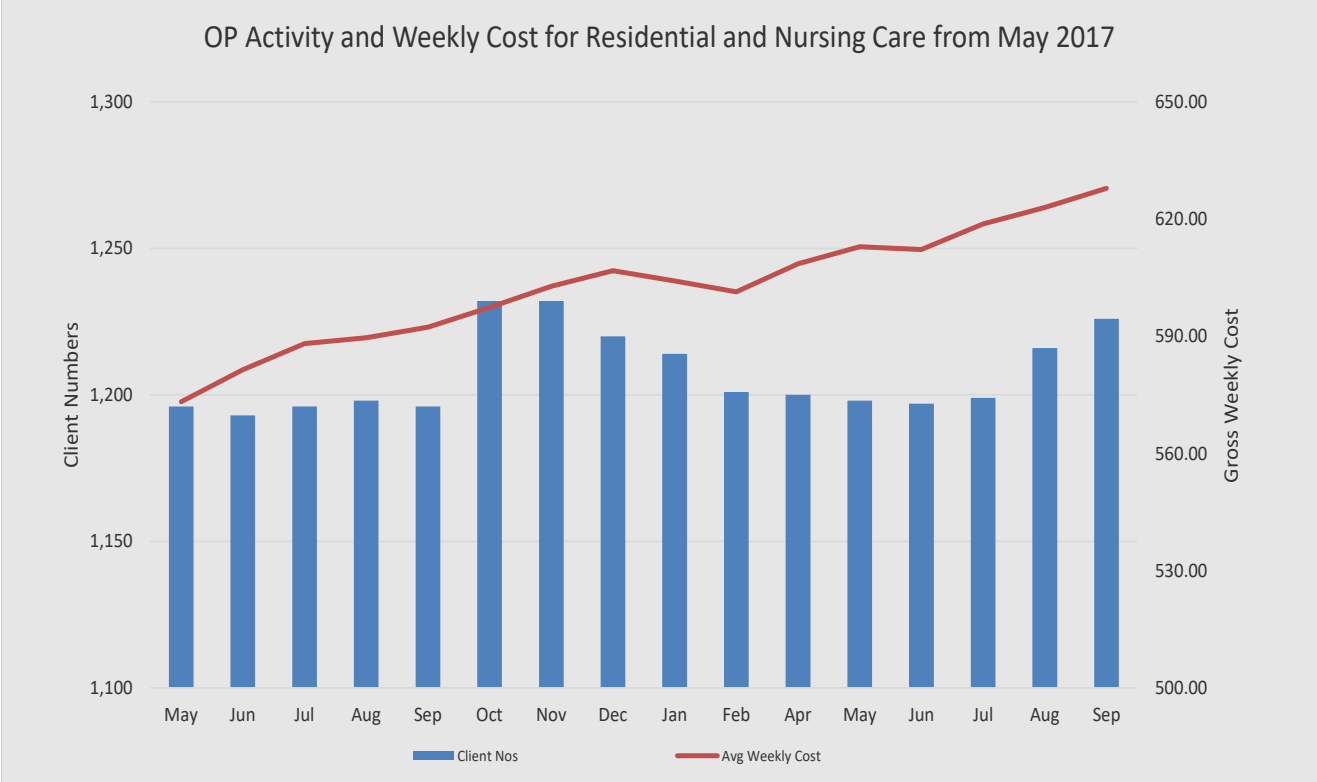
2.5.4 Key activity data to end of September for **Adult Mental Health** Services is shown below:

		BUDGET			ACTUAL (September)				Year End		
Service Type		*Expected No. of Service Users 2018/19*	*Budgeted Average Unit Cost (per week) £*	*Annual Budget £000's*	*Current Service Users*	*D o T*	*Current Average Unit Cost (per week) £*	*D o T*	*Forecast Actual £000's*	*D o T*	*Variance £000's*
Adult Mental Health	Community based support	11	£127	£71k	7	↑	£61	↓	£38k	↑	-£32k
	Home & Community support	164	£100	£857k	152	↓	£100	↓	£757k	↓	-£100k
	Nursing Placement	14	£648	£457k	17	↔	£694	↑	£598k	↑	£141k
	Residential Placement	75	£690	£2,628k	69	↓	£671	↑	£2,297k	↑	-£331k
	Supported Accomodation	130	£120	£792k	131	↓	£174	↑	£1,090k	↓	£298k
	Direct Payments	12	£288	£175k	14	↔	£233	↓	£212k	↑	£37k
Total Expenditure		**406**		**£4,980k**	**390**				**£4,993k**		**£12k**
	Health Contribution			-£298k					-£361k		-£63k
	Client Contribution			-£234k					-£183k		£51k
Total Income				**-£532k**					**-£545k**		**-£12k**
Adult Mental Health Net Total		**406**		**£4,448k**	**390**				**£4,448k**		**£k**

Direction of travel compares the current month to the previous month.

2.5.5 Key activity data to the end of September for **Older People** (OP) Services is shown below:

OP Total	BUDGET			ACTUAL (September 18)				Year End		
Service Type	***Expected No. of Service Users 2018/19***	***Budgeted Average Unit Cost (per week) £***	***Annual Budget £000***	***Current Service Users***	***D o T***	***Current Average Unit Cost (per week) £***	***D o T***	***Forecast Actual £000***	***D o T***	***Variance £000***
Residential	514	£541	£14,589k	469	↓	£558	↑	£14,786k	↓	£198k
Residential Dementia	389	£554	£11,286k	376	↑	£559	↑	£11,439k	↓	£153k
Nursing	312	£750	£12,284k	292	↔	£768	↑	£12,898k	↑	£614k
Nursing Dementia	62	£804	£2,593k	89	↑	£828	↑	£2,722k	↑	£130k
Respite			£1,562k					£1,796k	↑	£235k
Community based										
~ Direct payments	538	£286	£8,047k	502	↓	£332	↑	£8,142k	↑	£95k
~ Day Care			£1,097k					£1,048k	↑	-£50k
~ Other Care			£4,905k					£4,986k	↑	£82k
		per hour				*per hour*				
~ Homecare arranged	1,516	£16.31	£14,598k	1,452	↑	£16.17	↑	£14,660k	↑	£62k
~ Live In Care arranged	50		£2,086k	52	↔	£767.40	↓	£2,045k	↓	-£40k
Total Expenditure	3,381		£73,046k	3,180				£74,523k		£1,476k
Residential Income			-£9,274k					-£9,722k	↓	-£448k
Community Income			-£8,896k					-£9,631k	↓	-£735k
Health Income			-£651k					-£853k	↓	-£202k
Total Income			-£18,821k					-£20,206k		-£1,385k



2.5.6 Key activity data to the end of September for **Older People Mental Health** (OPMH) Services is shown below:

For both Older People's Services and Older People Mental Health:

- Respite care budget is based on clients receiving 6 weeks care per year instead of 52.
- Day Care OP Block places are also used by OPMH clients, therefore there is no day care activity in OPMH

Although this activity data shows current expected and actual payments made through direct payments, this in no way precludes increasing numbers of clients from converting arranged provisions into a direct payment.

OPMH Total	BUDGET			ACTUAL (September 18)				Year End		
Service Type	***Expected No. of Service Users 2018/19***	***Budgeted Average Unit Cost (per week) £***	***Annual Budget £000***	***Current Service Users***	***D o T***	***Current Average Unit Cost (per week) £***	***D o T***	***Forecast Actual £000***	***D o T***	***Variance £000***
Residential	27	£572	£801k	15	↓	£514	↓	£760k	↓	-£42k
Residential Dementia	26	£554	£740k	26	↓	£618	↑	£701k	↓	-£39k
Nursing	29	£648	£992k	16	↓	£649	↑	£895k	↑	-£97k
Nursing Dementia	84	£832	£3,720k	83	↑	£834	↑	£3,356k	↑	-£364k
Respite			£4k					£24k	↓	£20k
Community based										
~ Direct payments	13	£366	£241k	8	↓	£420	↑	£226k	↓	-£15k
~ Day Care			£4k					£4k	↑	£k
~ Other Care			£44k					£44k	↓	£k
~ Homecare arranged	50	*per hour* £16.10	£445k	39	↓	*per hour* £17.26	↑	£477k	↓	£32k
~ Live In Care arranged	4		£185k	3	↓	£869.48	↑	£152k	↓	-£33k
Total Expenditure	229		£6,991k	187				£6,639k		-£504k
Residential Income			-£1,049k					-£620k	↓	£429k
Community Income			-£97k					-£378k	↑	-£281k
Health Income			-£281k					-£10k	↑	£271k
Total Income			-£1,427k					-£1,008k		£419k

3. BALANCE SHEET

3.1 Reserves

A schedule of the planned use of Service reserves can be found in appendix 5.

3.2 Capital Expenditure and Funding

2018/19 In Year Pressures/Slippage

As at the end of September 2018 the capital programme forecast underspend continues to be zero. The level of slippage has not exceeded the revised Capital Variation budget of £10,469k. A forecast outturn will only be reported once slippage exceeds this level. However in September movements on schemes has occurred totaling £320k. The significant changes in schemes are detailed below;

- Sawtry Infant School; £230k slippage due to the start on site now being later than initially scheduled. Start on site scheduled 18th March 2019 with works to be complete September 2020.

A detailed explanation of the position can be found in appendix 6.

4. PERFORMANCE

The detailed Service performance data can be found in appendix 7 along with comments about current concerns.

The performance measures included in this report have been developed in conjunction with the Peoples & Communities management team and link service activity to key Council outcomes. The revised set of measures includes 15 of the previous set and 23 that are new. The measures in this report have been grouped by outcome, then by responsible directorate. The latest available benchmarking information has also been provided in the performance table where it is available. This will be revised and updated as more information becomes available. Work is ongoing with service leads to agree appropriate reporting mechanisms for the new measures included in this report and to identify and set appropriate targets.

Seven indicators are currently showing as RED:

- **Number of children with a Child Protection (CP) Plan per 10,000 children**

During August we saw the numbers of children with a Child Protection plan increase from 480 to 523.

The introduction of an Escalation Policy for all children subject to a Child Protection Plan was introduced in June 2017. Child Protection Conference Chairs raise alerts to ensure there is clear planning for children subject to a Child Protection Plan. This has seen a decrease in the numbers of children subject to a Child Protection Plan.

- **The number of Looked After Children per 10,000 children**

At the end of August there were 737 children who were looked after by the Local Authority and of these 85 were unaccompanied asylum seeking children and young people. There were 652 non asylum seeking looked after children and whilst there was a minimal increase in the number of looked after children overall, there has been a significant increase of unaccompanied asylum seeking children (11) who have spontaneously arrived within the Cambridgeshire border, the majority assessed as being between the ages of 16-17 years. This trend has not continued in September.

Cambridgeshire are supporting 105 care leavers who were previously assessed as being unaccompanied asylum seeking children and 32 adult asylum seekers whose claims have not reached a conclusion. These adults have been waiting between one and three years for a status decision to be made by the Home Office.

Actions being taken include:

- The Children's Director is in communication with our Eastern Region colleagues to raise the issue of the increasing demand in Cambridgeshire and to request assistance. Elected members have also been informed of the financial impact of this increased demand specifically in relation to the cohort of adult asylum seekers.
- There is currently a review underway of the Threshold to Resources Panel (TARP) which is chaired by the Assistant Director for Children's Services. The panel is designed to review children on the edge of care, specifically looking to prevent escalation by providing timely and effective interventions. The intention is to streamline a number of District and Countywide Panels to ensure close scrutiny of thresholds and use of resources but also to provide an opportunity for collaborative working across services to improve outcomes for children. It is proposed that the new panel structure will be in place for the implementation of the Change for Children transformation.
- Since the last update, the Partnership and Quality Assurance service have implemented a number of new initiatives which support and provide challenge to the care planning for children. A county wide Legal Tracker is in place which tracks all children subject to the Public Law Outline (pre proceedings), Care Proceedings and children accommodated by the Local Authority with parental agreement. This is having a positive impact on the care planning for Cambridgeshire's most vulnerable children, for example in the identification of wider family members in pre-proceedings where there are concerns that is not safe for children to remain in the care of their parents. In addition a monthly Permanency Tracker Meeting considers all children who are looked after, paying attention to their care plan, ensuring reunification is considered and if this is not possible a timely plan is made for permanence via Special Guardianship Order, Adoption or Long Term Fostering. The multi-agency Unborn Baby Panel operational in the South and North of the County monitors the progress of care planning, supporting timely decision making and permanency planning.
- Monthly Placement Strategy, Finance and Looked After Children Savings Meetings are now operational and attended by representatives across Children's Social Care, Commissioning and Finance. The purpose of these meetings is to provide increased scrutiny on financial commitments for example placements for looked after children, areas of specific concern and to monitor savings targets. This meetings reports into the People and Communities Delivery Board.
- Supporting this activity, officers in Children's Social Care and Commissioning are holding twice weekly placement forum meetings which track and scrutinise individual children's care planning and placements. These meetings, led by Heads of Service have positively impacted on a number of looked after children who have been consequently been able to move to an in house and in county foster care placement, plans have been made to de-escalate resources in a timely way or children have returned to live with their family. In Cambridgeshire we have 74% of our looked after children in foster care as opposed to 78% nationally and 42% of these children are placed with in-house carers as opposed to 58% in external placements.

- **Average monthly number of bed-day delays (social care attributable) per 100,000 18+ population**

In July 2018, there were 1006 ASC-attributable bed-day delays recorded in Cambridgeshire. For the same period the previous year there were 948 delays – a 6% increase. The Council is continuing to invest considerable amounts of staff and management time into improving processes, identifying clear performance targets and clarifying roles & responsibilities. We continue to work in collaboration with health colleagues to ensure correct and timely discharges from hospital.

Delays in arranging residential, nursing and domiciliary care for patients being discharged from Addenbrooke's remain the key drivers of ASC bed-day delays.

