ADULTS AND HEALTH COMMITTEE

Cambridgeshire County Council

Thursday, 14 December 2023

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

10:00

New Shire Hall
Alconbury Weald
Huntingdon
PE28 4YE

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

AGENDA

Open to Public and Press

CONSTITUTIONAL MATTERS

1.	**Apologies for absence and declarations of interest** *Guidance on declaring interests is available at* http://tinyurl.com/ccc-conduct-code	
2.	**Adults and Health Minutes - 5 October 2023**	**5 - 32**
3.	**Petitions and Public Questions**	

KEY DECISIONS

4.	**Procurement of All-Age Carers Service**	**33 - 42**
5.	**Commissioning Prevention in Primary Care**	**43 - 52**

Date of Next Meeting

Thursday 25 January 2024.

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The Adults and Health Committee comprises the following members:

Councillor Richard Howitt (Chair) Councillor Susan van de Ven (Vice-Chair) Councillor Mike Black Councillor Chris Boden Councillor Alex Bulat Councillor Steve Corney Councillor Adela Costello Councillor Claire Daunton Councillor Anne Hay Councillor Mark Howell Councillor Mac McGuire Councillor Kevin Reynolds Councillor Geoffrey Seeff Councillor Philippa Slatter and Councillor Graham Wilson Councillor Corinne Garvie (Appointee) Cllr Keith Horgan (Appointee) Councillor Steve McAdam (Appointee) Councillor Dr Haq Nawaz (Appointee) Cllr Rachel Wade (Appointee)

Clerk Name:	Tamar Oviatt-Ham
Clerk Telephone:	01223 715668
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Adults and Health Committee Minutes

Date: 5 October 2023

Time: 10.00 am - 4.02 pm

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

Present: Councillors Chris Boden, Mike Black, Alex Bulat, Adela Costello, Steve Count Claire Daunton, Jose Hales (Co-optee sub, part 1 only), Anne Hay, Keith Horgan (Co-optee, part 2 only), Mark Howell (part 1 only), Richard Howitt (Chair), Dr Haq Nawaz (Co-optee, part 2 only), Lucy Nethsingha, Geoffrey Seeff, Philippa Slatter.

192. Apologies for Absence and Declarations of Interest

Apologies were received from Councillor Susan van de Ven (Vice Chair), Councillor Graham Wilson (substituted by Councillor Lucy Nethsingha), Councillor Kevin Reynolds (substituted by Councillor Steve Count), Councillor Mac McQuire.

Part 2: Councillor Corrinne Garvie, (Councillor Garvie's substitute Councillor Jose Hales), Councillor Mairead Healy and Councillor Mark Howell.

There were no declarations of interest.

The Chair explained that item 8 on the agenda 'Adult Social Care Local Government Association Peer Review Update' would now be considered before item 7 'Rough Sleeper Drug and Alcohol National Grant Funding'.

The Chair stated that the report presenter for the 'Cambridgeshire and Peterborough Integrated Care System (ICS) Winter Plan 2023/24' report due to be heard in the afternoon scrutiny session was unwell and that it would be agreed by the Committee at the afternoon session how this would be taken forward. He also stated that agenda item 8 'Ombudsman Report on Prescribing in Drug and Alcohol Services' would be heard before agenda item 7 'Rough Sleeper Drug and Alcohol National Grant Funding'.

193. Adults and Health Committee Minutes 29 June 2023 and Action Log

The minutes of the meeting on 29 June 2023 were approved as an accurate record. The action log was noted.

Under matters arising, a member highlighted the report on Integrated Tobacco Control in the Cambridgeshire and Peterborough, which was discussed at the last committee meeting, and welcomed the recent announcement from the Prime

Minister regarding increasing the smoking age on an annual basis. The Chair acknowledged that there was cross party agreement on the proposals in Westminster.

194. Petitions and Public Questions

No petitions or public questions received.

195. Adult Social Care Workforce Provider Support Plan

The committee considered a report that summarised details and sought approval for the next steps and commissioning approach of the Adult Social Care Provider Workforce Support Plan 2023 – 2028.

The presenting officers highlighted;

- the plan covered the external workforce that sat with private providers that provided care and support for adults within the community, including residential care homes and within their own home.

- support to invest in the work programme and had an opportunity to invest a further £845,000 over a two-year period to bring a further skills intervention to the workforce.

- challenges in the workforce including poor recruitment and retention and there was no standardised baseline of skills.

- wanted to make the best use of council resources to intervene and strengthen skills. Have already done work around the real living wage.

- the work would be lead jointly with the Cambridgeshire and Peterborough Combined Authority, and have drawn in partners from health, skills for care and Healthwatch.

- the report gave an update on the programme progress to date targeted initially around the care certificate and now wanted to go beyond that in areas were there where pressures including where individuals with complex needs are supported to live in their own homes.

- corrected an error on 5.1 of the report that stated that one of the funding targets was for May 2023, and should say May 2024.

Individual members raised the following points in relation to the report;

- queried whether there would be further opportunity to influence the choice of name covered in the branding options. Officers explained that they were happy to pick up any suggestions with members outside of the meeting.

- questioned whether partners that were involved in chair-based exercise and walking partnerships in the districts would be involved. Officers explained that they had links through to these partnerships through public health colleagues and were looking to strengthen these links.

- highlighted the staffing turnover of 40% every year and queried where these individuals moved to and whether there was a danger creating a hybrid certificate would encourage individuals then to take their qualifications elsewhere. Officers stated that two-thirds of the 40% stayed in the care sector and there was a lot of movement between providers. When the workers move the next employer can have confidence in the individual's skills.

- sought clarity on whether there was a link in gaining a certificate to increase in pay on individuals that worked for external providers and if there was a link to reach a certain target. Officers explained that that currently there was not a direct link but they were looking to leverage influence by strengthening contractual arrangements.

- requested a comparison of figures for the programme quantitative KPIs against statistical neighbours as well as the national average. **Action Required**

- queried if the programme would also include those who support people with individual budgets. Officers explained that the programme was open to these individuals and there was ongoing work within the programme to prioritise where support needed to be focused.

- questioned whether there was collaboration with Cambridgeshire Skills and the ESOL programme. Officers stated that this had not been picked up currently but that they would include this in the international work that was being done regionally.

- sought clarity on if there was an update on the central government commitment for funding and if officers had been given a timeline. Officers highlighted that there had been a reduction in the funding since the government initiative had been launched in 2021 and that currently there was still no implementation plan for the funding.

- highlighted that the vacancy rate was lower than the national average and stated that the authority needed to also look at what it was doing right and how it could be built on.

Councillor Howitt (Chair) proposed the following amendment to the recommendations, seconded by Councillor Nethsingha.

d) agree to add to the strategy seeking to work in partnership with providers and trade unions, to promote an enabling environment for local social care workers to be able to access union protection, where they choose.

Members raised the following points in relation to the amendment:

- a member question if there had been an error in the drawing up of the report as the chair was bringing this as an additional recommendation and sought clarity on whether there was any evidence that individuals were not able to access unions were they chose.

- a member highlighted that the average hourly rate in this sector was lower than the national average and many were not on the minimum wage. He stated that he had witnessed individuals who were frightened to speak out about the conditions they worked under and that he supported this amendment.

- a member stated that she hoped this would also include professional associations as it was not just about money but safeguarding individuals. She stated that some unions did not have graded subscriptions which could be a deterrent.

- a member stated that being a member of a union was a luxury for some individuals and that the care work was a transient profession.

On being put to the vote, the amendment passed and became the substantive recommendation.

In debating the report;

- the Chair stated that he hoped the authority could lead authority on this issue and that the authority had sought feedback from the Department for Health and Social Care on this initiative. He stated that if the funding was agreed at committee, then it would pay itself back and would be healthier for finances. He highlighted the ongoing target for all care roles to be paid the real living wage currently this stood at 84% of roles and it was hoped that the target could be reached by next year.

- a member commented that it was a matter of public perception, and it was a duty of all members to promote training and skills development and to recognises and mark achievements.

- a member explained that clear stretch targets were important in order that achievements and progress could be measured against the funding. He commented that current international recruitment failed to target some groups particularly eastern europeans who were a dedicated workforce and worked in lower paid jobs that did not always equate to the qualifications that they held.

- a member commented that that individuals who were currently in the care profession needed to be involved in pulling together the marketing content.

- a member highlighted that it was unclear what the £800,000 would be spent on and that it was important that clear targets were set and agreed for the

initiative and circulated to the committee. Officers agreed to review and come back to committee on progress. **Action Required.**

- a member stated that it was important to highlight that it was a choice to join a union. She explained that it was crucial to make the opportunities available where the communities as this would give access to hard to reach groups including migrant communities.

It was resolved unanimously to:

a) approve the procurement of further skills interventions, up to the value of £845k, to support the ambitions in the Workforce Plan and to delegate the awarding and executing of contracts to the Executive Director of Adults, Health & Commissioning.

b) fully support the initiatives by Cambridgeshire County Council to support the workforce now, developing local initiatives to strengthen the workforce based on specific challenges faced by care professionals, providers, and individuals in the area. Committee are asked to note this report and approve the continued focus of the Adult Social Care Workforce Programme Board on the priorities identified.

c) to delegate the approval of the branding of the Adult Social Care Provider Workforce Programme to the Executive Director of Adults, Health and Commissioning in consultation with the Committee Chair.

d) agree to add to the strategy seeking to work in partnership with providers and trade unions, to promote an enabling environment for local social care workers to be able to access union protection, where they choose.

196. Adult Social Care Local Government Association (LGA) Peer Review Update

The committee considered a report that detailed the key recommendations of the LGA Peer review for Adult Social Care and the progress to date on the recommendations.

Individual members raised the following points in relation to the report;

- a member explained that he had raised the issue of employment opportunities for individuals with learning disabilities and autism, part of recommendation 9, on numerous occasions. He commented that he felt the authority was still failing to provide leadership in this area and there were no measures or targets in place for improvements. The Chair stated that there was also a cross party discussion on this subject at the last full council meeting as part of the People Strategy around this aspiration and an update on this would be included in the People Strategy Report going to the next Staffing and Appeals Committee.

- queried what was being done in terms of transport.

- sought clarity on how 'Care Together' was being rolled out. The Executive Director for Adults, Health and Commissioning explained that an update report on 'Care Together' and Market Shaping was scheduled for the December committee meeting.

- questioned if there was a strategy to target qualifications in the area of financial assessments.

- the Chair stated that more could be done in the voluntary sector with regards to care together and a report on this would be coming to the next meeting. He stated that he would like to see officers meeting major leaders in the voluntary sector to discuss the findings and seeing their response.

It was resolved to note and comment on the information outlined in this report.

197. A review of the Learning Disability Partnership Section 75 pooled budget financial risk share arrangements

The committee considered a report which sought agreement to a partial or full termination of the Section 75 partnership agreement between Cambridgeshire County Council and Cambridgeshire and Peterborough Integrated Care Board for the Learning Disability Partnership dependent on continuing discussions between the Council and the ICB.

The presenting officers highlighted;

- a report was presented to committee in March 2023 outlining the current position of the partnership and how it was run and how the budgets were pooled.

- the main issues were outlined in section two of the report. Since March 2023 there had been attempts to resolve the relationship, but this had not been successful, and notice had been given for the Section 75 Agreement to cease on 31 August 2024 if nothing changed.

- In March 2023, the Committee was informed about the potential savings of £7.1m which were already built into the Business Plan. Following the response by the ICB, resulting in the entirety of Section 75 Agreement being terminated, the savings could potentially rise. Work undertaken by an independent review suggested an additional saving to the authority of circa £1.55m.

- The potential would remain for agreements to be made for specific shared arrangements – e.g, shared funding of a joint commissioning team or a jointly funded community learning disabilities team could still be included within a Section 75 agreement.

- a new model of working would be developed over the coming months. This work would be led by the Executive Director of Adult Social Care (DASS). There was a meeting with the ICB on 25 September 2023 to agree the programme for the next 12 months. A co-production approach would be adopted to ensure that people with lived experience are involved in the development of the new model.

Individual members raised the following points in relation to the report;

- highlighted that the issues had been ongoing for a long period of time and had been hampered by COVID.

- a member expressed disappointment that the ICB had not shown partnership engagement and feared that the service would be diminished and the potential for the service to cost more in the long run. He stated that he felt that certain elements of the integrated care system were inadequate. Officers explained there would be no loss to the quality or support to the service users and that both sides had a responsibility to maintain this position, and the authority would be consulting individuals with lived experiences to shape the new service.

- a member highlighted that it was an indication of the financial and bureaucratic pressures across the whole system.

- a member commented that the losers will be the people that use the services provided by the partnership arrangement and sought further information regarding what partial termination of the agreement would involve and whether there would still be some sharing of budget. Officers explained that the ICB have included everything in scope so this had been superseded.

- a member queried what the savings would cover and that there was assurance that individuals would receive the same level of service that they were entitled to expect. A member commented that the savings had already been assumed in the business plan and therefore would show as a negative in the next financial year.

- the Chair explained that the service had received a requires improvement inspection report and that the authority had a responsibility for the quality of service. He commented that he was disappointed that a cost sharing arrangement had not been reached and that the ICB had indicated that they also wished to withdraw from providing and integrated service. He hoped that through discussions this could be reviewed and hear input from the voluntary sector. He also questioned whether there would be implications in relation to other collaboratives that had been set up with the ICB. The Executive Director: Adults, Health and Commissioning explained that the ICB had been clear that they wanted to continue to work with the authority in a collaborative and integrated way and the opportunities to work with the accountable business units to work on collaborative solutions. He explained that in terms of the LDP section 75 agreement the pooled fund officers needed to be

mindful of the financial challenges when looking at collaborative ways of working.

It was resolved unanimously to:

a) delegate all necessary legal steps to facilitate termination of the section 75 Agreement to the Executive Director.

b) note the potential financial impacts as set per para. 2.11 of this report.

c) allow the DASS to proceed and terminate arrangement and put in a new model of working as per section 3 of this report.

d) support the Council in seeking to retain the management of Integrated Health and Social Care Teams for People with Learning Disabilities.

198. Rough Sleeper Drug and Alcohol National Grant Funding

The Committee considered a report on the additional Rough Sleeper Drug and Alcohol Treatment Grant and the impact on commissioned services.

The Director of Public Health highlighted;

- this was a targeted grant funding to support people who were already addicted, on the streets to get into treatment. The grant would pay for outreach workers.

- it was proposed that the additional funding would go to 'Change Grow Live' the current providers of the service as this would allow for continuity of service provision.

- the timing of the grant may raise some concerns in relation to the ombudsman report on the committee agenda. Officers were confident that all of the issues raised by the Ombudsman in relation to 'Change Grow Live' had been addressed and their services outcomes were good, and they were in the best place to continue service provision.

Individual members raised the following points in relation to the report;

- highlighted that there was a need to record the results of the programme so that there could be learning for the future, as currently success rates were low in this area.

- the Chair stated that he had every confidence in 'Change Grow Live' and that this would be the best use of the grant funding and would lead to better outcomes.

- commented that it was key to give support in the early stages to stop people requiring ongoing interventions.

- Requested further detail on the outcomes of the programme as it developed, including how many individuals removed from homelessness, how many individuals taking up the programme etc. The Chair stated that it was key to understand the effectiveness of these programmes to affect these issues. The Director of Public Health stated that officers would come back to a future committee meeting with an update on the programme and outlining the key outcomes for the programme. **Action Required.**

It was resolved unanimously to:

a) the proposal for investing the additional grant funding into continuation of services to support rough sleepers/homeless or at risk of homelessness.

b) the commissioning of the current provider of the Drug and Alcohol Services, Change Grow Live (CGL) to provide the rough sleeper treatment provision of the service for an additional year (2024/25).

c) approve a contract variation for the estimated value of £499,190 for the current CGL integrated treatment contract (subject to confirmation of the final value of the Rough Sleeper Drug and Alcohol Grant).

199. Ombudsman Report on Prescribing in Drug and Alcohol Services

The committee considered a report which outlined the Local Government and Social Care Ombudsman (LGSCO) investigation Report into prescribing practice within the commissioned Drug and Alcohol Services.

The Director of Public Health highlighted;

- The investigation by the LGSCO involved a previous case for an individual dating back to 2022 which was then linked to the current case which had seen an audit of nine client records.

- Commissioned a specialist pharmacist to review the prescription records and they recommended improvements in the recording of client and clinician conversations. The authority had worked with CGL to review and improve its procedures and update its guidance in line with the NHSE guidelines and CGL had audited all of its clients in receipt of a benzodiazepine prescription. the authority would monitor that CGL continued to adhere to the recommendations.

- The committee were asked to refer the report to Full Council for consideration. There was also a requirement to publish the link to the ombudsman's report in the local press.

Individual members raised the following points in relation to the report;

- a member sought assurances that by Full Council officers were confident that our service providers have correct procedures in place and that the authority has correct auditing mechanism in place to audit service providers.

- a member queried what was meant by new investment, outlined at 3.3 and 3.4 of the report. The Director of Public Health stated that there had been considerable additional investment into these services through the national harm to hope policy and the report on this agenda.

- the Chair stated that that it was important that the committee welcomed the report as part of democratic checks and balances. He explained that he had through conversations with officers on the matter and commended that an independent pharmacist had been brought in to review procedures. He stated that he was confident that CGL had followed national guidance and policy and that the failure was in relation to the record keeping.

It was resolved unanimously to:

a) consider the findings and requirements of the LGSCO Report.

b) note the actions proposed and already undertaken by Public Health in collaboration with the provider.

c) recommend referral to Full Council to consider the report.

200. Customer Care Annual Report 01 April 2022 – 31 March 2023

The Committee received the Adult Social Care Customer Care Annual Report 2022-2023 which provided information about the complaints, compliments, representations and MP enquiries received for adult social care and the learning from this feedback and actions taken to improve services.

Individual members raised the following points in relation to the report;

- a member requested that the format be reviewed so that the data remained but so that the same format and wording was not used year on year and also to include the voices of those that had complaints that still had not been satisfied. Officers agreed to review the format of the report and include the voice of complainants. **Action Required**. He also queried what was being done to review transfers of care as this had the highest percentage of complaints at 72%. He commented that the authority should not have any complaints upheld by the Ombudsman and that there had been six in total. The chair stated that the authority had to accept that that they run complex services and that mistakes happen and that there should be a culture where it was accepted that mistakes would be made but lessons learnt.

- a member requested bar charts to show percentage terms. **Action Required.** He queried whether the authority requested proactive feedback. Officers explained that come feedback forms had recently been developed and officers were looking to roll them out shortly. The Executive Director: Adults Health and Commissioning commented that one of the challenges in this area

was around technology and capturing live feedback, and this was part of a piece of future work to explore this.

It was resolved unanimously to:

a) note and comment on the information in the Annual Adults Social Care Customer Care Report 2021-2022.

b) agree to the publication of Annual Adults Social Care Customer Care Report 2021-2022 on the Council's website.

201. Adults, Health and Commissioning Risk Register Update

The committee considered a report that gave an overview of the current risks in relation to Adults, Health and Commissioning.

Individual members raised the following points in relation to the report;

- a member queried why there was not a risk on the register in relation to the outstanding internal audit issues that related to the services covered by this committee, including the healthy child programme and drugs and alcohol treatment and queried if the Head of Internal Audit fed into the development of the risk register. The Executive Director for Adults, Health and Commissioning stated that this report was in relation to Adults, Health and Commissioning risks only whereas the outstanding audit actions were in relation to Public Health. He acknowledged that there was an outstanding action in relation to the direct payments policy and this was currently being worked on.
- a member questioned why risk I, in relation to provider failure, was green and commented that he felt that this was underreporting. The Executive Director of Adults, Health and Commissioning explained that the focus for the Council was the risk in relation to the quality of in-house providers. He explained that risks in relation to external providers were covered in a number of the risks on the register.

- a member queried if any of the risks on the register had materialised and if the mitigations in place had worked.

- a member questioned why there was not a risk on the register on the physical condition of care homes and queried if there were regular inspections. The Executive Director for Adults, Health and Commissioning explained that the Care Quality Commission (CQC) were responsible for inspecting care homes and the authorities responsibilities were around quality of care. He explained that there was a council team that inspected homes alongside the CQC and this was done on a continual basis. He explained that he would add some relevant wording in to the quality of care risk. **Action Required.**

- a member queried in relation to risk D 'The internal AHC workforce does not meet the business need', where Cambridgeshire stood in relation to approved social workers. The Executive Director of Adults, Health and Commissioning stated that workforce remained a constant challenge and there had been ongoing work to upskill approved mental health practitioners in the workforce.

- a member stated that there was not a risk on the register that covered the situation with the NHS including the effects of the scale of industrial action and workforce crisis and the ongoing impact this had on the social care sector. The Executive Director of Adults, Health and Commissioning explained that he continued to review the impact overall and there was not a specific risk on the register. He explained that the authority monitored delayed discharges of care and they were relatively low at the moment.

- a member questioned how the financial risk H in relation to the Councils financial position and the continued pressures in Adult Social care finances had played out in terms of the triggers and the mitigating actions that had been in place over the last few years and how this had affected the likelihood. The Executive Director for Adults, Health and Commissioning commented that there had been a deep dive recently on debt risk and concerns in this area had been addressed. He explained that he could report back on the mitigations in this area. **Action Required**.

- the Chair commented on risk L in relation to the shared care record and that more work needed to be done in this area. The Executive Director for Adults, Health and Commissioning explained that there had been IT issues but that these challenges had been overcome and the programme was moving forwards.

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

202. Finance Monitoring Report – August 2023

The committee received a report that outlined the financial position of services within its remit as at the end of August 2023.

Individual members raised the following points in relation to the report;

- a member raised his ongoing concerns regarding the Public Health reserves and failure to anticipate increases. He also raised concerns in relation to areas where no variances were shown on the report including around the drug and alcohol contract. The Chair stated that there had been a productive spokes meeting where this issue had been addressed. Officers stated that a huge amount of work went into forecasting outturns by the finance team. Officers stated that as had been discussed at previous committees there was a particular issue around Public Health billing from health partners and the finance team had been focussing on this issue. Officers explained that the underspends on smoking services had related to GPs and Pharmacies being

unable to take the service on in some areas and there was ongoing work to look at how these services could be done differently, which had been discussed at the last committee meeting. The Director of Public Health stated that payments on activity- based contracts were made on a quarterly basis. Officers explained that there was an option to have open book reporting in contracts but that there was a need to be proportionate and that this was a corporate wide issue.

- a member queried the black coding against the expansion of direct payments on the savings tracker. Officers stated that currently the savings had not yet been delivered but that there would be a clearer picture on this in the next report to Committee. The Executive Director for Adults, Health and Commissioning explained that there had also been significant changes in personnel in the direct payments team.

It was resolved to:

note the Adults, Health and Commissioning and Public Health Finance Monitoring Report as at the end of August 2023.

203. Public Health Key Performance Indicators

The committee received a report that gave an overview of the Public Health Performance indicators as at the end of Quarter one which was to the end of June 2023.

In discussing the report,

- a member highlighted that the indicators that covered certain time frames such as the Health Visiting mandates where they were shown as red should be shown as amber as the clarifications stated that if the timescales were extended by a few days they would show as green. The Director of Public Health stated that indeed most of these targets were met in a couple of extra days and that one of the reasons the indicators were showing as red was the difficulty in recruiting Health Visitors and the time spent on the higher end of need.

It was resolved to:

note and comment on the performance information outlined in this report and recommend any remedial action, as necessary.

204. Adult and Health Committee agenda plan, training plan and committee Appointments

A member requested a report at the December Committee on the resolution to the three outstanding recommendations overdue by three months in the actions in relation to the internal audit progress report that went to the last Audit and Accounts

Committee, in relation to the Healthy Child Programme and the Integrated Drugs and Alcohol Contract. **Action Required.**

A member requested that a report come to committee on the council's strategy as a major employer on employing individuals with learning disability and autism, following a previous motion at Full Council. The Leader of the Council confirmed that this would be on the agenda for Staffing and Appeals Committee in November 2023. **Action Required.**

Health Scrutiny

205. Chair's announcements

The order of business was revised from the published agenda due to officer illness and availability.

To make best use of the committee's time the first hour of the meeting was used to reflect on a recent health scrutiny best practice training and development session and the future health scrutiny workplan.

206. Cambridgeshire and Peterborough Integrated Care System Winter Plan 2023/24

Due to officer illness no-one was available to present the Integrated Care System's (ICS) report on the Winter Plan 2023/24.

The committee considered whether to:

i. reschedule the item to December
ii. send written questions for response
iii. establish a rapid review group to engage with the ICS at pace and provide feedback.

Given the time-critical nature of winter planning the committee favoured the agile response afforded by the establishment of a rapid review group. This Group would pursue the lines of questioning discussed informally by committee members at their scrutiny pre-meet. A copy of these questions would be sent immediately to the ICS. **Action Required**

Members expressed concern that no-one was available from the ICS to present the report.

The Executive Director for Adults, Health and Commissioning noted that social care produced its own winter plan, and suggested it would be better to have a co-produced version with health care providers. The question for scrutiny was how the system could look at this collectively.

It was resolved unanimously to:

a) Establish a rapid review to progress scrutiny of the Integrated Care System's Winter Plan 2023/24.

b) Appoint Councillors Black, Costello and Daunton to that review.

c) Delegate authority to the Democratic Services Officer or the officer supporting the review to provide feedback to the Integrated Care System on its Winter Plan 2023/24, at the direction of the Rapid Review Group and in consultation with Adults and Health Committee Spokes.

207. Health scrutiny training and future work plan

The committee discussed the recent training and development session on health scrutiny best practice. This had focused on the role of health scrutiny in making or enabling a positive difference to the lives of the people of Cambridgeshire. Members had discussed the pivotal role of the Francis Report (2013) in shaping health scrutiny practice and the more recent Health overview and scrutiny committee principles (2022) which stated that health scrutiny should be outcome focused, balanced, inclusive, collaborative and evidence informed. They had also discussed how this might best be embedded to further enhance the committee's own practice. A copy of the feedback and suggestions from individual committee members had been published on the meeting webpage for transparency, and members were invited to offer any further suggestions or comments.

The Chair suggested that earlier Member involvement in shaping the request to those being scrutinised, improvements in publishing the committee's findings and improved questioning skills, in addition to the new arrangements which allowed Members to ask supplementary questions to develop a line of enquiry, should also be pursued. He would also like to see background research carried out on scrutiny topics and shared with Members ahead of scrutiny sessions, and was discussing the capacity to deliver this with Democratic Services.

In discussing the outcomes of the health scrutiny training session individual members:

- felt that the long list of suggestions demonstrated Members' wish to move towards best practice scrutiny.

- expressed concern that it appeared that the quantity of health scrutiny was reducing under the current Joint Administration. The Chair stated that there was no intention to reduce the quantity of health scrutiny and suggested Spokes might review this at their next meeting. He did though note that the at the recent training session the external trainer had encouraged the committee to do less scrutiny, but to do it better. **Action Required**

- commented that it could be difficult to extrapolate health service provision from elements of the Council's own provision due to the close partnership working and co-production arrangements which existed.

- suggested a pre-scrutiny briefing session to clarify the different but complimentary roles of the County Council and the NHS in improving health outcomes for people with learning disabilities.

- spoke of the importance of questioning in scrutiny, and welcomed the ability to develop lines of questioning. The Chair stated that this issue had been raised by Spokes and the committee practice amended accordingly.

- shared their recollection that children's health issues had been analysed by the Children and Young People (CYP) Committee under the previous Administration, commenting that they saw this as a better arrangement. The Chair stated that the current arrangement was that CYP could propose items for health scrutiny and CYP Spokes would be invited to take part in the relevant meetings. He was though happy to discuss this again with the Chair of CYP. Scrutiny was inherent in the committee system, and matters could be referred to other committees for where appropriate.

- spoke of the difficult line to be balanced between the committee's role as a health system partner and its statutory health scrutiny role.

- an action-log style document would be introduced to ensure that committee recommendations were recorded and tracked. **Action Required**

The Committee reviewed the current health scrutiny workplan, and was invited to share ideas on potential topics where they judged scrutiny could add value and have a positive impact on health services for local people. Suggestions included:

i. residential care homes as a potential topic for scrutiny in relation to the scope for health promotion and preventative measures to avoid health deterioration, how these considerations could be embedded at the earliest stages of planning new care homes, and the facilities which could be made available to benefit the wider community.

ii. adding an item on improving health outcomes for people with learning disabilities to the December meeting, with a member briefing session arranged before the public scrutiny session. This was an area with a clear operational dimension and would enable the committee to invite the involvement of local community groups or charities. **Action Required**

iii. Dentistry: The ICB had taken over local responsibility for dentistry quite recently, so the committee would want to look at this once it had had chance to start work. Most levers were placed in the national contract with less at local level. A training session around this would be beneficial. **Action Required**

iv. children's mental health: The committee noted this had been scrutinised previously under the current Administration, but the Chair acknowledged the importance attached to this issue by the Committee and Members' wish to maintain a spotlight on this important subject. Potential lines of enquiry might include how was this supported by local health service providers; the role and availability of residential care locally; the health service support available locally to children and young people who self-harmed; and an analysis following Councillor Hoy's motion to cancel in January 2022 about the levels of children's mental health provision then and now.

v. addressing health inequalities: Potential lines of enquiry included a comparative look at health facilities and provision in different districts, disparities and inequalities and how to address those; pre-disposing factors; and whether decentralisation supported work to address health inequalities.

vi. excess deaths around covid: The Chair proposed a preliminary discussion around this by Spokes, commenting that there was no suggestion that covid vaccinations had done anything other than save lives. **Action Required**

vii. tackling obesity: Potential lines of enquiry included prescribing and bariatric surgery; tacking obesity in children and young people; and how much consultant or primary care time was being used for private care.

The Chair stated that there was an open invitation to all committee members and co-optees to take part in the liaison group meetings with local NHS providers which were used to help inform the public scrutiny agenda. County councillors appointed as partner governors to local NHS providers would also be invited to the relevant liaison meetings.

It was resolved unanimously to:

a) Add an item on improving health outcomes for people with learning disabilities to the 14th December meeting agenda.

b) Compile a list of potential future health scrutiny items for committee review.

208. Integrated Care Board Finance Report

The Cambridgeshire and Peterborough Integrated Care Board (ICB) had produced its first annual report and accounts in July 2023, and the committee considered that it would be timely to scrutinise and reflect on the ICB's finances at this point.
The ICB's Chief Finance Officer (CFO) stated that the ICB had finished the 2022/23 accounting period with a surplus £118k, and so had met its statutory duty to break even. Expenditure covered a wide range of areas including acute care, mental health services and community health service provision with a budget of around £1.8bn. However, expenditure across all NHS providers across Cambridgeshire and Peterborough was around £3.7bn and the ICB was accountable for this full sum. Funding for 2023/24 represented a real-term reduction of 2% as covid funding wound down. The ICB had been instructed by Government to exclude the impact of industrial action from its planning assumptions, so its break-even plan had been set

on that basis. The overall level of risk had reduced, and the year to date deficit stood at 0.3% of the ICB's total expenditure. This compared to deficits of between 0%-4.5% across the 42 Integrated Care Systems operating nationally, with the local position impacted more than some systems by its having three large acute providers.

The Chair expressed concern about the delays which had occurred in trying to conclude a fair cost sharing agreement in relation to the Learning Disability Partnership (LDP) Section 75 pooled budget (minute xxx above refers). He offered the opportunity to comment on this, and on the ICB's decision not to agree to the Council's proposal to retain a shared management structure if it withdrew from the pooled budget arrangements. The ICB CFO stated that this matter had not yet been discussed with the Integrated Care Board so she could only offer an officer-level perspective at this stage. She attached great value to partnership working and the LDP pooled budget was one of the first issues she had looked at when she joined the ICB the previous year. She had approved a £1.5m goodwill gesture on top of the existing arrangements to facilitate a conversation around making the LDP work to the benefit of patients. The independent adjudication process had run its course and her belief was that council officers had then walked away. Recollections might vary, but she would not have committed the additional £1.5m of funding if she did not believe the ICB was working towards a partnership agreement. In relation to the Council's proposal to retain a shared management structure, this was not possible if the Council withdrew from the pooled budget arrangements as the legal responsibility for those patients would revert back to the ICB once notice had been served. The Chair acknowledged that recollections might vary, but stated that the Council's commitment to partnership working was undiminished, expressed the hope that there might still be opportunities to resolve this issue. On officer advice, there would be no further discussion of this matter. A member commented that had they known this information previously they would not have voted in favour of the recommendations that morning.

Individual members raised the following issues:

- paragraph 2.14 reported that £100m of the £120m efficiency savings target for the year had already been achieved. Had those savings been banked, and had they been achieved from frontline service budgets. The ICB CFO stated that the savings had mainly been achieved in relation to procurement, IT and joint imaging work. Some planned service redesign had not been possible this year due to the focus on responding to industrial action, so that work had been deferred to the next financial year. She was not seeing the level of recurrent savings she would normally expect, and this was a concern shared by other ICB CFOs.

- asked if a breakdown was available of expenditure on management and administrative costs, clinical and primary health care and secondary and public health care. The ICB CFO stated that paragraph 2.3 of the report set out a breakdown of expenditure, with less than 1% spent on ICB management and running costs, which was around the third best performance globally. All NHS providers were required to show a breakdown on clinical and non-clinical spend in their accounts.

- emphasised the importance of placing the patient at the heart of the NHS.

- asked about the extent to which partnership working with the County Council was of value.

- sked about the breakdown of spend on pharmaceuticals and the split between primary care/ preventative measures and secondary care and pharmaceuticals. The ICB CFO stated that the local ICB had one of the best medicines optimisation teams in the country, which made it harder to find further savings year on year. The ICB was looking to work in partnership with acute providers to try to improve processes with primary care and medicine reviews to deliver real savings. Community pharmacy provision had been delegated to ICBs by NHS England earlier in the year, and if it could get prescribing right there would be benefits to patients and significant cost savings.

- noted the frequent discussions about shifting resources from acute care to preventative measures and asked how much was currently being spent on prevention and the milestones in place. The ICB CFO stated that it was hard to quantify the sums being spent on preventative services, but the ICB was committed to that shift. The difficulty was that while acute patients were still using services the ICB was paying the cost of both acute and preventative services, so it was using some transformation funding to bridge that gap. This was a system-wide issue.

- noted as a Partner Governor at Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) that the expected cost of out of area placements had decreased from £600k per month to £250k, but that CPFT's medical cover costs had increased. The ICB CFO stated that the high cost of out of area placements was a national trend. The opening of a new ward would help reduce CPFT's costs. The ICB was looking to take a more holistic approach to out of area placements and was currently conducting a review of this expenditure.

- spoke of the mental health crisis in the United Kingdom, and especially amongst young people, noting that the local ICB's spend on mental health services was below that of other ICBs in the East of England. The ICB CFO stated that that this was a priority area and acknowledged the growth in demand. Expenditure was ring-fenced by Government and independently audited. In the previous two years the Cambridgeshire and Peterborough ICB had overspent against its target expenditure. A joint review was being carried out with CPFT and the voluntary sector to look at how to make best use of the funds available, and work was taking place to identify how best to engage with patients including young people.

- asked about the messaging being received from Government, if it was appropriate to share this. The ICB CFO stated that the message was to manage those factors within its control. The ICB was receiving good support from both the regional and national teams and was looking to continue its improvement journey having moved out of special measures last year. The settlement for the first year of industrial action had more than covered the costs incurred. If the ICB reached a break-even position in the current financial year it could write off the £130m deficit carried forward from the local clinical commissioning group (CCG). It would

also receive capital finding which could be used for community projects. It was continuing to direct funding towards primary health care and tackling health inequalities, and was working closely with the Public Health team in relation to its plans for dentistry.

It was resolved unanimously to:

Delegate authority to the Democratic Services Officer, in consultation with the Chair and Vice Chair of the Adults and Health Committee, to send the Committee's conclusions to the Integrated Care Board.

[Chair]

ADULTS AND HEALTH COMMITTEE MINUTES - ACTION LOG

This is the updated action log as at 5 December 2023 and captures the actions arising from the most recent Adults and Health Committee meeting and updates Members on the progress on compliance in delivering the necessary actions

Meeting 9 March 2023						
Minute No.	Report Title	Action to be taken by	Action	Comments	Status	Review Date
169.	Major Trauma in the East of England and the Potential Establishment of a Second Major Trauma Centre in Norwich	Richenda Greenhill	Requested forecast data on the number of patients which would be seen by the proposed NNUH (North Norwich University Hospital) development, rather than Addenbrookes, that had an injury severity score rating above 15 (indicating the injury was life threatening or life changing).	20.04.23 request sent to NHS E for update awaiting response. 09.05.23 Chaser sent. 07.06.23 We have had confirmation that NHSE colleagues have left and are now chasing directly with Addenbrookes. 25.09.23: A response will be requested at the next Cambridge University Hospitals Quarterly liaison meeting.	In progress	

Meeting 29 June 2023						
Minute No.	Report Title	Action to be taken by	Action	Comments	Status	Review Date
189.	Cambridgeshire and Peterborough Shared Care Record	Richenda Greenhill	Digitisation in relation to social care was identified as a key issue and the committee would like to see timetables on that outside of the meeting.	The Shared Care Record Phase 2 (including social care records) is being scoped between now and end of December 2023. A further update will be provided when this work is complete.	In progress	
190.	Access to GP Primary Care Services	Richenda Greenhill	Requested that a copy of the ICS report on lessons learnt from Priors Field be sent to the committee once completed.	It is expected that the report will be taken to the Integrated Care Board in November 2023. A copy will be made available to the committee at that time.	In progress	

Meeting 5 October 2023						
Minute No.	Report Title	Action to be taken by	Action	Comments	Status	Review Date
195.a	Adult Social Care Workforce Provider Support Plan	Donna Glover	requested a comparison of figures for the programme quantitative KPIs against statistical neighbours as well as the national average.	Slide circulated on 4 December 2023	Closed	
195.b	Adult Social Care Workforce Provider Support Plan	Donna Glover	a member highlighted that it was unclear what the £800,000 would be spent on an that it was important that clear targets were set and agreed for the initiative and circulated to the committee. Officers agreed to review and come back to committee on progress.	Activity is underway and an update will be provided at the next committee once finalised and KPIs are in place	In progress	

198.	Rough Sleeper Drug and Alcohol National Grant Funding	Jyoti Atri/Val Thomas	requested further detail on the outcomes of the programme as it developed, including how many individuals removed from homelessness, how many individuals taking up the programme etc. The Chair stated that it was key to understand the effectiveness of these programmes to affect these issues. The Director of Public Health stated that officers would come back to a future committee meeting with an update on the programme and outlining the key outcomes for the programme.	A report will be taken to spokes on the impact of the additional Drugs and Alcohol grants. This will be in January 2024.	Closed	
200.a	Customer Care Annual Report 01 April 2022 – 31 March 2023	Fran Marshall/Liz Cook	a member requested that the format be reviewed so that the data remained but so that the same format and wording was not used year on year and also to include the voices of those that had complaints that still had not been satisfied. Officers agreed to review the format of the report and include the voice of complainants.	The Customer Care Manager is revising the format and content of the annual report to take forward the feedback from the member in the next annual report (2024-2025). Executive Director, PSW and Customer Care Manager will give consideration as to how the voices of those who were not satisfied with their complaint response can be included in the report. This raises a potential challenge as it should not impact / cross over on the complaint escalation process, which deals with dissatisfactions. The voice of complainants will be included in the next annual report	Closed	

200.b	Customer Care Annual Report 01 April 2022 – 31 March 2023	Fran Marshall/Liz Cook	a member requested bar charts to show percentage terms.	Percentages will be included in graphs going forward	Closed	
201.a	Adults, Health and Commissioning Risk Register Update	Patrick Warren Higgs	a member questioned why there was not a risk on the register on the physical condition of care homes and queried if there were regular inspections. The Executive Director for Adults, Health and Commissioning explained that the Care Quality Commission (CQC) were responsible for inspecting care homes and the authorities responsibilities were around quality of care. He explained that there was a council team that inspected homes alongside the CQC and this was done on a continual basis. He explained that he would add some relevant wording in to the quality of care risk.	AHC Risk Register is being reviewed and updated and will form part of an update to AH Committee in March 2024	Closed	

201.b	Adults, Health and Commissioning Risk Register Update	Patrick Warren Higgs	a member questioned how the financial risk H in relation to the Councils financial position and the continued pressures in Adult Social care finances had played out in terms of the triggers and the mitigating actions that had been in place over the last few years and how this had affected the likelihood. The Executive Director for Adults, Health and Commissioning commented that there had been a deep dive recently on debt risk and concerns in this area had been addressed. He explained that he could report back on the mitigations in this area.	AHC Risk Register is being reviewed and updated and will form part of an update to AH Committee in March 2024	Closed	
204.a	Adult and Health Committee agenda plan, training plan and committee Appointments	Jyoti Atri	A member requested a report at the December Committee on the resolution to the three outstanding recommendations overdue by three months in the actions in relation to the internal audit progress report that went to the last Audit and Accounts Committee, in relation to the Healthy Child Programme and the Integrated Drugs and Alcohol Systems Contract.	Report circulated on Friday 24 November 2023	Closed	

204.a	Adult and Health Committee agenda plan, training plan and committee Appointments	Tamar Oviatt-Ham	A member requested that a report come to committee on the council's strategy as a major employer on employing individuals with learning disability and autism, following a previous motion at Full Council. The Leader of the Council confirmed that this would be on the agenda for Staffing and Appeals Committee in November.	Update provided in the Peoples Strategy Report at Staffing and Appeals Committee on 7 November.	Closed	
206.	Cambridgeshire and Peterborough Integrated Care System Winter Plan 2023/24	Richenda Greenhill	A Rapid Review Group was established to pursue the lines of questioning discussed informally by committee members at their scrutiny pre-meet and to provide feedback to the ICS, in consultation with Spokes.	A provisional review meeting date has been set for 8th December 2023.	In progress	
207.a	Health scrutiny training and future work plan	Richenda Greenhill	Data on the number of health scrutiny reports considered under the previous and current Administrations to be reviewed by Spokes.	To be reviewed by Spokes on 23rd November 2023	In progress	
207.b	Health scrutiny training and future work plan	Richenda Greenhill	An action-log style document would be introduced to ensure that committee recommendations were recorded and tracked.	This will be included in the published papers for the December committee meeting.	Completed	

207.c	Health scrutiny training and future work plan	Richenda Greenhill	An item on improving health outcomes for people with learning disabilities would be added to the agenda plan for December, with a member briefing session arranged before the public scrutiny session.	This item has been added to the agenda plan for December. Work is continuing to arrange a member briefing session in advance of the meeting.	In progress	
207.d	Health scrutiny training and future work plan	Richenda Greenhill	A training session around dentistry this would be beneficial.	Timing to be confirmed once the Committee's 2024/25 workplan has been agreed.	In progress	
207.e	Health scrutiny training and future work plan	Richenda Greenhill	Spokes would have a preliminary discussion around a possible future health scrutiny session on excess deaths around covid.	To be discussed by Spokes on 23rd November 2023.	In progress	

Procurement of All-Age Carers Service

To:	Adults and Health Committee
Meeting Date:	14 December 2023
From:	Patrick Warren-Higgs, Executive Director, Adults, Health & Commissioning
Electoral division(s):	All
Key decision:	Yes
Forward Plan ref:	2023/088
Outcome:	Carers of all ages in Cambridgeshire can access information and support to enable them to maintain their caring role.
Recommendation:	Adults and Health Committee are being asked to: a) approve the general procurement approach and the overall value of £6,315,616 based on (2023/24 values) over 3 years + up to a 12-month extension period if required of the all-age carers service. b) delegate responsibility for awarding and executing contracts for the provision of the all-age carers service and extension periods to the Executive Director, Adults, Health & Commissioning in consultation with the Chair and Vice-Chair of the Adults & Health Committee.

Officer contact:
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1 Background

1.1 The Care Act 2014 defines a carer as: “someone who helps another person, usually a relative or friend, in their day-to-day life. This is different from someone who provides care professionally or through a voluntary organisation.”

1.2 Unpaid carers are an asset in society, helping to support people’s independence and meet their social care needs. The value of unpaid care now exceeds the value of the NHS budget in England and Wales[i] demonstrating just how significant the contribution of carers is. Whilst providing care can be a rewarding experience, it can also have an impact on the carer's own health, education, ability to remain employed, relationships and social life.

1.3 Under the Care Act (2014), the Council has a statutory duty to “recognise unpaid carers in law in the same way as those they care for”. The Act sets out unpaid carers’ legal rights to assessments and support. It relates predominantly to adult carers as young carers under the age of 18 years are assessed and supported under the Children and Families Act (2014).

1.4 In June 2023, Adults & Health Committee approved a new All-Age Carers strategy. The strategy encompasses all carers, including adult carers, parent carers and young carers. It sets out key priorities, gathered through engagement with carers and professionals and partners working with carers. Carers are a priority for the council and the strategy informs the specification of the carers service recommission. In this way the council has built on feedback and learning from the current service provision.

1.5 As part of its support for carers, the Council commissions an all-age carers service to ensure carers are recognised, valued, and supported in the areas of:

- Prioritising their own health and wellbeing
- Fulfilling their educational and employment potential
- Maximising their income
- Access to information and support in case of emergencies

This service enables carers to maintain their caring role for longer. This benefits the Local Authority, as it delays the need for individuals requiring a higher cost and longer-term adult social care placement.

The commissioned All-Age Carers service is enhanced through additional support offered by the Council. This includes small grants offered to voluntary organisations across Cambridgeshire districts. Some of these grants are used to provide local, place-based support for carers.

1.6 The contract for the current all-age carers service will expire on 31st July 2024 and the Council’s Contract Procedure Rules together with the Public Contract Regulations 2015 require the service to be retendered. This report sets out the proposed approach to recommissioning of the service.

2 Main Issues

Commissioning Approach

2.1 The recommissioning of the all-age carers service provides an opportunity to progress the Council's ambitions to increase support for carers. Central to the proposed commissioning approach are the key priorities identified in the new All-Age Carers strategy. These include:

- Identification of and support for Parent carers
- Identification of and support for young carers
- Young carers to be supported when moving into adulthood
- Support for carers at risk of domestic abuse
- Supporting the emotional and psychological wellbeing of all carers
- Joint working across health and social care for all carers
- Ensuring our webpages support easy access to information

2.1.1 The current all-age carers service has contributed to increased levels of support for local carers in recent years, despite the pandemic. The 2021 NHS Digital Survey of Adult Carers indicated that in Cambridgeshire progress made supporting carers includes:

- Carers reporting better knowledge and understanding of how to access information, advice, and support services
- Carers feeling better supported in their caring role
- Identification of a large number of previously hidden carers
- Increased numbers of 'What If' plans[1] being registered and activated
- Carers having a strong voice through Healthwatch Partnership Boards
- Timely access to advocacy and promotion of self-advocacy to enable carers to be confident to speak for themselves in future

The positive impact and achievements of the current service has been integrated into the commissioning plans to ensure this progress is built upon.[2]

2.1.2 To ensure the new all-age carers service really does meet the needs and wishes of local carers and their families, the service has been designed in collaboration with carers and people with lived experience of fulfilling a caring role. Building upon the engagement undertaken as part of the strategy's development, including feedback on the current service, Commissioners have undertaken further consultation and engagement activities with carers and partners to shape the proposals for the new service. This reflects the importance placed on the voices of experts-by-experience, carer groups, VCSO's and other partner organisations in shaping how we support carers.

2.1.3 Proposals for the new service also draw upon the latest best practice guidance for adult carers published by The National Institute of Health and Care Excellence (NICE) Guidance for adult carers. It forms the foundation for the recommissioned service. The NICE Guidance recommendations for adult carer support are outlined in 2.2.

[1] https://www.caringtogether.org/support-for-carers/adult-carers/whatifplan/
[2] Carer feedback following counselling support Nov 2023.docx

2.2 The new all-age carers service will continue to offer support to adult carers, adults caring for loved ones with mental health conditions, young carers and young adult carers caring for their family. The service will also continue to offer a range of services including:

Carers conversations/assessments	Guide carers to advice, information, and support available to help make life easier
Support with emergency planning (What If plans)[1]	Help carers put a plan in place for when there is an emergency
Counselling, training, and short breaks	Short breaks away from a caring role, training to give care safely e.g., lifting techniques, someone to talk to (can be a professional)
Community support groups	Place based carer groups offering peer to peer support
Information and advice	Outlines carers rights, what support they can access, where and how (includes a help line)
Care needs assessments	An assessment of needs for someone who requires care and support
Young carers digital offer	Online support groups with specific focuses and age groups to best meet the needs of young carers.

2.2.1 In addition to the existing offer, a number of innovations will be introduced to the service in line with feedback from people with lived experience and the key priorities in the new All-Age Carers strategy.

- Increasing support for young adult carers to transition into adults service
- increasing awareness and signposting for carers in situations of domestic abuse/violence
- Increasing support for adult carers caring for loved ones with dementia and Alzheimer's diagnoses
- Taking "Whole family" approaches with an intensive focus on high-risk young carers and services tailored to the needs, maturity, abilities, and choices of young carers

Procurement Approach

2.3 It is proposed to recommission the all-age carers service on a 3 + up to 1-year contract term. This is the preferred contract length indicated by the local market and enables the successful provider to embed and develop the service in a way that short term funding does not allow. There is an expectation that the procured service delivered by the contract will be subject to variation over its term to enable it to better deliver the All-Age Carers strategy. For example, closer connections with the NHS regarding carer involvement, when appropriate, in hospital to home transitions for loved ones.

2.4 The service will be commissioned in 3 lots (Adult Carers, Children and Young Carers and Carers for Adults with Mental Health needs), reflecting the different needs and specialisms basis.

2.5 The proposed budget for the new service is set out below

Figure 1: Lot structure and contract value

	Value per annum	MSIF funding Year 1 (8 months pro-rata)	Value over 3 years + 12 months
Lot 1 Adult Carers	£1,078,504	£92,664	£4,406,680
Lot 2 Children and Young Adult Carers	£355,700		£1,422,800
Lot 3 Adults Mental Health	£121,534		£486,136
Total	£1,555,738		£6,315,616

2.6 In keeping with the commitment made within the All-Age Carers Strategy to involve people with lived experience, carers will be invited to participate in the procurement. They will be included in setting an evaluation question which will then be evaluated by Officers.

2.7 All bidders will be required to demonstrate how their proposed service solution will deliver social value. Responses will be evaluated, and delivery of commitments monitored. Bidders' social value offer will be evaluated by the Social Value Portal.

2.8 Alternative procurement options considered and excluded include:
(1) In-house provision for the all-age carers service would cost considerably more, due to organisational overheads and would not represent value for money.
(2) Doing nothing and allow the contract to expire; The all-age carers service is a statutory duty of the Council, and the service is required to be procured, so this is not an option.

2.9 The risks for the local authority with the recommended approach are low. There may be a risk of eligibility to access carers services for carers who live on Cambridgeshire borders with Peterborough, Suffolk, Norfolk, Bedfordshire, Northamptonshire, Essex, and Hertfordshire. To mitigate this risk carers in border areas will have to evidence residence in Cambridgeshire or attend a Cambridgeshire school to access support from the county. OBJ

2.10 The key milestones for the procurement are set out below:

Specifications and consultation	Mid-December 2023
Tender Go Live	Mid-January 2024
Evaluation and moderation	End of March 2024
Decision to award/standstill period	Early-April 2024
Implementation and mobilisation	End-April 2024
Contract Go Live	1st August 2024

Service development during the course of the contract term

2.11 It is expected that the service will develop and flex to support carers needs using an iterative process that runs parallel to strategy development and implementation. This will include more co-production and co-design over the course of the contract.

2.12 The All-Age Carers Strategy 2022 – 26 will be reviewed in spring 2024 with a view to connecting its implementation with the Cambridgeshire Integrated Care Systems. Specifically, this relates to carer input to home discharges and how that transition can be made as seamless as possible for the carer and their loved one. The carers service will be reviewed and updated as required as part of this process.

Service Performance Management

2.13 Carer support is a key strategy for public sector organisations and as such will come under CQC (Care Quality Commission) scrutiny. It is therefore important that the service is able to evidence its support for carers and demonstrate that it is evolving in response to their requirements and aligned to the Carers Strategy.

2.14 To achieve this outcome and enable effective decision making in the future, Key Performance Indicator's (KPI's) will be developed with service providers and experts by experience. Aligned to NICE guidance for adult carers, they will connect the service provided to strategy implementation and corporate/national ambitions for carers. Over time the KPI's will provide evidence to support the narrative of service development.

3 Alignment with ambitions

3.1 Net zero carbon emissions for Cambridgeshire by 2045, and our communities and natural environment are supported to adapt and thrive as the climate changes

Method questions will include a question that supports the councils net zero carbon emissions for Cambridgeshire 2045 ambitions.

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3.2 Travel across the county is safer and more environmentally sustainable

There are no significant implications for this ambition.

3.3 Health inequalities are reduced

There are no significant implications for this ambition.

3.4 People enjoy healthy, safe, and independent lives through timely support that is most suited to their needs

The report above sets out the implications for this ambition in [1.5], [2.2] and [2.2.1]

3.5 Helping people out of poverty and income inequality
The following bullet point sets out details of implications identified by officers:

Unpaid carers are likely to reduce the hours they work or may even leave work entirely because of the demands of their caring role. This can result in unpaid carers being pushed into poverty while providing care and enabling their loved one to remain at home in their community. The carers service offers information and advice to help unpaid carers understand what support they can access and how they can access it including the financial support and benefits they may be entitled to. This is in line with the current budget allocated for the support of carers.

3.6 Places and communities prosper because they have a resilient and inclusive economy, access to good quality public services and social justice is prioritised

There are no significant implications for this ambition.

