HEALTH COMMITTEE

Cambridgeshire County Council

Date:Thursday, 13 September 2018

Democratic and Members' Services
Fiona McMillan
Deputy Monitoring Officer

13:30hr

Shire Hall
Castle Hill
Cambridge
CB3 0AP

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

AGENDA

Open to Public and Press

CONSTITUTIONAL MATTERS

1.	**Apologies for absence and declarations of interest** *Guidance on declaring interests is available at http://tinyurl.com/ccc-conduct-code*	
2.	**Minutes of the meeting on 12 July 2018**	**5 - 12**
3.	**Action Log** *To follow.*	
4.	**Petitions**	

DECISIONS

5.	**Finance and Performance Report - July 2018**	**13 - 32**
6.	**Update on Air Quality and Health across Cambridgeshire**	**33 - 46**

The Health Committee comprises the following members:

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

Councillor David Connor Councillor Lynda Harford Councillor David Jenkins Councillor Linda Jones Councillor Kevin Reynolds Councillor Simone Taylor Councillor Peter Topping and Councillor Susan van de Ven

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

Clerk Name: Daniel Snowdon

Clerk Telephone: 01223 699177

Clerk Email: Daniel.Snowdon@cambridgeshire.gov.uk

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HEALTH COMMITTEE: MINUTES

Date: Thursday 12 July 2018

Time: 1.30pm to 4.05pm

Present: Councillors C Boden, A Bradnam (substituting for Cllr van de Ven), D Connor, L Harford, P Hudson (Chairman), D Jenkins, L Jones, S Taylor P Topping and S van de Ven.

District Councillors G Harvey and J Tavener

Apologies: County Councillor van de Ven
District Councillor Cornwell

122. DECLARATIONS OF INTEREST

Councillor Taylor made a non-statutory declaration regarding

123. MINUTES AND ACTION LOG: 17th MAY 2018

The minutes of the meeting held on 17th May 2018 were agreed as a correct record and signed by the Chairman,

The Action Log was noted including the following update:

Minute 108 – Information had been received from the Clinical Commissioning Group (CCG) regarding the pharmacy at the re-located GP Out of Hours base at Addenbrooke's and would be circulated following clarification of certain points with partner organisations.

124. CO-OPTION OF DISTRICT MEMBERS

It was resolved unanimously to co-opt the following District Councillors as non-voting members of the Committee:

- from Cambridge City Council:
  Cllr Nicky Massey
- from East Cambridgeshire District Council:
  Cllr Carol Sennitt
- from Huntingdonshire District Council:
  Cllr Jill Tavener
- from South Cambridgeshire District Council:
  Cllr Geoff Harvey
- from Fenland District Council:
  Councillor Mike Cornwell

125. PETITIONS

There were no petitions.

126. EATING DISORDER SERVICE UPDATE

Before the report was introduced the Director of Public Health drew attention to advice provided to Health Committee members from the Monitoring Officer and the Director of Public Health regarding paragraph 2.6 of the report. It would not be appropriate for a member of the Health Committee given their scrutiny role to undertake the role of facilitator at a meeting between the Trust and Mr Hart.

Introducing the report, the Chief Executive of Cambridgeshire and Peterborough Foundation Trust (CPFT) informed the Committee that the action plan was fully implemented however, the service was constantly seeking improvement and there was further work required regarding care planning. Improvements had been implemented regarding staff supervision with increased regularity, improved recording of supervision on an electronic system and improved supervision notes which were also monitored. Mandatory training had been introduced that related to the sharing of information for staff and a family liaison officer had been appointed to work with and support bereaved families. The Trust also liaised with bereavement support provided by the Council.

The complaints management process had improved however the 30 day target response time was regularly not met and therefore close monitoring was taking place.

The Chief Executive informed Members that for serious incidents that involve multiple organisations but were under the care of the eating disorder unity would be investigated by the Clinical Commissioning Group (CCG). A particular area of failing was often that doctors in accident and emergency centres may have not encountered severe anorexia before and there was a need to make clinical staff aware of the risks and how patients presented, for example blood results often masked the illness and the danger patients were in.

Attention was drawn to the work undertaken with universities. The transition from home to university was a time of significant change for adolescents and therefore a protocol was developed in 2014 working with the University of East Anglia and was currently under review in advance of the new intake of students at the end of the summer. There continued, however to be a risk when young people moved across the country for university.

The Chief Executive informed Members that it was the decision of the author of the Marsipan guidelines to remove the case study from the appendix and would, with the permission of Mr Hart, will ask for the case study to be included following the issuing of the Local Government Ombudsman's report.

The Committee was informed that the Chief Executive now chaired monthly performance and risk meetings at which the executive team were able to examine service pressures, risks and delivery for each service. A decision was taken recently decision to pause Phoenix centre, eating disorder unit following meetings where concerns over changing needs of young people were raised. A community eating disorder service had been developed which had resulted in fewer admissions. Therefore as the service was changing, re-modelling work was required in order to ensure care quality and was anticipated that it would re-open in October 2018.

In conclusion the Chief Executive recognised the Trust's failings and had responded seriously to the issues raised. However, she recognised that there was further work to be carried out.

Discussing the report, members:

- In drawing attention to section 2.2 of the report commented that students from Cambridgeshire could attend universities around the country and therefore it was essential that learning needed to be shared nationwide.

- Noted that CPFT had worked with Cambridge University and their counselling services. Chancellors and Vice-Chancellors had a keen awareness of mental health issues including eating disorders.

- Sought clarity regarding the Stop the Line process and questioned how staff were affected when they invoked the process incorrectly. Members were informed that Stop the Line was a standing order item at management meetings and was confident that staff were comfortable using it and were congratulated for doing so. When Stop the Line was called by a member of staff, senior duty managers would work to understand and address the issues. In most cases Stop the Line was invoked due to a mismatch between demand and resources.

- Noted the CQC report regarding the use of drawing pins and patients having hair straighteners. The Chief Executive explained that the intention was to provide as normal an environment as possible and patients did not have access to them without supervision, however the CQC recommended they were removed.

- Noted that the Trust had general and specialist services. It was explained that specialist services was changing and becoming ever more specialised in their nature. There was increasing complexity of cases seen across the country with young people's mental health and it was therefore necessary to review services in order to meet the needs of patients and the demand.

- Highlighted the financial pressures faced by students and questioned whether such pressures were exacerbating mental health issues. The Chief Executive explained that for adolescents with underlying eating disorders then the transition to university presented increased risks as food may not be provided or the individual cooked for.

At the discretion of the Chairman, Mr Hart addressed the Committee and began by thanking the Committee for scrutinising CPFT and the Eating Disorder Service. Mr Hart expressed frustration that answers to questions that had been promised but not yet received. Mr Hart emphasised that his daughter's illness was treatable and drew attention to the care she received from the Eating Disorder Unit and informed the Committee that the Cambridgeshire coroner was looking into deaths of a similar nature.

In response the Chief Executive CPFT informed the Committee that services had improved and the multi-disciplinary team was working effectively. It was not possible to eradicate all risk and unfortunately there were some patients that did not engage with therapy. The Chief Executive offered for Members to visit the Eating Disorder Service in order to see the work that took place there.

It was resolved to:

a) Note the contents of the report

b) Request a further update regarding the Phoenix Centre and the CPFT complaints process in 6 months.

127. HEALTH COMMITTEE WORKING GROUP UPDATE

The Committee considered the Working Group update report that informed the Committee of the health scrutiny activities that had been undertaken or planned since 15th March 2018. Attention was drawn to paragraphs 2.2.2 and 2.3.2 which recommended future scrutiny items for consideration by the Committee.

During discussion of the report:

- Members sought clarification regarding the International GP scheme and the number recruited. Officers confirmed that 115 had been recruited to the eastern region and were anticipated to arrive in October 2018. There would be an induction and training programme they would have to complete prior to practicing.

- Highlighted the difficulties experienced in obtaining work permits for people to work in the United Kingdom.

- Regarding the recommendation contained at paragraph 2.2.2 of the officer report, members expressed frustration at the progress made regarding the sharing of patient records across the partner organisations and suggested further work be undertaken with a view to scrutinise the relevant organisations.

- Noted that regarding paragraph 2.1.1 of the officer report not all small GP practices would open for additional hours but arrangements were in place for neighbouring larger ones to do so.

- Councillor Harvey volunteered to be appointed to the Cambridgeshire and Peterborough Foundation Trust quarterly liaison group.

It was resolved unanimously to:

a) Note the content of the quarterly liaison groups and consider recommendations that may need to be included in the forward agenda plan

b) Note the forthcoming schedule of meetings

c) Agree memberships for each of the quarterly liaison meetings.

128. HEALTH COMMITTEE TRAINING PROGRAMME

The Committee received the Health Committee Training Programme that set out the training and development undertaken by the Committee in the 2017/18 municipal year and the training and development confirmed for the coming year.

Discussing the training plan, members

- Noted and agreed to the use of the reserve Committee date of 9th August to be utilised for Strategic Business Planning workshop.

- Commented and praised the high attendance levels at the training and development sessions.

- Confirmed that the Health in Fenland development session would take place at the Boathouse in Wisbech.

- Suggested development sessions regarding NHS apprenticeships for nurses at Cambridge University Hospitals, working permits for overseas health workers, recruitment and retention of staff at primary care surgeries and a briefing session regarding Health Trainers.

It was resolved unanimously to note the training plan.

129. NHS QUALITY ACCOUNTS – HEALTH COMMITTEE FINAL RESPONSE TO QUALITY ACCOUNTS 2017/18

The Committee received a report that set out the Health Committee final responses to the NHS Quality Accounts. The Chairman thanked those involved in the production of the responses to the Quality Accounts, in particular Councillor Linda Jones.

In discussion Members

- Commented that a summary of issues that had arisen throughout the year would have been helpful to add to the commentary.

- Questioned whether the responses to the Quality Accounts had been included in the published versions. Officers agreed to check whether they had been included or not. **ACTION**

It was resolved to:

Note the statements and responses sent to the NHS Provider Trusts.

130. FINANCE AND PERFORMANCE REPORT – MAY 2018

The Committee received the May 2018 iteration of the Finance and Performance Report. Officers reported a balanced forecast outturn for the Public Health Directorate.

During Discussion of the report:

- Questioned the figures relating to the smoking cessation service. It was explained that accruals were completed at year end which put a credit into the following financial year until invoices were received and smoking cessation services always ran 2 months behind. There had also been challenges regarding back logs of invoices from the Clinical Commissioning Group and the transition to the new Enterprise Resource Planning (ERP) system.

- Welcomed appendix 7 of the report but queried how the allocated funding was being used. Officers informed the Committee that detailed information was now available and would be circulated to Members. **ACTION**

- Queried the monitoring of the provision of children's centres. Members were informed that monitoring was based on feedback received. Officers commented that they were mindful of not reducing the offer and advised that they were producing a report that could be presented to a future meeting of the Committee. Members requested that the report be an outcomes based assessment. **ACTION**

- Requested that information regarding the Heathy Fenland Fund be provided as an appendix to the next iteration of the report. **ACTION**

- Questioned the overheads paid to LGSS and whether value for money was being achieved.

- Emphasised the benefits of interventions for cycle and pedestrian safety as an investment in the future. It was requested that officers explore ways to find funds in order to avoid any reduction in the "Bikeability" scheme. **ACTION**

It was resolved unanimously:

> To review and comment on the report and to note the finance and performance position as at the end of May 2018.

131. ANNUAL PUBLIC HEALTH PERFORMANCE REPORT 2017/18

The Committee received the annual Public Health Performance Report 2017/18. In presenting the report officers explained that the covering report highlighted areas that were not reported within in the Finance and Performance report.

Discussing the paper, members

- Welcomed the report and the evidence contained within the appendices and recommended the report as background reading to new members of the Committee. Appendix A, members commented was easier to follow as it was more difficult to understand what was working well in Appendix B.

- Expressed concern regarding the problems identified within the Drug and Alcohol service and requested information how the challenges were being addressed over the course of the next few months. Officers informed the Committee that new contracts have Key Performance Indicators that can be reported to the Committee following criticism that data from existing contracts did not provide answers.

- Were surprised to see the pharmacy was least effective in relation to smoking cessation. It was explained that there had been difficulties in recruiting and engaging with pharmacies which was experienced nationwide.

- Noted that the report focussed on process rather than outcomes. Officers explained that there were Key Performance Indicators built into the contracts and it was possible to provide a future report focussed on outcomes.

- Questioned whether regarding significant procurement exercises there was scope for greater Member involvement at an earlier stage of the procurement process.

Officers agreed to investigate further the possibility of earlier Member involvement. **ACTION**

- Noted that there were issues with receiving notifications of birth from hospitals and there was a focus on antenatal services targeting the most vulnerable families.

- Drew attention to the issues raised within the report and would therefore welcome future reports to the Committee that addressed the issues raised, in particular children's health checks and drug and alcohol services.

- Expressed concern that the Committee had decided not make the transition for nursery nurses to carry out health checks yet there appeared to be too few health visitors to provide the service.

It was resolved unanimously

a) To note the information in the Annual Public Health Performance Report (2017/18)

b) To request a report in 3 months regarding Health Visitors and recruitment and retention

132. LOCAL AUTHORITY HEALTHCARE PUBLIC HEALTH ADVICE SERVICE (CORE OFFER) TO CAMBRIDGESHIRE AND PETERBOROUGH CLINICAL COMMISSIONING GROUP: 2017/2018 ANNUAL REVIEW

The Committee received a report that provided a brief annual report covering the services provided by the Cambridgeshire County Council and Peterborough City Council Local Authority Healthcare Public Health Advice Service to NHS Cambridgeshire and Peterborough Clinical Commissioning Group for 2017/18.

During the course of discussion Members:

- Questioned whether the level of advice provided by the Public Health Advice Service was resource limited and whether it should be expanded through additional funding through the Clinical Commissioning Group (CCG). Officers explained that while the service was resource limited expansion was difficult as guidance made provision for 2.5 Public Health Consultants budgetary pressures had resulted in the provision being reduced, therefore it would challenging to agree funding from the

- Noted that reports would be presented regarding the Fenland Fund and falls prevention.

- Commented that it was difficult to evaluate the effectiveness of the work without supporting evidence and figures. Officers explained there were a large number of policy reviews that were tracked and Public Health consultants provided the directional steer for the polices.

It was resolved unanimously to:

Note the 2017/18 annual review of the Cambridgeshire County Council and Peterborough City Council Local Authority Healthcare Public Health Advice Service to the CCG and comment as appropriate

133. HEALTH COMMITTEE AGENDA PLAN AND APPOINTMENTS TO OUTSIDE BODIES

The Committee examined its agenda plan, taking into account various additions identified at the meeting, and also considered the appointment of a Member to the Papworth Hospital NHS Foundation Trust Council of Governors.

It was resolved unanimously to:

(i) note the Forward Agenda Plan, subject to the following changes made in the course of the meeting:

a) reserve date scheduled for 9th August to be utilised as a Strategic Business Planning Workshop

b) 13 September 2018 – add an item regarding Air Quality.

c) 11 October 2018 – add an item reporting on the Public Health Reserves (ear marked) including: Falls Prevention, Fenland Fund and Let's Get Moving

(ii) appoint Councillor Linda Jones to the Papworth Hospital NHS Foundation Trust Council of Governors.

Chairman

Agenda Item No: 5

FINANCE AND PERFORMANCE REPORT – JULY 2018

To:	**Health Committee**
Meeting Date:	**13th September 2018**
From:	**Director of Public Health** **Chief Finance Officer**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable** ***Key decision:*** **No**
Purpose:	**To provide the Committee with the July 2018 Finance and Performance report for Public Health.** **The report is presented to provide the Committee with the opportunity to comment on the financial and performance position as at the end of July 2018.**
Recommendation:	**The Committee is asked to review and comment on the report and to note the finance and performance position as at the end of July 2018.**

	Officer contact:		***Member contacts:***
Name:	Martin Wade	Names:	Cllr Hudson
Post:	Strategic Finance Business Partner	Post:	Health Committee Chair
Email:	martin.wade@cambridgeshire.gov.uk	Email:	Peter.hudson@cambridgeshire.gov.uk
Tel:	01223 699733	Tel:	01223 706398 (office)

1.0 BACKGROUND

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

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

2.0 MAIN ISSUES IN THE JULY 2018 FINANCE & PERFORMANCE REPORT

2.1 The July 2018 Finance and Performance report is attached at Appendix 1.

2.2 A balanced budget was set for the Public Health Directorate for 2018/19, incorporating savings as a result of the reduction in Public Health grant.

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

The July 2018 Finance and Performance report (F&PR) is attached at Appendix 1 and shows the forecast outturn for the Public Health Directorate is currently a balanced position.

Further detail on the outturn position can be found in Appendix 1.

2.3 The Public Health Service Performance Management Framework for June 2018 is contained within the report. Of the thirty one Health Committee performance indicators, seven are red, four are amber, seventeen are green and three have no status.

3.0 ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

3.1.1 There are no significant implications for this priority.

3.2 Helping people live healthy and independent lives

3.2.1 There are no significant implications for this priority

3.3 Supporting and protecting vulnerable people

3.3.1 There are no significant implications for this priority

4.0 SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

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

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

4.2.1 There are no significant implications for this priority

4.3 Statutory, Legal and Risk Implications

4.3.1 There are no significant implications within this category.

4.4 Equality and Diversity Implications

4.4.1 There are no significant implications within this category.

4.5 Engagement and Communications Implications

4.5.1 There are no significant implications within this category.

4.6 Localism and Local Member Involvement

4.6.1 There are no significant implications within this category.

4.7 Public Health Implications

4.7.1 There are no significant implications within this category.

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

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

From: Martin Wade **Agenda Item No: 5 – Appendix 1**

Tel.: 01223 699733

Date: 11 July 2018

Public Health Directorate

Finance and Performance Report – July 2018

1 SUMMARY

1.1 Finance

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

1.2 Performance Indicators

Monthly Indicators	Red		Amber	Green	No Status	Total
Jun (No. of indicators)	7		4	17	3	31

2. INCOME AND EXPENDITURE

2.1 Overall Position

Forecast Outturn Variance (Jun) £000	Service	Budget for 2018/19 £000	Actual to end of Jul 18 £000	Forecast Outturn Variance £000	Forecast Outturn Variance %
0	Children Health	9,266	1,576	0	0%
0	Drug & Alcohol Misuse	5,625	1,177	0	0%
0	Sexual Health & Contraception	5,157	662	0	0%
0	Behaviour Change / Preventing Long Term Conditions	3,812	126	0	0%
0	Falls Prevention	80	2	0	0%
0	General Prevention Activities	56	24	0	0%
0	Adult Mental Health & Community Safety	256	-9	0	0%
0	Public Health Directorate	2,019	475	0	0%
0	**Total Expenditure**	**26,271**	**4,033**	**0**	**0%**
0	Public Health Grant	-25,419	-12,916	0	0%
0	s75 Agreement NHSE-HIV	-144	144	0	0%
0	Other Income	-40	-0	0	0%
0	Drawdown From Reserves	-39	0	0	0%
0	**Total Income**	**-25,642**	**-12,772**	**0**	**0%**
0	**Net Total**	**629**	**-8,739**	**0**	**0%**

The service level budgetary control report for 2018/19 can be found in appendix 1.

Further analysis can be found in appendix 2.

2.2 Significant Issues

A balanced budget has been set for the financial year 2018/19. Savings totalling £465k have been budgeted for and the achievement of savings will be monitored through the monthly savings tracker, with exceptions being reported to Heath Committee and any resulting overspends reported through this monthly Finance and Performance Report.

2.3 Additional Income and Grant Budgeted this Period (De minimus reporting limit = £160,000)

The total Public Health ring-fenced grant allocation for 2017/18 is £26.253m, of which £25.541m is allocated directly to the Public Health Directorate.

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

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

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

3. BALANCE SHEET

3.1 Reserves

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

4. PERFORMANCE SUMMARY

4.1 Performance overview (Appendix 6)

The performance data reported on relates to activity in June 2018.

Sexual Health (KP1 & 2)
Performance of sexual health and contraception services remains good with all indicators green.

Smoking Cessation (KPI 5)
This service is being delivered by Everyone Health as part of the wider Lifestyle Service.

- Performance indicators for people setting and achieving a four week quit have moved to Red.
- Public Health Outcomes Framework (PHOF) data for 2017 has been released suggesting smoking prevalence in Cambridgeshire is similar to the England figure
- Appendix 6 commentary provides further details.

National Child Measurement Programme (KPI 14 & 15)

- The coverage target for the programme was met. Year end data for the 2017/18 programme will be available at the end of 2018.
- Measurements for the 2018/19 programme are taken during the academic year and the programme will re-commence in September 2018.

NHS Health Checks (KPI 3 & 4)

- Indicator 3 for the number of health checks completed by GPs is reported on quarterly. For Q1 this indicator is reporting as red.
- Indicator 4 for the number of outreach health checks remains red although there is an upward trajectory.
- Further details of the refocus for the service are available in the commentary in Appendix 6.