- **Proportion of Adults with Learning Disabilities in paid employment**

Performance remains low. As well as a requirement for employment status to be recorded, unless a service user has been assessed or reviewed in the year, the information cannot be considered current. Therefore this indicator is also dependent on the review/assessment performance of LD teams – and there are currently 53 service users identified as being in employment yet to have a recorded review in the current year. (N.B: This indicator is subject to a cumulative effect as clients are reviewed within the period.)

- **KS4 Attainment 8 (All Children)**

Performance for the 2016/17 year fell in comparison to the 2015/16 results but remains above the average for our statistical neighbours and the England average.

The results for 2017/18 will be released 23rd August 2018 however the provisional Attainment 8 figures will not be validated and released by the DFE until October 2018.

- **Percentage of disadvantaged households taking up funded 2 year old childcare places**

Performance decreased by just under 4 percentage points in comparison to the previous figure for the spring 2018 term.

- **Ofsted – Pupils attending special schools that are judged as Good or Outstanding**

Performance has remained the same as the previous month. Both the national figure and the statistical neighbour average remain unchanged.

There are currently 2 schools which received an overall effectiveness grading of requiring improvement and 104 pupils attend these schools in total.

Ofsted recently concluded a consultation on changes to their Official Statistics and Management Information. The key change is that, from June 2018, Ofsted include judgements from the predecessor schools for schools that have not yet been inspected in their current form.

In Cambridgeshire this has affected 1 special school with the old judgement, from their predecessor school, of requiring improvement now included. The previous inspection occurred in 2016.

APPENDIX 1 – P&C Service Level Budgetary Control Report

Forecast Outturn Variance (Aug) £'000		Service	Budget 2018/19 £'000	Actual Sept 2018 £'000	Forecast Outturn Variance £'000	%
		Adults & Safeguarding Directorate				
-2,146	1	Strategic Management - Adults	7,632	-13,975	-2,212	-29%

-0		Principal Social Worker, Practice and Safeguarding	1,575	681	-0	0%
0		Autism and Adult Support	925	313	-71	-8%
0	2	Carers	661	236	-150	-23%
		Learning Disability Partnership				
1,264	3	LD Head of Service	3,614	2,227	1,264	35%
599	3	LD - City, South and East Localities	34,173	17,666	651	2%
439	3	LD - Hunts & Fenland Localities	29,663	15,209	477	2%
352	3	LD - Young Adults	5,782	2,629	449	8%
91	3	In House Provider Services	6,071	2,884	91	1%
-636	3	NHS Contribution to Pooled Budget	-18,387	-9,194	-680	-4%
		Older People and Physical Disability Services				
0		OP - City & South Locality	19,257	9,574	0	0%
0		OP - East Cambs Locality	5,898	3,293	0	0%
0		OP - Fenland Locality	8,949	4,028	0	0%
0		OP - Hunts Locality	12,457	5,873	0	0%
0		Neighbourhood Cares	855	228	0	0%
0		Discharge Planning Teams	1,872	1,100	0	0%
0		Shorter Term Support and Maximising Independence	7,958	4,469	50	1%
0		Physical Disabilities	11,352	6,435	0	0%
		Mental Health				
0		Mental Health Central	368	399	-30	-8%
0		Adult Mental Health Localities	6,821	2,917	0	0%
0		Older People Mental Health	6,503	3,209	0	0%
-37		**Adult & Safeguarding Directorate Total**	**153,997**	**60,200**	**-161**	**0%**
		Commissioning Directorate				
0		Strategic Management –Commissioning	879	502	-0	0%
0		Access to Resource & Quality	865	306	0	0%
-10		Local Assistance Scheme	300	0	-10	-3%
		Adults Commissioning				
369	4	Central Commissioning - Adults	5,635	18,944	369	7%
0		Integrated Community Equipment Service	925	-586	0	0%
8		Mental Health Voluntary Organisations	3,730	1,378	8	0%
		Childrens Commissioning				
3,000	5	Looked After Children Placements	19,813	9,031	3,000	15%
0		Commissioning Services	2,452	1,012	-0	0%
750	6	Home to School Transport – Special	7,871	2,582	750	10%
0		LAC Transport	1,632	699	0	0%
4,117		**Commissioning Directorate Total**	**44,102**	**33,870**	**4,117**	**9%**

Forecast Outturn Variance (Aug) £'000		Service	Budget 2018/19 £'000	Actual Sept 2018 £'000	Forecast Outturn Variance £'000	%
		Communities & Safety Directorate				
0		Strategic Management - Communities & Safety	-38	64	0	0%
-50		Youth Offending Service	1,650	769	-50	-3%
0		Central Integrated Youth Support Services	953	246	0	0%
0		Safer Communities Partnership	947	533	0	0%
0		Strengthening Communities	521	309	0	0%
0		Adult Learning & Skills	2,660	1,118	0	0%
-50		**Communities & Safety Directorate Total**	**6,693**	**3,039**	**-50**	**-1%**
		Children & Safeguarding Directorate				
0		Strategic Management – Children & Safeguarding	3,774	1,568	0	0%
0		Partnerships and Quality Assurance	1,988	1,088	0	0%
1,400	7	Children in Care	14,013	7,789	1,367	10%
0		Integrated Front Door	2,660	1,324	0	0%
0		Children's Centre Strategy	70	45	0	0%
0		Support to Parents	2,870	159	0	0%
248	8	Adoption Allowances	5,282	2,787	248	5%
0		Legal Proceedings	1,940	1,055	0	0%
		<u>District Delivery Service</u>				
0		Safeguarding Hunts and Fenland	4,646	2,329	0	0%
0		Safeguarding East & South Cambs and Cambridge	4,489	1,873	0	0%
0		Early Help District Delivery Service –North	4,817	2,391	0	0%
0		Early Help District Delivery Service – South	4,736	2,550	0	0%
1,648		**Children & Safeguarding Directorate Total**	**51,285**	**24,960**	**1,615**	**3%**

Forecast Outturn Variance (Aug) £'000		Service	Budget 2018/19 £'000	Actual Sept 2018 £'000	Forecast Outturn Variance £'000	%
		Education Directorate				
0		Strategic Management - Education	3,563	426	-60	-2%
0		Early Years' Service	1,442	779	-0	0%
0		Schools Curriculum Service	62	-24	11	18%
0		Schools Intervention Service	1,095	615	60	5%
148	9	Schools Partnership Service	776	627	148	19%
0		Children's' Innovation & Development Service	214	164	30	14%
0		Teachers' Pensions & Redundancy	2,910	1,082	-40	-1%
		SEND Specialist Services (0-25 years)				
0		SEND Specialist Services	8,077	4,622	0	0%
0	10	Funding for Special Schools and Units	16,739	10,867	1,000	6%
0		Children's Disability Service	6,542	3,732	0	0%
1,500	11	High Needs Top Up Funding	13,599	8,487	1,500	11%
518	12	Special Educational Needs Placements	9,973	13,211	518	5%
0		Early Years Specialist Support	381	259	53	14%
291	13	Out of School Tuition	1,519	780	291	19%
		Infrastructure				
-90		0-19 Organisation & Planning	3,692	3,098	-90	-2%
0		Early Years Policy, Funding & Operations	92	-16	0	0%
0		Education Capital	168	3,266	0	0%
0		Home to School/College Transport – Mainstream	8,742	3,569	0	0%
2,367		**Education Directorate Total**	**79,586**	**55,544**	**3,421**	**4%**
		Executive Director				
504	14	Executive Director	833	359	504	61%
0	15	Central Financing	3,504	17	-3,413	-97%
504		**Executive Director Total**	**4,336**	**376**	**-2,909**	**-67%**
8,549		**Total**	**339,999**	**177,989**	**6,033**	**2%**
		Grant Funding				
-2,309	16	Financing DSG	-58,100	-29,050	-3,362	-6%
0		Non Baselined Grants	-38,635	-18,555	0	0%
-2,309		**Grant Funding Total**	**-96,735**	**-47,605**	**-3,362**	**3%**
6,240		**Net Total**	**243,263**	**130,384**	**2,671**	**1%**

APPENDIX 2 – Commentary on Forecast Outturn Position

Narrative is given below where there is an adverse/positive variance greater than 2% of annual budget or £100,000 whichever is greater.

Service	Budget 2018/19	Actual	Forecast Outturn Variance	
	£'000	£'000	£'000	%
1) Strategic Management – Adults	**7,632**	**-13,975**	**-2,212**	**-29%**
Grant funding provided to the Council from central government through the Improved Better Care Fund and Adult Social Care Support Grant has been applied to the Strategic Management – Adults budget line offset pressures on care budgets in Adults Services described below. This results in a favourable forecast outturn of -£2,212k on this budget line, countering overspend forecasts on care budgets that are shown separately. These grants are specifically to support local authorities in meeting cost and demand pressures in adult social care, and spending plans are agreed annually through Health and Wellbeing Board and General Purposes Committee respectively. In these spending plans, an element of both grants was earmarked to be applied in-year against emerging pressures, and further funding has been identified from other spend lines that have not happened or where there has been slippage.				
2) Carers	**661**	**236**	**-150**	**-23%**
The Carers service is expected to be -£150k underspent at the end of the year. The under spend is due to lower levels of direct payments to carers than was expected over the first half of the year. Uptake of direct payments has continued at 2017/18 levels, reflecting continued good progress to increase direct payments compared to previous years.				
3) Learning Disability Partnership	**60,916**	**31,421**	**2,252**	**4%**
An overspend of £2,931k is forecast against the Learning Disability Partnership (LDP) at the end of September 18. According to the risk sharing arrangements for the LDP pooled budget, the proportion of the over spend that is attributable to the council is **£2,252k**, an increase of £143k from August. Total new savings / additional income expectation of £5,329k are budgeted for 18/19. As at the end of September, a £1,232k shortfall is expected against the reassessment saving proposal and from the conversion of residential to supported living care packages. For both savings programmes, the shortfall is as a result of slippage of planned work and a lower level of delivery per case than anticipated. Demand pressures have been higher than expected, despite positive work that has reduced the overall number of people in high-cost out-of-area in-patient placements. New package costs continued to be high in 17/18 due to increased needs identified at reassessment that we had a statutory duty to meet. This, together with a shortfall in delivery of 17/18 savings, has led to a permanent opening pressure in the 18/19 budget above that level expected during business planning, reflected in the overall forecast at the end of August. Where there are opportunities to achieve additional savings that can offset any shortfall from the delivery of existing planned savings these are being pursued. For example, work is ongoing to maximise referrals to the in-house Assistive Technology team as appropriate, in order to increase the number of 'Just Checking' kits that can be issued to help us to identify the most appropriate level of resource for services users at night. £103k of savings are expected to be delivered by reviewing resource allocation as informed by this technology and this additional saving has been reflected in the forecast. Also, negotiations are continuing with CCGs outside of Cambridgeshire, where people are placed out of area and the CCG in that area should be contributing to the cost of meeting health needs. In addition, around £90k of pressure is forecast for the in-house provider units, due to lower than expected vacancy levels in-year. The provider units have managed within reducing budgets for a number of years, and this year they are working towards a 5% saving on their staffing costs. Staffing levels continue to be reviewed by the units in order to ensure staff members are being used as efficiently as possible, but a minimum level of staffing is required in units to ensure safe service delivery and to meet the regulatory standards of the Care Quality Commission.				

Service	Budget 2018/19	Actual	Forecast Outturn Variance	
	£'000	£'000	£'000	%
4) Central Commissioning – Adults	**5,635**	**18,944**	**369**	**7%**
An overspend of £369k is forecast for Central Commissioning – Adults. This is due to the slower than expected delivery of a major piece of work to transform the Council's Housing Related Support contracts. It is still expected that this piece of work will be completed and deliver in full, but that this will be phased over a longer time-period due to the large number of contracts and the amount of redesigning of services that will be needed rather than simply re-negotiating contract costs. This is partially offset by savings made through recommissioning other contracts, particularly the rationalisation of block domiciliary care car rounds from the start of 18/19.				
5) Looked After Children Placements	**19,813**	**9,031**	**3,000**	**15%**

LAC Placements budget continues to forecast an overspend of £3m this month. A combination of the expected demand pressures on this budget during 18/19, over and above those forecast and budgeted for, along with the part delivery of the £1.5m saving target in 18/19 and the underlying pressure brought forward from 17/18, results in a forecast overspend of £3m. This position continues to be closely monitored throughout the year, with subsequent forecasts updated to reflect any change in this position.

The budgeted position in terms of the placement mix is proving testing, in particular pressures within the external fostering line showing a +86 position. Given an average £800 per week placement costs, this presents a c. £70k weekly pressure. The foster placement capacity both in house and externally is overwhelmed by demand both locally and nationally, as has been evidenced at the end of the month with a sibling group of 8 children having to be accommodated within IFA provision, the costs for which are expected to be offset by some recent favourable placement fee changes. The real danger going forward is that the absence of appropriate fostering provision by default, leads to children and young people's care plans needing to change to residential services provision.

Overall LAC numbers at the end of September 2018, including placements with in-house foster carers, residential homes and kinship, were 736, 1 less than at the end of August. This includes 82 unaccompanied asylum seeking children (UASC).

External placement numbers (excluding UASC but including 16+ and supported accommodation) at the end of September were 373, 1 more than at the end of August.

External Placements Client Group	Budgeted Packages	31 Aug 2018 Packages	30 Sep 2018 Packages	Variance from Budget
Residential Disability – Children	1	2	2	+1
Child Homes – Secure Accommodation	0	1	1	+1
Child Homes – Educational	16	19	19	+3
Child Homes – General	39	34	37	-2
Independent Fostering	199	287	285	+86
Supported Accommodation	31	23	22	-9
Supported Living 16+	8	6	7	-1
TOTAL	**294**	**372**	**373**	**+79**

'Budgeted Packages' are the expected number of placements by Mar-19, once the work associated to the saving proposals has been undertaken and has made an impact.