3.7 Children and young people have opportunities to thrive

The report above sets out the implications for this ambition in [1.5], [2.2] and [2.2.1]

4 Significant Implications

4.1 Resource Implications
The report above sets out details of significant implications in [2.5]

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications
The report sets out details of significant implications in [1.6], [2.3], [2.5] and [2.6]

4.3 Statutory, Legal and Risk Implications
The following bullet point sets out details of significant implications identified by officers:

The priorities within the service are in alignment with duties placed on local authorities by the Care Act (2014) and Children and Families Act (2014) in respect of assessment and support planning for carers and wider duties around information and advice and market shaping within the Care Act (2014).

4.4 Equality and Diversity Implications
The public sector equality duty has been considered as part of the service development and an EQIA (Equality Impact Assessment) has been completed

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

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

4.7 Public Health Implications
The following bullet point sets out details of significant implications identified by officers:

It is important to recognise the contribution that unpaid carers make to supporting the health and wellbeing of those that they care for. The all-age carers' service includes actions relating to supporting unpaid carers in these areas to improve health outcomes for those that they care for.

4.8 Climate Change and Environment Implications on Priority Areas (See further guidance in Appendix 2):

4.8.1 Implication 1: Energy efficient, low carbon buildings.
Positive/neutral/negative Status: Neutral
Explanation: No change

4.8.2 Implication 2: Low carbon transport.
Positive/neutral/negative Status: Neutral
Explanation: No change

4.8.3 Implication 3: Green spaces, peatland, afforestation, habitats, and land management.
Positive/neutral/negative Status: Neutral
Explanation: No change

4.8.4 Implication 4: Waste Management and Tackling Plastic Pollution.
Positive/neutral/negative Status: Neutral
Explanation: No change

4.8.5 Implication 5: Water use, availability, and management:
Positive/neutral/negative Status: Neutral
Explanation: No change

4.8.6 Implication 6: Air Pollution.
Positive/neutral/negative Status: Neutral
Explanation: No change

4.8.7 Implication 7: Resilience of our services and infrastructure and supporting vulnerable people to cope with climate change.
Positive/neutral/negative Status: Neutral
Explanation: No change

5 Source documents guidance

5.1 Source documents - None

Have the resource implications been cleared by Finance? Yes
Name of Financial Officer: Justine Hartley

Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the Head of Procurement and Commercial? Yes
Name of Officer: Clare Ellis

Has the impact on statutory, legal and risk implications been cleared by the Council's Monitoring Officer or Pathfinder Legal? Yes
Name of Legal Officer: Anne Ferrario – Pathfinder Legal

Have the equality and diversity implications been cleared by your EqIA Super User? Yes
Name of Officer: Charlotte Knight

Have any engagement and communication implications been cleared by Communications? Yes
Name of Officer: Simon Cobby

Have any localism and Local Member involvement issues been cleared by your Service Contact? Yes
Name of Officer: Will Patten

Have any Public Health implications been cleared by Public Health? Yes
Name of Officer: Emily Smith

If a key decision, have any Climate Change and Environment implications been cleared by the Climate Change Officer? Yes
Name of Officer: Emily Bolton

[i] Petrillo & Bennett (2023) "Value of unpaid care now exceeds that of the NHS budget" Available at Value of unpaid care in England and Wales now exceeds that of NHS budget - the Centre for Care (Accessed 03/11/23)

Commissioning Prevention in Primary Care

To:	Adults and Health
Meeting Date:	14 December 2023
From:	Executive Director of Public Health
Electoral division(s):	All
Key decision:	Yes
Forward Plan ref:	2023/058
Outcome:	The Committee is asked to consider Primary Care prevention interventions and the proposal to commission them through a Section 76 with the Cambridgeshire and Peterborough Integrated Care Board (ICB)
Recommendation:	The Adults and Health Committee is asked to agree: a) The Primary Care prevention interventions. b) The establishment of a Section 76 with the ICB for Cambridgeshire County Council (CCC) and on behalf of Peterborough City Council (PCC) through a Delegation and Partnering Agreement. c) A Section 76 with a value of £1,000,000, £800,000 from CCC and £200,000 from PCC for it to commission the proposed prevention interventions. d) Delegate responsibility to the Executive Director of Public Health for awarding and executing a Section 76 with the ICB for it to commission primary care prevention services starting January 1 2024 and ending December 31, 2025.

Officer contact:
Name: Val Thomas
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1. Background

1.1 In July 2022 the Adults and Health Committee approved the allocation of £800,000 of Public Health Reserves to Prevention in Primary Care. The Strategy and Resources Committee had delegated responsibility to Adults and Health Committee for allocating the Public Health reserve funding.

1.2 Addressing obesity and its associated clinical risks are priority areas for the Local Authority and wider system. In particular, it supports the Local Authority's strategic ambitions to reduce health inequalities and people to have healthy, safe, and independent lives. It also supports the ambition to help people out of poverty and income inequality. Obesity leads to long term conditions that often mean people are unable to work and have high levels of sickness.

Obesity is also one of the four Joint Health and Well Being/Integrated Care Partnership Strategy priorities, which includes primary prevention but also the clinical risk factor associated with obesity.

1.3 The funding is for GP practices to contribute to the prevention of obesity and its associated clinical risks such as high blood pressure along with contributing to meeting the recommended targets for NHS Health Checks. It is proposed to establish a Section 76 with the ICB as this work, aligns with ongoing work that the ICB is undertaking with primary care and will support the engagement of GP practices. GP practices provide unique access to high-risk individuals and there is evidence that GP advice has an impact on patients' behaviours.

2. Main Issues

Rationale for commissioning prevention in primary care – GP practices

2.1 The increase in the rates of both childhood and adult obesity are well documented. Increases in recent years are associated with the COVID-19 pandemic. Childhood obesity amongst 11-year-olds is around 32% an increase from 28% in 2017/18. Since 2015/16 adult obesity has been around or above 60% of the population.
Childhood and adult obesity are inextricably linked as often they are part of families where adults are obese, and it is recognised that targeting adult obesity has an impact on childhood obesity.
Obesity in adulthood is associated with reduced life expectancy and high risk of, cardiovascular disease, stroke, cancer, liver disease, type 2 diabetes, respiratory and mental health conditions. For example, in Cambridgeshire as in England, around 25% of preventable deaths are associated with cardiovascular disease. Many of these health outcomes are preventable by reducing the rates of obesity and identifying early the risks associated with obesity such as high blood pressure and high cholesterol.

2.2 The causes of obesity are complex and social, economic, cultural, and environmental factors are linked and shape behaviours that contribute to obesity. It is a priority for the Joint Health and Well Being/Integrated Care Partnership Strategy because it demands a system wide approach. The work that is being taking forward as part of its delivery involves all parts of the system from planning to schools.

2.3 Primary Care is traditionally seen as providing treatment, but it is very well placed to support prevention and early intervention to prevent poor health outcomes. In 2018, it was reported that over 80% of people see their GP between once of three times per year, over 20% of these see them three times per year. There are also reports due to the increase in virtual consultations that this rate has increased. The funding will be for GPs to weigh all their patients who are seen in a practice at least once a year and to identify those with obesity related clinical risks.

2.4 The frequency of GP visits means that GPs have unique access to a large proportion of the 60% of the population in Cambridgeshire who are obese and are at risk of developing poor health. A visit to the GP practice provides the opportunity for patients to be weighed, to be provided with health behaviour advice, clinical treatment, and a referral if necessary to weight management support services. The weight measurements are incorporated into patient records and provide a benchmark for monitoring any improvements or worsening. Currently information about rates of adult obesity is from the national Active Lives Survey but this has limitations. These measurements will improve our understanding of the rates as it will provide a much more robust measure of adult obesity rates over time and in local areas.

2.5 GP patient records are unique and allows practices to identify those most at risk of poor health outcomes. The data is owned by the practices which again puts them in a unique position for accessing and identifying patients at high risk of poor health outcomes.

2.6 Public Health commissions NHS Health Checks which are a cardiovascular risk assessment for an eligible population. This proposal will enable identification of the eligible population and we will align it closely with NHS Health Checks, where activity has been slowly recovering since the COVID-19 pandemic.

2.7 Recent analysis of the identification and treatment of obesity related clinical risk factors in primary care clearly indicates that the outcomes from obesity could be improved. Table 1 shows the gap between the estimated prevalence of risk factors and identification, then secondly the gap between those diagnosed and treated. Practice data systems enables the identification of these cohorts and follow up by practices for addressing any health-related behaviours, diagnosis, and treatment when necessary.

Table 1: Obesity associated clinical risk factors (Cambridgeshire and Peterborough

Clinical risk factor	Estimated prevalence	Undiagnosed	Remaining patients to diagnose/assess to reach target	Diagnosed and untreated	Diagnosed and treated
Hypertension	167,364	33,473 (20%)	35,147 (21%)	19,749 (12%)	81,205 (49%)
Diabetes	61,567	13,112 (21%)		4,230 (7%)	BP managed: 16,330 (27%) BP managed to target: 27,895 (45%)

CVD risk assessment (QRISK >20%) and cholesterol reading	411,099	192,775 (25%)	167,619 (41%)	Assessed and untreated: 117,540 (28%) QRISK >20% and untreated: 8,675 (2%)	14,490 (4%)

2.8 In addition to having access to patients it is also well evidenced and researched that GP or nurse advice is well received by patients and is likely to be strong motivator for behaviour change.

What the funding will deliver

2.9 The Public Health funding is non-recurring, and the objective is to embed the routine weighing of adult patients when they visit their practice. There is stigma associated with obesity and if it is to be addressed it needs to be normalised into being an important part of care for everyone including self-care. Similarly, it is important to improve and embed into practice routine care, the identification and management of risk factors will contribute to the management of obesity.

2.10 The £800,000 from CCC and £200k from PCC is Public Health reserve funding. Activity across the two local authorities will be on a pro-rata basis that reflects the different funding allocations. In Cambridgeshire, the expected phasing of the funding is £400,000 each year for two years. Similarly in Peterborough the funding phasing will be £100,000 each year for two years.

The funding will enable the following activity in GP practices over two years.

- All practices will be offered funding to weigh and measure their adult patients (aged 18 - 85 years) on an annual basis.
- Practices that have high rates of the clinical risk factors, high blood pressure and cholesterol, which are associated with obesity, will be offered funding to identify these patients and text them advising them to contact their GP practice. The funding will enable 12 to 20 practices across Cambridgeshire and Peterborough practices to pilot this approach. These practices have already been identified by the ICB as having a high level of need and are termed the “deep end practices.”
- Alongside the identification of patients with high risks practices will also be asked to increase their identification of those patients eligible for an NHS Health Check, but this does not include any payment but is part of the drive to focus upon cardiovascular disease.

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2.11 The Programme has been developed over the past year through collaborative working between Public Health, the ICB and lead clinicians. It is a pilot, and the objective is to embed the interventions into primary care practice and ICB funding streams. Cardiovascular Disease is now a priority area for the Integrated Care System and the work over the past

year has helped to engage considerable support for the priority.

The ICB's Commissioning and Investment Committee has approved £219,000 over the next two years to commission the Eclipse Data Management platform to support practice engagement in this Programme. This will involve data being identified centrally and patients with a high risk being sent a text message advising them to contact their GP. The use of text messaging patients by GP practices is now common and there is evidence that it improves outcomes. Practices constrained by capacity will have the option using the Eclipse system.

2.12 The ICB has a system of governance and oversight of the Programme. The ICB Commissioning and Investment Committee will have a high-level overview of its investment. The ICB Cardiovascular Disease Prevention Oversight Group is co-chaired by the Cambridgeshire County Council Deputy Director of Public Health and will be responsible for ensuring that the Programme is progressing and delivering its outputs and outcomes alongside an overall evaluation. This Group reports into ICB Population Health Improvement Board which is co-chaired by the Director of Public Health.

In addition, the practices will be supported, and performance managed on an operational level by an ICB Manager who will report to the governance structure.

There is now a Cardiovascular Prevention Plan which includes population level early prevention as well as secondary prevention along with additional workforce capacity. These will help the Programme gain traction. For example, there is a system wide workshop planned for clinicians and other stakeholders in December to increase their engagement in the Programme and more widely.

Also, an additional contextual factor is the new NHS Major Condition Strategy, which although not published in full, clearly includes the major conditions associated with obesity and wider expectations around the role of the NHS in prevention and management.

Commissioning the Programme

2.13 There are number of commissioning options.

Option 1: Not Recommended
Competitive procurement: The rationale for commissioning GPs reflects their unique access to patients and their data for identification along with the influence that they have upon patient health related behaviours. It is likely that a competitive procurement would not result in any compliant bids that would deliver an effective solution.

Option 2: Not Recommended
Direct commissioning of GP practices: Currently we commission a number of Public Health services from GP practices. Under this option, the Public Contracts Regulations, and therefore a waiver would be required to directly award contracts. This would be based on the unique access, identification, and ability to influence the target population. (Pease note From January 1 2024 this will be the Provider Selection Regime will apply to any health related commission)

Option 3: Recommended option
Section 76 with the ICB: A Section 76 agreement will mean that the funding will be

transferred to the ICB for the commissioning of these services in primary care. This is the recommended commissioning approach due to the existing volume of commissioning responsibilities that the ICB has with primary care that engenders greater traction and influence. A clear governance system that includes a dedicated Manager to support and monitor the Programme will further enhance the traction and support for GP practices to deliver. The current capacity issues in practices have led to a decrease in GP commissioned activity and this help with the support that practices require.

The following legal advice was provided by Pathfinder Ltd.

Pathfinder Ltd advised that Section 76 of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) and the National Health Service (Conditions relating to Payments by Local Authorities to NHS Bodies) Directions 2013 permit payments to be made by a local authority to a clinical commissioning group. This is for expenditure incurred or to be incurred in connection with the performance of prescribed functions which includes the services set out in this report. N.B. Clinical commissioning groups have been replaced by integrated care boards.

2.10 System wide collaborative integration is an ambition for the organisations working across the system to maximise impact and use of resources. The ICB already through public sector agreements provides funding to help meet the additional demand for the weight management services that we commission. Along with other services, for example mental health. Addressing obesity is the current most challenging Public Health priority and as all the evidence indicates, it is the one where collaborative integrated working is most necessary.

3. Alignment with ambitions

3.1 Net zero carbon emissions for Cambridgeshire by 2045, and our communities and natural environment are supported to adapt and thrive as the climate changes.

- There are no significant implications for this ambition.

3.2 Travel across the county is safer and more environmentally sustainable.

- There are no significant implications for this ambition.

3.3 Health inequalities are reduced.

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

- Addressing obesity and reducing the associated clinical risk factors in the whole population and targeting areas with high rates with more specific interventions will address health inequalities.

3.4 People enjoy healthy, safe, and independent lives through timely support that is most suited to their needs.

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

- Addressing obesity and reducing the associated clinical risk factors will enable people to have improved health outcomes that will support them to have healthy, safe, and independent lives.

3.5 Helping people out of poverty and income inequality.
The following bullet points set out details of implications identified by officers:

- Obesity has a high risk of developing long term conditions that can lead to high levels of sickness absenteeism and unemployment.

3.6 Places and communities prosper because they have a resilient and inclusive economy, access to good quality public services and social justice is prioritised.

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

- Reducing obesity and the risk clinical risks will enable more people to secure and retain employment and they are able to access a wider range of health improving services.

3.7 Children and young people have opportunities to thrive.

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

- Addressing adult obesity will reduce the risk of obesity amongst children living with adults with an unhealthy weight.

4. Significant Implications

4.1 Resource Implications
The report above sets out details of significant implications in 2.8.

4.2 Procurement/Contractual/Council Contract Procedure Rules

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

- The Public Contracts Regulations are not applicable to Section 76 arrangements, and therefore a competitive procurement is not required.
- The option of a competitive procurement has been considered and is not likely to achieve an effective or value for money solution.

4.3 Statutory, Legal and Risk Implications

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

- Legal implications relate solely to ensuring that the funding from CCC and PCC is conducted in full compliance with the relevant legislation and guidance as set out in Section 76 of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) and the National Health Service (Conditions relating to Payments by Local Authorities to NHS Bodies) Directions 2013.
- Legal will prepare the Section 76 Agreement.
- Legal will prepare the Delegation and Partnering Agreement between CCC and PCC to delegate the functions from PCC to CCC and PCC's financial contribution.
- The statutory process that will be followed by CCC in relation to this proposal complies with all relevant guidance on the subject and legislation that prescribes how the funding must be utilised.
- The risks for this proposal have been explored in full in section 2 of the report.

4.4 Equality and Diversity Implications

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

- Any equality and diversity implications arising from these service developments will be identified and addressed before any additional service expansion.

4.5 Engagement and Communications Implications

The report above sets out details of significant implications in 2.5.

4.6 Localism and Local Member Involvement

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

- We will work with local members to ensure they are fully aware of service developments to inform their work with individuals and communities.

4.7 Public Health Implications

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

- Obesity is the current biggest Public Health challenge. Identification and management of obesity and associated clinical risk factors will contribute to prevention and reduce the risk of poor health outcomes.

4.8 Climate Change and Environment Implications on Priority Areas

4.8.1 Implication 1: Energy efficient, low carbon buildings.
Status: Neutral
Explanation: This service will not impact on buildings

4.8.2 Implication 2: Low carbon transport.
Status: Neutral
Explanation: This service will not impact transport

4.8.3 Implication 3: Green spaces, peatland, afforestation, habitats, and land management.
Status: Neutral
Explanation: This service will not impact on any of these factors.

4.8.4 Implication 4: Waste Management and Tackling Plastic Pollution.
Status: Neutral
Explanation:

4.8.5 Implication 5: Water use, availability, and management:
Status: Neutral
Explanation:

4.8.6 Implication 6: Air Pollution.
Status: Positive
Explanation: Weight management services include supporting people to become physically active including using active travel alternatives.

4.8.7 Implication 7: Resilience of our services and infrastructure and supporting vulnerable people to cope with climate change.
Status: Positive
Explanation: People using weight management services will be encouraged to be active and less dependent on motor vehicles. In addition, high temperatures pose a greater risk for obese people, and they are provided with information about these risks.

Have the resource implications been cleared by Finance? Yes
Name of Financial Officer: Rebecca Bartram 07/09/23

Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the Head of Procurement and Commercial? Yes
Name of Officer: Claire Ellis 14/11/2023

Has the impact on statutory, legal and risk implications been cleared by Pathfinder Legal? Yes
Name of Legal Officer: Zoheb Fazil 07/09/23 and Emma Duncan 5/12/23

Have the equality and diversity implications been cleared by your EqIA Super User? Yes
Name of Officer: Jyoti Atri 28/11/23

Have any engagement and communication implications been cleared by Communications? Yes
Name of Officer: Simon Coby 4/9/23

Have any localism and Local Member involvement issues been cleared by your Service Contact? Yes
Name of Officer: Jyoti Atri 28/11/23

Have any Public Health implications been cleared by Public Health? Yes

Name of Officer: Jyoti Atri 28/11/23

If a Key decision, have any Climate Change and Environment implications been cleared by the Climate Change Officer?
Yes
Name of Officer: Emily Bolton 5/9/23

5. Source documents guidance

5.1 Source documents

Public Health Outcomes Framework (PHOF) Public Health Outcomes Framework - OHID (phe.org.uk)

NHS Digital Data (digital.nhs.uk) & Appointments in General Practice - NHS Digital

Using text message reminders in health care services: A narrative literature review
Frank J. Schwebel, Mary E. Larimer
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6112101/

Perceptions of receiving behaviour change interventions from GPs during routine consultations: A qualitative study Epton T. et al 2020
https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0233399

Public Health Primary Care Commissioning and Procurement Governance.

To:	Adults and Health
Meeting Date:	14 December 2023
From:	Executive Director of Public Health
Electoral division(s):	All
Key decision:	Yes
Forward Plan ref:	2023/020
Outcome:	The Committee is asked to consider the proposals for the commissioning of public health services from primary care and approve the proposed contractual arrangements.
Recommendation:	The Adults and Health Committee is asked to agree: a) The use of a waiver process to directly award contracts to individual primary care providers for delivery of Public Health services for 2023/24 and for future years in line with the Procurement Regulations current in the contractual period. b) To directly award contracts to primary care if in line with the regulations of the new Provider Selection Regime from 2024/25 onwards. c) The adoption of a Section 75 for the recharging of medicines and devices that are prescribed as part of the public health services provided by primary care.

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1. Background

1.1 The Health and Social Care 2013 saw a range of Public Health functions transferred from the NHS to local authorities. This included responsibility for commissioning a wide range of services from different providers including primary care. The contracts held by the NHS essentially novated to local authorities, as these contracts ended, competitive procurements were undertaken, and new local authority contracts were established.

1.2 The exception were contracts with primary care where Public Health was advised to undertake annual waivers, meaning that GP practices and community pharmacies would be awarded the contracts directly and did not have to take part in a competitive procurement. This reflects the unique position of primary care in relation to delivery and the value of contracts with, at that time nearly 90 practices, averaging up to around £23,000 to £25,000 per annum for all the services they provide.

1.3 Each practice and community pharmacy have an individual contract that is for the various public health services that they provide. The individual service specifications are included as part of these contracts. However, each year a waiver has been sought for the aggregated value of all the practice contracts for each of the services.

1.4 Practices are paid for each unit of activity that they complete. The average practice income from delivering primary care services fell during the COVID-19 pandemic due to decreased activity. Activity recovered in 2022/23 and is continuing in 2023/24. This is increasing the value of individual contracts towards the pre-pandemic value of circa £23,000 to £25,000 and the aggregated value of contracts, especially for NHS Health Checks and to a lesser degree, stop smoking services.

Table 1: Total costs and average practice income (actual) from delivering Public Health Services.

Public Health Services	22/23 total	22/23 average per GP (70 sites)
Long-Acting Reversible Contraception (LARCs)	622,170.85	8,888.16
NHS Health Checks	341,389.00	4,876.99
Stop Smoking Services	16,060.00	229.43
Chlamydia Screening	660.00	9.43
Total	**980,279.85**	**14,004.01**

1.5 The public health services commissioned from primary care includes GPs prescribing medications and devices as part of the service they provide. GP practices obtain these via the NHS Supply Chain and the former Clinical Commissioning Group (CCG) now the Integrated Care Board (ICB) recharge these costs to the Local Authority. GP practices are not involved in these transactions other than supplying the validating data.

1.6 The re-charge system was advised when Public Health transferred and has remained in place since then. However, the Local Authority now requires that any payment for goods/services needs to be linked to an entry on the Contract Register. This along with the

value of the re-charges means that we now need to formalise this arrangement through a Section 75 agreement.

1.7 This paper covers a number of procurement and contractual issues and requirements. The use of the flexibilities in the 2013 Health and Social Care Act have been reviewed and we need to ensure that we meet the current Procurement Regulations. Also required is consideration of the new Provider Selection Regime that will come into force in January 2024 as it is anticipated that this will have an impact on any contractual arrangements with primary care.

2. Main Issues

Commissioning Primary Care

2.1 Currently the services commissioned from primary care are:

- NHS Health Checks (mandatory service)
- Long-Acting Reversible Contraception (LARCs) (includes prescribing intra-uterine devices and sub-dermal implants)
- Stop Smoking Services (includes prescribing Nicotine Replacement therapy (NRT) and oral medication: zyban and champix)
- Chlamydia Screening and treatment
- Emergency Hormonal Contraception (EHC) (community pharmacies)

All these services are preventative, NHS Health Checks is a cardiovascular risk assessment and intervention service. LARCs and EHC are highly cost-effective means of preventing unwanted pregnancies. Stop Smoking Services help prevent smokers developing the poor health outcomes associated with smoking and chlamydia screening not only reduces the risk of infection spread but also poor reproductive health outcomes.

2.2 There are a number of reasons why direct contract awards to primary care were the procurement and contractual routes adopted for use with these providers. Overall, primary care providers are in a unique position to support prevention and early intervention to prevent poor health outcomes through providing these services.

- In 2018, it was reported that over 80% of people see their GP between once of three times per year, over 20% of these see them three times per year. There are also reports due to the increase in virtual consultations that this rate has increased. The frequency of GP visits means that GPs have unique access to a large proportion of the population.

- Along with the frequency of access GP practices through their patient records have access to patient clinical notes. Identification of people at risk or for example, need to be called for an NHS Health Check is dependent upon access to these notes. There are no other competitors who have the same access to patients and their clinical notes, and GP practices own this data.

- In addition to having access to patients it is also well evidenced and researched that

GP or nurse advice is well received by patients and is likely to be strong motivator for behaviour change.

- With regard to community pharmacies the EHC service is aimed at the more vulnerable high-risk groups who would be unlikely to seek emergency contraception from a GP for a number of reasons, including not being registered or fears about confidentiality. Community pharmacies are very accessible in terms of locations and opening hours, relatively anonymous, all vitally important if it is to be obtained, within the very short timeframe to avoid an unwanted pregnancy.

2.3 The current Contract Procedure Rules (CPRs) allows us to make a direct award where Regulation 32 of the Public Contract Regulations is applicable. The Regulation allows for the use of a negotiated procedure without prior publication where competition is absent for technical reasons. However, the CPRs state that legal advice must be sought to confirm the regulation's applicability and identify any risks. Legal advice was sought externally and is found in Appendix 1. (This appendix is confidential and exempt from publication)

In summary it concluded that as the average spend per **individual practice is circa £23,000 a competitive tender was not required**. This advice was based on the general position under the Public Contracts Regulations 2015 ("the Regulations") that, all Contracts for Services with a value below £213,477 are exempt from the full requirement to go through a Competitive Process complying with the Regulations.

Moreover, the "threshold value" limit for Social and other Specific Services under 74-77 of the Regulations is £663,540 and above that sum are subject to the "light touch regime". These excluded categories do include training services related to administrative, social, educational, health care and cultural services and, accordingly, would appear to include certain categories of the services provided. Under this regime, the requirements for a full Tender Process when awarding a contract is dispensed with, but the Award of Contract requires a notice.

The advice also referenced the argument that as a principle a competitive process is not required under regulation 32 of the Regulations where "Competition is absent for technical reasons", which is relevant for GP practices.

2.4 The external legal advice also articulated the caveat that value for money should always be secured irrespective of the contractual arrangement. We have developed several processes over the years to ensure that our contracts with primary care are robust and that the services provide quality and value for money.

- Primary Contracts are based on a unit price for each intervention, we benchmarked our unit costs against other local authorities in the East of England. Across all the services our unit costs are below or average when compared with other local authorities.

- The Integrated Care Board (ICB) Primary Care Information Team extracts activity data from practice systems and sends to Public Health which is then cross referenced to payment claims.

- Due to the volume of practices and relatively low value it is not practical to have regular monthly contract monitoring. However, during the financial year practices are contacted virtually to discuss activity and data returns. Practices are visited if there are any concerns around activity and the data.

- Prior to the COVID-19 pandemic primary care audit tools were developed and there was an annual cycle of audits undertaken in practices. Post the pandemic we have reviewed and updated these tools but delayed the audit cycle due to practice capacity and Public Health team capacity. But these will be re-commenced shortly.

- Data from community pharmacies is captured through a data platform that (Pharmaoutcomes) enables data to be extracted from their systems which is used for validation.

2.5 Due to capacity in primary care, activity fell dramatically during the COVID-19 pandemic and was slow to recover but has improved in recent months. The relationship with GPs and pharmacies has been established over many years and they work collaboratively with our other commissioned services to boost capacity. They have shared data with our commissioned Behaviour Change Services to enable them to provide additional capacity and we have a commissioned the local GP Federations to provide additional NHS Health Checks. GP Federations are groups of general practices that form an organisational entity and share responsibility for delivering primary care services for their combined patient communities.

We want to maintain these commissioning and collaborative arrangements with GP practices due to the advantages that this brings to service delivery, but we acknowledge the workforce capacity issues and look to potential providers to support delivery.

Provider Selection Regime

2.6 Moving forward new legislation, the Provider Selection Regime (PSR), will, subject to parliamentary scrutiny and agreement, come into force in January 2024. These new regulations will require local authorities to follow the same procurement regulations as the NHS when commissioning health services. It will mean a more flexible approach to procurement and is in response to the creation of Integrated Care Systems. However, the Local Authority must have a clearly defined process for the decision.

2.7 The PSR has implications for how we commission the majority of the Public Health contracts. The Local Authority requirement to establish a process for adopting the PSR for health service contracts is currently being developed the Authority's Procurement and Commercial Team.

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In terms of the primary care contracts new ones will need to be in place for April 2024. Initial Procurement advice is that the contracts with primary care for health services would be subject to PSR regulations.

NHS Recharges for Medications and Devices prescribed as part of the Public Health Services commissioned from Primary Care

2.8 GP practices that provide Long-Acting Reversible Contraception (LARCs) and Stop Smoking Services (SSS) which as described above involves prescribing devices and medications.

- Nicotine Replacement Therapy (NRT) and oral medication Zyban (bupropion) and Champix (varenicline)
- Intra-Uterine Devices and Subdermal Contraception

The Integrated Care Board (ICB) supplies these devices and medicines to GP practices. through a FP10 request (NHS coding system) to enable them to provide the service. The ICB then recharges the costs from the Public Health Grant. The alternative option is to commission a supplier which would bring additional costs and the local authority would not. have the cost advantages associated with the scale of purchasing that the NHS Supply Chain has, which provides substantial leverage with the drug companies.

N.B. Nalmafene is medication used as part of structured alcohol treatment programme. The medication is prescribed by GPs and through the Drug and Alcohol Treatment Service that the Local Authority commissions from Change Grow Live (CGL). Recharges for Nalmafene against the Public Health Grant should only be made if it was part of a treatment programme with CGL alongside psychosocial interventions. Currently there is very limited prescribing of Namafene, approximately £1,000 per annum. Consequently, the ICB has agreed not to recharge. However, it is possible that in the future this situation could change.

2.9 The value of the re-charged FP10s over the last five years is shown in Table 2 below. The value fell during the COVID-19 pandemic but overall, as activity has recovered the re-charges have increased.

Table 2: FP10 Prescribing Costs recharged to the Local Authority.

Financial Year	Smoking: NRT and medicines	LARC – Implants/Injections	LARC – IUD/Coils	Nalmafene
2018-19	£301,444	£147,918	£161,876	£1378
2019-20	£304,485	£186,928	£215,660	£1142
2020-21	£266,684	£120,080	£137,459	£1183
2021-22	£239,383	£171,919	£210,263	£1108
2022-23	£232,624	£161,591	£218,774	£952

2.10 The use of a recharge arrangement is no longer tenable due to the requirement in the Local Authority that any payment cannot be made to third party unless it is linked to contracts. As part of the external legal advice secured regarding the commissioning of primary care, we received advice about the best contractual route for these recharges to minimise any risk to the Local Authority.

The external legal advice deemed that although the Section 75 of the NHS Act 2006 does state that the Secretary of State may by regulation make provision for "… the making of payments by a Local Authority to an NHS Body [for or in connection with the exercise by a

Local Authority on behalf of an NHS Body on prescribed functions of the NHS Body" there is nothing specifically relating to this re-charge agreement.

Therefore, the advice was that we follow the normal process of having a documented agreement that is, a Short Form Agreement setting out the obligations between the parties including payment.

2.11 We asked specifically if the provision of these medications and devices were covered under the Procurement Regulations. The advice was that the items supplied are provided by the NHS to NHS Contractors on a "free issue" basis, and here the cost is being recouped.

It was observed that it is not a "Public Contract" as this term is defined in the Regulations, i.e., a contract for pecuniary interest having as its object the supply of products. It is more of a function of reallocating grant monies. The Council never receive the products themselves. Making payments from grant payments are not generally subject to the Procurement Regime.

In relation to any similar governance issues the response was that generally, arrangements between NHS Bodies and Local Authorities under the NHS Act 2006 are part of the "joint arrangement" for the provision of health services associated with the reallocation of public health responsibilities from NHS Bodies into the hands of Local Authorities some years ago, which are frequently covered by "umbrella" agreements. As such, the legal opinion was that the intent of the Government is that these relationships are not "contractual," except where they need to be.

2.12 The legal conclusion was that it is more a case of documenting joint arrangements and allocating public monies. In some cases that this Agreement could be part of a general Joint Agreement related to spending on Section 75 activities, which is what other Local Authorities do, but it was acknowledged that that this is unrealistic in this context.

This was followed up with the Local Authority's legal team who supported the drawing up of a Section 75 to ensure that there is a documented agreement between the Local Authority and the ICB.

2.13 In 2.4 the processes for monitoring GP practice activity and spend were described to demonstrate that we meet the requirement to ensure that delivery is robust, and contracts provide value for money. Prescribing activity is an intrinsic part of this monitoring and again we receive the raw data from the ICB which enables us to identify claims that cannot be set against the Public Health Grant. For example, we can extract data relating to prescribing of LARCs for gynaecological purposes as opposed to contraception. At the end of 2022/23 we did a review of the F10 devices ordered and the LARC activity. We identified a number of practices where there was an apparent discrepancy. This resulted in six practice visits and conformation that the data was accurate.

3. Alignment with ambitions

3.1 Net zero carbon emissions for Cambridgeshire by 2045, and our communities and natural environment are supported to adapt and thrive as the climate changes.

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

All commissioned services include a requirement of providers to demonstrate how they are meeting the net zero ambitions.

3.2 Travel across the county is safer and more environmentally sustainable.

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

- Commissioned services include a requirement of providers where possible to offer virtual services to minimise travel across the Cambridgeshire.

3.3 Health inequalities are reduced.

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

- The majority of Public Health services are commissioned for the whole population, but providers are required to ensure that population groups who experience health inequalities are able to easily access services.

3.4 People enjoy healthy, safe, and independent lives through timely support that is most suited to their needs.

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

- Public Health commissions primary care to provide timely and accessible services for the residents of Cambridgeshire. These proposals ensure that the commissioning and contracting processes support effective and accessible services.

3.5 Helping people out of poverty and income inequality.

- There are no significant implications for this ambition.

3.6 Places and communities prosper because they have a resilient and inclusive economy, access to good quality public services and social justice is prioritised.

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

- Public Health commissions primary care to provide services for the residents of Cambridgeshire. These proposals ensure that the services are of good quality and accessible.

3.7 Children and young people have opportunities to thrive.

- There are no significant implications for this ambition.

4. Significant Implications

4.1 Resource Implications

The report above sets out details of significant implications in 1.2, 2.4, 2.3, 2.9.

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

The report above sets out details of significant implications in 1.1, 1.4, 2.3, 2.5, 2.6, 2.7, 2.8, 2.11, 2.12, 2.13.

4.3 Statutory, Legal and Risk Implications

The following bullet points set out details of significant implications identified by officers: The paper lays out the existing and new statutory, legal and risk implications which will inform any ongoing and new commissioning of primary care to provide services and other health services that will under the new Provider Selection Regime.

4.4 Equality and Diversity Implications

The report above sets out details of significant implications in 2.2.

In addition, the following bullet points set out details of significant implications identified by officers.

- Any equality and diversity implications arising from these service developments will be identified and addressed before any additional service expansion.

4.5 Engagement and Communications Implications

The following bullet point sets out details of significant implications identified by officers:

- Any equality and diversity implications affecting engagement and communications will be identified before any service developments are implemented and promoted.

4.6 Localism and Local Member Involvement

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

- We will work with local members to ensure they are fully aware of service developments to inform their work with individuals and communities.

4.7 Public Health Implications

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

- The report above sets out details of significant implications in 2.1, 2.2. The services that are commissioned from primary care contribute greatly to preventing poor health outcomes and primary care clinicians have a key role in influencing health behaviours.

4.8 Environment and Climate Change Implications on Priority Areas

4.8.1 Implication 1: Energy efficient, low carbon buildings.
Status: Neutral
Explanation: This is not covered in the paper

4.8.2 Implication 2: Low carbon transport.
Status: Positive
Explanation: Primary care services enable residents to access services closer to their homes with less need to travel.

4.8.3 Implication 3: Green spaces, peatland, afforestation, habitats, and land management.
Status: Neutral
Explanation: This is not covered in the paper

4.8.4 Implication 4: Waste Management and Tackling Plastic Pollution.
Status: Neutral
Explanation: This is not covered in the paper

4.8.5 Implication 5: Water use, availability, and management:
Status: Neutral
Explanation: This is not covered in the paper

4.8.6 Implication 6: Air Pollution.
Status: Positive
Explanation: Primary care services enable residents to access services closer to their homes with less need to travel.

4.8.7 Implication 7: Resilience of our services and infrastructure and supporting vulnerable people to cope with climate change.
Status: Positive
Explanation: Residents seen in primary care may have health conditions susceptible to climate changes. Primary care clinicians are able to advise how they can mitigate the impact of climate change on their health.

Have the resource implications been cleared by Finance? Yes
Name of Financial Officer: Justine Hartley 30/11/23

Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the Head of Procurement? Yes
Name of Officer: Claire Ellis 14/11/23

Has the impact on statutory, legal and risk implications been cleared by the Council's Monitoring Officer or LGSS Law? Yes
Name of Legal Officer: Emma Ducan 5/12/13

Have the equality and diversity implications been cleared by your Service Contact? Yes
Name of Officer: Jyoti Atri 28/11/23

Have any engagement and communication implications been cleared by Communications?
Yes
Name of Officer: Simon Coby 16/11/23

Have any localism and Local Member involvement issues been cleared by your Service Contact? Yes
Name of Officer: Jyoti Atri 28/11/23

Have any Public Health implications been cleared by Public Health?
Yes
Name of Officer: Jyoti Atri 28/11/23

If a Key decision, have any Environment and Climate Change implications been cleared by the Climate Change Officer?
Yes
Name of Officer: Emily Bolton 30/11/23

5. Source documents guidance

5.1 Source documents

Laws et al; National Library of Medicine 2009: An exploration of how clinician attitudes and beliefs influence the implementation of lifestyle risk factor management in primary healthcare: a grounded theory study.

NHS Digital Data (digital.nhs.uk) & Appointments in General Practice - NHS Digital
An exploration of how clinician attitudes and beliefs influence the implementation of lifestyle risk factor management in primary healthcare: a grounded theory study - PMC (nih.gov)

Swann et al Health, NICE/WHO/NHS systems, and health-related behaviour change: a review of primary and secondary evidence

Health systems and health-related behaviour change: (nice.org.uk)

Falls Prevention Strategy

To:	Adults and Health Committee
Meeting Date:	14 December 2023
From:	Executive Director of Public Health
Electoral division(s):	All
Key decision:	No
Forward Plan ref:	N/A
Outcome:	Adults and Health Committee is being asked to endorse Cambridgeshire County Council's role within the Cambridgeshire and Peterborough Falls Prevention Strategy to enable the provision of clear strategic direction to prevent falls and falls-related injuries across the Integrated Care System.
Recommendation:	Adults and Health Committee is being asked to endorse Cambridgeshire County Council's role within the Cambridgeshire and Peterborough Falls Prevention Strategy.

Officer contact:
Name: Helen Tunster
Post: Senior Partnership Manager
Email: helen.tunster@cambridgeshire.gov.uk
Tel: n/a

1. Background

1.1 Falls and related injuries are a common and significant problem for older adults and a major public health issue. Falls are a major cause of disability and injury related death in people aged 75+ and have a large impact on quality of life[1]. Around one in three people over 65 years old and half of those over 80 experience a fall at least once a year[2]. In Cambridgeshire and Peterborough in 2022/23, there were 2,699 emergency admissions due to falls and 1,015 admissions due to a hip fracture. The estimated combined total cost of these hospital admissions was £16.3M, an increase of over £1.9M on the previous year[3]. These costs do not include wider health and social care costs such as primary care, ambulance or adult social care costs[3]. The prevalence of falls and fractures is expected to rise along with a rise in associated burdens on the wider health and social care services due to the ageing population in Cambridgeshire and Peterborough[3].

1.2 Falls and frailty are increasingly being identified as a priority by the Integrated Care System on a system, place and neighbourhood level. The Integrated Care Board has assigned a Falls and Frailty Lead and developed a Falls and Frailty workstream. Furthermore, the North and South Place Partnerships, as well as many of the Integrated Neighbourhoods in Cambridgeshire, have a priority around falls and/or frailty.

1.3 The new three-year Falls Prevention Strategy and detailed delivery plan have been developed collaboratively by the multi-agency Cambridgeshire and Peterborough Falls Prevention Strategy Group, which is a partnership group with representation from a range of ICS partners, including Cambridgeshire County Council (CCC). It builds upon a one-year Falls Prevention Strategy (2022/23) developed as an interim strategy to support recovery of services following Covid. The strategy includes a number of interventions that have been shown to be cost and clinically effective at preventing some falls and fractures, resulting in improved health outcomes and independence for older people.

1.4 The intended outcome of the strategy is a reduction in the rate of hip fracture admissions, and as a result, there may be reduced costs to health and social care (not cash releasing). A recent return on investment tool has demonstrated that certain interventions, such as strength and balance programmes and home hazard assessment and improvement programmes, demonstrate a financial and societal return on investment. On an individual level, the strategy intends to improve quality of life and healthy life expectancy.

1.5 The strategy has no financial implications for the council at this present time.

2. Main Issues

2.1 The system wide strategy outlines the plans of organisations across Cambridgeshire and Peterborough to reduce falls and falls-related injuries by taking a system wide approach to falls prevention and bone health (Appendix 1). It details six priorities to achieve the vision of *"working together to reduce the rate of falls and reduce hip fracture admissions amongst*

[1] NICE. Falls: Assessment and prevention of falls in older people. *NICE Clinical Guidance 161*. 2013. 1 (nice.org.uk)
[2] Todd C, Skelton D. What are the main risk factors for falls amongst older people and what are the most effective interventions to prevent these falls ? *World Health*. 2004;(March):28. [Accessed 17 May 2022]: Copenhagen, WHO Regional Office for Europe (Health Evidence Network report; http://www.euro.who.int/document/E82552.pdf,
[3] Cambridgeshire and Peterborough Falls Prevention Strategy 2023-2026. Available at: Appendix 1.

older adults, by preventing first falls and reducing the risk of subsequent falls to enable older people in Cambridgeshire and Peterborough to enjoy an active, fulfilling life".

For each of the priorities there is a detailed action plan outlining existing and planned interventions to enable the implementation of the strategy. (Note, only CCC actions are highlighted in the action plan within the accompanying strategy). The priorities are:

- Prevention and early identification of people at risk of falls
- Evidence-based and good practice falls prevention interventions and services
- Action to address risk in hospital
- Action to address risk in care homes
- Detection and management of fragility fracture
- Inclusive services

The actions for Cambridgeshire County Council (CCC) against these priorities are summarised below.

2.2 Priority 1: Prevention and early identification of people at risk of fall

The aim of this priority is to intervene at the earliest opportunity to prevent and reduce the number of people who have a first fall. A focus for action by CCC is on ensuring the public and front line staff engaging with older adults have the information they need to make informed choices about falls risk factors and have access to opportunities to live and age well. This includes further use and development of the 'Stronger for Longer' campaign messaging as well as promoting and evaluating the use of the recently launched interactive 'Steady on Your Feet' online tool. The tool is designed to support older adults who have not fallen to identify and take action to reduce their own personal risk factors for falling using the information, advice and service signposting provided in their action plan.

Physical activity is another major area for action under this priority. There is a focus on supporting active, independent mid-older aged adults living in the community to be physically active as part of upstream primary prevention. This includes improving awareness, accessibility and uptake of opportunities, supported by workforce development, as well as the commissioning of physical activities for this cohort. CCC Public Health have commissioned local providers to strengthen the offer of strength and balance activities in line with the falls prevention exercise pathway. The CCC Care Together programme have been instrumental in supporting this through their sound understanding of local communities and work to embed physical activity into their local programmes. The strategy strongly recognises the importance of scaling up physical activity in preventing falls and reducing the risk of falls, and this is weaved throughout the different priorities targeting different ability levels and settings, influenced by CCC (see priority summaries below).

This priority also acknowledges the potential role of the outdoor environment in supporting mid-older age adults to be active and this will be considered in the development of the Healthy Places Joint Strategic Needs Assessment by CCC over the coming year.

2.3 Priority 2: Evidence-based and good practice falls prevention interventions and services

The aim is to ensure that people who have fallen have timely access to services, interventions and opportunities that will support a reduction in the risk of falls and falls-related injuries. The focus is on system partners working together to improve the join up of services to facilitate this, underpinned by robust risk stratification, good cross system

communication, strengthening the uptake/delivery of specific interventions and workforce development. CCC Public Health Team will support this by providing specialist public health advice and support to ensure falls prevention guidance is adopted and through the monitoring of the Falls Prevention Action Plan. CCC Adult Social Care services will be be part of the development of the integrated system-wide falls prevention pathway, ensuring that their services are considered and built in.

Again, physical activity is a key focus of this priority. Ensuring that all older adults have the opportunity to be more active and have access to strength and balance exercise proven to reduce the rate and risk of falls is a key focus. CCC Reablement Team plan to build in movement and physical activity into the support plans of all service users accessing Reablement.

2.4 Priority 3: Action to address risk in hospital

The aim is to minimise the risk of inpatient falls, repeat falls and re-admissions, and improve quality of life. All the actions under this priority are led by Cambridge University Health Foundation Trust (CUHFT) and NWAFT with the support of CCC as relevant. For example:

- CCC Public Health Team and Adult Social Care Early Intervention and Prevention teams will continue to influence and support the development of communication systems that allow the sharing of multi-factorial falls risk assessment outcomes with CCC and other community providers to support the join-up of services and improve patient outcomes.
- They will also raise awareness and promote the uptake of relevant Adult Social Care Early Intervention and Prevention services on discharge such as Reablement, TEC and Sensory services.
- CCC Public Health Team will continue to support and encourage the CUHFT to build movement and activity into daily routines to prevent and address deconditioning of older adults admitted to hospital.
- CCC will also encourage the Emergency Department (ED) to identify and signpost people who present to hospital due to fall with a serious injury to receive a multi-factorial falls risk assessment, as recognised as a gap in the gap analysis.

2.5 Priority 4: Action to address risk in care homes

The aim of this priority is to prevent, reduce and manage falls in nursing and residential home residents in order to reduce the risk and consequences of fragility fracture and a long-lie, improve quality of life and reduce system wide pressures. CCC will support this priority by leading a project with care and residential homes and CPFT to embed movement and physical activity into the daily lives of residents.

2.6 Priority 5: Detection and management of fragility fractures

The aim is to ensure early identification and management of osteoporosis risk factors to prevent a first or subsequent fragility fracture and provide optimal support after a fragility fracture. CCC Public Health have taken a key role to understand local needs and develop a bone health strategy to outline necessary local action. CCC will support the development of a business case to support the commissioning and delivery of a Fracture Liaison Service (FLS) in North West Anglia Foundation Trust (NWAFT), which covers the north of Cambridgeshire. This is intended to enable the system to take action to reduce inequalities in health outcomes around bone health.

2.7 Priority 6: Inclusive services

The aim is to ensure early falls prevention services are inclusive and accessible to all service users in line with the Equality Act and Public Sector Equality Duty to enable all older adults to receive falls prevention interventions that meets their needs. CCC will support this by using the work underpinning the Equality Impact Assessment of the strategy to develop and provide guidance to falls prevention services to support them to review the needs of their older clients and consider improvements if needed. Similarly, CCC will involve older adults in the co-production of falls prevention related services, campaigns and projects led by them to deliver on the strategy and will influence partners and actions in the strategy to do the same. CCC Public Health Team plan to commission qualitative research with older adults to better understand their journey through local falls prevention services and interventions and their views of strength and balance exercise/physical activity.

2.8 An engagement exercise for the strategy has been completed. The strategy has been presented to a variety of Cambridgeshire County Council Adult Social Care Boards and ICS Boards with the feedback incorporated into the strategy. Feedback from older adults has been obtained via a survey to CPFT service users which has indicated that the strategy should consider engagement with GPs/Primary Care to better understand how they can support the falls pathway. Further engagement is planned with the Older People's Partnership Board prior to the Committee to build on feedback received from the Board for the one-year strategy.

2.9 The strategy will be monitored by the Cambridgeshire and Peterborough Falls Prevention Strategy Group bi-monthly. It will report to the Joint Commissioning and Executive Group (JCPEG)(or other appropriate Board as advised) and Health and Wellbeing Board, as requested.

3. Alignment with ambitions

3.1 Net zero carbon emissions for Cambridgeshire by 2045, and our communities and natural environment are supported to adapt and thrive as the climate changes

There are no significant implications for this ambition.

3.2 Travel across the county is safer and more environmentally sustainable

There are no significant implications for this ambition.

3.3 Health inequalities are reduced

The Falls Prevention Strategy supports the ambition of the Joint Health and Wellbeing/Integrated Care System Strategy to:

- Reduce inequalities in death in under 75s
- Increase the number of years that people live in good health.

It supports the priority to "Create an environment to give people the opportunities to be as healthy as they can be" through action to help improve access to prevention services and opportunities to be more physically active.

The strategy will consider how to target the delivery of the pathway to those with most need to reduce health inequalities. It is known that falls and hip fractures are more prevalent in people in the most deprived deciles compared to those in the least deprived deciles[3].

3.4 People enjoy healthy, safe, and independent lives through timely support that is most suited to their needs

- The report sets out the significant implication in 1.3.

3.5 Helping people out of poverty and income inequality

There are no significant implications for this ambition.

3.6 Places and communities prosper because they have a resilient and inclusive economy, access to good quality public services and social justice is prioritised

There are no significant implications for this ambition.

3.7 Children and young people have opportunities to thrive

There are no significant implications for this ambition.

4. Significant Implications

4.1 Resource Implications
There are no significant implications within this category.

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

4.3 Statutory, Legal and Risk Implications
The following bullet point sets out details of significant implications identified by officers:

- The priorities in the strategy support the prevention priority of the Care Act (2014).

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

4.5 Engagement and Communications Implications

- The report sets out details of significant implications in 2.8.

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

4.7 Public Health Implications
The report above sets out details of significant implications in 1.1, 1.3 and 1.4.

4.8 Climate Change and Environment Implications on Priority Areas (See further guidance in Appendix 2):

4.8.1 Implication 1: Energy efficient, low carbon buildings.

Neutral
Explanation: No change

4.8.2 Implication 2: Low carbon transport.
Neutral:
Explanation: No change

4.8.3 Implication 3: Green spaces, peatland, afforestation, habitats and land management.
Neutral
Explanation: No change

4.8.4 Implication 4: Waste Management and Tackling Plastic Pollution.
Neutral
Explanation: No change

4.8.5 Implication 5: Water use, availability and management:
Neutral
Explanation: No change

4.8.6 Implication 6: Air Pollution.
Neutral
Explanation: No change

4.8.7 Implication 7: Resilience of our services and infrastructure, and supporting vulnerable people to cope with climate change.
Neutral
Explanation: No change

Have the resource implications been cleared by Finance? Yes
Name of Financial Officer: Justine Hartley

Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the Head of Procurement and Commercial? Yes
Name of Officer: Clair Ellis 14/11/23

Has the impact on statutory, legal and risk implications been cleared by the Council's Monitoring Officer or Pathfinder Legal? Yes
Name of Officer: Approved by CCG 15/11/23

Have the equality and diversity implications been cleared by your EqIA Super User?
Yes
Name of Officer: Jyoti Atri 28/11/23

Have any engagement and communication implications been cleared by Communications?
Yes
Name of Officer: Simon Coby 16/11/23

Have any localism and Local Member involvement issues been cleared by your Service Contact? Yes
Name of Officer: Jyoti Atri 28/11/23

Have any Public Health implications been cleared by Public Health?
Yes
Name of Officer: Jyoti Atri 28/11/23

If a Key decision, have any Climate Change and Environment implications been cleared by the Climate Change Officer?
Yes
Name of Officer Emily Bolton 19/11/23

5. Source documents guidance

5.1 Source documents

A full list of resources used in the Strategy are in the full Cambridgeshire and Peterborough Falls Prevention Strategy 2023-2026 document (Appendix 1).

Falls Prevention Strategy Detailed Action Plan. New Shire Hall: Public Health Team.

NICE. Falls: Assessment and prevention of falls in older people. *NICE Clinical Guidance 161*. 2013. Available at: 1 (nice.org.uk)

Todd C, Skelton D. What are the main risk factors for falls amongst older people and what are the most effective interventions to prevent these falls ? *World Health*. 2004;(March):28. [Accessed 17 May 2022]: Copenhagen, WHO Regional Office for Europe (Health Evidence Network report; http://www.euro.who.int/document/E82552.pdf,

Cambridgeshire and Peterborough Integrated Care System. 2022. Joint Health and Wellbeing Integrated Care Strategy. Available from: Cambridgeshire & Peterborough Insight – Health and Wellbeing – Public Health – Health and Wellbeing Integrated Care Strategy (cambridgeshireinsight.org.uk)

Cambridgeshire and Peterborough

Falls Prevention Strategy

2023-2026

Adults and Health Committee

Cambridgeshire and Peterborough Falls Prevention Strategy Group

FINAL DRAFT

For more information email: publichealth.adminteam@cambridgeshire.gov.uk

Contents

Executive Summary

Falls are a major cause of morbidity and the primary cause of injury related deaths in people aged 75+ in the UK[1]. This can include distress, chronic pain, loss of confidence, activity avoidance, loss of independence, social isolation and increasing frailty[1]. Falls have a significant impact on health and social care services. 255,000 falls-related emergency hospital admissions occur in people aged 65 and older every year in England and these are estimated to cost the NHS £2.3 billion a year[2].

Osteoporosis is a key risk factor for injurious falls as it increases bone fragility and susceptibility to fracture after a fall. Approximately, 549,000 patients present with fragility fractures to hospitals in the UK each year[3]. The estimated cost to the NHS of fragility fractures in 2017 was estimated to be £4.7 billion per annum nationally[3]. Hip fractures make up approximately 69,000 emergency hospital admissions per year, equivalent to 1.3 million bed days and costing the NHS of £1.5 billion per year[4].