Lifestyle Services (KPI 5,16-30)

- There are now 16 Lifestyle Service indicators reported on, the overall performance is good and shows 12 green, 1 amber and 3 red indicators.
- Appendix 6 provides further explanation on the red indicators for the personal health trainer service, proportion of Tier 2 clients completing weight loss interventions and smoking cessation.

Health Visitor and School Nursing Data (KPI 6-13)

The performance data provided reports on the Q1 (April –June 2018) for the Health Visiting and School Nurse service.

Health Visiting

- The breastfeeding target for 2018/19 will remain at 56% although this is recognised across the county that this is a challenging target. Performance indicator for the first quarter is at amber.
- Breastfeeding rates are very varied across Cambridgeshire and Appendix 6 provides more detail on this.
- Health visiting mandated checks (face to face antenatal contact with HV from 28 weeks) indicator is at red. A local target for 50% has been set in Cambridgeshire. Although the overall performance for this quarter has decreased by 1% this does not reflect the month on month improvements. Appendix 6 provides further details
- Health Visiting mandated checks for new birth visit with HV (within 14 days) indicator is green. Mandated checks for both 6-8 week review and 12-15 month review are both at Amber for this quarter. Cambridgeshire exceeds the national average for the 6-8 week review.

School Nursing

- Performance indicator 13 has been further broken down into number of calls made to the duty desk (13a) and number of young people who access advise and support though Chat Health (13b).
- In quarter 1 period the duty desk has received 801 calls offering immediate access to staff and support. Chat Health has been accessed by 742 children and young people in this quarter. More detail is available in Appendix 6

4.2 Health Committee Priorities

Priorities identified on 7 September 2017 are as follows:

- Behaviour Change
- Mental Health for children and young people
- Health Inequalities
- Air pollution
- School readiness
- Review of effective public health interventions
- Access to services.

4.3 Health Scrutiny Indicators

Priorities identified on 7 September 2017 are as follows

- Delayed Transfer of Care (DTOCs)
- Sustainable Transformation Plans
    - Work programme, risk register and project list
    - Workforce planning
    - Communications and engagement
    - Primary Care developments

The Health Committee has requested routine monthly data reports on the “Fit for the Future” programme circulated prior to meetings, these are being received sporadically. The remaining scrutiny priorities around communications and engagement and Primary Care Developments requires further consideration from the committee on reporting requirements.

APPENDIX 1 – Public Health Directorate Budgetary Control Report

Previous Outturn (Jun) £'000	Service	Budget 2018/19 £'000	Actual to end of July £'000	Outturn Forecast £'000	%
	Children Health				
0	Children 0-5 PH Programme	7,253	251	0	0%
0	Children 5-19 PH Programme - Non Prescribed	1,706	1,044	0	0%
0	Children Mental Health	307	281	0	0%
0	**Children Health Total**	**9,266**	**1,576**	**0**	**0%**
	Drugs & Alcohol				
0	Drug & Alcohol Misuse	5,625	1,177	0	0%
0	**Drugs & Alcohol Total**	**5,625**	**1,177**	**0**	**0%**
	Sexual Health & Contraception				
0	SH STI testing & treatment – Prescribed	3,829	617	0	0%
0	SH Contraception - Prescribed	1,176	45	0	0%
0	SH Services Advice Prevn Promtn - Non-Presribed	152	0	0	0%
0	**Sexual Health & Contraception Total**	**5,157**	**662**	**0**	**0%**
	Behaviour Change / Preventing Long Term Conditions				
0	Integrated Lifestyle Services	2,062	335	0	0%
0	Other Health Improvement	299	-47	0	0%
0	Smoking Cessation GP & Pharmacy	735	-231	0	0%
0	NHS Health Checks Prog – Prescribed	716	68	0	0%
0	**Behaviour Change / Preventing Long Term Conditions Total**	**3,812**	**126**	**0**	**0%**
	Falls Prevention				
0	Falls Prevention	80	2	0	0%
0	**Falls Prevention Total**	**80**	**2**	**0**	**0%**
	General Prevention Activities				
0	General Prevention, Traveller Health	56	24	0	0%
0	**General Prevention Activities Total**	**56**	**24**	**0**	**0%**
	Adult Mental Health & Community Safety				
0	Adult Mental Health & Community Safety	256	-9	0	0%
0	**Adult Mental Health & Community Safety Total**	**256**	**-9**	**0**	**0%**

Previous Outturn (Jun) £'000	Service	Budget 2018/19 £'000	Actual to end of July £'000	Outturn Forecast £'000	%
	Public Health Directorate				
0	Children Health	189	50	0	0%
0	Drugs & Alcohol	287	61	0	0%
0	Sexual Health & Contraception	164	38	0	0%
0	Behaviour Change	753	176	0	0%
0	General Prevention	199	55	0	0%
0	Adult Mental Health	36	8	0	0%
0	Health Protection	53	16	0	0%
0	Analysts	338	71	0	0%
0		**2,019**	**475**	**0**	**0%**
0	**Total Expenditure before Carry forward**	**26,271**	**4,033**	**0**	**0%**
0	**Anticipated contribution to Public Health grant reserve**	**0**	**0**	**0**	**0.00%**
	Funded By				
0	Public Health Grant	-25,419	-12,916	0	0%
0	S75 Agreement NHSE HIV	-144	144	0	0%
0	Other Income	-40	0	0	0%
	Drawdown From Reserves	-39	0	0	0%
0	**Income Total**	**-25,642**	**-12,772**	**0**	**0%**
0	**Net Total**	**629**	**-8,739**	**0**	**0%**

APPENDIX 2 – Commentary on Expenditure Position

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

Service	Budget 2018/19 £'000	Forecast Outturn Variance	
		£'000	%

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

Awarding Body : DofH

Grant	Business Plan £'000	Adjusted Amount £'000	Notes
Public Health Grant as per Business Plan	**26,253**	**26,253**	Ring-fenced grant
Grant allocated as follows;			
Public Health Directorate	25,419	25,419	
P&C Directorate	283	283	
P&E Directorate	130	130	
CS&T Directorate	201	201	
LGSS Cambridge Office	220	220	
Total	**26,253**	**26,253**	

APPENDIX 4 – Virements and Budget Reconciliation

	£'000	Notes
Budget as per Business Plan		
Virements		
Non-material virements (+/- £160k)		
Budget Reconciliation		
Current Budget 2018/19		

APPENDIX 5 – Reserve Schedule

Fund Description	Balance at 31 March 2018	2018/19		Forecast Closing Balance	Notes
		Movements in 2018/19	Balance at end July 2018		
	£'000	£'000	£'000	£'000	
General Reserve					
Public Health carry-forward	**1,040**	0	1,040	**1,040**	
subtotal	**1,040**	**0**	**1,040**	**1,040**	
Other Earmarked Funds					
Healthy Fenland Fund	300	0	300	200	Anticipated spend £100k per year over 5 years.
Falls Prevention Fund	378	0	378	259	Planned for use on joint work with the NHS in 2017/18 and 2018/19.
NHS Healthchecks programme	270	0	270	270	This funding will be used to install new software into GP practices which will identify patients for inclusion in Health Checks. The installation work will commence in June 2017. Funding will also be used for a comprehensive campaign to boost participation in NHS Health Checks.
Implementation of Cambridgeshire Public Health Integration Strategy	579	0	579	300	£517k Committed to the countywide 'Let's Get Moving' physical activity programme which runs for two years from July 2017-June 2019.
subtotal	**1,527**	**0**	**1,527**	**1,029**	
TOTAL	**2,567**	**0**	**2,567**	**2,069**	

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

Fund Description	Balance at 31 March 2018	2018/19		Forecast Closing Balance	Notes
		Movements in 2018/19	Balance at end July 2018		
	£'000	£'000	£'000	£'000	
General Reserve					
Joint Improvement Programme (JIP)	136	0	136	136	
Improving Screening & Immunisation uptake	9	0	9	9	£9k from NHS ~England for expenditure in Cambridgeshire and Peterborough
TOTAL	**145**		**145**	**145**	

APPENDIX 6 PERFORMANCE

	More than 10% away from YTD target
	Within 10% of YTD target
	YTD Target met

↓	Below previous month actual
↔	No movement
↑	Above previous month actual

The Public Health Service Performance Management Framework (PMF) for June 2018 can be seen within the tables below:

	Measures										
KPI no.	Measure	Period data relates to	Y/E Target 2018/19	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous period actual	Current period target	Current period actual	Direction of travel (from previous period)	Comments
1	GUM Access - offered appointments within 2 working days	May-18	98%	98%	100%	102%	G	99%	98%	98%	↓	
2	GUM ACCESS - % seen within 48 hours (% of those offered an appointment)	May-18	80%	80%	93%	116%	G	92%	80%	93%	↑	
3	Number of Health Checks completed (GPs)	Q1 (Apr - Jun18)	18,000	4500	3489	78%	R	N/A	4500	3489	↔	
4	Number of outreach health checks carried out	Jun-18	1,800	400	332	83%	R	78%	122	93%	↑	The Lifestyle Service is commissioned to provide outreach Health Checks for hard to reach groups in the community and in workplaces. The key challenge is securing access to workplaces in Fenland where there are high risk workforces. Mean while Wisbech Job Centre Plus have received sessions for staff and those claiming benefits. In addition sessions in community centres in areas that have high risk populations are booked. A mobile service is being considered. Performance in Fenland continues to be good with it currently hitting 106% of its monthly target. However performance in the rest of county has improved target has been achieved. The service is now asked to focus upon areas where there is higher risk of cardio vascular disease and where GP Health Checks are low.
5	Smoking Cessation - four week quitters	May-18	2154	295	195	66%	R	55%	162	69%	↑	•There has been some improvement which reflects new staff have now been recruited. there had bee a problem with ling term sickness and recruitment. • There is an ongoing programme to improve performance that includes targeting routine and manual workers (rates are known to be higher in these groups) and the Fenland area. •The most recent Public Health Outcomes Framework figures released in July 2018 with data for 2017) suggest the prevalence of smoking in Cambridgeshire is statistically similar to the England figure , 14.5% v 14.9%. All districts are now statistically similar to the England figure. Most notable has been the improvement in Fenland where it has dropped from 21.6% to 16.3%, making it lower than the Cambridge City rate of 17.0%

KPI no.	Measure	Period data relates to	Y/E Target 2018/19	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous period actual	Current period target	Current period actual	Direction of travel (from previous period)	Comments
6	Percentage of infants being breastfed (fully or partially) at 6 - 8 weeks	Q1 April - June 2018	56%	56%	53%	53%	A	50%	56%	53%	↑	The breastfeeding prevalence target will remain at 56% in 2018/19, although it is recognised that across the county this is a challenging target. Breastfeeding statistics have seen a 3% increase since the last reporting period. Analysis does show very different breastfeeding rates across the county. Breast feeding rates in South Cambridgeshire is 67% over this period, whilst the rates for East Cambs and Fenland are currently 33%. An action plan is in place and the Health Visitor Infant Feeding lead is working with acute midwifery units to attempt to improve the breastfeeding rates collaboratively. A pilot is to begin whereby mothers are contacted via telephone on discharge from hospital to offer an early follow up appointment to support breast feeding. In order to measure the impact and outcome of this pilot a change in process needs to take place within System One - this is being addressed. Overall however, the breastfeeding rates in Cambridgeshire remains higher than the national average of 44%. Breastfeeding prevalence rates will continue to be monitored closely, particularly in East Cambs and Fenland, with the aim of achieving the 56% target.
7	Health visiting mandated check - Percentage of first face-to-face antenatal contact with a HV from 28 weeks	Q1 April - June 2018	50%	50%	20%	20%	R	21%	50%	20%	↓	In Cambridgeshire a local target has been set for 50%, with the longer term goal of achieving a target of 90% by 2020. The overall performance this quarter has decreased by 1%. However, this does not reflect the month on month improvements in working towards this target. There was, in April an initial fall in performance to 14%, but then has been followed by significant improvement in June reaching 27% of face to face contacts completed. Looking at each individual areas, all have seen improvements with Huntingdon achieving 38%, East Cambs and Fenland reaching 37% and Cambs City and South reaching 13%. Whilst all areas need to continue to improve, a particular focus is required to improve the position in Cambs City and South. These improvements are in part due to the improvements in the notification process with midwifery, but also as a result of the health visiting team now beginning to recognise the importance of this assessment and are therefore beginning to embed this contact into their day to day working practice. An electronic process has been established with the Queen Elizabeth Hospital EH and went live two weeks ago. The clinical lead has had successful discussions with Hinchinbrook and Peterborough midwifery units and we are awaiting a 'go live' date. Once these hospital are established negotiations will then commence with Addenbrookes.
8	Health visiting mandated check - Percentage of births that receive a face to face New Birth Visit (NBV) within 14 days, by a health visitor	Q1 April - June 2018	90%	90%	95%	95%	G	95%	90%	95%	↔	The 10 - 14 new birth visit remains consistent each month and numbers are well within the 90% target.
9	Health visiting mandated check - Percentage of children who received a 6 - 8 week review	Q1 April - June 2018	90%	90%	85%	85%	A	84%	90%	85%	↑	The performance for the 6 - 8 week review has increased one percentile this quarter, from 84% in Q4 2017/18, to 85%. Cambridgeshire continues to exceed the national average for this visit, which in 2016/17 was 82.5%. Analysis of the data shows that the 90% target was achieved in both Cambs City and South (91%) and Hunts (95%), but East Cambs and Fenland only achieved 66%. This was a local capacity issue in East Cambs and Fenland. Consequently it was locally agreed not to prioritise the review, meaning completion levels in this area fell, impacting the county figure as a whole. The Area Manager is working with staff to ensure this is re-prioritised moving forward.
10	Health visiting mandated check - Percentage of children who received a 12 month review by 15 months	Q1 April - June 2018	95%	95%	85%	85%	A	85%	95%	85%	↔	Performance against the 12 month visit by 15 months target has remained at 85% this quarter. However if exception reporting is accounted for, this increases to a quarterly average of 95%, thus meeting the target. This quarter 72 visits were not wanted by the family and a further 90 were not attended. Staff working in the East Cambs and Fenland locality have now returned to offering this review as a home visit rather than in a clinic setting as data demonstrated that clinic appointments increased the number of people not attending. By returning to home visits there has been an increase in success of completing this assessment in this area.
11	Health visiting mandated check - Percentage of children who received a 2 -2.5 year review	Q1 April - June 2018	90%	90%	67%	67%	R	77%	90%	67%	↓	The number of two year old checks completed this quarter has declined, from 77% in Q4 2017/18 to 67%. If data is looked at in terms exception reporting, which includes parents who did not want/attend the 2 year check then the average percentage achieved for this quarter increases to 82%. During this quarter,137 appointments were not wanted and 118 were not attended. Both Cambs City and South and Huntingdon Districts have performed at 72% and 75% respectively, but East Cambs and Fenland only achieved 56% during this quarter. A decrease in performance is attributed to a change in delivery model for the East Cambridgeshire and Fenland team, who introduced development clinics to account for staffing and capacity issues. This is led to an increase in DNA's, however due to pre-booked appointments, the team are unable to return to home-visiting until July. This has now been addressed and performance is expected to improve next quarter. There has also been recruitment to 2.6fte Nursery Nurse posts. These are currently progressing through the recruitment process. One post will be placed in East Cambs and Fenland and the remaining will work in Cambs City. These posts will increase the teams capacity and ability to meet this target.
12	School nursing - Number of young people seen for behavioural interventions - smoking, sexual health advice, weight management, emotional health and well being, substance misuse or domestic violence	Q1 April - June 2018	N/A	N/A	100	N/A	N/A	N/A	N/A	100	N/A	Whilst the school nursing services has seen changes to the way it is delivered the service continues to offer face to face interventions to children and young people in settings relating to a range of subjects. There has been a fall in the number of interventions around emotional health and well being, although this may be attributed to the introduction of CHUMS Counselling and Talking Therapies service and Emotional Wellbeing Practitioners, who are offering services to children and young people and supporting existing services including schools and the School Nursing service.
13a	School nursing - number of calls made to the duty desk	Q1 April - June 2018	N/A	N/A	801	N/A	N/A	Not applicable	N/A	801	N/A	The school nursing service has developed over the last 12 months, which includes the introduction of a duty desk, which operates as a single point of access and CHAT Health, a text based support service for children and young people. As a result the information collected and reported has changed and therefore the measure provided in this report has been changed to reflect the services being accessed via the 5 - 19 services. The duty desk has received 801 calls during the quarter 1 period offering immediate access to staff for support, referral and advice. Chat Health has been accessed by 742 children and young people over the quarter. Analysis of the Chat Health attributes indicate that the service has been used to support an additional 11 CYP regarding sexual health, 27 for emotional health and well being concerns and 2 for substance misuse.
13b	School nursing - Number of children and young people who access health advices and support through Chat Health	Q1 April - June 2018	N/A	N/A	742	N/A	N/A	Not applicable	N/A	742	N/A	

KPI no.	Measure	Period data relates to	Y/E Target 2018/19	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous period actual	Current period target	Current period actual	Direction of travel (from previous period)	Comments
14	Childhood Obesity (School year) - 90% coverage of children in year 6 by final submission (EOY)	Jun-18	90%	90.0%	90.4%	100%	G	72.0%	90.0%	90.0%	↑	The National Child Measurement Programme (NCMP) has been completed for the 2016/17 academic year. The coverage target was met and the measurement data has been submitted to the PHE in line with the required timeline. The cleaned measurement data will be available at the end of the year.
15	Childhood Obesity (School year) - 90% coverage of children in reception by final submission (EOY)	Jun-18	90%	90.0%	93.5%	104%	G	70.0%	90.0%	90.0%	↑	
15	Overall referrals to the service	Jun-18	5610	1287	2591	201%	G	194%	393	185%	↑	
17	Personal Health Trainer Service - number of Personal Health Plans produced (PHPs) **(Pre-existing GP based service)**	Jun-18	1670	401	421	105%	G	91%	117	55%	↓	
18	Personal Health Trainer Service - Personal Health Plans completed **(Pre-existing GP based service)**	Jun-18	1252	301	264	88%	R	96%	88	82%	↓	This is being carefully monitored.
19	Number of physical activity groups held **(Pre-existing GP based service)**	Jun-18	730	175	221	126%	G	129%	51	116%	↓	The trend id downwards but the target is still exceeded.
20	Number of healthy eating groups held **(Pre-existing GP based service)**	Jun-18	495	120	168	140%	G	131%	35	186%	↑	
21	Personal Health Trainer Service - number of PHPs produced (Extended Service)	Jun-18	795	192	239	124%	G	167%	56	84%	↓	The trend is downwards but the year to date target is exceeded.
22	Personal Health Trainer Service - Personal Health Plans completed (Extended Service)	Jun-18	596	144	148	103%	G	87%	42	126%	↑	
23	Number of physical activity groups held (Extended Service)	Jun-18	913	219	159	73%	A	90%	64	91%	↑	
24	Number of healthy eating groups held (Extended Service)	Jun-18	627	150	198	132%	G	102%	44	181%	↑	
25	Proportion of Tier 2 clients completing the intervention who have achieved 5% weight loss.	Jun-18	30%	30%	22.0%	73.3%	R	17%	30%	31%	↑	
26	Proportion of Tier 3 clients completing the course who have achieved 10% weight loss	Jun-18	60%	60%	65.0%	108.3%	G	67.0%	60%	54.0%	↓	The trend is downward but the year to date target is exceeded.
27	% of children recruited who complete the weight management programme and maintain or reduce their BMI Z score by agreed amounts	Jun-18	80%	80%	80%	100.0%	G	N/A	80%	80%	↔	There have been ongoing issues with this services that reflect the national issues of recruitment and retention. This summer a different approach is being implemented that utilizes the summer school holiday period.

KPI no.	Measure	Period data relates to	Y/E Target 2018/19	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous period actual	Current period target	Current period actual	Direction of travel (from previous period)	Comments
28	Number of referrals received for multi factorial risk assessment for Falls Prevention	Jun-18	425	102	129	126%	G	121%	30	197%	↑	
29	Number of Multi Factorial Risk Assessments Completed - Falls Prevention	Jun-18	180	43	188	437%	G	406%	13	338%	↓	
30	Number clients completing their PHP - Falls Prevention	Jun-18	230	55	58	105%	G	100%	16	163%	↑	

* All figures received in July 2018 relate to June 2018 actuals with exception of Smoking Services, which are a month behind and Health Checks, some elements of the Lifestyle Service, School Nursing and Health Visitors which are reported quarterly.

** Direction of travel against previous month actuals

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

APPENDIX 7

PUBLIC HEALTH MOU 2018-19 UPDATE FOR Q1

This will be provided in the next F&PR report.