Mitigating factors to limit the final overspend position include:

- Reconstitution of panels to ensure greater scrutiny and supportive challenge.

Service	Budget 2018/19	Actual	Forecast Outturn Variance	
	£'000	£'000	£'000	%
Looked After Children Placements continued • Monthly commissioning intentions (sufficiency strategy work-streams), budget and savings reconciliation meetings attended by senior managers accountable for each area of spend/practice. Enabling directed focus on emerging trends and appropriate responses, ensuring that each of the commissioning intentions are delivering as per work-stream and associated accountable officer. Production of datasets to support financial forecasting (in-house provider services and Access to Resources). • Investment in children's social care commissioning to support the development of robust commissioning pseudo-dynamic purchasing systems for external spend *(to be approved)*. These commissioning models coupled with resource investment will enable more transparent competition amongst providers bidding for individual care packages, and therefore support the best value offer through competition driving down costs. • Provider meetings scheduled through the Children's Placement Service (Access to Resources) to support the negotiation of packages at or post placement. Working with the Contracts Manager to ensure all placements are funded at the appropriate levels of need and cost. • Regular Permanence Tracking meetings (per locality attended by Access to Resources) chaired by the Independent Reviewing Service Manager to ensure no drift in care planning decisions, and support the identification of foster carers suitable for SGO/permanence arrangements. These meetings will also consider children in externally funded placements, ensuring that the authority is maximizing opportunities for discounts (length of stay/siblings), volume and recognising potential lower cost options in line with each child's care plan. • Additional investment in the recruitment and retention of the in-house fostering service to increase the number of fostering households over a three year period. • Recalculation of the Unaccompanied Asylum Seeking Children (UASC) Transfer Scheme allotment (0.07% of the 0-18 year old population to 0.06% - the aim that this will create greater capacity within the local market in the long term). • Access to the Staying Close, Staying Connected Department for Education (DfE) initiative being piloted by a local charity offering 16-18 year old LAC the opportunity to step-down from residential provision, to supported community based provision in what will transfer to their own tenancy post 18. • Greater focus on those LAC for whom permanency or rehabilitation home is the plan, to ensure timely care episodes and managed exits from care.				
6) Home to School Transport – Special	**7,871**	**2,582**	**750**	**10%**
Home to School Transport – Special is reporting an anticipated £750k overspend for 2018/19. This is largely due to increasing demand for SEND Transport, with a 9% increase in pupils attending special schools between May 2017 and May 2018 and an 11% increase in pupils with EHCPs over the same period. An increase in complexity of need has meant that more individual transport, and transport including a passenger assist, is needed. Further, there is now a statutory obligation to provide post-19 transport putting further pressure on the budget. While only statutory provision is provided in this area, and charging is in line with our statistical neighbours, if this level of growth continues then it is likely that the overspend will increase from what is currently reported. This will be clearer in October once routes have been finalised for the 18/19 academic year. Actions being taken to mitigate the position include • A review of processes in the Social Education Transport and SEND teams with a view to reducing costs • A strengthened governance system around requests for costly exceptional transport requests • A change to the process around Personal Transport Budgets to ensure they are offered only when they are the most cost-effective option • Implementation of an Independent Travel Training programme to allow more students to travel to school and college independently.				

Service	Budget 2018/19	Actual	Forecast Outturn Variance	
	£'000	£'000	£'000	%
Home to School Transport – Special continued Some of these actions will not result in an immediate reduction in expenditure, but will help to reduce costs over the medium term.				
7) Children in Care	**14,013**	**7,789**	**1,367**	**10%**

The Children in Care budget is forecasting a £1.367m over spend.

The UASC U18 budget is currently forecasting a £439k overspend
There has been a significant increase in numbers of unaccompanied children and young people over the last 10 weeks (26 spontaneous arrivals in Cambridgeshire and 2 via the National Transfer Scheme). As of the 30 September 2018 there were 82 under 18 year old UASC. Support is available via an estimated £2m Home Office grant but this does not fully cover the expenditure. Semi-independent accommodation for this age range has traditionally been possible to almost manage within the grant costs but the majority of the recent arrivals have been placed in high cost placements due to the unavailability of lower cost accommodation.

The UASC Leaving Care budget is forecasting a £392k overspend.
Support is available via an estimated £550k Home Office grant but this does not fully cover the expenditure. We are currently supporting 103 UASC care leavers of which 32 young people have been awaiting a decision from the Home Office on their asylum status for between 1 and three years. The £502k overspend is partially offset by £50k from the migration fund and £60k from the 14-25 team budget.

Actions being taken:
The team proactively support care leavers in claiming their benefit entitlements and other required documentation and continue to review all high cost placements in conjunction with commissioning colleagues but are restricted by the amount of lower cost accommodation available.

The Staying Put budget is currently forecasting a £261k overspend. A £32k reduction from last month due to placement movement.
This is a result of the increasing number of staying put arrangements agreed for Cambridgeshire children placed in external placements, the cost of which is not covered by the DFE grant. We currently support 13 in-house placements and 15 independent placements and the DCLG grant of £171k does not cover the full cost of the placements. Staying put arrangements are beneficial for young people, because they are able to remain with their former foster carers while they continue to transition into adulthood. Outcomes are much better as young people remain in the nurturing family home within which they have grown up and only leave they are more mature and better prepared to do so.

The fostering service will be undertaking a systematic review of all staying put costs for young people in external placements to ensure that financial packages of support are needs led and compliant with CCC policy.

The Supervised Contact budget is forecasting an over spend of £275k.

This is due to the use of additional relief staff and external agencies required to cover the current (end Sep 2018) 216 Supervised Contact Cases which equate to 467 supervised contact sessions a month.

327 children are currently open to the service.

An exercise is underway reviewing the structure of Children's Services. This will focus on creating capacity to meet additional demand.

Service	Budget 2018/19	Actual	Forecast Outturn Variance	
	£'000	£'000	£'000	%
8) Adoption	**5,282**	**2,787**	**248**	**5%**
The Adoption Allowances budget is forecasting a £248k over spend. In 2018/19 we are forecasting additional demand on our need for adoptive placements. We have re-negotiated our contract with Coram Cambridgeshire Adoption (CCA) based on an equal share of the extra costs needed to cover those additional placements. The increase in Adoption placements is a reflection of the good practice in making permanency plans for children outside of the looked after system and results in reduced costs in the placement budgets.				
9) Schools Partnership Service	**776**	**627**	**148**	**19%**
Schools Forum took the decision to discontinue the de-delegation for the Cambridgeshire Race Equality & Diversity Service (CREDS) from 1st April 2018, resulting in service closure. The closure timescales have led to a period of time where the service is running without any direct funding and a resulting pressure of £148k. This will be a pressure in 2018/19 only, and mitigating underspends elsewhere in the Education directorate will be sought.				
10) Funding to Special Schools and Units	**16,739**	**10,867**	**1,000**	**6%**
A £1m overspend against Funding to Special Schools and Units is being forecast. This anticipated overspend is a result of increasing numbers of young people with Education Health and Care Plans (EHCP), and a corresponding increase of young people taking up a place at Special Schools or Specialist Units. This budget is funded from the Dedicated Schools Grant (DSG) High Needs Block and will be managed within the overall available DSG resources. Work is being done as part of the SEND Strategy to reduce the pressure on this budget. This will comprise both short-term mitigations such as reviewing high-cost provision to ensure that the additional support being provided is still required, and longer term structural review looking at the role of Special Schools and Units within the county's overall SEN provision.				
11) High Needs Top Up Funding	**13,599**	**8,487**	**1,500**	**11%**
Numbers of young people with Education Health and Care Plans (EHCP) in Post-16 Further Education providers continue to increase and there has been an increase in the number of secondary aged pupils in receipt of an EHCP. We anticipate that this increase will result in a £1.5m overspend at the end of the 2018/19 financial year. This budget is funded from the Dedicated Schools Grant (DSG) High Needs Block and will be managed within the overall available DSG resources. <u>Actions going forward:</u> Through the current Strategic Review of High Needs Provision, we have developed an action plan to ensure longer term financial sustainability of this budget whilst improving outcomes for young people. In summary, the initial focus will be on: - A detailed analysis and review of all high cost packages, to ensure that the additional support is still needed, and also look at alternatives to providing ongoing support for small groups of children with a similar need; - The development of a Tiered funding model for schools. This is already in place for 3 and 4 year olds, and will be in place for further education from September 2019. It would provide schools with funding for shorter term interventions, and reduce demand on EHCPs; - A review of top up rates, to ensure that they are comparable to statistical neighbours, taking account of the funding rates for Cambridgeshire schools.				

Service	Budget 2018/19	Actual	Forecast Outturn Variance	
	£'000	£'000	£'000	%
12) SEN Placements	**9,973**	**13,211**	**518**	**5%**

The SEN Placements budget continues to forecast an overspend of £0.5m at the end of September. This is due to a combination of factors, including:

- Placement of one young person in out of county school needing residential provision, where there is appropriate educational provision to meet needs.
- Placement of a young person in out of county provision as outcome of SENDIST appeal.
- We are currently experiencing an unprecedented increase in requests for specialist SEMH (social, emotional and mental health) provision. Our local provision is now full, which is adding an additional demand to the high needs block.

The first of these pressures highlights the problem that the Local Authority faces in accessing appropriate residential provision for some children and young people with SEN. Overall there are rising numbers of children and young people who are LAC, have an EHCP and have been placed in a 52 week placement. These are cases where the child cannot remain living at home. Where there are concerns about the local schools meeting their educational needs, the SEN Placement budget has to fund the educational element of the 52 week residential placement; often these are residential schools given the level of learning disability of the young children, which are generally more expensive.

In addition, there are six young people not able to be placed in county due to lack of places in SEMH provision. Some of these young people will receive out of school tuition package whilst waiting for a suitable mainstream school placement, with support. Others have needs that will not be able to be met by mainstream school, and if no specialist places are available in county, their needs will have to be met by independent/out county placements.

- The SEN Placement budget is funded from the High Needs Block (HNB) element of the Dedicated Schools Grant (DSG).

Actions being taken:

- SEND Sufficiency work is underway to inform future commissioning strategy. This will set out what the SEND need is across Cambridgeshire, where it is and what provision we need in future, taking account of demographic growth and projected needs. As part of this, the SEMH Review is well underway and options for sufficient provision in the right places is being developed.
- Alternatives such as additional facilities in the existing schools, looking at collaboration between the schools in supporting post 16, and working with further education providers to provide appropriate post 16 course is also being explored in the plan;
- Peterborough and Cambridgeshire SEND Strategy is being developed with a renewed focus and expectation of children and young people having their needs met locally.
- Review and renegotiation of packages with some providers to ensure best value is still being achieved. Part of this work includes a proposed SEND platform of the PAT team in Adults Services to look at effective and cost efficient ways to meet need.

13) Out of School Tuition	**1,519**	**780**	**291**	**19%**

The Out of School Tuition budget continues to forecast a £0.3m overspend at the end of September – this is after the application of £0.4m of High Needs pressure funding being allocated to the Out of School Tuition budget in 18/19. The overspend is due to a combination of a higher number of children remaining on their existing packages and a higher number of children accessing new packages, due to a breakdown of placement, than the budget can accommodate.

There has been an increase in the number of children with an Education Health and Care Plan (EHCP) who are awaiting a permanent school placement, with many of those placements unable to commence until September 2018.

Service	Budget 2018/19	Actual	Forecast Outturn Variance	
	£'000	£'000	£'000	%
Out of School Tuition continued Several key themes have emerged throughout the last year, which have had an impact on the need for children to receive a package of education, sometimes for prolonged periods of time: • Casework officers were not always made aware that a child's placement was at risk of breakdown until emergency annual review was called. • Casework officers did not have sufficient access to SEND District Team staff to prevent the breakdown of an education placement in the same way as in place for children without an EHCP. • There were insufficient specialist placements for children whose needs could not be met in mainstream school. • There was often a prolonged period of time where a new school was being sought, but where schools put forward a case to refuse admission. • In some cases of extended periods of tuition, parental preference was for tuition rather than in-school admission. It has also emerged that casework officers do not currently have sufficient capacity to fulfil enough of a lead professional role which seeks to support children to return to mainstream or specialist settings. Proposals going forward to address the underlying issues: • Proposal to create an in-house "bank" of teachers, tutors, teaching assistants or specialist practitioners and care workers in order to achieve a lower unit cost of provision; • Move to a Dynamic Purchasing System, which would provide a wider, more competitive market place, where a lower unit cost of provision could be achieved; • Enhance the preventative work of the Statutory Assessment Team by expanding the SEND District Team, so that support can be deployed for children with an EHCP, where currently the offer is minimal and more difficult to access; • Creation of an outreach team from the Pilgrim PRU to aid quicker transition from tuition or inpatient care, back into school; and • Review of existing tuition packages to gain a deeper understanding of why pupils are on tuition packages and how they can be supported back into formal education.				
14) Executive Director	**833**	**359**	**504**	**61%**
The Executive Director Budget is currently forecasting an overspend of £504k. This is mainly due to costs of the Mosaic project that were previously capitalised being moved to revenue. Changes in Children's Services, agreed at the Children's and Young People's committee, have led to a change in approach for the IT system for Children's Services. At its meeting on 29th May General Purposes Committee supported a recommendation to procure a new Children's IT System that could be aligned with Peterborough City Council. A consequence of this decision is that the Mosaic system will no longer be rolled out for Children's Services. Therefore £504k of costs for Mosaic, which were formerly charged to capital, will be a revenue pressure in 2018/19.				
15) Central Financing	**3,504**	**17**	**-3,413**	**97%**
The underspend within the Central Financing policy line reflects the allocation of the £3.413m smoothing fund reserve to support Children's Services pressures, as recommended by CYP Committee and approved by General Purposes Committee.				
16) Financing DSG	**-58,100**	**-29,050**	**-3,362**	**-6%**
Within P&C, spend of £58.1m is funded by the ring fenced Dedicated Schools Grant. A contribution of £3.36m has been applied to fund pressures on a number of High Needs budgets including High Needs Top Up Funding (£1.50m), Funding to Special Schools and Units (£1.0m), SEN Placements (£0.52m) and Out of School Tuition (£0.29m). For this financial year the intention is to manage within overall available DSG resources.				