In Cambridgeshire and Peterborough, there were 2,699 falls-related emergency admissions in 2022/23 at an estimated cost of nearly £16.3M for hospital treatment alone (excludes costs to the wider health and social care system). This is a substantial increase of over £1.9M compared to the previous year, which can be attributed to an increase in hip fracture admissions in both the North and South Place partnership. In an ageing population, as seen in Cambridgeshire and Peterborough, the prevalence of falls and osteoporosis-related fragility fractures is expected to rise, along with the associated burdens on the wider health and social care services.

A number of interventions have been shown to be cost and clinically effective at preventing some falls and fractures, resulting in improved health outcomes and independence for older people, and savings to health and care services. Research and clinical guidance indicate that this includes multi-factorial falls risk assessment (MFFRAs), strength and balance training, home hazard assessments, and Fracture Liaison Services, to name a few[2]. The effective and integrated commissioning of these interventions will reduce demand by shifting the focus towards prevention, reduce variation in the quality, safety and outcomes of care, and improve efficiency. The recent publication of the World Guidelines provides a detailed blueprint for commissioning evidence-based falls prevention services in practice, with care pathways linking primary and community services to specialists where required[5].

A review of local service provision against NICE clinical guidance for falls prevention has shown that there are some fundamental changes that need to take place in the Cambridgeshire and Peterborough system to improve outcomes for people who are at risk of falling. The analysis shows that local falls prevention services involved in falls risk assessment or providing interventions in primary care, secondary care or community are disjointed and working in isolation. This results in older adults receiving an inconsistent assessment and offer of interventions to reduce their risk depending on where they present in the system. It is paramount that the system addresses this inequity in assessment and multi-factorial intervention and ensures that older adults are receiving all

[1] NICE. Falls: Assessment and prevention of falls in older people. NICE Clinical Guidance 161. 2013. Available at: 1 (nice.org.uk)

[2] Public Health England. Falls and Fragility Fracture Consensus Statement. Supporting Commissioning for Falls Prevention London: Public Health England. 2017. Available at: https://www.gov.uk/government/publications/falls-and-fractures-consensus-statement [Accessed 14 June 2019]

[3] National Osteoporosis Guideline Group (NOGG). Clinical Guideline for the Prevention and Treatment of Osteoporosis. 2021. Full Guideline | NOGG

[4] NHS Right Care falls and fragility fractures pathway. 2017. https://www.england.nhs.uk/rightcare/products/pathways/falls-and-fragility-fractures-pathway/

[5] World guidelines for falls prevention and management for older adults: a global initiative (nih.gov)

the interventions necessary to reduce their risk. The evidence is clear that assessments alone do not reduce risk, but they must be accompanied by multi-factorial intervention. This strategy outlines plans to develop a system-wide, integrated[6] falls prevention pathway linking primary and community services to specialists where required.

Another clear gap is the commissioning and delivery of a Fracture Liaison Service (FLS) in North West Anglia Foundation Trust (NWAFT). FLS's have been shown to benefit patient outcomes, through a significant reduction in subsequent fragility fractures and gains in quality of life, whilst at the same time reducing hospital bed days, surgeries, need for institutional social care, and their associated costs. A previous scoping exercise conducted by Cambridgeshire and Peterborough Public Health Team has shown that there is a gap in the delivery of a resilient and robust Fracture Liaison Service at NWAFT. Resourcing an FLS in NWAFT will provide high quality care to patients across the ICS, currently only available to those with access to CUHFT. This will directly contribute towards the ICS's stated aim to "increase the number of years people spent in good health".

In addition to addressing the two gaps above, this three-year strategy, 2023-2026, outlines the plans of organisations across Cambridgeshire and Peterborough to reduce falls and falls-related injuries by taking a system wide approach to falls prevention and bone health. It details six priorities to achieve the vision of *"working together to reduce the rate of falls and reduce hip fracture admissions amongst older adults, by preventing first falls and reducing the risk of subsequent falls to enable older people in Cambridgeshire and Peterborough to enjoy an active, fulfilling life".*

The priorities are:

1. Prevention and early identification of people at risk of fall
   The aim is to intervene at the earliest opportunity to prevent and reduce the number of people who have a first fall. The focus is on ensuring the public and staff engaging with older adults have the information they need to make informed choices about falls risk factors and have access to opportunities to live and age well. The strategy strongly recognises the importance of scaling up physical activity in preventing falls and reducing the risk of falls, and this is weaved throughout the different priorities and settings. The strategy attempts to define action for active, independent older adults as well less active, dependent adults who may be receiving support from Adult Social Care and Care and Residential Homes. The aim is to ensure that all older adults have the opportunity to be more active and have access to strength and balance training to reduce falls and frailty.

2. Evidence-based and good practice falls prevention interventions and services
   The aim is to ensure that people who have fallen have timely access to services, interventions and opportunities that will support a reduction in the risk of falls and injurious falls. The development of the integrated falls prevention pathway will support this.

3. Action to address risk in hospital
   The aim is to minimise the risk of inpatient falls, repeat falls and re-admissions, and improve quality of life. A key focus in both CUHFT and NWAFT is the development of electronic, multi-disciplinary multi-factorial falls risk assessments. This should support an improvement in

[6] In this context, integration describes the co-ordination of care into a single or coordinated pathway across disciplines and organisations e.g., the development of shared protocols. It does not describe the establishment of a new integrated service.

communication of valuable information with external partners and contribute to a whole system approach.

4. Action to address risk in care homes
   The aim is to prevent, reduce and manage falls in nursing and residential home residents in order to reduce the risk and consequences of fragility fracture and a long lie, improve quality of life and reduce system wide pressures. Key features of this priority include supporting care and residential homes to conduct multi-factorial falls risk assessments, manage people who have fallen and embed movement and activity in the lives of residents.

5. Detection and management of fragility fracture
   The aim is to ensure early identification and management of falls and osteoporosis risk factors to prevent a first or subsequent fragility fracture and provide optimal support after a fragility fracture. This priority outlines how the system plans to address the gap in a robust and resilient FLS identified by the gap analysis. Public Health resource has been allocated to take forward the scoping and development of a strategy and to support the development of a business case in year 1 of the strategy. This is intended to enable the system to take action to reduce inequalities in health outcomes.

6. Inclusive services
   The aim is to ensure early falls prevention services are inclusive and accessible to all service users in line with the Equality Act and Public Sector Equality Duty to enable all older adults to receive falls prevention interventions that meets their needs**.**

The success of the strategy action plan will be measured by the reduction in the rate of hip fracture admissions. The strategy will be monitored by the Cambridgeshire and Peterborough Falls Prevention Strategy Group bi-monthly. It will report to the Joint Commissioning and Executive Group (JCPEG) and Health and Wellbeing Board, as requested.

View the actions agreed in the action plan.

1.0 Strategy

1.1 Vision/aim

“Health, social care and voluntary sector partners to work together over the next three years to reduce the rate of falls and reduce hip fracture admissions amongst older adults, by preventing first falls and reducing the risk of subsequent falls to enable older people in Cambridgeshire and Peterborough to enjoy an active, fulfilling life”.

1.2 Strategic priorities

The strategic priorities are informed by local need and national research and evidence on what works to prevent falls. Our approach is centred on the need to employ a whole-system falls prevention approach comprising an array of evidence-based interventions targeted at specific population groups and the delivery of services in an integrated manner by a range of sectors and partners across the system. The approach will address varying phases of need across the population ranging from older people who are well and mobile with no risks identified; those demonstrating risk factors for falls; those who have fallen and injured themselves; and those with significant frailty and multi-morbidities that may have already had interventions related to falls.

The priorities are underpinned by good communication, information sharing, and workforce development to enable staff and volunteers to be confident and competent in delivering falls prevention support.

This strategy provides the opportunity for partners to work together on agreed priorities to ensure that Cambridgeshire and Peterborough residents are able to benefit from effective, high quality falls prevention.

The six priorities for this falls prevention strategy are:

1. Prevention and early identification of people at risk of falls - to intervene at the earliest opportunity to prevent and reduce the number of people who have a first fall,

2. Evidence-based and good practice falls prevention interventions and services – to ensure that people who have fallen have timely access to services, interventions and opportunities that will support a reduction in the risk of falls and injurious falls,

3. Action to address risk in hospital – to minimise the risk of inpatient falls, repeat falls and re-admissions, and improve quality of life,

4. Action to address risk in care homes - to prevent, reduce and manage falls in nursing and residential home residents in order to reduce the risk and consequences of fragility fracture and a long-lie, improve quality of life and reduce system wide pressures,

5. Detection and management of fragility fractures – to ensure early identification and management of falls and osteoporosis risk factors to prevent a first or subsequent fragility fracture and provide optimal support after a fragility fracture,

6. Inclusive services - to ensure early falls prevention services are inclusive and accessible to all service users in line with the Equality Act and Public Sector Equality Duty to enable all older adults to receive falls prevention interventions that meets their needs**.**

2.0 Introduction

2.1 Background

Falls and related injuries are a common and significant problem for older adults[1]. The combination of high incidence and susceptibility to injury in older adults makes falls a major public health issue. Both the incidence and severity of falls and falls-related injuries increases after the age of 60 years old[7].

Around one in three people over 65 years old, and half of those over 80, experience a fall at least once a year[1,8] . The incidence rates of falls in people living in nursing homes and patients admitted to hospitals are almost three times the rates of those living in the community[8]. Those who fall once are two to three times more likely to fall again within the year[8].

Falls are a major cause of morbidity and the primary cause of injury related deaths in people aged 75+ in the UK[1]. Approximately 10% of falls in the community result in serious injury and 5% of these are fractures[8] . Injury rates are considerably higher in nursing homes and hospitals with 10-25% of institutional falls resulting in fracture, laceration, or the need for hospital care[8]. Hip fractures are one of the most serious injuries resulting from a fall with approximately 10% of people who fracture a dying within one month and a further third within a year[8]. Up to 90% of older patients who fracture their hip do not return to their previous level of mobility or independence[9]. Falls are a significant factor in people having to move from their own homes into high cost long term residential care[9].

Falls have a large impact on quality of life as well as physical health. This can include distress, chronic pain, loss of confidence, activity avoidance, loss of independence, social isolation and increasing frailty[1,2]

The impact of falls on healthcare costs is significant. Approximately, 255,000 falls-related emergency hospital admissions occur in people aged 65 and older every year in England and these are estimated to cost the NHS £2.3 billion a year[2]. Fragility fractures are estimated to cost the UK £4.4bn; £2bn of this can be attributed to hip fractures and £1.1bn to social care[2].

In Cambridgeshire and Peterborough, there were 2,699 emergency admissions due to falls and 1,015 admissions due to a hip fracture in 2022/23. The estimated combined cost of these hospital admissions was £16.3M, an increase of over £1.9M from the previous year (£14.4M in 2021/22)[10]. This does not include wider health and social care costs such as primary care, ambulance or adult

[7] American Geriatrics Society 2001. Guidelines for prevention of falls in older persons. *J Am Geriatr Soc.*49:664-672
[8] Todd C, Skelton D. What are the main risk factors for falls amongst older people and what are the most effective interventions to prevent these falls ? *World Health*. 2004;(March):28. [Accessed 17 May 2022]: Copenhagen, WHO Regional Office for Europe (Health Evidence Network report; http://www.euro.who.int/document/E82552.pdf,
[9] Cambridgeshire JSNA. Preventing ill-health in older people. 2013. Prevention-of-Ill-Health-in-Older-People-JSNA-2013.pdf (cambridgeshireinsight.org.uk)
[10] Costs calculated by Public Health Intelligence Team, June 2023 from DSCRO SusCP.ip_spell_all. Definition: Emergency admissions of 'falls where primary diagnosis is a hip fracture', 'S72.0 Fracture of neck of femur', 'S72.1', 'S72.2' and 'All other falls'. Average cost of hip fracture £9,890 and cost of 'other fall' £3,166.

social care costs. One study estimating costs to health and social care as a result of a fall suggested that 60% of the total health and social care costs were incurred by social services[11].

It was anticipated that the Coronavirus pandemic would have an impact on the incidence of falls as a result of decreased physical activity during the restrictions and the subsequent increase in deconditioning in some older age groups, with some groups disproportionately affected[12]. The level of impact is unclear. Data shows that the overall rate of falls admissions in over 65s in Cambridgeshire and Peterborough has not increased since a statistically significant decrease at the start of the pandemic. However, data shows that there is an increasing trend in the rate of hip fractures across both Cambridgeshire and Peterborough since 2020/21. This could potentially be associated with the decrease in physical activity and deconditioning during the pandemic. Whilst there are signs that physical activity levels have recovered and now exceed pre-COVID levels[13], it is unclear whether the level of activity has increased in the population groups disproportionately affected by deconditioning and whether it is sufficient to reverse the deconditioning or how this relates to hip fractures. Local services (Adult Social Care) have reported a significant increase in service users presenting to the service since the pandemic who are deconditioned and have a higher level of need.

Osteoporosis is another key risk factor for injurious falls that is critical to include in the strategy as it increases bone fragility and susceptibility to fracture after a fall. Osteoporosis is a common condition affecting 2% of the population at 50 and 25% at 80 years of age[14]. Approximately, 549,000 patients present with fragility fractures to hospitals in the UK each year[3]. The estimated cost to the NHS of fragility fractures in 2017 was estimated to be £4.7 billion per annum nationally[3Error! Bookmark not defined.]. People who sustain a fragility fracture are at least twice as likely to sustain a further fracture[15]. Treatment can reduce the risk of fragility fracture and its complications[15].

This strategy sets out Cambridgeshire and Peterborough's plans to reduce falls and falls-related injuries by taking a system wide approach to falls prevention. The strategy has been developed by a multi-agency Falls Prevention Strategy Group (Appendix 1) and informed by a local needs assessment and national policy and guidance, including the Public Health England Falls and Fracture Consensus Statement[2], NHS Rightcare Falls and Fragility Fractures Pathway[4], NICE clinical guidance 161[1] and the recent World Guidelines for falls prevention[16]. It builds upon the achievements of the one-year strategy and enters a period of more stability with the Integrated Care System (ICS) being more established and services having advanced along their recovery journey post-COVID to return to business as usual.

The implementation of the first strategy for Cambridgeshire and Peterborough has seen good progress. It has been used as a tool to help galvanise partners working on falls prevention across the system and facilitate the start of more joined-up system working. It has seen strengthened relationships from a broader group of key stakeholders and opportunities to join-up, and the establishment of structures to monitor and provide accountability for driving forward the key actions in the action plan. Positively, the period of the strategy saw a decrease in hospital admissions due to fall in 2021/22 compared to 2020/21, however, it also saw an increase in admissions for hip

[11] Craig J, Murray A, Mitchell S et al. The high cost to health and social care of managing falls in older adults living in the community in Scotland. Scottish Medical Journal 2013;58(4):198-203. http://scm.sagepub.com/content/58/4/198.
[12] Public Health England. Wider impacts of COVID-19 on physical activity, deconditioning and falls in older adults. 2021. Wider impacts of COVID-19 on physical activity, deconditioning and falls in older adults (publishing.service.gov.uk)
[13] Active Lives Adult Survey November 2021-22 Report (sportengland-production-files.s3.eu-west-2.amazonaws.com)
[14] NICE. Osteoporosis: assessing the risk of fragility fracture. NICE Clinical Guidance 146: 2012. Overview | Osteoporosis: assessing the risk of fragility fracture | Guidance | NICE
[15] British Orthopaedic Association (2007). The care of patients with fragility fracture. Blue Book (bgs.org.uk)
[16] World guidelines for falls prevention and management for older adults: a global initiative (nih.gov)

fractures during the same period. This highlights the ever-increasing and critical challenge for the local system to come together to prevent and manage falls and their related injuries to help our residents to enjoy and active and fulfilling older age.

This longer-term 2023-2026 strategy will provide clearer direction on what is needed to achieve the vision. The findings of a comprehensive gap analysis against NICE guidance and feedback from older adults about current services have contributed to this. These have shown that the multi-disciplinary management of falls will be important to successfully driving down rates of falls and hip fracture admissions. The establishment of an ICB Falls and Frailty lead and workstream, combined with the priority around personalised care, (leading to a focus on frailty) of the North and South Accountable Business Units (ABUs), provides an opportunity to drive the necessary integration that will improve outcomes for older adults who experience falls:

"We need to make a transformative cultural shift from individual organisational working to a partnership approach." Joint Forward Plan Summary[17]

2.2 Strategic context

2.2.1 NHS Long Term Plan 2019

The NHS long-term plan sets out key ambitions for the NHS over the next 10 years. Supporting people to age well is covered under the government's key commitment to a new NHS service model in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting[18]. The following commitments are particularly relevant to falls prevention:

- Expansion of community multidisciplinary teams including GPs, allied health professionals, social care and the voluntary sector to work together in an integrated way to provide tailored support that helps people live well and independently at home for longer
- Assessment of risk of unwarranted health outcomes of the local population by Primary Care Networks working with local community services to make support available to people where it is most needed. Falls prevention schemes, including exercise classes and strength and balance training, are explicitly stated.
- Upgrading NHS support in care homes including making sure there are strong links between care homes, local general practices and community services through the delivery of The Framework for Enhanced Health in Care Homes (EHCH)
- Developing more rapid community response teams, to support older people with health issues before they need hospital treatment and help those leaving hospital to return and recover at home.

2.2.2 Integrated Care Systems

In the last year, significant changes have taken place in the way the health and care system is organised following the formalisation of Integrated Care Systems (ICSs) as statutory bodies on the 1 of July 2022. ICSs are partnerships that bring together providers and commissioners of NHS services across a geographical area with local authorities and other local partners to collectively plan health

[17] Joint Forward Plan | CPICS Website
[18] nhs-long-term-plan.pdf

and care services to meet the needs of their population. Key aspirations of ICSs are to achieve greater integration of health and care services; improve population health and reduce inequalities. ICSs and are a key part of the future direction for the NHS as set out in the NHS Long-Term Plan.

The Cambridgeshire and Peterborough ICS comprises an Integrated Care Board (ICB) and Integrated Care Partnership (ICP) Board and five Accountable Business Units (ABUs) (See Appendix 2 for governance structure). Two of the ABUs are place-based partnerships (the North Care Partnership and the South Care Partnership) and are of relevance to the strategy as they are responsible for the co-ordination, planning and delivery of integrated services and personalised care in the area.

The Cambridgeshire and Peterborough ICS has published its Joint Forward Plan and Health and Wellbeing Integrated Care Strategy 2023-28 setting out their vision for health and care services in Cambridgeshire, Peterborough and Royston for the next five years. The shared vision across partners 'All Together for Healthier Futures' centres on four priorities as follows:

- Our children are ready to enter education and exit prepared for the next phase of their lives
- Reducing poverty through better employment and housing
- Creating an environment to give people the opportunities to be as healthy as they can be
- Promoting early intervention and prevention measures to improve mental health and well-being.

The North Care Partnership and the South Care Partnership delivery plans have priorities around frailty and/or falls.

2.2.3 Care Together

Care Together is a co-produced place-based programme to help older people remain living independently in their own homes for longer. Work began in East Cambridgeshire in 2021-22 and has been expanded across the rest of Cambridgeshire, following significant investment by Cambridgeshire County Council and partnerships with multiple stakeholders, including PCNs and local voluntary, community and voluntary and community sector (VCSE) organisations. A key aim of the programme is to collaboratively improve care and support for older people in the community to promote independence and delay demand for long term health and social care services. This means rethinking how services are commissioned and delivered, transforming them into an easy-to-access local offer wrapped around individuals, rather than a one-size fits all approach.

2.3 Causes of falls and fractures

The causes of falls are multifactorial, and over 400 separate risk factors have been identified[1]. These risk factors can be classified as either intrinsic or extrinsic and may be modifiable or non-modifiable.

Major intrinsic risk factors include muscle weakness, poor balance, visual impairment, and a number of specific conditions. These include a wider range of long-term conditions such as arthritis, cognitive impairment, depression, diabetes, high alcohol consumption, incontinence, Parkinson's disease, stroke and syncope[2]. Major extrinsic risk factors include polypharmacy (i.e., taking over four prescription medications), psychotropic medications, and environmental hazards such as inadequate lighting, poorly fitted carpets, and lack of equipment for bathing[2].

The risk of falling has been shown to increase as the number of risk factors increases[7] - a fall generally results from an interaction between multiple diverse risk factors and situations[19]. For example, environmental hazards may create conditions likely to cause trips or slips for an older person who may already have multiple risk factors for fall and this risk may be aggravated by behavioural risk factors – such as the faller was hurried or moving beyond limits of stability - leading to a fall[19].

Previous history of falls is a significant predictor of future falls[4].

Major risk factors for fragility fractures are varied. They include low bone mineral density, previous fracture, age, female sex, previous falls, use of glucocorticoids, rheumatoid arthritis, smoking, high alcohol consumption, low BMI and visual impairment[4].

Falls can affect a diverse range of older adults right through from the youngest-old to the oldest-old. Falls can be a sign of a new health condition (potentially temporary one) or the worsening of chronic underlying health issues such as frailty[2].

2.4 Local context

2.4.1 Demography

The resident population aged 65+ in Cambridgeshire and Peterborough in 2021 was 127,090 and 30,685 respectively. The number of older people aged 65 and over is forecast to increase significantly between 2021 and 2041, increasing by 58,445 in Cambridgeshire and 13,895 in Peterborough, an increase of 46% and 45.3% respectively.

Based on the population in 2021, approximately 38,127 people aged 65 and over in Cambridgeshire and 9,206 people in Peterborough will have experienced a fall at least once during the year. Applying modelled proportions of people who fall to local population estimates in 2041 suggests that 55,661 over 65s in Cambridgeshire and 13,374 in Peterborough will fall in 2041.

Table 1: Cambridgeshire and Peterborough 65+ Population forecast

	2021	2026	2031	2036	2041	% change between 2021 and 2041
Cambridgeshire	127,090	141,590	160,275	176,130	185,535	46%
Peterborough	30,685	33,775	37,915	42,030	44,580	45.3%

Source: Cambridgeshire County Council 2021 based population forecasts[20]

[19] Karen L. Perell, et al., Fall Risk Assessment Measures: An Analytic Review, *The Journals of Gerontology: Series A*, Volume 56, Issue 12, 1 December 2001, Pages M761–M766, https://doi.org/10.1093/gerona/56.12.M761

[20] Cambridgeshire Insight – Population – Local Population Estimates and Forecasts

2.4.2 Incidence of falls and hip fractures

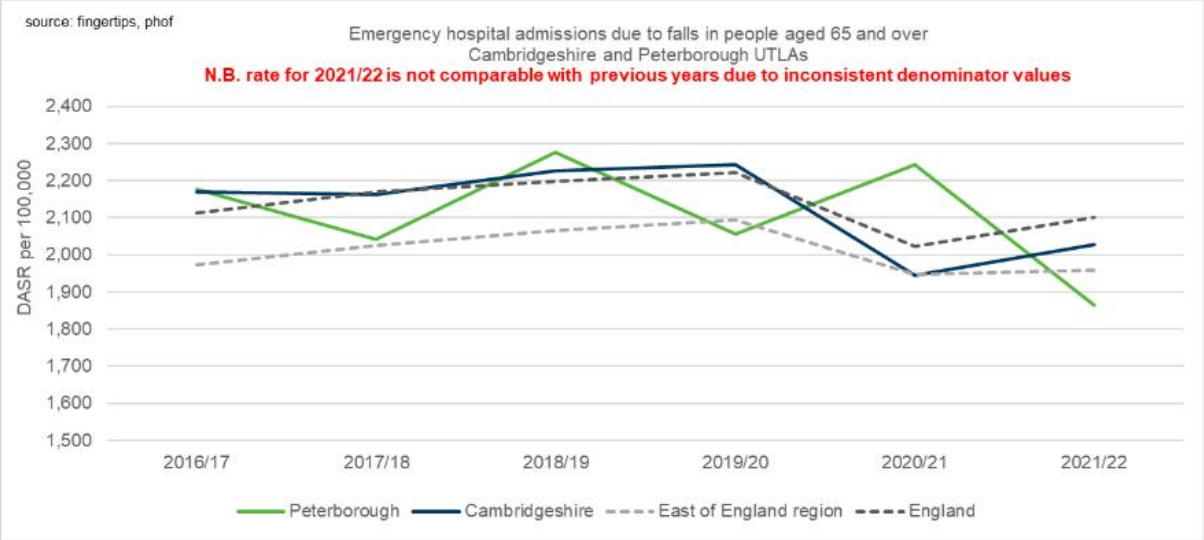
2.4.2.1 County level

The Public Health Outcomes Framework reports on admissions for injury due to falls and hip fractures. In 2021/22, the directly age-standardised rate (DASR) of hospital admissions for injury *due to falls* in people aged 65+ years in Cambridgeshire was statistically similar to the national average (2,027 per 100,000 in Cambridgeshire compared to 2,100 per 100,000 in England) and in Peterborough it was statistically significantly better than the England average (1,865 per 100,000 in Peterborough compared to 2,100 per 100,000 in England)(Figure 1)(Appendix 3)[21].

Compared to its nearest CIPFA[22] neighbours, Cambridgeshire was ranked 9th out of 16 when ranked by highest (worst) to lowest (best) rate of admission due to falls in 2021/22 and Peterborough was ranked 13th out of 16 neighbours.

The risk of falling and emergency admissions for injury due to falls and hip fracture increases substantially with age and the highest rates of admission are in those aged 80 years and above (Cambridgeshire in 2021/22: rate of admissions due to falls in 65-79 years was 876 per 100,000 compared to 5,367 per 100,000 in the 80+. Peterborough rate of admissions due to falls in 65-79 years was 995 per 100,000 compared 4,388 per 100,000 in the 80+).

Figure 1: Emergency admissions due to falls in over 65s in Cambridgeshire and Peterborough



Source: Fingertips, Public Health Outcomes Framework

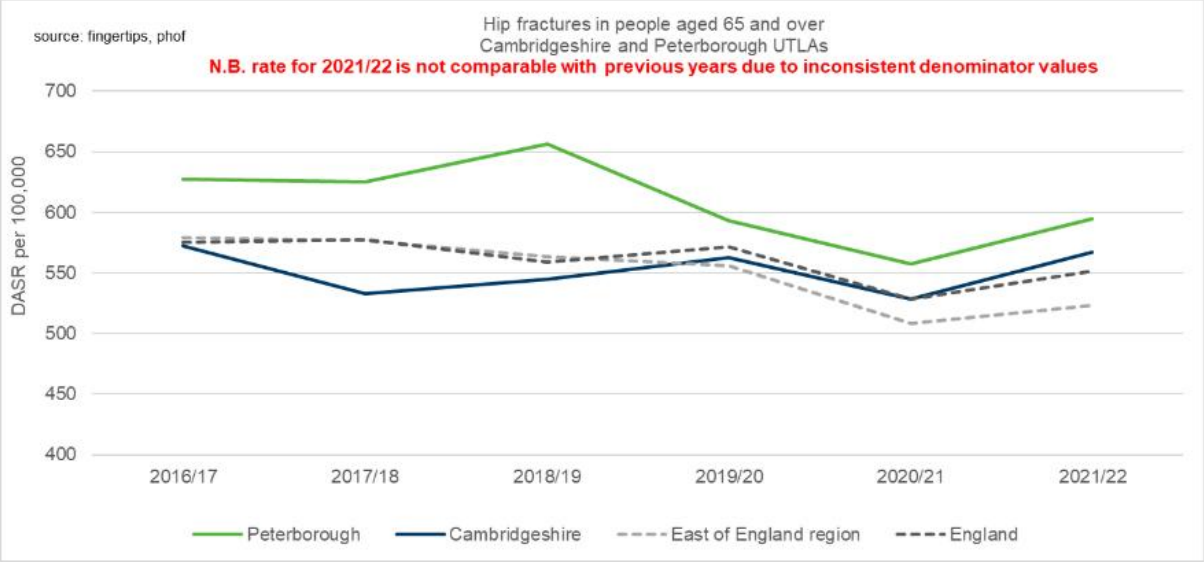
The age-standardised rate of admissions due to *hip fractures* in people aged 65+ in Cambridgeshire and Peterborough was statistically similar to the England average in 2021/22 (Cambridgeshire: 567 per 100,000; Peterborough: 594 per 100,000; England 551 per 100,000)(Appendix 4)[21.] Compared to

[21] Office for Health Improvement & Disparities. Public Health Profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022

[22] Chartered Institute of Public Finance and Accounting (CIPFA) nearest neighbours model uses statistical processes to classify local authorities into similar groups based on a range of socio-economic indicators to allow comparison and benchmarking across local authorities.

their nearest CIPFA[23] neighbours, Cambridgeshire was ranked 4th out of 16 when ranked by highest (worst) to lowest (best) rate of admission due to hip fracture in 2021/22 and Peterborough was ranked 6th out of 16 neighbours.

Figure 2: Emergency admission due to hip fracture in 65+ in Cambridgeshire and Peterborough



Source: Fingertips, Public Health Outcomes Framework

2.4.2.2 District level

Analysis of the rate of admissions *due to falls* in 2021/22 by district shows that all the districts in Cambridgeshire had a rate of admissions for falls that was similar or better than the national average[21] (Appendix 5). Similarly, the rate of admissions for *hip fractures* was similar to the national average in all Cambridgeshire districts in 2021/22.

2.4.2.3 Falls and hip fractures by deprivation

Analysing the PHOF data by deprivation shows that there are health inequalities associated with admissions due to falls and hip fractures. The data shows that there are higher rates of admissions due to falls and hip fractures in the most deprived lower super output areas (LSOAs) in England compared to the least deprived LSOAs (Appendix 6)[21]. There is no data available to reflect this at the Cambridgeshire or Peterborough level but national level data can be used as a proxy.

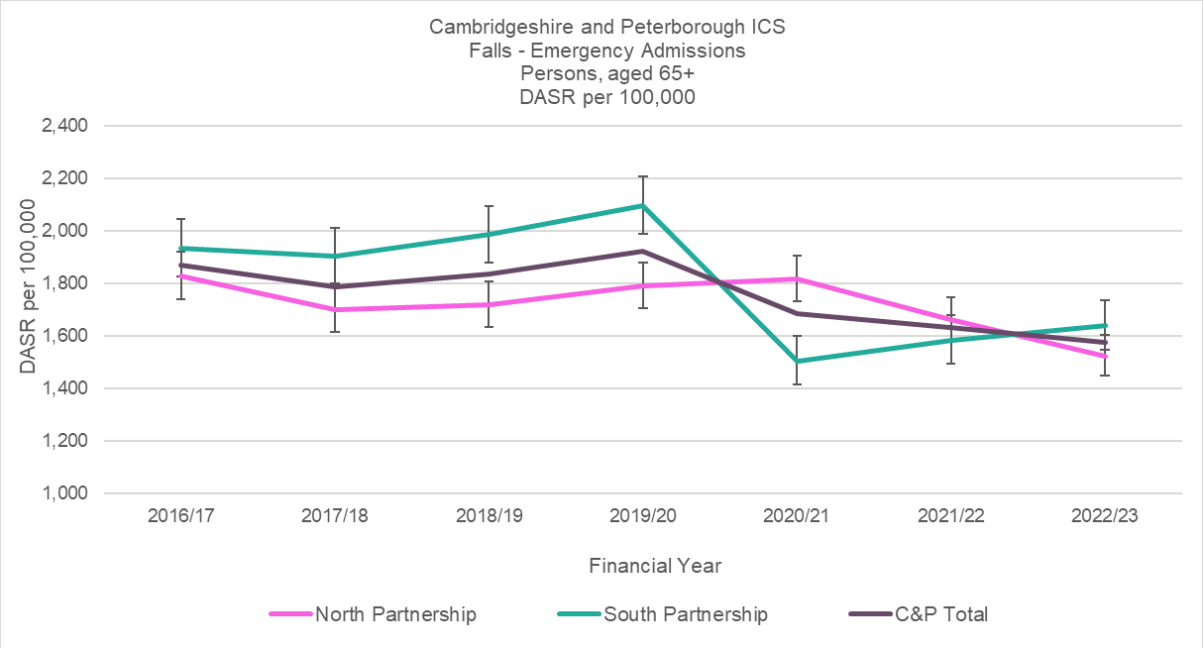
2.4.2.4 North and South Place

The directly age-standardised rate (DASR) of hospital admissions for injury *due to falls* in people aged 65+ years living in the North and South Partnership Places of Cambridgeshire and Peterborough in 2022/23 was 1,524 per 100,000 and 1,639 per 100,000 respectively (number of admissions was 1,496 in the North Place and 1,203 in the South Place)(Figure 3). This continues the slight downward

[23] Chartered Institute of Public Finance and Accounting (CIPFA) nearest neighbours model uses statistical processes to classify local authorities into similar groups based on a range of socio-economic indicators to allow comparison and benchmarking across local authorities.

trend in admissions since 2020/21 in the North Place (DASR = 1,816 per 100,000 in 2020/21 and number of admissions was 1,714) and continues the upward trend in admissions since 2020/21 in the South Place (DASR = 1,505 per 100,000 and number of admissions was 1,046)(Appendix 7). It should be noted that a statistically significant decrease in the rate of admissions due to falls was observed in the South Place between 2019/20 and 2020/21, decreasing from the highest to the lowest rate in the South Place during the last 5 years (DASR of falls admissions was 2,095 per 100,000 in 2019/20 and 1,505 per 100,000 in 2020/21). This decrease correlates with the onset of the first lockdown of the coronavirus pandemic in March 2020. However, as stated previously, the trend has now reversed and is on an upward trajectory.

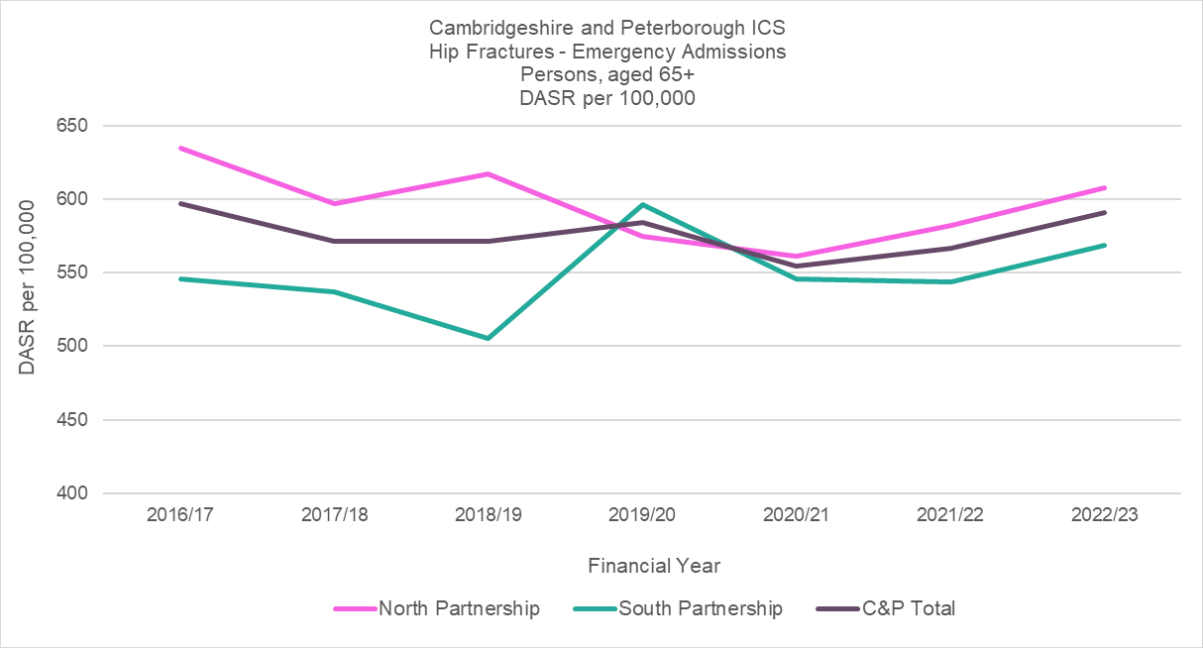
Figure 3: Age standardised rate of admissions for injury due to fall by in 65+, by Place



Source: CCG DSCRO SusCP.ip_spell_all

The directly age-standardised rate (DASR) of hospital admissions due to *hip fracture* in people aged 65+ living in the North and South Places of Cambridgeshire and Peterborough in 2022/23 was 608 per 100,000 and 569 per 100,000 respectively (number of hip fracture admissions was 599 in the North and 416 in the South)(Figure 4). This represents an upward trend in admissions in the North Place in the two years since 2020/21 (DASR = 561 per 100,000 in 2020/21 and n=529)(Appendix 8). The admissions in the South Place have increased in the last year between 2021/22 and 2022/23 having been on a decreasing trajectory for two years between 2019/20 and 2021/22.

Figure 4: Age standardised rate of admissions due to hip fracture by Integrated Care Partnership



Source: CCG DSCRO SusCP.ip_spell_all

2.4.2.5 Primary Care Network (PCN) level

Analysis of the rate of admissions by Primary Care Network (PCN) shows that Cambridge City PCN was the only PCN in the ICS to have a statistically significantly higher rate of hospital admissions due to *injurious falls* in people 65+ than the ICS average in 2022/23 (2,026 per 100,000 in Cambridge City PCN compared to 1,575 per 100,000 in the ICS)(Appendix 7). Furthermore, rates were statistically significantly high in this PCN in six of the last seven years between 2016/17 and 2023, with the exception of 2020/21 where the rate was similar to the ICS average. Central Thistlemoor and Thorpe Road PCN and BMC Paston PCN were the only PCNs to have a statistically significantly lower rate of admissions *due to falls* than the ICS average in 2022/23 (1,005 per 100,000 in Central Thistlemoor and Thorpe Road PCN and 1,240 per 100,000 in BMC Paston compared to 1,575 per 100,000 in the ICS). The rates in Central Thistlemoor and Thorpe Road PCN were statistically significantly lower in six out of the last seven years, with the exception of 2018/19 which was similar to the ICS average. All the other PCNs had rates similar to the ICS average in 2022/23.

Analysis of the rate of admissions for *hip fracture* by PCN shows that Meridian PCN had a statistically significantly lower rate of admissions than the ICS average in 2022/23. All the other PCNs had a rate of hospital admissions for hip fracture similar to the ICS average in 2022/23 (Appendix 8).

2.4.2.6 Admissions by age, gender and ethnicity

Analysis of the characteristics of individuals admitted as a result of injury due to falls in 2022/23 shows that 48% were aged 85+ years, 67% were female and 83% were White British. Admissions due to hip fracture showed a similar picture (Appendix 9).

2.4.3 Summary of epidemiology

- the population is ageing and rapidly increasing in number

- falls and fracture risk increases substantially with age
- the coronavirus pandemic is expected to increase the number of people experiencing a fall as a result of deconditioning
- costs to the health and social care system are substantial and will increase over time.

3.0 The evidence

The evidence base to support falls prevention activities is strong and a number of national documents have been published in recent years to provide guidance to local areas on the high-impact interventions needed to reduce falls in older people living in the community.

3.1 World Guidelines for falls prevention and management for older adults: A global initiative

The World clinical guidelines outline a framework and set of evidence based and expert recommendations to support the identification and assessment of falls risk[5]. The guidelines, developed by a World Falls Task Group and published in Age and Ageing in 2022, offer a more up-to-date and accurate understanding of current research evidence and implications for practice in the interim of the National Institute for Health and Care Excellent (NICE) updating their 2013 guideline.[24] The framework is based around the following principles:

- Falls Risk Stratification

- Assessment

- Management and Interventions

- Assessment and Treatment algorithm.

The full list of recommendations that should be offered can be found in Appendix 10.

3.2 NICE guidelines

3.2.1 NICE Clinical Guideline CG161 - Falls: assessment and prevention of falls in older people

NICE Clinical Guideline CG161 (2013) outlines the preventable nature of some falls and provides guidance on the assessment and prevention of falls in older people both in the community and in hospital settings[1].

The key recommendations are:

- ***Case or risk identification***: Older people in contact with healthcare professionals should be asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of the fall(s). Older people reporting a fall or considered at risk of falling should be observed for balance and gait deficits and considered for their ability to benefit from interventions to improve strength and balance.

- ***Multifactorial risk assessment:*** All older people with recurrent falls, or assessed as being at increased risk of falling, should be considered for an individualised multifactorial intervention assessment by a multi-disciplinary team. This assessment should identify and

[24] Surveillance decision | Evidence | Falls in older people: assessing risk and prevention | Guidance | NICE

address future risk, and offer individualised intervention aimed at promoting independence and improving physical and psychological function.

- ***Multifactorial intervention programmes:*** All older people with recurrent falls or assessed as being at increased risk of falling should be considered for an individualised multifactorial intervention. In successful programmes the following specific components are common:

    o strength and balance training,

    o home hazard assessment and intervention,

    o vision assessment and referral,

    o medication review with modification/withdrawal.

- ***Strength and balance training:*** Recommended particularly for older people living in the community with a history of recurrent falls and/or balance and gait deficit

- ***Exercise in extended care settings:*** Multifactorial interventions with an exercise component are recommended for older people in extended care settings who are at risk of falling

- ***Home hazard and safety intervention:*** Older people who have received treatment in hospital following a fall should be offered a home hazard assessment and safety intervention/modifications by a suitably trained healthcare professional

- ***Psychotropic medications:*** Older people on psychotropic medications should have their medication reviewed, with specialist input if appropriate, and discontinued, if possible, to reduce their risk of falling

- ***Cardiac pacing:*** Cardiac pacing should be considered for older people with cardioinhibitory carotid sinus hypersensitivity who have experienced unexplained falls

- ***Information and education:*** Older people should be encouraged to participate in falls prevention programmes including education and information about how to prevent further falls

- ***Professional education:*** All healthcare professionals dealing with patients known to be at risk of falling should develop and maintain basic professional competence in falls assessment and prevention.

The key recommendations for preventing falls in older people during a hospital stay are:

- Regard as being at risk of falling in hospital: inpatients over 65; and patients aged 50 to 64 years who are judged by a clinician to be at higher risk of falling because of an underlying condition and manage their care according to guidelines

- For patients at risk of falling in hospital, consider a multifactorial assessment and a multifactorial intervention

- Ensure that any multifactorial assessment identifies the patient's individual risk factors for falling in hospital that can be treated, improved or managed during their expected stay.

3.2.2 NICE clinical guideline 146: Osteoporosis

NICE guidance on osteoporosis is relevant to reducing the risk of fractures from falls[14]. The short clinical guideline (CG 146) on osteoporosis for people 18+ years aims to provide guidance on the selection and use of risk assessment tools in the care of people who may be at risk of fragility fractures in all settings in which NHS care is received. It recommends considering assessment of fracture risk:

- In all women aged 65 years and over and all men aged 75 years and over
- in women aged under 65 years and men aged under 75 years in the presence of risk factors[25]
- In people aged under 50 years if they have major risk factors.

To accompany the clinical guideline, NICE have produced a number of technical appraisals to support the primary and secondary prevention of osteoporosis and to provide guidance around the use of bisphosphonates for treating osteoporosis[26,27,28].

3.2.3 NICE clinical guideline 124: Hip fracture management

This guideline aims to improve care from the time people aged 18 and over are admitted to hospital with a hip fracture through to when they return to the community[29]. Recommendations emphasise the importance of early surgery and coordinating care through a multidisciplinary hip fracture programme to help people recover faster and regain their mobility. It includes recommendations on imaging options in occult hip fracture, timing of surgery, pain relief, anaesthesia and surgical procedures, mobilisation strategies, multidisciplinary management, patient and carer information.

3.3 NHS RightCare pathway: Falls and Fragility fractures

The NHS RightCare pathway: Falls and Fragility fractures defines the key interdependent components required for an optimal system for the prevention and management of falls and fragility fractures[4]. It states that commissioners responsible for falls and fractures should:

- focus on the three priorities for optimisation:
    i. Falls prevention
    ii. Detecting and Managing Osteoporosis
    iii. Optimal support after a fragility fracture
- work across the system to ensure that schemes to deliver the higher value interventions are in place to address variation, improve outcomes and reduce cost to the NHS:
    - Targeted case-finding for osteoporosis, frailty and falls risk
    - Strength and balance training for those at low to moderate risk of falls
    - Multi-factorial intervention for those at higher risk of falls
    - Fracture liaison service for those who have had a fragility fracture
- use the Falls Prevention Consensus Statement and Resource Pack.

25 Risk factors include: previous fragility fracture; current use or frequent recent use of oral or systemic glucocorticoids; history of falls; family history of hip fracture; other causes of secondary osteoporosis; low body mass index (BMI) (less than 18.5 kg/m2); smoking; alcohol intake of more than 14 units per week for men and women.
26 https://www.nice.org.uk/guidance/ta160
27 http://www.nice.org.uk/guidance/TA161
28 https://www.nice.org.uk/guidance/ta464
29 NICE. The management of hip fracture in adults. 2011. Available from: www.nice.org.uk/guidance/cg124

3.4 Falls and fractures consensus statement and resource pack and Return on Investment Tool

Public Health England (PHE) and the National Falls Prevention Coordination Group member organisations have produced a falls and fractures consensus statement and resource pack detailing key interventions, approaches to commissioning and the commitment to national support[2]. These documents were followed by a Return on Investment Tool in 2018[30].

The consensus statement advocates a whole system approach to prevention, response and treatment which includes:

- promotion of healthy ageing across the different stages of the life course to reduce exposure to risk factors e.g., physical inactivity, inadequate nutrition, smoking, and high alcohol consumption
- optimising the reach of evidence-based case finding and risk assessment (around both falls and fractures)
- commissioning of services that provide:
    i. an appropriate response attending people who have fallen
    ii. multifactorial risk assessment and timely and evidence based tailored interventions for those at high risk of falls (shown to reduce the incidence of falls by 24%)
    iii. evidence based strength and balance programmes and opportunities for those at low to moderate risk of falls (home-based and group-based strength and balance programmes (e.g., FaME) reduce the incidence by 29% and 32% respectively. Both demonstrate a £1:£1 financial return on investment, and a societal return on investment of around £2.20:1)
    iv. home hazard assessment and improvement programmes (shown to reduce the rate of falls by 31% with a financial ROI of £3.17:£1 spent and a societal ROI of £7.34:£1[31])
- ensuring that local approaches to improve poor or inappropriate housing address falls prevention and promote healthy ageing
- action to reduce risk in high-risk health and residential care environments
- providing fracture liaison services in line with clinical standards including access to effective falls interventions when necessary
- providing evidence-based collaborative, interdisciplinary care for falls-related serious injuries supported by clinical audit programmes.

[30] Public Health England (2018). A Return on Investment Tool for the Assessment of Falls Prevention Programmes for Older People Living in the Community. London: Public Health England. Available at: https://www.gov.uk/government/publications/falls-prevention-cost-effective-commissioning [Accessed 14 June 2019]

[31] Delivery of an Occupational Therapy-led Home Hazard Assessment and Improvement Programme reduces the rate of falls by 31% and shows a good ROI (Financial ROI is £3.17:£1 spent and a societal ROI of £7.34:£1)[Error! Bookmark not defined.,30]. The effectiveness is greatest when delivered by OTs and targeted at those at highest risk of falls (People aged 65+, with a history of falls, and also possess more than one other risk factor for falls e.g. use of mobility device, requiring assistance for activities of daily living (ADLs), use of psychoactive medicines.)[31&31].

3.5 Wider impacts of COVID-19 on physical activity, deconditioning and falls in older adults

Public Health England reviewed and modelled the impact of COVID-19 on falls in older people and proposed a number of recommendations to address the predicted increase in rate of falls as a result of decreased physical activity and deconditioning[12,32]. The report recommends a population level approach and a targeted approach to increase participants' levels of strength and balance activities so that they can also safely resume activities they engaged in before the pandemic, such as other forms of physical activity, social activities, accessing healthcare, and work.

Key recommendations for the whole population are:

- promotion and increased availability of strength and balance activity for older adults, involving a gradual increase in activity in order to reduce falls risk and to enable safe and confident participation on other forms of exercise and physical activity
- ensuring that physical activity recovery measures reach those who stand to benefit most from them, including older adults who shielded, with multimorbidity, with dementia, in social care settings and from more deprived backgrounds
- identifying locally which older adults have reduced their levels of physical activity during the COVID-19 pandemic, with a focus on populations where the largest reductions are likely to be found. The largest reductions in strength and balance activity identified in this report were seen in males aged 65 to 74 and females aged 65 to 84.

Key recommendations for the targeted population are:

- referral of older adults with functional loss, transition towards frailty or fear of falls resulting from deconditioning to appropriate rehabilitations services
- raising awareness amongst health and social care staff of post-COVID-19 syndrome, communicating the risks of building up levels of activity levels too rapidly and the need to refer to post-COVID-19 syndrome clinics where symptoms are severe, in order that clinical judgement can be used about whether graded exercise therapy should be recommended.

3.6 Cochrane reviews

The Cochrane Collaboration has produced a series of systematic reviews pertinent to falls prevention with the following being the most recent.

3.6.1 Multifactorial and multiple component interventions for preventing falls in older people

This 2018 review assessed whether fall-prevention strategies which target two or more risk factors for falls (multifactorial interventions) or fixed combinations of interventions (multiple component interventions) are effective in preventing falls in older people living in the community[33]. The conclusion was that:

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[32] Deconditioning is the syndrome of physical, psychological and functional decline that occurs as a result of prolonged inactivity and associated loss of muscle strength

[33] Hopewell S., et al. Multifactorial and multiple component interventions for preventing falls in older people living in the community. Cochrane Database of Systematic Reviews 2018, Issue 7. Accessed 04 July 2022. Multifactorial and multiple component interventions for preventing falls in older people living in the community - Hopewell, S - 2018 | Cochrane Library

- Multifactorial interventions may reduce the rate of falls[34] by 23% (low-quality evidence). However, there may be little or no effect on other fall-related outcomes.
- Multiple interventions probably reduce the rate of falls by 26% and risk of falls[35] by 18% (moderate-quality evidence).

3.6.2 Exercise for preventing falls in older people living in the community

This 2018 review assessed the effects of exercise interventions for preventing falls in older people living in the community[36]. The conclusion was:

- Balance and functional exercises reduce the rate of falls by 24% and the number of people experiencing one or more falls by 13% (high-certainty evidence)
- Multiple types of exercise (most commonly balance and functional exercises plus resistance exercises) probably reduce the rate of falls by 34% and the number of people experiencing one or more falls by 22% (moderate-certainty evidence)
- Tai Chi may reduce the rate of falls by 19% (low-certainty evidence) as well as reducing the number of people who experience falls by 20% (high-certainty evidence).

3.6.3 Interventions for preventing falls in older people living in the community

This 2012 review assessed the effects of interventions designed to reduce the incidence of falls in older people living in the community[37]. Some of the interventions have been reviewed in more recent Cochrane reviews covered above but other interventions not covered by more recent reviews include:

- Home safety assessment and modification interventions reduced the rate of falls by 19% and risk of falling by 12%
- Pacemakers reduced the rate of falls in people with carotid sinus hypersensitivity by 27% but not the risk of falling
- First eye cataract surgery in women reduced rate of falls by 34%, but the second eye cataract surgery did not
- Gradual withdrawal of psychotropic medication reduced rate of falls by 66%, but not the risk of falling
- A prescribing modification programme for primary care physicians significantly reduced risk of falling by 39%
- An anti-slip shoe device reduced rate of falls in icy conditions by 58%
- Multifaceted podiatry, including foot and ankle exercises with standard podiatry in people with disabling foot pain, significantly reduced the rate of falls by 36%, but not the risk of falling.

3.6.4 Interventions for preventing falls in older people in care facilities and hospitals

This 2018 review assessed the effectiveness of interventions designed to reduce falls in older people in care facilities and hospitals[38].

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[34] Rate of falls refers to the number of falls and is measured as the number of falls per person in time

[35] Risk of falls is defined as the number of people with 1 or more falls

[36] Sherrington C., et al. Exercise for preventing falls in older people living in the community. 2019. Cochrane Database of Systematic Reviews. Exercise for preventing falls in older people living in the community - Sherrington, C - 2019 | Cochrane Library. Accessed 04 July 2022.

[37] Gillespie LD., et al. Interventions for preventing falls in older people living in the community. 2012. Cochrane Database of Systematic Reviews. Interventions for preventing falls in older people living in the community - Gillespie, LD - 2012 | Cochrane Library. Accessed 04 July 2022

[38] Cameron ID., et al. Interventions for preventing falls in older people in care facilities and hospitals. 2018. Cochrane Database of Systematic Reviews. Interventions for preventing falls in older people in care facilities and hospitals - Cameron, ID - 2018 | Cochrane Library Accessed 04 July 2022.

Key conclusions for hospital settings:

- Multifactorial interventions in hospitals may reduce rate of falls in hospitals although the reduction may be more likely in a subacute setting (there is a statistically significant reduction of 33% in a subacute setting)(low-quality evidence).

Key findings for care facilities:

- Prescription of vitamin D reduces the rate of falls in care home residents but it probably makes little or no difference to the risk of falling in care home residents (moderate quality evidence)[39]. The population in the studies were deficient in vitamin D.
- The effectiveness of other interventions such as exercise, multifactorial interventions, general medication review and psychological interventions on the rate of falls was uncertain in 2019. The quality of evidence was low or very low quality and therefore the authors proposed more research is required to address the inconclusive findings.
- Further research specifically around environment/assistive technology and knowledge/education is warranted as there was a lack of evidence around these topics.

3.6.5 Interventions for preventing falls in Parkinson's disease

This 2022 review has shown that exercise probably reduces the rate of falls by 26% and the number of people experiencing one or more falls by 10% in people with low to moderate Parkinson's disease[40].