Agenda Item No: 6

Update on Air Quality and Health across Cambridgeshire

To:	**Health Committee**
Meeting Date:	**Thursday 13th September 2018**
From:	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**n/a** *Key decision:* **NO**
Purpose:	**To outline progress on air quality in Cambridgeshire to date and describe potential next steps.**
Recommendation:	**The Health Committee is asked to note and comment on progress to date and agree the next steps in paragraphs 3.1 - 3.6**

	Officer contact:		***Member contacts:***
Name:	Stuart Keeble	Names:	Councillor Peter Hudson
Post:	Consultant in Public Health	Post:	Chairman, Health Committee
Email:	Stuart.keeble@Peterborough.gov.uk	Email:	Peter.hudson@cambridgeshire.gov.uk
Tel:	07816 597855	Tel:	01223 706398 (office)

1 BACKGROUND

1.1 Cambridgeshire County Council Health Committee identified air quality as one of its priorities in September 2017. Discussions at subsequent committee meetings have outlined the complexities involved in addressing poor air quality and shown that the air quality agenda is not owned by a single organisation but rather different public sector organisations across the system are responsible for different aspects (i.e. monitoring is the responsibility of the District and City Councils, transport interventions lie with the County Council and Combined Authority – as the transport authority). This has made progress challenging. The aim of this paper is to provide the committee with an update of actions to date and to propose actions going forward.

2 Progress to date

In response to the issues raised a number of activities have been taken forward over the last nine months, namely:

- Air quality training for transport officers and others with an air quality remit.
- An air quality learning event for members and officers.
- Development of an air quality resource on Cambridgeshire Insight Website
- Continued engagement with the combined authority and transport leads (e.g. inputting into the public transport/bus review undertaken by the combined authority).
- Review of the City and District Councils Air Quality annual status reports and air quality action plans.

These are outlined in more detail below.

2.1 Air quality training event for Transport Managers and air quality leads

In recognition of the impact of transport infrastructure on air quality, Public Health commissioned external trainers to provide a half day training event in May on air quality for transport planners and districts/city councils air quality leads. The event focused on:

- The Health Impact of Air Pollution
- Traffic as a main source of air pollution (including the impact of Diesel Particulates)
- How transport planners can help to minimise the impacts
- The different responsibilities of the District and City Council's and the County Council on Air Quality.

The event also gave the chance for officers to meet colleagues working across the county from different departments and organisations and discuss how to work together more effectively.

In total 27 officers attended the training event, with representation from the City and district councils, the County Council, the Combined Authority, and the Greater Cambridge Partnership. An important action resulting from the event was the need to engage development management (planning officers) in air quality discussions and that future training if available should be focused towards them. Feedback from the event is summarised in Appendix A.

2.2 Air quality learning and sharing event

In June public health organised an Air Quality Learning and Networking Event in order to increase knowledge and promote closer working across Cambridgeshire on air quality. The

event brought together 32 elected members, officers from District/City and County Councils as well as representative from Parish Councils. Speakers included national and local experts and provided an opportunity to share knowledge and discuss how we can work together more effectively.

The event was rated as 'Good or Very good' by all those who completed the evaluation and the content was rated as extremely or very helpful by 14 out of 15 (full feedback provided in Appendix B)

A core part of the learning and networking event was to capture the views of attendees to inform next steps. Questions included:

1. What did attendees want from the day?
2. What is current level of knowledge (among residents, members and officers)?
3. What should be the next steps?

A summary of potential next steps identified during the workshop are summarised below. Where feasible/appropriate for public health to take forward these have been incorporated into the next steps outlined in paragraphs 3.1-3.6:

1. **Improved communication** (messages in plain English, targeting behaviour change, supported by evidence)
2. **Greater collaborative working** (engage the NHS, explore the possibility of creating a network/forum)
3. **Air quality embedded in decision making process** (e.g. local plans, procurement etc.)
4. **Training** (develop materials or training for officers, members and the public to raise awareness of Air Quality)
5. **Improved monitoring** (use mobile technology, expand monitoring network)
6. **Transport Interventions** (promote active travel, smart travel, bus fleet)

A more detailed summary of the question answers can be found in Appendix B along with the evaluation of the event.

2.3 **Development of an air quality section on the Cambridgeshire insight website**
Public health have been working with the Cambridgeshire Insight team to develop a new air quality section on the Cambridgeshire Insight website.
https://cambridgeshireinsight.org.uk/environment/airquality/
The site brings together local information including individual districts Air Quality Status Reports (ASR), data on Air Quality Management Areas (AQMAs) and links to national air quality monitoring data, and pollution forecasts.

2.4 **Continued engagement with the combined authority and transport leads**
Public Health contributed to the public transport/bus review undertaken by the Combined Authority, to ensure that the solutions consider the importance of a system approach to integrated transport and the importance of active travel. In addition, concerns were raised about the need for a solution that acknowledges the difference in access to transport in rural areas versus city areas across Cambridgeshire and Peterborough to prevent the widening of health inequalities.

2.5 **Review of the City and District Councils Air Quality annual status reports and air quality action plans.**
Public health have continued to review the air quality annual status reports (ASR) produced by the city and district councils, and have contributed to the Cambridge City Air Quality Action plan and Steering Group.

2.6 **Supporting the development of the Local Cycling and Walking Infrastructure Plans (LCWIP)**
Cambridgeshire County Council are leading the development of a new strategic approach to identifying cycling and walking improvements required at the local level. The plans are meant to enable a long-term approach to developing local cycling and walking networks, ideally over a 10 year period. Public Health are working with the Cycling Infrastructure team to factor in the health benefits of walking and cycling

3 Next Steps and actions

Discussions held over the last nine months and insight captured as part of the different events have helped identify a number of potential actions which could be taken forward. It is essential that these actions are taken forward in partnership with other organisations including the air quality leads from the Cambridgeshire Pollution Prevention Group (CPPG), which is made up of representatives from each of the District and City Councils in Cambridgeshire and Peterborough. Public health does not hold all of the expertise or levers on air quality and for progress to be sustainable actions need to be owned and delivered by partners.

3.1 Development of communication resources
Stakeholders at the air quality learning and sharing event identified the need for more accessible, robust and targeted information and materials on air quality and its impact on health. This was also identified as a priority by Cambridge City as part of their Air Quality Action Plan.

Proposed Action

- Further develop Cambridgeshire Insight and explore the feasibility of linking to real time monitoring data held by the district councils (where available).
- Explore the feasibility of developing a resource for councils and the public containing key messages on air quality in accessible formats (to be made available through Cambridgeshire Insight)

3.2 Air quality training
The National Air Quality NICE guidance recommends that air quality is considered in the planning process (both through the development of local plans and as a material consideration). To date air quality training and engagement has focused predominately on transport planners and air quality specialists.

Proposed Action

- Explore and commission, if feasible, a bespoke training package for Development Management (Planning Officers) and Planning Policy officers in the City and District Councils.

- Further engage planning teams in the City and District Councils in the air quality agenda though the Chief Planning Officers Group.

3.3 Guidance on air quality monitoring

There is an increasing number of citizen scientists who feel passionate about air quality and are working hard to identify issues in local communities. These groups/individuals are using a variety of personal air quality monitoring devices which may not be designed for wider environmental use and there is a risk of misinterpreting the data they produce when comparing that data to the air quality standards and objectives.

Proposed Action

- Consider developing guidance for communities engaging in "citizen science" to ensure that monitoring is robust and any data obtained is understood and used appropriately.

3.4 Collaborative working

Discussion at the health committee and at the learning and sharing event show there is considerable passion for, and interest in tacking poor air quality across Cambridgeshire. Other areas have developed wider air quality networks which bring together stakeholders across the system.

Proposed Action

- Discuss with the air quality leads in the City and District Councils the opportunity to create a wider air quality network to drive the air quality work forward.

3.5 Closer working with the NHS

The NHS was identified as an important stakeholder in relation to air quality given its role in managing health conditions related to air pollution but also the size of the organisation and number of transport journeys associated with its activities e.g. staff and patients.

A new air quality modelling tool has recently been developed by PHE which models the potential impact of air pollution locally on disease incidence, health service usage and mortality. This will be helpful in making the case for change along with tools and other guidance such as the NICE Air Quality guidance.

Proposed Action

- Next year there may be an opportunity to apply to host an NHS Sustainability Fellow (these are public health trainees with an interest in sustainability) who could support a more comprehensive engagement approach with NHS partners over a 6 month – 12 month period.

3.6 Decision making process

A key output of the Combined Authority Non Statutory Spatial Plan 2 is the development of the "Quality Charter for Inclusive Growth". Public health have been asked to feed into the development of the "Quality Charter for Inclusive Growth".

Proposed Action

- Work with the combined authority to include air quality as a consideration and feature within the new Quality Charter for Growth.

4 ALIGNMENT WITH CORPORATE PRIORITIES

4.1 **Developing the local economy for the benefit of all**
4.2 **Helping people live healthy and independent lives**
4.3 **Supporting and protecting vulnerable people**

5 SIGNIFICANT IMPLICATIONS

5.1 **Resource Implications**

There are no significant implications within this category.

5.2 **Procurement/Contractual/Council Contract Procedure Rules Implications**
There are no significant implications within this category.

5.3 **Statutory, Legal and Risk Implications**
There are no significant implications within this category.

5.4 **Equality and Diversity Implications**
There are no significant implications within this category.

5.5 **Engagement and Communications Implications**
There are no significant implications within this category.

5.6 **Localism and Local Member Involvement**
There are no significant implications within this category.

5.7 **Public Health Implications**
See main body of the report.

Implications	**Officer Clearance**
Have the resource implications been cleared by Finance?	Yes Name of Financial Officer: Clare Andrews
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	Yes Name of Officer: Paul White
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	Yes Name of Legal Officer: Duncan Dooley-Robinson

Have the equality and diversity implications been cleared by your Service Contact?	Yes Name of Officer: Dr Liz Robin
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?	Yes Name of Officer: Dr Liz Robin
Have any Public Health implications been cleared by Public Health	Yes Name of Officer: Dr Liz Robin

Source Documents	Location
Health Committee Paper 16 March 2017 - AIR QUALITY IN CAMBRIDGESHIRE – IMPLICATIONS FOR POPULATION HEALTH, and associated Minutes	Web Link to Committee Paper Web link to minutes

Feedback and next steps – transport managers training event:

1. Overall, how would you rate the event?

Excellent	Very Good	Good	Fair	Poor
1	3	5	2	0

2. How useful was the information presented?

Extremely helpful	3
Very helpful	5
Somewhat helpful	3
Not so helpful	0
Not at all helpful	0

3. Will you make any changes to the way you work based on the information provided today?

Yes	No	Other comments
7	2	Maybe – already working quite well RE: AQ and partnership working towards improvements, but will definitely think on possible enhancements

4. What was the most useful aspect of the event?

- Good detail + presentation copy will await reference
- Overview of AQ Assessments + info on damage costs
- Mitigation measures – planning application process/need to recognise PM2.5 + incorporate into policy
- All equal. Good information
- A more detailed understanding of the causes and elements contributing to air quality
- Speaking to other PCC staff about the issues/general overview
- Mitigation measures
- Details of the types of pollutants would like to see more case studies
- Thought provoking/liked the idea of costing air pollution damage
- Meeting transport planners

5. What was the least useful aspect of the event?

- No biscuits
- None identified
- Bit longer than needed
- Too many facts and figures/was looking for more practical

Next Steps

Question	Comments
1. What changes will you make to the way you work following today's event?	• Try to engage transport and local planners in AQ (Subject to resources) • Ensure measurements reflect work being done • Better understanding on AQ – especially whilst consulting on planning applications
2. What else can we do to disseminate todays learning to your colleagues?	• Cascade training information/presentation slide material to delegates (so can then be passed onto colleagues)
3. Any further comments or reflections?	• Good basis into AQ + LA responsibilities • Why trees will not reduce public exposure to air quality (hierarchy of transport sustainability)

Appendix B (1)
Evaluation – Air quality learning and network event
Feedback from the event was positive and is summarised below

1. Overall, how would you rate today's event?

Very good – 10
Good – 5
OK – 0
Fair – 0
Poor - 0

2. Overall how useful was the information presented?

Extremely helpful – 5
Very helpful – 8
Somewhat helpful – 1
Not so helpful – 0
Not at all helpful - 0

3. How would you rate the individual sessions?

Session	Extremely Helpful	Very Helpful	Somewhat helpful	Not so helpful	Not at all helpful
Air quality and health	8	5	1		
Current situation across Cambridgeshire	6	6	2		
Legislative framework - who is responsible for what?	5	8	1		
Co-benefits of increasing active travel and improving air quality and health	4	4	3	1	

4. What was the most useful aspect of the event?

Regulatory framework information/Brief discussions in groups.

- Connecting with county, city, S Cambs.
- Opportunities identified for next steps.
- Having key member and officers present – to take this back.

Good location. Well prepared presentations.
Networking
Mixture of speakers from a range of backgrounds, and breakout sessions with opportunities to talk to partner organisations – pitched at the right level. Learnt a lot!

Ability to network and learn what is being done in other authorities.

Networking, sharing knowledge.

Not one aspect. As someone coming to this afresh, it's been very useful. Thank you.

All very useful.

Learning from experts, hearing about other parts of the county, meeting others and discussing ideas.

Legislative framework and who is responsible and liaising with those present.

1. – excellent introduction to the topic, thorough and wide-ranging.
2. – good at responding to the questions and great for local overview.
3. – thorough again and well presented.
4. – nicely presented overview.
5. – excellent.

Bringing together a large range of interests and knowledge bases.

Great to see local politicians engaged in AQ and health improvement. Hopefully this can be a real kick start to better air quality and active transport and cleaner buses and taxis.

Understanding the lack of support on this issue from actual government and the need for co-ordination between authorities.

5. What was the least useful aspect of the event?

Not enough time for Qs.

Chance to discuss City AQ Action Plan.

Limited attendance across councils.

Was it really a good use of officer time?

Not having enough time!

None

Could we have a list of attendees?

Lack of focus on active travel from presenters view in another authority that has done more than us!

Lack of clear objectives set, so lack of assessment of whether event has met them.

Presented training -

- directed at organisations (NHS) schools/school children
- Officers at different levels.
- Active travel work with communications.

3. Information and insight captured at air quality training and sharing event

A core part of the learning and networking event was to capture the views of attendees as part of breakout sessions in order to inform next steps. Questions included:

4. What did attendees want from the day?
5. What is current level of knowledge (among residents, members and officers)?
6. What should be the next steps?

Outputs from the discussions are captured in the table below

Appendix B (2)
Feedback from attendees at Air Quality Learning and Sharing event

What did attendees want from the day?	What is current level of knowledge	What should be the next steps

• How to raise awareness.
• How to increase engagement with members, pubic and management.
• Examples of initiatives.
• What to tell planners? Justification evidence? EG's of SPD's – county wide?
• How to improve partnership working?
  ○ To encourage/ educate that ALL have to contribute to some of the problem.
  ○ To encourage partnership working.
  ○ 3 tier organisation – integrate.
• How we use technology.
	Public
	• Has increased but still some way to go.
	• Low awareness re AW/health.
	• Some pockets of high awareness – often around specific issues eg A14.
	• Potentially areas with low knowledge eg Fenland – corresponds with deprivation.
	• Confusing messaging – need consistent messages about what action they can take.
	• Need to Shift to electric vehicles.
	• Awareness there but not the behaviour change.
	• Conflicting advice.
	• Want to have confidence in information given and up to date.
	• Lack of appreciation of individual contribution. Could be a major barrier to change.
	• Knowledge increasing with 'Citizen Scientist'?
		COMMUNICATIONS
		• Key messaging in plain English.
		• Message needed which can People resistant to changing behaviour
		• Need robust evidence base – support/inform citizen scientists
		COLLABORATIVE WORKING
		• Joint leadership and partnership working.
		• Identify Champions
		• Organise critical mass of key players to co-ordinate actions or provide a Forum for action, sharing good practice.
		• Establish special interest group to harness energy.
		• Bring in wider partners such as the NHS e.g. Addenbrookes.
		• Engage with CA and build on CA Spatial strategy
		• Liaise with planners.
		• Gain political buy-in.
		Decision making process
		• Mainstream AQ into all decision making including procurement eg vehicles.
		• Integrated into Local Plan and supported by evidence.
		• Develop policy hooks to justify/enforce requirements.
		• Greater harmonisation/collaboration of plans eg joint local plans, joint AQ strategies (SCDC/City).
		• Be clear about who is responsible for what?
		Training
		• Develop tailored information/training materials for member, officers and resident to raise awareness of AQ across all disciplines.

	Officers • Local government has increased – but what about other organisations eg Highways England. • Transport Officers, planning, NHS? • Little more knowledge than public but still gaps. • Some experts. • Awareness when it affects them – public (planning system doesn't adequately take account of AQ).	• Build on NICE guidelines. • Share best practice. • Raise awareness with transport officers. • Educate resident about hybrid/EV vehicles to encourage purchase including costing (whole life costs for EVs). Educate especially taxi drivers. **Monitoring** • Expand AQ monitoring network according to locally identified hot spots. • Use new mobile technology for monitoring. **Transport Interventions** • Develop sustainable communities. • Promote active travel. • Put services on first – new clean buses and part funding to support this. Congestion charge and WP Parking levy will re-coup this funding/cost. • Put infrastructure in after the service (new bus). • Issue is funding to give to provide operators. • Technology in transport – smart apps + information. • Buses to carry bikes + trains. • Electric bikes – extend the geography. • Bus franchise possible under new Bus Act (2017). • Public transport – integrated transport system. Have to have cars. • Promote better transport (bus and taxi) EV system and this will encourage update of private EV.
	Members • Has gone up but some way to go. • Unlikely to be aware unless in area with an AQ problem. • Depends on political priorities – need to make it personal. • Messages need to be clear, consistent, and achievable. • Some councillors don't have knowledge – choose not to know. • Lack of visibility of AQ as a political priority.	

Agenda Item No: 7

Proposed response to Cambridge City Council Air Quality Action Plan Consultation

To:	**Health Committee**
Meeting Date:	**Thursday 13th September 2018**
From:	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**n/a** *Key decision:* **No**
Purpose:	**To outline the proposed response to the Cambridge City Air Quality Action Plan consultation**
Recommendation:	**The Health Committee is asked to comment on and agree the proposed consultation response.**

	Officer contact:		***Member contacts:***
Name:	Stuart Keeble	Names:	Cllr Peter Hudson
Post:	Consultant in Public Health	Post:	Health Committee Chair
Email:	Stuart.keeble@Peterborough.gov.uk	Email:	Peter.hudson@cambridgeshire.gov.uk
Tel:	07816 597855	Tel:	01223 706398 (office)

1. BACKGROUND

1.1 Local authorities in the UK are required to carry out a review and assessment of air quality in their area. This involves measuring air pollution and trying to predict how it will change in the next few years. The aim of the review is to make sure that the national air quality objectives are met. If a local authority finds any area(s) where the objectives are not likely to be met or are being exceeded, it must declare an Air Quality Management Area (AQMA) for that/those area(s). This could be just one or two streets, or it could be much bigger[1]. Local authorities with declared AQMA's are required to prepare and implement an Air Quality Action Plan and carry out further air quality assessments (Stage IV) under the Environment Act 1995.

Cambridge City declared AQMA in the city centre due to exceedances of Nitrogen Dioxide in 2005, the area encompasses the inner ring road and all the land within it (including a buffer zone around the ring road and its junctions with main feeder roads).

Although air quality in Cambridge City has improved over the last few years there are still areas where the air quality objectives are unlikely to be met. Therefore, Cambridge City Council has updated its Air Quality Action Plan (public health are part of the steering group and have contributed to the production of the action plan). The plan sets out priorities for the next five years, for improving areas of poor air quality and maintaining areas of good air quality as Cambridge continues to grow

1.2 A consultation on the plan is being run between 21 June 2018 and 18 September 2018, and residents and partners are being asked:

1. What they think of the action plan.
2. Does it go far enough?
3. How could it be improved?
4. What actions could be included in the future?

1.3 Given that air quality was identified as a priority by the Health Committee the committee is asked to comment on and agree the proposed consultation response.

2 Evidence underlying the action plan

2.1 The main air pollutant of focus in Cambridge City, as part of the Local Air Quality Management process, is nitrogen dioxide (NO_2). The main source of NO_2 in Cambridge is from vehicle emissions, so the Air Quality Action Plan focuses primarily on ways to reduce these emissions, as well as reducing other sources of air pollution (see Appendix A for more detailed information).

There are also legal limits for small particulate matter less than 10 microns (known as PM_{10}). The levels of PM_{10} in Cambridge are below the legal limits, however there is no regulatory standard for $PM_{2.5}$ (for local authorities in England) or a specific regulatory actions for the Local Authority to reduce emissions or concentrations of $PM_{2.5}$, however, Local Authorities are expected to work towards reducing emissions and concentrations of $PM_{2.5}$ in their local area as far as reasonably practicable. In doing so they are not required to carry out any additional local review and assessment (including monitoring) but make

[1] https://uk-air.defra.gov.uk/aqma/

use of national monitoring data. Action to tackle PM_{10} and NO_2 would usually contribute to reducing emissions of $PM_{2.5}$[2].