APPENDIX 3 – Grant Income Analysis

The table below outlines the additional grant income, which is not built into base budgets.

Grant	Awarding Body	Expected Amount £'000
Grants as per Business Plan		
Public Health	Department of Health	293
Better Care Fund	Cambs & P'Boro CCG	26,075
Social Care in Prisons Grant	DCLG	372
Unaccompanied Asylum Seekers	Home Office	2,200
Staying Put	DfE	171
Youth Offending Good Practice Grant	Youth Justice Board	531
Crime and Disorder Reduction Grant	Police & Crime Commissioner	127
Troubled Families	DCLG	2,031
Children's Social Care Innovation Grant (MST innovation grant)	DfE	313
Opportunity Area	DfE	3,400
Opportunity Area - Essential Life Skills	DfE	523
Adult Skills Grant	Skills Funding Agency	2,123
AL&S National Careers Service Grant	European Social Fund	335
Non-material grants (+/- £160k)	Various	142
Total Non Baselined Grants 2018/19		**38,635**

Financing DSG	Education Funding Agency	58,100
Total Grant Funding 2018/19		**96,735**

The non-baselined grants are spread across the P&C directorates as follows:

Directorate	Grant Total £'000
Adults & Safeguarding	26,567
Children & Safeguarding	4,885
Education	3,422
Community & Safety	3,761
TOTAL	**38,635**

APPENDIX 4 – Virements and Budget Reconciliation

Virements between P&C and other service blocks:

	Eff. Period	£'000	Notes
Budget as per Business Plan		**239,124**	
Strategic Management – Education	Apr	134	Transfer of Traded Services ICT SLA budget to Director of Education from C&I
Childrens' Innovation & Development Service	Apr	71	Transfer of Traded Services Management costs/recharges from C&I
Strategic Management – Adults	June	-70	Transfer Savings to Organisational Structure Review, Corporate Services
Strategic Management – C&S	June	295	Funding from General Reserves for Children's services reduced grant income expectation as approved by GPC
Children in Care	June	390	Funding from General Reserves for New Duties – Leaving Care as approved by GPC
Strengthening Communities	Aug	2	Transfer of Community Resilience Development Team from Planning & Economy
Strategic Management – Commissioning	Sept	-95	Transfer of Advocacy budget to Corporate
Central Financing	Sept	3,413	Financing Items, Use of Smoothing Fund Reserve as per GPC
Budget 2018/19		**243,263**	

APPENDIX 5 – Reserve Schedule as at Close 2017/18

(Update for 2018/19 will be available for the Oct 18 F&PR)

Fund Description	Balance at 1 April 2017	2017/18		Year End 2017/18	Notes
		Movements in 2017/18	Balance at Close 17/18		
	£'000	£'000	£'000	£'000	
General Reserve					
P&C carry-forward	540	-7,493	-6,953	-6,953	Overspend £6,953k applied against General Fund.
subtotal	**540**	**-7,493**	**-6,953**	**-6,953**	
Equipment Reserves					
IT for Looked After Children	133	-69	64	64	Replacement reserve for IT for Looked After Children (2 years remaining at current rate of spend).
subtotal	**133**	**-69**	**64**	**64**	
Other Earmarked Reserves					
Adults & Safeguarding					
Homecare Development	22	-22	0	0	Managerial post worked on proposals that emerged from the Home Care Summit - e.g. commissioning by outcomes work.
Falls prevention	44	-44	0	0	Up scaled the falls prevention programme with Forever Active
Dementia Co-ordinator	13	-13	0	0	Used to joint fund dementia co-ordinator post with Public Health
Mindful / Resilient Together	188	-133	55	55	Programme of community mental health resilience work (spend over 3 years)
Increasing client contributions and the frequency of Financial Re-assessments	14	-14	0	0	Hired fixed term financial assessment officers to increase client contributions as per BP
Brokerage function - extending to domiciliary care	35	-35	0	0	Trialled homecare care purchasing co-ordinator post located in Fenland
Hunts Mental Health	200	0	200	200	Provision made in respect of a dispute with another County Council regarding a high cost, backdated package
Commissioning					
Capacity in Adults procurement & contract management	143	-143	0	0	Continuing to support route rationalisation for domiciliary care rounds
Specialist Capacity: home care transformation / and extending affordable care home capacity	25	-25	0	0	External specialist support to help the analysis and decision making requirements of these projects and tender processes
Home to School Transport Equalisation reserve	-240	296	56	56	A £296k contribution has been made back to reserves to account for 2017/18 having fewer schools days where pupil require transporting
Reduce the cost of home to school transport (Independent travel training)	60	0	60	60	Programme of Independent Travel Training to reduce reliance on individual taxis
Prevent children and young people becoming Looked After	25	-25	0	0	Re-tendering of Supporting People contracts (ART)

Fund Description	Balance at 1 April 2017	2017/18		Year End 2017/18	Notes
		Movements in 2017/18	Balance at Close 17/18		
	£'000	£'000	£'000	£'000	
Disabled Facilities	44	-6	38	38	Funding for grants for disabled children for adaptations to family homes.
Community & Safety					
Youth Offending Team (YOT) Remand (Equalisation Reserve)	150	-90	60	60	Equalisation reserve for remand costs for young people in custody in Youth Offending Institutions and other secure accommodation.
Children & Safeguarding					
Child Sexual Exploitation (CSE) Service	250	-250	0	0	The funding was required for a dedicated Missing and Exploitation (MET) Unit and due to a delay in the service being delivered this went back to GPC to obtain approval, as originally the Child Sexual Exploitation service was going to be commissioned out but now this was bought in house within the Integrated Front Door and this funding was required in 2017/18 to support this function (1 x Consultant Social Worker & 4 x MET Hub Support Workers).
Education					
Cambridgeshire Culture/Art Collection	47	106	153	153	Providing cultural experiences for children and young people in Cambs - fund increased in-year due to sale of art collection
ESLAC Support for children on edge of care	36	-36	0	0	Funding for 2 year post re CIN
Cross Service					
Develop 'traded' services	30	-30	0	0	£30k was for Early Years and Childcare Provider Staff Development
Improve the recruitment and retention of Social Workers (these bids are cross-cutting for adults, older people and children and young people)	78	-78	0	0	This funded 3 staff focused on recruitment and retention of social work staff
Reduce the cost of placements for Looked After Children	110	-110	0	0	Used for repairs & refurb to council properties: £5k Linton; £25k March; £20k Norwich Rd; £10k Russell St; Alterations: £50k Havilland Way Supported the implementation of the in-house fostering action plan: £74k
Other Reserves (<£50k)	149	-57	92	92	Other small scale reserves.
subtotal	**1,423**	**-709**	**714**	**714**	
TOTAL REVENUE RESERVE	**2,096**	**-8,271**	**-6,175**	**-6,175**	

Fund Description	Balance at 1 April 2017	2017/18		Year End 2017/18	Notes
		Movements in 2017/18	Balance at Close 17/18		
	£'000	£'000	£'000	£'000	
Capital Reserves					
Devolved Formula Capital	780	980	1,760	717	Devolved Formula Capital Grant is a three year rolling program managed by Cambridgeshire Schools.
Basic Need	0	32,671	32,671	0	The Basic Need allocation received in 2017/18 is fully committed against the approved capital plan.
Capital Maintenance	0	4,476	4,476	0	The School Condition allocation received in 2017/18 is fully committed against the approved capital plan.
Other Children Capital Reserves	1,448	1,777	3,225	5	£5k Universal Infant Free School Meal Grant c/fwd.
Other Adult Capital Reserves	379	3,809	4,188	56	Adult Social Care Grant to fund 2017/18 capital programme spend.
TOTAL CAPITAL RESERVE	**2,607**	**43,713**	**46,320**	**778**	

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

APPENDIX 6 – Capital Expenditure and Funding

6.1 Capital Expenditure

2018/19					TOTAL SCHEME	
Original 2018/19 Budget as per BP	Scheme	Revised Budget for 2018/19	Actual Spend (Sep 18)	Forecast Outturn (Sep 18)	Total Scheme Revised Budget	Total Scheme Forecast Variance
£'000		£'000	£'000	£'000	£'000	£'000
	Schools					
44,866	Basic Need – Primary	34,189	16,329	32,997	309,849	7,328
35,502	Basic Need - Secondary	36,939	8,972	30,282	274,319	0
1,222	Basic Need - Early Years	1,488	0	1,488	6,126	0
2,400	Adaptations	2,381	1,115	2,560	7,329	0
3,476	Specialist Provision	486	-16	516	26,631	6,870
2,500	Condition & Maintenance	2,500	2,621	2,500	9,927	-123
1,005	Schools Managed Capital	1,599	0	1,599	25,500	0
100	Site Acquisition and Development	100	113	100	200	0
1,500	Temporary Accommodation	1,500	486	1,500	13,000	0
295	Children Support Services	370	6	415	2,850	75
5,565	Adult Social Care	5,565	5,491	5,565	43,241	0
-12,120	Capital Variation	-10,469	0	-2,874	-58,337	1,651
1,509	Capitalised Interest	1,509	0	1,509	8,798	0
87,820	**Total P&C Capital Spending**	**78,157**	**35,117**	**78,157**	**669,433**	**15,801**

Basic Need - Primary £7,328k increase in scheme cost

A total scheme variance of £7,328k has occurred due to changes since the Business Plan was approved in response to adjustments to development timescales and updated school capacity information. The following schemes require the cost increases to be approved by GPC for 2018/19;

- St Ives, Eastfield / Westfield / Wheatfields; £7,000k overall scheme increase of which £300k will materialise in 2018/19. The scope of the project has changed to amalgamate Eastfield infant & Westfield junior school into a new all through primary.
- St Neots, Wintringham Park; £5,150k increase in total scheme cost. £3,283k will materialise in 2018/19. Increased scope to build a 3FE Primary and associated Early Years, Offset by the deletion of the St Neots Eastern Expansion scheme.
- Wing Development; £400k additional costs in 2018/19. New school required as a result of new development. Total scheme cost £10,200k, it is anticipated this scheme will be funded by both the EFA as an approved free school and S106 funding.
- Bassingbourn Primary School; £3,150k new scheme to increase capacity to fulfil demand required from returned armed forces families. £70k expected spend in 2018/19.

The following scheme has reduced in cost since business plan approval.

- St Neots – Eastern expansion; £4,829k reduction. Only requirement is spend on a temporary solution at Roundhouse Primary. Wintringham Park scheme will be progressed to provide places.

Basic Need - Primary £1,192k slippage

The following Basic Need Primary schemes have experienced slippage in 2018/19 as follows;

- Waterbeach Primary scheme has experienced slippage of £631k due to start on site now being January 2019, a one month delay. The contract length has also increase from 13 to 15 months.
- North West Cambridge (NIAB) scheme has incurred accelerated spend of £100k to undertake initial ground works within the planning permission timescales.

- Wyton Primary has experienced £149k slippage due to slighter slower progress than originally expected.
- St Neots – Eastern expansion has experienced £35k slippage as a proportion of costs will not due until 2019/20 financial year.
- Ermine Street Primary has experienced £140k slippage due to revised phasing of the scheme.
- Littleport 3rd Primary has experienced £180k slippage as the scheme is now not required until September 2021.
- Sawtry Infant School £230k and Sawtry Junior school £40k due to the revised start on site dates of 18th March 2019 with completion to remain at September 2020.

The slippage above has been offset by accelerated expenditure incurred on Meldreth, Fulbourn, Sawtry Infants and Bassingbourn where progress is ahead of originally plan.

Basic Need - Secondary £6,657k slippage
The following Basic Need Secondary schemes have experienced slippage in 2018/19 as follows;

- Northstowe Secondary & Special has experienced £4,700k slippage in 2018/19 due to a requirement for piling foundations on the site, which will lead to an increase in scheme cost and also extend the build time, also enabling works are only being completed for the SEN provision and part of the Secondary school in 2018/19, this is not what was initialled planned.
- Alconbury Weald Secondary & Special has to date forecasting £200k slippage as currently there is no agreed site for the construction. Scheme expected to be delivered for September 2022.
- Cambourne Village College is not starting on site until February 2019 for a September 2019 completion the impact being £1,932k slippage.
- North West Fringe School; £50k slipped as the scheme has not yet progressed.

Specialist Provision £6,870k increase in scheme cost
Highfields Special School has experienced £250k additional cost in 2018/19. New scheme to extend accommodation for the current capacity and create teaching space for extended age range to 25 total cost £6,870k

Adaptations £179k accelerated spend
Morley Memorial Scheme is experiencing accelerated spend as works is progressing slightly ahead of the original planned timescales.

Devolved Formula Capital
The revised budget for Devolved Formula capital has reduced by £123k due to government confirming the funding for 2018/19 allocations.

Children's Minor Works and Adaptions £75k increased scheme costs. £45k 2018/19 overspend.
Additional budget to undertake works to facilitate the Whittlesey Children's Centre move to Scaldgate Community Centre. There has also been further increase in the cost of the Scaldgate scheme resulting in an estimated £45k overspend in 2018/19.