3.7 World Health Organisation Strategy for preventing falls across the lifecourse

The World Health Organisation strategy recommends key interventions to prevent falls[41]. In addition to the strongly evidence-based recommendations covered previously, it promotes:

- Implementing community wide, low-cost home modification programmes which can include modifications such as grab rails, stair rails, non-slip surfaces, improved lighting and reduced slip and trip hazards
- To deter the use of ladders, chairs, etc. to access heights, as ladder related deaths are high among older people, make alternatives available such as home help services or tradespersons to older people
- Requiring landlords to make necessary modifications to homes
- Homes and other buildings to be built to safe standards, including universal access and design principles
- Wearable personal alarms, fall sensors, mobile phones with SOS emergency buttons for older people at high risk of falls who spend much of their time alone
- Encouraging older people to wear enclosed sturdy shoes around the house, rather than slip-on footwear
- Improved accessibility of neighbourhoods and public spaces to help older people remain safe and active. This includes the need for road crossings designed and timed to allow older people to cross safely, and for parks and recreation spaces to be inviting, safe and accessible to older people in order to encourage regular physical activity
- Make Tai Chi (also called Tai Chi Chuan and Tai Chi Quan) accessible to older people living independently in the community

[39] Interventions for preventing falls in older people in care facilities and hospitals - Cameron, ID - 2018 | Cochrane Library
[40] Allen, N.E. et al. Interventions for preventing falls in Parkinson's disease. 2022. Cochrane Database of Systematic Reviews Interventions for preventing falls in Parkinson's disease - Allen, NE - 2022 | Cochrane Library
[41] Step Safely: Strategies for preventing and managing falls across the life-course (who.int)

- Make specialized, local “falls-prevention” (evidence-based balance and functional exercise) groups and home programmes available as an accessible part of preventative health care.
- Provide education about falls and specific factors such as footwear, glasses, high-risk situations and behaviours: Knowledge and education alone does not prevent falls, but improving awareness of the resources, behaviours and support available, and of the preventable nature of falls, is important.

3.8 National audit of inpatient falls 2022

The Falls and Fragility Fracture Audit Programme (FFFAP) is a national clinical audit run by the Royal College of Physicians (RCP). It is committed to improving patient outcomes and the efficiency of care that patients with fragility fractures and inpatient falls receive in acute and primary care settings, and to facilitating quality improvement (QI) initiatives.

The Falls and Fragility Fracture Audit Programme (FFFAP) is a suite of three national clinical audits, commissioned by the Healthcare Quality Improvement Partnership (HQIP), funded by NHS England and the Welsh Government. It includes:

- the National Audit of Inpatient Falls (NAIF)
- the National Hip Fracture Database (NHFD)
- Fracture Liaison Service Database (FLS-DB).

The audits provide a quality improvement platform for trusts in England, aiming to help local clinical teams and health service managers understand why people fall in hospital, the care that should be provided for fragility fractures, and what can and should be done to prevent future fractures.

The findings of the 2022 National Audit of Inpatient Falls annual report continues to emphasise the importance of risk factor detection and management using a Multi-factorial Falls risk Assessment (MFRA) and corresponding interventions[42]. KPIs have been set to focus on individual components of MFRA to effectively assess MFRA quality and improvements over the next year.

3.9 Rapid review of Care homes

Since the Cochrane review assessing effective interventions for preventing falls in older people in care facilities and hospitals was published in 2018 (Section 3.5.4), several studies showing evidence of effect in care homes have been published.

In regard to physical activity, a recent systematic review has been completed (not by the Cochrane Collaboration) and in addition to this, several individual studies have emerged. The systematic review and meta-analysis of 14 randomised controlled trials (RCTs) showed that long-term balance exercise significantly reduced falls in nursing homes.[43] The Sunbeam program, a combined high-level balance and moderate intensity progressive resistance training programme, was shown to significantly reduce the rate of falls in long-term residential care and was judged to be cost-effective

[42] Royal College of Physicians. National Audit of Inpatient Falls annual report 2022. London: RCP, 2021. National Audit of Inpatient Falls annual report 2022 – HQIP

[43] Wang, F., & Tian, B., 2022. The effectiveness of physical exercise type and length to prevent falls in nursing homes: A systematic review and meta-analysis. Journal of Clinical Nursing (John Wiley & Sons, Inc.) 31(1), pp. 32-42

by the authors in the country of the study[44,45.] The Sunbeam program was also shown to significantly reduce the rate of falls (50%), risk of falls (31%), multiple falls (40%) and injurious falls (44%) in long term care residents with mild-moderate cognitive impairments/dementia[46]. In regard to the OTAGO exercise program, individual RCTs have shown the programme to be feasible and effective at improving balance and physical performance in older adults living in a nursing home[47] and at reducing the number of falls in older adults living in a nursing home[48].

Cholinesterase inhibitors may reduce the rate of falls by 50% but the effectiveness on the risk of falls is uncertain[49]. Cholinesterase inhibitors may increase the rate of non fall-related adverse events by 60%. Most adverse events were mild and transient in nature. No data was available regarding the cost-effectiveness of medication for fall prevention.

An RCT has shown that the Guide to Action for falls prevention in Care Homes (GtACH) programme reduces the rate of falls by 43% during months 4-6[50,51.]The programme systematically trains and supports care home staff in the assessment of residents' risk of falling and the generation of a falls reduction care plan. Embedding the programme into usual practice routines is important for long-term effectiveness.

It is expected that these individual RCTs will be included in future Cochrane systematic reviews on the topic of preventing falls in care homes and a robust assessment of the quality of the studies will be conducted, but in the interim, they provide promising indications of some potentially effective interventions to reduce falls in this setting.

3.10 Housing

The BRE paper Home and Ageing in England provides an overview of the housing conditions of older people and estimates the costs to the NHS in England of leaving people living in the poorest housing in England in 2012. 1.3 million households aged 55 years and over lived in 'poor housing'[52] in 2012 at an estimated cost of £624 million per annum to the NHS in first year treatment costs[53]. A significant proportion of the category 1 hazards were associated with falls (on stairs, on a level, between levels and baths; n=794,689) and excess cold (n=689,666). Cold homes have been linked to an increased risk of lower strength and dexterity leading to an increased risk of falls[54]. Category 1 hazards are

[44] Hewitt et al., 2018. Progressive Resistance and Balance Training for Falls Prevention in Long-Term Residential Aged Care: A Cluster Randomized Trial of the Sunbeam Program. Journal of the American Medical Directors Association 19(4), pp. 361-369

[45] Hewitt, J. et al. 2019.An economic evaluation of the SUNBEAM programme: a falls-prevention randomized controlled trial in residential aged care. Clinical Rehabilitation 33(3), pp. 524-534

[46] Mak, A. et al. 2022. Sunbeam Program Reduces Rate of Falls in Long-Term Care Residents With Mild to Moderate Cognitive Impairment or Dementia: Subgroup Analysis of a Cluster Randomized Controlled Trial. Journal of the American Medical Directors Association 23(5), pp. 743

[47] Zou, Z., et al. 2022. The effect of group-based Otago exercise program on fear of falling and physical function among older adults living in nursing homes: A pilot trial. Geriatric Nursing 43, pp. 288-292

[48] Jahanpeyma, P., et al. 2021. Effects of the Otago exercise program on falls, balance, and physical performance in older nursing home residents with high fall risk: a randomized controlled trial. European Geriatric Medicine 12(1), pp. 107-115

[49] Allen, N.E. et al. 2022. Interventions for preventing falls in Parkinson's disease. Cochrane Database of Systematic Reviews 2022, Issue 6. Art. No.: CD011574. DOI: 10.1002/14651858.CD011574.pub2.

[50] Logan, P. et al. 2021. Multifactorial falls prevention programme compared with usual care in UK care homes for older people: Multicentre cluster randomised controlled trial with economic evaluation. BMJ2021;375:e066991 http://dx.doi.org/10.1136/ bmj-2021-066991

[51] Logan, P et al. 2022. A multidomain decision support tool to prevent falls in older people: the FinCH cluster RCT. Health Technology Assessment. Vol. 26 Issue 9, pp. 1–136

[52] with at least one Category 1 hazard under the Housing Health and Safety Rating System (HHSRS) i.e., a home that did not meet the minimum standard for housing in England

[53] BRE. Homes and Ageing in England. 86749-BRE_briefing-paper-PHE-England-A4-v3.pdf

[54] Briefing7_Fuel_poverty_health_inequalities.pdf (publishing.service.gov.uk)

more common in houses that were built before 1919 and generally, the houses in rural areas are older. Mitigating the risks of falls and cold by instigating repairs to the poorest housing would result in savings to the NHS of nearly £100 million and £440 million per annum, respectively. Some of the repairs for falls are inexpensive and include providing additional lighting and the repair or installation of handrails to reduce risks on stairs and repairing paths and floors to reduce risk on the level. The BRE estimated that work to repair category 1 hazards on stairs and on the level would pay for itself in 6.5 years and 4.5 years respectively. In regard to the impact of cold homes on falls, PHE recognise that people who have attended hospital due to a fall are a group who are vulnerable to health problems associated with cold homes and suggest falls and fracture liaison services consider using an opportunistic 'Making Every Contact Count' (MECC) approach for referral to cold homes services[55].

4.0 Current Cambridgeshire and Peterborough services

There are a number of services that provide interventions for people who have fallen or at risk of falling. These have been mapped out in the Falls Prevention and Management Pathway (Appendix 11) and key services are detailed in Appendix 12.

The two main organisations that deliver multi-factorial falls risk assessments and strength and balance exercise programmes (OTAGO or FaME) for older people 65+ years are Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) and Everyone Health. They are part of an integrated community falls prevention pathway that work together to provide evidence-based interventions for different cohorts based on specific eligibility criteria. A specific community falls prevention pathway is in Appendix 13.

5.0 Assets/achievements

Much good work has taken place in Cambridgeshire and Peterborough over recent years to implement the evidence base and good practice in order to improve outcomes. The following indicates key pieces of work that has taken place in Cambridgeshire and Peterborough (not an exhaustive list) and these serve as a basis for further work.

5.1 Community

- ***New community falls prevention pathway*** - Roll out of the pathway across Cambridgeshire and Peterborough to standardise the provision of quality multi-factorial falls risk assessments (MFRAs), improve equity of access and increase the scale of delivery by CPFT and Everyone Health (includes the St Ives Falls Pilot in 2016-2017 funded by the CCG and STP Falls Prevention Programme in 2017-2019 joint-funded by the STP, Cambridgeshire County Council and Better Care Fund)
- ***Enhanced Falls Prevention Pathway*** – Delivery of enhanced MFRAs containing occupational therapy-led home hazard assessments and subsequent modifications in Cambridge City and Fenland from 1 April 2022 by CPFT as part of a new 3-year falls prevention programme (Funded by CCC)

[55] Data sources to support local services tackling health risks of cold homes (publishing.service.gov.uk)

- ***Falls Prevention Lead/Co-ordinator*** – Post to strengthen the co-ordination of falls prevention across the health and care system (Funded by STP Falls Prevention Programme, 2017-2021)
- ***'Stronger for Longer' social marketing campaign*** (STP Falls Prevention Programme, 2017-2021 and CCC Falls Prevention Programme, 2022-2025):
    - Development and launch of a campaign in 2018 alongside a suite of assets e.g., Super Six leaflets and primary prevention booklets based on the Chartered Society of Physiotherapy 'Get up and go' leaflet.
    - Delivery of regular communications and campaigns under this branding including news articles and distribution of materials through multiple mechanisms and routes including Stay Well the Winter Packs, PCN Flu clinics and COVID vaccination centres.
- ***Continued development of the falls exercise pathway*** for both primary and secondary prevention to ensure a progressive, long-term, quality assured and evidence-based exercise pathway as part of the 3-year Falls Prevention Programme (CCC Falls Prevention Programme, 2022-2025) including:
    - ***Falls Management Exercise (FaME) programme*** – Roll out of the programme by the Healthy You Falls Prevention Health Trainer service with an increase in staff capacity from April 2021
    - ***Community Strength and Balance Activities*** – Commissioning of leisure providers to ensure a continuum of falls prevention exercise interventions are in place across Cambridgeshire and Peterborough from February 2022.
- ***Enhanced Response Service (ERS)*** – Commissioning and deployment of the ERS in Cambridgeshire in 2017 by Cambridgeshire County Council and extension to cover Peterborough in 2022 to provide an equitable and appropriate 24/7 response to telecare alerts for people who require non-emergency assistance, including non-injured fallers who require help (See appendix 12).
- ***Lifelines -*** Cambridgeshire County Council became a provider of lifeline Services in Cambridgeshire in October 2020 and Peterborough in March 2022 to support people through the provision of digital lifelines and peripheral services. This supports a host of other lifeline providers including South Cambridgeshire District Council, Sanctuary, Chorus, Circle, Kings Lynn Careline, Anchor/Hanover, Housing and Care 21 and Age UK.
- ***Cambridgeshire County Council and Peterborough City Council Falls Prevention pathway*** – Development and implementation of policy and guidance in 2021 to support frontline staff to screen and make onward referrals for falls interventions
- ***Peterborough City Council Handyperson service*** – Continued delivery of the service to maintain, repair and assist people to continue to live independently at home following confirmed continuation of funding into 2022/23
- ***Age UK Cambridgeshire and Peterborough*** – continued provision of services, which whilst taking a holistic approach to support needs, do have a specific element of giving falls prevention input. These include: the Cambridgeshire Handyperson Service; Community Wardens; Home Support and Day Services; Hospital discharges; and admission avoidance (Appendix 11)
- ***Cambridgeshire Fire and Rescue Service*** - Continued delivery of Safe and Well visits (Home Safety Check) since 2016, including assessment of falls risk factors, to support the safety and

wellbeing of the most vulnerable residents aged 65+ in the community, by Cambridgeshire Fire and Rescue Service.

- ***REACT Falls Cars -*** Commissioning of two 'falls' urgent response vehicles staffed by a Paramedic or Nurse and a Therapy Assistant in Cambridgeshire for Autumn/Winter 2022/23, to provide enhanced clinical assessment and assistance for people who have fallen within their own home, who may have sustained an injury, but who do not need to attend hospital.
- ***Care Together Programme*** - Roll out of the place-based approach to co-production at Integrated Neighbourhood level of services that support older adults to live happily and healthily at home, including seed-funding for expansion of strength and balance exercise classes for over 65s and support for Fitness Rush mobile gymnasium to visit rural villages in Fenland and Huntingdonshire. Care Together has transformed the way Early Intervention and Prevention services are commissioned, incorporating physical activity and healthy lifestyles into specifications alongside opportunities for social inclusion of older adults.

5.2 Primary care

- ***Falls Prevention Pathway*** – Development and incorporation of primary care specific pathway on SystmOne with training delivered to GPs by CPFT to support appropriate referrals

5.3 Hospitals

- Cambridge University Hospital Foundation Trust (CUHFT):
    - ***Fracture Liaison Service (FLS)*** - Launch of a comprehensive, multi-disciplinary FLS in 2017 to reduce the risk of subsequent fractures by systematically identifying, assessing, treating and referring to appropriate services all eligible patients aged 50+ who have suffered a fragility fracture (Funded by Cambridgeshire and Peterborough CCG).

- North West Anglia Foundation Trust (NWAFT)
    - Development of enhanced care policy in support of the falls policy to enable enhanced care risk assessment and increased frequency of observations for patients at risk of falls.

5.4 Care Homes

- ***Dedicated Falls Prevention Therapy Assistant*** – New CPFT post in 2022 to support care homes to identify and manage falls risks. Currently focussing on the development and testing of training tools.

5.5 Pharmacy

The following national pharmacy services are outlined within the Community Pharmacy Contractual Framework and provide an opportunity to consider falls risk locally:

- ***The New Medicine Service (NMS)* -** provides support for people with long-term conditions prescribed a new medicine to help improve medicines adherence; it is focused on specific patient groups and conditions[56]
- ***The Discharge Medicines Service (DMS)* -** supports patients with their medication when they are discharged from secondary care back to primary care. The service seeks to ensure better communication of changes made to a patient's medicines in hospital[57].

6.0 Gap analysis

A gap analysis was undertaken to assess local falls prevention service provision and quality compared with NICE clinical guidance 161: Falls in older people, to understand areas for improvement. Service leads across CPFT, CUHFT, NWAFT, Healthy You and others contributed to a review of provision in their organisation (Appendix 14).

Key findings of the analysis:

1. **Falls Prevention services (and services providing comprehensive geriatric assessment (CGA) or interventions) are disjointed,** with medical and therapy teams in primary care, secondary care and community services working in isolation, with a lack of awareness of other services and poor inter-service communication resulting in duplication and inefficiencies (and/or sharing of assessments or assessment outcomes between services).

2. **There is an inadequate system-wide risk assessment and stratification in place** to ensure people who experience a fall are seen by the professional with the right skills to assess and facilitate necessary multi-factorial intervention and in a place-based manner. This is particularly noticeable around the absence of multidisciplinary assessment of unexplained fallers.

3. **Unwarranted variation in the delivery and receipt/uptake of recommended multi-factorial interventions** to reduce the risk of fall after assessment, including:

    - Medication review and modification of fall-risk increasing drugs (FRIDs) in primary and secondary care
    - Bone health assessment and proactive review of people with fragility fractures or 2+ falls in a year
    - Strength and balance training and step-down exercise pathway for a cohort of frailer, housebound older adults.

4. **Older adults who have had a serious fall and present to hospital are falling through the net, as demonstrated by:**

    - Inequity in all this cohort being offered multi-factorial falls risk assessment to help reduce their risk of a future fall
    - Inequity in all this cohort being offered multidisciplinary assessment at the front door, as an inpatient or in the community

[56] https://psnc.org.uk/national-pharmacy-services/advanced-services/nms/
[57] https://psnc.org.uk/national-pharmacy-services/essential-services/discharge-medicines-service/

- Home hazard assessment and safety intervention/modifications by trained healthcare professionals not being routinely considered and offered as part of discharge planning.

5. **Prevention and early intervention opportunities are being missed** as opportunistic case finding and risk identification is not routinely implemented (based on NICE guidelines):
    - Health and care professionals do not routinely ask all older adults if they have had a fall in the last year (Acute sector, All CPFT Older People's services, Primary care)
    - There is no local definition of people 'at risk of falling' and people with long-term health conditions under 65 may be being missed
    - Older adults in all settings are not routinely being observed for strength and balance deficit and considered/referred by non-therapy staff for strength and balance training.
6. **Limited therapy capacity in acute sector and community** to support multi-factorial falls risk assessments and interventions such as strength and balance training and home hazard assessments. Includes therapy capacity at the front door, inpatient and community trust and is demonstrated by inequity of offer of MFFRA and long waiting times in the community.
7. **Prevention of deconditioning is not being addressed** at scale in hospital and care home settings.

7.0 Engagement with patients

CPFT patient views on experience of the local falls prevention pathway

CPFT Enhanced Falls Prevention pathway practitioners conducted a face-to-face survey between August and September 2023 with patients who had received a multi-factorial falls risk assessment in Cambridge City and Fenland (n=14). 93% of respondents received a falls assessment within 4 weeks of referral and the majority thought this length of wait was 'just right' (64%) and a fifth reported it was too long (21%). The most common interventions recommended in the assessment were a referral to the GP to review medications (93%), assessment of home hazards and provision of equipment (92%), developing a falls plan (86%) and a referral to the GP to review possible medical causes of fall (85%). Patients reported a positive experience of the pathway and the support given. Key themes emerging were that a third of patients recommended a medication review had not received one by 6+ weeks after the assessment (30%), half of patients recommended a medical review with their doctor had not received one by 6+ weeks after assessment (50%), and one patient mentioned they had encountered issues reaching their specialist healthcare team between appointments.

8.0 What does success look like?

The Falls Prevention Strategy Group will be responsible for monitoring the success of the strategy. Success will be monitored by reducing the direct age-standardised rate of admissions due to hip fractures in people 65+ in Cambridgeshire and Peterborough from 590.9 per 100,000 in 2022/23 to 588.1 per 100,000 in 2023/24 (SUS data). This equates to 5 hip fractures over the next year. The aim is to reduce the number of hip fractures by 5 every year over the next three years – a total of 15 hip fractures. It is not possible to calculate a reduction in age-standardised rate over the full three years.

9.0 Monitoring plan

The overarching outcomes are as listed above. All of the actions in the action plan will contribute to these population outcomes. The action plan of the Peterborough Falls Prevention Working Group will contribute to the overarching Cambridgeshire and Peterborough Falls Prevention action plan. To enable timely monitoring of admissions data, the strategy group will monitor SUS admissions quarterly.

Each of the actions in the action plan will establish outputs and these will be monitored by action leads with overall programmes monitored by the falls strategy group.

The overarching governance is as follows:

- ***Joint Clinical and Professional Executive Group –*** The Falls Prevention Strategy Group will report into the group upon request.
- ***Health and Wellbeing Board -*** The Falls Prevention Strategy group will provide updates as requested to the Health and Wellbeing Board which has overall responsibility for monitoring the health of the population.
- ***South Care Partnership -*** The Falls Prevention Strategy Group will provide updates to the Proactive and Personalised Care Programme Board, which reports to the Cambridgeshire South Care Partnership Joint Strategic Board.
- ***North Care Partnership -*** The reporting structure in the North is to be defined.
  Peterborough Falls Prevention Working Group – This working group will report into the Cambridgeshire and Peterborough Falls Prevention Strategy Group.

10.0 Action

10.1 Priority 1: Prevention and early identification of people at risk of falls

Aim: to intervene at the earliest opportunity to prevent and reduce the number of people who have a first fall

Objectives:

A. Raise awareness and understanding of falls risk factors and the benefits of an active, healthy lifestyle across the life course,
B. Enable and empower older adults to make informed choices about interventions to reduce their falls risk and to take responsibility for looking after their health,
C. Use technology to promote physical activity amongst adults in mid to later life,
D. Ensure adults 50+ years are able to access a range of accessible physical activity in the community, including strength and balance activities as a general community provision and as a referral route from the FaME programme delivered by the Healthy You,
E. Increase professional and volunteer knowledge and skills around physical activity,
F. Support the development of Age Friendly Communities in Cambridgeshire and Peterborough.

Action Ref	Objective	Action	Lead
1.1	A & B	Implement, promote and evaluate an online multi-factorial falls self-assessment tool across Cambridgeshire and Peterborough to enable adults to independently screen their own risk factors and take action to reduce their risk.	Senior Partnership Manager, Public Health, Cambridgeshire County Council (CCC)
1.2	A & B	Provide older adults across Cambridgeshire and Peterborough with accurate written information on falls risk factors, healthy ageing and signposting to further resources/information.	Senior Partnership Manager, Public Health, Cambridgeshire County Council (CCC)
1.3	A, B & C	Inform and educate members of the public across Cambridgeshire and Peterborough about the early signs of increasing falls risk and services/interventions to support healthy ageing, to include the use of validated apps.	Senior Partnership Manager, Public Health, Cambridgeshire County Council (CCC)

Action Ref	Objective	Action	Lead
1.4	D	Support and strengthen community strength and balance activities across Cambridgeshire and Peterborough in line with the local falls prevention exercise framework (to include the role of grass root and voluntary sector organisations).	Senior Partnership Manager, Public Health, Cambridgeshire County Council (CCC)
1.5	D	Strengthen the offer and/or public awareness of primary prevention physical activity opportunities in the community across Cambridgeshire and Peterborough to increase uptake in older adults and prevent falls and frailty.	
1.6	A & E	Support education, awareness and training for all professionals and volunteers involved in promotion of physical activity for older people across Cambridgeshire and Peterborough.	
1.7	F	Support the development of the Healthy Places Joint Strategic Needs Assessment and the inclusion of Age Friendly communities.	Public Health Registrar, CCC

10.2 Priority 2: Evidence-based and good practice falls prevention interventions and services

Aim: to ensure that people who have fallen have timely access to services, interventions and opportunities that will support a reduction in falls risk and injurious falls

Objectives:

A. Improve the join-up of services in primary care, secondary care and community services involved in falls risk assessments and/or falls prevention interventions to improve the assessment and outcomes of older adults who experience a fall,
B. Strengthen the community falls prevention pathway to improve the onward referral pathway for medication review to ensure older people living at home receive consistent, robust and high-quality medication reviews and action is taken to change medication to reduce falls and osteoporotic risk,
C. Increase capacity of CPFT to deliver the multi-factorial falls risk assessment (MFRA) for older people at high risk of falls to improve identification and management of falls risks,
D. Increase staff awareness of falls prevention and early intervention services to improve access to timely, holistic support to reduce risk,
E. Identify new technology to improve the detection and management of falls,
F. Improve identification and referral for an MFRA of people who have fallen and present to primary care,
G. Reduce sedentary behaviour and increase mobilisation and physical activity in clients receiving support from Adult Social Care and improve participation in home-based or community strength and balance classes post-support,
H. Raise awareness amongst frail older people, their families and frontline staff of deconditioning and provide access and encouragement to participate in strength and balance activity to enable a safe, confident and gradual increase in physical activity.

Action Ref	Objective	Action	Lead
2.1	2A, C, D & F 3A, B & C	Develop and implement a robust, whole system, integrated falls response, support and prevention pathway across Cambridgeshire and Peterborough to ensure equity of access to multifactorial interventions.	

2.2	B	Continue to implement, monitor and evaluate the 'Enhanced Falls Prevention Pathway' pilot in Cambridge City and Fenland, including the development of strong referral pathways and links with key stakeholders such as hospitals, reablement and primary care.	
2.3	E	Technology Enabled Care (TEC) Teams to focus on identifying and testing more robust falls prevention solutions, considering proactive smart solutions that can predict changes in needs to prevent deterioration reducing the need for reactive services. Promote shared knowledge between the authorities through the TEC Steering Group.	TEC Strategy Board Chair, CCC
2.4	G	Explore the incorporation of appropriate exercises into the support plan of clients attending Cambridgeshire County Council Reablement Service.	Head of Service Operations Prevention & Early Intervention, CCC
2.5	G	Develop a list of options to pilot to support maintenance of strength and balance in people who are housebound.	Public Health, CCC
2.6	D	Support falls prevention education, awareness and training for all professionals and volunteers involved in engaging older people across Cambridgeshire and Peterborough.	
2.7	G	Work with the Peterborough City Council Older People's Day Services manager to investigate the opportunity for the staff to be trained in strength and balance, so that clients can be offered structured movement as part of their day centre experience and falls prevention.	
2.8	G	Work with Peterborough City Council colleagues in Housing Needs regarding the two new posts being developed to work in the hospital with a housing/homeless prevention	

		focus. To ensure that falls prevention is part of their conversation and that clients who had fallen prior to admission are identified.	
2.9	G	Work with colleagues in Adult Social Care to work towards the inclusion of exercise/structured movement within care and support plans. To explore whether the Adult Social Care trainer can incorporate this into the strength-based conversation training and refreshers.	Consultant in Public Health, CCC
2.10	A & B	Strengthen the links with the Integrated Neighbourhoods to enable scoping of opportunities to strengthen falls prevention in a personalised and place-based manner.	Senior Partnership Manager (Public Health) and Integrated Neighbourhood Managers

10.3 Priority 3: Action to address risk in hospital

Aim: to minimise the risk of inpatient falls, repeat falls and re-admissions, and improve quality of life

Objectives:

A. Improve completion and communication of inpatient MFRA and falls-related care plan actions to ensure the patient receives the right care both in and out of hospital,
B. Ensure onward referral of patients for appropriate interventions and services following an MFRA,
C. Improve the two-way communication of medical and multi-factorial falls risk assessment information between acute and community services,
D. Ensure people attending hospital ED as a result of a fall are offered information, advice and referral to community services as relevant to support them to reduce their falls risk when back at home,
E. Prevent inpatients from deconditioning and support the reconditioning of patients who have deconditioned.

Action Ref	Objective	Action	Lead
3.1	A & C	Cambridge University Hospital NHS Foundation Trust (CUH) to complete ongoing project to roll out a multi-disciplinary, multi-factorial falls risk assessment across wards at CUH and communicate the findings and care plan in the discharge summary.	
3.2	A & B	Cambridge University Hospital NHS Foundation Trust (CUH) to complete ongoing project at CUH to develop, roll out and monitor the role of ward falls advocate to improve falls prevention and management at ward level.	
3.3	A & B	Cambridge University Hospital NHS Foundation Trust (CUH) to use learning from thematic analysis and investigations into inpatient falls at CUH to develop Quality Improvement Projects (QIPs).	
3.4	D	Cambridge University Hospital NHS Foundation Trust (CUH) to develop and implement a robust falls pathway when a patient is medically fit to go home from ED.	

3.5	A & C	North West Anglia Foundation Trust (NWAFT) to start project to switch multifactorial falls risk assessment to an electronic format then rollout to all staff.	
3.6	A & C	North West Anglia Foundation Trust (NWAFT) to further develop the falls link role within the falls advisors.	
3.7	E	North West Anglia Foundation Trust (NWAFT) to work with the therapy team to implement keep moving project and make changes to our training to help support staff have the confidence to mobilise patients.	
3.8	D	North West Anglia Foundation Trust (NWAFT) to develop the volunteer role in ED.	

10.4 Priority 4: Action to address risk in care homes

Aim: to prevent, reduce and manage falls in nursing and residential home residents in order to reduce the risk and consequences of falls, fragility fracture and a long lie, improve quality of life and reduce system wide pressures

Objectives:

A. To ensure nursing and residential home residents receive high quality multi-factorial falls risk assessment (MFRA) and interventions on admission and after a fall and/or a change in their condition,
B. To ensure a robust onward referral process is in place and implemented to review, reduce and/or stop medications that increase the risk of falls and to ensure that bone strengthening medications, calcium and vitamin D supplementation are prescribed where appropriate,
C. To ensure that residents are offered and encouraged to participate in opportunities and activities to improve activity levels and strength and balance with support from their staff, family, and relevant services,
D. To ensure staff have knowledge and skills to provide assessment and lifting support following a fall in a timely, caring and dignified way to reduce the amount of time that residents spend on the floor after a fall.

Action Ref	Objective	Action	Lead
4.1	A & B	Develop a toolkit and provide training to support nursing and residential home staff to systematically embed a systemic approach to reducing falls risk within care homes.	
4.2	B	Review the onward referral process following a fall in a care home.	
4.3	C	Explore opportunities to provide access and support for nursing and residential home residents to participate in strength and balance activities to build muscle strength.	
4.4	C	Embed physical activity within care plans for older adults in residential care.	Consultant in Public Health, CCC

4.5	D	Continue to deliver and evaluate the impact of the falls lifting equipment pilot, offering a choice of 2 lifting chairs supported by a post fall assessment App, and offer support to care homes as relevant.	

10.5 Priority 5: Detection and management of fragility fracture

Aim: to maximise primary and secondary prevention of osteoporosis-related fragility fractures and ensure optimal support is provided after a fragility fracture has occurred

Objectives:

A. To understand what action to take locally to improve the detection and management of osteoporosis and improve outcomes of people with risk factors for osteoporosis and those who have experienced a fragility fracture,
B. To obtain investment to implement a robust Fracture Liaison Service at NWAFT,
C. To ensure that people accessing the CUH or NWAFT Fracture Liaison Services are referred to and receive strength and balance training to reduce risk the risk of a fall and a subsequent fragility fracture.

Action Ref	Objective	Action	Lead
5.1	A	Review current pathways and service provision against evidence base and local insight, to understand and develop a strategy to address any gaps and maximise opportunities for integration and joined-up working.	Public Health Registrar, CCC
5.2	B	Develop a FLS business case for NWAFT.	TBC
5.3	C	Develop and implement a formal onward referral pathway from the CUHFT and NWAFT Fracture Liaison Services to Healthy You FaME programme for strength and balance training.	

10.6 Priority 6: Inclusive services

Aim: to ensure early falls prevention related services are inclusive and accessible to all service users in line with the Equality Act and Public Sector Equality Duty to enable all older adults to receive falls prevention interventions that meets their needs

Objectives:

A. To provide support and guidance around different types of data to support inclusive service design,
B. To embed co-production into the design and delivery of falls prevention services to ensure the voice of older adults is heard and acted upon,
C. To ensure disabled older adults enjoy the benefits of an active lifestyle without the barriers placed by society.

Action Ref.	Objective	Action	Lead
6.1	A	Provide guidance to support and enable services to review the needs of all their clients and to consider improvements if needed.	All
6.2	B	Involve older adults in the co-production of services, campaigns and projects to obtain meaningful qualitative feedback to inform delivery.	All
6.3	C	Strengthen the links between the Falls Prevention Strategy Group and the Disability Strategic Group to support the implementation outcomes of the county-wide disability strategy.	

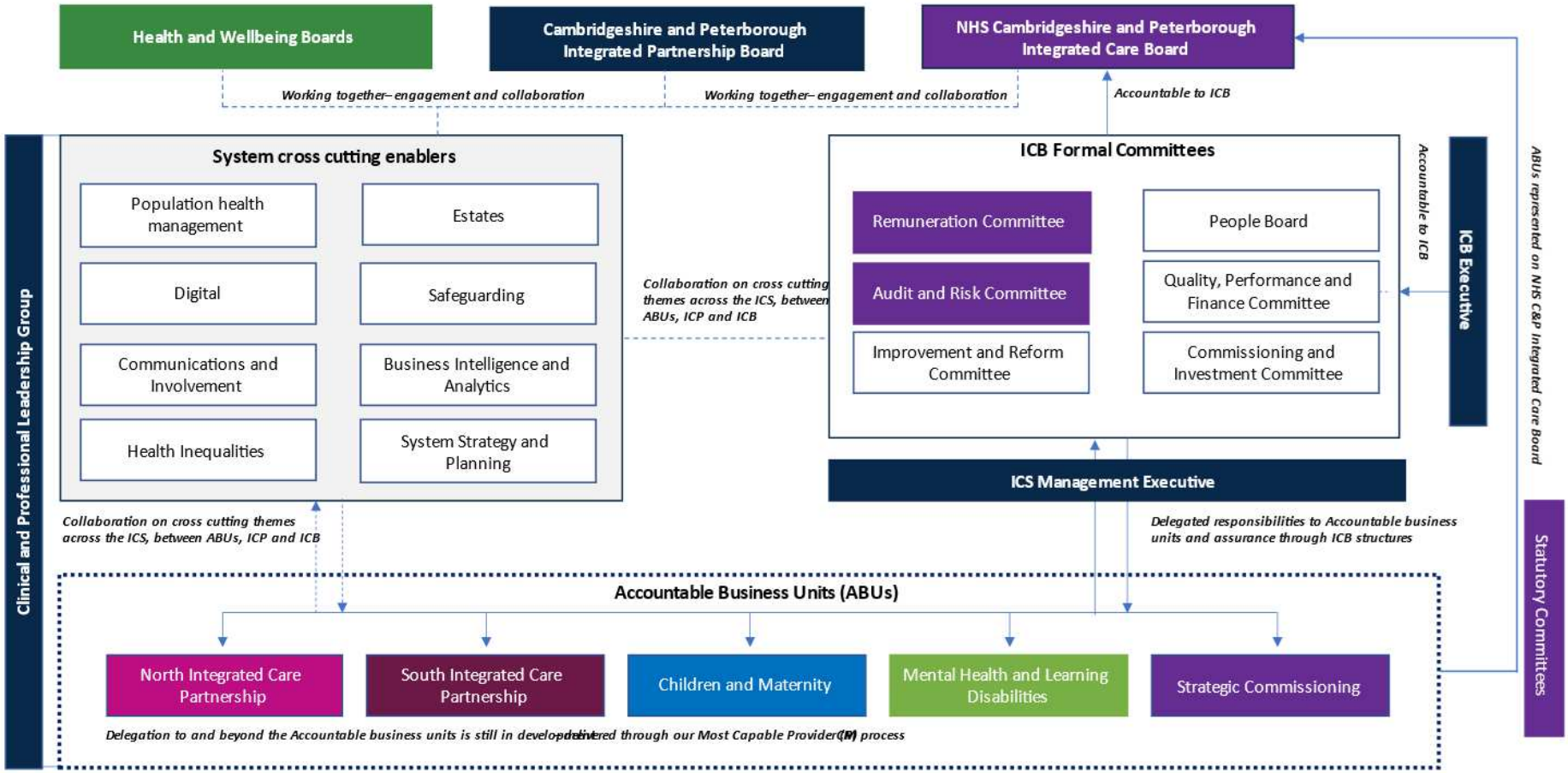
11.0 Appendices

Appendix 1 – Cambridgeshire and Peterborough Falls Prevention Strategy Group membership

Dr Abby Richardson	Acting Deputy Medical Director and Clinical Lead for Primary Care & Clinical Policies and Clinical Lead for Integrated Neighbourhoods. North Place, Cambridge University Hospital Foundation Trust (CUHFT)
Amber O'berg	Integrated Neighbourhood Project Manager North Place - Cambridgeshire & Peterborough Integrated Care System (ICS)
Annami Palmer	Falls Prevention Clinical Lead - CPFT and on behalf of Neighbourhood Teams
Ashling Bannon	Integrated Neighbourhood Programme Manager - East Cambridgeshire, South Integrated Care Partnership - Cambridgeshire & Peterborough integrated Care System (ICS)
Belinda Child – **Vice Chair**	Head of Housing, Prevention and Early Intervention - Peterborough City Council
Erin Lilley	Director, ICP Development & Transformation – South - Integrated Care Partnership - CUHFT
Dale Parnell	Health and Wellbeing Manager - Vivacity
Diana MacKay	Commissioning Manager - Early Intervention and Prevention – Cambridgeshire County Council
Emma Goddard	Business and Partnerships Lead –East of England Ambulance Service NHS Trust
Graeme Hodgson	Senior Commissioning Manager – Adult Social Care - Cambridgeshire County Council
Hayley Korsman	Senior Improvement & Transformation Manager - CUHFT
Helen Garfoot	Acting Clinical Quality Lead - Cambridgeshire and Peterborough Integrated Care System (ICS)
Helen Tunster - **Chair**	Senior Partnership Manager (Healthy Ageing), Public Health - Cambridgeshire County Council
Dr Jane Wilson	Geriatrician and Clinical Falls Lead - Cambridge University Hospital Foundation Trust (CUHFT)
James Ball	Community Risk & Resilience Manager (South) - Cambridge Fire and Rescue Service
Joanna Clarke	Falls and Fracture Specialist Nurse - Peterborough City Hospital
Jo Peadon	Active Lifestyles and Health Manager - Huntingdonshire District Council)
Dr Lelane Vanderpoel	Geriatrician and Clinical Frailty Lead - Cambridge University Hospital Foundation Trust (CUHFT)
Lewis Holland	Falls Prevention Service Co-ordinator, Healthy You
Lesley McFarlane	Development Officer, Health Specialist - South Cambridgeshire District Council

Lucy Davies	Head of Commissioning, Early Intervention and Prevention – Cambridgeshire County Council
Dr Madhavi Vindlacheruvu	Orthogeriatrician - Cambridge University Hospital Foundation Trust (CUHFT)
Melanie Pittock	Chief Executive Officer - Age UK
Nicole Uyan	Service Lead, Early Intervention Team - Cambridge University Hospital Foundation Trust (CUHFT)
Rebecca Marr	Occupational Therapist Team Lead – Cambridgeshire County Council
Rita Bali	Executive Officer - Cambridgeshire and Peterborough Local Pharmaceutical Committee
Sara Rodriguez-Jimenez	Associate Director of Performance and Operations - Cambridgeshire and Peterborough Integrated Care System
Simon Hanna	Senior Clinical Exercise Specialist - CPFT
Teresa Stratton	Falls and Fracture Specialist Nurse - Peterborough City Hospital
Vicki Dye	Project and Service Improvement Manager – Cambridgeshire and Peterborough Integrated Care System (ICS)
Dr Viveca Kirthisinga	Community Geriatrician - CPFT

Appendix 2 - Cambridgeshire & Peterborough Integrated Care System function and decision map



Appendix 3 – Trends in emergency admissions due to falls in Cambridgeshire and Peterborough between 2010/11 and 2021/22

Table 1: Admissions due to falls in Cambridgeshire up to 2020/21

Period		Cambridgeshire Count	Value	95% Lower CI	95% Upper CI	East of England	England
2010/11	🟢	1,973	1,965	1,879	2,054	1,886	2,126
2011/12	🟢	2,080	2,002	1,916	2,090	1,917	2,128
2012/13	🟠	2,291	2,119	2,033	2,208	1,973	2,097
2013/14	🔴	2,577	2,316	2,227	2,408	2,025	2,154
2014/15	🟠	2,448	2,130	2,046	2,217	2,026	2,199
2015/16	🟠	2,613	2,232	2,147	2,320	1,989	2,169
2016/17	🟠	2,600	2,170	2,088	2,256	1,974	2,114
2017/18	🟠	2,659	2,164	2,082	2,248	2,026	2,170
2018/19	🟠	2,785	2,225	2,143	2,310	2,065	2,199*
2019/20	🟠	2,895	2,242	2,161	2,326	2,094	2,222
2020/21	🟢	2,560	1,945	1,870	2,022	1,946	2,023

Source: Public Health Outcomes Framework[58].

Table 2: Admissions due to falls in Cambridgeshire in 2021/22

Recent trend: Could not be calculated

Period		Cambridgeshire Count	Value	95% Lower CI	95% Upper CI	East of England	England
2021/22	🟠	2,640	2,027	1,950	2,106	1,959	2,100

Table 3: Admissions due to falls in Peterborough

Period		Peterborough Count	Value	95% Lower CI	95% Upper CI	East of England	England
2010/11	🔴	678	2,746	2,540	2,964	1,886	2,126
2011/12	🔴	680	2,634	2,438	2,842	1,917	2,128
2012/13	🔴	648	2,480	2,291	2,681	1,973	2,097
2013/14	🟠	619	2,287	2,109	2,476	2,025	2,154
2014/15	🔴	665	2,440	2,256	2,634	2,026	2,199
2015/16	🔴	663	2,348	2,171	2,535	1,989	2,169
2016/17	🟠	628	2,176	2,008	2,355	1,974	2,114
2017/18	🟠	602	2,041	1,880	2,212	2,026	2,170
2018/19	🟠	685	2,275	2,107	2,453	2,065	2,199*
2019/20	🟠	635	2,057	1,899	2,224	2,094	2,222
2020/21	🔴	700	2,243	2,080	2,416	1,946	2,023

Table 4: Admissions due to falls in Peterborough

Recent trend: Could not be calculated

Period		Peterborough Count	Value	95% Lower CI	95% Upper CI	East of England	England
2021/22	🟢	585	1,865	1,716	2,023	1,959	2,100

Red dots are statistically significantly higher (worse) than the England average; Green dots are statistically significantly lower (better) than the England average; Orange dots are similar to the England average.

[58] Office for Health Improvement & Disparities. Public Health Profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022

Appendix 4 – Trends in emergency admissions due to hip fractures in Cambridgeshire and Peterborough between 2010/11 and 2021/22

Table 1: Admissions due to hip fractures in Cambridgeshire

Period		Cambridgeshire Count	Value	95% Lower CI	95% Upper CI	East of England	England
2010/11	●	639	636	588	688	607	615
2011/12	●	600	572	527	620	597	612
2012/13	●	683	630	583	679	601	599
2013/14	●	698	628	582	677	616	614
2014/15	●	635	554	512	599	582	599
2015/16	●	681	583	540	629	583	589
2016/17	●	684	572	530	617	579	575
2017/18	●	654	533	493	575	577	578
2018/19	●	680	545	505	588	563	559*
2019/20	●	725	562	522	605	556	572
2020/21	●	700	528	490	569	508	529

Table 2: Admissions due to hip fractures in Peterborough

Period		Peterborough Count	Value	95% Lower CI	95% Upper CI	East of England	England
2010/11	●	157	620	526	727	607	615
2011/12	●	180	686	588	794	597	612
2012/13	●	177	674	577	781	601	599
2013/14	●	196	722	624	832	616	614
2014/15	●	192	705	608	813	582	599
2015/16	●	164	573	488	669	583	589
2016/17	●	181	627	539	726	579	575
2017/18	●	185	625	538	723	577	578
2018/19	●	195	656	567	755	563	559*
2019/20	●	185	593	510	686	556	572
2020/21	●	175	557	477	647	508	529

Source: Public Health Outcomes Framework[59].

Table 2: Admissions due to hip fractures in Cambridgeshire in 2021/22

Recent trend: Could not be calculated

Period		Cambridgeshire Count	Value	95% Lower CI	95% Upper CI	East of England	England
2021/22	●	740	567	527	610	523	551

Table 4: Admissions due to hip fractures in Peterborough 2021/22

Recent trend: Could not be calculated

Period		Peterborough Count	Value	95% Lower CI	95% Upper CI	East of England	England
2021/22	●	185	594	512	686	523	551

Red dots are statistically significantly higher (worse) than the England average; Green dots are statistically significantly lower (better) than the England average; Orange dots are similar.

[59] Office for Health Improvement & Disparities. Public Health Profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022

Appendix 5: Admissions to hospital due to injurious falls and hip fracture in 65+ in 2021/22, by district

	Number of admissions due to injurious falls in 65+	Rate of admissions due to injurious falls in 65+ (per 100,000)	Number of admissions due to hip fractures in 65+	Rate of admissions due to hip fractures in 65+ (per 100,000)
Huntingdonshire	770	2,145	215	603
Fenland	495	2073	140	584
East Cambridgeshire	390	2088	105	556
Cambridge City	400	2,214	110	601
South Cambridgeshire	585	1729	170	501
Cambridgeshire	2,640	2027	740	567
England	223,101	2100	58,685	551
East of England	25,405	1959	6,805	523

Key: The Districts statistically significantly lower than the England average are shaded green and those statistically significantly similar to the England average and amber.

Source: Public Health Outcomes Framework - Productive Healthy Ageing Profile - Data - OHID (phe.org.uk)

Appendix 6 – Graphs showing admissions for injury due to falls and hip fracture in England in 2021/22 by deprivation decile

Table 1: Emergency hospital admissions due to falls in people aged 65 and over – rate per 100,000

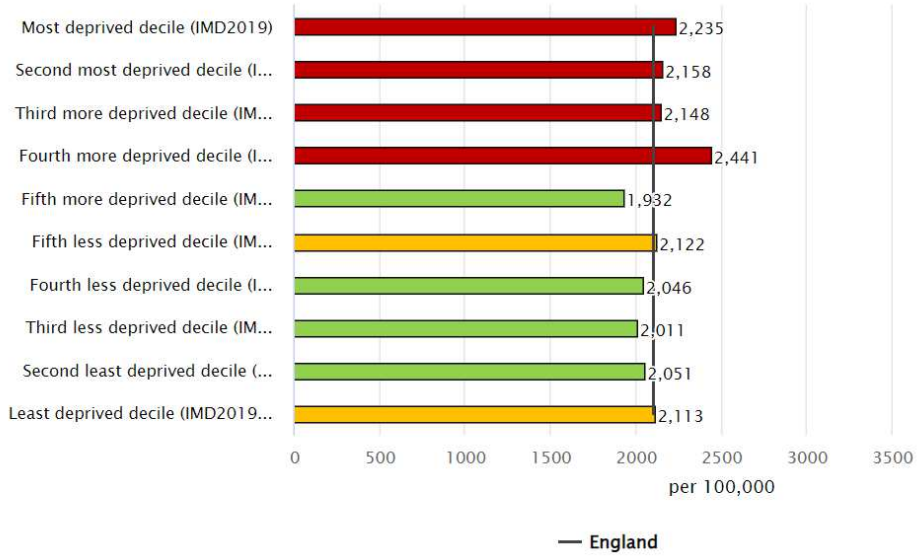
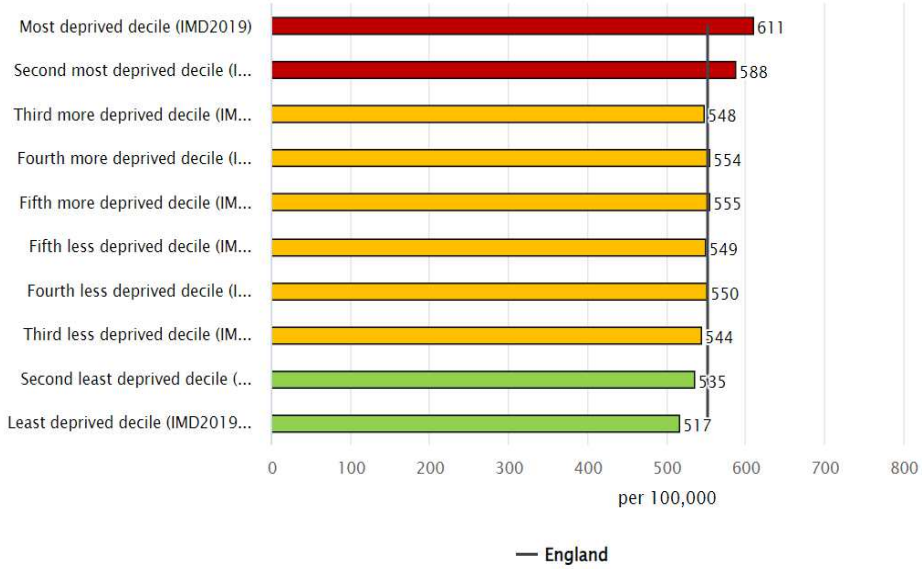


Table 2: Hospital admissions due to hip fractures in people aged 65 and over - rate per 100,000



Key: The deciles of deprivation statistically significantly lower (better) than the England average are shaded green. The deciles of deprivation statistically significantly similar to the England average are shaded amber and the deciles of deprivation significantly higher (worse) than the England average are shaded red.