3 Brief summary of Cambridge City Air Quality Action Plan

3.1 The plan's proposed actions fall into three main categories:

- Reducing local traffic emissions as quickly as possible
- Maintaining levels of pollutants below national objectives
- Protecting public health by improving air quality in the future

The seven main areas for action (the sets of measures) are:

1. Reduce emissions from Taxis by requiring low emission taxis
2. Reduce emissions from Buses and Coaches
3. Reduce emissions from HGVs
4. Reduce emissions from all traffic/other traffic by providing better public transport
5. Maintaining Low Emissions through the planning process and long-term planning
6. Improving Public Heath
7. Leading By Example

4 Consultation questions and response

The consultation sets out 14 questions. Responses for questions that have direct public health implications are outlined below, we do not intend to respond to all the questions in the consultation, however if members would like to respond to these, they can be incorporated.

Question 1. First of all we would like to know if you work in Cambridge and/or are you a resident, a visitor, or a student? Add any comment in the box, including if more than one applies.
Proposed response
This is a response on behalf of Cambridgeshire Country Council Health Committee rather than an individual resident's response.

Question 2. Are you responding as an individual, or on behalf of an organisation? If you are responding on behalf of an organisation, please include the name in the box below.
Proposed response
This is a response on behalf of Cambridgeshire Country Council Health Committee

Question 3. How important do you think the issue of air quality is in Cambridge?
Proposed response
Very important

Question 4. What is your personal experience of poor air quality, if any?
Proposed response
This is a response on behalf of Cambridgeshire Country Council Health Committee rather than an individual resident's response.

Question 5. Do you agree with the overall approach described in the Plan (reduce air pollution, then maintain good air quality, then improve air quality further)? If not, why not?

[2] https://laqm.defra.gov.uk/documents/LAQM-PG16-April-16-v1.pdf

Proposed response
We support Cambridge City Council's proposed approach of:

- *Reducing local traffic emissions as quickly as possible*
- *Maintaining levels of pollutants below national objectives*
- *Protecting public health by improving air quality in the future*

The focus on reducing traffic emissions is evidence based using source apportionment data (information about the pollution sources and the amount they contribute to measured concentrations) showing that road traffic emissions are the primary source of emissions in the Cambridge Air Quality Management Area.

The action plan recognises the challenges associated with local housing growth in the area and the need for plans to mitigate impact on air quality going forward.

We are pleased to see a future focus on protecting public health by improving future air quality as although the majority of monitoring sites are below national air quality thresholds they are still close to limits, so a continued focus is needed.

The Air Quality Action Plan notes the importance of fine particulates ($PM_{2.5}$) on health whilst also acknowledging that the majority of $PM_{2.5}$ in Cambridge is due to background levels.

The proposed actions to tackle NO_2 locally will support further reductions of PM_{10} and $PM_{2.5}$ in hotpots.

Question 6. Can we make any improvement to the overall approach?
Proposed Response:
Lead by example
We welcome Cambridge City's ambition to 'lead by example', however, we would challenge the authority to be more ambitious and look at how wider public sector partners in Cambridge could be involved in supporting the City's ambition. The public sector in Cambridge City is considerable with large anchor institutions[3] such as Cambridge University Hospital Foundation Trust and Cambridge University.

Mode shift
The action plan identifies the importance of shifting modes of transport from individual private cars to active travel. Public health commission the road safety team in Cambridgeshire County Council to deliver "mode shift stars" for schools across Cambridgeshire which is a joint road safety and active travel intervention. Opportunities may exist for shared communication as part of this work.

Cambridgeshire County Council are currently developing a new strategic approach to identifying cycling and walking improvements required at the local level. The plans are meant to enable a long-term approach to developing local cycling and walking networks, ideally over a 10 year period. This could provide an opportunity to strengthen active travel interventions across the area.

When working with Greater Cambridgeshire Partnership on interventions to improve walking and cycling infrastructure we would ask Cambridge City to also highlight the need for interventions to support behaviour change. Evidence shows that a combination of physical infrastructure and

[3] An anchor institution is one that, alongside its main function, plays a significant and recognised role in a locality by making a strategic contribution to the local economy.

packages of behavioural support are more effective at maximising use of new cycling and walking infrastructure.

Quality Bus Partnership
Although not a direct issue for Cambridge City there are concerns that an unintended consequence of the implementation of the Quality Bus Partnership and requirement for "cleaner" buses serving Cambridge City may lead to less "cleaner" buses being pushed out to other areas in Cambridgeshire which could lead to worsening air quality in other parts of the County.

Question 7. Please list the top three actions that should be taken to address air quality in the city. These can be measures already in the Plan or measures that are not included.
Proposed Response:
We suggest the actions focused on shifting modes of transport from car to cycling, walking or public transport (public transport generally involves walking or cycling at both ends of the journey) will have the greatest impact on health and wellbeing. Modelling studies show that the increased levels of physical activity due active travel lead to greater improvements in health than the related decrease in air pollution.

Question 8. We get a few complaints each year about vehicle idling. Does vehicle idling affect you?
Proposed Response:
Vehicle idling has been identified as an issue in other parts of country with a main focus on Taxis, and parents picking up/dropping off children at school. In Cambridge buses and coaches have also been raised as an issue. There are powers which the City can take through the "Road Traffic (Vehicle Emissions) (Fixed Penalty) (England) Regulations 2002". The logistics of enforcement e.g. getting around a whole city, means that it can only practically be applied at bus stations or taxi ranks, or opportunistically in places where Heavy Good Vehicles or Light Goods Vehicles are parked for lengthy periods[4].

Question 9. Car free days have been in the news recently. Is this something we should consider in Cambridge?
Proposed Response:
Yes - as vehicles are the main source of air pollution in Cambridge City, car free days would likely impact on NO_2 levels in the city. Evidence from Cardiff[5] found that NO_2 levels reduced by 69% during a car free day event. If the aim is to implement Car Free Days as one off events then this needs to be part of a wider plan as to how changes in travel behaviour can be sustained in the longer term.

Question 10. Everyone is affected by the quality of the air that we breathe and everyone has a role to play to help to improve air quality in Cambridge. Which of these ways to improve air quality do you already do? PLEASE USE Q14 instead, which will allow you to use multiple choices. Apologies for the inconvenience.

Proposed Response:

[4] https://www.islington.gov.uk///~/media/sharepoint-lists/public-records/environmentalprotection/information/guidance/20122013/2013013114costeffectiveactionstocutairpollutioninlondon

[5] https://www.airqualitynews.com/2018/07/11/cardiff-sees-no2-reduction-on-car-free-day/

This is a response on behalf of Cambridgeshire Country Council Health Committee rather than an individual resident's response.

Question 11. What action would you be willing to take to improve air quality?
Proposed Response:
Cambridgeshire County Council Public Health Directorate is already represented on the Cambridge Air Quality Action Plan group and will continue to work closely with the City Council.

Air quality is one of the priorities of the Cambridgeshire Health Committee and a programme of work is ongoing. Our desire is to add value and support partners by working at scale across the county.

One common area which has been identified by recent stakeholder events is the need for more accessible, robust and targeted information and materials on air quality and its impact on health. We would welcome joint working with Cambridge City on this issue to take it forward.

Public Health England continue to publish new evidence and tools on the health impact of air quality e.g. the new air quality modelling tool which looks at the impact of air pollution on the local incidence of disease and hospital admissions. Public Health will work with Cambridge City to maximise the use of these tools.

When responding to Local Plan consultations and policy documents we will continue to raise air quality as an issue. We will look to influence strategic documents such as the Quality Charter for Inclusive growth which is being developed on behalf of the Combined Authority.

Question 12. What are the things which prevent you from doing these things now?
Proposed Response:
Addressing poor air quality is complex and the air quality agenda is not owned by a single organisation but rather different public sector organisations across the system are responsible for different aspects (i.e. monitoring is the responsibility of the District and City Councils, transport interventions lie with the County Council and Combined Authority – as the transport authority).

Question 13. Do you have any other comments to make about improving air quality in Cambridge?
Proposed Response:
No other comments

14. Everyone is affected by the quality of the air that we breathe and everyone has a role to play to help to improve air quality in Cambridge. Which of these ways to improve air quality do you already do?
Proposed Response:
This is a response on behalf of Cambridgeshire Country Council Health Committee rather than an individual resident's response.

5 ALIGNMENT WITH CORPORATE PRIORITIES

5.1 Developing the local economy for the benefit of all

5.2 Helping people live healthy and independent lives

5.3 Supporting and protecting vulnerable people

6 SIGNIFICANT IMPLICATIONS

6.1 Resource Implications

There are no significant implications within this category.

6.2 Procurement/Contractual/Council Contract Procedure Rules Implications

There are no significant implications within this category.

6.3 Statutory, Legal and Risk Implications

There are no significant implications within this category.

6.4 Equality and Diversity Implications

There are no significant implications within this category.

6.5 Engagement and Communications Implications

There are no significant implications within this category.

6.6 Localism and Local Member Involvement

There are no significant implications within this category.

6.7 Public Health Implications

See main body of the report.

Implications	**Officer Clearance**
Have the resource implications been cleared by Finance?	Yes Name of Financial Officer: Clare Andrews
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	Yes Name of Officer: Paul White
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	Yes Name of Legal Officer: Duncan Dooley-Robinson

Have the equality and diversity implications been cleared by your Service Contact?	Yes Name of Officer: Dr. Liz Robin
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?	Yes Name of Officer: Dr. Liz Robin
Have any Public Health implications been cleared by Public Health	Yes Name of Officer: Dr. Liz Robin

Please include the table at the end of your report so that the Chief Executive/Executive Directors/Directors clearing the reports and the public are aware that you have cleared each implication with the relevant Team.

SOURCE DOCUMENTS GUIDANCE

It is a legal requirement for the following box to be completed by the report author.

Source Documents	**Location**
Cambridge City Air Quality Action Plan	Web link to AQAP
Consultation document	Web link to consultation document
Consultation survey	Survey link

Appendix A

Findings of Cambridge City Council source apportionment exercise in 2017.

NO2	PM10	PM2.5
City Centre - NOx sources 81% of NOx emissions are from Roads, of which 45% NOx are emitted from buses, 31% from HGV, 9% from taxis, 8% from cars, and 6% from LDV (LGV). **Ring Road** - NOx sources 73% of NOX emissions are from Roads, of which 14% NOx are emitted from buses, 19% from HGV, 4% from taxis, 43% from cars, and 20% from LDV (LGV).	Background estimates across Cambridge vary between 15 and 17 micrograms per cubic metre (2016), with an average of 16 micrograms per cubic metre. PM10 is measured at three locations in Cambridge – Gonville Place, Montague Road (adjacent to Elizabeth Way) and Parker Street. These stations recorded 20 – 22 micrograms per cubic metre annual mean in 2016, demonstrating that around 25% of PM10 in Cambridge is locally derived. The Source Apportionment study demonstrated that most of the additional PM10 in Cambridge results from traffic, with a component from demolition and construction dust.	Background maps shows that most background PM2.5 has a regional component (95%). Estimates across Cambridge vary between 11 and 12 micrograms per cubic metre (2016). PM2.5 is measured at two locations in Cambridge – Gonville Place and Newmarket Road. Recent measurements of PM2.5 at Newmarket Road indicate that there is a very small roads component in this location (11 micrograms per cubic metre annual mean), but at Gonville Place there is an additional contribution of up to 3 micrograms per cubic metre PM2.5 34 (15 micrograms per cubic metre annual mean). Most parts of Cambridge have 'background' levels of PM2.5 but it appears likely that hotspots are present in locations of high traffic density.

Agenda Item No: 8

CHILDREN'S MENTAL HEALTH - UPDATE

To:	**Health Committee**
Meeting Date:	**13th September 2018**
From:	**Cambridgeshire and Peterborough Clinical Commissioning Group**
Electoral division(s):	**All**
Forward Plan ref:	**n/a** *Key decision:* **No**
Purpose:	**The Committee is asked to consider the update to the full report presented in March 2018. Link below** https://cmis.cambridgeshire.gov.uk/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/542/Committee/6/Default.aspx
Recommendation:	**The committee are asked to note and comment on the report.**

	Officer contact:		***Member contacts:***
Name:	**Lee Miller**	Names:	Councillor Peter Hudson
Post:	Head of Transformation and Commissioning (Children and Maternity)	Post:	Chairman
Email:	Lee.miller@nhs.net	Email:	Peter.Hudson@cambridgeshire.gov.uk
Tel:	07501098812	Tel:	01223 706398 (office)

1. BACKGROUND

1.1 At a previous Committee (March 2018) a paper was presented, giving an overview of Child and Adolescent Mental Health Services (CAMHS) in Cambridgeshire. In this paper, a number of challenges were highlighted. The committee asked for more detailed information on the challenges including supporting data. This paper gives a brief update on progress since the March 18 report and focuses on the 4 areas of challenge.

- **Increase in demand**
- **Waiting Times**
- **Child and Adolescent Mental Health Service (CAMHS) Access targets**
- **Workforce**

2. MAIN ISSUES

2.1 **Update**

Since the previous committee report, the following the following has changed.

Emotional Wellbeing service – this service has embedded well and is providing welcome additional support to schools. There has been a recent agreement of additional funding for 2 additional posts from the East Cambs and Fenland Opportunity Fund, they will join the existing staff but provide a specific focus for schools in East Cambs and Fenland.

First Response Service (FRS) – The CCG has agreed to fund an additional 3.6 WTE CAMHS posts within the FRS to enable the service to provide emergency assessments and support, especially at times of high demand (4-11pm)

Transforming Care – The CCG now has a dedicated Transforming Care lead for Children (from 9th July 18). This is an 18-month post and will work together with Local Authority colleagues to reduce the number of children and young people with Learning Disabilities and/or Autism being admitted to CAMHS inpatient units or being placed out of area.

2.2 **Challenges**

The challenges below should be seen within the context of a significant growth in provision and investment detailed in the March 18 report
Cambridgeshire and Peterborough CCG is now investing an annual total of £9.4m per annum in CAMHS. This has built from a baseline of £6.6m per annum in 15/16

1. ***Increasing demand***

Demand for services and intervention is increasing. Our strategy has been to invest as much resource as possible into a wide range of early intervention provision so that intervention is rapid when required. However, this must be balanced against the need to achieve the targets set by NHS England, especially for Access to CAMHS Treatment
National prevalence rates for Children's mental health have not been revised for 14 years. Currently, rates are stated as 10% of school age children having a diagnosable mental health disorder.

Prevalence rates are currently being revised nationally and expected to be published in the Autumn. It is widely anticipated that these will show an increase from the existing rates. Increase in referrals has been particularly evident in the new Jointly Commissioned early intervention services for children's mental health.

CHUMS were awarded the contract to provide services across Cambridgeshire and Peterborough, from January 2018.
The contract identifies the number of children and young people receiving an intervention to be a minimum of 2000 per year. The number of referrals received in the first 6 months of the contract has been 2200. Although the referral rate has dropped in Q2 of the contract, the numbers are still high compared with those expected to receive an intervention.
The high demand indicates a level of unmet need and demand for a service. Unfortunately, some schools have decommissioned counselling services, for the school in recent months which has added to expected referral numbers.

Commissioners are working closely with CHUMS to increase capacity through recruitment of additional staff and providing group interventions where appropriate. Referrals are also triaged to ensure risks are identified and appropriately dealt with.

We are also working closely with schools through our new Emotional wellbeing teams to provide support training and advice to enable school staff to effectively support children with mental health problems within the school setting

Specialist CAMHS services provide intensive, evidence based therapeutic interventions and prescribe and monitor medication where appropriate. Capacity is limited and referrals to the service are sometimes more appropriate for other provision.
A Single Point of Access (SPA) is in operation to enable rapid triage of all referrals to the service, at which point, some are identified as being best dealt with by other provision. Approximately 60% of referrals are accepted into the service post triage, others are supported to access other appropriate services.

CAMHS - Accepted into Treatment Referrals

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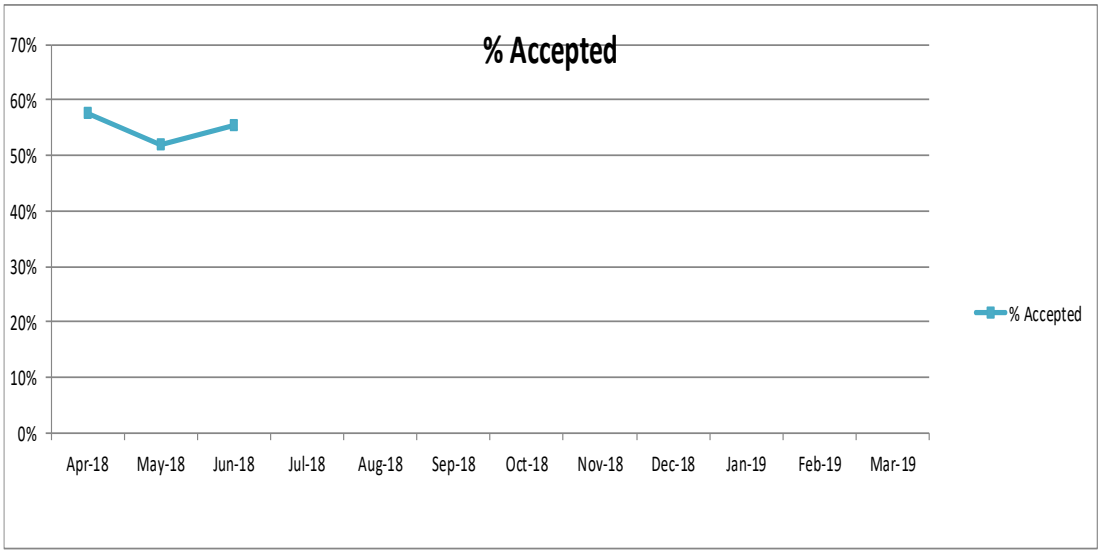
By Referral to CAMHs

Tab 2a



Actual numbers

Referred to CAMHs	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Not Accepted	99	141	114									
Accepted direct to Team	120	116	111									
Accepted to Team via SPA	67	85	89									
Still with SPA at month end	38	46	47									
Grand Total	324	388	361									
% Not Accepted	31%	36%	32%									
% Accepted	58%	52%	55%									
% Still with SPA	12%	12%	13%									

We are working with specialist CAMHS to ensure that resources are used most effectively and have agreed that an additional 500 children and young people will be provided with treatment in specialist services in 18/19

2. *Waiting times*

Although significantly lower than in previous years, we would like waiting times for specialist services to reduce. We will work with providers to ensure that all opportunities are maximised to achieve the lowest possible waits.
Below is a graph and table highlighting the waiting times for specialist CAMHS.

Less than 3% of referrals wait more than 18 weeks to be assessed, with over 50% being seen within 6 weeks. In the longer term, we would like waiting times to be shorter and are working with providers to ensure this happens, whilst maintaining the increases required in numbers accessing the services.

CAMHS - Community Waited for Assessment

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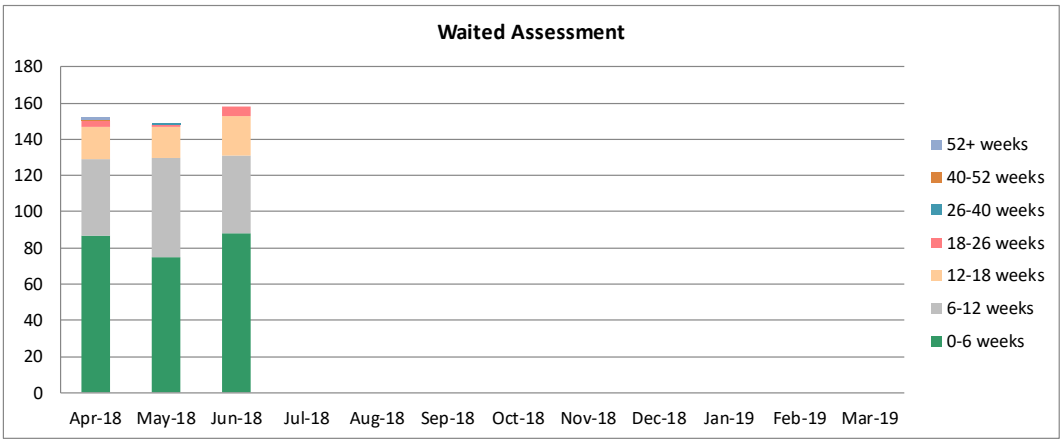
Waited for Assessment (first contact) Excluding SPA

Tab 17c



Actual numbers

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	2018/19 Year to date
0-6 weeks	87	75	88										250
6-12 weeks	42	55	43										140
12-18 weeks	18	17	22										57
18-26 weeks	3	1	5										9
26-40 weeks	0	1	0										1
40-52 weeks	1	0	0										1
52+ weeks	1	0	0										1
Total	152	149	158	0	0	0	0	0	0	0	0	0	459

CHUMS is contracted by Peterborough City council as a lead commissioner for both Peterborough and Cambridgeshire Councils and the CCG. As discussed previously, the high demand for the services has caused some difficulties with capacity, which has led to Waiting times longer than hoped.
In Q1 18/19, maximum waiting times to assessment vary in the different districts and by route into the service. The longest wait is 23 weeks in South Cambridgeshire, however, the majority of referrals are assessed in much shorter timescale.