P&C Capital Variation

The Capital Programme Board recommended that services include a variation budget to account for likely slippage in the capital programme, as it is sometimes difficult to allocate this to individual schemes in advance. As forecast underspends start to be reported, these are offset with a forecast outturn for the variation budget, leading to a balanced outturn overall up until the point where slippage exceeds this budget. The allocation for P&C's negative budget adjustments has been calculated as follows, shown against the slippage forecast to date:

2018/19					
Service	**Capital Programme Variations Budget** **£000**	**Forecast Outturn Variance (Sep 18)** **£000**	**Capital Programme Variations Budget Used** **£000**	**Capital Programme Variations Budget Used** **%**	**Revised Outturn Variance (Sep 18)** **£000**
P&C	-10,469	7,595	7,595	72.5	-2,874
Total Spending	-10,469	7,595	7.595	72.5	-2,874

6.2 Capital Funding

2018/19				
Original 2018/19 Funding Allocation as per BP	**Source of Funding**	**Revised Funding for 2018/19**	**Forecast Funding Outturn (Sep 18)**	**Forecast Funding Variance - Outturn (Sep 18)**
£'000		**£'000**	**£'000**	**£'000**
24,919	Basic Need	24,919	24,919	0
4,043	Capital maintenance	4,202	4,202	0
1,005	Devolved Formula Capital	1,599	1,599	0
4,115	Adult specific Grants	4,171	4,171	0
5,944	S106 contributions	6,324	6,324	0
833	Other Specific Grants	833	833	0
1,982	Other Capital Contributions	1,982	1,982	0
47,733	Prudential Borrowing	36,881	36,881	0
-2,754	Prudential Borrowing (Repayable)	-2,754	-2,754	0
87,820	**Total Funding**	**78,157**	**78,157**	**0**

APPENDIX 7 – Performance at end of August 2018

Outcome	Adults and children are kept safe									
Measure	**Responsible Directorate(s)**	**Previous period**	**Target**	**Actual**	**Date of latest data**	**Direction of travel (up is good, down is bad)**	**RAG Status**	**Stat Neighbours**	**England**	**Comments**
% of adult safeguarding enquiries where outcomes were at least partially achieved	Adults & Safeguarding	73.0%	n/a	95.0%	Mar-18	↑	**No target**	n/a	n/a	Performance is improving as the 'Making Safeguarding Personal' agenda become imbedded in practice
% of people who use services who say that they have made them feel safer	Adults & Safeguarding	84.8%	n/a	83.2%	2017/2018	↓	**No target**	n/a	n/a	Performance has fallen since last year's survey, however the change is not considered statistically significant based on the survey methodology used.
Rate of referrals per 10,000 of population under 18	Children & Safeguarding	41.5	n/a	28.1	Aug	↑	**No target**	455.8	548.2	The referral rate is favourable in comparison to statistical neighbours and the England average
% children whose referral to social care occurred within 12 months of a previous referral	Children & Safeguarding	20.8%	20.0%	15.9%	Aug	↑	**On target (Green)**	22.3%	21.9%	Performance in re-referrals to children's social care has gone back below target this month and remains well below average in comparison with statistical neighbours and the England average.

Outcome	Adults and children are kept safe									
Measure	Responsible Directorate(s)	Previous period	Target	Actual	Date of latest data	Direction of travel (up is good, down is bad)	RAG Status	Stat Neighbours	England	Comments
Number of children with a Child Protection Plan per 10,000 population under 18	Children & Safeguarding	35.7	30.0	38.9	Aug	↓	Off target (Red)	36.93	43.3	During August we saw the numbers of children with a Child Protection plan increase from 480 to 523. The introduction of an Escalation Policy for all children subject to a Child Protection Plan was introduced in June 2017. Child Protection Conference Chairs raise alerts to ensure there is clear planning for children subject to a Child Protection Plan. This has seen a decrease in the numbers of children subj0ect to a Child Protection Plan.
Proportion of children subject to a Child Protection Plan for the second or subsequent time (within 2 years)	Children & Safeguarding	3.8%	5%	2.6%	Aug	↑	On target (Green)	22.5%	18.7%	In August there were 8 children subject to a child protection plan for the second or subsequent time. The rate is favourable in comparison to statistical neighbours and the England average and below target. NOTE: Target added in July 2018.

Outcome	Adults and children are kept safe									
Measure	Responsible Directorate(s)	Previous period	Target	Actual	Date of latest data	Direction of travel (up is good, down is bad)	RAG Status	Stat Neighbours	England	Comments
The number of looked after children per 10,000 population under 18	Children & Safeguarding	53.9	40	54.9	Aug	↓	Off target (Red)	44.9	62	At the end of August there were 737 children who were looked after by the Local Authority and of these 85 were unaccompanied asylum seeking children and young people. There were 652 non asylum seeking looked after children and whilst there was a minimal increase in the number of looked after children overall, there has been a significant increase of unaccompanied asylum seeking children (11) who have spontaneously arrived within the Cambridgeshire border, the majority assessed as being between the ages of 16-17 years. This trend has not continued in September. Cambridgeshire are supporting 105 care leavers who were previously assessed as being unaccompanied asylum seeking children and 32 adult asylum seekers whose claims have not reached a conclusion. These adults have been waiting between one and three years for a status decision to be made by the Home Office. Actions being taken include: The Children's Director is in communication with our Eastern Region colleagues to raise the issue of the increasing demand in Cambridgeshire and to request assistance. Elected members have also been informed of the financial impact of this increased demand specifically in relation to the cohort of adult asylum seekers. There is currently a review underway of the Threshold to Resources Panel (TARP) which is chaired by the Assistant Director for Children's Services. The panel is designed to review children on the edge of care, specifically looking to prevent escalation by providing timely and effective interventions. The intention is to streamline a number of District and Countywide Panels to ensure close scrutiny of thresholds and use of resources but also to provide an opportunity for collaborative working across services to improve outcomes for children. It is proposed that the new panel structure will be in place for the implementation of the Change for Children transformation. Since the last update, the Partnership and Quality Assurance service have implemented a number of new initiatives which support and provide challenge to the care planning for children. A county wide Legal Tracker is in place which tracks all children subject to the Public Law Outline (pre proceedings), Care Proceedings and children accommodated by the Local Authority with parental agreement. This is having a positive

Outcome	Adults and children are kept safe									
Measure	Responsible Directorate(s)	Previous period	Target	Actual	Date of latest data	Direction of travel (up is good, down is bad)	RAG Status	Stat Neighbours	England	Comments
										impact on the care planning for Cambridgeshire's most vulnerable children, for example in the identification of wider family members in pre-proceedings where there are concerns that is not safe for children to remain in the care of their parents. In addition a monthly Permanency Tracker Meeting considers all children who are looked after, paying attention to their care plan, ensuring reunification is considered and if this is not possible a timely plan is made for permanence via Special Guardianship Order, Adoption or Long Term Fostering. The multi-agency Unborn Baby Panel operational in the South and North of the County monitors the progress of care planning, supporting timely decision making and permanency planning. Monthly Placement Strategy, Finance and Looked After Children Savings Meetings are now operational and attended by representatives across Children's Social Care, Commissioning and Finance. The purpose of these meetings is to provide increased scrutiny on financial commitments for example placements for looked after children, areas of specific concern and to monitor savings targets. This meetings reports into the People and Communities Delivery Board. Supporting this activity, officers in Children's Social Care and Commissioning are holding twice weekly placement forum meetings which track and scrutinise individual children's care planning and placements. These meetings, led by Heads of Service have positively impacted on a number of looked after children who have been consequently been able to move to an in house and in county foster care placement, plans have been made to de-escalate resources in a timely way or children have returned to live with their family. In Cambridgeshire we have 74% of our looked after children in foster care as opposed to 78% nationally and 42% of these children are placed with in-house carers as opposed to 58% in external placements.
Number of young first time entrants into the criminal justice system, per 10,000 of	Community & Safety	3.38	n/a	2.18	Q1	↑	**No target**			Awaiting comparator data to inform target setting

Outcome	Adults and children are kept safe									
Measure	Responsible Directorate(s)	Previous period	Target	Actual	Date of latest data	Direction of travel (up is good, down is bad)	RAG Status	Stat Neighbours	England	Comments
population compared to statistical neighbours										

Outcome	Older people live well independently									
Measure	Responsible Directorate(s)	Previous period	Target	Actual	Date of latest data	Direction of travel (up is good, down is bad)	RAG Status	Stat Neighbours	England	Comments
Number of contacts for community equipment in period	Adults & Safeguarding		n/a				**No target**	n/a	n/a	New measure, currently in development
Number of contacts for Assistive Technology in period	Adults & Safeguarding		n/a				**No target**	n/a	n/a	New measure, currently in development
Proportion of people finishing a reablement episode as independent (year to date)	Adults & Safeguarding	55.8	57%	54.7%	Aug	🡻	**Within 10% (Amber)**	n/a	n/a	The throughput volumes are close to the expected target and this measure is expected to improve across the rest of the year

Outcome	Older people live well independently									
Measure	Responsible Directorate(s)	Previous period	Target	Actual	Date of latest data	Direction of travel (up is good, down is bad)	RAG Status	Stat Neighbours	England	Comments
Average monthly number of bed day delays (social care attributable) per 100,000 18+ population	Adults & Safeguarding	117	114	137	Jul	↓	**Off target (Red)**	**n/a**	n/a	In July 2018, there were 1006 ASC-attributable bed-day delays recorded in Cambridgeshire. For the same period the previous year there were 948 delays – a 6% increase. The Council is continuing to invest considerable amounts of staff and management time into improving processes, identifying clear performance targets and clarifying roles & responsibilities. We continue to work in collaboration with health colleagues to ensure correct and timely discharges from hospital. Delays in arranging residential, nursing and domiciliary care for patients being discharged from Addenbrooke's remain the key drivers of ASC bed-day delays.
Number of Community Action Plans Completed in period	Adults & Safeguarding	125	n/a	125	Aug	→	**No target**	n/a	n/a	No change against the previous period.
Number of assessments for long-term care completed in period	Adults & Safeguarding	175	n/a	123	Aug	↓	**No target**	n/a	n/a	Performance decreased against the previous period. This is likely to be related to annual leave being taken over the school holidays.

Outcome	Older people live well independently									
Measure	**Responsible Directorate(s)**	**Previous period**	**Target**	**Actual**	**Date of latest data**	**Direction of travel (up is good, down is bad)**	**RAG Status**	**Stat Neighbours**	**England**	**Comments**
BCF 2A PART 2 - Admissions to residential and nursing care homes (aged 65+), per 100,000 population	Adults & Safeguarding	118.0	564.0	164.8	Aug	🡻	**On Target (Green)**	n/a	n/a	The implementation of the Transforming Lives model, combined with a general lack of available residential and nursing beds in the area has continued to keep admissions below national and statistical neighbour averages. N.B. This is a cumulative figure, so will always go up. An upward direction of travel arrow means that if the indicator continues to increase at the same rate, the ceiling target will not be breached.

Outcome	People live in a safe environment									
Measure	**Responsible Directorate(s)**	**Previous period**	**Target**	**Actual**	**Date of latest data**	**Direction of travel (up is good, down is bad)**	**RAG Status**	**Stat Neighbours**	**England**	**Comments**
Victim-based crime per 1,000 of population compared to statistical neighbours (hate crime)	Community & Safety	59.44	n/a	59.61	Q1	🡻	**No target**	55.81	69.23	New measure, in development

Outcome	People with disabilities live well independently

Measure	Responsible Directorate(s)	Previous period	Target	Actual	Date of latest data	Direction of travel (up is good, down is bad)	RAG Status	Stat Neighbours	England	Comments
Proportion of adults with a primary support reason of learning disability support in paid employment (year to date)	Adults & Safeguarding	0.5%	6.0%	0.8%	Aug	↑	**Off Target (Red)**	n/a	n/a	Performance remains low. As well as a requirement for employment status to be recorded, unless a service user has been assessed or reviewed in the year, the information cannot be considered current. Therefore this indicator is also dependent on the review/assessment performance of LD teams – and there are currently 53 service users identified as being in employment yet to have a recorded review in the current year. (N.B: This indicator is subject to a cumulative effect as clients are reviewed within the period.)
Proportion of adults in contact with secondary mental health services in paid employment	Adults & Safeguarding	12.6%	12.5%	12.2%	Aug	↓	**Within 10% (Amber)**	n/a	n/a	Performance at this measure is below target. Reductions in the number of people in contact with services are making this indicator more variable while the numbers in employment are changing more gradually.
Proportion of adults with a primary support reason of learning disability support who live in their own home or with their family	Adults & Safeguarding	67.1%	72.0%	68.0%	Aug	↑	**Within 10% (Amber)**	n/a	n/a	Performance is slightly below target, but improving

Outcome	People with disabilities live well independently									
Measure	Responsible Directorate(s)	Previous period	Target	Actual	Date of latest data	Direction of travel (up is good, down is bad)	RAG Status	Stat Neighbours	England	Comments
Proportion of adults in contact with secondary mental health services living independently, with or without support	Adults & Safeguarding	80.7%	75.0%	80.7%	Aug	→	On Target (Green)	n/a	n/a	No change against the previous period.
Proportion of adults receiving Direct Payments	Adults & Safeguarding	24.4%	24%	24.2%	Aug	↓	On Target (Green)	n/a	n/a	Performance is slightly above target
Proportion of carers receiving Direct Payments	Adults & Safeguarding	96.3%	n/a	96.4%	Jul	↑	No target	n/a	n/a	Direct payments are the default option for carers support services, as is reflected in the high performance of this measure.

Outcome	Places that work with children help them to reach their full potential									
Measure	Responsible Directorate(s)	Previous period	Target	Actual	Date of latest data	Direction of travel (up is good, down is bad)	RAG Status	Stat Neighbours	England	Comments
% of EHCP assessments completed within timescale	Children & Safeguarding	57.6%	70.0%	69.5%	Aug	↑	Within 10% (Amber)			Performance improved in August and is now only slightly below target.
Number of young people who are NEET, per 10,000 of population compared to statistical neighbours	Children & Safeguarding	305.0	n/a	306.0	Aug	↓	No target	213.8	271.1	The rate increased against the previous reporting period. The rate remains higher than statistical neighbours.