Source: Public Health Outcomes Framework - Productive Healthy Ageing Profile - Data - OHID (phe.org.uk)

Appendix 7 – Emergency admissions for injury due to falls in persons aged 65+, broken down by PCN, 2016/17 to 2022/23

Emergency Admissions, Falls, Age 65+ (rates compared to ICS)

PCN	2016/17		2017/18		2018/19		2019/20		2020/21		2021/22		2022/23	
	Number	DASR per 100,000	Number	DASR per 100,000	Number	DASR per 100,000	Number	DASR per 100,000	Number	DASR per 100,000	Number	DASR per 100,000	Number	DASR per 100,000
A1 Network PCN	141	1,963	129	1,730	132	1,720	148	1,863	151	1,824	153	1,741	159	1,759
BMC Paston PCN	93	1,236	108	1,442	115	1,518	125	1,610	162	2,048	124	1,595	96	1,240
Bretton, Park and Hampton PCN and Peterborough and East PCN*	246	1,801	221	1,585	237	1,665	251	1,746	245	1,713	232	1,609	211	1,468
Central Thistlemoor and Thorpe Road PCN	25	1,100	24	962	33	1,327	36	1,280	26	914	34	1,068	33	1,005
Fenland PCN	123	1,677	110	1,485	143	1,883	149	1,947	125	1,584	137	1,733	145	1,840
Huntingdon PCN	129	2,070	131	2,032	136	2,080	168	2,510	128	1,911	123	1,780	120	1,681
Peterborough Partnerships PCN	38	1,246	53	1,736	56	1,843	51	1,704	72	2,329	43	1,312	51	1,487
South Fenland PCN	105	1,818	100	1,683	121	1,966	91	1,452	120	1,873	103	1,602	116	1,764
South Peterborough PCN	160	1,712	121	1,268	108	1,093	151	1,483	186	1,807	179	1,712	140	1,293
St Ives PCN	162	1,851	153	1,690	145	1,550	150	1,540	175	1,778	143	1,427	174	1,698
St Neots PCN	119	2,051	128	2,137	126	2,022	135	2,103	131	2,050	128	1,942	109	1,613
Wisbech PCN	239	2,449	229	2,303	210	2,096	211	2,057	193	1,868	197	1,910	142	1,343
North Total	**1,580**	**1,826**	**1,507**	**1,699**	**1,562**	**1,720**	**1,666**	**1,790**	**1,714**	**1,816**	**1,596**	**1,663**	**1,496**	**1,524**
CAM Medical PCN	71	1,995	86	2,341	72	1,923	71	1,799	44	1,077	58	1,423	52	1,237
Cambridge City 4 PCN	160	2,213	162	2,262	159	2,198	146	2,007	119	1,591	126	1,720	137	1,818
Cambridge City PCN	181	2,293	174	2,170	180	2,265	240	2,996	133	1,670	168	2,139	162	2,026
Cambs Northern Villages PCN	144	1,760	160	1,899	202	2,275	179	2,000	136	1,504	160	1,715	155	1,616
Cantab PCN	92	1,971	81	1,705	67	1,333	97	1,837	63	1,211	75	1,416	88	1,577
Ely North PCN	137	1,941	137	1,896	175	2,382	173	2,241	133	1,706	132	1,646	137	1,639
Ely South PCN	131	2,138	104	1,662	104	1,654	126	1,914	103	1,519	99	1,443	102	1,439
Granta PCN	191	1,735	208	1,831	206	1,761	233	1,925	190	1,532	169	1,319	220	1,654
Meridian PCN	122	1,583	123	1,533	153	1,868	167	1,949	125	1,419	132	1,464	150	1,546
South Total	**1,229**	**1,933**	**1,235**	**1,903**	**1,318**	**1,985**	**1,432**	**2,095**	**1,046**	**1,505**	**1,119**	**1,585**	**1,203**	**1,639**
C&P Total	**2,809**	**1,871**	**2,742**	**1,786**	**2,880**	**1,835**	**3,098**	**1,922**	**2,760**	**1,686**	**2,715**	**1,631**	**2,699**	**1,575**

** Bretton, Park and Hampton and Peterborough and East PCNs are shown together due to data coding issues.*

Definition of emergency admission for falls:
Persons aged 65+, ICD10 Primary Diagnosis: Injury, Poisoning and certain other consequences of external causes (S00-T98) and ICD10 Falls (W00-W19) at any position
Key: PCNs statistically significantly lower than the ICS average are shaded green**.** PCNs statistically significantly higher than the ICS average are shaded red
Source of the data: DSCRO SusCP.ip_spell_all

Appendix 8 - Emergency admissions due to hip fracture in persons 65+, broken down by PCN, 2016/17 to 2022/23

Emergency Admissions, Hip Fractures, Age 65+ (rates compared to ICS)

PCN	2016/17		2017/18		2018/19		2019/20		2020/21		2021/22		2022/23	
	Number	DASR per 100,000	Number	DASR per 100,000	Number	DASR per 100,000	Number	DASR per 100,000	Number	DASR per 100,000	Number	DASR per 100,000	Number	DASR per 100,000
A1 Network PCN	41	567	43	575	43	577	51	639	56	694	53	613	60	675
BMC Paston PCN	44	603	44	593	37	501	46	596	50	635	59	757	49	629
Bretton, Park and Hampton PCN and Peterborough and East PCN*	99	714	97	698	101	713	100	693	83	579	89	617	86	589
Central Thistlemoor and Thorpe Road PCN	7	314	12	531	12	492	17	612	13	493	13	436	13	419
Fenland PCN	39	539	49	657	49	644	35	452	34	431	48	604	58	736
Huntingdon PCN	34	542	46	717	45	687	41	615	33	485	38	545	49	673
Peterborough Partnerships PCN	12	434	24	788	27	905	13	387	15	472	18	544	16	477
South Fenland PCN	29	512	33	563	36	597	32	514	44	681	29	445	48	738
South Peterborough PCN	75	801	47	491	50	505	65	640	50	486	75	719	58	532
St Ives PCN	56	636	47	517	55	580	42	437	52	542	51	498	73	692
St Neots PCN	40	695	27	454	40	646	42	658	29	449	38	573	33	481
Wisbech PCN	72	740	60	605	65	650	50	487	70	676	49	474	56	528
North Total	**548**	**635**	**529**	**597**	**560**	**617**	**534**	**575**	**529**	**561**	**560**	**582**	**599**	**608**
CAM Medical PCN	13	363	22	595	19	509	24	613	21	513	20	490	14	334
Cambridge City 4 PCN	41	565	34	470	36	492	51	689	44	588	37	506	49	645
Cambridge City PCN	50	635	61	770	40	491	55	689	46	578	61	776	51	659
Cambs Northern Villages PCN	40	492	50	594	54	614	52	582	50	546	59	635	60	624
Cantab PCN	26	554	16	343	15	302	25	467	22	418	25	467	27	497
Ely North PCN	48	684	33	456	42	573	52	675	48	614	51	643	44	520
Ely South PCN	52	849	30	479	32	514	38	579	26	384	28	406	41	582
Granta PCN	48	440	67	591	62	529	70	575	70	564	57	445	91	686
Meridian PCN	29	382	35	430	36	441	41	479	52	589	46	513	39	397
South Total	**347**	**546**	**348**	**537**	**336**	**505**	**408**	**596**	**379**	**546**	**384**	**544**	**416**	**569**
C&P Total	**895**	**597**	**877**	**571**	**896**	**571**	**942**	**584**	**908**	**554**	**944**	**566**	**1,015**	**591**

** Bretton, Park and Hampton and Peterborough and East PCNs are shown together due to data coding issues.*

Definition of emergency admission for hip fractures:
Persons; aged 65+, ICD10 Primary Diagnosis: S72.0 Fracture of neck of femur, Fracture of hip NOS. S72.1 Pertrochanteric fracture, Intertrochanteric fractures, Trochanteric fracture. S72.2 Subtrochanteric fracture
Source of the data: DSCRO SusCP.ip_spell_all
Key: PCNs statistically significantly lower than the ICS average are shaded green. PCNs statistically significantly higher than the ICS average are shaded red

Appendix 9 – Age, gender and ethnicity of admission

Cambridgeshire and Peterborough ICS , Falls – Emergency Admissions, Persons, aged 65+

Age Band	No. of Spells
n65 - 69	153
o70 - 74	272
p75 - 79	446
q80 - 84	545
s85+	1,283
Total 2022/23	**2,699**

Gender	No. of Spells
Female	1,800
Male	899
Total 2022/23	**2,699**

Ethnic Group	Ethnicity	No. of Spells
Asian or Asian British	Any other Asian background	<=5
	Bangladeshi	<=5
	Indian	6
	Pakistani	8
Black or Black British	African	<=5
	Caribbean	<=5
Mixed	White and Black African	<=5
	White and Black Caribbean	<=5
Not Stated	Not known	233
	Not stated	97
Other Ethnic Groups	Any other ethnic group	<=5
	Chinese	<=5
White	Any other White background	80
	British	2,241
	Irish	16
	Total 2022/23	**2,699**

source: DSCRO SusCP.ip_spell_all

Falls:
Emergency Admissions; Persons; aged 65+
ICD10 Primary Diagnosis: Injury, poisoning and certain other consequences of external causes
(S00-T98) and
ICD10 Falls (W00-W19) at any position

Cambridgeshire and Peterborough ICS, Hip Fractures – Emergency Admissions, Persons, aged 65+ - DASR per 100,000

Age Band	No. of Spells
n65 - 69	38
o70 - 74	92
p75 - 79	170
q80 - 84	210
s85+	505
Total 2022/23	**1,015**

Gender	No. of Spells
Female	711
Male	304
Total 2022/23	**1,015**

Ethnic Group	Ethnicity	No. of Spells
Asian or Asian British	Indian	<=5
	Pakistani	<=5
Black or Black British	African	<=5
	Caribbean	<=5
Not Stated	Not known	103
	Not stated	21
Other Ethnic Groups	Any other ethnic group	<=5
White	Any other White background	27
	British	849
	Irish	7
	Total 2022/23	**1,015**

source: DSCRO SusCP.ip_spell_all

Hip Fractures:
Emergency Admissions; Persons; aged 65+
ICD10 Primary Diagnosis: S72.0 Fracture of neck of femur Fracture of hip NOS
S72.1 Pertrochanteric fracture Intertrochanteric fracture Trochanteric fracture
S72.2 Subtrochanteric fracture

Appendix 10 – List of World Guideline recommendations

The recommendations below are taken from the World Guidelines for falls prevention and management for older adults: a global initiative[60].

The recommendations have been graded by strength and quality. Strength of recommendations is reflected by a 1 for strong and 2 for weak or conditional. Quality is denoted by A for high quality, B for intermediate quality and C for low quality. E refers to expert opinion as a result of no quality evidence being available.

1. Falls risk stratification and algorithm

1.1 Opportunistic case-finding

Strong recommendation. Clinicians should routinely ask about falls in their interactions with older adults, as they often will not be spontaneously reported. GRADE: 1A.

Expert recommendation. Older adults in contact with healthcare for any reason should be asked, at least once yearly, if they have (i) experienced one or more falls in the last 12 months, and (ii) about the frequency, characteristics, context, severity and consequences of any fall/s. GRADE: E.

Expert recommendation. If resources and time are available, we conditionally recommend to additionally ask (iii) if they have experienced dizziness, loss of consciousness or any disturbance of gait or balance and (iv) if they experience any concerns about falling causing limitation of usual activities. GRADE: E.

Strong recommendation. Older adults who affirm any of the above inquiries should be offered an objective assessment of gait and balance for differentiating intermediate and high from low risk of falls as a component of initial falls risk stratification. GRADE: 1A

1.2 Older adults presenting with falls or related injuries

Expert recommendation. Older adults presenting with a fall or related injury should be asked about the details of the event and its consequences, previous falls, transient loss of consciousness or dizziness and any pre-existing impairment of mobility or concerns about falling causing limitation of usual activities. GRADE: E.

Expert recommendation. An adult who sustains an injury requiring medical (including surgical) treatment, reports recurrent falls (≥2) in the previous 12 months, was laying on the floor unable to rise independently for at least one hour, is considered frail or is suspected to have experienced a transient loss of consciousness should be regarded as at high risk of future falls. GRADE: E

Strong recommendation. Regarding specific tests, we recommend including Gait Speed for predicting falls risk. GRADE: 1A. As an alternative, the Timed Up and Go Test can be considered, although the evidence for fall prediction is less consistent. GRADE: 1B

1.3 Assessment and algorithm flow

Strong recommendation. Regarding specific tests, we recommend including Gait Speed for predicting falls risk. GRADE: 1A. As an alternative, the Timed Up and Go Test can be considered, although the evidence for fall prediction is less consistent. GRADE: 1B

[60] World guidelines for falls prevention and management for older adults: a global initiative - PMC (nih.gov)

2.0 Assessment

2.1 Incorporating the perspective of the older adult

Strong recommendation. As part of a multifactorial falls risk assessment clinicians should enquire about the perceptions, the older adult holds about falls, their causes, future risk and how they can be prevented. GRADE: 1B.

Expert recommendation. As part of a multifactorial falls risk assessment clinicians should enquire about the goals and priorities; attitudes to activities, independence and risk; and willingness and capability of older adults to inform decision making on potential interventions. GRADE: E

2.2 Multifactorial falls risk assessment

Strong recommendation. Offer multi-professional, multifactorial assessment to community-dwelling older adults identified to be at high risk of falling, to guide tailored interventions. GRADE: 1B.

2.3 Assessment details for individual components

2.3.1 Gait and balance assessment

Strong recommendation. Gait and Balance should be assessed as part of the risk assessment of falls. GRADE: 1B

2.3.2 Medication assessment

Strong recommendation. Assess for fall history and the risk of falls before prescribing potential fall risk increasing drugs (FRIDs) to older adults. GRADE: 1B.

Strong recommendation. Use a validated, structured screening and assessment tool to identify FRIDs when performing a general medication review or medication review targeted to falls prevention. GRADE: 1C.

2.3.3 Cognitive assessment

Strong recommendation. Assessment of cognition should be included as part of a multifactorial falls risk assessment in older adults. GRADE: 1B.

2.3.4 Concerns about falling and falls

Strong recommendation. Include an evaluation of concerns about falling in a multifactorial falls risk assessment of older adults. GRADE: 1B.

Strong recommendation. Use a standardized instrument to evaluate concerns about falling such as the Falls Efficacy Scale International (FES-I) or Short FES-I in community dwelling older adults. GRADE: 1A.

2.3.5 Cardiovascular assessment

Strong recommendation. Perform, as part of a multifactorial falls risk assessment, a cardiovascular assessment that initially includes cardiac history, auscultation, lying and standing orthostatic blood pressure, and surface 12-lead electrocardiogram. GRADE: 1B.

Strong recommendation. In the absence of abnormalities on initial cardiovascular assessment, no further cardiovascular assessment is required, unless syncope is suspected (i.e., described or witnessed syncope/pre-syncope or recurrent unexplained falls). GRADE: 1C.

Strong recommendation. We recommend that the further cardiovascular assessment for unexplained falls should be the same as that for syncope, in addition to the multifactorial falls risk assessment. GRADE: 1A.

2.3.6 Dizziness and vestibular disorders assessment

Expert recommendation. Routinely ask about dizziness symptoms, and undertake follow-up assessment as necessary to identify cardiovascular, neurological and/or vestibular causes. GRADE: E.

2.3.7 Vision and hearing assessment

Expert recommendation. Enquire about vision impairment as part of a multifactorial falls risk assessment, measure visual acuity and examine for other visual impairments such as hemianopia and neglect where appropriate. GRADE: E.

Expert recommendation. Enquire about hearing impairment as part of a multifactorial falls risk assessment, measure and examine for hearing impairments and refer to a specialist where appropriate. GRADE: E.

2.3.8 Urinary symptoms and incontinence assessment

Expert recommendation. Enquire about urinary symptoms as part of a multifactorial falls risk assessment GRADE: E

2.3.9 Pain assessment

Expert recommendation. Enquire about pain as part of a multifactorial falls risk assessment, followed as indicated by a comprehensive pain assessment. GRADE: E

2.3.10 Environmental assessment

Strong recommendation. Identification of an individual's environmental hazards where they live and an assessment of their capacities and behaviours in relation to them, by a clinician trained to do so, should be part of a multifactorial falls risk assessment. GRADE:1B.

2.3.11 Depression assessment

Expert recommendation. Enquire about depressive symptoms as part of a multifactorial falls risk assessment, followed by further mental state assessment if necessary and referral to a specialist where appropriate. GRADE: E

2.3.12 Nutritional assessment including vitamin D

Expert recommendation – Assess nutritional status including vitamin D intake as part of a multifactorial falls risk assessment, followed by supplementation where appropriate. GRADE: E

1.0 Management and interventions

3.3 Management of older adults at low fall risk

Expert recommendation. Provide advice on how to maintain safe mobility and optimise physical functioning to older adults at low risk of falls from a clinician trained to do so. Such advice should consider the circumstances, priorities, preferences and resources of the older adult. This advice should

reinforce health promotion/prevention messaging relevant to falls and fracture risks such as those on physical activity, lifestyle habits and nutrition including vitamin D intake. GRADE: E.

3.3 Interventions for community dwelling older adults at intermediate fall risk

Expert recommendation. Offer an exercise programme based on an individual assessment and according to the recommendations in the Exercise Interventions section. GRADE: E.

3.3 Multidomain interventions for community dwelling older adults at high fall risk

Strong recommendation. A care plan developed to prevent falls and related injuries should incorporate the values and preferences of the older adult. GRADE: 1B.

Strong recommendation. When creating falls prevention care plans for older adults with cognitive impairment, both the older adults' and their caregivers' perspectives should be included as it improves adherence to interventions and outcomes. GRADE: 1C.

Multidomain falls risk intervention Strong recommendation. Offer multidomain interventions, informed by a multi-professional, multifactorial falls risk assessment to community-dwelling older adults identified to be at high risk of falling. GRADE: 1B.

3.4 Component interventions

3.4.1 Exercise and physical activity interventions

Strong recommendation. Exercise programmes for fall prevention for community-dwelling older adults that include balance challenging and functional exercises (e.g., sit-to stand, stepping) should be offered with sessions three times or more weekly which are individualised, progressed in intensity for at least 12 weeks and continued longer for greater effect. GRADE: 1A.

Strong recommendation. Include, when feasible, of Tai Chi and/or additional individualised progressive resistance strength training. GRADE: 1B.

3.4.2 Medication interventions

Strong recommendation. A medication review and appropriate deprescribing of FRIDs should be part of multidomain falls prevention interventions. GRADE: 1B.

Strong recommendation. We recommend that in long-term care residents, the falls prevention strategy should always include rational deprescribing of fall-risk-increasing drugs. GRADE: 1C.

3.4.3 Cardiovascular interventions

Strong recommendation. Management of orthostatic hypotension should be included as a component of a multidomain intervention. GRADE: 1A.

Strong recommendation. Interventions for cardiovascular disorders identified during assessment for risk of falls should be the same as that for similar conditions when associated with syncope, in addition to other interventions based on the multifactorial falls risk assessment. GRADE 1B.

3.4.4 Telehealth and technology interventions

Expert recommendation. Use telehealth and/or smart home systems (when available) in combination with exercise training as part of falls prevention programmes in the community. GRADE: E.

Conditional recommendation. Current evidence does not support the use of wearables for falls prevention. However, emerging evidence show that when wearables are used in exercise programs to prevent falls, they may increase participation. GRADE: 2C.

3.4.5 Environmental interventions

Strong recommendation. Recommendations for modifications of an older adult's physical home environment for fall hazards that consider their capacities and behaviours in this context should be provided by a trained clinician, as part of a multidomain falls prevention intervention. GRADE: 1B.

3.4.6 Vestibular interventions

Expert recommendation Managing vestibular issues should be considered as part of multifactorial approach. GRADE: E

3.4.7 Pain interventions

Expert recommendation. Adequate pain treatment should be considered as part of the multidomain approach. GRADE: E.

3.4.8 Concerns about falling and falls interventions

Strong recommendation. We recommend exercise, cognitive behavioural therapy and/or occupational therapy (as part of a multidisciplinary approach) to reduce concerns about falling in community-dwelling older adults. GRADE: 1B.

3.4.10 Vision interventions

Expert recommendation. Management of impaired vision should be considered as part of the multifactorial approach. GRADE: E.

4.0 Falls in hospitals

4.1 Risk stratification and assessment

Conditional recommendation. Perform a multifactorial falls risk assessment in all hospitalised older adults >65 years of age. We recommend against using scored falls risk screening tools in hospitals for multifactorial falls risk assessment in older adults. GRADE: 2B.

Strong recommendation. We recommend using the FESI or especially the Short FES-I for assessing concerns about falling in acute care hospitals. GRADE: 1B.

Expert recommendation. We recommend conducting a post-fall assessment in hospitalised older adults following a fall in order to identify the mechanism of the fall, any resulting injuries, any precipitating factors (such as new intercurrent illness, complications or delirium), to reassess the individual's fall risk factors, and adjust the intervention strategy accordingly. GRADE: E.

4.2 Management and interventions

Strong recommendation. A tailored education on falls prevention should be delivered to all hospitalised older adults (≥65 years of age) and other high-risk groups. GRADE: 1A.

Strong recommendation. Personalised single or multidomain falls prevention strategies based on identified risk factors, behaviours or situations should be implemented for all hospitalised older adults (≥65 years of age), or younger individuals identified by health professionals as at risk of falls. GRADE: 1C (Acute care), GRADE: 1B (Sub-acute care)

5.0 Falls in care homes

5.1 Risk stratification and assessment

Strong recommendation. Do not perform falls risk screening to identify care home residents at risk for falls as all residents should be considered at high risk of falls. GRADE: 1A.

Strong recommendation. Perform a comprehensive multifactorial assessment at admission to identify factors contributing to fall risk and implement appropriate interventions to avoid falls and fall-related injuries in care home older adults. GRADE: 1C.

Expert recommendation. We recommend conducting a post-fall assessment in care home residents following a fall in order to identify the mechanism of the fall, any resulting injuries, to reassess the resident's fall risk factors, adjust the intervention strategy for the resident and avoid unnecessary transfer to hospital. GRADE: E.

Strong recommendation. We recommend using the FES-I or especially the Short FES-I for assessing concerns about falling in long-term care facilities. GRADE: 1B.

5.2 Management and interventions

Strong recommendation. Take a multifaceted approach to falls reduction for care home residents including care home staff training, systematic use of a multidomain decision support tool and implementation of falls prevention actions. GRADE: 1B.

Strong recommendation. Do not use of physical restraints as a measure for falls prevention in care homes. GRADE: 1B. Strong recommendation. Perform nutritional optimisation including food rich in calcium and proteins, as well as vitamin D supplementation as part of a multidomain intervention for falls prevention in care home residents. GRADE: 1B.

Strong recommendation. Include the promotion of exercise training (when feasible and safe) as part of a multidomain falls prevention intervention in care homes. GRADE: 1C.

6.0 Specific clinical populations

6.1 Falls and PD and related disorders

6.1.1 Assessment

Conditional recommendation. Consider a falls risk assessment for older adults with PD, including a self-report 3-risk factor assessment tool, which includes a history of falls in the previous year, freezing of gait (FOG) in the past month, and slow gait speed. GRADE: 2B.

6.1.2 Management and interventions

Conditional recommendation. Older adults with PD should be offered multidomain interventions, based on PD specific assessment and other identified falls risk factors. GRADE: 2B. Strong recommendation. Older adults with PD at an early to mid-stage and with mild or no cognitive impairment should be offered individualised exercise programmes including balance and resistance training exercise. GRADE: 1A.

Strong recommendation. Consider offering exercise training, targeting balance and strength to people with complex phase PD if supervised by a physiotherapist or other suitably qualified professional. GRADE: 1C.

6.2 Stroke

Conditional recommendation. Older adults after a stroke should be offered participation in individualised exercise programmes aimed at improving balance/strength/walking to prevent falls. GRADE: 2C.

6.3 Mild cognitive impairment and dementia

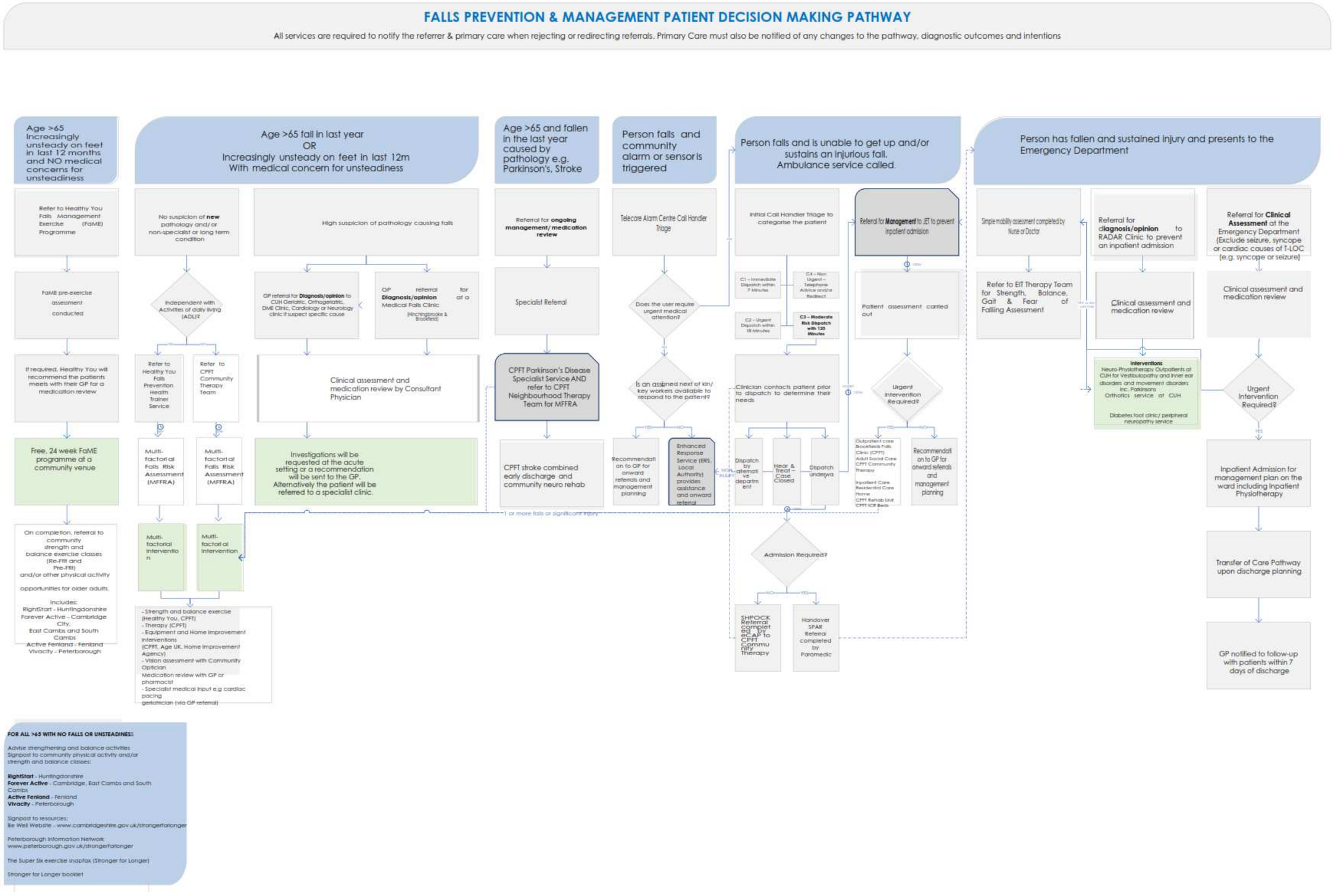
Strong recommendation. Community-dwelling older adults with cognitive impairment (mild cognitive impairment and mild to moderate dementia) should be offered an exercise programme to prevent falls. GRADE: 1B.

6.4 Hip fracture Strong recommendation.

Older adults after sustaining a hip fracture should be offered an individualised and progressive exercise programme aimed at improving mobility (i.e., standing up, balance, walking, climbing stairs) as a fall prevention strategy. GRADE: 1B.

Conditional recommendation. Such programmes for older adults after a hip fracture are best commenced in hospital (GRADE: 2C) and continued in the community (GRADE: 1A).

Appendix 11 - System wide Falls Prevention and Management Pathway



Appendix 12 - Summary of key falls-related services

SERVICE NAME	SERVICE OVERVIEW	ELIGIBILITY CRITERIA	LOCATION(S)	OPERATING TIMES	FUNDING SOURCE	CLINICAL LEAD	CLINICAL LEAD EMAIL
CPFT Community Therapy	CPFT Community Therapy are part of the CPFT Neighbourhood Teams, supporting all adults requiring community services. The wider Neighbourhood team includes integrated District Nurses, Integrated Support Workers and Mental Health Practitioners and works in partnership with other services including out-of-hours nursing, intermediate care, podiatry, dietetics, mental health teams, speech and language therapy and JET. Evidence based patient pathways have been developed for a number of health conditions to ensure the services in the Neighbourhood team manage their patients in the same way and teams work in a coordinated way to support those at highest risk of hospital or care home admission. The falls prevention pathway forms part of the Community Therapy remit. This includes the provision of multi-factorial falls risk assessments, strength and balance exercise programmes, rehabilitation programmes, equipment and housing adaptations. Equipment is prescribed from the Integrated Community Equipment Service (NRS contract) - a service commissioned by CCC.	Eligibility for a multi-factorial falls risk assessment: 1) Person 65+ who has had one or more falls in the last 12 months and 2) are not independent with their activities of daily living i.e. they are not able to complete one or more of the following: • Transfer on and off toilet •Transfer on and off the bed and chair without help • Walk safely and independently with or without a walking aid •Manage to wash, dress and prepare meals and drinks independently or have adequate help to enable to complete these tasks •Leave the house with or without help	Countywide - Cambridgeshire and Peterborough	08:00-16:00	Cambridgeshire and Peterborough ICS	Area Therapy Managers: •Hayley Litchfield Falls Prevention Clinical Lead: Annami Palmer	Hayley.litchfield@cpft.nhs.uk Louise.pitt@cpft.nhs.uk Sarah.wood@cpft.nhs.uk Annami.palmer@cpft.nhs.uk
Healthy You/Everyone Health Falls Prevention Health Trainer Service	The service forms part of the integrated community falls prevention pathway with CPFT and offers multi-factorial risk assessments for people who are independent with ADLs, followed by appropriate referral for interventions. In addition, it offers a free, 24 week programme of group strength and balance classes (Falls Management Exercise programme, FaME).	•Cambridgeshire and Peterborough residents 65+. •Criteria for a multi-factorial falls risk assessment: 1) Have fallen one or more times in the last year and 2) Be able to manage activities of daily living (with or without support). •Criteria for the FaME programme: 1) Have become increasingly unstable on their feet in the last year 2) Be able to manage activities of daily living (with or without support)	Countywide community clinics - within the local authority boundaries of Cambridgeshire County Council and Peterborough City Council	Monday-Friday 09:00-17:00	Cambridgeshire County Council and Peterborough City Council	Charlina Robinson	CharlinaRobinson@healthyyou.org.uk
CPFT Enhanced Falls Prevention Pathway	3-year funded programme in Cambridge City and Fenland only commissioned by Cambridgeshire County Council to deliver multifactorial falls risk assessments (MFRA)	Cambridgeshire residents 65+ who has had two or more falls in the last 12 months, and/or they have been admitted to hospital as a result of a fall, and live within the catchment areas of the following NTs: Cambridge City North, Cambridge City South, Fenland, Wisbech	NTs: Cambridge City North, Cambridge City South, Fenland, Wisbech	08:00-16:00	Cambridgeshire County Council	Annami Palmer	Annami.palmer@cpft.nhs.uk

SERVICE NAME	SERVICE OVERVIEW	ELIGIBILITY CRITERIA	LOCATION(S)	OPERATING TIMES	FUNDING SOURCE	CLINICAL LEAD	CLINICAL LEAD EMAIL
Addenbrooke's Hospital - Emergency Department	The ED provides an assessment of people who have fallen which includes: medical history, medication review, examination, lying & standing BP, investigations (i.e., CG/glucose check), bone health assessment	All Falls Patients excluding seizure, syncope or cardiac causes of Transient loss of consciousness (TLoC) (e.g., syncope or seizure)	Hills Rd, Cambridge CB2 0QQ	24/7	Cambridgeshire and Peterborough ICS	Dr Diane Williamson	diane.williamson1@nhs.net
Addenbrooke's Hospital – Front Door Frailty Service	The CUH Front Door Frailty Service, initiated in August 2023, offers a Comprehensive Geriatric Assessment (CGA) to patients presenting to ED. The team comprises 2 Consultant Geriatricians and a Pharmacist.	Patients with a frailty score of 6 and over on the Clinical Frailty Scale, 80+ years of age and Care and Residential home residents.	Hills Rd, Cambridge CB2 0QQ	08:00-17:00 Monday - Friday.	Cambridgeshire and Peterborough ICS	Dr Lelane Vanderpoel	l.vanderpoel@nhs.net
Addenbrooke's Hospital - Early Intervention Team (EIT)	The EIT carry out a simple mobility test; based on this outcome patients will either continue to be managed in the Emergency Department or EIT will use the assessment to create appropriate referrals to onward services to avoid an admission.	All patients age >65 years who present to the ED with a fall	Hills Rd, Cambridge CB2 0QQ	08:00 - 20:00 Monday - Sunday (Therapy is limited to 08:00 - 18:00 due to workforce shortage)	Cambridgeshire and Peterborough ICS	Service Lead: Jo Barker Therapy Lead: Nicole Uyan	jo.barker3@nhs.net Nicole.uyan1@nhs.net
Addenbrooke's Hospital – General Medical Clinics	The Geriatrician-led Medical Falls Clinics provide the medical part of a CGA including full clinical exam, medical review, medication review and social history. Approximately two new referrals and two returning patients are seen per clinic (or up to five returns). The clinic can refer into other CUH specialist clinics e.g., Syncope clinic, Cardiology, ENT, Dexa scan etc.	No explicit criteria (person fallen and GP requests review) but referrals are triaged into appropriate geriatric service clinics as needed.	Hills Rd, Cambridge CB2 0QQ	Clinics run afternoons every day, Monday to Friday.	Cambridgeshire and Peterborough ICS	Dr Joanna Hampton	joanna.hampton@nhs.net
NWAFT Front Door Frailty Team	The NWAFT Front Door Frailty Service, initiated in Peterborough City Hospital (PCH) in September 2021 and Hinchingbrooke Hospital (HH) in April 2023, offers a Comprehensive Geriatric Assessment (CGA) to patients presenting with acute frailty to the emergency department at PCH or HH. The CGA is an in-depth medical review and covers 5 core pillars of the CGA. In PCH, the team liaise with the NWAFT Front Door Therapy Team and in HH, the team liaise with the CPFT Front Door Therapy Team. The team comprises 1.5 Consultant Geriatricians, 4 Physician Associates, 1 Registrar, 2 Lead Nurses, and 3 Frailty Nurses.	Patients with a Rockwood frailty score of 6 and above	Peterborough City Hospital, Bretton Gate, Peterborough, PE3 9GZ Hinchingbrooke Hospital, Hinchingbrooke Park Huntingdon, PE29 6NT	PCH: 7 days a week, 08:00-18:00 weekdays and 08:00-16:00 on weekends HH: 5 days a week (Monday to Friday), 08:00-18:00	Cambridgeshire and Peterborough ICS	Dr Lucy Daniels	lucy.daniels3@nhs.net

SERVICE NAME	SERVICE OVERVIEW	ELIGIBILITY CRITERIA	LOCATION(S)	OPERATING TIMES	FUNDING SOURCE	CLINICAL LEAD	CLINICAL LEAD EMAIL
NWAFT General Medical Clinics	The Geriatrician-led General Medical Clinic offers comprehensive medical assessment (similar to a CGA) and medication review for patients referred from the GP or hospital therapists. The Peterborough City Hospital (PCH) clinic is run by four Consultant Geriatricians who see up to five new patients per week. The Hinchingbrooke Hospital clinic is run by two Consultant Geriatricians.	There is no explicit referral criteria for the General Medical Clinics although the patients are triaged by the Geriatric Service into the appropriate clinics. Patients with recurrent falls are accepted into the General Medical Clinic.	Peterborough City Hospital, Bretton Gate, Peterborough, PE3 9GZ Hinchingbrooke Hospital, Hinchingbrooke Park Huntingdon, PE29 6NT	PCH: Clinics run on a Tuesday and a Wednesday afternoon every week HH: Clinics run on Monday afternoon and Friday morning	Cambridgeshire and Peterborough ICS	Dr Olugbenro Akintade HH: Dr Alice Cole or Dr Elizabeth Ellis	olugbenro.akintade@nhs.net Alice.cole1@nhs.net elizabeth.ellis2@nhs.net
CCC & PCC Reablement Team	The reablement service takes a holistic approach to assessment and goal setting of people discharged from hospital to maintain or enhance their level of independent function in daily living activities. This involves the person and their family / carers but also aims to consider the benefits of accessing wider, preventative services such as technology enabled care, therapy services, housing related support, housing services and community navigators. The team also follow the Falls Prevention pathway. The programme lasts up to 6 weeks (longer if required). The service is led by Occupational Therapists.	**Inclusion** 18+ years and is a resident in Cambridgeshire or Peterborough. Person would benefit from a short-term, targeted programme of reablement, and / or reassessment, in order to maintain or enhance their level of independent function in daily living activities and reduce their need for statutory services. **Exclusion** The person has: • a rapidly deteriorating condition or prognosis, with complex needs that cannot be met by the reablement service and would be best met by health services – either Intermediate Care or NHS Continuing Health Care • a health need that requires a specific clinical rehabilitation programme or Intermediate Care • requires care and support while their family carers are on holiday • Adults who are homeless and do not have suitable accommodation for a Reablement programme to take place. • Adults who have No Recourse to Public Funds (NRPF). • People who are unable to engage in a reablement intervention due to severe cognitive ability and / or are not engaged in a programme of rehabilitation support.	Countywide - within the local authority boundaries of Cambridgeshire County Council and Peterborough City Council.	7-days per week between the core operating hours of 7am and 10pm. The services operate adequate 'on call' and 'out of hours' cover	Cambridgeshire County Council and Peterborough City Council	Rebecca Garry (CCC) Carol Farrar (PCC)	Rebecca.gary@cambridgeshire.gov.uk carol.farrar@peterborough.gov.uk

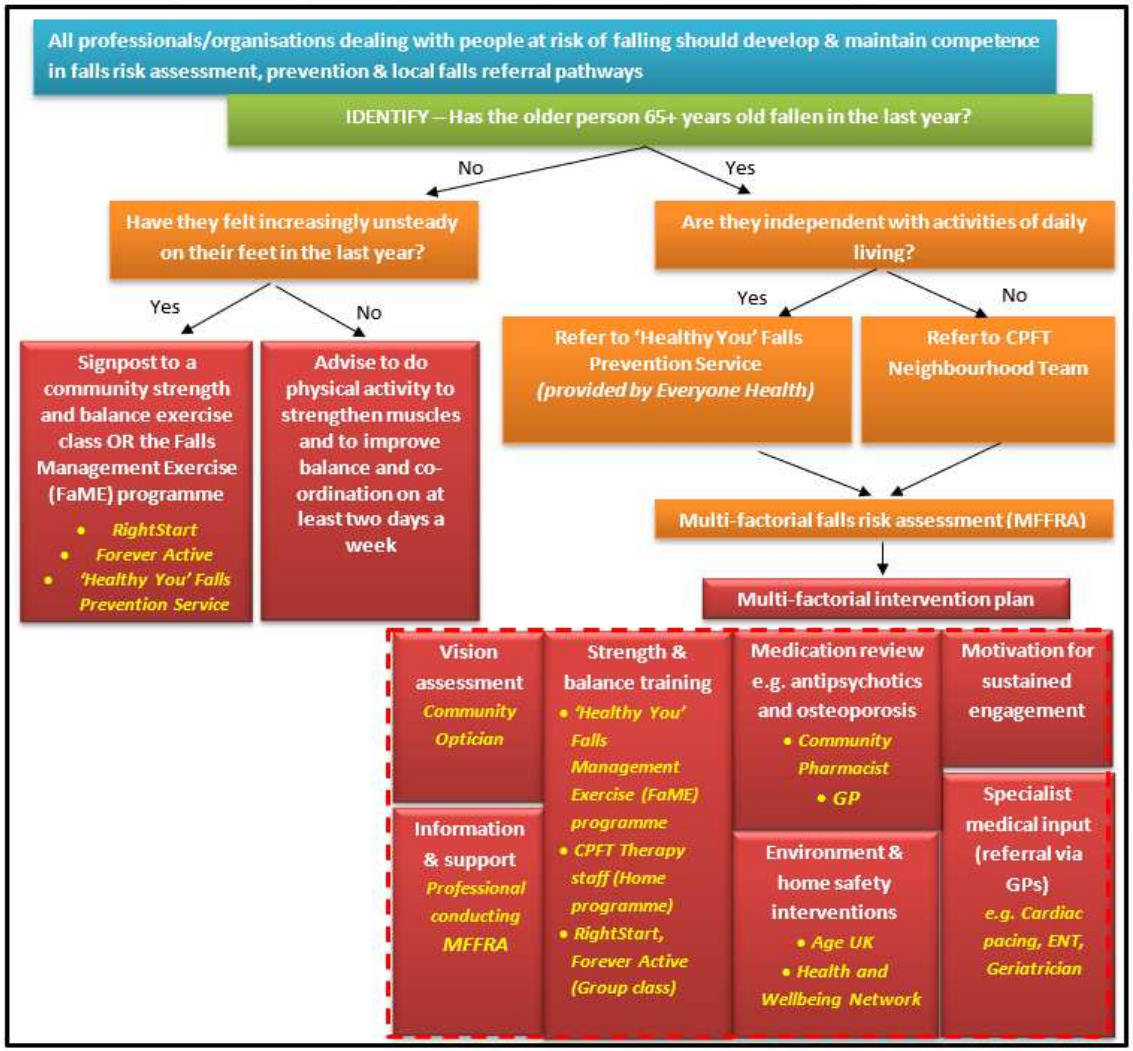
SERVICE NAME	SERVICE OVERVIEW	ELIGIBILITY CRITERIA	LOCATION(S)	OPERATING TIMES	FUNDING SOURCE	CLINICAL LEAD	CLINICAL LEAD EMAIL
CPFT Intermediate Care Team	The intermediate care service comprises of two main community pathways supporting patients with different levels of dependency: Pathway 1: Home with care and therapy Pathway 2: Rehabilitation in a bedded facility (health interim) The aim of Intermediate Care services is to promote faster recovery from illness; support safe and timely discharge from hospital; prevent unnecessary hospital admission; prevent premature admission to long-term residential care; maximise independent living in the community. Each intermediate care service provides a range of functions that include: Triaging of referrals and discharge planning from acute hospitals; Initial Assessment within 48 hours of admission to pathway; Care and therapy goal planning in the community; Care co-ordination, allocation and management; Delivery of care; Transfer of care planning from intermediate care services.	**Inclusion** • Patients who are clinically fit to leave hospital OR •Patients who can be prevented from being admitted to an acute hospital AND are: • Adults aged 18+ registered with a Cambridgeshire and Peterborough GP • People rehabilitating following acute medical or surgical health conditions where it is anticipated that their functional status will improve. E**xclusion** • Patients who need long term care packages • Patients whose existing care package meets their needs • Patients who require permanent placement into a nursing or care home • Patients whose needs can be met by Local Authority reablement services because the primary need is not related to an acute health medical or surgical illness • Patients who have an acute mental health need or who have a psychiatric crisis • Patients who require maintenance for a long-term condition • Patients whose only need is medicines management • Patients who require assessment for NHS Continuing Health Care, including Fast Track end of life care and complex case management.	Countywide	7 days a week, 07:00-22:00	Cambridgeshire and Peterborough ICS	Vanessa Bunn Barry Underwood	Vanessa.bunn@cpft.nhs.uk Barry.underwood@cpft.nhs.uk
Peterborough City Council Home Service Delivery Team	The Home Service Delivery Team brings together teams across Adult Social Care and Housing to keep people living in their homes independently and safely for as long as possible. It is a 'One stop shop' approach for clients which looks at both their ability to carry out activities of daily living and their physical home environment. The service brings together Reablement; Therapy Services (including sensory impairment and assistive technology); Care and Repair Home Improvement Agency (including Handyperson Service); Housing Programmes; Adult Early Help; and Older Peoples Day Services at the Cresset	Varies but is for Peterborough residents only	Peterborough wide	Varies	Peterborough City Council	Belinda Child	belinda.child@peterborough.gov.uk

SERVICE NAME	SERVICE OVERVIEW	ELIGIBILITY CRITERIA	LOCATION(S)	OPERATING TIMES	FUNDING SOURCE	CLINICAL LEAD	CLINICAL LEAD EMAIL
CCC Enhanced Response Service (ERS)	ERS respond to telecare alerts via Lifeline Alert centres or referrals from EEAST for people who need non-emergency assistance, 24 hours a day, 7 days a week. Their target response time is 60 minutes. The service: • Provides assistance to get a person up from the floor following a fall • Provides personal care that is needed in an urgent and unplanned circumstance, i.e., not part of a regular care package. • Provides reassurance following an incident at home • The Enhanced Response Service is not an emergency service, nor are they clinical or medical responders. They are registered with the Care Quality Commission to provide social care activities.	Cambridgeshire and Peterborough residents who have a lifeline	Countywide - Within the local authority boundaries of Cambridgeshire County Council and Peterborough City Council	24/7	Cambridgeshire County Council	Grace E Clarke (CCC) Belinda Child (PCC)	GraceE.Clark@cambridgeshire.gov.uk belinda.child@peterborough.gov.uk
Age UK Cambridgeshire and Peterborough Handyperson Service	The Cambridgeshire Handyperson Service offers wellbeing assessments to older people and adults with a disability, whether short or long term. Following assessment, measures such as grab and banister rails and half steps can be installed, as well as carrying out small jobs around the home, which can also prevent a fall. In carrying out lower level interventions, pressures on statutory therapy services can be reduced and ultimately those requiring such support wait less for this to be implemented.	Any older person aged 65+. Any adult aged 18 plus with a disability, whether short or term, physical or mental.	Cambridgeshire wide (not Peterborough)	9am to 4.30pm Monday to Friday	•Cambridgeshire County Council • South Cambridgeshire DC •Cambridge City Council •East Cambridgeshire DC •Huntingdonshire DC •Fenland DC	Diana MacKay	Diana.Mackay@cambridgeshire.gov.uk
Age UK Cambridgeshire and Peterborough Community Wardens, Home Support and Day Services	Community Wardens, Home Support and Day Services - Regular input from these services ensures needs are continuously assessed and potential risks from falls can be averted. Close communication with clinicians ensures medical needs are reviewed on a timely basis, again reducing the risk of falls.	•Aged 60 plus, living alone or with another older person who would benefit from the support •Residing in the areas a Community Warden service is offered	Wardens in 20 areas of Cambridgeshire and Peterborough. Home Support in Peterborough. Day Services in various areas countywide	Each weekday	Various including County, District and Parish councils. Local charities, trust funds and donations	Various Contact: Melanie Pittock	Melanie.Pittock@ageukcap.org.uk
Age UK Cambridgeshire and Peterborough Hospital Discharge support and	In assisting hospital discharges and admission avoidance, Age UK Cambridgeshire and Peterborough ensure timely help is given, regular visits from staff and volunteers are made, meaning further decline in health and mobility is less likely. Installing key safes and other falls prevention measures on discharge enables care	Aged 60 plus, recently discharged from hospital or at risk of being admitted.	Cambridgeshire and Peterborough	10am to 4pm 7 days per week	Collaboration through Voluntary Sector Alliance (VSA), ICS funding	Various Contact: Melanie Pittock	Melanie.Pittock@ageukcap.org.uk

SERVICE NAME	SERVICE OVERVIEW	ELIGIBILITY CRITERIA	LOCATION(S)	OPERATING TIMES	FUNDING SOURCE	CLINICAL LEAD	CLINICAL LEAD EMAIL
admission avoidance	or reablement to begin as soon as a person is home.						
Right Start Group Exercise Classes	Delivers a programme of exercise classes for older people from Chair Based, Strength and Balance (Otago), Postural Stability Exercise (including floor work). Full list available at www.huntingdonshire.gov.uk/rightstart	Older adults and those who require additional support to exercise. Different levels from 1-5 depending on ability. For those who have fallen, who are unsteady or to generally improve balance and co-ordination. Also available Right Start Aqua and Right Start Indoor Cycling www.huntingdonshire.gov.uk/rightstart	Huntingdonshire District including: Huntingdon, Ramsey, St Ives, St Neots and villages: Alconbury Weald, Brampton, Catworth, the Hemingfords, Houghton, and Warboys. Programme subject to change and growth.	Monday - Friday Generally daytime	Customers pay as they go or a variety of payment methods are available. Funding from Public Health for new 'strength and balance activities' project	Jo Peadon	jo.peadon@huntingdonshire.gov.uk
Forever Active	Provides exercise/activity sessions for the over 50 age groups within Cambridge City, South Cambridgeshire and East Cambridgeshire. Sessions range from chair-based exercises, which are suitable for people with mobility problems, to activities and sports for the active 50+. Full list available at: https://www.forever-active.org.uk/classes/sports/	Generally open access but my vary by exercise class	Cambridge City, South Cambridgeshire and East Cambridgeshire - list on website https://www.forever-active.org.uk/classes/sports/	Monday - Friday Generally daytime	Customers pay as they go or become a member. Funding from Public Health for new 'strength and balance activities' project	Jane Jones	jane.jones@forever-active.org.uk
Vivacity	Delivers a range of exercise classes for older people including strength and balance classes and other activities. https://www.vivacity.org/sport-events/health-wellbeing/strength-balance-classes/	Generally open access but my vary by exercise class	Peterborough wide	Monday - Friday Generally daytime	Customers pay as they go or a variety of payment methods are available. Funding from Public Health for new 'strength and balance activities' project	Emma Walker	emma.walker@vivacity.org

SERVICE NAME	SERVICE OVERVIEW	ELIGIBILITY CRITERIA	LOCATION(S)	OPERATING TIMES	FUNDING SOURCE	CLINICAL LEAD	CLINICAL LEAD EMAIL
Active Fenland (Fenland District Council's Physical Activity and Healthy Lifestyle department)	Provides physical activity and healthy lifestyle opportunities which includes but is not limited to opportunities for older adults such as FaME, Strength and Balance, Yoga (low level seated can be accommodated where needed) Forever Fit (Table Tennis, badminton, short tennis and indoor curling) Walking Sports (Football, Netball and Cricket), Walking Groups, Tea Dance, Health MOTs, Love to Move, metal wellbeing sessions, 12 week physical activity interventions /taster sessions and many more physical activity opportunities.	Projects vary on eligibility but the service as a whole is for anyone living England.	Fenland	Sessions are at varied times a coordinator is available office hours Monday-Friday	Pay as you go, variety of payment methods. Funding from Public Health Healthy You Project and the new 'strength and balance activities' project.	Lauren Bremner	lbremner@fenland.gov.uk

Appendix 13 – Community Falls Prevention pathway



Appendix 14 – Gap analyses from organisations

1) Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)

CPFT Falls Prevention Gap Anal

2) Healthy You

Healthy You Falls Prevention Gap Anal

3) Cambridge University Hospital NHS Foundation Trust (CUHFT)

CUHFT falls prevention gap analy

4) North West Anglia Foundation Trust (NWAFT)

NWAFT Falls Prevention Gap Anal

Agenda Item No: 8

Public Health Risk Report

To:	Adults and Health Committee
Meeting Date:	14 December 2023
From:	Executive Director: Public Health
Electoral division(s):	All
Key decision:	No
Forward Plan ref:	N/A
Outcome:	Committee are briefed on the risks in relation to public health.
Recommendation:	Adults and Health Committee are recommended to note the Public Health risk registers.

Officer contact: Anthony Griggs
Name:Anthony Griggs
Post: Public Health Operations Manager
Email: Anthony.Griggs@Cambridgeshire.gov.uk
Tel: 07443 147448

1. Background

1.1 It is a requirement to present the risk reports to Committee regularly throughout the year and recommended that public health risks and adult risks are brought to alternating committees to allow for appropriate scrutiny of each risk register. This report focuses on public health risks.

2. Main Issues

2.1 The Cambridgeshire County Council has a clear and approved Risk Management framework, policy and procedures which set out the key aspects of identifying, assessing and mitigating risks for the Council which includes:

- Rating of risks are based upon their probability and their impact from a scale of 1-5 (5 being the highest level of concern) and multiplied to gain a risk score.

- Impact of risks are scored against five categories:
    - Legal and Regulatory
    - Financial
    - Service Provision
    - People and Safeguarding
    - Reputation

- The Council tolerable level of risk is set at 16, where all risks of 16 or above will be escalated for further action / decision as required. This could mean; accepting the risk rating at that time; applying additional mitigating actions and/or other actions to lower the risk level as appropriate.

2.2 The Public Health Services Directorate risk register can be found as Appendix 1. There are currently 8 risks with all risks being rated as amber. There are currently no green or red risks on the public health risk log.

3. Alignment with ambitions

3.1 Net zero carbon emissions for Cambridgeshire by 2045, and our communities and natural environment are supported to adapt and thrive as the climate changes.

There are no significant implications for this ambition.

3.2 Travel across the county is safer and more environmentally sustainable.

There are no significant implications for this ambition.

3.3 Health inequalities are reduced.

Appendix 1 sets out the implications for this ambition.

3.4 People enjoy healthy, safe, and independent lives through timely support that is most suited to their needs.

Appendix 1 sets out the implications for this ambition.

3.5 Helping people out of poverty and income inequality.

There are no significant implications for this ambition.

3.6 Places and communities prosper because they have a resilient and inclusive economy, access to good quality public services and social justice is prioritised.

There are no significant implications for this ambition.

3.7 Children and young people have opportunities to thrive.

There are no significant implications for this ambition.

4. Significant Implications

4.1 Resource Implications
There are potential implications which will continue to be monitored as part of business as usual.

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications
Any related procurement activity will be compliant with the Council's Contract Procedure Rules

4.3 Statutory, Legal and Risk Implications
Appendix 1 sets out the implications.

4.4 Equality and Diversity Implications
There are no significant implications for this priority.

4.5 Engagement and Communications Implications
There are no significant implications for this priority.

4.6 Localism and Local Member Involvement
There are no significant implications for this priority.

4.7 Public Health Implications
Appendix 1 sets out the implications.

4.8 Climate Change and Environment Implications on Priority Areas (See further guidance in Appendix 1): There are no significant implications for this priority.

4.8.1 Implication 1: Energy efficient, low carbon buildings.
Positive/neutral/negative Status:
Explanation: No items in the public health risk log relate to this implication

4.8.2 Implication 2: Low carbon transport.
Positive/neutral/negative Status:
Explanation: No items in the public health risk log relate to this implication

4.8.3 Implication 3: Green spaces, peatland, afforestation, habitats and land management.
Positive/neutral/negative Status:
Explanation: No items in the public health risk log relate to this implication

4.8.4 Implication 4: Waste Management and Tackling Plastic Pollution.
Positive/neutral/negative Status:
Explanation: No items in the public health risk log relate to this implication

4.8.5 Implication 5: Water use, availability and management:
Positive/neutral/negative Status:
Explanation: No items in the public health risk log relate to this implication

4.8.6 Implication 6: Air Pollution.
Positive/neutral/negative Status:
Explanation: No items in the public health risk log relate to this implication

4.8.7 Implication 7: Resilience of our services and infrastructure, and supporting vulnerable people to cope with climate change.
Positive/neutral/negative Status:
Explanation: No items in the public health risk log relate to this implication

Have the resource implications been cleared by Finance? N/A Information Item

Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the Head of Procurement and Commercial? N/A Information Item

Has the impact on statutory, legal and risk implications been cleared by the Council's Monitoring Officer or Pathfinder Legal? N/A Information Item

Have the equality and diversity implications been cleared by your EqIA Super User?
N/A Information Item

Have any engagement and communication implications been cleared by Communications?
N/A Information Item

Have any localism and Local Member involvement issues been cleared by your Service Contact? N/A Information Item

Have any Public Health implications been cleared by Public Health?
N/A Information Item

If a Key decision, have any Climate Change and Environment implications been cleared by the Climate Change Officer?
N/A Information Item

5. Source documents guidance

5.1 Source documents

None

APPENDIX 1 – Public Health Risk Log – November 2023

The below table outlines how risks are scored on the likelihood and impact of each risk. Scores between 1-4 are green, 5-15 are amber, and 16 or over is above the Council's tolerable level and will be highlighted as a high red risk.

VERY HIGH	5	10	15	20	25
HIGH	4	8	12	16	20
MEDIUM	3	6	9	12	15
LOW	2	4	6	8	10
NEGLIGIBLE	1	2	3	4	5
IMPACT LIKELIHOOD	VERY RARE	UNLIKELY	POSSIBLE	LIKELY	VERY LIKELY

Public Health Matrix of Risks:

The below matrix provides an overview of the current risk scores for all risks relating to Adults Services. The letters indicate which risk it relates too. These risks are explored in more detail in the table below.