Below is a breakdown of waiting times by method of entry into the service (referral by professional and self-referral) and by geographical area.

CHUMS – Waiting times January –June 2018										
Area	Cambridge		East Cambs		Fenland		Huntingdon		South Cambs	
Time period	Q4	Q1	Q4	Q1	Q4	Q1	Q4	Q1	Q4	Q1
Waiting Times (in days)										
Min wait from referral date to opt-in date (client calls to book appt)		0		0		0		5		47
Max wait from referral date to opt-in date (client calls to		144		130		48		106		155

book appt)										
Min wait from opt-in date (client calls to book appt) to assessment		0		33		8		8		0
Max wait from opt-in date (client calls to book appt) to assessment		41		33		70		62		0
Min wait for assessment (from referral date)	21	0	33	0	0	0	11	29	19	19
Min wait after assessment for intervention	7	7	28	0	4	7	13	36	12	0
Max wait for assessment (from referral date)	120	134	117	157	112	152	91	140	85	163
Max wait after assessment	36	36	28	0	47	52	35	36	36	0
No. on waiting list	13	14	23	31	17	40	42	63	36	36

As of September 2018, there will be an increase in the number of group interventions, which is planned to increase capacity and reduce the waiting times across the service. Progress will be monitored over coming months with CHUMS as the service continues to embed.

3. Increased access targets

NHS England require CCG's to meet national targets for under 18 year olds receiving Mental health interventions.
This continues to provide a challenge to our local system. Services have been redesigned to ensure that they work in the most effective and efficient way and are able to treat increased numbers of young people. However, the increase from our current 30% rate to the target of 35% by 2020 will require further innovation and focus.
The table below gives the baseline number of children with a diagnosable Mental Health condition in Cambridgeshire and Peterborough (16,583) and then the targets for the numbers expected to be provided with an evidence based intervention in each year across Cambridgeshire and Peterborough

Year			17/18	18/19	19/20
Baseline % of children with diagnosable Mental Health condition	100%	Target % of children provided with Evidence based intervention	30%.	32%	35%
Baseline number of children with diagnosable Mental Health condition	16583	Target number of children provided with Evidence based intervention	4975	5307	5804

The table below gives a breakdown by provider of the number of children provided with Mental Health treatment in 17/18, as reported by NHS England

Actual 17/18 end of year return	Local Target	17/18 position reported by NHS England
CPFT	2200	2655*
Other NHS providers		200
CHUMS	115	110
LA Parenting	1309	1275
Kooth	1000	180#
Centre 33	365	527*
Total	4989	4947
%	30%	30%

* CPFT end of year position reported by NHS England was 300 lower than the actual CPFT figure. Centre 33 data not included in official figures due to NHSE error in data quality process. This issue has been raised with NHSE, however, because of cut off dates, the NHSE figures are not able to be amended.
# The definition for Online interventions was not clear at the beginning of the year and still requires some clarification. As a result, actual numbers for Kooth were significantly lower than planned.

Targets have been agreed with providers for 18/19, which, if achieved, will enable Cambridgeshire and Peterborough CCG to achieve the 32% NHS England target for the year.

4. Workforce

The challenges above have intensified because of the lack of availability of an appropriately skilled workforce to deliver the increased expectations.
Our specialist provider CPFT currently have an overall vacancy rate of 13.8%
There are particular challenges in recruiting qualified clinical staff (nursing and therapists) and recruitment for posts in Cambridge is more challenging than elsewhere due to cost of living.
However, this is a national problem with a shortage of staff being reported in most areas.

We have invested local funding on looking at ways to recruit and retain staff and there is a national programme of training for new staff. Cambridgeshire and Peterborough have made maximum use of the national training programme and will continue to develop opportunities to develop. For example, we have been allocated the maximum possible number of places to train ‘Children’s Wellbeing Practitioners’ in 2019. However, there remain significant gaps in the workforce, which, have given real problems locally. We will continue to work as a system to ensure that we train as many new staff as possible as well as developing programmes to ‘grow our own’ from the existing children’s workforce.
Nationally. NHS England has identified 5 priority areas as part of a 10 year NHS plan. Mental health services, especially those for Children are one of the priorities, although they caution that because of lack of staff, major improvements could take 5 years

Conclusion

There has been considerable progress in development of services for Children's mental health over recent years and a significant increase in investment which has led to increased capacity both in early intervention and specialist services. There will be continued increases in the number of children provided with a service in future years and we will continue to focus on the challenges above to ensure that the needs of children and young people are met with appropriate interventions.

Source documents	**Location**
Report to Health Committee, March 2018	https://cmis.cambridgeshire.gov.uk/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/542/Committee/6/Default.aspx

Agenda Item No: 9

Community First (Learning Disability Beds Consultation)

To: Cambridgeshire Health Committee

Meeting Date: 13/09/2018

From: Marek Zamborsky, Head of Contracting & Commissioning Adult MH & Adult LD, Cambridgeshire and Peterborough CCG

Purpose: This document sets out the CCG proposal to consult on closure of inpatient beds, in order to invest in alternatives to hospital and community based services for patients with learning disabilities and autism in Cambridgeshire and Peterborough, in line with the recommendations of the Department of Health review of care at the Winterbourne Hospital.

Recommendation: It is recommended that the Committee:

a) Note the report and
b) Support a nine-week formal consultation on the reconfiguration of the Learning Disability bed base and development of Community Services (Friday 10 August – 5pm Friday 12 October 2018).

	Officer contact:	***Member contacts:***
Name:	**Marek Zamborsky**	Name:
Post:	Head of Commissioning and Contracting Adult MH and LD, CCG	Post:
Email:	Marek.zamborsky@nhs.net	Email:
Tel:	07919 624577 (PA support)	Tel:

1. BACKGROUND

1.1 A number of Department of Health reports concluded that commissioning across health and care services should aim to reduce the number of inappropriately placed people in treatment and assessment centres. This is now known nationally as the Transforming Care (TC) Programme for people with learning disabilities and autism.

2. MAIN ISSUES

2.1 In Cambridgeshire and Peterborough, there are currently sixteen beds for people with learning disabilities in total. This is broken down into six beds at the Intensive Assessment and Support Service (IASS) on the Ida Darwin site in Cambridge which were closed due to falling demand in 2016 and ten beds at The Hollies at the Cavell Centre in Peterborough. Of these:

- all six beds at the IASS were commissioned by the Learning Disability Partnership (LDP) and have been closed since 2016 and a proportion of funding was re-invested into Community Services.
- five beds at The Hollies are commissioned from Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) by the Cambridgeshire Learning Disability Partnership (LDP) pooled budget for patients from Cambridgeshire.
- five beds at The Hollies are commissioned by the CCG for patients from Peterborough.

2.2 The local TC Programme is proposing the reconfiguration of the current 10 beds in The Hollies, due to low occupancy levels and also to meet national requirements to reduce the number of inpatient beds for people with a learning disability and/or autism.

This would mean:

- the ratification of the formal closure of the six beds in IASS Ward which have been closed since 2016;
- the need to consult on the closure of the service in The Hollies, currently 10 beds;
- commissioning 5 beds for LD patients.

2.3 The proposed changes are achievable within existing local budgets, and the savings would be reinvested into community services and a ‘crash pad’ resource – a non-hospital based crisis management service.

2.4 The proposed changes deliver positive patient clinical outcomes, enhance patient experience, and maintain patient safety and will allow people to receive care closer to home when their clinical needs change.

2.5 **Supporting Information for the reduction of local beds - Number of beds and utilisation**

- Bed occupancy at The Hollies has been between consistently low for the last two years in the region of 30–60%.
- The local system has not been using the IASS beds from 1 April 2016 due to low

demand.

- The TC Partnership do, however, have out of area placements where patients from Cambridgeshire and Peterborough have to go to a hospital in another part of the country (Norfolk and Hertfordshire borders) for treatment. Out of area placements account for 60% of current admissions due to acuity and The Hollies' inability to support for reasons other than bed availability.
- The average length of stay in a hospital for people with a learning disability and/or autism is measured in years in many cases for long stay patients. The local system has only one patient that has been in the hospital for over 5 years, and their care is actively managed now. Most admissions in Cambridgeshire and Peterborough are short term with 80% of all admissions discharged within 90 days.

2.6 The local service at The Hollies is not able to support all patients for reasons other than just acuity. Analysis shows that the make-up of the local inpatient population currently consists of several groups:

- Patients that can be supported by the assessment and treatment unit locally.
- Patients that can be supported in the mental health ward with reasonable adjustments, but end up in a specialist learning disability bed because they have a learning disability.
- Patients that require appropriate, more specialist inpatient provision, such as autism services, locked rehabilitation, or any other expert skill not available locally due to scale of economy

2.7 Considered Options

Below are the options that have been considered by the TC Partnership.

Option 1- Do Nothing
Continue to commission the 10 beds at the Hollies as per the current use and close six beds at IASS.
Option 2 – Retain local beds only with no option of out of area beds or further community investment
Consolidate all bed requirements to a local Assessment and Treatment Unit (ATU) based at The Hollies and close six beds at IASS.
Option 3- No dedicated local beds
Move to a 'No Bed Model' and develop spot purchase arrangement for beds in other hospitals with some local reasonable adjustments for patients with learning disabilities and/or autism that can function on mental health wards in addition to the enhancement to community teams.
Option 4 –5 beds and expand community services
Move to 5 beds model, spot purchase for speciality needs, reinvest the money to enhance local community services for people with learning disabilities.

2.8 Preferred Option

The local TC Partnership is proposing to contract and commission five beds in the new service model for assessment and treatment with reasonable adjustments to local mental health inpatient ward(s), for people with a learning disability who can be safely and

appropriately supported.

This will mean a formal closure of the six beds in the IASS Ward which have not been used since 2016, and formal closure of the 10 beds at The Hollies. The total number of specialist inpatient treatment and assessment beds for people with a learning disability and/or autism would then be five locally for the purpose of assessment and treatment.

The actual location of the five beds and the actual provider of the beds will need to be determined as the post consultation model is implemented and finalised.

The new service model would be cost neutral as the savings from closing the beds would be reinvested into services for people with a learning disability and/or autism. The reduced number of beds will be supported by the enhancement of community teams and crash pad (non-hospital based crisis management service), as well as enhancement of community autism services.

What are people with a learning disability are getting now	What we propose people with a learning disability get in the future
• Beds at IASS (not used, building not suitable) • Ten beds at The Hollies (30-60% occupancy) • Out of CCG area placements for specialist - and sometimes non specialist - treatments • 9-5 community mental health services and Intensive Support Team in Peterborough • 9-5 and when required out of hours integrated health and social care team in Cambridgeshire	• Five treatment and assessment beds for people with a learning disability, as the very last resort of support when really needed • Extended community support in terms of extra capacity and out of hours support as required (note not 24/7) – from a unified, integrated team across Peterborough and Cambridgeshire, based on the LDP model (another milestone of the local TC Programme) • Crisis house - a “crisis pad” for when the reason for hospital admission is a breakdown of social care placement only due to changes in Clinical Needs • Out of CCG area placements for specialist needs (1-5 placements maximum) • Enhanced adult autism services compared to the current baseline

3. ALIGNMENT WITH CORPORATE PRIORITIES

The proposed consultation:

- is in line with national and CCG policies;
- delivers better clinical outcomes, and improves patient experience and provides care closer to home;
- is supported by the CCG Impact Assessments and support the change in service model;
- is consistent with models of care which have been implemented in other localities

across the country;
- delivers within existing budgets and allows efficient use of money by reinvesting resources into community services, to support people to remain in a community setting.

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 proposed service model will enable people with learning disability to live healthy and independent lives by improvement and enhancement of the community provision which will prevent unnecessary hospital admissions.

3.3 Supporting and protecting vulnerable people

The details of implications identified by officers are set out below.

- Community provision will be enhanced to support individuals in crisis through increasing hours of operation.
- 'Crash pad' facilities will be commissioned to accommodate and support individuals in a crisis, where previously hospital admission might have been an option.
- A defined number of specialist beds for people with a learning disability and/or autism will continue to be commissioned to facilitate hospital admission where absolutely necessary.
- In addition, mainstream adult mental health wards will 'reasonably adjust' to accommodate the needs of some patients that can function well and safely in an adult mental health ward setting.

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

The preferred option is possible within the existing budgets by investing back into the community services. Proposed utilisation of released finances from beds reconfiguration:

Area of Investment	Investment
Extended Community Service capacity and crisis management	£635,000
Crisis Pad	£240,000
Autism Post Diagnostic Services Support/Treatment	£240,000
Forensic Community Support	£200,000

4.2 Equality and Diversity Implications

The future service model will increase accessibility with reasonable adjustment arrangements within mainstream mental health inpatient services, and increase capacity to better support people with autism across the health and social care system in the community.

4.3 Engagement and Communications Implications

Full formal consultation is delivered by the CCG. Reasonable adjustments and easy read documents are produced for people with learning disabilities.

Source Documents	Location
CCG Governing Body report	https://www.cambridgeshireandpeterboroughccg.nhs.uk/easysiteweb/getresource.axd?assetid=15485&type=0&servicetype=1
National Guidance: Building the Right Support	https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-nat-imp-plan-oct15.pdf
Appendices **Appendix 1: Consultation Document** **Appendix 2: Consultation Document – Easy Read** **Appendix 3: Impact Assessments**	Attached as PDFs

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

‘Community First’ - consultation on proposed changes to the provision of inpatient beds for people with a learning disability in Cambridgeshire and Peterborough

10 August 2018 to 5pm 28 September 2018

Consultation extended to 5pm on Friday 12 October 2018

This consultation is aimed at patients registered at GP practices within Cambridgeshire and Peterborough Clinical Commissioning Group's area.

This document is available in other languages and formats, including Easy Read, on request.

To request alternative formats, or if you require the services of an interpreter, please contact us on:

- 01223 725304
- CAPCCG.contact@nhs.net

Pokud byste požadovali informace v jiném jazyce nebo formátu, kontaktujte nás

જો તમને માહિતી બીજી ભાષા અથવા રચનામાં જોઈતી હોય તો, કૃપા કરી અમને વિનંતી કરો.

Se desiderate ricevere informazioni in un'altra lingua o in un altro formato, siete pregati di chiedere.

Jei norėtumėte gauti informaciją kita kalba ar formatu, kreipkitės į mus.

Jeżeli chcieliby Państwo uzyskać informacje w innym języku lub w innym formacie, prosimy dać nam znać.

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Amended on 22 August 2018

The consultation process

You can give your views in a number of ways:

- Fill in the questionnaire found online on the CCG's website at www.cambridgeshireandpeterboroughccg.nhs.uk

- Fill in the paper copy of the questionnaire in this consultation document at page 18 and send it FREEPOST to Freepost Plus RSCR-GSGK-XSHK, Engagement Team, Cambridgeshire and Peterborough CCG, Lockton House, Clarendon Road, Cambridge CB2 8FH (you do not need a stamp).

- Telephone the Communications and Engagement Team on 01223 725304.

- Attend one of the public meetings detailed below and tell us what you think:

Date	Venue	Time
Thursday 16 August 2018	Forli Room, Town Hall, Bridge Street, **Peterborough, PE1 1FH**	**1.30pm - 3.30pm**
Thursday 23 August 2018	Suite 1, Stanton Training and Conference Centre, Stanton House, Stanton Way, **Huntingdon, PE29 6XL**	**1pm - 3pm**
Thursday 6 September 2018	The Meadows Community Centre, Arbury, **Cambridge, CB4 3XJ**	**1pm - 3pm**
Thursday 11 October 2018	Forli Room, Town Hall, Bridge Street, **Peterborough, PE1 1FH**	**1pm - 3pm**

* Please note that we are unable to provide refreshments at meetings

- If you belong to a group or organisation, you can invite us along to one of your meetings by contacting the Communications and Engagement Team on 01223 725304 or by emailing CAPCCG.contact@nhs.net

- Current patients and carers will be contacted directly about how they can discuss these changes and feedback their views.

Who we are and what we do

Cambridgeshire and Peterborough Clinical Commissioning Group (the CCG) is a statutory body set up to commission health services on behalf of patients registered at a GP practice in our area. The CCG and GP member practices work together collaboratively to fulfil the purpose of the CCG. The CCG's Constitution sets out how the organisation is governed and how commissioning decisions are made.

The CCG is a membership organisation. We are one of the largest CCGs in England, by patient population. We have 101 GP practices as members, which cover all GP practices in Cambridgeshire and Peterborough as well as three practices in North Hertfordshire (Royston) and two in Northamptonshire (Oundle and Wansford).

We have a patient population of around 967,000 which is diverse, ageing, and has significant inequalities. We manage a budget of around £1.2bn to spend on healthcare for the whole population of this area, which is just over £1,000 per person.

The NHS receives a fixed budget to buy and provide health services for the local population. When commissioning (the process of planning and buying) health services we do so specifically for the health needs which have been identified locally for our population. We make decisions about which health services to purchase, based on these identified needs. Like many CCGs up and down the country, there is greater demand on our budget than we have the budget to spend.

The challenge faced by all organisations across the NHS is how to spend the available budget in ways that most benefit the health of the whole population and which deliver good value for money. We have a growing population, which is also an ageing population that is diverse and has significant inequalities. We have a limited budget and a growing demand for all types of healthcare services, as well as a financial deficit that needs to be cleared.

The CCG has to evaluate every service that it commissions to see if it offers good quality, good outcomes, and good value for money, as well as whether it is an effective and equitable way of allocating our resources for the benefit of the whole population.

What is this document about?

This document is about proposed changes to the commissioning of adult inpatient beds – beds in hospitals - for people with a learning disability who need extra support, including a mental health condition; and reinvestment in community services to ensure care and support is provided at home or in the normal care setting wherever possible.

The consultation applies to people registered at a GP practice in Cambridgeshire and Peterborough but not those in Hertfordshire or Northamptonshire.

What are the issues that need to be addressed?

People with a learning disability and/or autism have the right to the same opportunities as anyone else; to live satisfying and varied lives and to be treated with dignity and respect.

Like everyone else, people with a learning disability and/or autism should be able to expect to live in their own home or another place of care within their local community, to develop and maintain positive relationships, and to receive the support they need to be healthy, safe, and an active part in society. See 'Building the Right Support'[1].

The national Transforming Care Programme was established in 2012 following the Department of Health review[2] into poor treatment and abuse of people with a learning disability and/or autism at Winterbourne View.

The Transforming Care Programme aims:

- to reduce the use of specialist hospitals, especially where people were being placed a long way from home and spending a significant period of time there
- to develop robust, community based services that can offer support in a crisis
- for assessment and treatment beds in hospitals to be used only where absolutely necessary, and with timely discharge back into the community.

In 2014 Sir Stephen Bubb undertook a further review[3] that led to a more structured approach to the Transforming Care Programme, with greater oversight and monitoring by NHS England through a national board. Local boards have also been set up to ensure that targets are met locally, with a focus on developing community services for people who have been in hospital for over five years. Developing community services to respond in a crisis, as well as developing the workforce and services, continue to be key in avoiding admitting people to hospital.

The CCG, Cambridgeshire County Council, Peterborough City Council, and Cambridgeshire and Peterborough NHS Foundation Trust (our local mental health and community services provider), with others, have written a strategy for delivering the Transforming Care Programme locally. The local strategy, Building on Strong Foundations (June 2016), aims to help people live satisfying and fulfilling lives as close to home as possible and with the right support. The aim is to ensure that the right care and support is delivered in the community wherever possible.

We would like to invest more money in community services and reduce the need for inpatient beds. In most circumstances, if community services are able to support more people to live at home or closer to home, then we can reduce the need for inpatient services.

[1] https://www.england.nhs.uk/learning-disabilities/natplan/

[2] https://www.gov.uk/government/publications/winterbourne-view-hospital-department-of-health-review-and-response

[3] https://www.england.nhs.uk/wp-content/uploads/2014/11/transforming-commissioning-services.pdf

However, it is important to emphasise that where a hospital admission is the most appropriate option for a person with a learning disability and/or autism then they should be able to access inpatient services as required. Our aim is that these services should be a last resort, of high quality, integrated with community services, and focus on people's recovery so that they can be discharged back to the community in a timely way.

To do this we are planning to redesign inpatient services and to invest in community and primary preventative services for people with a learning disability and/or autism. We are asking for your views on our proposals.

In Cambridgeshire and Peterborough, inpatient services for people with a learning disability and/or autism who need extra support, including a mental health condition, are commissioned by:

- Cambridgeshire and Peterborough CCG and Learning Disability Partnership for patients living in the Cambridgeshire County Council area
- Cambridgeshire and Peterborough CCG for patients living in the Peterborough City Council area.

Across Cambridgeshire and Peterborough there is currently a total of 16 inpatient beds, commissioned by the CCG and the Learning Disability Partnership, for people with a learning disability and/or autism. Six of the beds are at the IASS ward on the Ida Darwin site at Fulbourn and ten beds are at The Hollies at the Cavell Centre in Peterborough.