Outcome	Places that work with children help them to reach their full potential									
Measure	Responsible Directorate(s)	Previous period	Target	Actual	Date of latest data	Direction of travel (up is good, down is bad)	RAG Status	Stat Neighbours	England	Comments
Proportion of young people with SEND who are NEET, per 10,000 of population compared to statistical neighbours	Children & Safeguarding		n/a	738	Q1		No target	524		The figure is higher than statistical neighbours.
KS2 Reading, writing and maths combined to the expected standard (All children)	Education	58.7%	65.0%	60.9%	2017/18	↑	**Within 10% (Amber)**	61.3% (2016/17)	64.3% (2017/18)	2017/18 Performance increased but remains below that of the national average. Please note the 2017/18 figures have been calculated from provisional data which means it is subject to changes in future revised releases. In addition it means the 2017/18 statistical neighbour average is not yet available so the 2016/17 figure has been left in as a comparison and will be updated as soon as new data becomes available.
KS4 Attainment 8 (All children)	Education	51.5	50.1	47.7	2016/17	↓	**Off target (Red)**	47.5	46.3	Performance fell in comparison to the previous reporting period but is above the average for our statistical neighbours and the England average. GCSE results for the 2017/18 year will be released 23/08/18 however the provisional Attainment 8 figures will not be validated and released by the DFE until October 2018.

Outcome	Places that work with children help them to reach their full potential									
Measure	Responsible Directorate(s)	Previous period	Target	Actual	Date of latest data	Direction of travel (up is good, down is bad)	RAG Status	Stat Neighbours	England	Comments
% of Persistent absence (All children)	Education	9.2%	8.5%	8.9%	2016/17	↑	Within 10% (Amber)	10.0%	10.8%	2016/17 Persistent absence has reduced from 9.2% to 8.9% and is below both the statistical neighbour and national averages.
% Fixed term exclusions (All children)	Education	3.47%	3.7%	3.76%	2016/17	↓	On target (Green)	4.30%	4.76%	The % of fixed term exclusions rose by 0.5 percentage points in 2016/17 in comparison to the previous year. This is well below the statistical neighbour average and the national figure.
% receiving place at first choice school (Primary)	Education	91.3%	93.0%	93.2%	Sept-17	↑	On target (Green)	90.1%	90.0%	Performance increased by 1.9 percentage points in comparison to the previous reporting period and is above both the statistical neighbour average and the national figure.
% receiving place at first choice school (Secondary)	Education	92.9%	91.0%	92.5%	Sept-17	↓	On target (Green)	88.4%	83.5%	Performance fell by 0.4 percentage points in comparison to the previous reporting period and is still above both the statistical neighbour average and the national figure.
% of disadvantaged households taking up funded 2 year old childcare places	Education	70.6%	75.0%	68%	Summer term 2018		Off target (Red)	73.3% (2018)	71.8% (2018)	Performance decreased by just under 4 percentage points in comparison to the previous figure for the spring 2018 term. The annual figure for Cambridgeshire is 68% and this is below the annual figures for statistical neighbour and national comparators.

Outcome	Places that work with children help them to reach their full potential									
Measure	Responsible Directorate(s)	Previous period	Target	Actual	Date of latest data	Direction of travel (up is good, down is bad)	RAG Status	Stat Neighbours	England	Comments
Ofsted - Pupils attending schools that are judged as Good or Outstanding (Primary Schools)	Education	80.4%	90%	80.4%	Aug-17	➔	Within 10% (Amber)	88.0%	87.9%	Performance has remained the same as the previous month. The national figure remains unchanged and the statistical neighbour average only saw a 0.2 percentage point change.
Ofsted - Pupils attending schools that are judged as Good or Outstanding (Secondary Schools)	Education	86.1%	90%	86.1%	Aug-17	➔	Within 10% (Amber)	84.9%	81.0%	Performance has remained the same as the previous month. The national figure remains unchanged and the statistical neighbour average only saw a 0.5 percentage point change.
Ofsted - Pupils attending schools that are judged as Good or Outstanding (Special Schools)	Education	89.6%	100%	89.6%	Aug-17	➔	Off target (Red)	94.7%	94.0%	Performance has remained the same as the previous month. Both the national figure and the statistical neighbour average remain unchanged. There are currently 2 schools which received an overall effectiveness grading of requiring improvement and 104 pupils attend these schools in total.
Ofsted - Pupils attending schools that are judged as Good or Outstanding (Nursery Schools)	Education	100%	100%	100%	Aug-17	➔	On target (Green)	100%	98.1%	Performance is high and has remained the same as the previous month. Both the national figure and the statistical neighbour average remain unchanged.

Outcome	The Cambridgeshire economy prospers to the benefit of all residents									
Measure	Responsible Directorate(s)	Previous period	Target	Actual	Date of latest data	Direction of travel (up is good, down	RAG Status	Stat Neighbours	England	Comments

						is bad)				
Proportion of new apprentices per 1,000 of population, compared to national figures	Community & Safety		n/a				**No target**			New measure in development
Engagement with learners from deprived wards as a proportion of the total learners engaged	Community & Safety		n/a				**No target**			New measure in development

Savings Tracker 2018-19

September 2018-19

					Planned £000						Forecast £000									
				1,947	-11,818	-1,801	-1,451	-1,512	**-16,582**	-11,281	-1,247	-896	-925	**-14,347**	**2,235**				
Reference	Title	Description	Committee	Investment 18-19 £000	Original Phasing - Q1	Original Phasing - Q2	Original Phasing - Q3	Original Phasing - Q4	Original Saving 18-19	Current Forecast Phasing - Q1	Current Forecast Phasing - Q2	Current Forecast Phasing - Q3	Current Forecast Phasing - Q4	Forecast Saving	Variance from Plan £000	RAG	Direction of travel	Forecast Commentary	Links with partner organisations
A/R.6.001	P&C Contribution to Organisational Review Mileage Saving	As part of the Organisational Review (C/R.6.102) a cross cutting review of mileage allowances in 2017-18 was undertaken and areas where mileage could be reduced without impacting front line services were identified.	P&C Cross Committee	0	-63	0	0	0	-63	-63	0	0	0	-63	**0**	Green	↔	On track	0
A/R.6.111	Physical Disabilities - Supporting people with physical disabilities to live more independently and be funded appropriately	In line with the Council's commitment to promote independence, work will be undertaken to establish more creative ways to meet the needs of people with physical disability. This will include making better use of early help, community support and building on community and family support networks. It will also include work with the NHS to ensure health-funding arangements are appropriate.	Adults	0	-110	-110	-110	-110	-440	-110	-110	-110	-110	-440	**0**	Green	↔	On track	0
A/R.6.114	Learning Disabilities - Increasing independence and resilience when meeting the needs of people with learning disabilities	Continuing the existing programme of service user care reassessments which requires each person's care needs to be reassessed in line with the Transforming Lives model and with the revised policy framework with a view to identifying ways to meet needs in the most appropriate way	Adults	786	-1,706	-464	-465	-465	-3,100	-1,409	-328	-327	-327	-2,391	**709**	Red	↑	A refreshed scoping of potential savings has been undertaken, and this work has taken into account previous experiences around the complexity and the level of challenge which impact on the pace at which savings can be delivered. In addition we anticipate a challenging round of fee uplift negotiations requiring officer input - these two aspects have resulted in the projected shortfall in savings.	Savings will be made on health elements of care packages as well, providing savings to the CCG
A/R.6.115	Retendering for domiciliary care for people with learning disabilities	Part-year savings were delivered in 2017/18 through retendering domicilary care contracts, effective from 1 November 2017. The remaining effect of this saving will be delivered in 2018/19.	Adults	0	-100	0	0	0	-100	0	-100	0	0	-100	**0**	Green	↔	On track	0
A/R.6.122	Transforming Learning Disability In-House & Day Care Services	Developing a model of day opportunities for people with learning disabilities that is focused on enabling progression and skills development, supporting people with LD into employment where appropriate. Most of this saving will be delivered in 19/20 with a small amount in the latter part of 18/19.	Adults	0	0	0	0	-50	-50	-13	-13	-13	-13	-50	**0**	Green	↔	On track to deliver saving through vacancy savings, reducing service running costs such as travel, telephony (budgeted within service)	0
A/R.6.126	Learning Disability - Converting Residential Provision to Supported Living	This is an opportunity to de-register a number of residential homes for people with learning disabilities and change the service model to supported living. The people in these services will benefit from a more progressive model of care that promotes greater independence.	Adults	0	-400	-394	0	0	-794	-25	-143	0	0	-168	**626**	Red	↓	Having better appreciation with level of challenge from family carers, service user advocates and housing providers in the last financial year has resulted in a better forecast in this complex and very volatile area. The process has a set timescale with a number of dependencies that can affect delivery and phasing.	Savings will be made on health elements of care packages as well, providing savings to the CCG.
A/R.6.127	Care in Cambridgeshire for People with Learning Disabilities	Work to enable people with learning disabilities who have been placed 'out of county' to move closer to their family by identifying an alternative placement which is closer to home. To be approached on a case by case basis and will involve close work with the family and the person we support.	Adults	75	-78	-79	-79	-79	-315	-168	-49	-49	-49	-315	**0**	Green	↔	On track	Savings will be made on health elements of care packages as well, providing savings to the CCG
A/R.6.128	Use of grant funding to reduce demand and service pressures	Grant funding is provided to Adults services to support investment to reduce demand and mitigate service pressures.	Adults	0	-7,200	0	0	0	-7,200	-7,200	0	0	0	-7,200	**0**	Green	↔	On track	Will help meet financial pressures on Adults Services, enabling it to better respond to system-wide challenges
A/R.6.129	Russell Street Learning Disability Provision Re-design	Provide the existing permanent residential provision through an external provider as a supported living project and develop a traded in-house service that can respond to immediate needs for carer and support using the vacated residential provision.	Adults	0	0	0	-70	0	-70	0	0	-70	0	-70	**0**	Green	↔	On track	0
A/R.6.132	Mental Health Demand Management	The programme of work to transform the social care offer for adults and older people with mental health needs will deliver savings totalling £400k through a combination of demand management, staffing restructures, strategic commissioning and ensuring people receive appropriate health funding.	Adults	340	-275	-125	0	0	-400	-275	-125	0	0	-400	**0**	Green	↔	Completed.	Reducing demand versus expected levels should lead to lower than expected health needs
A/R.6.143	Homecare Retendering	The Council has retendered its contract for home care and this will release some efficiencies. The Council is also developing alternative ways of delivering home care support building on innovation and best practice across the country including the expansion of direct payments	Adults	100	-306	0	0	0	-306	-306	0	0	0	-306	**0**	Green	↔	On track	0
A/R.6.172	Older People's Demand Management Savings	Building on current work and plans to enable older people to stay living at home and in the community successfully through the provision of assistive technology, early help, community equipment and housing related support. Work will be undertaken to increase effectiveness of Reablement and to prevent falls in collaboration with partners.	Adults	116	-250	-250	-250	-250	-1,000	-250	-250	-250	-250	-1,000	**0**	Green	↔	On track	Should reduce demand on health system as fewer older people than expected require interventions. Reablement and Carers work should aid with DTOC.
A/R.6.173	Adult Social Care Service User Financial Reassessments	Continuing the programme of reassessing clients in receipt of adult social care services more regularly to ensure full contributions are being collected.	Adults	280	-180	-129	-77	-26	-412	-180	-129	-77	-26	-412	**0**	Green	↔	On track	0
A/R.6.174	Review of Supported Housing Commissioning	The Council is undertaking a review of all existing housing related support commissioned arrangements, with a view to ensuring contracts are efficient and to developing a single housing related support model across Cambridgeshire and Peterborough.	Adults	250	-250	-250	-250	-250	-1,000	-100	0	0	-150	-250	**750**	Red	↔	The phasing of this saving will now be over several years - a major redesign of some services is needed, and this will need to be done in conjunction with changes in the housing support being provided by district councils.	District councils also provide housing support services
A/R.6.175	Automation - Mosaic and Adult Business Support Processes	Efficiencies resulting from implementation of Mosaic replacing current processes.	Adults	0	0	0	-150	0	-150	0	0	0	0	0	**150**	Black	↔	Realignment of business support ahead of Mosaic implementation is not expected to deliver this saving in year, but the alignment of support functions will be reviewed next year once the Mosaic implementation is complete.	0

September 2018-19

					Planned £000					Forecast £000									
				1,947	-11,818	-1,801	-1,451	-1,512	**-16,582**	-11,281	-1,247	-896	-925	**-14,347**	**2,235**				
Reference	**Title**	**Description**	**Committee**	**Investment 18-19 £000**	**Original Phasing - Q1**	**Original Phasing - Q2**	**Original Phasing - Q3**	**Original Phasing - Q4**	**Original Saving 18-19**	**Current Forecast Phasing - Q1**	**Current Forecast Phasing - Q2**	**Current Forecast Phasing - Q3**	**Current Forecast Phasing - Q4**	**Forecast Saving**	**Variance from Plan £000**	**RAG**	**Direction of travel**	**Forecast Commentary**	**Links with partner organisations**
A/R.6.177	Further savings required within Adults Services	This is the saving that will be delivered if the proposed changes to service-user care contributions policies are agreed (accounting for all appropriate benefits in contributions for day- and overnight-care, and adopting a preference for direct debits). If these changes are not agreed, additional savings will need to be found with Adults budgets in addition to savings already identified.	Adults	0	0	0	0	-282	-282	-282	0	0	0	-282	**0**	Green	↔	On track	0
A/R.7.110	Learning Disability - Joint Investment with Health Partners in rising demand	Negotiating with the NHS for additional funding through reviewing funding arrangements, with a focus on ensuring Council investment in demand pressures re matched appropriately by the NHS.	Adults	0	-900	0	0	0	-900	-900	0	0	0	-900	**0**	Green	↔	On track	0

Agenda Item No: 11

PEOPLE & COMMUNITIES RISK REGISTER

To:	**Adults Committee**
Meeting Date:	**15 November 2018**
From:	**Executive Director, People & Communities: Wendi Ogle-Welbourn**
Electoral division(s):	**All**
Forward Plan ref:	**N/A** *Key decision:* **No**
Purpose:	**To provide an annual update of the current People and Communities Risk Register**
Recommendation:	**The Committee is asked to note and comment on the people and communities risk register**

	Officer contact:		***Member contacts:***
Name:	Denise Revens	Names:	Cllr Bailey
Post:	Executive Officer	Post:	Chair of Adults Committee
Email:	Denise.revens@cambridgeshire.gov.uk	Email:	anna.bailey@cambridgeshire.gov.uk
Tel:	01223 699692	Tel:	01223 706398

1. BACKGROUND

1.1 Cambridgeshire County Council have a corporate risk register and this is reported to the Audit and Accounts Committee as part of Performance report and reviewed annually at the General Purposes Committee.