VERY HIGH 5		FGHI			
HIGH 4			BD		
MEDIUM 3			C	AE	
LOW 2					
NEGLIABLE 1					
IMPACT LIKELIHOOD	1 VERY RARE	2 UNLIKELY	3 POSSIBLE	4 LIKELY	5 VERY LIKELY

The Risk	**A. Insufficient resources to maintain service levels**
OWNER	Executive Director Public Health: Jyoti Atri
RAG:	Likelihood = 4
	Impact = 3
	Score = 12
	Direction of Risk: Steady
Triggers:	• Future Public Health grant allocations are insufficient to cover inflationary pressures. • Insufficient internal staffing capacity to meet current service levels and ambitions of the health and wellbeing strategy. • In ability to sustain current staffing due to ending of short-term grant funding or cessation of externally funded posts. • Increase in reserves could lead to reduction in future grant allocations.
Potential consequences	• Worse health outcomes for service users if there is a reduction in services offered due to insufficient funding. • Population health outcomes do not improve and potentially worsen • Additional pressures on the wider health and social care system. • Health inequalities are not reduced and could widen further.
Controls	• Ongoing prioritisation exercises based on clear evidence-based criteria to assess current service provision. • Working with partner organisations to maximise the value of service provision. • Active management of reserve spends to reduce the risk of significant underspend. • Planning underway for a process to strengthen the workforce to support the delivery of plans. • Working with service providers to identify more efficient service delivery, e.g., hybrid/digital delivery models, revised skill mix.
Contingency plans	• Further prioritisation of services based on clear evidence-based criteria if there is a need to review service provision due to a lack of funding or other resource. • Seek further efficiencies through alternative delivery methods. • Contingency spending plans.
Date Risk Reviewed	10/11/2023

The Risk	**B. There is a risk of increasingly diverse needs across the populations and local authorities of Cambridgeshire and Peterborough.**
OWNER	Executive Director Public Health: Jyoti Atri
RAG:	Likelihood = 3
	Impact = 4
	Score = 12
	Direction of Risk: Increasing
Triggers:	• Separation of key shared operational services (i.e., IT). • Further changes in key process areas required for operational delivery (i.e., finance, legal, procurement etc). • Different commissioning decisions are reached by the two authorities. • Increasingly diverse population needs across Cambridgeshire and Peterborough.
Potential consequences	• An increase in staffing hours spent on operational management/issues. • Difficulties/delays in specific areas i.e., recruitment, procurement etc. • Loss of efficiencies that were previously gained through collaborative working across the local authorities. • Loss of economies of scale in commissioning.
Controls	• Clarifying and establishing alternative processes for collaborative working with regard to shared posts, and joint commissioning. • Planning underway for a process to strengthen the workforce to meet the diverse needs across Cambridgeshire and Peterborough.
Contingency plans	• Adaptions to service delivery where appropriate. • Forward planning to identify potential risks.
Date Risk Reviewed	10/11/2023

The Risk	**C. There is a risk of barriers to sufficient systemwide collaboration on public health.**
OWNER	Executive Director Public Health: Jyoti Atri
RAG:	Likelihood = 3
	Impact = 3
	Score = 9
	Direction of Risk: Steady
Triggers:	• Lack of clear roles and responsibilities. • Complex multilateral agreements with unclear governance pathways. • Challenging finances across the system lead to a retraction of preventative investments.
Potential consequences	• Worse population health outcomes. • Opportunities for prevention are missed leading to escalating need for health and social care. • Resources are not used efficiently. • Longer waiting times for services.
Controls	• Ongoing work to produce MOUs to clarify roles and responsibilities between the local auhtority and partner organisations. • Participation in system-wide boards and groups to promote public health as a system priority and support the wider work of the healthcare system. • Planning underway for a process to strengthen the workforce to support the delivery of plans with capacity to support partnership working and system leadership.
Contingency plans	• Refocus capacity towards system leadership to ensure system resources are maximised for improving health outcomes, prevention and reducing inequalities.
Date Risk Reviewed	10/11/2023

The Risk	**D. There is a risk that the council and partnership response to future outbreaks/pandemics (including new variants of Covid-19) of infectious disease will be insufficient.**
OWNER	Executive Director Public Health: Jyoti Atri
RAG:	Likelihood = 3
	Impact = 4
	Score = 12
	Direction of Risk: Steady
Triggers:	• Insufficient comprehensive CPLRF lessons learnt process is conducted. • Insufficient national steer as to the expectations of local authorities regarding health protection moving forward. • Insufficient system resilience and public health/system resource to respond to a future outbreak.
Potential consequences	• Worse health outcomes for the population of Cambridgeshire if another outbreak of a pandemic pathogen occurs. • Avoidable morbidity and mortality occurs. • Increased pressure on the wider health and social care system, and other partner organisations who would be affected.
Controls	• Support for and participation in CPLRF lessons learned exercises. • Allocation of resource for resilience measures, such as FFP3 fit testing capacity. • Participation in system-wide planning exercises. • CPLRF lessons learned process ongoing.
Contingency plans	• Development of an MOU with UKHSA • Development of a pandemic plan and prolonged incident plan
Date Risk Reviewed	10/11/2023

The Risk	**E. There is a risk that system staffing capacity will be insufficient to implement or maintain commissioned services.**
OWNER	Executive Director Public Health: Jyoti Atri
RAG:	Likelihood = 4
	Impact = 3
	Score = 12
	Direction of Risk: Steady
Triggers:	• Lack of skilled workforce in general within the system. • Lack of specific workforce cohorts creates competition amongst services with workers attracted to organisations that can pay higher salaries. • Short-term grant funding streams making job offers less attractive and causes fluctuating staffing resource.
Potential consequences	• Provider services cannot deliver the services commissioned or meet mandatory targets. • Waiting times increase for services • Delays in implementing new services due to staffing shortages.
Controls	• Skill-mix workforce modelling to promote the availability of necessary staff skill mixes to implement and maintain services. • Reviewing service delivery such as digital or hybrid offers to reduce staffing capacity required for service delivery.
Contingency plans	• Work with providers on a case-by-case basis to support service delivery where issues arise.
Date Risk Reviewed	10/11/2023

The Risk	**F. There is a risk of data breach or similar event could take place in the event of a lack of sufficient Information governance controls.**
OWNER	Executive Director Public Health: Jyoti Atri
RAG:	Likelihood = 2
	Impact = 5
	Score = 10
	Direction of Risk: Steady
Triggers:	• Increasing complexity of data sharing given integration across the system increases the risk of poor compliance with good information governance principles and increases monitoring requirements. • Increased complexity of data storage options places a greater burden on commissioned providers, requiring high levels of IT capability. This increases risks of data breaches for services who may lack specialist internal IT expertise/capacity. • Smaller/third sector providers having insufficient resource to properly understand/implement the necessary data management controls. • Insufficient staff training in proper information governance practices and principles.
Potential consequences	• Breach of client/patient confidentiality. Financial penalties in the event of data breach. • Lack of access to the data required to inform the work of the Public Health Directorate. • Reduced levels of trust in the public health directorate and the local authority more generally.
Controls	• Discussions with ICS/NHS partners to secure robust and comprehensive data sharing agreements moving forward. • Ensure that data storage is compliant with source organisations IG rules and find solutions where current IT solution is not viable. • Ensure all provider contracts contain adequate data protection clauses and clear data sharing agreements which are monitored through contract processes. • Ongoing review of data storage and the data held by public health to ensure compliance with appropriate regulations.
Contingency plans	• Respond to any incidents that occur in a timely fashion and using the proper guidelines and process that are outlined by the data management team.
Date Risk Reviewed	10/11/2023

The Risk	**G. There is a risk of liability for injury or other serious incident for service users in services commissioned or otherwise organised by the Public Health Directorate**
OWNER	Executive Director Public Health: Jyoti Atri
RAG:	Likelihood = 2
	Impact = 5
	Score = 10
	Direction of Risk: Steady
Triggers:	• Insufficient risk assessment/health and safety procedures in place to ensure preventable incidents do not occur. • Insufficient communication between Public Health and commissioned services on appropriate health and safety arrangements.
Potential consequences	• Potential harm to service users • Financial/legal liability. • Reputational damage.
Controls	• Ongoing review by senior commissioning leads to review the health and safety practices that are in place, and to create a more streamlined process by which services can report health and safety incidents. • Improved reporting of incidents, complaints, quality improvement plans to public health via the Public Health Commissioning Governance Group. • Review of prescribing in commissioned services • Directorate health and safety group formed as part of the wider local authority system for responding to health and safety incidents, and to implement an effective lesson learned process. • Training being delivered to commissioning managers to provide a better understanding of health and safety legislation, implementation of health and safety requirements as part of an effective procurement process, and effective ongoing review as part of the ongoing contract management process.
Contingency plans	• Respond to any incidents that occur in a timely fashion and using the proper guidelines, mechanisms and processes that are outlined by the health and safety team.
Date Risk Reviewed	01/11/2023

The Risk	**H. There is a risk of contract failure in our commissioned services**
OWNER	Executive Director Public Health: Jyoti Atri
RAG:	Likelihood = 2
	Impact = 5
	Score = 10
	Direction of Risk: Steady
Triggers:	• Significant inflationary pressures, especially in areas such as energy costs (estates & travel) and NHS pay awards. • Provider failure due to inability to recruit an appropriately trained workforce. • Insufficient contract management systems in place for jointly commissioned services. • Insufficient PH grant funding or other factors which prevent adjustment to deal with inflationary pressures. • Insufficient capacity within the public health team to appropriately manage commissioned services.
Potential consequences	• Worse health outcomes from loss of access to services. • Additional pressure on the wider health and social care system.
Controls	• Ongoing contract management processes to promote early identification of any potential contract failures. • Where appropriate, using larger well established system providers to reduce the risk of contract failure.
Contingency plans	• Implementation of a contingency plan will take place on a case-by-case basis due to the wide variation in types and criticality of commissioned services, supported by appropriate business continuity plans.
Date Risk Reviewed	01/11/2023

The Risk	**I. Risk of poor commissioning governance**
OWNER	Executive Director Public Health: Jyoti Atri
RAG:	Likelihood = 2
	Impact = 5
	Score = 10
	Direction of Risk: Steady
Triggers:	• Insufficient workforce capacity and /or skills to undertake more specialist procurement and audit functions • Insufficient internal Directorate skills to undertake clinical audit of commissioned services
Potential consequences	• Potential lack of identification of lack of value for money and quality of services not maximised. • Clinical risk could impact on service user outcomes. • Reputational risks associated with poor service user outcomes.
Controls	• Review of all contracts to ensure that they include all necessary clauses for financial, service, and clinical audit • Strengthening of contract management of commissioned services • Secure capacity and support from specialist officers from Procurement and Audit Teams
Contingency Plans	• All staff in the Directorate with commissioning responsibilities to complete all internal related training and external training at an appropriate level for key specialist areas. • Secure support through a flexible contractual arrangement with a clinical specialist to provide clinical input to commissioned services as required.
Date risk reviewed	12/11/23

Finance Monitoring Report – October 2023

To:	Adults and Health Committee
Meeting Date:	14 December 2023
From:	Executive Director: Adults, Health & Commissioning Executive Director: Public Health Executive Director: Finance and Resources
Electoral division(s):	All
Key decision:	No
Forward Plan ref:	N/A
Outcome:	The committee should have considered the financial position of services within its remit as at the end of October 2023.
Recommendation:	Adults and Health Committee is recommended to note the Adults, Health and Commissioning and Public Health Finance Monitoring Report as at the end of October 2023.

Officer contact:
Name: Justine Hartley
Post: Strategic Finance Manager
Email: justine.hartley@cambridgeshire.gov.uk

1. Background

1.1 Finance Monitoring Reports (FMR) are produced monthly, except for April, by all services. They report on a range of financial information to enable a view of each service's financial position to be taken.

1.2 Budgets for services are agreed by Full Council in the business plan in February of each year and can be amended by budget virements. In particular, the FMR provides a revenue budget forecast showing the current projection of whether services will be over- or under-spent for the year against those budgets.

1.3 The presentation of the FMR enables Members to review and comment on the financial position of services within the committee's remit.

1.4 Generally, the FMR forecasts explain the overall financial position of each service and the key drivers of any budget variance, rather than explaining changes in forecast month-by-month.

1.5 The contents page of the FMR shows the key sections of the report. In reviewing the financial position of services, members of this committee may wish to focus on these sections:

- Section 1 – providing a summary table for services that are the responsibility of this committee and setting out the significant financial issues (replicated below).
- Section 5 – the key activity data for Adult Services provides information about service-user numbers and unit costs, which are principle drivers of the financial position
- Appendices 1-3 – these set out the detailed financial position by service and provide a detailed commentary for services projecting a significant variance from budget.
- Appendix 4 – this sets out the savings for Adults, Health and Commissioning and Public Health in the 2023/24 business plan, and savings not achieved and brought forward from previous years that are still thought to be deliverable.
- Appendix 5 – contains information on earmarked reserves, grant income and budget virements.

2. Main Issues

2.1 The FMR provides summaries and detailed explanations of the financial position of Adults, Health and Commissioning and Public Health services. At the end of October, Adults, Health and Commissioning has an underlying forecast of £1.1m overspend mainly driven by movements in the numbers of older adults placed into bed-based care. However, work to review the usage of grants across Adult Social Care has released grant funding to support these emerging pressures, reducing the net forecast position to an underspend of £365k. Public Health, excluding Children's Public Health, is forecasting an underspend of 2% of budget (£621k). Headline figures are set out in the tables below:

Table 1: Adults Health and Commissioning position

Forecast Outturn Variance (Previous) £000	Directorate	Gross Budget £000	Income Budget £000	Net Budget £000	Actual £000	Forecast Outturn Variance £000	Forecast Outturn Variance %
2,462	Adults, Health and Commissioning	343,526	-129,830	213,696	123,343	1,066	0.5%
2,462	**Total Expenditure**	**343,526**	**-129,830**	**213,696**	**123,343**	**1,066**	**0.5%**
-2,517	Mitigations	0	0	0	0	-1,431	0.0%
-55	**Total**	**343,526**	**-129,830**	**213,696**	**123,343**	**-365**	**0.2%**

Table 2: Public Health position

Forecast Outturn Variance (Previous) £000	Directorate	Gross Budget £000	Income Budget £000	Net Budget £000	Actual £000	Forecast Outturn Variance £000	Forecast Outturn Variance %
0	Public Health - Children	14,631	-4,150	10,481	5,574	-31	0.3%
-412	Public Health	30,183	-37,437	-7,254	-13,983	-621	-2.1%
-412	**Total Expenditure**	**44,814**	**-41,587**	**3,227**	**-8,409**	**-652**	**-1.5%**
0	Drawdown from reserves	-3,227	0	-3,227	-674	0	0.0%
-412	**Total**	**41,587**	**-41,587**	**0**	**-9,084**	**-652**	**-1.6%**

2.2 Public Health reserves

2.2.1 The Public Health reserve balance at the end of October 2023 stood at £6.64m. Further details of the breakdown of Public Health reserves is set out in Appendix 5 of the FMR report, section 5.3.2. Of this balance, £5.93m was committed to specific projects, and £709k was uncommitted.

2.2.2 The Council's Public Health team have been reviewing the potential usage of the uncommitted reserves and put forward to Strategy, Resources and Partnership Committee the following proposals for work to reduce health inequalities and help the pandemic recovery:

Table 3: Proposed Public Health reserves usage

Reserve usage	Total Cost
1. School based interventions to address obesity	£389,000
2. Tackling childhood anxiety	£320,000

2.2.3 Further detail on these areas is set out below:

1. School based interventions to address obesity

   Obesity is considered to be the most pressing public health challenge. There is robust data collected through the annual National Child Weight Measurement Programme (NCMP) that measures reception (5/6 year) and year 6 (10/11 years) children in maintained schools. For over two decades rates of childhood obesity have increased and stagnated at a high level. The COVID-19 pandemic exacerbated these high rates especially amongst year 6 children, with around a third either overweight or obese.

   During the past two years in Cambridgeshire, we provided funding for piloting primary school-based interventions to address low levels of physical activity and poor nutrition. Additional COMF funding has been secured to build on this pilot work because of the impact that the Covid-19 pandemic has had on childhood obesity, which is one of criteria for allocating the Fund. There is increasing evidence that incentives have a role in behaviour change at an individual but also at an organisational level. The proposal for use of Public Health reserves is that an incentive payment is made to schools where their projects/interventions have evaluated positively in terms of changing the school environment, pupil and staff behaviour change. The aim is to increase engagement but also encourage and support schools to embed and sustain their projects without ongoing funding.

2. Tackling childhood anxiety

   A whole school approach and holistic model to address and prevent anxiety and to support children, young people, school teachers and parents to tackle anxiety and other mental health related issues. The funds will be primarily focused to support the schools in Cambridgeshire that do not currently benefit from having mental health support teams (157 out of 285 schools do not have an MHST allocated). This is approximately 60% of Cambridgeshire schools. However, it is also expected that some of the funds will be spent to provide specific and extra support to the schools that do have mental health support teams to add additional resource where needed.

   The funds will buy expert resources in terms of employing trained specialists to work in and with schools to design and deliver tiered programmes of activity working with CYP, teachers and parents with evidence-based interventions that are known to address anxiety.

2.2.4 This will fully commit the current Public Health reserve balance.

2.3 Debt position

2.3.1 The following position on debt as at the end of October 2023 for Adults, Health and Commissioning and Public Health was reported to Audit and Accounts Committee in early December. NHS debt has been included because this largely relates to Adult Social Care:

Table 4: Overall Age Debt Position - By Directorate

	Overdue			Trend Performance	
Directorate	**Current Month**	**Previous Month**	**Last Year**	**Monthly**	**Yearly**
NHS Services	£5,693,195	£3,808,493	£7,020,506		
Adults, Health & Commissioning	£18,843,256	£19,223,587	£15,199,443		
Public Health	£11,472	£11,472	-£80,546		
Grand Total	**£24,547,923**	**£23,043,552**	**£22,139,493**		

Table 5: ASC Age Debt Analysis

Overall Age Debt by - Debt Status
[Include monthly / Annual Trend Analysis - Movement on Overdue]

									Overdue			Trend Performance	
Debt Status	**Current**	**1-30**	**31-90**	**91-183**	**184-365**	**366-730**	**730+**	**Grand Total**	**Current Month**	**Previous Month**	**Last Year**	**Monthly**	**Yearly**
Automated Dunning Cycle	£77	£445,642	£404,243	£5,076	£6,186	£3,363	£0	£864,588	£864,511	£1,245,797	£4,018	↑	↓
Awaiting Appointee / Court of Protection / Power of Attorney	£292,936	£232,134	£484,587	£859,005	£1,261,750	£1,526,364	£583,213	£5,239,989	£4,947,053	£4,649,074	£3,029,374	↓	↓
Awaiting Service Response	£52,053	£77,441	£202,215	£465,903	£448,598	£792,446	£396,389	£2,435,044	£2,382,991	£2,236,938	£1,238,106	↓	↓
DCA Action - Ongoing	£0	£0	£0	£0	£0	£5,709	£29,498	£35,207	£35,207	£42,877	£0	↑	→
Debt Team Dealing	£0	£20,601	£538,027	£621,624	£496,030	£402,924	£392,785	£2,471,991	£2,471,991	£2,287,216	£4,881,419	↓	↑
Deceased - Pending Probate / Settlement of Account	£166,534	£140,992	£327,615	£874,818	£1,078,046	£1,332,139	£1,703,989	£5,624,132	£5,457,598	£5,480,993	£4,183,939	→	↓
Full Cost Non-Disclosure	£0	£0	£12,659	£27,331	£32,929	£100,253	£117,767	£290,940	£290,940	£290,940	£153,620	→	↓
Income Team Dealing	-£69,301	-£74,707	£122,507	£225,827	£216,574	£281,664	£39,912	£742,474	£811,776	£1,315,695	£249,098	↑	↓
Legal Action - Ongoing	£0	£0	£3,922	£14,598	£27,633	£48,713	£365,346	£460,211	£460,211	£460,211	£381,918	→	↓
Payment Plan	£1,171	£2,179	£12,496	£36,255	£60,935	£117,348	£334,878	£565,262	£564,091	£564,798	£515,446	→	↓
Pending Write-off	£0	£2,615	£3,004	£5,748	£3,581	£17,686	£97,697	£130,332	£130,332	£110,042	£173,969	↓	↑
Pre-Dunning Cycle	£3,044,093	£277,148	£2,011	£0	£0	£0	£0	£3,323,251	£279,158	£391,610	£0	↑	→
Secured Property Charge	£0	£0	£0	£0	£2,428	£10,827	£134,141	£147,396	£147,396	£147,396	£388,536	→	↑
Grand Total	**£3,487,561**	**£1,124,044**	**£2,113,285**	**£3,136,186**	**£3,634,690**	**£4,639,436**	**£4,195,615**	**£22,330,817**	**£18,843,256**	**£19,223,587**	**£15,199,443**		

Key Highlights

ASC has seen a £3.6m increase over the last twelve months across all age brackets, with £1.9m relating to aged debts that are more than a year old. In the main the increase is across four key areas as shown below:

- £1.9m increase in debts awaiting Court of Protection (COP) – These debts are where Service Users have lost capacity to manage their financial affairs and applications are made to the COP for a family member, Advocate or the council through Client Funds to take over responsibility for property and affairs decisions. The Council has seen a significant increase in the time that such applications are completed from 16 weeks to 9 months or more. This problem is not specific to the Council and is a national problem.
- £1.1m increase in debts requiring support from ASC – Due to the vulnerable nature of the customer base these debts can be quite complex in some cases. Debts are likely to be overstated where customer is initially assessed as 'Full Cost' and then reassessed (as a result of a change in circumstances or where a customer had not previously engaged with the Council's financial assessment process) resulting in a lower contribution and therefore a reduction in debt.
- £563k increase in respect of queries being managed by the Income Team, where investigations are ongoing in respect of customers who have advised payment has been made. Payment allocation difficulties can be caused where customer do not provide enough details of the service they are paying for.

2.3.2 Through the business planning process, the Corporate Leadership Team commissioned a Deep Dive on Adult Social Care debt and client contributions. This has resulted in a Debt Management Improvement Plan with initiatives assigned to the corporate Finance Operations services as well as Adult Social Care teams, particularly Financial Assessments. Improvements in the following areas have been identified:

2.3.3 Financial Assessments

Reduce backlogs through service improvement actions, which will support a reduction in debt and improved income collection.

Implement operational deep dives to review process and technology for improvements to efficiency and effectiveness.

Continue to recruit to reach full establishment, with two new starters in August, and one further role to recruit to.

2.3.4 Improve digitalisation

Implement an online Portal within Financial Assessments to improve efficiency and possible automation.

Explore the use of Mosaic as core billing system or improved interfaces, which will require a full review of business processes and any operational risks from such a change.

Channel shift customers to preferred methods of payment where Direct Debit would be the most effective method of payment.

Increase paperless billing and reminders to improve customer experience and reduce operational costs through better use of technology.

2.3.5 Debt Team

Perform a review of the current operating target model, identifying and implementing improvements that will increase revenue streams for the council. Work has already commenced with the recruitment of a Strategic Exchequer Manager which came into effect on the 6 November 2023. This role will oversee the Debt team, the Deep Dive and implement key improvement activity, including:

- Lead the provision of sound income collection and recovery strategies and technical guidance, both internal to and external to Financial Operations and develop effective relationships with appropriate national bodies and other local authorities, to inform and enhance the quality of the work of the post-holder's team.

- Work collaboratively with other service areas, on projects and programmes that support developments/improvements for the Debt and Income Service in a professional and positive way. To facilitate the execution of the Council’s Use of Resources and Value for Money strategies by providing Income and recovery support, analysis, and interpretation.

- Ensuring that the service delivers long-term positive outcomes locally for people and communities. Build and promote successful partnership working across all sectors and with service users to deliver more cost effective and valued services. Ensuring that the needs of service users are met by demonstrating behaviour which fosters equality of opportunity in service provision and employment.

2.3.6 The Deep Dive will be run as a formal project with senior sponsorship by an Executive Director. Standard project governance will be adopted. A high-level update on progress will be provided at future meetings.

3. Alignment with ambitions

3.1 Net zero carbon emissions for Cambridgeshire by 2045, and our communities and natural environment are supported to adapt and thrive as the climate changes

There are no significant implications for this ambition.

3.2 Travel across the county is safer and more environmentally sustainable

There are no significant implications for this ambition.

3.3 Health inequalities are reduced

The overall financial position of the Public Health directorate underpins this ambition and elements of both Public Health reserve and grant spend have been committed to projects which seek to reduce health inequalities.

3.4 People enjoy healthy, safe, and independent lives through timely support that is most suited to their needs

The overall financial position of the Adults, Health and Commissioning and Public Health directorates underpin this ambition.

3.5 Helping people out of poverty and income inequality

Public Health grant and reserve spend in 2023/24 is helping fund work undertaken to address this ambition.

3.6 Places and communities prosper because they have a resilient and inclusive economy, access to good quality public services and social justice is prioritised

There are no significant implications for this ambition.

3.7 Children and young people have opportunities to thrive

There are no significant implications for this ambition.

4. Source documents guidance

4.1 Source documents

Finance Monitoring Reports are produced monthly, except for April, for all of the Council's services. These are uploaded regularly to the website below.

4.2 Location

Finance and performance reports - Cambridgeshire County Council

Appendix 1: Adults, Health and Commissioning and Public Health Finance Monitoring Report October 2023

See separate document

Service: Adults, Health and Commissioning and Public Health
Subject: Finance Monitoring Report – October 2023/24
Date: 13th November 2023

Contents

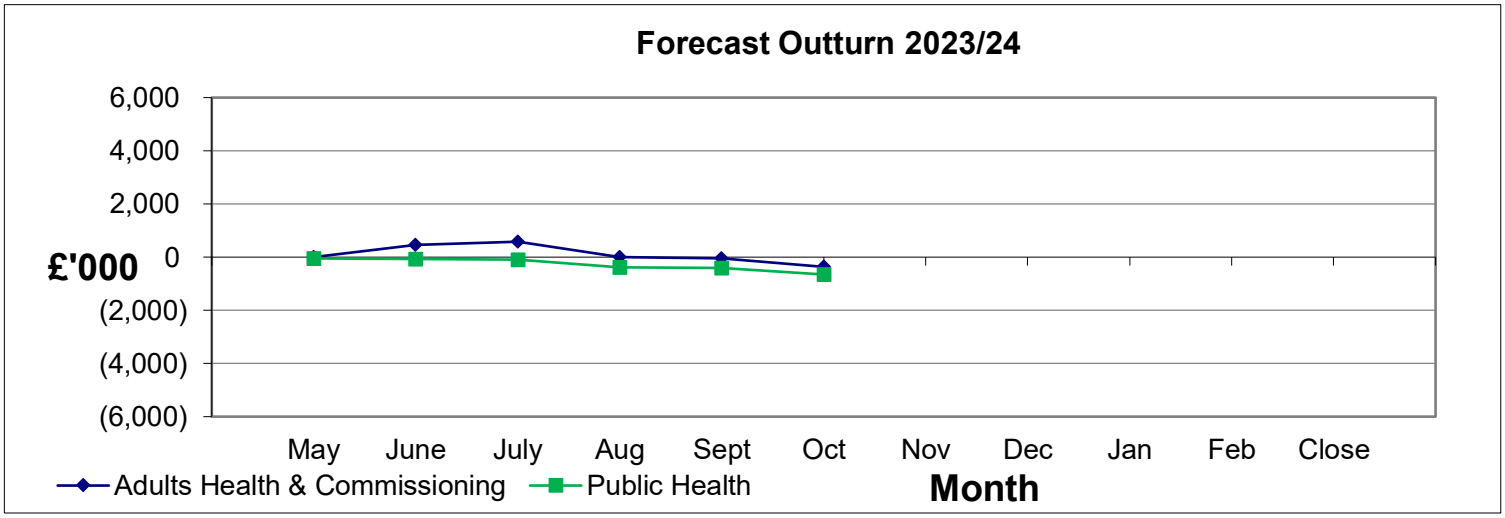
Section	Item	Description
1	Revenue Executive Summary	High level summary of information and narrative on key issues in revenue financial position
2	Capital Executive Summary	Summary of the position of the Capital programme within Adults, Health and Commissioning and Public Health
3	Savings Tracker Summary	Summary of the latest position on delivery of savings
4	Technical Note	Explanation of technical items that are included in some reports
5	Key Activity Data	Performance information linking to financial position of main demand-led services
Appx 1a	Service Level Financial Information	Detailed financial tables for Adults, Health and Commissioning main budget headings
Appx 1b	Service Level Financial Information	Detailed financial tables for Public Health main budget headings
Appx 2	Service Commentaries	Detailed notes on revenue financial position of services that have a significant variance against budget
Appx 3	Capital Appendix	This contains more detailed information about the capital programme, including funding sources and variances from planned spend.
Appx 4	Savings Tracker	Each quarter, the Council's savings tracker is produced to give an update of the position of savings agreed in the Business Plan.
Appx 5	Technical Appendix	Each quarter this contains technical financial information showing: Earmarked reserves Grant income received Budget virements

1. Revenue Executive Summary

1.1 Overall Position

At the end of October 2023, Adults, Health and Commissioning is projected to deliver a small forecast underspend of £365k. This masks significant underlying pressures of £1.4m, although these have reduced from previous months. Pressures are being offset by grant funding in 2023/24, but much of this is one off and so pressures will be carried forward into future years. Public Health is projected to be £652k underspent.

1.2 Summary of Revenue position by Directorate



1.2.1 Adults, Health and Commissioning

Forecast Outturn Variance (Previous) £000	Directorate	Gross Budget £000	Income Budget £000	Net Budget £000	Actual £000	Forecast Outturn Variance £000	Forecast Outturn Variance %
2,462	Adults, Health and Commissioning	343,526	-129,830	213,696	123,343	1,066	0.5%
2,462	**Total Expenditure**	**343,526**	**-129,830**	**213,696**	**123,343**	**1,066**	**0.5%**
-2,517	Mitigations	0	0	0	0	-1,431	0.0%
-55	**Total**	**343,526**	**-129,830**	**213,696**	**123,343**	**-365**	**0.2%**

1.2.2 Public Health

Forecast Outturn Variance (Previous) £000	Directorate	Gross Budget £000	Income Budget £000	Net Budget £000	Actual £000	Forecast Outturn Variance £000	Forecast Outturn Variance %
0	Public Health - Children	14,631	-4,150	10,481	5,574	-31	0.3%
-412	Public Health	30,183	-37,437	-7,254	-13,983	-621	-2.1%
-412	**Total Expenditure**	**44,814**	**-41,587**	**3,227**	**-8,409**	**-652**	**-1.5%**
0	Drawdown from reserves	-3,227	0	-3,227	-674	0	0.0%
-412	**Total**	**41,587**	**-41,587**	**0**	**-9,084**	**-652**	**-1.6%**

1.3 Significant Issues

1.3.1 Adults, Health and Commissioning

The overall position for Adults, Health and Commissioning at the end of October 2023 is a small forecast underspend of £365k (0.2% of budget). This masks underlying pressures of £1.2m on care and support costs. However, this is a significant improvement on the position reported in September, largely due to increased expectations around client contributions to care costs. This is an ongoing volatile position with some high-cost packages which can change the forecast quickly. As a result, close attention is paid to changes in demand and costs and income as the year progresses and forecasts are adjusted accordingly.

The current in year pressures are mainly driven by movements in the net numbers of older adults supported in bed-based care. In the years immediately following the covid pandemic we had seen reduced numbers of net placements into care settings, for Older Adults, compared to pre pandemic levels. As such it has proven more challenging to use historical trends to forecast future demand and activity. Net placements during 2023/24 have been rising once more and exceeding forecast numbers built into our budget for 2023/24. Mitigations through the application of grants are in place for 2023/24, but much of this funding is one off and will not be available in 2024/25. Therefore, the current increases in net care placements will lead to continuing pressures in the years ahead as the full year effect of current year increases is seen.

Further mitigating actions involve a review of those people in receipt of services in areas where the overspend is reported, to ensure forecasts for the remainder of the year for both expenditure and income reflect planned activity. There is also a deep dive review of domiciliary care, along with the use of bed-based care against the forecast budget, in particular for discharges from hospital to ensure the correct pathways are being maximised.

The legacy of Covid is still being felt, and impact on Adult Social Care is not fully understood, on demand for our broad range of services, as well as with capacity of providers to deliver our requirements and continue to provide support to markets. Adult Social Care continues to feel the consequences of paused work and backlog on teams, and of reviews and assessments, changing demographics projections and the demand for services. The care market also manages the impact with both resident population and staff recruitment and retention a factor.

Whilst there has been significant investment into the care sector, primarily through Adult Social Care Market Sustainability and Improvement Fund which has helped, the whole adult social care market remains fragile to other factors that may impact on it. Care providers are continuing to report cost pressures related to both workforce issues and the current cost of living crisis. The position of the care market, particularly around specific types of provision and location, is making some placements more difficult to source, particularly at the more complex end of provision.

Hospital Discharge systems continue to be pressured to manage flows and demand on their services, with a subsequent focus on timely, safe and effective discharges into the correct pathways; although additional funding has been provided to both the Council and wider partners to help address these issues. The long-term legacy of the impact of the pandemic remains unclear and the implications this has on future demand for services, greater need for community support due to backlogs in elective surgery, and the availability of a skilled and experienced workforce and the wider health inequalities on our communities.

The budget for 2022/23 assumed an increased contribution from the NHS towards Learning Disability packages reflecting a shift in the percentage of packages that should be funded from Health budgets. For the current financial year we have made provision for this increased contribution, but the joint project between the ICB and CCC to review those packages required to agree a revised split of costs going forwards for the pool did not proceed as expected. The Council has now served notice to end the cost sharing arrangements of the pooled budget. There is a risk of short term financial pressures from this decoupling as we move to separate budgets for health and social care.

Adult social care debt (excluding debt with Health partners) stood at £18.8m at the end of October, down from £19.2m at the end of September. Actions being taken following a recent deep dive into some of the factors resulting in the levels of debt, along with additional resources to work on backlogs of financial assessments, are starting to see a positive impact on the current figures. However, debt over 90 days old remained at £15.6m at the end of October which is little changed from the £15.5m balance at the end of August. The level of aged debt has a knock-on impact on the bad debt provision and likelihood of write offs.

1.3.2 Significant Issues – Public Health

At the end of October 2023, the Public Health Directorate is forecasting an underspend of £652k (1.6%).

The Public Health Directorate is funded wholly by ringfenced grants, mainly the Public Health Grant. The work of the Directorate was severely impacted by the pandemic, as capacity was re-directed to outbreak management, testing, and infection control work. The Directorate has now returned to business as usual following the pandemic but there are ongoing issues that continue to impact on activity and spend:

i) much of the Directorate's spend is contracts with, or payments to Primary Care (GP practices and community pharmacies) for specific work. Primary Care continues to be under pressure, and it may take some time for activity levels to return to pre pandemic levels; and

ii) the unprecedented demand for Public Health staff across the country meant recruitment became very difficult through the pandemic resulting in underspends on staffing budgets. The position within the Public Health team has improved with recruitment becoming easier, but recruitment challenges continue to be reflected in our provider services which has affected their ability to deliver consistently.

The Public Health Directorate is currently looking to develop its structure and therefore have frozen recruitment to posts until ready to proceed with the new structure to give staff a fair chance and minimise redundancy risks.

Detailed Public Health financial information is contained in Appendix 1, with Appendix 2 providing a

narrative from those services with a significant variance against budget.

2. Capital Executive Summary

Scheme category	Scheme budget £000	Scheme forecast variance £000	Budget 2023/24 £000	Actuals 2023/24 £000	Forecast outturn variance 2023/24 £000
Adults, Health and Commissioning capital schemes	73,860	0	5,975	4,783	0

At the end of October 2023, the capital programme forecast underspend is zero. The level of slippage and underspend in 2023/24 is currently anticipated to be £0k and as such has not yet exceeded the Capital Variation Budget. A forecast outturn will not be reported unless this happens.

Further information on capital schemes is provided in Appendix 3 of the FMR.

3. Savings Tracker Summary

The savings trackers are produced quarterly to monitor delivery of savings against agreed plans. The second quarterly savings tracker for 2023/24 is included at Appendix 4.

4. Technical note

On a quarterly basis, a technical financial appendix is included as Appendix 5 of the FMR. This appendix covers:

- Grants that have been received by the service, and where these have been more or less than expected
- Budget movements (virements) into or out of the directorate from other services, to show why the budget might be different from that agreed by Full Council
- Service earmarked reserves – funds held for specific purposes that may be drawn down in-year or carried-forward – including use of funds and forecast draw-down.

The second quarterly technical note for 2023/24 is included within this FMR report.

5. Key Activity Data

In the following key activity data for Adults & Safeguarding, the information given in each column is as follows:

- Budgeted number of care services: this is the number of full-time equivalent (52 weeks) service users anticipated at budget setting
- Budgeted average unit cost: this is the planned unit cost per service user per week, given the budget available
- Actual care services and cost: these reflect current numbers of service users and average cost; they represent a real time snapshot of service-user information.

A consistent format is used to aid understanding, and where care types are not currently used in a particular service those lines are greyed out.

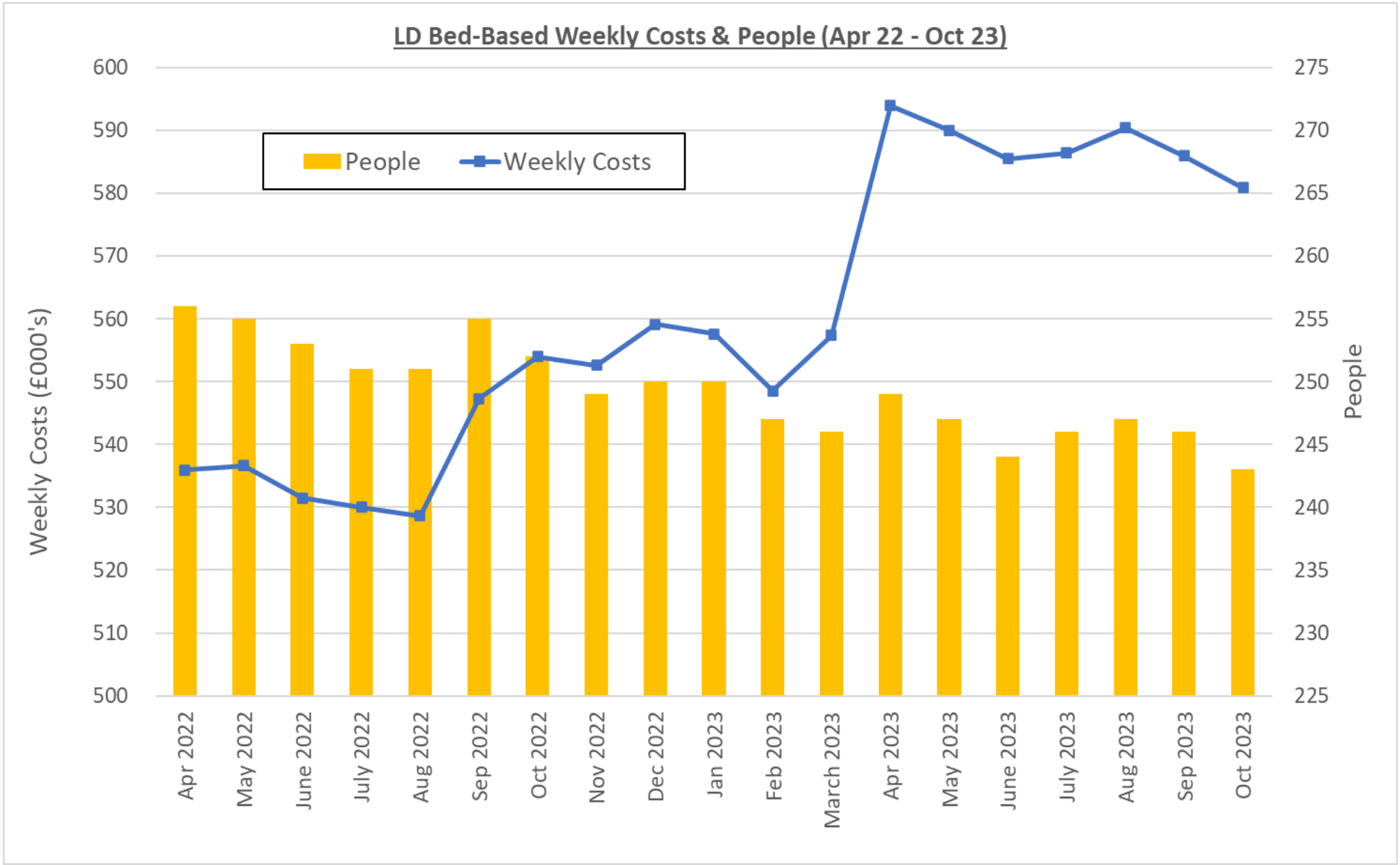
The direction of travel (DoT) compares the current month's figure with the previous month.

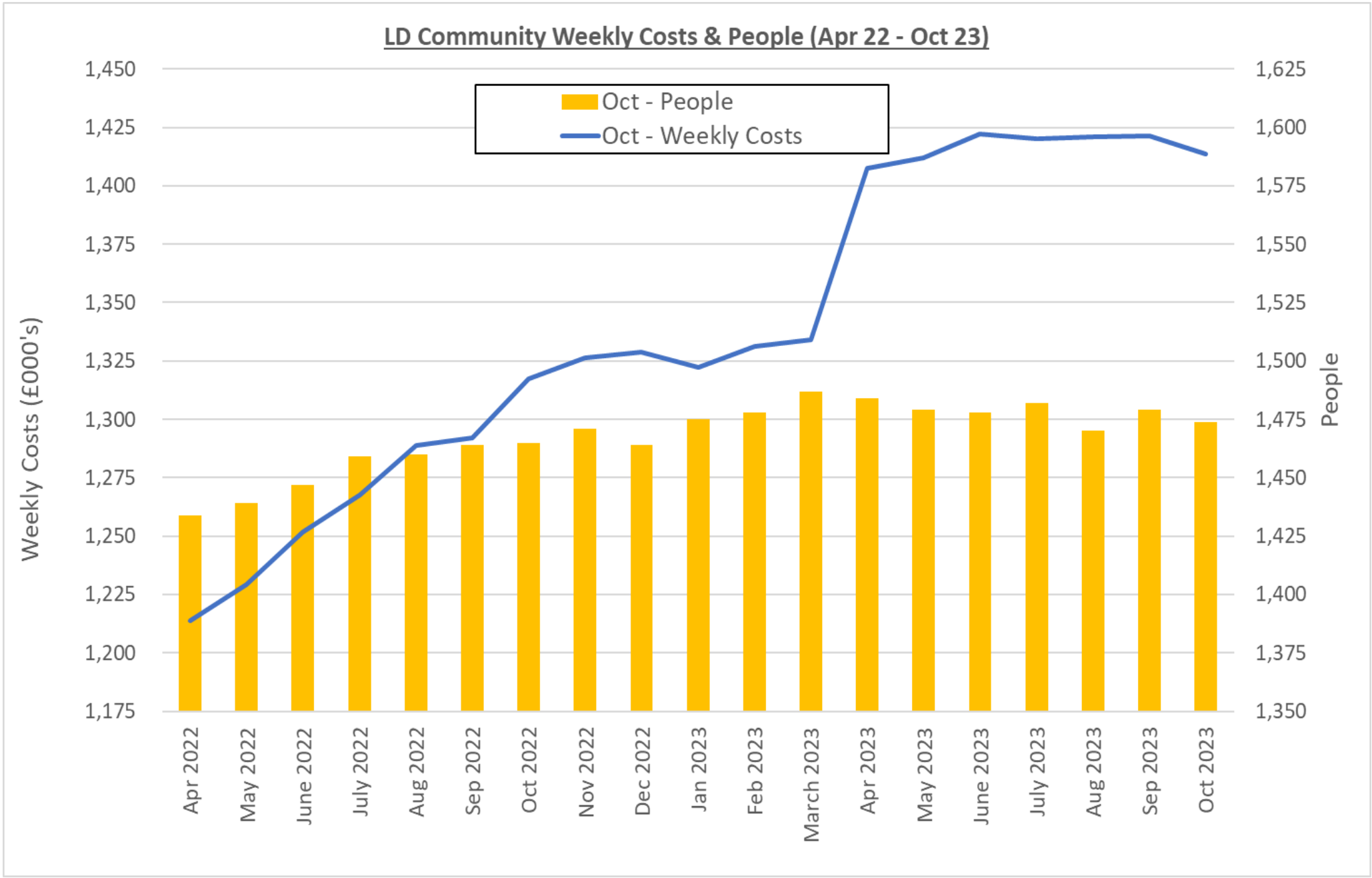
The activity data for a given service will not directly tie back to its outturn reported in Appendix 1. This is because the detailed variance includes other areas of spend, such as care services which have ended and staffing costs, as well as the activity data including some care costs that sit within Commissioning budgets.

5.1 Key activity data at the end of October 2023 for Learning Disability Partnership is shown below:

Learning Disability Partnership	BUDGET			ACTUAL (October 2023)				Outturn		
Service Type	*Expected No. of Care Packages 2023/24*	*Budgeted Average Unit Cost (per week)*	*Annual Budget*	*Current Care Packages*	*DoT*	*Current Average Unit Cost (per week)*	*DoT*	*Total spend/ income*	*DoT*	*Variance*
Accommodation based										
~Residential	245	£2,271	£28,942k	233	↔	£2,307	↑	£28,546k	↓	-£396k
~Nursing	10	£4,568	£2,220k	9	↓	£4,959	↑	£2,246k	↓	£27k
~Respite	15	£840	£656k	18	↔	£637	↔	£601k	↑	-£54k
Accommodation based subtotal	**270**	**£2,230**	**£31,818k**	**260**		**£2,239**		£31,394k		-£424k
Community based										
~Supported Living	605	£1,522	£47,947k	591	↓	£1,541	↑	£46,651k	↑	-£1,295k
~Homecare	350	£502	£9,160k	380	↑	£513	↑	£10,832k	↑	£1,672k
~Direct payments	386	£536	£10,781k	408	↓	£550	↑	£10,410k	↓	-£371k
~Live In Care	3	£2,997	£388k	4	↑	£3,411	↑	£395k	↓	£7k
~Day Care	538	£203	£5,683k	651	↑	£208	↓	£5,396k	↓	-£287k
~Other Care	269	£138	£1,937k	281	↑	£116	↑	£2,111k	↑	£173k
Community based subtotal	**2,151**	**£678**	**£75,896k**	**2,315**		**£653**		£75,794k		-£101k
Total for expenditure	**2,421**	**£851**	**£107,713k**	**2,575**		**£813**		£107,188k	↑	-£525k
Care Contributions			-£5,156k					-£5,034k	↑	£121k

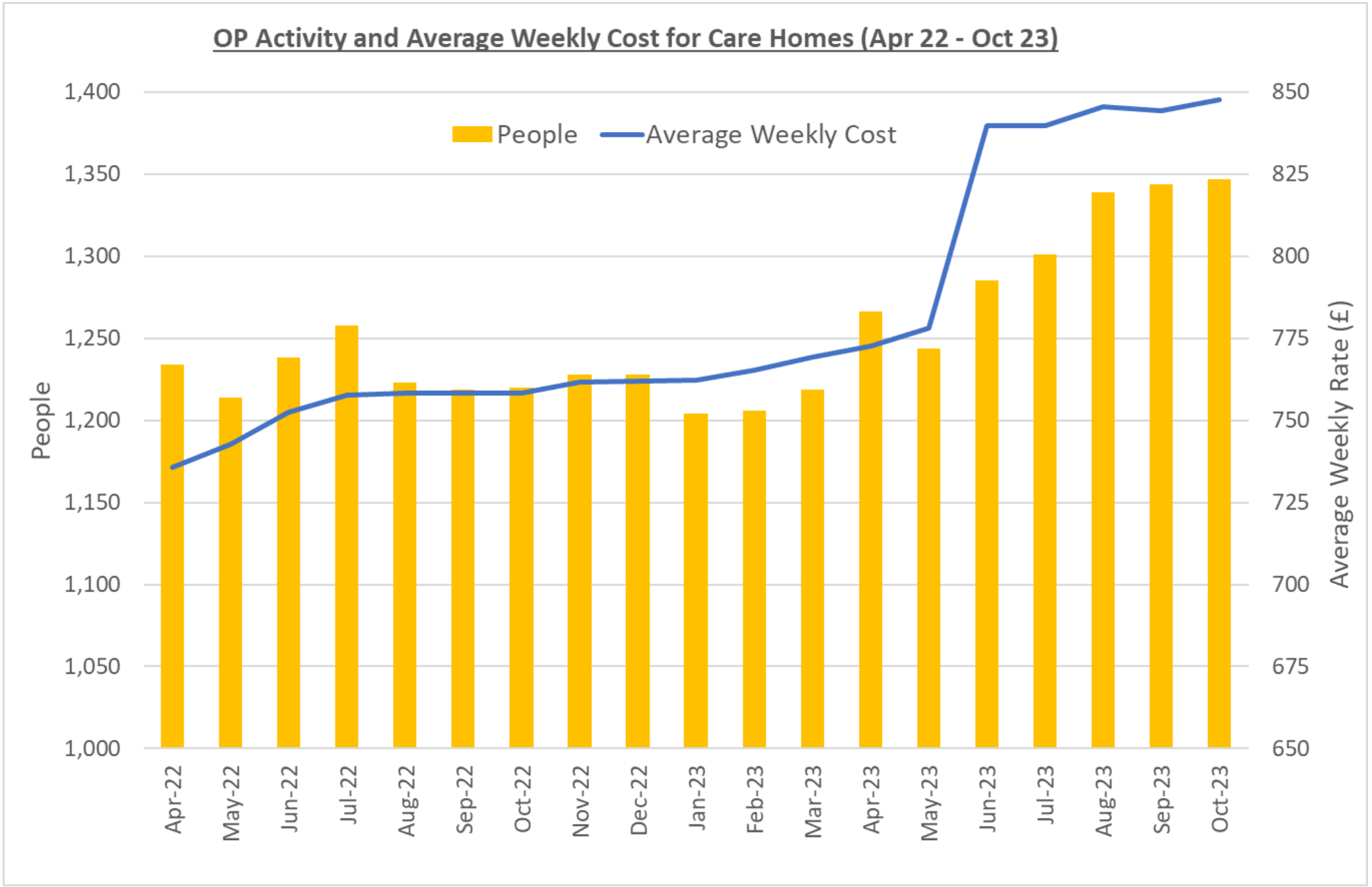
The LDP includes service-users that are fully funded by the NHS, who generally have very high needs and therefore costly care packages.