The IASS was a six-bed inpatient ward for people with a learning disability. It was commissioned by the Learning Disability Partnership and was run by Cambridgeshire and Peterborough NHS Foundation Trust, our local NHS mental health and community services provider. The unit has not been used since 1 April 2016 due to very low demand and the building not being fit for purpose. This allowed commissioners to temporarily consolidate the beds into The Hollies.

The Hollies is a specialist, ten-bed unit which provides assessment and treatment for adults with a learning disability. The service at The Hollies is commissioned as follows:

- Five beds commissioned from Cambridgeshire and Peterborough NHS Foundation Trust by the Learning Disability Partnership for patients from Cambridgeshire
- five beds commissioned by the CCG for patients from Peterborough.

In addition, the Learning Disability Partnership and the CCG commission Cambridgeshire and Peterborough NHS Foundation Trust to provide community services across the whole of the Cambridgeshire and Peterborough Transforming Care Partnership area.

We also commission a small number of 'out of area' beds as required. These are inpatient beds outside of Cambridgeshire and Peterborough CCG's area which are

additional to the number of locally-commissioned beds, and usually purchased to meet particular special needs or requirements.

By reducing the number of inpatient beds we will be able to reinvest the money we save into strengthening community services. This will help us to achieve the Transforming Care Programme's aim of commissioning and delivering better care closer to home, and improved services for people with a learning disability and/or autism and their families.

Why are we consulting with you now?

In line with the progress of the national and local programme, we have analysed our local use of inpatient beds and believe that the proposed changes will provide better clinical and patient experience outcomes for our patients, whilst delivering more effective and safe services.

What we are asking you

We have set out the options that we have considered, below. Having reviewed all of these options, we have agreed a **preferred option (Option 4)** that we are now seeking views and comments on. We believe that Option 4 will be the best option to deliver the future model of service provision as well as the objectives of the local Transforming Care Plan ('Building on Strong Foundations' 2016), in line with the expectations of the national policy called 'Building the Right Support'.

Option 1 – Do nothing

Continue to commission the 10 beds at the Hollies as per the current use and close six beds at IASS. This in brief includes five beds commissioned through Cambridgeshire and Peterborough CCG and five beds commissioned through the Learning Disability Partnership. This would also include the continuation of spot purchasing out of area beds as required.

Pros	Cons
No Change.	The Hollies ward is not used fully, because the unit cannot support all the people that would need hospital admission, so we need to buy other hospital beds out of area.
	Not cost effective because commissioners are required to 'double fund' placements by placing patients out of area whilst there are vacant beds at the local ward.
	Outcomes for Transforming Care Programme and NHS England would not be met.

Option 2 – Retain local beds only with no option of out of area beds or further community investment

Consolidate all bed requirements to a local Assessment and Treatment Unit (ATU) based at the Hollies and close six beds at IASS, with no spot purchased out of area beds which are currently used in situations where the Hollies is not able to support the person.

Pros	Cons
Inpatient services would remain local and provide greater accessibility for patients and visitors including family members.	Capacity of local ATU to care effectively and safely for a range of needs that may require a diversity of support and treatment including intermediate care or 'safe and secure' rehab type pathways.
Existing skill set and staff experience would be retained.	Experience of existing provision and the reality, even with enhanced 'safer staffing' levels, of not being able to meet the needs of local patients having to be placed out of area sometimes at the behest of the local ATU itself.
Eliminate the need to send patients out of area away from their families and local communities making it, in theory, easier to facilitate timely discharge with local community services.	Limitation of commissioners to purchase bespoke inpatient services for patients with highly complex needs that may require highly specialised provision or hospital care within a single occupancy setting.
Provide greater cost effectiveness with commissioners no longer required to 'double fund' placements by placing patients out of area whilst there are vacant beds at the local ATU.	Impact on alternatives to admission and the capacity to change the service across the health system with resources tied up in bed based provision, hampering the requirement to build up new and innovative community alternatives in 'cash flat' times.
Improve monitoring of care and treatment and consistency of quality with provision consolidated in one inpatient setting.	Future intent of current provider regarding hospital estate and service development beyond provision of inpatient services for people with learning disabilities.
	Significant environmental changes would need to be made to the Hollies ward to meet the needs of patients.

	Significant changes to and for staff would need to be made and accommodated for increased intensity and complexity of patient needs.
	With increase in intensity, unpredictability, complexity, and nature of this cohort of patients, there will be increased risks associated both to staff and to other patients on the ward.

Option 3 – No dedicated local beds

Decommissioning of local ATU (10 beds at the Hollies) and six beds at IASS. Instead move to a 'No Bed Model' and develop spot purchase arrangement for beds in other hospitals with some local reasonable adjustments for patients with learning disabilities and/or autism that can function on mental health wards in addition to the enhancement to community teams.

Pros	Cons
Secure a funding stream that would guarantee re-investment in community services and alternative inpatient services as and when required. This means expansion of specialist community services including larger community teams with broader skills, which would reduce the need to admit patients. Investment into crisis accommodation called 'crash pad'.	There will be a risk of increased out of area admissions which does not support the outcomes of the national Transforming Care Programme.
Patient centred spot purchased beds may best ensure highly complex patient needs are met, which could result in shorter hospital admissions and timely patient discharges.	Out of area admissions at a distance from the person's home would be contrary to Transforming Care agenda and counterproductive, with care being provided away from local community, potential for increased length of stay in institutional settings, and the practical difficulties of monitoring quality of care and slowdown in discharge preparation.
Create new pathways and better integration with other specialist and mainstream services including the local First Response Service and access to existing community provision with reasonable adjustment as examples.	Loss of skills as specialist inpatient staff may be redeployed outside of specialty or transferred to newly commissioned alternative providers.

Create the capacity to recycle specialist skills within enhanced community services and share skills with wider provision to embed reasonable adjustments and make it a reality.	Integration of patients with a learning disability in mental health wards may work for some but not all within the spectrum of learning disabilities, placing the most complex and vulnerable people at further risk.
Better meeting the needs and preferences of people with learning disabilities and their families as support and interventions are provided in the least restrictive manner in their own homes within the community.	Capacity and willingness of providers of non-learning disability services to want to embrace a model that may impact negatively on existing mental health pathways.
Develop a robust independent and in house (council) community provider marketplace that supports the prevention agenda with a skilled and trained workforce.	May require additional money to support 'reasonable adjustment' in mental health inpatient settings with the assumption that the existing estate could accommodate any necessary capital work.
	Potential issues with sourcing and securing an out of area specialist bed when needed (as the last resort) if on a spot purchase basis; as experience is that bed capacity is limited, and will be further limited as the Transforming Care Programme progresses nationally with sites affected across the independent hospital sector.

Option 4 – preferred option

Decommissioning of the local ATU (10 beds at the Hollies) and six beds at IASS with reinvestment to develop the following services:

- Investment to enhance the local community teams, to provide more capacity for early intervention to prevent crises developing, and more capacity to support people intensively who do reach crisis.

- Strengthening the expertise of staff in local care, support, and housing agencies to support people who need extra support.

- Development of more 'crash pad' facilities that can offer a break from current living arrangements, with support and interventions from experienced staff who know the person, to avoid admission to hospital.

- Where a mental health condition is the overriding issue and where this is considered the most appropriate response, make reasonable adjustments for

people with learning disabilities and/or autism to access mainstream mental health wards (ideally one in Cambridgeshire and one in Peterborough).

- Commission five specialist inpatient beds to meet the needs of those people who cannot be supported on mainstream mental health wards, or for whom this would not be appropriate. This could be commissioned from Cambridgeshire and Peterborough NHS Foundation Trust, another NHS trust, or an independent sector provider. The CCG will want to consider all options.

Pros	Cons
Continuity of medical professional for patients admitted in area would reduce the risk of delayed discharges and best ensure focused and holistic assessment and treatment.	Economy of scale cannot be ensured with a reduced number of beds thus this arrangement may be more expensive for a commissioned service.
The enhanced local forensic pathway* linked with the mainstream pathway would better ensure targeted assessment, treatment, and after care support. (*Forensic mental health services work with people who have mental health conditions and have committed a serious criminal offence, or are thought to be at high risk of committing an offence. (Definition taken from South West London and St George's Mental Health NHS Trust website)).	Retain resources disproportionately in bed based provision which may significantly compromise capacity to develop and deliver community based alternatives.
Create new pathways and better integrate with other specialist and mainstream services, including the local First Response Service, and access to existing community provision with reasonable adjustment as examples.	Impact of decommissioning intent in the Independent sector and commitment and mandate from NHSE not to place in such services
Reassure medical professionals treating patients with a learning disability that bed availability is within the new model when absolutely required.	Flexibility of provision and contract as new provider may require a significant financial commitment in order to undertake provision including 'locking' commissioners into a block contract arrangement.
Create the capacity to recycle specialist skills within enhanced community services and share skills with wider provision to embed reasonable adjustment and make it reality.	Risk that mainstream beds become blocked if they are not ring-fenced for patients with a learning disability which would result in increased out of area placements.

Release money to invest in ‘alternative to admission’ provision including ‘crash pad’ type facilities locally.	Risk that the reasonable adjustments to mainstream beds, including Learning Disability Nurses, may not be consistently available which may result in unnecessary out of area placements.
Better meeting the needs and preferences of people with learning disabilities and their families, as support and interventions are provided in the least restrictive manner in their own homes within the community.	
Develop a robust independent and in house (council) community provider market place that supports the prevention agenda with a skilled and trained workforce.	
Expansion of specialist community services by investing in larger community teams with broader skills would reduce need for patients to be admitted.	
Use of spot-purchased out of area beds would be reduced thus meeting TCP and NHS England outcomes and trajectories.	
Local commissioned ATU beds could be enhanced and underpinned by medical professionals in the community within the enhanced community model; thus maximising investment and reducing a fragmented approach which will result in improving the patient ‘experience’ and outcomes	

Engagement to date

We have engaged with stakeholders, including people with a learning disability and/or autism and their carers, through a range of meetings, including:

- the Transforming Care Partnership Board
- other cross agency meetings.

We also held a health and social care event called ‘Community First’ in Cambridgeshire in October 2017 and presented to a Cambridgeshire-wide Speak Out Council event in Isleham about our transforming care plan. We realise that we need to engage much further as part of this consultation.

How to tell us your views

- Fill in the questionnaire on our website: www.cambridgeshireandpeterboroughccg.nhs.uk/get-involved/consultations

- Fill in the paper copy of the questionnaire found on page 18 of this consultation document and send it FREEPOST to: Freepost Plus RSCR-GSGK-XSHK, Cambridgeshire and Peterborough CCG, Lockton House, Clarendon Road, Cambridge CB2 8FH. You do not need a stamp.

- Telephone the Communications and Engagement Team on 01223 725304.

- Current patients and carers will be contacted directly about how they can discuss these changes and feedback their views.

- We will attend meetings organised by groups who are interested in the proposed changes. If you would like us to attend your meeting please contact us as below:

    - Phone: 01223 725304

    - Email: capccg.contact@nhs.net

Why we consult

Legal requirements

This consultation document has been drawn up in accordance with the following legal requirements and guidance:

Cabinet Office Consultation Principles July 2012

This guidance sets out the principles that Government departments and other public bodies should adopt for engaging stakeholders when developing policy and legislation. It replaces the Code of Practice on Consultation issued in July 2008. The governing principle is proportionality of the type and scale of consultation to the potential impacts of the proposal or decision being taken, and thought should be given to achieving real engagement rather than merely following bureaucratic process. Consultation forms part of wider engagement and decisions on whether and how to consult should in part depend on the wider scheme of engagement.

Policy makers should bear in mind the Civil Service Reform principles of open policy making throughout the process and not just at set points of consultation, and should use real discussion with affected parties and experts as well as the expertise of civil service learning to make well informed decisions. Modern communications technologies enable policy makers to engage in such discussions more quickly and in a more targeted way than before, and mean that the traditional written consultation is not always the best way of getting those who know most and care most about a particular issue to engage in fruitful dialogue.

The full consultation principles document can be accessed via the Cabinet Office website at:
https://www.gov.uk/government/publications/consultation-principles-guidance

Section 14Z2 Health and Social Care Act 2012

14Z2 Public involvement and consultation by clinical commissioning groups

(1) This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by a clinical commissioning group in the exercise of its functions ("commissioning arrangements").

(2) The clinical commissioning group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways)—

> (a) in the planning of the commissioning arrangements by the group,
>
> (b) in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are

delivered to the individuals or the range of health services available to them, and

(c) in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

(3) The clinical commissioning group must include in its constitution—

(a) a description of the arrangements made by it under subsection (2), and

(b) a statement of the principles which it will follow in implementing those arrangements.

(4) The Board may publish guidance for clinical commissioning groups on the discharge of their functions under this section.

(5) A clinical commissioning group must have regard to any guidance published by the Board under subsection (4).

(6) The reference in subsection (2) (b) to the delivery of services is a reference to their delivery at the point when they are received by users.

For more on the Section 14Z2 Health and Social Care Act 2012 see http://www.legislation.gov.uk/ukpga/2012/7/section/26/enacted

Assurance of service change

The five tests of service change:

There must be clear and early confidence that a proposal satisfies the government's four tests, NHS England's test for proposed bed closures (where appropriate), best practice checks, and is affordable in capital and revenue terms. The government's four tests of service change are:

- Strong public and patient engagement.
- Consistency with current and prospective need for patient choice.
- Clear, clinical evidence base.
- Support for proposals from clinical commissioners.

NHS England introduced a new test applicable from 1 April 2017. This requires that in any proposal including plans to significantly reduce hospital bed numbers NHS England will expect commissioners to be able to evidence that they can meet one of the following three conditions:

i. Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
ii. Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or

iii. Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme).

CCG Constitution Section 5.2.

5.2. General Duties - in discharging its functions the NHS C& P CCG will:

5.2.1. Make arrangements to ***secure public involvement*** in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements by:

a) ensuring that individuals to whom the services are being or may be provided are involved:

(i) in the planning of the CCG's commissioning arrangements;
(ii) in the development and consideration of the proposals by the CCG for changes in commission arrangements;
(iii) in the decisions of the CCG affecting the operation of commissioning arrangements, where the decisions would, if made, impact on the manner in which the services are delivered to the individuals or the range of health services available to them;

b) in order to understand the views of patients and the public and to disseminate relevant information to them, establishing and working closely with:

(i) a Patient Reference Group which is constituted as a committee of the Governing Body in accordance with this Constitution; membership will be formed from patient representatives elected by local patient forums;
(ii) the Quality, Outcomes and Performance Committee which is constituted as a committee of the Governing Body and considers patient experience, complaints and feedback;
(iii) Patient Participation Groups which will seek the views of local populations and assist with the dissemination of information, and representatives of which will sit on each local patient forum;

c) in order to understand the views of patients and the public and to disseminate relevant information to them, ensuring regular liaison and the development of close working relationships with each of the following bodies:

(i) Patient Forums, which are intended to give individuals the opportunity to raise questions or concerns about the provision of healthcare services at the wider county level;
(ii) Healthwatch, which gathers views of local people on local health services;
(iii) Health Overview and Scrutiny Committees which review the planning, commissioning and delivery of health services;
(iv) Health and Wellbeing Boards, each of which is a group of key leaders representing health and care organisations who work together to understand what their local communities need from health and care services and to agree priorities;

d) publishing a Communications Membership and Engagement Strategy, approved by its Governing Body and regularly revised to take into account any new guidance published by NHS England, which will be designed to ensure that the CCG involves patients and the public by a range of means that are suitable to different aspects of its commissioning arrangements, those means to include as appropriate:

(i) the publication of documents to disseminate relevant information about the commissioning arrangements;
(ii) regular attendance at key meetings, forums and events for the purpose of listening to the views of patients and the public, providing information about and explaining actions being taken or considered by the CCG, and answering questions;
(iii) the dissemination of information by means of the CCG website, emails, newsletters targeted at specific groups, media campaigns, advertising, and targeted engagement events;
(iv) the provision of an opportunity for patients and the public to make their views known via the CCG website, emails and other suitable means;
(v) the publication of consultation documents in relation to certain planning and commissioning activities, and the creation of specific engagement opportunities such as the use of public surveys and feedback forms;

e) in the implementation of the arrangements described above, acting consistently with the following principles:

(i) ensuring that appropriate time is allowed for the planning of activities and commissioning arrangements;
(ii) proactively seeking engagement with the communities which experience the greatest health inequalities and poorest health outcomes;
(iii) commencing patient and public involvement as early as possible and allowing appropriate time for it;
(iv) using plain language, and sharing information as openly as is reasonably practicable;
(v) treating with equality and respect all patients and members of the public who wish to express views;
(vi) carefully listening to, considering and having due regard to all such views;
(vii) providing clear feedback on the results of patient and public involvement.

You can read more about the CCG's duties to engage and consult in section 5.2 of the CCG's Constitution

https://www.cambridgeshireandpeterboroughccg.nhs.uk/easysiteweb/getresource.axd?assetid=4360

The questionnaire

1. Do you agree with our preferred option 4 starting on page 10?

2. If yes, why?

3. If not, why not?

4. Are there any other comments you would like to make in relation to the proposals outlined in this consultation document?

If organisations or groups would like to respond to this consultation, we are happy to receive letters or emails using the contact information below. In our end of consultation report we enclose full copies of these responses so please indicate if you wish your organisation or group response to remain private:

By post: (no stamp required)

Freepost Plus RSCR-GSGK-XSHK
Engagement Team
Cambridgeshire and Peterborough CCG
Lockton House
Clarendon Road
Cambridge
CB2 8FH

By email: capccg.contact@nhs.net

The closing date for receipt of responses to this consultation has been extended to 5pm on 12 October 2018.

Finally, to understand who has given their views, we would like to collect some details.

Any information provided in this section will only be used by Cambridgeshire and Peterborough Clinical Commissioning Group for the purpose of understanding who has responded to this consultation.

Can you tell us which of the following age bands you belong to?

	16-29 years		30-44 years		45-59 years		60-74 years		75+ years

How would you describe your gender?

How would you describe your ethnic background?

Do you consider yourself to have any disabilities and/or impairments?

Yes ☐ No ☐ Prefer not to answer ☐

Finally, please could you tell us the first part of your postcode?

Thank you for taking the time to complete this questionnaire.

The closing date for receipt of responses to this consultation has been extended to 5pm on 12 October 2018.

Through this public consultation your views will be fed into the development of the final proposal. All of the feedback received from all of the responses to this consultation will be collated into a report for the CCG's Governing Body to consider before it makes any decisions on the future of these services.

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

CONSULTATION

Transforming Care for Adults with Learning Disabilities and/or Autism

10 August 2018 to
5pm 28 September 2018

Consultation extended to
5pm on Friday 12 October 2018

What will you read about?

Amended on 22 August 2018

Introduction

The care and treatment of patients at Winterbourne View was very bad.

People should have good and safe care. People should feel safe and happy.

Care and support needs to be better for people with a learning disability or autism.

This plan is about how we would like to make care and support better for adults with a learning disability or autism in Cambridgeshire and Peterborough.

And **we want your opinions.**

What we plan to do

This **consultation** is about plans to pay for specialist hospital beds for people who have a learning disability or autism.

This change is needed so that we can make services in your **community** better.

This is so patients get care and support closer to their homes.

It is also about how we support people with a learning disability or autism out of hospital.

The Hollies in Peterborough

In this document we are talking about hospital beds at the Hollies (Cavell Centre). They are specialist beds for people who have learning disabilities.

We want you to have your say on how we plan to make services better for adults with a learning disability or autism in Cambridgeshire and Peterborough.

When we have your views at the end of the **consultation** we will make a final plan on how we can make services better for you and need less **specialist hospital beds**.

Why we need to do it

The need to transform care started after people with a learning disability were abused at **Winterbourne View**.

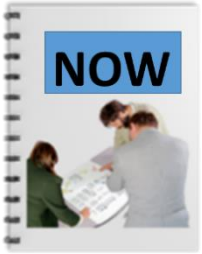
After what happened at Winterbourne View, a Government report called **Building the Right Support** told us what we needed to do to start making things better.

This job was given to Transforming Care Partnerships (TCPs).

Transforming Care is about making care and support better for people with a learning disability, autism, or both who need extra support during times of distress or illness**.**

We want there to be less specialist hospitals in the future.

With the right support people should be able to live in their own homes they have chosen in their **communities.**



At the moment in Cambridgeshire and Peterborough we pay for 10 hospital beds at the Hollies and support in the community. We also pay for some patients to be in hospital beds outside of Cambridgeshire and Peterborough.

What we need to do

Fewer hospital beds

People should only go into specialist hospital if:

- they are at risk of hurting themselves or other people
- when assessment and treatment cannot safely be given in the community.

Care and treatment in hospital must be what is right for the patient.
It must aim to get people well and back in to the community.

People should be in hospital for as little time as possible.

Plans for people to come out of hospital should be made as soon as the person goes in to hospital.

Hospitals should work with community services to make sure people get the right support when they leave hospital.