1.2 In addition to the Corporate Risk Register, People and Communities have their own risk register which highlights the key strategic risks across People and Communities and links to the corporate risk register.

2. MAIN ISSUES

2.1 The People and Communities Risk Register contains the main strategic risks from across the whole Directorate which include Adults and these are reported to the Adults Committee on an annual basis and can be seen in Appendix 1. The main focus for Adults Committee would be the following risk areas:

1. Safeguarding
2. Partnership agreements with NHS being agreed
3. Recruitment and retention of the social care workforce
4. Market capacity
5. Demand Management

2.2 Overall, the strategic risks have remained similar to that of last year, but with more emphasis on recruitment and retention of social care workforce across both Adults and Childrens. In addition to a greater focus on market capacity to meet need, mainly within Adult services.

2.2 The People and Communities Risk Register is reviewed by Senior Officers on a monthly basis and there is also a mechanism which captures and monitors more operational risks across People and Communities.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

There are no significant implications for this priority.

3.2 Helping people live healthy and independent lives

There are no significant implications for this priority.

3.3 Supporting and protecting vulnerable people

There are no significant implications for this priority.

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

There are no significant implications within this category.

4.2 **Procurement/Contractual/Council Contract Procedure Rules Implications**

There are no significant implications within this category.

4.3 **Statutory, Legal and Risk Implications**

There are no significant implications within this category.

4.4 **Equality and Diversity Implications**

There are no significant implications within this category.

4.5 **Engagement and Communications Implications**

There are no significant implications within this category.

4.6 **Localism and Local Member Involvement**

There are no significant implications within this category.

4.7 **Public Health Implications**

There are no significant implications within this category.

This is a monitoring report and does not require relevant sign off

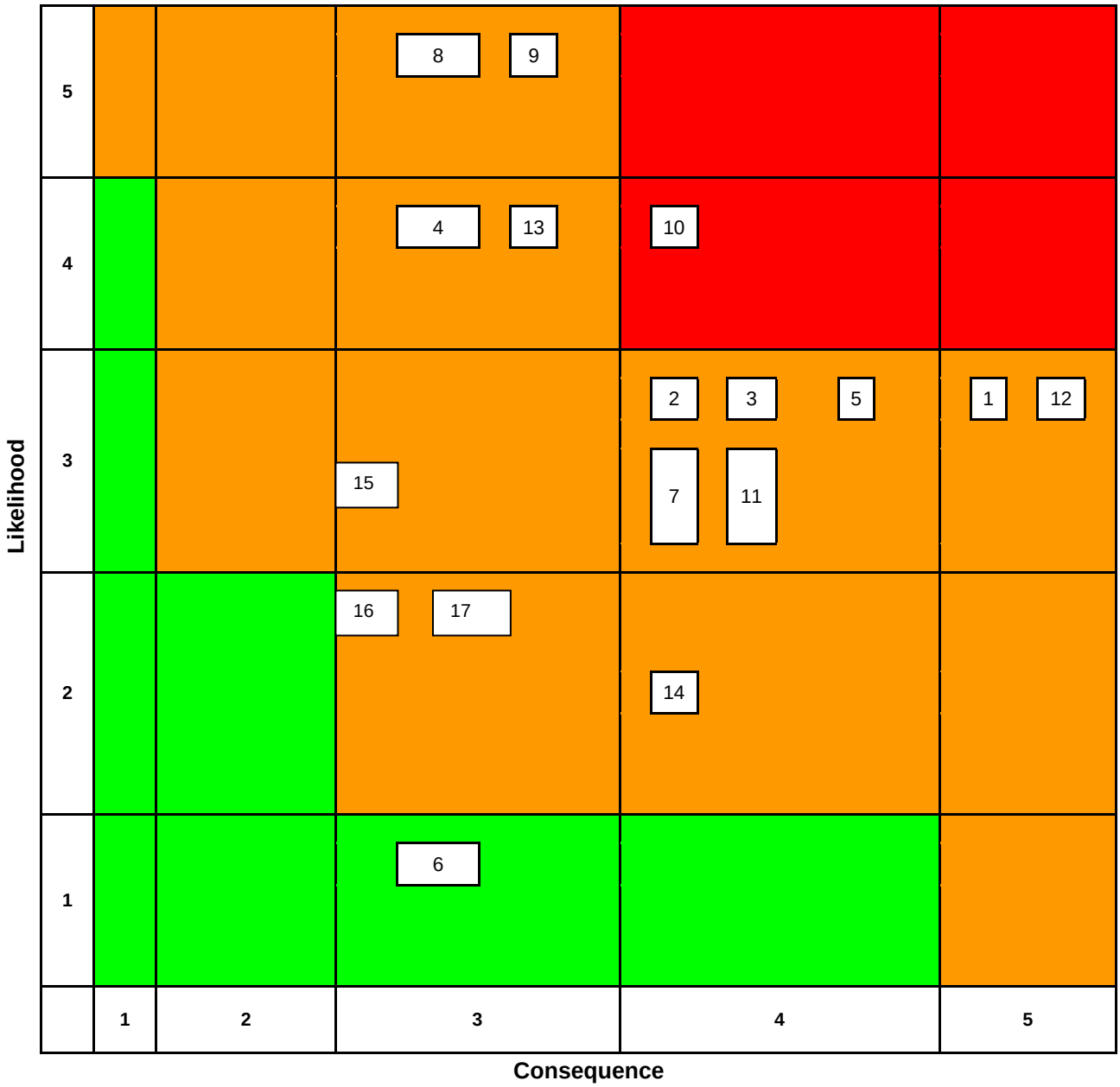
SOURCE DOCUMENTS

Source Documents	Location
Cambridgeshire County Council Corporate Risk Register	tom.barden@cambridgeshire.gov.uk

Appendix 1 – People & Communities Risk Register:

People & Communities Risk Summary

Entity: CCC People and Communities (including children), Risk Register open, Current Risk version, Risk is open, Residual Risk Level is at or greater than 1, Residual Risk Level is at or less than 25



Risk	Risk	Triggers	Residual Risk Level	Risk Appetite	Control
1	Failure of the Council's arrangements for safeguarding vulnerable children and adults	Children's Social Care: 1. Children's social care caseloads reach unsustainable levels as indicated by the unit case load tool 2. More than 25% of children whose referral to social care occurred within 12 months of a previous referral 3. Serious case review is triggered Adult Social Care (Inc. OPMH) 1. Care homes, supported living or home care agency suspended due to a SOVA (safeguarding of vulnerable adults) investigation 2. Serious case review is triggered 3. Outcomes of reported safeguarding concerns reveals negative practice	15	10	1. Multi-agency Safeguarding Boards and Executive Boards provides multi agency focus on safeguarding priorities and provides systematic review of safeguarding activity 2. Skilled and experienced safeguarding leads and their managers. 3. Comprehensive and robust safeguarding training, ongoing development policies and opportunities for staff, and regular supervisions monitor and instil safeguarding procedures and practice. 4. Continuous process of updating practice and procedures, linking to local and national trends, including learning from local and national reviews such as Serious Case Reviews. 5. Multi Agency Safeguarding Hub (MASH) for both Adults and Children supports timely, effective and comprehensive communication and decisions on how best to approach specific safeguarding situation between partners. 6. Robust process of internal Quality Assurance (QA framework) including case auditing and monitoring of performance 7. Whistleblowing policy, robust Local Authority Designated Officer (LADO) arrangements and complaints process inform practice 8. Regular monitoring of social care providers and information sharing meetings with other local organisations, including the Care Quality Commission 9. Joint protocols, practice standards and QA ensure appropriate joint management and case transfer between Children's Social Care and Enhanced and Preventative Services 10. Coordinated work between multi-agency partners for both Adults and Childrens. In particular Police, County Council and other agencies to identify child sexual exploitation, including supporting children and young people transitions to adulthood, with the oversight of the LSCB.

Risk	Risk	Triggers	Residual Risk Level	Risk Appetite	Control
					11. Audits, reviews and training provided to school staff, governors and settings. All schools must have child protection training every 3 years. Education CP Service supports schools and settings with safeguarding responsibilities
2	Failure to provide our legal requirement for every child of statutory school age to access a place and within a 'reasonable' distance from their home (less than 2 miles for 4 to 8 year olds and up to 3 miles for 9 to 16 year olds) / Cut in Government funding for school places	1.Demand on places outstrips sufficiency	12	12	1) The School Organisation plan and demographic forecasts are presently being updated for review and publication by Council. The School Organisation Plan provides details, by area, of the Council's response to the demographic changes affecting the county. 2) Sufficient resources identified in MTFP to support known requirements in the next 3 years if forecasts remain accurate 3) Quality of relationship with schools means schools have over-admitted to support the Council with bulge years 4) On-going review of the Council's five year rolling programme of capital investment. Priority continues to be given to the identified basic need requirement for additional school places 5) Annual School Capacity Review to the Department for Education (DfE) completed in a way which aims to maximise the Council's basic need funding allocation.
3	Insufficient capacity to manage organisational change	1. Staffing restructures result in loss of project and support staff	12	9	1. Resource focussed appropriately where needed to deliver savings. 2. P&C Management Team review business plans and check that capacity is aligned correctly. 3. Programme and project boards provide governance arrangements and escalation processes for any issues 4. Commissioning work plans regularly reviewed by Management Team. 5. P&C Management Team monitors achievement of savings on a monthly basis - including ensuring capacity is provided
4	Failure to attract or	1. Spend on agency staff within	12	12	1. Extensive range of qualifications and training available to

Risk	Risk	Triggers	Residual Risk Level	Risk Appetite	Control
	retain a sufficient social care workforce	social care workforce is above target as identified by Strategic Recruitment and Workforce Development Board 2. High turnover of social care staff as identified by Strategic Recruitment and Workforce Development Board 3.High vacancy rates of identified key social care roles as identified by Strategic Recruitment and Workforce Development Board			staff to enhance capability and aid retention 2. Increased use of statistical data to shape activity relating to recruitment and retention 3. ASYE programme ensures new social workers continue to develop their skills, knowledge and confidence. 4. Frontline managers support their own professional development through planning regular visits with frontline services 5. Cross directorate Social Care Strategic Recruitment and Workforce Development Board and Social Work Recruitment and Retention Task and Finish Group proactively address the issue of social care recruitment and retention. 6. Improved benefits and recognition schemes in place
5	Insufficient capacity of Early Help Services to support children, young people and families	1. The number of children and families on the 'prioritisation list' increases	12	9	1. Children's Centres services are available locally to families at Children Centres, clinics, pre-school settings and community facilities including libraries 2. Targeted parenting programmes and specialist activity groups (such as for those with anxiety or confidence difficulties) 3. Think family principles embedded in all services working with children, adults and families 4. Advice and coordination team at the MASH (early help hub) increases responsiveness 5. Ensure eligible families take up the offer of free education for 2 year olds and wider support and intervention with families is planned in an integrated way across early childhood sector
6	Insufficient availability of supported housing	1. Closure of supported housing schemes	3	3	Following public consultation, the Government has published its findings which confirm no fundamental

Risk	Risk	Triggers	Residual Risk Level	Risk Appetite	Control
	schemes due to the impact of Government funding changes	2. Proportion of adults with learning disabilities in their own home or with family below target (P&C Performance board) 3. Housing associations /providers suspend building of new schemes due to viability concerns			changes to the way that supported housing costs are to be funded. This means that there is greater confidence in the market, and that any negative financial implications for the council are unlikely to materialise.
7	Insufficient availability of affordable Looked After Children (LAC) placements	1. The number of children who are looked after is above the number identified in the LAC strategy action plan 2. % LAC placed out of county and more than 20 miles from home as identified in P&C performance dashboard 3. The unit cost of placements for children in care is above targets identified in the LAC strategy action plan	12	12	1. Regular monitoring of numbers, placements and length of time in placement by P&C management team and services to inform service priorities and planning 2. Maintain an effective range of preventative services across all age groups and service user groups 3. Looked After Children Strategy provides agreed outcomes and describes how CCC will support families to stay together and provide cost effective care when children cannot live safely with their families. 4. Community resilience strategy details CCC vision for resilient communities 5. P&C management team assess impacts and risks associated with managing down costs 6. Edge of care services work with families in crisis to enable children and young people to remain in their family unit
8	Insufficient availability of care services at affordable rates	1. Average number of ASC attributable bed-day delays per month is above national average	15	15	1. Data regularly updated and monitored to inform service priorities and planning 2. Maintain an effective range of preventative services