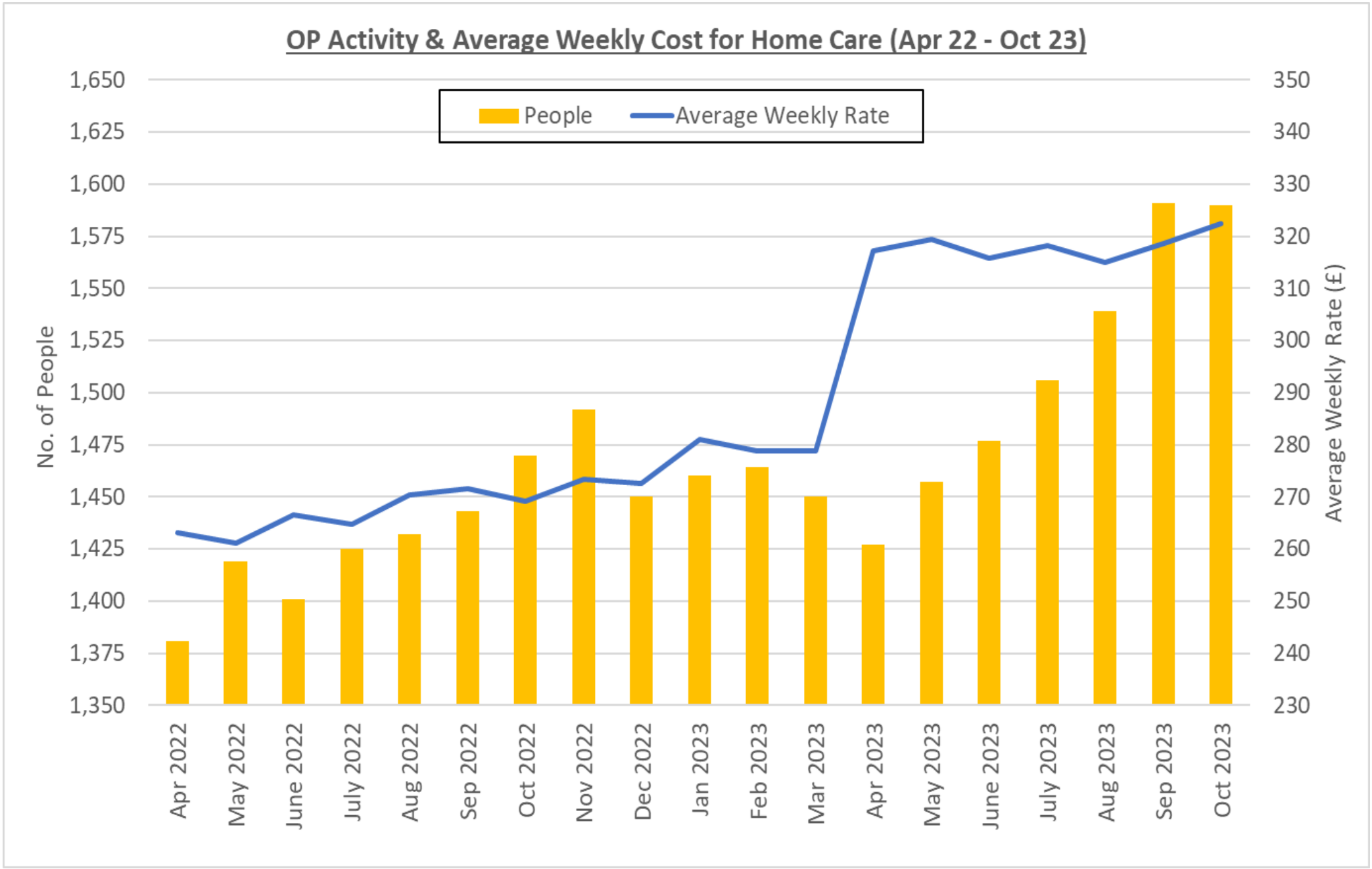

LD Bed-Based Weekly Costs & People (Apr 22 - Oct 23)
People
Weekly Costs
Weekly Costs (£000's)
People
600
590
580
570
560
550
540
530
520
510
500
275
270
265
260
255
250
245
240
235
230
225
Apr 2022
May 2022
June 2022
July 2022
Aug 2022
Sep 2022
Oct 2022
Nov 2022
Dec 2022
Jan 2023
Feb 2023
March 2023
Apr 2023
May 2023
June 2023
July 2023
Aug 2023
Sep 2023
Oct 2023


LD Community Weekly Costs & People (Apr 22 - Oct 23)
Oct - People
Oct - Weekly Costs
Weekly Costs (£000's)
People
1,450
1,425
1,400
1,375
1,350
1,325
1,300
1,275
1,250
1,225
1,200
1,175
1,625
1,600
1,575
1,550
1,525
1,500
1,475
1,450
1,425
1,400
1,375
1,350
Apr 2022
May 2022
June 2022
July 2022
Aug 2022
Sep 2022
Oct 2022
Nov 2022
Dec 2022
Jan 2023
Feb 2023
March 2023
Apr 2023
May 2023
June 2023
July 2023
Aug 2023
Sep 2023
Oct 2023

5.2 Key activity data at the end of October 2023 for Older People and Physical Disabilities Services for Over 65s is shown below:

Older People and Physical Disability Over 65	BUDGET			ACTUAL (August 2023)				Outturn		
Service Type	*Expected No. of Care Packages 2023/24*	*Budgeted Average Unit Cost (per week)*	*Annual Budget*	*Current Care Packages*	*DoT*	*Current Average Unit Cost (per week)*	*DoT*	*Total spend/ income*	*DoT*	*Variance*
Accommodation based										
~Residential	399	£833	£17,372k	381	↓	£788	↑	£17,691k	↑	£319k
~Residential Dementia	450	£861	£20,258k	492	↑	£791	↓	£22,931k	↑	£2,673k
~Nursing	272	£1,040	£14,784k	276	↓	£920	↑	£16,029k	↑	£1,245k
~Nursing Dementia	188	£1,184	£11,638k	198	↔	£1,003	↑	£12,538k	↑	£900k
~Respite			£762k	78		£128		£761k	↑	-£1k
Accommodation based subtotal	**1,309**	**£936**	**£64,815k**	**1,425**		**£801**		**£69,950k**		**£5,135k**
Community based										
~Supported Living	436	£302	£6,876k	426	↓	£121	↓	£6,736k	↓	-£140k
~Homecare	1,547	£312	£25,211k	1,590	↑	£322	↓	£26,272k	↑	£1,061k
~Direct payments	168	£406	£3,570k	165	↔	£480	↓	£3,819k	↓	£250k
~Live In Care	34	£1,024	£1,821k	37	↔	£991	↑	£2,043k	↑	£222k
~Day Care	57	£221	£659k	70	↑	£65	↓	£684k	↑	£25k
~Other Care			£99k	9	↑	£23		£117k	↑	£17k
Community based subtotal	**2,242**	**£325**	**£38,236k**	**2,297**		**£298**		**£39,671k**		**£1,435k**
Total for expenditure	**3,551**	**£550**	**£103,051k**	**3,722**		**£491**		**£109,621k**	↑	**£6,570k**
Care Contributions			-£28,688k					-£34,068k		-£5,381k


OP Activity and Average Weekly Cost for Care Homes (Apr 22 - Oct 23)
People
Average Weekly Cost
People
Average Weekly Rate (£)
1,400
1,350
1,300
1,250
1,200
1,150
1,100
1,050
1,000
850
825
800
775
750
725
700
675
650
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23


OP Activity & Average Weekly Cost for Home Care (Apr 22 - Oct 23)
People
Average Weekly Rate
No. of People
Average Weekly Rate (£)
1,650
1,625
1,600
1,575
1,550
1,525
1,500
1,475
1,450
1,425
1,400
1,375
1,350
350
340
330
320
310
300
290
280
270
260
250
240
230
Apr 2022
May 2022
June 2022
July 2022
Aug 2022
Sep 2022
Oct 2022
Nov 2022
Dec 2022
Jan 2023
Feb 2023
Mar 2023
Apr 2023
May 2023
June 2023
July 2023
Aug 2023
Sep 2023
Oct 2023

5.3 Key activity data at the end of October 2023 for Physical Disabilities Services for Under 65s is shown below:

Physical Disabilities Under 65s	BUDGET			ACTUAL (August 2023)				Outturn		
Service Type	*Expected No. of Care Packages 2023/24*	*Budgeted Average Unit Cost (per week)*	*Annual Budget*	*Current Care Packages*	*DoT*	*Current Average Unit Cost (per week)*	*DoT*	*Total spend/ income*	*DoT*	*Variance*
Accommodation based										
~Residential	24	£1,229	£1,542k	25	↔	£1,152	↓	£1,531k	↑	-£11k
~Residential Dementia	4	£897	£188k	5	↑	£845	↑	£225k	↑	£37k
~Nursing	20	£1,286	£1,345k	23	↑	£1,193	↓	£1,415k	↑	£70k
~Nursing Dementia	0	£0	£k	0	↔		↔	£k	↔	£k
~Respite			£65k	13	↑	£64	↑	£14k	↓	-£50k
Accommodation based subtotal	**48**	**£1,225**	**£3,140k**	**66**		**£916**		**£3,185k**		**£45k**
Community based										
~Supported Living	21	£343	£376k	34	↑	£451	↓	£578k	↑	£202k
~Homecare	353	£278	£5,139k	341	↔	£295	↓	£5,047k	↓	-£91k
~Direct payments	188	£372	£3,654k	182	↓	£434	↑	£3,561k	↓	-£94k
~Live In Care	27	£994	£1,403k	22	↔	£1,010	↑	£1,287k	↑	-£116k
~Day Care	20	£89	£93k	22	↑	£109	↓	£119k	↑	£26k
~Other Care			£1k	7	↑	£166	↓	£1k	↔	£k
Community based subtotal	**609**	**£335**	**£10,667k**	**608**		**£363**		**£10,593k**		**-£74k**
Total for expenditure	**657**	**£400**	**£13,807k**	**674**		**£417**		**£13,777k**	**↑**	**-£29k**
Care Contributions			-£1,421k					-£1,225k		£196k

5.4 Key activity data at the end of October 2023 for Older People Mental Health (OPMH) Services:

Older People Mental Health	BUDGET			ACTUAL (October 2023)				Outturn		
Service Type	*Expected No. of Care Packages 2023/24*	*Budgeted Average Unit Cost (per week)*	*Annual Budget*	*Current Care Packages*	*DoT*	*Current Average Unit Cost (per week)*	*DoT*	*Total spend/ income*	*DoT*	*Variance*
Accommodation based										
~Residential	37	£723	£1,122k	40	↓	£716	↓	£1,294k	↓	£172k
~Residential Dementia	48	£815	£1,670k	47	↓	£817	↑	£1,735k	↓	£65k
~Nursing	33	£847	£1,271k	33	↓	£896	↑	£1,356k	↓	£85k
~Nursing Dementia	86	£953	£3,715k	81	↓	£1,015	↑	£3,772k	↓	£57k
~Respite	3	£602	£124k	3	↓	£355	↓	£81k	↑	-£43k
Accommodation based subtotal	**207**	**£849**	**£7,903k**	**204**		**£877**		**£8,239k**		**£336k**
Community based										
~Supported Living	11	£213	£45k	6	↔	£247	↑	£43k	↑	-£2k
~Homecare	57	£355	£1,182k	76	↑	£381	↓	£1,429k	↑	£248k
~Direct payments	8	£645	£227k	6	↔	£758	↔	£220k	↓	-£6k
~Live In Care	10	£1,169	£699k	9	↓	£1,047	↓	£570k	↓	-£129k
~Day Care	5	£55	£1k	6	↔	£71	↔	£2k	↔	£1k
~Other Care	5	£14	£3k	4	↓	£51	↑	£3k	↓	£k
Community based subtotal	**96**	**£414**	**£2,156k**	**107**		**£421**		**£2,267k**		**£111k**
Total for expenditure	**303**	**£711**	**£10,059k**	**311**		**£720**		**£10,506k**	**↓**	**£447k**
Care Contributions			-£1,318k					-£1,837k	↓	-£519k

5.5 Key activity data at the end of October 2023 for Adult Mental Health Services is shown below:

Adult Mental Health	BUDGET			ACTUAL (October 2023)				Outturn		
Service Type	*Expected No. of Care Packages 2023/24*	*Budgeted Average Unit Cost (per week)*	*Annual Budget*	*Current Care Packages*	*DoT*	*Current Average Unit Cost (per week)*	*DoT*	*Total spend/ income*	*DoT*	*Variance*
Accommodation based										
~Residential	64	£852	£2,794k	61	↔	£967	↑	£2,980k	↑	£186k
~Residential Dementia	1	£900	£47k	0	↓		↓	£k	↓	-£47k
~Nursing	9	£829	£467k	10	↔	£1,047	↔	£602k	↑	£134k
~Nursing Dementia	1	£882	£55k	1	↔	£951	↔	£55k	↑	-£1k
~Respite	1	£20	£40k	1	↔	£10	↔	£20k	↓	-£20k
Accommodation based subtotal	**76**	**£839**	**£3,403k**	**73**		**£964**		**£3,656k**		**£252k**
Community based										
~Supported Living	133	£469	£4,178k	127	↓	£462	↑	£4,033k	↓	-£145k
~Homecare	158	£119	£1,465k	165	↓	£130	↑	£1,730k	↑	£265k
~Direct payments	14	£240	£181k	18	↔	£251	↑	£239k	↑	£58k
~Live In Care	2	£1,210	£134k	2	↓	£1,771	↑	£215k	↓	£81k
~Day Care	5	£62	£18k	6	↓	£65	↑	£28k	↑	£10k
~Other Care	6	£789	£2k	5	↔	£37	↑	£43k	↓	£41k
Community based subtotal	**318**	**£290**	**£5,977k**	**323**		**£275**		**£6,288k**		**£311k**
Total for expenditure	**394**	**£396**	**£9,380k**	**396**		**£402**		**£9,943k**	↑	**£563k**
Care Contributions			-£386k					-£487k	↓	-£101k

5.6 Key activity data at the end of October 2023 for Autism is shown below:

Autism	BUDGET			ACTUAL (October 2023)				Outturn		
Service Type	*Expected No. of Care Packages 2023/24*	*Budgeted Average Unit Cost (per week)*	*Annual Budget*	*Current Care Packages*	*DoT*	*Current Average Unit Cost (per week)*	*DoT*	*Total spend/ income*	*DoT*	*Variance*
Accommodation based										
Accommodation based subtotal	**4**	**£1,835**	**£295k**	**2**	↔	**1,354**		**£252k**	↓	**-£11k**
Community based										
~Supported Living	26	£671	£1,065k	25	↑	£925	↑	£1,142k	↑	£77k
~Homecare	31	£219	£374k	32	↓	£186	↑	£345k	↑	-£30k
~Direct payments	31	£204	£621k	32	↓	£350	↑	£566k	↓	-£56k
~Day Care	26	£92	£125k	26	↑	£67	↓	£99k	↓	-£27k
~Other Care	13	£57	£35k	7	↓	£159	↓	£53k	↑	£18k
Community based subtotal	**127**	**£265**	**£2,221k**	**122**		**£353**		**£2,204k**		**-£17k**
Total for expenditure	**131**	**£313**	**£2,516k**	**124**		**£370**		**£2,456k**		**-£28k**
Care Contributions			-£123k					**-£156k**		**-£33k**

Appendix 1a – Detailed Financial Information - Adults, Health and Commissioning

Forecast Outturn Variance (Previous) £000	Committee	Budget Line	Gross Budget £000	Income Budget £000	Net Budget £000	Actual £000	Forecast Outturn Variance £000	Forecast Outturn Variance %
		Executive Director						
-320	A&H	Executive Director - Adults, Health & Commissioning	20,435	-50,135	-29,700	-30,256	-442	-1%
-2	A&H	Performance & Strategic Development	2,970	-16	2,954	1,322	-6	0%
0	A&H	Principal Social Worker	467	0	467	374	0	0%
		Service Director – LDP and Prevention						
0	A&H	Service Director – LDP and Prevention	399	-28	371	-22	0	0%
-85	A&H	Prevention & Early Intervention	10,970	-1,018	9,952	5,955	-85	-1%
0	A&H	Transfers of Care	2,075	0	2,075	1,341	0	0%
0	A&H	Autism and Adult Support	2,989	-118	2,871	1,528	-67	-2%
		Learning Disabilities						
2	A&H	Head of Service	7,095	0	7,095	851	3	0%
-72	A&H	LD - City, South and East Localities	49,080	-2,584	46,496	29,338	-59	0%
-282	A&H	LD - Hunts and Fenland Localities	46,260	-2,216	44,044	27,365	-331	-1%
-284	A&H	LD - Young Adults Team	15,487	-392	15,095	9,313	318	2%
69	A&H	In House Provider Services	9,592	-275	9,316	5,456	69	1%
0	A&H	NHS Contribution to Pooled Budget	0	-29,464	-29,464	-14,206	0	0%
0		**Learning Disabilities Total**	**127,514**	**-34,931**	**92,583**	**58,117**	**0**	**0%**
		Service Director – Adults Community Operations						
0	A&H	Service Director - Care & Assessment	832	0	832	509	0	0%
0	A&H	Assessment & Care Management	4,732	-41	4,691	2,559	0	0%
0	A&H	Safeguarding	1,470	0	1,470	963	0	0%
0	A&H	Adults Finance Operations	1,816	-10	1,806	511	15	1%

Forecast Outturn Variance (Previous) £000	Committee		Gross Budget £000	Income Budget £000	Net Budget £000	Actual £000	Forecast Outturn Variance £000	Forecast Outturn Variance %
		Older People's and Physical Disabilities Services						
692	A&H	Older Peoples Services - North	46,990	-13,199	33,791	21,659	167	0%
1,206	A&H	Older Peoples Services - South	52,819	-15,658	37,161	24,976	802	2%
382	A&H	Physical Disabilities – North	6,367	-700	5,667	3,766	344	6%
3	A&H	Physical Disabilities - South	7,517	-1,050	6,466	4,386	-99	-2%
2,283		**Older People's and Physical Disabilities Services Total**	**113,693**	**-30,608**	**83,085**	**54,786**	**1,214**	**1%**
		Service Director - Commissioning						
0	A&H	Service Director - Commissioning	1,068	-20	1,048	275	0	0%
0	A&H	Adults Commissioning - Staffing	2,504	0	2,504	1,717	0	0%
0	CYP	Children's Commissioning - Staffing	1,234	0	1,234	738	59	5%
-201	A&H	Adults Commissioning - Contracts	10,215	-4,321	5,894	3,919	-179	-3%
0	A&H	Housing Related Support	6,506	-596	5,909	3,447	-81	-1%
137	A&H	Integrated Community Equipment Service	7,903	-5,802	2,101	1,973	137	7%
		Mental Health						
44	A&H	Mental Health - Staffing	3,511	-54	3,457	1,994	44	1%
37	A&H	Mental Health Commissioning	2,999	-339	2,660	1,526	73	3%
387	A&H	Adult Mental Health	7,353	-386	6,967	4,666	407	6%
183	A&H	Older People Mental Health	9,870	-1,406	8,464	5,402	-24	0%
650		**Mental Health Total**	**23,733**	**-2,185**	**21,548**	**13,588**	**500**	**2%**
2,462		**Adults, Health & Commissioning Total**	**343,526**	**-129,830**	**213,696**	**123,343**	**1,066**	**1%**
		Mitigations						
-2,517		Grant Funding contributing to cost increases where allowed by grant conditions (part one off)	0	0	0	0	-1,431	
-2,517		**Mitigations Total**	**0**	**0**	**0**	**0**	**-1,431**	
-55		**Overall Total**	**343,526**	**-129,830**	**213,696**	**123,343**	**-365**	**0.2%**

Appendix 1b – Detailed Financial Information – Public Health

Forecast Outturn Variance (Previous) £000	Committee		Gross Budget £000	Income Budget £000	Net Budget £000	Actual £000	Forecast Outturn Variance £000	Forecast Outturn Variance %
		Children Health						
0	CYP	Children 0-5 PH Programme	10,707	-3,315	7,392	4,329	0	0%
0	CYP	Children 5-19 PH Programme - Non Prescribed	2,591	-778	1,814	1,008	0	0%
-11	CYP	Children Mental Health	341	0	341	-20	-11	-3%
0	CYP	Drug & Alcohol Misuse – Young People	415	0	415	197	-20	-5%
0	CYP	Children's Weight Management	350	0	350	0	0	0%
0	CYP	Childrens Integrated Lifestyles	228	-58	169	60	0	0%
-11		**Children Health Total**	**14,631**	**-4,150**	**10,481**	**5,574**	**-31**	**0%**
		Drugs & Alcohol						
-10	A&H	Drug & Alcohol Misuse	6,113	-1,179	4,934	1,825	-17	0%
-10		**Drugs & Alcohol Total**	**6,113**	**-1,179**	**4,934**	**1,825**	**-17**	**0%**
		Sexual Health & Contraception						
-40	A&H	SH STI testing & treatment - Prescribed	5,468	-1,816	3,652	1,783	0	0%
-25	A&H	SH Contraception - Prescribed	1,086	0	1,086	334	-20	-2%
-16	A&H	SH Services Advice Prevention/Promotion - Non-Prescribed	542	-31	511	223	-16	-3%
-81		**Sexual Health & Contraception Total**	**7,096**	**-1,847**	**5,249**	**2,340**	**-36**	**-1%**
		Behaviour Change / Preventing Long Term Conditions						
-32	A&H	Integrated Lifestyle Services	3,157	-867	2,290	754	-34	-1%
0	A&H	Post Covid weight management services	440	0	440	184	0	0%

Forecast Outturn Variance (Previous) £000	Committee		Gross Budget £000	Income Budget £000	Net Budget £000	Actual £000	Forecast Outturn Variance £000	Forecast Outturn Variance %
-105	A&H	Smoking Cessation GP & Pharmacy	765	0	765	138	-115	-15%
0	A&H	NHS Health Checks Programme - Prescribed	914	0	914	192	-107	-12%
0	A&H	Other Health Improvement	276	-4	272	84	-2	-1%
-137		**Behaviour Change / Preventing Long Term Conditions Total**	**5,552**	**-871**	**4,681**	**1,352**	**-258**	**-6%**
		General Prevention Activities						
0	A&H	General Prevention Activities	561	0	561	-16	-3	-1%
0	A&H	Falls Prevention	461	0	461	309	-3	-1%
0		**General Prevention Activities**	**1,023**	**0**	**1,023**	**293**	**-7**	**-1%**
		Adult Mental Health & Community Safety						
0	A&H	Adult Mental Health & Community Safety	507	-203	304	43	-12	-4%
0		**Adult Mental Health & Community Safety Total**	**507**	**-203**	**304**	**43**	**-12**	**-4%**
		Public Health Directorate						
-48	A&H	Public Health Directorate Staffing and Running Costs	4,725	-28,577	-23,852	-19,475	-66	0%
-125	A&H	Health in All Policies	247	0	247	0	-225	-91%
0	A&H	Household Health & Wellbeing Survey	160	0	160	0	0	0%
0	A&H	Social Marketing Research and Campaigns	0	0	0	0	0	0%
0	A&H	Enduring Transmission Grant	214	-214	0	-253	0	0%
0	A&H	Contain Outbreak Management Fund	4,546	-4,546	0	-109	0	0%
-173		**Public Health Directorate Total**	**9,892**	**-33,337**	**-23,445**	**-19,837**	**-291**	**-1%**

Forecast Outturn Variance (Previous) £000	Committee		Gross Budget £000	Income Budget £000	Net Budget £000	Actual £000	Forecast Outturn Variance £000	Forecast Outturn Variance %
-412	**Total Expenditure**		**44,814**	**-41,587**	**3,227**	**-8,409**	**-652**	**-1%**
		Funding						
0	A&H/CYP	Drawdown from reserves	-3,227	0	-3,227	-674	0	0%
0		**Funding Total**	**-3,227**	**0**	**-3,227**	**-674**	**0**	**0%**
-412	**Overall Total**		**41,587**	**-41,587**	**0**	**-10,850**	**-652**	**-2%**

Appendix 2a – Service Commentaries on Forecast Outturn Position - Adults, Health and Commissioning

Narrative is given below where there is an adverse/positive variance greater than 2% of annual budget or £100,000 whichever is greater for a service area.

1) Executive Director – Adults, Health and Commissioning

Gross Budget £000	Income Budget £000	Net Budget £000	Actuals £000	Forecast Variance £000	Forecast Variance %
20,435	-50,135	-29,700	-30,256	-442	-1%

Underspends from vacant posts were larger in the first half of 2023/24 than assumed in the budget and are forecast to contribute £517k to the Directorate's overall financial position by year end. This forecast underspend is partially offset by a forecast overspend of £76k on Adults Social Care transport which has an outstanding savings target of £91k brought forward from 2021/22. The work to deliver this saving has been completed, but unusually high inflationary pressures on transport costs have meant cost reductions could not be delivered as originally planned.

2) Learning Disability Services

Gross Budget £000	Income Budget £000	Net Budget £000	Actuals £000	Forecast Variance £000	Forecast Variance %
127,514	-34,931	92,583	58,117	0	0%

The Learning Disability Partnership is a pooled budget between the council and the NHS, with shares of 77% and 23% respectively. The budget covers the care costs of people with very complex needs, which can be very hard for the care market to meet. Therefore, although the budget is currently forecasting a balanced position, there is a lot of uncertainty around this forecast. This is the area of adult social care where we are experiencing the most difficulty in finding placements, particularly at higher levels of need. There is currently a significant number of people waiting for placements or changes to their current placements.

Over the past two years we have seen placement costs rising faster than they had previously. These increased costs were driven partly by increasing complexity of need, but also by cost pressures faced by providers, particularly related to staffing shortages and price inflation. The cost pressures faced by the provider market have also created a risk around the budget for uplifts paid on current placements. This is a significant risk, with some of our providers requesting uplifts far exceeding the budget available. Uplift negotiations are being managed with these providers on an individual basis.

Adults Commissioning are developing an LD Accommodation Strategy that will enable them to work with the provider market to develop the provision needed for people with learning disabilities. This should lead to more choice when placing people with complex needs and consequently reduce costs in this area. However, this is a longer-term programme and is unlikely to deliver any improvements in the market this financial year. The LDP social work teams and Adults Commissioning are also working on strategies to increase the uptake of direct payments, to deliver more choice for service users and decrease reliance on the existing care market.

And a further strategy is in development to help people with learning disabilities develop their independence so they can remain living in community-based settings for longer.

The budget for 2022/23 assumed an increased contribution from the NHS reflecting a shift in the percentage of packages that should be funded from Health budgets. For the current financial year we have made provision for this increased contribution, but the joint project between the ICB and CCC to review those packages required to agree a revised split of costs going forwards for the pool did not proceed as expected. The Council has now served notice to end the cost sharing arrangements of the pooled budget and is continuing to work with the ICB to explore opportunities to agree new arrangements to meet the needs of service users whilst delivering revised cost shares for the future. There is a risk of short term financial pressures from this decoupling as we move to separate budgets for health and social care

3) Older People's and Physical Disabilities Services

Gross Budget £000	Income Budget £000	Net Budget £000	Actuals £000	Forecast Variance £000	Forecast Variance %
113,693	-30,608	83,085	54,786	1,214	1%

Older People's and Physical Disabilities Services demand patterns have changed significantly in recent years, particularly in relation to Older Peoples care home placements which experienced no overall growth, as previously reported. This resulted in a significant underspend in 2022/23, with the change in activity being factored into business planning assumptions for 2023/24 budgets. In addition, £0.75m from this budget for this financial year was redistributed to offset pressures elsewhere in Adults, Health, and Commissioning whilst recognising the potential risk of an emerging pressure within this budget area should activity increase.

Subsequently, Older People's care home demand has returned in 2023/24 with increases in placement numbers similar to pre-pandemic levels. The cost of new placements continues to rise despite additional investment from the Adult Social Care Market Sustainability and Improvement Fund, and the recent closure of a number of care homes has added additional pressure to the budget. In addition to the significant overspend on care home placements, demand for domiciliary care has been steadily rising after a period of stability between January and May 2023.

Income from clients contributing to the cost of their care has been increasing steadily throughout the year. Services have been working to streamline processes and improve the client's journey through the financial assessments process so that their assessment can be completed in a more timely manner in order to resolve a backlog of historic outstanding cases. These improvements, in conjunction with rising demand for services, have increased the level of income expected from clients contributing towards the cost of their care. In light of this, we have reassessed expected income due and have made an adjustment to the forecast of -£1.0m, reducing the forecast overspend to £1.2m.

4) Adults Commissioning - Contracts

Gross Budget £000	Income Budget £000	Net Budget £000	Actuals £000	Forecast Variance £000	Forecast Variance %
10,215	-4,321	5,894	3,919	-179	-3%

Adults Commissioning – Contracts is forecasting an underspend of -£179k at the end of October. This is due to savings made through the decommissioning of a number of local authority funded rapid discharge and transition cars as part of the wider homecare commissioning model. The long-term strategy is to decommission all the local authority funded cars, meeting the need for domiciliary care through other, more cost-effective means, such as:

- A sliding scale of rates with enhanced rates to support rural and hard to reach areas.
- Providers covering specific areas or zones of the county, including rural areas.
- Supporting the market in building capacity through recruitment and retention, as well as better rates of pay for care staff.

5) Integrated Community Equipment Service

Gross Budget £000	Income Budget £000	Net Budget £000	Actuals £000	Forecast Variance £000	Forecast Variance %
7,903	-5,802	2,101	1,973	137	7%

The Integrated Community Equipment Service is forecasting an overspend of £137k at the end of October. The service is a pooled budget with the NHS, with partners contributing 51.8% (NHS) and 48.2% (CCC).

The overspend is due to increased levels of activity on the community equipment service contract. The number of orders for standard equipment is 17% higher than at this point last year, and 10% higher than in any other year we have data for. The increase in orders for specialist equipment is 83% on this time last year and 2% higher than in any other year. Credits from returned equipment (that is then re-issued) are also up on previous years – 40% compared to this time last year (a year when credits were low). Although credits to date are only 1% higher than in any previous year.

Work is taking place to analyse the likely cause of such demand increases. Early indications suggest some of this is related to increased demand coming from hospital discharges, and people with more complex needs being supported to live in the community. This complexity of need has also driven the increase in Special (non-stock) equipment. In a few cases these costs can be recharged to CHC, but only for those patients who are CHC eligible. Some of the high value stock equipment (hoists and plus size beds) is aging which means that an increasing number are scrapped upon return to the warehouse as they are beyond economical repair. This affects the value of credit applied. We are also seeing an increasing amount of plus size equipment being requisitioned which is more costly than items with a standard user weight.

6) Mental Health

Gross Budget £000	Income Budget £000	Net Budget £000	Actuals £000	Forecast Variance £000	Forecast Variance %
23,733	-2,185	21,548	13,588	500	2%

Mental Health Services are forecasting an overspend of £500k. There are significant demand pressures across both community and bed-based care for both Adult and Older People's Mental Health. However, the underlying demand pressures for care in Older People's Mental Health are being offset by a correspondingly high level of income from people contributing towards the cost of their care.

Due to significant recent increases in demand, an enhanced expectation for incoming demand over previously budgeted expectations has been included in the forecast position. Ongoing analysis will be carried out to review activity information and other cost drivers in detail to continually validate the reported position. This remains subject to variation as circumstances change and more data comes through the system.

7) Mitigations

Gross Budget £000	Income Budget £000	Net Budget £000	Actuals £000	Forecast Variance £000	Forecast Variance %
0	0	0	0	-1,431	0%

Given the pressures on care budgets for Older People and Mental Health, priorities around the use of grant funding have been revisited. This identified additional spend that can be funded from external grant, freeing up £1.4m of grant monies to contribute to the identified pressures. This is a reduction from last month as the lower forecasted pressures on Adult Social Care budgets have allowed the release of grant funding not restricted to spend on Adult Social Care, to support other areas of the Council.

Appendix 2b – Service Commentaries on Forecast Outturn Position – Public Health

Narrative is given below where there is an adverse/positive variance greater than 2% of annual budget or £100,000 whichever is greater for a service area

1) Smoking Cessation GP & Pharmacy

Gross Budget £000	Income Budget £000	Net Budget £000	Actuals £000	Forecast Variance £000	Forecast Variance %
765	0	765	138	-115	-15%

In the past, activity on smoking services was largely delivered through primary care – GPs and pharmacies. In the aftermath of the pandemic, activity in these services has been slow to recover resulting in a significant in year forecast underspend. We have therefore developed alternative routes to increase activity.

2) NHS Health Checks Programme - Prescribed

Gross Budget £000	Income Budget £000	Net Budget £000	Actuals £000	Forecast Variance £000	Forecast Variance %
914	0	914	102	-107	-12%

Activity on health checks is largely delivered through primary care – GPs. In the aftermath of the pandemic, activity in these services has been slow to recover resulting in a significant in year underspend. GP activity is now improving and in addition, efforts are being made to offer access to health checks through other providers.

3) Health in All Policies

Gross Budget £000	Income Budget £000	Net Budget £000	Actuals £000	Forecast Variance £000	Forecast Variance %
247	0	-247	0	-225	-91%

This was a new investment in 2022/23 Business Planning but was superseded by the move to an integrated self-assessment tool of which Health in All Policies will form a part. As such spend has been significantly less than budgeted for.

Appendix 3 – Capital Position

4.1 Capital Expenditure

Original 2023/24 Funding Allocation as per Business Plan £000	Committee	Scheme	Total Scheme Budget £000	Total Scheme Forecast Variance £000	Revised Budget for 2023/24 £000	Actual Spend (October) £000	Forecast Outturn Variance (October) £000
14,370	Adults & Health	Independent Living Service: East Cambridgeshire	19,035	-	380	7	-
5,070	Adults & Health	Disabled Facilities Grant	50,700	-	5,070	4,776	-
400	Adults & Health	Integrated Community Equipment Service	4,000	-	400	-	-
0	Adults & Health	Capitalisation of interest costs	182	-	182	-	-
0	Adults & Health	Capital variations	-57	-	-57	-	-
19,840		**Total**	**73,860**	**0**	**5,975**	**4,783**	**0**

No schemes have significant variances (>£250k) either due to changes in phasing or changes in overall scheme costs. However, the timing of forecast spend for the Independent Living Service scheme in East Cambridgeshire has been pushed back from assumptions in the Business Plan due to delays in the land acquisition for the scheme.

4.2 Capital Funding

Original 2023/24 Funding Allocation as per Business Plan £000	Source of Funding	Revised Funding for 2023/24 £000	Forecast Spend – Outturn (October) £000	Forecast Variance – Outturn (October) £000
5,070	Grant Funding	5,070	5,070	-
14,770	Prudential Borrowing	905	905	-
19,840	**Total Funding**	**5,975**	**5,975**	**-**

Appendix 4 – Savings Tracker

4.1 Adults, Health and Commissioning Savings Tracker Quarter 2

RAG	BP Ref	Title	Original Saving £000	Forecast Saving £000	Variance from Plan £000	% Variance	Commentary for publication
Amber	C/F 21-22 Saving	Adult Social Care Transport	-91	-10	81	89%	All routes retendered in 22/23. Saving achieved was lower than expected due to the inflationary pressures on transport.
Black	C/F 22-23 Saving	Micro-enterprises Support	-103	0	103	100%	Not fully delivered due to low number of people with a Direct Payment (DP) and Individual Service Fund (ISF) utilising capacity created in East Cambs. The Self Directed Support programme will increase uptake of DPs and ISFs and improve the pathway to Micro-enterprise provision.
Amber	C/F 22-23 Saving	Increased support for carers	-129	-28	101	78%	Carers Strategy approved and action plan in development. Reprofiled savings as part of action plan development.
Amber	C/F 22-23 Saving	Learning Disability Partnership Pooled Budget Rebaselining	-1,125	-1,125	0	0%	A one off additional contribution has been received pending detailed work with ICB to review the pool position. However, savings built into the Business Plan for future years remain at risk until the review work is completed.
Green	A/R.6.176	Adults Positive Challenge Programme	-154	-154	0	0%	On track
Green	A/R.6.185	Additional block beds - inflation saving	-263	-263	0	0%	On track

RAG	BP Ref	Title	Original Saving £000	Forecast Saving £000	Variance from Plan £000	% Variance	Commentary for publication
Black	A/R.6.200 plus C/F 22-23	Expansion of Direct Payments	-113	0	113	100%	Delivery of savings has been delayed, as has investment. This is a four year programme and cashable savings are only expected in towards the end of Year 2 (24/25)
Green	A/R.6.202	Adults and mental health employment support	-40	-40	0	0%	Complete
Blue	A/R.6.203	Decommissioning of block contracts for Car rounds providing homecare	-1,111	-1,290	-179	-16%	Complete
Green	A/R.6.204	Post hospital discharge reviews	-310	-310	0	0%	On track
Amber	A/R.6.205	Mental Health s75 vacancy factor	-150	-70	80	53%	Partially unacheived due to staffing reorganisation and high-cost interim appointments in CPFT.
Amber	A/R.6.206	Learning Disability mid-cost range placement review	-203	-102	101	50%	Project started September. This has led to a 3-6 month delay to benefits realisation.
Green	A/R.6.208	Integration with the Integrated Care System on digital social prescribing	-61	-61	0	0%	On track
			-3,853	**-3,453**	**400**		

4.2 Public Health Savings Tracker Quarter 2

RAG	BP Ref	Title	Original Saving £000	Forecast Saving £000	Variance from Plan £000	% Variance	Commentary for publication
Green	E/R.6.002	Vacancy factor for Public Health staffing	-80	-80	0	0%	On track
Green	E/R.6.003	Public Health savings	-201	-201	0	0%	On track
			-281	**-281**	**0**		

Key to RAG Ratings:

Total saving	Over £500k	100-500k	Below 100k
Black	100% non-achieving	100% non-achieving	100% non-achieving
Red	% variance more than 19%	-	-
Amber	Underachieving by 14% to 19%	% variance more than 19%	% variance more than 19%
Green	% variance less than 14%	% variance less than 19%	% variance less than 19%
Blue	Over-achieving	Over-achieving	Over-achieving

APPENDIX 5 – Technical Note

5.1.1 The table below outlines the additional Adults, Health and Commissioning grant income, which is not built into base budgets.

Grant	Awarding Body	Amount £'000
Public Health	Department of Health and Social Care (DHSC)	53
Improved Better Care Fund	Department for Levelling Up, Housing & Communities (DLUHC)	15,170
Disabled Facilities Grant	DLUHC	5,512
Market Sustainability and Improvement Fund	DHSC	5,442
Market Sustainability and Improvement Fund - Workforce	DHSC	3,535
ASC Discharge Fund	DHSC	2,127
Social Care in Prisons Grant	DHSC	330
Total Non-Baselined Grants 23/24		**32,169**

5.1.2 The table below outlines the additional Public Health grant income, which is not built into base budgets.

Grant	Awarding Body	Amount £'000
Public Health	DHSC	27,890
Rough Sleeping Drug and Alcohol Treatment	DLUHC	360
Contain Outbreak Management Fund	DHSC / UK Health Security Agency (UKHSA)	4,546
Enduring Transmission	UKHSA	255
Supplementary Substance Misuse Treatment Grant	Office for Health Improvement & Disparities (OHID)	592
Substance Misuse for Crime and Disorder Reduction Grant	Office of the Police and Crime Commissioner	94
Total Non-Baselined Grants 23/24		**33,737**

5.2.1 Virements and Budget Reconciliation (Adults, Health and Commissioning)

(Virements between Adults, Health and Commissioning and other service blocks)

	Eff. Period	£'000	Notes
Budget as per Business Plan		**215,038**	
Executive Director People Services	Apr	-300	Transfer to Strategy and Partnerships from Executive Director People Services
Various policy lines	Apr	351	Allocation of centrally held funding for former People Services restructuring
Various policy lines	May	506	Budget resetting movements as outlined in May IFMR
Various policy lines	June	-1,621	23-24 Business Planning virements to replace expenditure budgets with reserve draw down lines
Integrated Community Equipment Service	June	-53	Adjust Public Health income budget to match amounts to be transferred under PH Memorandum of Understanding
Strategic Management - Commissioning	July	-34	Transfer to Strategy and Partnerships from Commissioning for contract administered in S&P
Executive Director – Adults, Health and Commissioning	July	-4	Realignment of transport staffing budgets to match current operating model requiring a small transfer between Adult's and Children's transport staffing budgets.
Executive Director – Adults, Health and Commissioning	August	15	Moving Budget for ADASS Regional costs to Adults from Childrens- Association of Directors of Adult Social Services (ADASS)
Various policy lines	August	-198	Move of Executive Assistant and Personal Assistant budgets to Strategy and Partnerships
Learning and Development	October	-5	Transfer budget to Learning and Development team to cover cost of Deprivation of Liberty Standards signatory training
Budget 23/24		**213,696**	

5.2.2 Virements and Budget Reconciliation (Public Health)

(Virements between Public Health and other service blocks)

	Eff. Period	£'000	Notes
Budget as per Business Plan		**0**	
Budget 23/24		**0**	

5.3.1 Adults, Health and Commissioning Earmarked Reserve Schedule

Budget Heading	Opening Balance 2023/24 £'000	Net Movements to October 2023/24 £'000	Forecast Year End Balance £'000	Reserve Description
Adult Social Care risk reserve	4,664	0	3,874	Reserve held against risk of demand for social care support exceeding the level of demand assumed in the Business Plan. In year transfers out have been approved as a contribution to 2023/24 inflation and to support work around ASC reform.
Learning Disability pooled budget reserve	1,538	0	413	Reserve to cover costs of review of the appropriate cost splits of spend in the Learning Disability pool, and to cover additional income assumed from the rebaselining of the LDP pool shares until such time as review work is complete and new cost sharing arrangements finalised.
Debt reserve	809	0	500	Reserve held to offset escalating debt position in ASC. This includes reserve for old debt pre the transition of the Cambridgeshire and Peterborough CCG to the ICB which was subject to a debt settlement but the final invoices of which are still being worked through.
Discharge reserve	500	0	0	Funding set aside as part of Discharge spend in 2022/23.
TOTAL EARMARKED RESERVES	**7,511**	**0**	**4,787**	

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

5.3.2 Public Health Earmarked Reserve Schedule

Budget Heading	Opening Balance 2023/24 £'000	Net Movements to October £'000	Forecast Year End Balance £'000	Reserve Description
Children's Public Health:				
Best Start in Life	191	-35	111	Contribution to Best Start in Life programme
Public Health Children's Manager	54	-20	8	Additional Staffing Capacity £78k total – to be spent over 2 years – commenced in 2022/23
Tackling childhood anxiety	0	320	0	New request being taken to Strategy, Resources and Performance Committee in December
Public Mental Health:				
Public Mental Health Manager	80	-20	37	Additional Staffing Capacity - Anticipated spend over 2 years
Support for families of children who self-harm.	77	-40	26	Rolling out pilot family self-harm support programme across Cambridgeshire
Training Programme Eating Disorders	44		5	Training Programme £78k total – to be spent over 2 years – commenced in 2022/23
Adult Social Care & Learning Disability:				
Falls Prevention Fund	110		32	Partnership joint funded falls prevention project with the NHS, £78k pa committed in Healthy Lifestyle contract
Enhanced Falls Prevention Section 75	669	11	379	Enhanced Falls Prevention Anticipated spend over 3 years to 2024/25
Public Health Manager - Learning Disability	78		60	Additional Staffing Capacity - Anticipated spend over 2 years
Improving residents' health literacy skills to improve health outcomes	400	-150	250	Additional funding to existing Adult Literacy programme
PHI and Emergency Planning:				
Quality of Life Survey	368	-152	208	Annual survey for 3 years to assess long term covid impact
Public Health Emergency Planning	9		0	Additional funds to respond to Health Protection incidents
Prevention and Health Improvement:				
Stop Smoking Service	71	-29	27	Additional Staffing Capacity - Focused on post to reduce smoking during pregnancy
Smoking in pregnancy	220		156	To fund work to decrease smoking in pregnancy
NHS Healthchecks Incentive Funding	407	-194	407	Funding to increase the number of health checks that can be undertaken to catch up with some of the missed checks during the pandemic.

Budget Heading	Opening Balance 2023/24 £'000	Net Movements to October £'000	Forecast Year End Balance £'000	Reserve Description
Sexual & Reproductive Health Needs Assessment	50		40	Delivery of Health Needs Assessment
Psychosexual counselling service	69		35	Anticipated spend over 2 years
Primary Care LARC training programme	60	-60	0	Long-Acting Reversible Contraception (LARC) training programme for GPs and Practice Nurses
Tier 2 Adult Weight Management Services	205	-68	137	
Tier 3 Weight Management Services post covid	1,465		1,119	To increase capacity of weight management services over 3 years
Social Marketing Research and Campaigns	500		350	Social marketing research and related campaigns
Support for Primary care prevention	800		400	Anticipated spend over 2 years
Strategic Health Improvement Manager	165	-25	111	Additional Staffing capacity - Anticipated spend over 2 years from 2023/24
Service improvement activity for Stop Smoking Services and NHS Health Checks	0	100	0	Additional service funding for stop smoking and health checks
???	0	389	0	New request being taken to Strategy, Resources and Performance Committee in December
<u>Traveller Health:</u>				
Gypsy Roma and Travelers Education Liaison officer	25	-12	1	Additional Staffing Capacity - Anticipated spend over 2 years to 2023/24
Traveller Health	30	-10	20	To increase access to services, support and advice through drop-in centre model
<u>Health in All Policies:</u>				
Effects of planning policy on health inequalities	170		137	
Training for Health Impact Assessments	45		23	Training Programme agreed as part of 2022/23 Business Plan
<u>Miscellaneous:</u>				
Healthy Fenland Fund	23		0	Project extended to 2023
Health related spend elsewhere in the Council	600	-400	200	Agreed as part of 2022/23 Business Plan to be spent over 3 years to 2024/25
Voluntary Sector Support for the Health and Well Being Strategy	50		50	
Uncommitted PH reserves	820	-820	652	Includes forecast allocation of reserves to …transfer of in year underspend of £652k to reserves at year end
TOTAL EARMARKED RESERVES	**7,854**	**-1,214**	**4,971**	

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

Agenda Item No: 10

Adults Corporate Performance Report

To:	Adults & Health Committee
Meeting Date:	14 December 2023
From:	Patrick Warren-Higgs – Executive Director for Adults, Health and Commissioning
Electoral division(s):	All
Key decision:	No
Forward Plan ref:	N/A
Outcome:	To provide the Committee with a performance monitoring information update.
Recommendation:	The Committee is asked to: a) Note and comment on performance information and act, as necessary

Officer contact:
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1. Background

1.1 The Performance Management Framework sets out that Policy and Service Committees should:

- Set outcomes and strategy in the areas they oversee.
- Select and approve the addition and removal of Key Performance Indicators (KPIs) for the committee performance report.
- Track progress quarterly.
- Consider whether performance is at an acceptable level.
- Seek to understand the reasons behind the level of performance.
- Identify remedial action.

1.2 This report, delivered quarterly, continues to support the committee with its performance management role. It provides an update on the status of the selected Key Performance Indicators (KPIs) which track the performance of the services the committee oversees.

1.3 The report covers the period of quarter two 2023/24, up to the end of September 2023.

1.4 The most recent data for indicators for this committee can be found in the dashboard at Appendix 1. The dashboard includes the following information for each KPI:

- Current and previous performance and the projected linear trend.
- Current and previous targets. Please note that not all KPIs have targets, this may be because they are being developed or the indicator is being monitored for context.
- Red / Amber / Green / Blue (RAGB) status.
- Direction for improvement to show whether an increase or decrease is good.
- Change in performance which shows whether performance is improving (up) or deteriorating (down).
- The performance of our statistical neighbours. This is only available, and therefore included, where there is a standard national definition of the indicator.
- KPI description.
- Commentary on the KPI.

1.5 The following RAGB criteria are being used:

- Red – current performance is 10% or more from target.
- Amber – current performance is off target by less than 10%.
- Green – current performance is on target or better by up to 5%.
- Blue – current performance is better than target by 5% or more.
- Baseline – indicates performance is currently being tracked in order to inform the target setting process.
- Contextual – these KPIs track key activity being undertaken, to present a rounded view of information relevant to the service area, without a performance target.
- In development - KPI has been agreed, but data collection and target setting are in development.

2. Main Issues

2.1 Current performance of indicators monitored by the Committee is as follows:

Status	Number of KPIs	Percentage of KPIs*
Red	0	0%
Amber	0	0%
Green	0	0%
Blue	0	0%
Baseline	0	0%
Contextual	0	0%
In Development	11	100%
Suspended	0	0%

**Figures may not add to 100 due to rounding.*

2.2 Commentary on the indicators is as follows:

2.2.1 Indicator 230: Number of new client contacts for Adult Social Care per 100,000 of the population

New client contacts per 100,000 of population increased across all 4 quarters in 2022/23 compared to 2021/22. The demand continues to grow the lowers number of contacts in covid periods have not been sustainable and currently we are receiving a higher percentage of calls in to ASC requesting for support and remain on par with the equivalent quarters for 2021/22.

Cambridgeshire recorded a higher number of new client contacts in 2022/23 compared to the previous two financial years. In part this is attributable to the new reporting processes implemented in the latter part of the 2021/22 financial year, as well as normal statistical variation. However, there has been a level of increase in new client contacts that is felt to be linked to need in the community (see indicator 231), reflected in the increased numbers of new client assessments for care and support being undertaken (2021/22 monthly average of completed assessments/reassessments: 330, 2022/23 monthly average = 392).

Part of the increase in contact numbers may also be due to proactive work with primary care social prescribers to increase awareness of prevention and early intervention services such as lifeline alarms. During the 2022/23 financial year, Cambridgeshire implemented a system to receive electronic referrals from GP and social prescribing systems to improve the referral route and increase the quality of information received.

2.2.2 Indicator 231: % of new client contacts not resulting in long term care and support

The percentage of new client contacts not resulting in long-term care and support has shown a decreasing trend over the last year but has now stabilised around 88%. This figure is slightly higher than the overall percentage for 2021/22 but remains below the equivalent quarter last year. When interpreted in line with indicator 230, which presents slightly less contacts for Q2 2023/24 compared to 2022/23, the overall picture is that the need for Long

Term services remains high compared to 2021/22 but has provisionally stabilised in terms of contact numbers and the % progressing to Long Term support.

2.2.3 Indicator 232: Proportion of people receiving long term support who had not received a review in the last 12 months, % of all people funded by ASC in long-term

The % of clients at the end of Q2 2023/24 with no review in the last 12 months is the lowest across the last 3 financial years.

During 2022/23, there was a significant level of activity undertaken to clear review backlogs that built up during the pandemic. An external agency was commissioned from March 2022 to work through the backlog of reviews for clients receiving long-term services. This additional capacity significantly increased the number of reviews being completed; in 2021-22 there was an average of 294 reviews completed per month, increasing to an average of 472 reviews for the completed financial year 2022-23.

2.2.4 Indicator 233: Number of carers assessed or reviewed in the year per 100,000 of population

A move away from carers assessments by default to a more constructive and timely conversation accounts for the lower volume of carers assessments. This should be seen alongside our carers conversation and carers triage activity. During Q2 2023/24 we have completed 152 assessments and reviews. A paper of carers recommissioning is being presented to committee which will set the road map for future carers provision.

2.2.5 Indicator 105: Percentage of those able to express desired outcomes who fully or partially achieved their desired outcomes

We continue to have reporting gaps for safeguarding. New dashboards are currently in development meaning not all the data needed to inform these indicators is available for routine use by staff.

2.2.6 Indicator 126: Proportion of people using social care who receive direct payments

The percentage of people receiving direct payments in Q2 2023/24 continues to be low, reflecting the challenge in making direct payments an attractive solution. The general decrease in performance across the last year compared to 2021/22 is mostly driven by an increase in the number of people using social care rather than the number of people receiving direct payments, which has remained relatively stable (828 at the end of Q4 2021/22 compared to 808 at the end of the latest quarter). The alternative options like individual service funds are being explored to increase choice of control to Adults receiving care in the community.

Our work with Community Catalyst around micro enterprises seeks to build more opportunities for people to use direct payments to access care and support opportunities local to them.

The council has recently introduced Individual Service Funds, a personal budget managed by a provider of the persons choice rather than held by themselves. This alongside the

work to develop place based micro-enterprises within the Care Together programme should help to build on the range of options available.

2.2.7 Indicator 140: Proportion of people receiving reablement who did not require long term support after reablement was completed

The proportion of people not requiring long-term support after a period of reablement remains high compared to the national and statistical neighbour average. Q2 2023/24 has decreased showing the complexity of cases coming through needing further support following a short-term intervention.

2.2.8 Indicator 234: % total people accessing long term support in the community aged 18-64

The percentage of clients accessing long term support in the community aged 18-64 has remained relatively static over the last 12 months but increased slightly to 90.77% in Q2 2022/23. The overall number of community-based clients has also increased, from 2243 in Q2 2022/23 to 2360 in Q2 2023/24. Increasing need for long term services in general and community clients specifically has been experienced throughout the last year for 18-64 clients.

2.2.9 Indicator 235: % total people accessing long term support in the community aged 65 and over

The percentage of clients aged 65+ accessing long term support in the community had increased during 2022/23 but has now dropped to a comparable rate with last year (62% in Q2 2022/23, 61% in Q2 2023/24). The number of clients receiving long term support and support in the community specifically have both increased marginally in the last 12 months.

2.2.10 Indicator 236: Percentage of Cases where Making Safeguarding Personal (MSP) questions have been asked

Performance in this area continues to be high and comparable with national and statistical neighbour averages (96% in Q2 of 2023-24)

We continue to have reporting gaps for safeguarding. New dashboards are currently in development meaning not all the data needed to inform these indicators is available for routine use by staff. However, current performance suggests that the Making Safeguarding Personal agenda is fully imbedded in the safeguarding process.

2.2.11 Indicator 229: Percentages of safeguarding enquiries where risk has been reduced or removed

We have been consistent is our approach and have been managing risk well and in over 88% of safeguarding cases risk is removed or reduced. Safeguarding pathways are being revisited to increase the number of S42's to give further considerations to risks.

3. Alignment with ambitions

3.1 Net zero carbon emissions for Cambridgeshire by 2045, and our communities and natural environment are supported to adapt and thrive as the climate changes

There are no significant implications for this ambition.

3.2 Travel across the county is safer and more environmentally sustainable

There are no significant implications for this ambition.

3.3 Health inequalities are reduced

There are no significant implications for this ambition.

3.4 People enjoy healthy, safe, and independent lives through timely support that is most suited to their needs

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

• The indicators proposed here provide an overview of performance in key priority areas, to enable appropriate oversight and management of performance.

3.5 Helping people out of poverty and income inequality

There are no significant implications for this ambition.

3.6 Places and communities prosper because they have a resilient and inclusive economy, access to good quality public services and social justice is prioritised

There are no significant implications for this ambition.

3.7 Children and young people have opportunities to thrive

There are no significant implications for this ambition.

4. Significant Implications

4.1 Resource Implications
There are no significant implications within this category.

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

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

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

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

4.6 Localism and Local Member Involvement

There are no significant implications within this category.

4.7 Public Health Implications
There are no significant implications within this category.

4.8 Climate Change and Environment Implications on Priority Areas:

4.8.1 Implication 1: Energy efficient, low carbon buildings.
Positive/neutral/negative Status: There are no significant implications within this category.
Explanation: There are no significant implications within this category.

4.8.2 Implication 2: Low carbon transport.
Positive/neutral/negative Status: There are no significant implications within this category.
Explanation: There are no significant implications within this category.

4.8.3 Implication 3: Green spaces, peatland, afforestation, habitats and land management.
Positive/neutral/negative Status: There are no significant implications within this category.
Explanation: There are no significant implications within this category.

4.8.4 Implication 4: Waste Management and Tackling Plastic Pollution.
Positive/neutral/negative Status: There are no significant implications within this category.
Explanation: There are no significant implications within this category.

4.8.5 Implication 5: Water use, availability and management:
Positive/neutral/negative Status: There are no significant implications within this category.
Explanation: There are no significant implications within this category.

4.8.6 Implication 6: Air Pollution.
Positive/neutral/negative Status: There are no significant implications within this category.
Explanation: There are no significant implications within this category.

4.8.7 Implication 7: Resilience of our services and infrastructure, and supporting vulnerable people to cope with climate change.
Positive/neutral/negative Status: There are no significant implications within this category.
Explanation: There are no significant implications within this category.

Have the resource implications been cleared by Finance?
Name of Financial Officer: N/A

Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the Head of Procurement and Commercial?
Name of Officer: N/A

Has the impact on statutory, legal and risk implications been cleared by the Council's Monitoring Officer or Pathfinder Legal?
Name of Legal Officer: N/A

Have the equality and diversity implications been cleared by your EqIA Super User?

Name of Officer: N/A

Have any engagement and communication implications been cleared by Communications?
Name of Officer: N/A

Have any localism and Local Member involvement issues been cleared by your Service Contact?
Name of Officer: N/A

Have any Public Health implications been cleared by Public Health?

Name of Officer: N/A

If a Key decision, have any Climate Change and Environment implications been cleared by the Climate Change Officer?