Better support in the community

Enhanced community support.
It means expert community support in the community for people with a learning disability or autism and who need extra support.

How you can contact us

Legal requirements
The full consultation principles document can be accessed via the Cabinet Office website at:
https://www.gov.uk/government/publications/consultation-principles-guidance
For more information please call the Communications and Engagement Team on 01223 725304.

Languages
This document is available in other languages and formats on request.
To request alternative formats, or if you require the services of an interpreter, please call us on 01223 725304.

Information on this consultation
Please call the Communications and Engagement Team on 01223 725304.

How we plan to do it

Option 1
Stay the same


The Hollies in Peterborough

✓ 10 beds at the Hollies in Peterborough.

Beds outside of Cambridgeshire and Peterborough.

Option 2
Use one hospital in Cambridgeshire/Peterborough


The Hollies in Peterborough

✓ 10 beds at the Hollies in Peterborough.

No beds outside of Cambridgeshire and Peterborough.

Option 3
No hospital beds – all community support


The Hollies in Peterborough

No hospital beds.

Enhanced community support.

Option 4 – The preferred option
Fewer hospital beds and better community support

Five hospital beds in Cambridgeshire and Peterborough.

Use the money saved from hospitals to provide more community services.

The Questionnaire

1. Which is your preferred option? ☑

	Option 1
	Option 2
	Option 3
	Option 4

2. Why is this your preferred option?

3. Is there anything you would like to say about any of the proposals outlined in this consultation document?

At the end of our consultation report we use copies of your questionnaires so please ☑ if you would like your questionnaire to be private:

☐ Yes, I am happy for my response to be seen by others.

☐ No, I would like my response to be private.

To have your say

Fill in the questionnaire on our website: www.cambridgeshireandpeterboroughccg.nhs.uk/get-involved/consultations

Send a completed copy of page 8 to:

Freepost Plus RSCR-GSGK-XSHK
Cambridgeshire and Peterborough CCG
Lockton House, Clarendon Road
Cambridge CB2 8FH.

You do not need a stamp.

Attend one of the public meetings detailed below and tell us what you think:

Peterborough
Date: Thursday 16 August
Time: 1.30pm - 3.30pm
Venue: Forli Room, Town Hall, Bridge Street, Peterborough, PE1 1FH

Huntingdon
Date: Thursday 23 August 2018
Time: 1pm - 3pm
Venue: Suite 1, Stanton Training and Conference Centre, Stanton House, Stanton Way, Huntingdon, PE29 6XL

Cambridge
Date: Thursday 6 September 2018
Time: 1pm - 3pm
Venue: The Meadows Community Centre, Arbury, Cambridge, CB24 5NW

Peterborough
Date: Thursday 11 October 2018
Time: 1pm - 3pm
Venue: Forli Room, Town Hall, Bridge Street, Peterborough, PE1 1FH

* Please note that we are unable to provide refreshments at meetings.

If you would like us to attend your meeting, please contact us on the number below.
www.cambridgeshireandpeterboroughccg.nhs.uk or contact the Communications and Engagement Team:

Phone: 01223 725304
Email: capccg.contact@nhs.net

Telephone the Communications and Engagement Team on 01223 725304.

The closing date for receipt of responses to this consultation is 5pm on 12 October 2018.

More information for you

Building the Right Support

https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-net-plan-er.pdf

Winterbourne View Report

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213216/easy-read-of-final-report.pdf

Transforming Care

https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-serv-model-er.pdf

https://www.england.nhs.uk/wp-content/uploads/2017/02/easy-read-model-service-pec.pdf

Words section

Commission = planned services that we pay for.

Proposal = option.

Funding = pay for a service.

Specialist hospital bed = a bed in a hospital for people with a learning disability and / or autism who need assessment and treatment for mental health problems or who need extra support. They are NOT general hospital beds where patients go for an operation or after an accident.

Programme = a plan for the future.

Communities = for this document we mean the area that you live in because it means ‘home’ for you.

Enhanced = improvement or making services better.

Impact Assessments for;

Project 110123 – Learning Disabilities – BRS Model

QIA

Project Name	**110123 - Learning Disabilities - BRS Model**
Is a QIA required?	Yes
Reason why a QIA is not required*	
Clinical Effectiveness Description	Community enhancement is already taking root with enhance provision locally and the implementation of 'wrap around' support for individuals in crisis and acuity this has effectively prevented and avoided hospital admission. Occupancy levels within commissioned inpatient provision has reduced significantly in recent years as clinical services and health and social care professionals develop and implement community solutions to effectively manage crisis, risk and behaviours that challenge.
Clinical Effectiveness Consequence	3
Clinical Effectiveness Likelihood	3
Clinical Effectiveness Risk	9
Clinical Effectiveness Mitigating Actions	Systemic qualification of need for admission through the Transforming Care CTR process and scheduled multi-agency review of all hospital admissions ensure that support is in place for hospital admission and alternatives to admission as required.
Clinical Effectiveness Post Mitigating Risk	9
Patient Experience Description	Hospital admission can be a highly distressing experience for people with learning disabilities and /or autism. Admission periods are often lengthy and can lead to loss of accommodation and support. Some admissions require Out of Area placement due to inability of local services to support individuals within their home communities. A small number of people will require hospital admission where absolutely necessary and provision should be in the most appropriate setting linked to a community pathway to facilitate timely discharge and on-going support.
Patient Experience Consequence	4
Patient Experience Likelihood	3
Patient Experience Risk	12

Patient Experience Mitigation	Alternatives to hospital admission are at the centre of implementation of the BRS model. The preferred option invests and implements community solutions including enhanced community provision available out of hours and local facilities such as a 'crash pad' to accommodate and support individuals during crisis. Specialist inpatient beds will be retained to care and support those that require admission and these facilities will be closer aligned to community pathways to facilitate timely discharge and more robust discharge arrangement.
Patient Experience Post-mitigation Risk	6
Patient Safety Description	Future BRS model will invest resources in community pathways as an alternative to hospital admission. This may increase risk within the community and to the individual patient if effective community responses are not in place and accessible at the point of need. The proposed BRS model (preferred option) seeks investment and realignment of resources toward community solutions such as enhanced intensive support teams and 'crash pad' facilities. The preferred option also includes access to a reduced number of hospital beds when absolutely necessary and when all other least restrictive arrangements have been exhausted.
Patient Safety Consequence	5
Patient Safety Likelihood	3
Patient Safety Risk	15
Patient Safety Mitigation	Community provision will be enhanced to support individuals in crisis through increasing hours of operation (8am till 8pm and weekends). 'Crash pad' facilities will be commissioned to accommodate and support individuals in crisis where previously hospital admission may have been an option. A defined number of specialist LD and /or Autism beds will continue to be commissioned to facilitate hospital admission where absolutely necessary. In addition mainstream AMH wards will 'reasonably adjust' to accommodate the needs of some patients that can function well and safely in an AMH ward setting.
Patient Safety Post Mitigation Risk	9
IA Submitted for Review	To be reviewed
Impact Assessment Approved	To be reviewed

EIA

Project Name	110123 - Learning Disabilities - BRS Model
What are the aims and objectives?	Consultation on the implementation of the 'Building the Right Support' (BRS) model for people with learning disabilities and/or autism across Cambridgeshire and Peterborough. Specifically engagement and views sought on a preferred option. The preferred option requires investment in community based provision and least restrictive alternatives to hospital admission. This will include enhancement of intensive support provision and extension of operating hours of community teams. The establishment of a 'crash pad' facility in support of crisis in the community and further investment in Positive Behavioural Support training to upskill workforces to better meet need and acuity in the community. The preferred option is part of the local Transforming Care Partnership work plan 'Building on Strong Foundations' (2016) linked to the NHS England hospital bed trajectory target for Cambridgeshire and Peterborough. The proposal calls for a reduced number of commissioned learning disabilities specialist beds based on national directive and evidence of reducing occupancy levels in recent years as alternatives to admission and better ways of managing need in community settings take root.
What are the desired outcomes?	To provide contemporary care and support in the least restrictive environment. To secure investment and enhancement in community based provision. To continue to provide a reduced number of inpatient beds to be used only as a last resort when all least restrictive alternatives have been exhausted. To deliver 'parity of esteem' and 'reasonable adjustment' in services that could meet the needs of some people with learning disabilities and /or autism with better access and support i.e. AMH wards To consult and engage with people with learning disabilities and/or autism about a future model / preferred option and utilise those views positively.
What changes or actions changes or actions do you propose to take as a result of any consultation	The outcome of the consultation will shape preferred option proposal and may change the way community services are delivered and bed configuration. Consultation phase June/July. Outcome of consultation and preferred option changes august / sept. Implementation phase beginning 1 October 2018.
What changes or actions do you propose to make or take as a result of research and/or consultation?	Consultation and engagement planned for June 2018. Consultation period will be lengthened to account for needs of people with learning disabilities and others. Advocacy agencies will work in partnership with regard to engagement strategies including user accessible material and community meetings throughout consultation period.

What factors could contribute to the desired outcomes?	Transforming Care Partnership committed to community model of investment and service delivery. Performance management arrangements and KPI's set and monitored by NHS England. Positive outcome from consultation and engagement on the preferred option proposal. Evidence base locally and reduced occupancy levels in inpatient settings overtime.
What factors could detract from the desired outcomes?	Outcome of intended consultation and engagement. Commitment of commissioners and providers to make the required changes. Progress on project plan within expected timeframes. Financial pressures within the local health and social care economy.
What monitoring/evaluation/review systems have been put in place?	There is a robust project plan in place which has been positively received at NHS England. A steering Group will support the consultation, engagement and implementation of preferred option outcome. TCP Board and TCP executive direct monitor and support all activities within the TCP work plan and associated milestone targets.
What was the outcome of the consultation, if undertaken?	Yet to take place.
When will it be reviewed?	Weekly/monthly
Which of the following protected characteristics could be disadvantaged	Groups listed below
Who are the main stakeholders?	Service users and their families Care providers and care professionals Commissioners and contracting
Who is responsible?	Transforming Care Partnership - SRO's
Who will benefit?	Service users and their families will benefit from securing care and support in their own homes or homely settings. Health and social care provision will benefit from investment in contemporary models of service delivery. Commissioning authorities will benefit as resources are targeted more effectively and efficiently and not locked up in traditional outmoded models of care that are not optimally performing.
Will the planned changes lower any negative impacts?	Yes
Will the planned changes to the proposal provide an opportunity to promote equality, equal opportunity	Yes
Will the proposed changes ensure the remaining negative impacts are legal	Yes
Proposal impact on groups identified	Better meeting the needs and preferences of people with learning disabilities and or autism and their families as support and intervention during periods of crisis and raised acuity are provided in the least restrictive arrangements in their own homes within their communities.
Age	Yes
Race	Yes
Disability	Yes

Religion and Belief	Yes
Religious/Cultural Observance	No
Sex/Gender	Yes
Sexual Orientation	Yes
Employment/Training	Yes
Taking into account the views of the groups consulted and the available evidence, please clearly sta	Consultation has not yet taken place. Local evidence would indicate need for inpatient provision is falling both local occupancy rates and OOA placements. Enhanced arrangements in community i.e. IST in Peterborough and 'wrap around' support in Cambridgeshire is taking root. However research into the effectiveness of such models is limited and the evidence base is not strong enough to determine which model(s) provides the most effective care (community - based Services for People with Intellectual Disability and Mental Health problems - faculty report, May 2015 - The Royal Colleague of Psychiatry.
Pregnancy Leave Related and Maternity Leave Related	No
Pregnancy and Maternity	Yes
Marriage and Civil partnership	
Positive Impacts	Sustain community presence and continuity of living. Improve access to wider provision, securing right care in right place at right time. Meet diversity and cultural needs in own home or community setting. Prevent restrictive practice and inappropriate care regimes Reduce stigmatization linked to hospital admission Reduce out of area placement and institutionalised care pathways.
Negative Impacts	Could lead to further out of area placement by default if reduced local beds become 'blocked' and community infrastructure fails to sustain people at risk of admission in community setting.
Has the E&D Advisor requested that the EIA form below is completed?	No
Has the equality and Diversity Advisor seen and approved the screening tool above?	No
Have you consulted on the proposal, if so, with whom, if not why not?	The intention is to consult and engage fully pending approval at GB on 24th May 2018
Date Submitted	
Date Reviewed	
Assessor Comments	
Assessment Approved	

Initial IA

Project Name	**110123 - Learning Disabilities - BRS Model**
Q1 How many people will be affected by this change?	30 -50
Q2 What is their age range?	18 - 75
Q3 Where is they living?	Cambridgeshire and Peterborough
Q4 What are their other defining features?	Adults with learning disabilities and /or autism
Q5 Are there existing inequalities within the group?	The persistence of health inequalities between different population groups has been well documented, including the inequalities faced by people with learning disabilities. Today (2018), people with learning disabilities die, on average, 15 -20 years sooner than people in the general population, with some of those deaths identified as being potentially amenable to good quality healthcare.
Q6 Are there existing inequalities between groups of patients?	People with learning disabilities and /or autism who come into contact with specialist provision often have a complex mix of co-morbidities including developmental disorders, mental illnesses, personality disorders, substance misuse, and physical disorders including epilepsy. Some of these present with challenging behaviour others do not. This cohort within the larger learning disabilities and /or autism population are more likely to be subject to specialist hospital admission and restrictive practices of care and for some involvement in the criminal justice services. criminal
Q7 Have the communications team been consulted around a consultation?	Yes
Q8 Is a consultation required?	Yes
Date Submitted for Review	
Date of first review	
Assessor Comments	
Date Assessment Approved	

HIA

Project Name	110123 - Learning Disabilities - BRS Model
Q1 What type of impact will the proposal have on health, mental health and wellbeing?	Positive
Rationale for Q1	The BRS model preferred option will realise a substantial shift away from reliance on inpatient care with a clear commitment to support people to live in their own homes within the community, supported by local services and community pathways. The preferred option recognises the need for retention of access to some inpatient provision but only when absolutely necessary and as a consequence of when all alternative to admission are fully exhausted.
Q2 What will the impact be on an individual's ability to improve their own health and wellbeing?	Positive
Rationale for Q2	The BRS model and preferred option moves away from historical solutions in supporting individuals in crisis and poor mental health through overreliance on inpatient care or other restrictive approaches. Investment in community solutions means people can recover in their own home environment with early intervention and 'wrap around' support.
Q3 What will the impact be on social, economic and environmental living conditions?	Positive
Rationale for Q3	The intensive community support based model evidence base is small however Mineen et al (1997) compared 25 patients treated in a hospital with 25 patients who recieved outreach treatment from the community learning disability team. They found that outreach treatment was equally effective as reducing psychiatric symptoms and was also more cost effective.
Q4 What will the impact be on demand/access to health and social care?	Positive
Rationale for Q4	The 'mixed economy' arrangement of enhanced community support and reduced inpatient reliance - but there when absolutely required will remove inappropriate access and perverse incentive in the health and social care economy. This however may lead to an increase in social care costs as community solutions tale precedent.
Q5 Will the proposal on global health be positive, neutral or negative?	Positive
Rationale for Q5	Hassiotis et al (2000) found that, in people with psychosis and learning disabilities (borderline intellectual functioning), intensive support community care led to significantly less time spent in hospital in comparison to standard care.
Q6 Are any outcome risks on your Risk Register?	Yes

Q7 Has the HIA Advisor seen and approved a screening tool?	No
Q8 Has the HIA Advisor requested that the full form be completed?	No
Q9 Will the health impacts be medium to long term?	
Rationale for Q9	
Q10 Do each of the negative health impacts have a mitigation in place?	
Rationale for Q10	
Q11 Are the health impacts likely to generate public concern?	
Rationale for Q11	
Q12 Are the health impacts likely to generate cumulative and/or synergistic impacts?	
Rationale for Q12	
Q13 will the health impacts have an overall positive or negative impact on health of the local popul	
Rationale for Q13	
Q14 Quantify or describe important health impacts	
Q15 Recommendations to improve the project to maximise the health outcomes for the local population	
Top Indicator 1.Title	
Impact Indicator 1	Neutral
Rationale for Indicator 1	
Top Indicator 2.Title	
Impact Indicator 2	Neutral
Rationale for Indicator 2	
Top Indicator 3.Title	
Impact Indicator 3	Neutral
Rationale for Indicator 3	
Top Indicator 4.Title	
Impact Indicator 4	Neutral
Rationale for Indicator 4	
Top Indicator 5.Title	
Impact Indicator 5	Neutral
Rationale for Indicator 5	
Top Indicator 6.Title	
Impact Indicator 6	Neutral
Rationale for Indicator 6	
Top Indicator 7.Title	
Impact Indicator 7	Neutral
Rationale for Indicator 7	
Other Indicators	

Impact for Other Indicators	Neutral
Rationale for Other Indicator	
Submitted for Review	FALSE
IA Submitted for Review	
IA Reviewed	
IA Approved	
Assessor Comments	

HIIA

Project Name	110123 - Learning Disabilities - BRS Model
Q1 What evidence have you considered to determine what health inequalities exist in relation to your	Health status from the Public Health Observatory profiles for both Cambridgeshire and Peterborough. Data from LD health registers and forward strategic planning Data and narrative from 'Building on Strong Foundations' C & P Transforming Care Partnership Plan Bed Occupancy and CTR data since September 2015 National service specifications detailed in NHSE Guidance Data provided by NHS England regarding patient trajectory performance
Q2 Will this work produce any specific changes in inequalities in access?	yes
Impact Q2	Positive
Rationale for Q2	Improvement in crisis response provision specifically for people with learning disabilities and /or autism. Access to mainstream AMH provision including inpatient beds through 'reasonable adjustment' and parity of esteem
Q3 Will this work produce any specific changes in inequalities in health outcome?	yes
Impact Q3	Positive
Rationale for Q3	Inequalities in accessing provision should be reduced and more responsive local provision secured which will reduce the need for restrictive forms of care including out of area placement.
Q4 If this service was provided in an integrated way within NHS what would be the impact?	Service is in part provided by the NHS within an integrated model commissioned through Section 75 arrangement, block and spot. Revising the Section 75 arrangements based on implementation of the BRS Model will further improve integration and reduce health inequality.
Impact Q4	Positive
Rationale for Q4	Realisation of the local TCP Plan and key milestone targets including specific pathways that will address in part inequity.
Q5 If this service was provided in an integrated way with Social Care, what would be the impact?	As above the service is in part integrated with social care and in the case of the LDP, CCC fully integrated on both a commissioning and provision level (health and social care)
Impact Q5	Positive
Rationale for Q5	See above

Q6 What is the potential overall impact of your work on health inequalities?	Development of a community based model that facilitates greater access to relevant support and care which will reduce the historical reliance on restrictive options that habituate and sustain inequity and at times remove people with learning disabilities and/or autism from their families and communities for significant periods of time.
Impact Q6	Positive
Rationale for Q6	Commitment to Building the Right Support (2015) and the three year national Transforming Care programme.
Date Submitted	
Date Reviewed	
Date Approved	

PIA

Project Name	**110123 - Learning Disabilities - BRS Model**
Q1 Will the project involve any data from which individuals can be identified	No
Rational for Q1	
Q2 Will the project result in you making important decisions about individuals?	No
Rationale for Q2	
Q3 Will the project require you to contact the individuals in ways they may find intrusive?	No
Rationale for Q3	
Q4 Will the project involve the collection of new information about individuals?	No
Rationale for Q4	
Q5 Will the project compel individuals to provide information about themselves?	No
Rationale for Q5	
Q6 Will information about individuals be disclosed to new organisations/people?	No
Rationale for Q6	
Q7 Are you using information about individuals for a new purpose/in a new way?	No
Rationale for Q7	
Q8 Will you be using a new system or using an existing system in a different way?	No
Rationale for Q8	Not in relation to data
Q9 Does the project involve you using new technology which might be perceived as being intrusive?	No
Rationale for Q9	
Q10 Is this project using the same processes and procedures that have historically been in place?	Yes
Rationale for Q10	
DPO Sign-off	Yes

SIRO Approval	No

SIA

Project Name	**110123 - Learning Disabilities - BRS Model**
Q1 Offer employment opportunities to local people	Yes
Impact Q1	Positive
Rationale for Q1	RS Model will provide new community pathways and encourage new social care providers into Cambridgeshire and Peterborough. The enhanced community services will required additional health and social care professionals and may afford redeployment opportunities for inpatient staff making transition to community services.
Q2 Offer employment opportunities to disadvantaged groups	Unsure
Impact Q2	Neutral
Rationale for Q2	There is potential to secure experts by experience in support of community pathways but this would have to be worked through in the context of staffing requirements relating to the community pathways and provision ie enhanced community teams and 'crash pad' facilities.
Q3 Promote and encourage a sustainable local economy	Yes
Impact Q3	Positive
Rationale for Q3	Changes to commissioned services will be through reinvest of resources traditionally locked into inpatient services and made available to fund and sustain the BRS community preferred option.
SIA Q4 Does this change affect other providers?	yes
Impact Q4	Positive
Rationale for Q4	Encourage new social care providers to the localities. Existing providers may have to realign their provision in order to support implementation of community pathways and future. inpatient bed configuration
SIA Q5 Does this change minimise care miles?	yes
Impact Q5	Positive
Rationale for Q5	BRS Model is about local community provision and solutions to crisis and ill health that sustains people in their home settings. In line with the vision of 'Transforming Care' and Cambridgeshire and Peterborough TCP bed trajectory target. - Out of Area placements will continue to reduce and not be required as community provision including the use of assisted technology provide least restrictive solutions.
SIA Q6 Promote prevention of LTC and improve self-management	yes
Impact Q6	Positive