Risk	Risk	Triggers	Residual Risk Level	Risk Appetite	Control
		(aged 18+) as identified by P&C performance dashboard 2. Delayed transfers of care from hospital attributable to adult social care as identified by P&C performance dashboard 3. Home care pending list			across all age groups and service user groups including adults and OP 3. Community resilience strategy details CCC vision for resilient communities 4. Directorate and P&C Performance Board monitors performance of service provision 5. Coordinate procurement with the CCG to better control costs and ensure sufficient capacity in market 6. Take flexible approach to managing costs of care 7. Market shaping activity, including building and maintaining good relationships with providers, so we can support them if necessary 8. Capacity Overview Dashboard in place to capture market position 9. Residential and Nursing Care Project has been established as part of the wider Older People's Accommodation Programme looking to increase the number of affordable care homes beds at scale and pace. 10. Development of a Home Care Action Plan
9	Vulnerable aspects of the care market are fragile and therefore lack of market capacity to meet need	1. Provider organisation report not having capacity to deliver services when we need them 2. Length of time services users wait for appropriate services 3. Care home providers reduce the numbers of nursing beds (due to difficulty recruiting qualified nurses)	15	12	1. Support Home Care providers to develop recruitment and retention strategies 2. Workforce offer to the provider organisations based on the Skills for Care Learning and Development matrix. This includes Care Certificate, vocational qualifications (Level 2 - 5) and Social Care Commitment. 3. Assess impacts and risks to recruitment associated with managing down costs 4. Regular monitoring of provider staff members and vacancy levels of LD and LAC placements by Access to Resources Team 5. Home Care Development Manager in post who works with Homecare providers to develop workforce. 6. Access to Resources Team consider and challenge staff pay in tendering process

Risk	Risk	Triggers	Residual Risk Level	Risk Appetite	Control
					7. Regular engage with commissioners and providers to put action plans in place to resolve workforce issues
					11. Robust Controlling and monitoring procedures
					12. Effective use of PQQs (pre-qualifier questionnaires)
					13. Active involvement by commissioners in articulating strategic needs to the market
					14. Risk-based approach to in-contract financial monitoring
					15. New specifications for Voluntary and Community Sector (VCS) infrastructure support contract focuses on business development activity, consortia working, commissioning and procurement activity.
					16. Closer working between compliance agencies, & CCC (E.G. Env Health, H & S, Police, Fire service, CQC, Safeguarding etc.)
					17. Provide support to failing care homes to improve standards
					18. Robust performance management and processes to manager providers
					19. Managing Provider Failure Process in place to ensure care and support needs of those receiving services continue to be met if an provider fails
					20. Early Warning Dashboard in place, to alert to likelihood of provider failure
10	Partnership agreements with NHS are not agreed between partners	1. S75 with CPFT for mental health Social Workers is not signed off 2. S75 with CCG for pooled budget for LDP has not been agreed	16	16	1. Options and alternatives are being explored by Head of Mental Health and Assistant Director Commissioning
11	Children and young people do not reach their potential (educational attainment)	1. The attainment gap between vulnerable groups of CYP and their peers of school age are below targets identified in P&C performance dashboard 2. End of key stage 2 and 4 attainment targets are below those	12	12	1. Good governance of Accelerating Achievement and School Improvement strategies and action plans, checking progress and challenging performance, involving executive and service management
					2. Cambridgeshire School Improvement Board focused on securing improvements in educational outcomes in schools by ensuring all parts of the school system working together

Risk	Risk	Triggers	Residual Risk Level	Risk Appetite	Control
		identified in the P&C performance dashboard 3.Percentage of 16-19 years old who are NEET increases as identified in P&C performance board)			3. Effective monitoring, challenge, intervention and support of school and setting 4. Develop all children's services to include educational achievement as a key outcome 5. 18-25 team supports care leavers to remain in education or helps them find employment or training 6. A joint approach to support and promote good mental health for CYP has been developed with and for schools and a programme is in place which is supported by Learning, Public Health and voluntary partners 7.Provides support and guidance to schools to support the stability of educational placements and transition to post 16 for LAC 8. Cambridgeshire School Improvement Board improves educational outcomes in schools by all parts of the school improvement system working together. 9. Residual Information, Advice and Guidance function overseen by the local authority focuses on the most vulnerable
12	Failure of information and data systems, particularly with the implementation of MOSAIC	1. Amount of time P&C Business Systems (Social Care, LEA, Case Management) are working and available (uptime) is below Service Level Agreement (SLA) levels 2 System availability due to infrastructure issues (network, end-user devices, SAN etc.) is below	15	15	1. Individual Services Business Continuity Plans. 2. LGSS IT Disaster Recovery Plan 3. LGSS IT service resilience measures (backup data centre, network re-routing). 4. Version upgrades to incorporate latest product functionality 5. Training for P&C Business systems prior to use 6. Information sharing agreement

Risk	Risk	Triggers	Residual Risk Level	Risk Appetite	Control
		SLA levels. 3 Amount of time data-sharing with partners is impossible as a result of system failure.			7. Backup systems for mobile working 8. Backup systems for P&C Business Systems 9. Corporate (Information Governance Team) monitor data handling and security position and improvements 10. Robust MOSAIC programme has been established and a clear plan for implementation is in place
13	Failure of key partnerships	1. Section 75 agreements not adhered to 2. Joint commissioning arrangements break down 3. Break down of key partnership groups (e.g. LSCB or Public Services Board)	12	12	1. Local Safeguarding Children's Board (LSCB) and Adult Safeguarding Board have oversight of multi-agency safeguarding arrangements 2. Data sharing protocol agreed through Public Service Board 3. Cambridgeshire Executive Partnership Board oversees joint working between adults social care and health and monitors Better Care Fund 4. Joint commissioning unit monitors and oversees joint commissioning of child health service 5. School Improvement Board improves educational outcomes in schools by all parts of the school improvement system working together. 6. MASH brings together children's social care, the Police, Probation, the Fire Service, NHS organisations, key voluntary sector organisations, Peterborough City Council and adult social care providing multi agency focus on safeguarding priorities and provides systematic review of safeguarding activity 7. Clear communication strategies in place 8. Monitoring and performance management of contracts 9. Effective governance and monitoring of Section 75 agreements and joint commissioning arrangements through Monitoring and Governance Groups and Committees. 10. Newly developed Communities and Partnerships Committee aims to enhance the development of working across partnerships

Risk	Risk	Triggers	Residual Risk Level	Risk Appetite	Control
14	Failure to work within regulation and/or regulatory frameworks	1. Poor inspection and/or ombudsman results 2. Higher number of successful legal challenges to our actions/decisions 3. Low assurance from internal audit	8	8	1. LGSS legal team robust and up to date with appropriate legislation. 2. Service managers share information on changes in legislation by the Monitoring Officer, Government departments and professional bodies through Performance Boards 3. Inspection information and advice handbook available which is continually updated 4. Code of Corporate Governance 5. Community impact assessments required for key decisions 6. Programme Boards for legislative change (e.g. Care Act Programme Board) 7. Training for frontline staff on new legislation 8. Involvement in regional and national networks in children's and adults services to ensure consistent practice where appropriate 9. P&C have made arrangements for preparing within Inspections 10. Next Steps Board oversees preparation for Ofsted inspections of services for children in need of help and protection
15	Failure of the council to prevent and delay demand for statutory interventions	Increased cost pressures in both adult social care and children's services, and resultant increases in packages and interventions. Reduction in positive outcomes for residents.	9	9	1. Formal demand management approach led by the Communities and Safety Service Directorate, and overseen by the Communities and Partnerships Committee. 2. Development and agreement of the Think Communities strategy – a public sector system wide approach to designing and delivering services with and for communities, and developing community based alternatives to statutory interventions. 3. Continued investment in, and monitoring of, VCS activity to ensure it is aligned to our overall demand management objectives.

Risk	Risk	Triggers	Residual Risk Level	Risk Appetite	Control
					4. Regular monitoring of preventative demand management activity, to ensure it remains relevant and is meeting need.
16	Increased prevalence of adolescent young people entering the criminal justice system.	Existing preventative activity does not meet the needs and behaviours of young people. High demand for some crime types resulting in reduced levels of intervention from some of our partners.	6	6	1. Continued development of the shared services Youth Offending Service with Peterborough, ensuring best practice is shared and resources are flexed where they are most needed.
					2. Development of the statutory youth justice board to ensure a system wide approach is taken to supporting adolescent young people.
					3. Continued development of positive interventions, including National Citizen Service, to engage proactively with young people.
17	Increased demand for domestic abuse and sexual violence services.	Increased prevalence of DASV incidents being reported to the council and the police.	6	6	1. System wide governance of DASV services by a multiagency partnership group.
					2. Review existing service provision to ensure it meets current and forecast demand.
					3. Strengthen the relationships between social care and DASV services to ensure a seamless pathway is in place.

ADULTS POLICY AND SERVICE COMMITTEE AGENDA PLAN	Published on 1 November 2018 Updated 6 November 2018	Cambridgeshire County Council	**Agenda Item: 12 A**

Notes

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

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

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

The following are standing agenda items which are considered at every Committee meeting:
- Minutes of previous meeting and Action Log;
- Finance and Performance Report;
- Agenda Plan, and Appointments to Outside Bodies.

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for reports	Agenda despatch date
13/12/18	Minutes and Action Log	Democratic Services	Not applicable	30/11/18	05/12/18
	Service Committee Review of Draft Revenue and Capital Business Planning Proposals for 2019-20 to 2023-24	W Ogle-Welbourn	Not applicable		
	Finance and Performance Report	S Howarth	Not applicable		
	Agenda Plan, Appointments and Training Plan	Democratic Services	Not applicable		
10/01/19	Minutes and Action Log	Democratic Services	Not applicable	21/12/18	31/12/18

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for reports	Agenda despatch date
	Adults Self-Assessment	C Black	Not applicable		
	Delayed Transfers of Care – progress report	C Black / W Patten	Not applicable		
	CPFT –Six monthly report	F Davies / O Hayward	Not applicable		
	Finance and Performance Report	S Howarth	Not applicable		
	Agenda Plan, Appointments and Training Plan	Democratic Services	Not applicable		
14/02/19 Provisional meeting				*01/02/19*	*05/02/19*
21/03/19	Minutes and Action Log	Democratic Services	Not applicable	08/03/19	12/03/19
	Finance and Performance Report	S Howarth	Not applicable		
	Agenda Plan, Appointments and Training Plan	Democratic Services	Not applicable		
14/04/19 Provisional meeting				*01/04/19*	*05/04/19*
16/05/19	Minutes and Action Log	Democratic Services	Not applicable	03/05/19	08/05/19
	Full Evaluation of Neighbourhood Cares (May 2019)	L Tranham / C Black	Not applicable		
	Finance and Performance Report	S Howarth	Not applicable		
	Agenda Plan, Appointments and Training Plan	Democratic Services	Not applicable		
13/06/19 Provisional meeting				*31/05/19*	*05/06/19*

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for reports	Agenda despatch date
04/07/19	Minutes and Action Log	Democratic Services	Not applicable	21/06/19	26/06/19
	Finance and Performance Report	S Howarth	Not applicable		
	Agenda Plan, Appointments and Training Plan	Democratic Services	Not applicable		
15/08/19 Provisional meeting				*02/08/19*	*07/08/19*
12/09/19	Minutes and Action Log	Democratic Services	Not applicable	31/08/19	04/09/19
	Finance and Performance Report	S Howarth	Not applicable		
	Agenda Plan, Appointments and Training Plan	Democratic Services	Not applicable		
10/10/19				28/09/19	02/10/19
07/11/19				25/10/19	30/11/19
12/12/19				29/11/19	04/12/19
16/01/20				03/01/19	08/01/20
13/02/20 Provisional date				*31/01/20*	*05/02/20*
12/03/20				28/02/20	04/03/20
23/04/20 Provisional date				*10/04/20*	*15/04/20*

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for reports	Agenda despatch date
21/05/20				08/05/20	13/05/20

To be programmed:

- Review of the number of people waiting for a change to their current domiciliary care service, or for a new package of domiciliary care (monitoring item identified at meeting on 8 March 2018)
- Adult Early Help / Prevention / Early Intervention (J Galwey)
- Learning Disability Partnership Section 75 and pooled budget arrangements (Will Patten)

Agenda Item No: 12b

Adults Committee Training Plan 2018/19 – updated 6 November 2018

Below is an outline of dates and topics for potential training committee sessions and visits. The preference would be to organise training and visits prior to Committee meetings and utilising existing Reserve Committee dates:

Date	Timings	Topic	Presenter	Location	Audience
12 April 2018	2:30 - 4:30pm	Adults Positive Challenge	Geoff Hinkins	KV Room	Completed
Friday 12 October 2018	10.30am – 12.30pm This overview will be on the agenda at this Members seminar	An overview of Mental Health	Katrina Anderson	Kreis Viersen Room, Shire Hall, Cambridge.	Completed
Friday 26 October 2018	9.00am – 5.00pm	A service-users journey Induction to early intervention and prevention: - ATT - Adults early help - Sensory - Reablement	Jackie Galwey	Various	Completed
Tuesday 6 November 2018	11.30am -1.00pm	Commissioning Services – what services are commissioned and how our services are commissioned across P&C	Oliver Hayward / Shauna Torrance	KV Room	Completed
Friday 16 November 2018 **OR**	10.30am – 12.30pm This overview will be on the agenda	An overview of the Adults Social Care: - Support plans - Advocacy - Assessments - Performance To include LD, MASH, DoLs	Jackie Galwey	*Amunsden House / Hinchingbrooke Hospital*	All Adults Members

Date	Timings	Topic	Presenter	Location	Audience
Wednesday 20 February 2019	at this Members seminar				
Tuesday 4 December 2018	9.00am – 5.00pm	A service-users journey Introduction to Learning Disability / Physical Disability	Tracey Gurney	TBC	
14 February 2019 (Utilise reserve meeting)	2.00pm - 5.00pm	Safeguarding: - Overview of safeguarding - Visit to the Multi-agency Safeguarding Hub (MASH)	Helen Duncan	Chord Park	All Adult Members
March 2019 - Date TBC		An overview of the Council's work in relation to Carers	Helen Duncan	March 2019	
TBC	2.00pm – 5.00pm	An overview of Adults social care finance	Stephen Howarth	TBC	All Adults Members
As and when required		Neighbourhood cares	Louise Tranham	1 Member (tba)	Please contact Lesley Hart to arrange a visit or for further information.
		Counting Every Adult	Tom Tallon	1 Member (tba)	
		LD Provider Services	Emily Wheeler	1 Member (tba)	
		Discharge Planning Team	Social Worker	1 Member (tba)	

Reserve Committee dates for 2018/19:

- 14 February 2019