Rationale for Q6	Preventative solutions including the 'upskilling' of workforce and carers with Positive Behavioural Support (PBS) training will help providers and individuals better manage periods of crisis and potential heightened distress and give a range of solutions other than hospital admission
SIA Q7 Provide evidence-based, personalised care that provides VFM	yes
Impact Q7	Positive
Rationale for Q7	Though the enhanced intensive community support evidence base is small as it is across much of learning disabilities research - Mineen et al (1997) compared 25 patients treated in a hospital with 25 patients who received outreach treatment from the community learning disability team. They found that outreach treatment was equally effective as reducing psychiatric symptoms and was also more cost effective. Hassiotis et al (2000) found that, in people with psychosis and borderline intellectual functioning, intensive community care led to significantly less time spent in hospital in comparison to standard care. Locally the use of the Transforming Care Local Area Emergency Protocol (LEAP) and community CTR process has resulted in fewer hospital admissions as community options are formally agreed between statutory agencies and put into place to prevent admission.
SIA Q8 Deliver integrated care, that improves coordination and removes duplication	yes
Impact Q8	Positive
Rationale for Q8	BRS Model has explicit support from the local Transforming Care Partnership with all statutory agencies committed to providing integrated care. The Section 75 agreements between both LA's and CPCCG are based on the premise of integrated health and social care provision and work particularly well in Cambridgeshire through the Learning Disability Partnership.
SIA Q9 Support the CCG's objectives to reduce carbon emissions and become more sustainable?	Not applicable
Impact Q9	Neutral
Rationale for Q9	
SIA Q10 Affect the use of energy or water?	Not applicable
Impact Q10	Neutral
Rationale for Q10	
SIA Q11 Affect pollution to air, land or water?	Not applicable
Impact Q11	Neutral
Rationale for Q11	

SIA Q12 Will specific environmental outcomes to be accounted for in procurement?	Yes
Impact Q12	Positive
Rationale for Q12	Social outcome of sustaining people with needs in their home communities through least restrictive practices will be made explicit within procurement framework based upon the principles of BRS Model
SIA Q13 Will the change stimulate innovation among providers to reduce environmental impact?	yes
Impact Q13	Positive
Rationale for Q13	Providers will need to demonstrate innovative ways of supporting people that may challenge in community settings including alternative to admission responses ie 'crash pad' facilities.
SIA Q14 will implementation promote ethical and sustainable procurement?	Not applicable
Impact Q14	Neutral
Rationale for Q14	
SIA Q15 Will implementation promote greater efficiency of resource use?	yes
Impact Q15	Positive
Rationale for Q15	Sustaining people locally is far more efficient and effective than costly and distant out of area placement. Bed occupancy levels throughout the three-year Transforming Care programme and reliance on out of area placement often at the behest of the current local bed provider suggests that the model of service delivery within the block contract arrangement is not working optimally with monies locked into underutilised and inappropriate provision.
SIA Q16 Will implementation obtain maximum value for money?	Not applicable
Impact Q16	Neutral
Rationale for Q16	
SIA Q17 Will implementation support local or regional supply chains?	Not applicable
Impact Q17	Neutral
Rationale for Q17	
SIA Q18 Will implementation make current activities more efficient or alter service delivery models?	yes
Impact Q18	Positive
Rationale for Q18	The reinvestment from bed reduction and subsequent enhancement of community provision with the option of individualized bed procurement if required is financially more viable and sustainable as available resources are focused on presenting need as required as oppose to being locked into inflexible block arrangements that are over commissioned locally with further resources tied up in 'double funding' of out of area placements.

SIA Q19 Will it provide / improve / promote alternatives to car based transport?	Not applicable
Impact Q19	Neutral
Rationale for Q19	
SIA Q20 Support more efficient use of cars	Not applicable
Impact Q20	Neutral
Rationale for Q20	
SIA Q21 Promote active travel (cycling, walking)?	Not applicable
Impact Q21	Neutral
Rationale for Q21	
SIA Q22 Affect vehicle use, mileage or other transport or travel activity?	Yes
Impact Q22	Negative
Rationale for Q22	Potentially more vehicle use by providers to support enhanced community based working
SIA Q23 Improve the resource efficiency of new or refurbished buildings?	Not applicable
Impact Q23	Neutral
Rationale for Q23	
SIA Q24 Increase safety and security in new buildings and developments?	Yes
Impact Q24	Positive
Rationale for Q24	Former specialist LD ward (Hollies) at Cavell Centre being utilized to provide safer settings for other service users i.e. female PICU
SIA Q25 Reduce greenhouse gas emissions from transport?	no
Impact Q25	Neutral
Rationale for Q25	
SIA Q26 Provide sympathetic and appropriate landscaping around new development?	Not applicable
Impact Q26	Neutral
Rationale for Q26	
SIA Q27 Support adaptation to the likely effects of climate change?	Not applicable
Impact Q27	Neutral
Rationale for Q27	
Submitted for Review	FALSE
IA Submitted review	
Assessor Comments	
Impact Assessment Approved	

Agenda Item No: 10

STP UPDATE ON STRATEGIC DIRECTION FOR 2018/19

To:	**CAMBRIDGSHIRE HEALTH COMMITTEE**
Meeting Date:	**13 September 2018**
From:	**Roland Sinker, Interim Accountable Officer for the Cambridgeshire and Peterborough STP.**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable**
Purpose:	**The Cambridgeshire Health Committee is asked to consider the strategic direction for the Sustainability and Transformation Partnership for 2018/19.**
Recommendation:	**The Committee is being asked to discuss this strategic direction.**

Officer contact:	Member contact
Name: Catherine Pollard **Post**: Executive Programme Director **Email:** CAPCCG.transformationprogramme@nhs.net	Non-applicable

BACKGROUND

1.1 This report sets out the future model of leadership of the Cambridgeshire and Peterborough Sustainability and Transformation Partnership (STP System).

1.2 The system is a partnership between the organisations who plan, pay for and provide health and care on behalf of patients and the population within a geography covering 900,000 people. The ideas and proposals set out in this report have been developed in conjunction with all partners and will now form the basis of further co-production and engagement over the coming months.

1.3 The partners demonstrate real enthusiasm for the potential of the system; everyone wants to deliver benefits for local people. Crucially, they are also committed to tackling the profound underlying performance and financial challenges facing the system. Our approach must be grounded in our patients, citizens and staff.

1 MAIN ISSUES

1.1 **New leadership** Roland Sinker has been appointed as the Interim Accountable Officer for the Cambridgeshire and Peterborough STP for a period of six to nine months
Roland will undertake the STP Accountable Officer role on an interim basis in addition to his role as Chief Executive of Cambridge University Hospitals NHS Foundation Trust.
This has been formally approved by NHS Improvement and NHS England.

1.2 Progress

Over the past few months, progress has been made on matters that impact 2018/19 delivery as well as matters that are of strategic significance to the System.

2.2.1 North and South Provider Alliances

At the 23 May Health and Care Executive, the Health and Care Executive agreed to shift towards a more place-based approach to delivering transformation across the system. This shift was in recognition of the important of formalising natural relationships which tend to occur between providers all caring for the same population. This has resulted in changes to the STP Delivery Groups for 2018/19, creating North and South Alliance Delivery Groups to replace Urgent and Emergency Care (UEC) and Proactive Care and Integrated and Neighbourhoods (PCIN) Delivery Groups. This took effect from 1 June 2018.

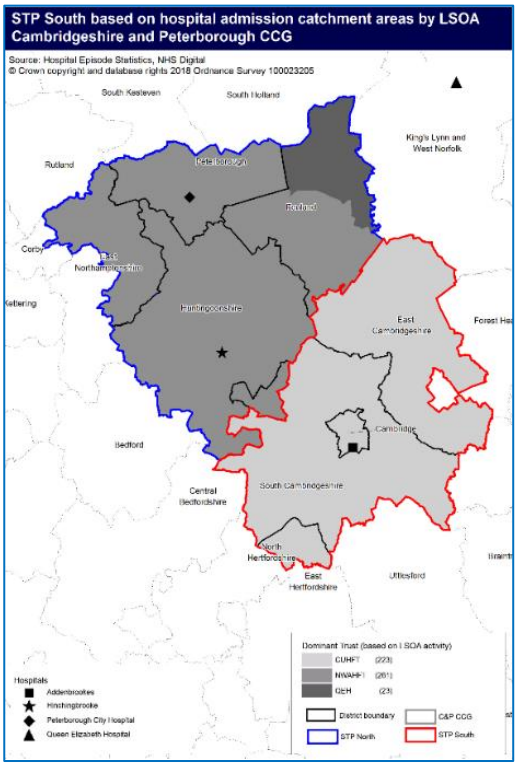
The boundary for the North area covers the local authority areas of Peterborough, Fenland, Huntingdonshire and the Papworth area of South Cambridgeshire. The registered population based on the practices within the North boundary is almost 543,000, whilst the South has almost 425,000. The

boundary for the South area covers the local authority areas of Cambridge City, East Cambridgeshire (including the Isle of Ely), South Cambridgeshire and areas of North Hertfordshire. (see map below)

STP boundary	Resident population [1]	Registered population [2]
North	494,841	542,545
South	389,516	424,762
Total	884,357	967,307

Table 1: Population
1 Mid 2016 LSOA population estimates, Office for National Statistics
2 Based on location of GP practice. Quarterly registered population, April 2018, NHS Digital

The boundary is based on hospital admission catchment areas to NWangliaFT and CUHFT, as shown in the map (right)



Map 1: STP Boundaries

Each alliance, which has representation not only from health and social care commissioners and providers, but also from patients and the voluntary sector, has identified priorities for transforming care for their local people. These priorities include developing integrated neighbourhoods for populations of 30-60k, that support a preventative and holistic approach to care and support, enabling people to live longer and more independently.

Other priorities include, supporting the ongoing work around smoothing discharge pathways, ensuring consistent adoption of evidence-based care for specific groups of people (e.g., residents of care homes, or people with diabetes), enabling remote/ telephone access to hospital specialists and working with the public to adopt more healthy behaviours. These are all long-term projects to help address underlying health and care needs and are aligned with the councils' social care transformation priorities.

2.2.2 Other System successes

We have:

- implemented **Guaranteed Income Contracts (GICs)** between acute providers and the CCG for 2018-19 which will better incentivise whole system working, collective financial management and help to address the drivers of the deficit;

- co-ordinated CEO-level interventions to agree and implement a **plan to tackle Delayed Transfers of Care (DTOC)** in a sustainable way;
- agreed **system-level analysis to better understand and articulate the drivers of the deficit** as well as an emerging single system capacity, capital and estates plan;
- launched the stroke **Early Supported Discharge (ESD)** service from April 2018 leading to measurable reductions in length of stay within weeks of implementation –a great example of cross-organisational collaboration, including the third sector, to effect change for patients;
- implemented the **Primary Care Mental Health Service (PRISM)** across all the surgeries in Cambridgeshire and Peterborough to provide specialist mental health support so that patients with mental ill health can access prompt advice and support, receive help in a community setting and experience a more joined-up approach to care;
- put the **Epic electronic patient record into the Granta practice group,** South Cambridgeshire**,** as a first step towards wider roll-out across primary care.
- agreed an **external Communications and Engagement Plan**. This plan was endorsed by HCE on 12 July and has been published as part of the Cambridgeshire Health and Wellbeing Board papers for the meeting on 26 July. The Strategy sets out how the System plans to strengthen the role of partners, the public and key stakeholders in the planning, development and implementation of our programmes of work.
- Continued to develop **the System Road Map, and underpinning activity and finance models** to address our significant system challenges and demonstrate how we are tackling them head on, we are developing a System Road Map for discussion with Regulators in October. The Road Map represents a refreshed implementation plan for working towards an Integrated Care System.

1.3 Continued challenges

1.3.1 Operational Performance

However, a number of persistent system challenges remain, and they must be the focus of collective, targeted action over the next nine months:

- our delayed transfers of care (DTOC) are unacceptably high at 7.2% over 2017-18 (average across all acute providers) and have been as high as 8.3% in 2018-19;
- as a system we are also failing the A&E four hour wait standard (86.9% over 2017-18 and the Referral to treatment (RTT) standard (performance was 89.2% over 2017-18);
- A&E attendances were up 1.9% over 2017-18 (compared to the national average of 0.8%) and emergency admissions were up 5.5% over 2017-18 (compared to the national average of 3.4%);

- We have pockets of primary care at scale and the beginnings of integrated neighbourhood teams, but we are a long way behind other systems, including full involvement of mental health.

1.3.2 Financial Deficits

We are forecasting a collective system deficit of £500m by 2021 – only one system in the country has a higher deficit as a proportion of total income. We have undertaken detailed work on the drivers of our deficit and are focusing our efforts on areas within our control. Cambridge and Peterborough's emerging deficit drivers are not unique to this system, and are likely to include:

- **Funding** – Funding per head is inadequate, for both local and specialised services
- **Structural** – Some of our hospital assets are too highly-specified, purchased at a premium through lease contracts (e.g., PFI), while other hospital assets are too small
- **System capacity** – There is a lack of beds (in part due to forced closure), exacerbated by avoidable admissions & high DTOC levels
- **Disjointed commissioning** – The legacy of layered services with multiple organisations

2.4 Strategic direction for 2018/19

2.4.1 Diagnostic

Our failure to deliver greater change cannot be explained by some unique combination of underlying conditions which make it harder to progress here than elsewhere. Six key themes have come out of conversations with system partners:

- Starting with outcomes for local people
- Prioritising and planning sensibly
- Resetting accountability
- Build open, trusting relationships
- Using data to guide action
- Support Primary Care to lead

2.4.2 System priorities for 2018-19

Based on these themes for improvement and the core challenges faced by our system, our proposed system priorities for 2018/19 will: a) deliver core operational basics this year; and b) build for the future.

Delivering the operational basics this year

- **System finances:** collective action to tackle the drivers of the deficit and deliver whole system savings. This includes commissioner savings

of £35m of which £12.9m will be delivered through the Guaranteed Income Contracts (GIC). We will agree a single system capacity and capital plan, agree to shadow a single system control total underpinned by open book accounting, and design the whole population payment approach for 2019-20.

- **Delayed transfers of care (DTOC):** sustainable, system-wide reductions in DTOC. Our DTOCs will not exceed 3.5% over Q4 of 2018-19.
- **A&E:** interventions to reduce the growth in A&E attendances by one third when compared with the three-year run rate.

Building for the future

- **Integrated neighbourhoods:** deliver year one of a three-year plan for integrated neighbourhoods focusing on piloting with one primary care network in each of the North and South of the system, as well as supporting the development of integrated neighbourhoods covering 30,000 – 60,000 population across the whole of the patch.
- **Safe & effective hospital care:** developing networks of care that maximise use of acute capacity, spread world class research & evidence based care (GIRFT and RightCare); reimagine outpatients;
- **Digital:** improving digital capability as a vital enabler of change through the development of a Digital Innovation Hub and Local Integrated Care Record Exemplar (LICRE) and in support of cross-organisational transformation.
- **Workforce:** ensuring our workforce are fit, healthy, skilled, motivated and proud to work in our system – by providing support, development and flexible career pathways; addressing our people pipeline;
- **Estates:** capturing benefits from implementing our Estate Strategy, including progressing a range of major capital projects that address our significant capacity shortfalls and emerging safety concerns;
- **Shared services:** cost effective back office, aligned purchasing and joint contracts;
- **Continued work on existing organisational strategies:** including NWAngliaFT's clinical services strategy, the relocation to new Royal Papworth, as well as the potential developments of a Cancer Research Hospital and regional children's services.

3. WHAT'S NEXT

In addition to the priorities outlined above, we recognise we need to give more attention to how we engage our staff and local residents about system working.

We need to further encourage them to be active participants in this work in whatever way they can. This will require senior leaders to demonstrate their trust in each other and commitment to this direction of travel. In order to achieve this we must continue to develop and demonstrate a common view

about approaching our longer-term financial sustainability. We must address this issue at a pace that reflects the scale of behaviour change required and enables us to redirect resources to where it needs to be. Tackling these big issues will be the focus of the STP Board at the end of September, with the aim of agreeing our Road Map for System working – in advance of conversations with the NHS regulators. We should be in a position to share publicly the conclusions of these conversations in November.

Source documents	**Location**
None	

HEALTH COMMITTEE TRAINING PLAN 2018/19	Updated September 2018	**Agenda Item No: 11**

Ref	Subject	Desired Learning Outcome/Success Measures	Priority	Date	Responsibility	Nature of training	Attendance by:	Cllrs Attending	Percentage of total
7.	***Health in Fenland***	To provide a deep dive into reviewing and understand the key health inequalities in the Fenland District. To be held at FDC Boathouse, Wisbech	1	19th Sep 2018	Public Health	Development Session	All members of Health Committee		
1.	***Business Planning (Strategic)***	To provide the committee members with an overview of CCC strategic Business Planning timescales and deadlines	1	9th August	Public Health	Development session	All CCC Health Committee members	6	60%
2.	***Business Planning (Operational)***	To discuss the Public Health Business Planning priorities for 2019/20	1	13th Sept 2018	Public Health	Development Session	All		
3.	***Sustainable Transformation Programme***	To be agreed							

In order to develop the annual committee training plan it is suggested that:

- The relevant Executive/Corporate/Service Directors review training needs and develop an initial draft training plan;
- The draft training plan be submitted to a meeting of the relevant committee spokesmen/women for them (in consultation with their Groups as appropriate) to identify further gaps/needs that should be addressed within the training plan; The draft plan should be submitted to each meeting of the committee for their review and approval. Each committee could also be requested to reflect on its preferred medium for training (training seminars; more interactive workshops; e-learning etc and also to identify its preferred day/time slot for training events.)
- Each attendee should be asked to complete a short evaluation sheet following each event in order to review the effectiveness of the training and to guide the development of future such events

HEALTH POLICY AND SERVICE COMMITTEE AGENDA PLAN	Published 3rd September 2018 Updated 05.09.18	

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 six clear working days before the meeting

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
13/09/18	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		
	Update on Air Quality and Health across Cambridgeshire	Stuart Keeble	Not applicable		
	Proposed response to Cambridge City Council Air Quality Action Plan Consultation	Stuart Keeble	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Child and Adolescent Mental Health Services (scrutiny item)	Lee Miller	Not applicable		
	Air Quality in Cambridgeshire	Liz Robin	Not applicable		
	STP: Introduction to the Accountable Officer and new strategic direction *(scrutiny item)	Roland Sinker	Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
	Scrutiny Item: 'Community First' - Consultation on proposed changes to the future provision of inpatient beds for people with a learning disability and / or autism in Cambridgeshire and Peterborough Clinical Commissioning Group's area	Jessica Bawden	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Daniel Snowdon	Not applicable		
	Agenda plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
11/10/18	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Children and Young People's Drug and Alcohol Treatment Services Procurement.	Val Thomas	2018/043		
	Public Health Reserves (earmarked) Including (Falls Prevention, Fenland Fund and Let's Get Moving	Liz Robin	Not applicable		
	Scrutiny Item: Minor Injury Unit Update		Not applicable		
	The Adoption of A Dynamic Purchasing System (DPS) Process for Public Health Primary Care Commissioning	Val Thomas	2018/069		
	Committee training plan (standing item)	Kate Parker/ Daniel Snowdon	Not applicable		
	Agenda plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
08/11/18	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Health Visiting – Recruitment and Retention		Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
	Drugs and Alcohol Service		Not applicable		
	STP: Workforce Development, Recruitment and Retention	Kate Parker	Not applicable		
	Scrutiny Item: Update on the Clinical Commissioning Group's financial position and improvement plan	Kate Parker	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Daniel Snowdon	Not applicable		
	Agenda plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
06/12/18	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	STP: Digital/IT Work Stream Update	Kate Parker.	Not applicable		
	NHS Dentistry Provision (Scrutiny Item) to include Healthwatch review.		Not applicable		
	Committee training plan (standing item)	Kate Parker/ Daniel Snowdon	Not applicable		
	Agenda plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
17/01/19	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Scrutiny Item: Eating Disorders Service	Tracy Dowling	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Daniel Snowdon	Not applicable		
	Agenda plan and appointments to outside bodies	Daniel Snowdon	Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
[07/02/19] Provisional meeting					
14/03/19	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Daniel Snowdon	Not applicable		
	Agenda plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
[11/04/19] Provisional meeting					
23/05/19	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Daniel Snowdon	Not applicable		
	Agenda plan and appointments to outside bodies	Daniel Snowdon	Not applicable		