Name of Officer: N/A

5. Source documents guidance

5.1 Source documents

Adults Corporate Performance Report Appendix 1 Quarter 1 2023/24

Adults Corporate Performance Report Appendix 2 Quarter 2 2023/24

Produced on: 17 August 2023

Performance Report

Quarter 1

2023/24 financial year

Adults and Health Committee

Governance & Performance
Cambridgeshire County Council
Governanceand Performance@cambridgeshire.gov.uk

Key

Cambridgeshire County Council

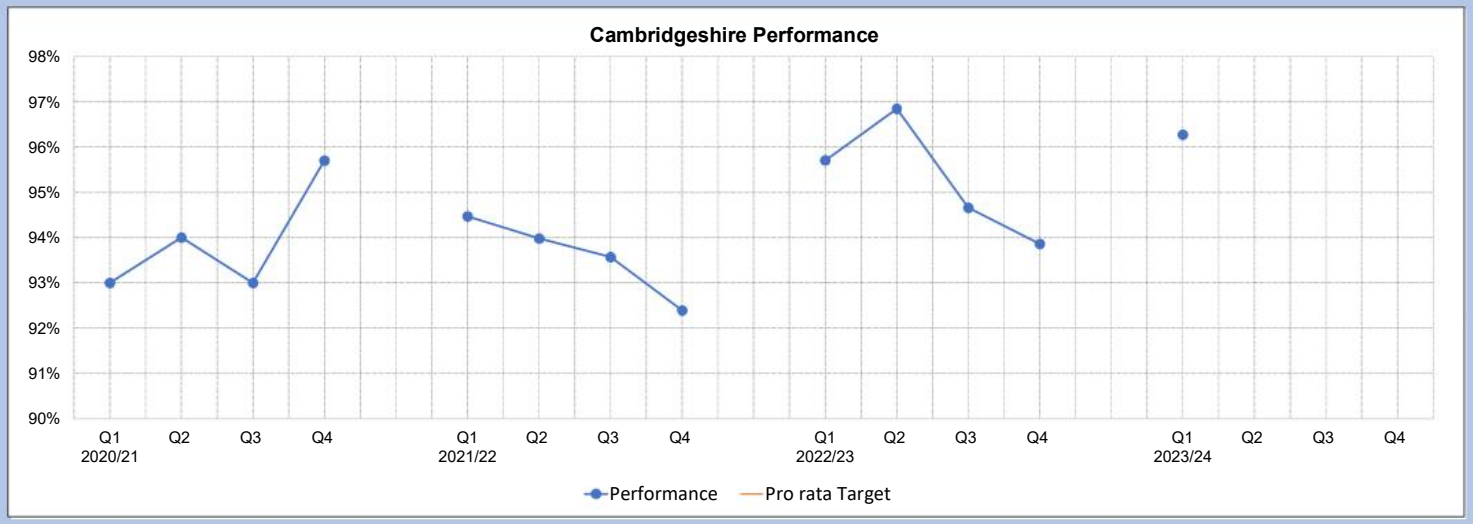
Data Item	Explanation
Target / Pro Rata Target	The target that has been set for the indicator, relevant for the reporting period
Current Month / Current Period	The latest performance figure relevant to the reporting period
Previous Month / previous period	The previously reported performance figure
Direction for Improvement	Indicates whether 'good' performance is a higher or a lower figure
Change in Performance	Indicates whether performance is 'improving' or 'declining' by comparing the latest performance figure with that of the previous reporting period
Statistical Neighbours Mean	Provided as a point of comparison, based on the most recently available data from identified statistical neighbours.
England Mean	Provided as a point of comparison, based on the most recent nationally available data
RAG Rating	• **Red** – current performance is off target by more than 10% • **Amber** – current performance is off target by 10% or less • **Green** – current performance is on target by up to 5% over target • **Blue** – current performance exceeds target by more than 5% • **Baseline** – indicates performance is currently being tracked in order to inform the target setting process • **Contextual** – these measures track key activity being undertaken, to present a rounded view of information relevant to the service area, without a performance target. • **In Development** - measure has been agreed, but data collection and target setting are in development
Indicator Description	Provides an overview of how a measure is calculated. Where possible, this is based on a nationally agreed definition to assist benchmarking with statistically comparable authorities
Commentary	Provides a narrative to explain the changes in performance within the reporting period
Actions	Actions undertaken to address under-performance. Populated for 'red' indicators only
Useful Links	Provides links to relevant documentation, such as nationally available data and definitions

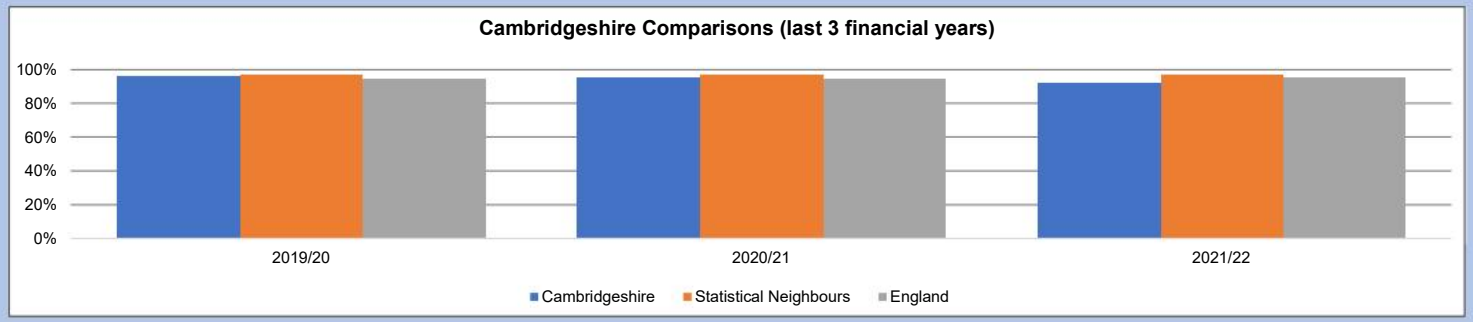
Indicator 105: Percentage of those able to express desired outcomes who fully or partially achieved their desired outcomes

Return to Index December 2023

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
In Development	↑	96.3%	93.9%	Improving

Statistical Neighbour Mean	England Mean	RAG Rating
97.1%	95.4%	In Development





Indicator Description

The Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.

As part of the statutory reporting of safeguarding cases, those adults at risk may be asked what their desired outcomes of a safeguarding enquiry are. Where desired outcomes have been expressed, after completion of the safeguarding enquiry, the achievement of these outcomes is reported. This data is collected as part of the statutory Safeguarding Adults Collection.

This indicator links to indicator 236 and monitors how well we have been able to support the person to achieve the outcomes they wanted from the safeguarding enquiry.

Calculation:

(X/Y)*100

Where:

X = The number of concluded enquiries where outcomes were either achieved or partially achieved.

Y = The number of concluded enquiries where the adult(s) expressed desired outcomes.

Commentary

Performance for quarter 1 2023/24 was better than the previous 2 quarters and above the England average. Making Safeguarding Personal and ensuring we hear the voice of the person throughout is a key priority for the service. A lack of regular reporting has impacted our ability to track in the previous couple of years, however this is now available and hence will ensure a clearer focus.

Useful Links

Measures from the Adult Social Care Outcomes Framework from NHS Digital

The local area benchmarking tool from the Local Government Association

The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions:

Actions

Data contained in this report will be used to inform a target setting process and targets will be reported from Q4 onwards

Indicator 126: Proportion of people using social care who receive direct payments

Return to Index December 2023

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
In Development	↑	17.8%	19.3%	Declining

Statistical Neighbour Mean	England Mean	RAG rating
27.6%	26.7%	In Development

Indicator Description

Direct payments provide people with more choice and control over how they meet their care and support needs.

The scope of this indicator is limited to people who receive long term support only. These include people whose self directed support is most relevant. This will better reflect the council's progress in delivering personalised services for users and carers.

Both measures for self directed support and direct payments have also been split into two. They will focus on users and carers separately. This measure reflects the proportion of people who receive a direct payment either through a personal budget or other means.

Calculation:

(X/Y)*100

X = The number of users receiving direct payments and part direct payments at the end of the period.

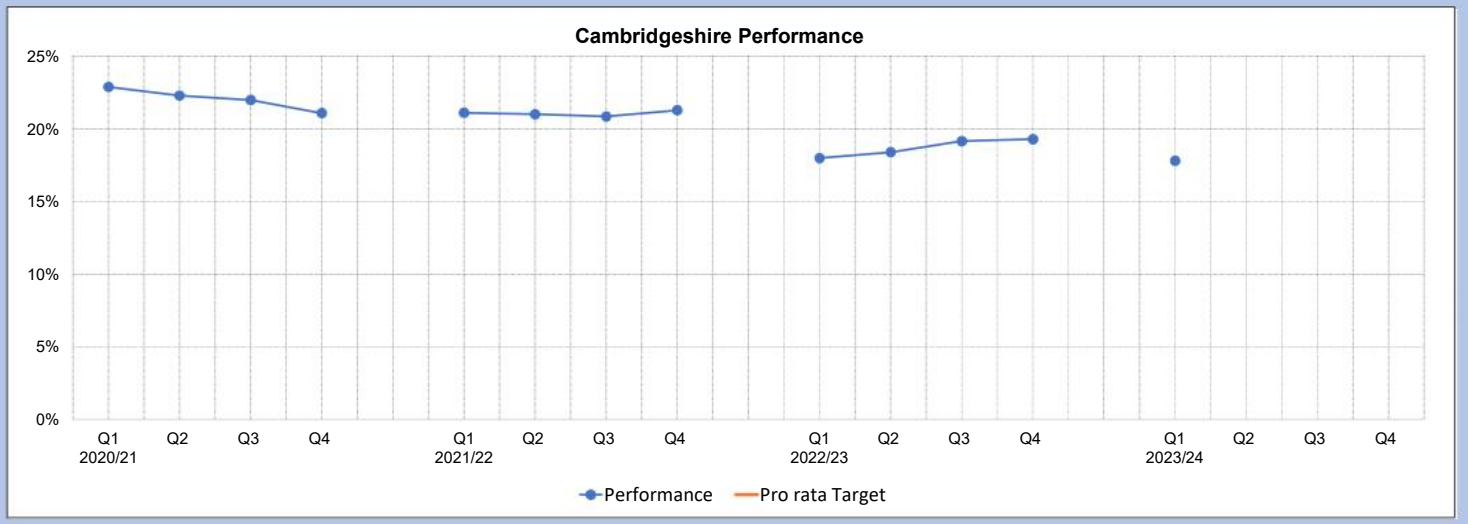
Y = Clients aged 18 or over accessing long term support at the end of the period.

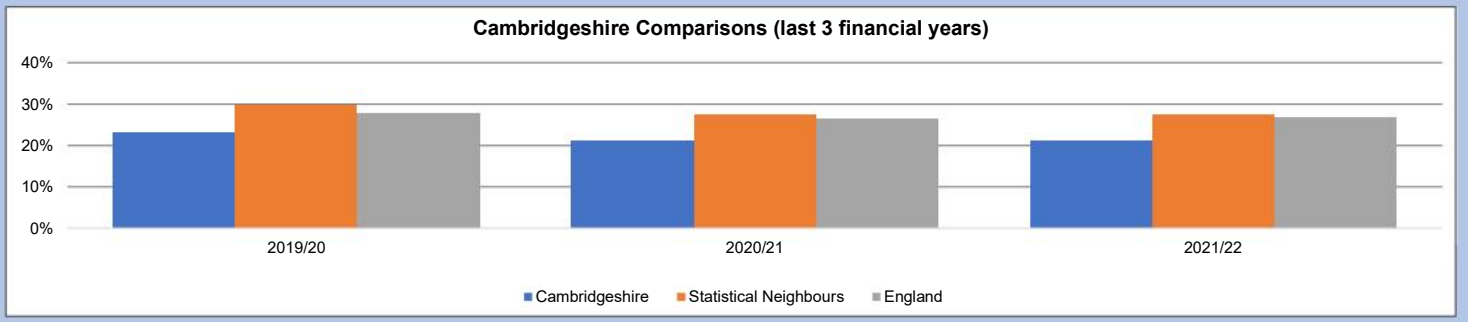
Useful Links

Measures from the Adult Social Care Outcomes Framework from NHS Digital

The local area benchmarking tool from the Local Government Association

The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions:





Commentary

The percentage of people receiving direct payments in Q1 2023/24 continues to be low, reflecting the challenge in making direct payments an attractive solution. This is a key area for improvement on our imporvement plan with a programme of work including the follow actions:
Our work with Community Catalyst around micro enterprises seeks to build more opportunities for people to use direct payments to access care and support opportunities local to them.
The council has recently introduced Individual Service Funds, a personal budget managed by a provider of the persons choice rather than held by themselves. This alongside the work to develop place based micro-enterprises within the Care Together programme should help to build on the range of options available. Although numbers appears to have decreased this is iin part due to one off payments only conting in the year they are made and it being early in the currently financial year.

Actions

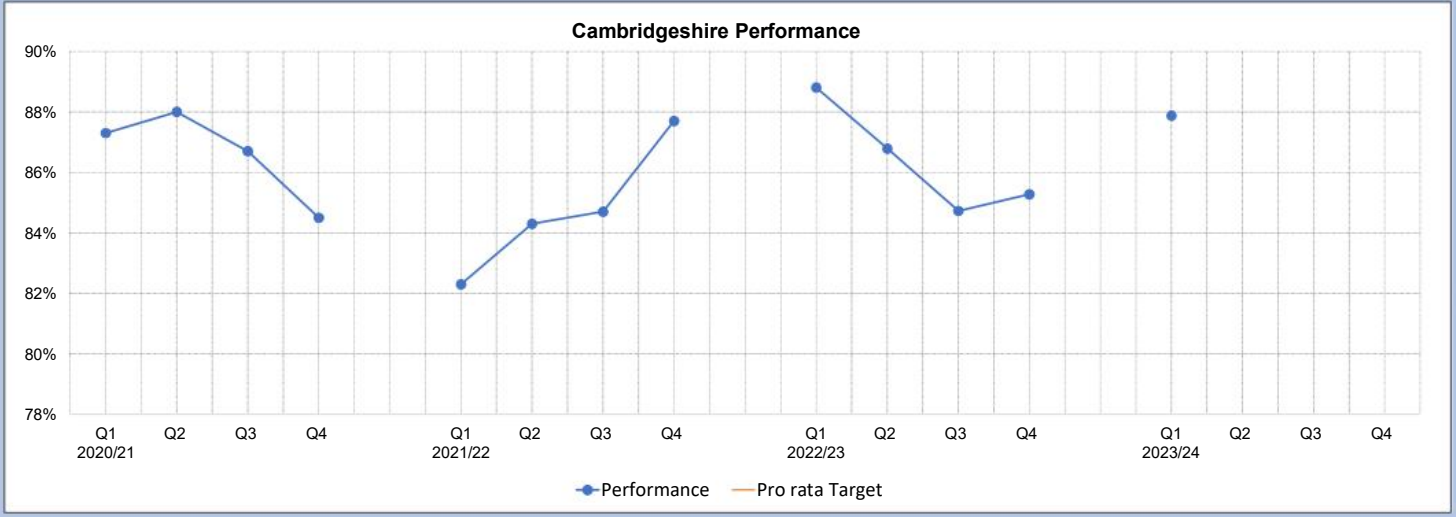
Data contained in this report will be used to inform a target setting process and targets will be reported from Q4 onwards. We now have a programme manager in place to oversee the work to increase direct payments and hopefully this will support progress to begin to deliver a noticeable impact.

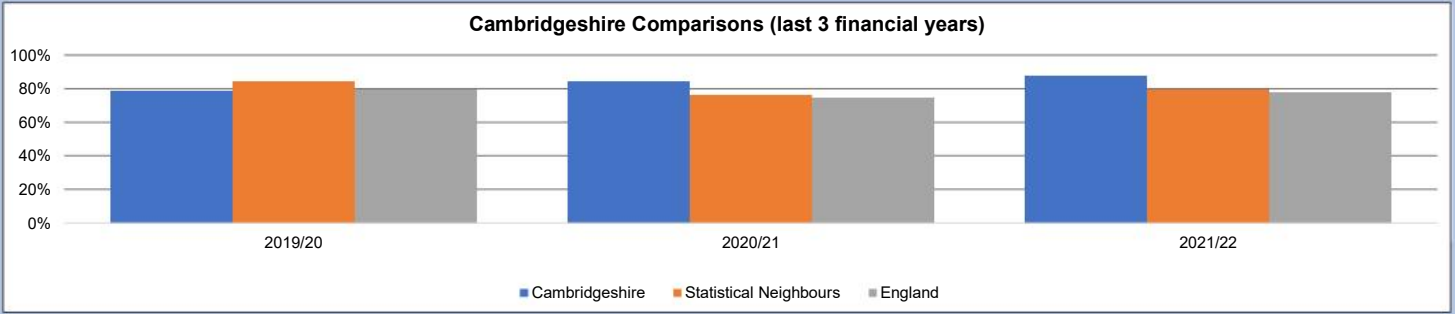
Indicator 140: Proportion of people receiving reablement who did not require long term support after reablement was completed

Return to Index December 2023

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
In Development	↑	87.9%	85.3%	Improving

Statistical Neighbour Mean	England Mean	RAG Rating
79.3%	77.6%	In Development





Indicator Description

This indicator shows the proportion of new clients who received short term services during the year, where no further request was made for ongoing support. Reablement support has best results for those who can be prevented from requiring long term care and support. However, it can also benefit people in receipt of long-term care and support by supporting improvement and enhancing their level of independence. Setting a target too high on this indicator can be a perverse incentive to reduce the service for those with more complex needs. A target should be set that reflects a balance of use. This indicator can be viewed alongside the trends on new clients with long term service outcomes (indicator 231) to ensure that more complex cases are not being diverted straight into long term care.

Short term support is designed to maximise independence. Therefore, it will exclude carer contingency and emergency support. This stops the inclusion of short term support services which are not reablement services.

Calculation:

(X/Y)*100

Where:

X = Number of new clients where the sequel to "Short Term Support to maximise independence" was "Ongoing Low Level Support", "Short Term Support (Other)", "No Services Provided - Universal Services/Signposted to Other Services", or "No Services Provided - No identified needs".

Y = Number of new clients who had short term support to maximise independence. Clients with a sequel of either early cessation due to a life event, or who have had needs identified but have either declined support or are self funding are not included in this total.

Commentary

The proportion of people not requiring long-term support after a period of reablement remains high compared to the national and statistical neighbour average. The higher percentages in Quaeter 1 represent a larger proportion of reablement referrla scoming from the hospitals, which more frequently result in no long term care and support. The aim is to be able to take more refrrals from the community where we can limit the rather than fully remove relaiance on long term care and support.

Useful Links

Measures from the Adult Social Care Outcomes Framework from NHS Digital

The local area benchmarking tool from the Local Government Association

The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions:

Actions

Data contained in this report will be used to inform a target setting process and targets will be reported from Q4 onwards

Indicator 229: Percentages of safeguarding enquiries where risk has been reduced or removed

Return to Index December 2023

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
In Development	↑	91.7%	87.5%	Improving

Statistical Neighbour Mean	England Mean	RAG Rating
92.0%	91.2%	In Development

Indicator Description

This indicator tracks the effectiveness of safeguarding enquiries in reducing or removing risk. It should be viewed alongside indicators 236 and 105, which reflect the desired outcomes of the person at risk. This is to ensure that there is not a perverse incentive to go against the person's wishes and eliminate risk when that person has capacity to decide on a level of risk that is acceptable to them.

Calculation:

(X/Y)*100

Where:

X = The number of enquiries where the risk had been reduced or removed when the enquiry concluded

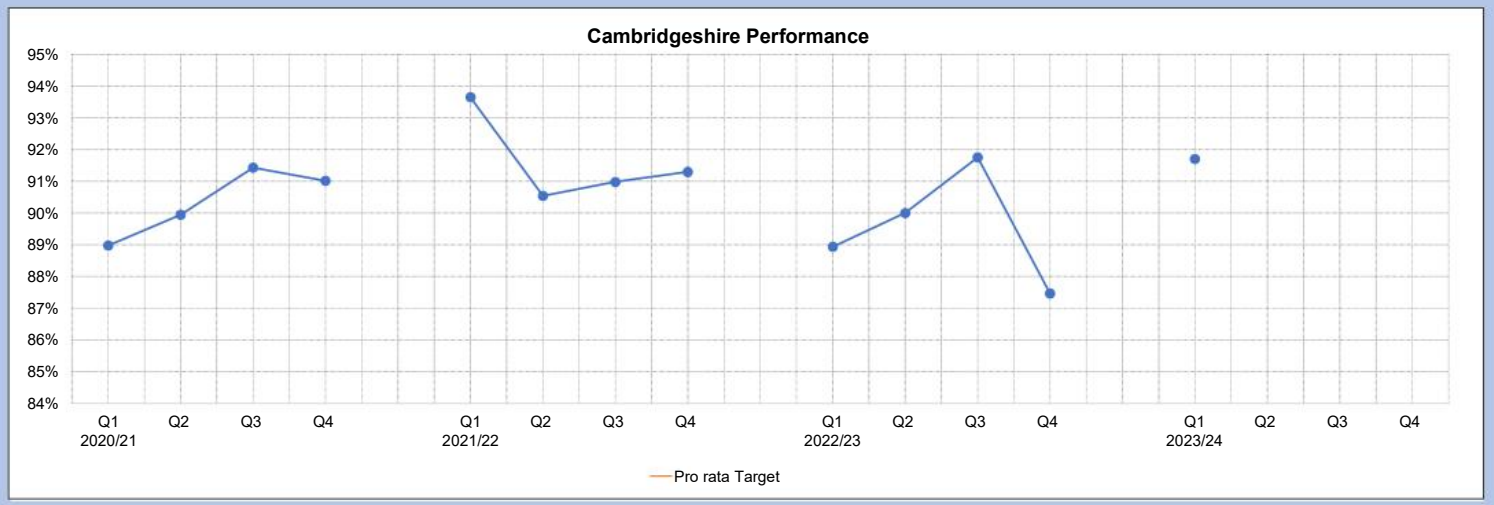
Y = The number of concluded enquiries where a risk was identified

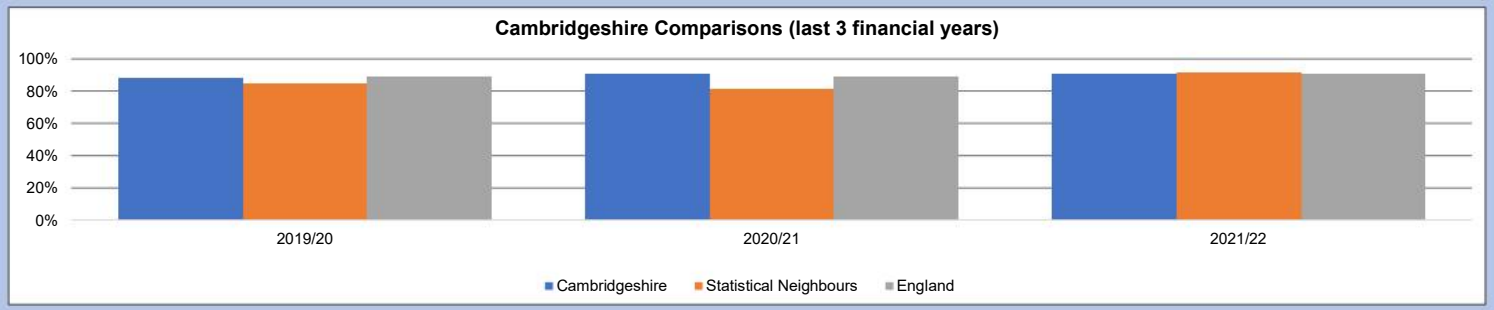
Useful Links

Measures from the Adult Social Care Outcomes Framework from NHS Digital

The local area benchmarking tool from the Local Government Association

The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions:





Commentary

Performance has increased from 88.94% in Q1 2022/23 to 91.18% in Q1 2023/24. Within the last year, staff have been supported by new interactive dashboards to manage performance. In comparison to statistical neighbours we look slightly low but this is in part due to our MASH processes and the use of a information gathering step to investigate and resolve issues where appropraite to do so outside of a full Section 42 safeguarding enquiry this means that the isues goignto a full enquiry are more likely to be complex.

Actions

Data contained in this report will be used to inform a target setting process and targets will be reported from Q4 onwards

Indicator 230: Number of new client contacts for Adult Social Care per 100,000 of the population

Return to Index

December 2023

Pro Rata Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
In Development	↑	1060.9	4560.4	Declining

Statistical Neighbour Mean	England Mean	RAG Rating
4477.9	4450.5	In Development

Indicator Description

Effective community prevention and information services should minimise the number of people needing to contact adult social care directly. A marked growth in the number of contacts might show that universal community services are not meeting need. Conversely a marked reduction might suggest that we are not providing the right pathways into adult social care for those who do need it.

This measure only includes requests for support relating to new clients. In line with statutory reporting guidance, the definition of "new" is that the client is not in receipt of any long term support at the time the contact was made.

Calculation:

(X/Y)*100,000

Where:

X = Total number of new requests for support from people aged 18+ as defined by SALT guidance (tables STS001 1a and STS001 1b)

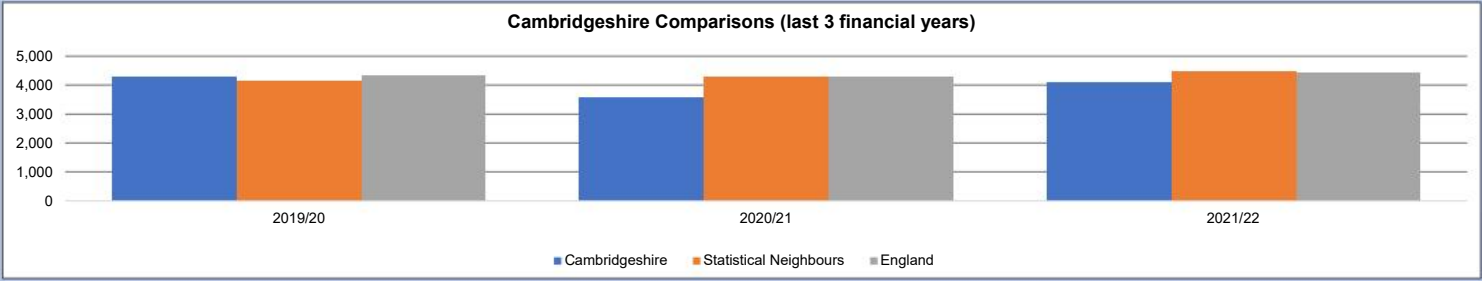
Y = 18+ population

Useful Links

Measures from the Adult Social Care Outcomes Framework from NHS Digital

The local area benchmarking tool from the Local Government Association

The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions:



Commentary

New client contacts per 100,000 of population increased across all 4 quarters in 2022/23 compared to 2021/22. The figures have decreased slightly in Q1 2023/24 compared to last year, but still remain above the equivalent quarters for 2020/21 and 2021/22.
Cambridgeshire recorded a higher number of new client contacts in 2022/23 compared to the previous two financial years. In part this is attributable to the new reporting processes implemented in the latter part of the 2021/22 financial year, as well as normal statistical variation. However, there has been a level of increase in new client contacts that is felt to be linked to need in the community (see indicator 231), reflected in the increased numbers of new client assessments for care and support being undertaken (2021/22 monthly average of completed assessments/reassessments: 330, 2022/23 monthly average = 392). Part of the increase in contact numbers may also be due to proactive work with primary care social prescribers to increase awareness of prevention and early intervention services such as lifeline alarms. During the 2022/23 financial year, Cambridgeshire implemented a system to receive electronic referrals from GP and social prescribing systems in order to improve the referral route and increase the quality of information received. - We can see this has continued to be the case in 2023/24.

Actions

Indicator 231: % of new client contacts not resulting in long term care and support

Return to Index December 2023

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
In Development	↑	87.6%	87.6%	Improving

Statistical Neighbour Mean	England Mean	RAG Rating
91.7%	91.8%	In Development

Indicator Description

This indicator is important to look at in line with indicator 230 as it shows whether change in contact numbers are from people needing long term care, or people whose needs could be met with preventative or low level community support. It helps us understand what might be driving a growth or reduction in contacts.

This measure only includes requests for support relating to new clients. In line with statutory reporting guidance, the definition of "new" is that the client is not in receipt of any long term support at the time the contact was made.

Calculation:

(X/Y)*100

Where:

X = Total number of new requests for support from people aged 18+ as defined by SALT guidance (tables STS001 1a and STS001 1b) that do not result in the need for long term care and support

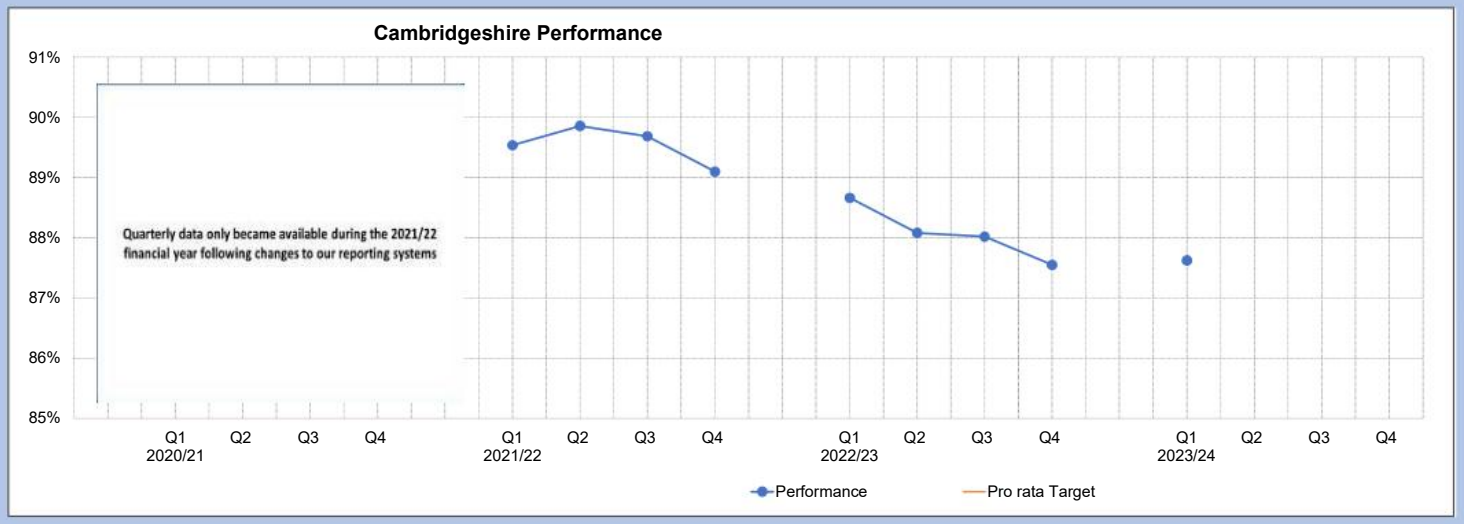
Y = Total number of new requests for support from people aged 18+ as defined by SALT guidance (tables STS001 1a and STS001 1b)

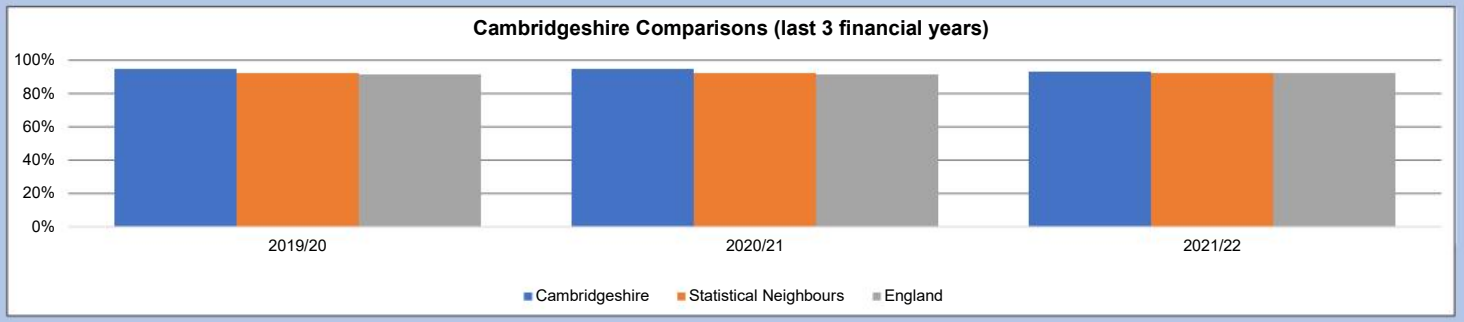
Useful Links

Measures from the Adult Social Care Outcomes Framework from NHS Digital

The local area benchmarking tool from the Local Government Association

The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions:





Commentary

The percentage of new client contacts not resulting in long-term care and support has shown a decreasing trend over the last year, alhtough rising sligtly in Quarter 1 demand from new clinets remains high. When interpreted in line with indicator 230, the overal picture is that the need for Long Term services remains high compared to 2021/22, the increase is predominantly by growth in demand from people in the community as hospital discharges have been quite static.

Actions

Indicator 232: Proportion of people receiving long term support who had not received a review in the last 12 months, % of all people funded by ASC in long-term

Return to Index December 2023

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
In Development	↓	19.3%	25.2%	Improving

Statistical Neighbour Mean	England Mean	RAG Rating
41.3%	45.0%	In Development

Indicator Description

It is a statutory duty to review long term care and support plans at least once a year. Regular reviews can help safeguard from risk, but also support personalisation by continuing to support people to connect to their communities and make the most of the local assets.

Calculation:

(X/Y)*100

Where:

X = Number of people receiving long-term support for over 12 months who had not received a review in the last 12 months

Y = Total number of people receiving long-term support for over 12 months at the end of the period

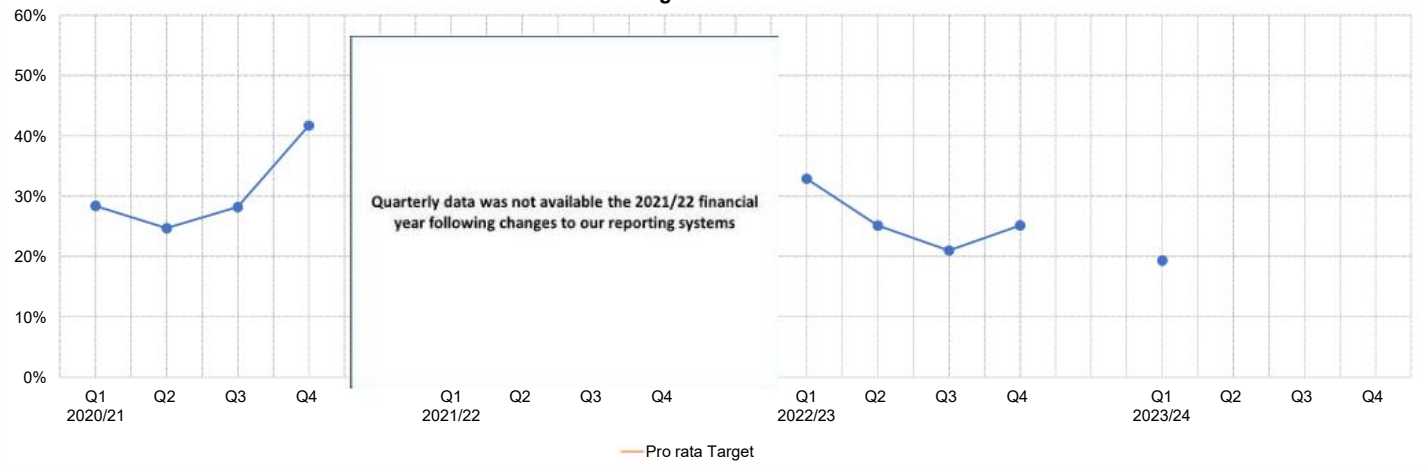
Useful Links

Measures from the Adult Social Care Outcomes Framework from NHS Digital

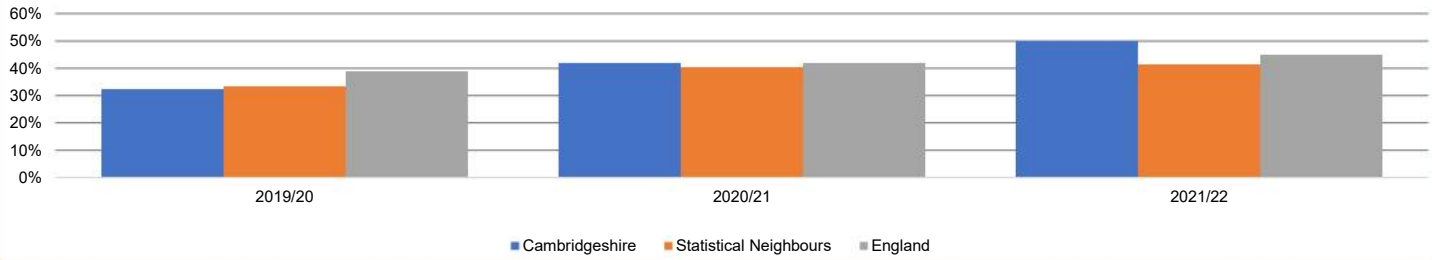
The local area benchmarking tool from the Local Government Association

The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions:

Cambridgeshire Performance



Cambridgeshire Comparisons (last 3 financial years)



Commentary

The % of clients at the end of Q1 2023/24 with no review in the last 12 months is the lowest across the last 3 financial years.

During 2022/23, there was a significant level of activity undertaken to clear review backlogs that built up during the pandemic. An external agency was commissioned from March 2022 to work through the backlog of reviews for clients receiving long-term services. This additional capacity significantly increased the number of reviews being completed; in 2021-22 there was an average of 294 reviews completed per month, increasing to an average of 472 reviews for the completed financial year 2022-23. In Q1 2023/24, there were 457 reviews completed on average per month, partly due to the continued involvement of the ASC external team.

Actions

Indicator 233: Number of carers assessed or reviewed in the year per 100,000 of the population

Return to Index December 2023

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
In Development	↑	14.1	87.0	Declining

Statistical Neighbour Mean	England Mean	RAG Rating
440.8	1398.3	In Development

Indicator Description

Reviews are also an important time to make contact with carers to check that they remain able to offer their critical support. Assessments and reviews can be done jointly or separately from the cared for person. It is an opportunity to support carers to continue their caring role but also to plan for the future.

Calculation:

(X/Y)*100,000

Where:

X = Total number of carers with a carers assessment or review in the period

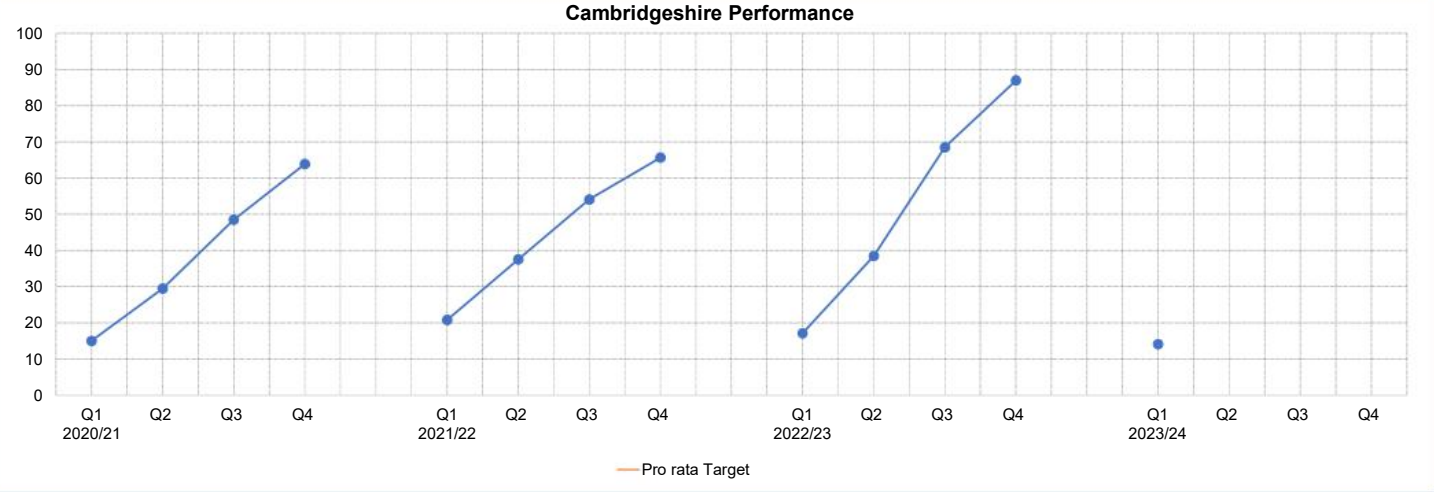
Y = 18+ population

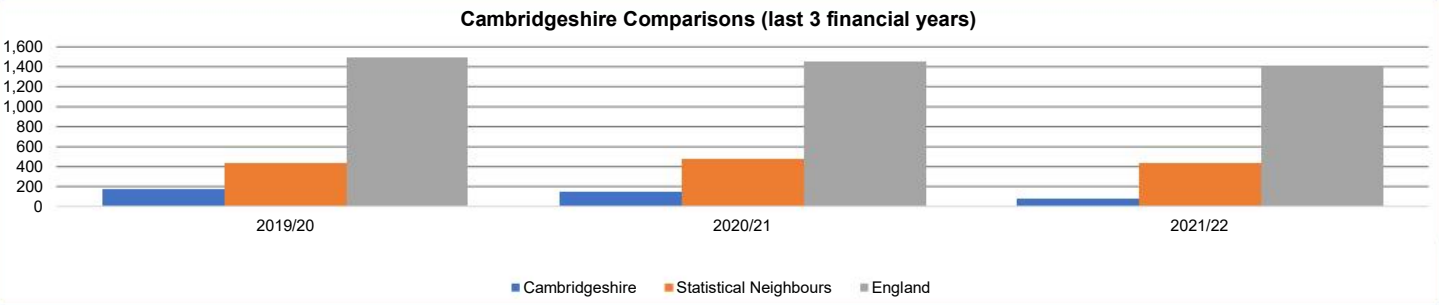
Useful Links

Measures from the Adult Social Care Outcomes Framework from NHS Digital

The local area benchmarking tool from the Local Government Association

The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions:





Commentary

A move away from carers assessments by default to a more constructive and timely conversation accounts for the lower volume of carers assessments. This should be seen alongside our carers conversation and carers triage activity. During Q1 2023/24 we have completed:
•64 carers assessments
•13 carers reviews
•798 carers conversation steps (often completed when assessing the cared-for service user - see bullet point below)
The number of carers assessed or reviewed in the period is significantly below the national average, and the average of our statistical neighbours. This is due to how carer activity is recorded in Cambridgeshire and a reflection of our process. Activity by teams supporting carers can be recorded as carers conversations, which would not be counted in the above measure. As part of our revised carers strategy and related action plan we would expect to see an increase in carers assessments and reviews as we look to increase carers breaks options.

Actions

Data contained in this report will be used to inform a target setting process and targets will be reported from Q4 onwards

Indicator 234: % total people accessing long term support in the community aged 18-64

Return to Index December 2023

Target	Direction for Improvement	Current Month	Previous Month	Change in Performance
In Development	↑	90.7%	90.7%	Declining

Statistical Neighbour Mean	England Mean	RAG Rating
82.4%	84.7%	In Development

Indicator Description

We want people to be supported in a community setting whenever that is best for them. Community settings include sheltered housing and extra care housing. Residential and nursing homes are the right choice for those with the most complex needs but good performance on this indicator should reflect partnership working with housing to provide alternatives for housing with support. Using an indicator that splits ages helps monitor equity between client groups.

Calculation:

(X/Y)*100

Where:

X = Total number of people accessing long-term support in the community aged 18-64

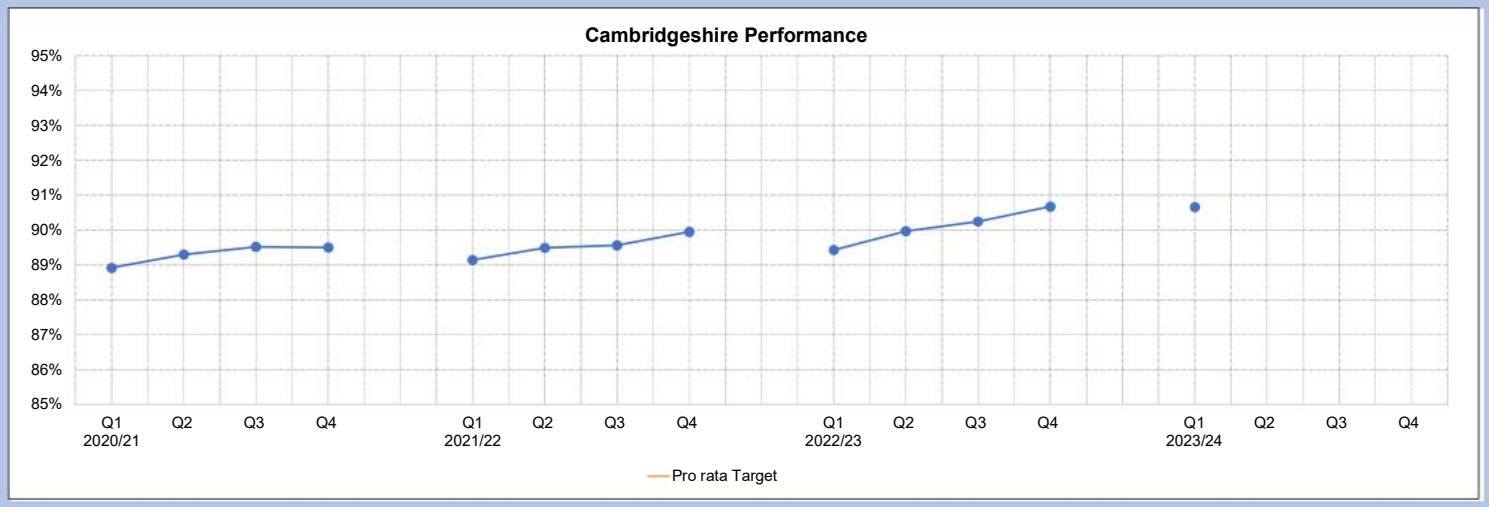
Y = Total number of people accessing long-term support aged 18-64

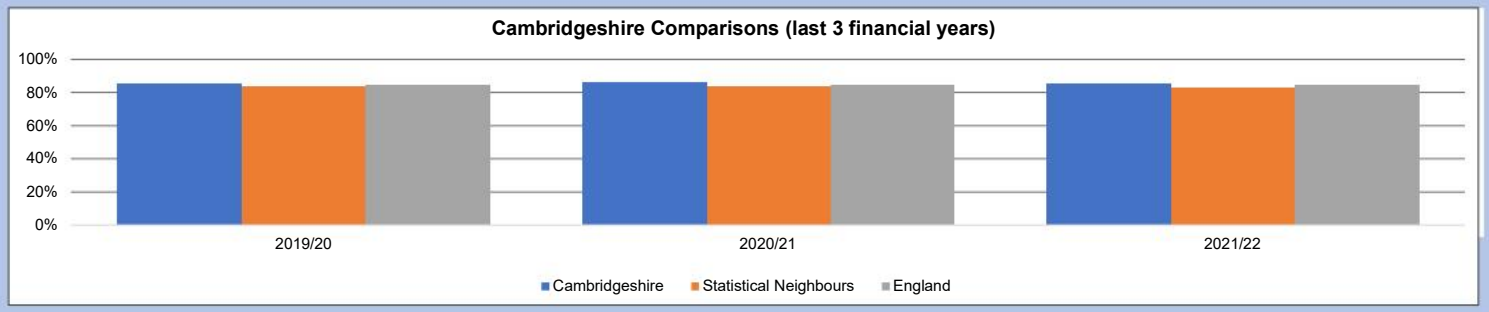
Useful Links

Measures from the Adult Social Care Outcomes Framework from NHS Digital

The local area benchmarking tool from the Local Government Association

The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions:





Commentary

Please note, Q4 data for Cambridgeshire is only provisional and will be updated to reflect statutory returns once published. Annual comparisons with statistical neighbours and England will also be available further to the national publication of statutory data for 2022/23.

The percentage of clients accessing long term support in the community aged 18-64 has remained relatively static over the last 12 months, but increased slightly from 89.4% in Q1 2022/23. The overal number of community based clients has also increased, from 2157 in Q1 2022/23 to 2271 in Q1 2023/24. Increasing need for long term services in general and community clients specifically has been experienced throughout the last year for 18-64 clients.

Actions

Data contained in this report will be used to inform a target setting process and targets will be reported from Q4 onwards

Indicator 235: % total people accessing long term support in the community aged 65 and over

Return to Index December 2023

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
In Development	↑	60.7%	64.5%	Declining

Statistical Neighbour Mean	England Mean	RAG rating
59.3%	62.4%	In Development

Indicator Description

We want people to be supported in a community setting whenever that is best for them. Community settings include sheltered housing and extra care housing. Residential and nursing homes are the right choice for those with the most complex needs but good performance on this indicator should reflect partnership working with housing to provide alternatives for housing with support. Using an indicator that splits ages helps monitor equity between client groups.

Calculation:

(X/Y)*100

Where:

X = Total number of people accessing long-term support in the community aged 65 and over

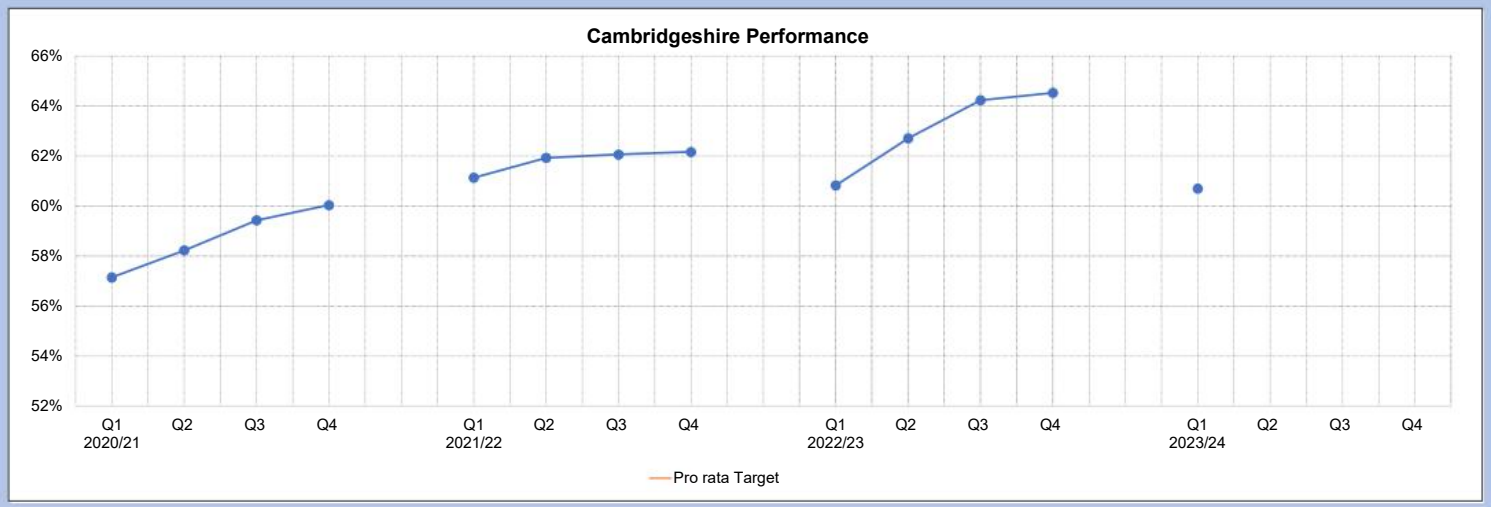
Y = Total number of people accessing long-term support aged 65 and over

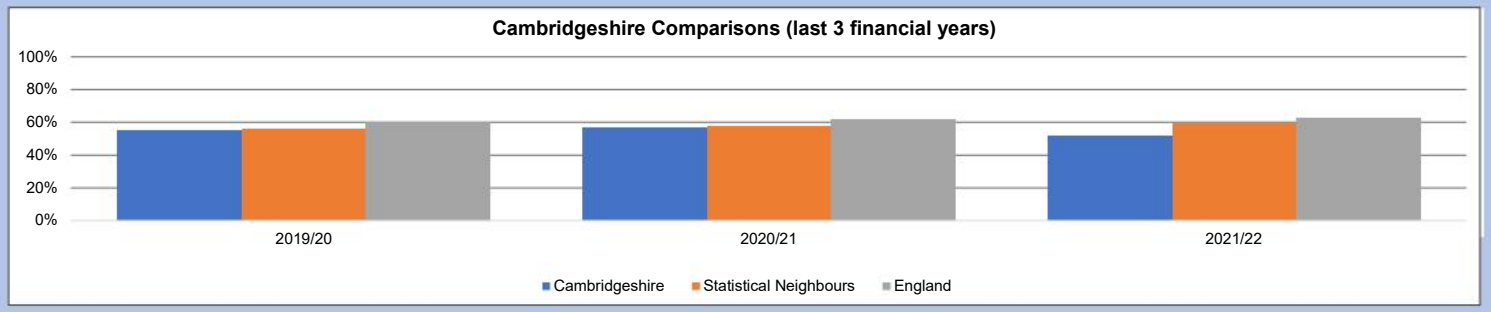
Useful Links

Measures from the Adult Social Care Outcomes Framework from NHS Digital

The local area benchmarking tool from the Local Government Association

The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions:





Commentary

Please note, Q4 data for Cambridgeshire is only provisional and will be updated to reflect statutory returns once published. Annual comparisons with statistical neighbours and England will also be available further to the national publication of statutory data for 2022/23.

The percentage of clients aged 65+ accessing long term support in the community had increased during the course of 2022/23, but has now dropped to a comparable rate with last year (60.83% in Q1 2022/23, 60.69% in Q1 2023/24). The number of clients receiving long term support and support in the community specifically have both increased marginally in the last 12 months.

Actions

Data contained in this report will be used to inform a target setting process and targets will be reported from Q4 onwards

Indicator 236: Percentage of Cases where Making Safeguarding Personal (MSP) questions have been asked

Return to Index December 2023

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
In Development	↑	96.4%	87.2%	Improving

Statistical Neighbour Mean	England Mean	RAG Rating
81.6%	79.7%	In Development

Indicator Description

It is important when undertaking a safeguarding enquiry that the person to whom it relates is engaged and is able to say what they want as an outcome, where they have capacity to do so. This indicator monitors how well we are involving people in this way.

Calculation:

(X/Y)*100

Where:

X = The number of concluded enquiries where the adult or adult's representative was asked what their desired outcomes were

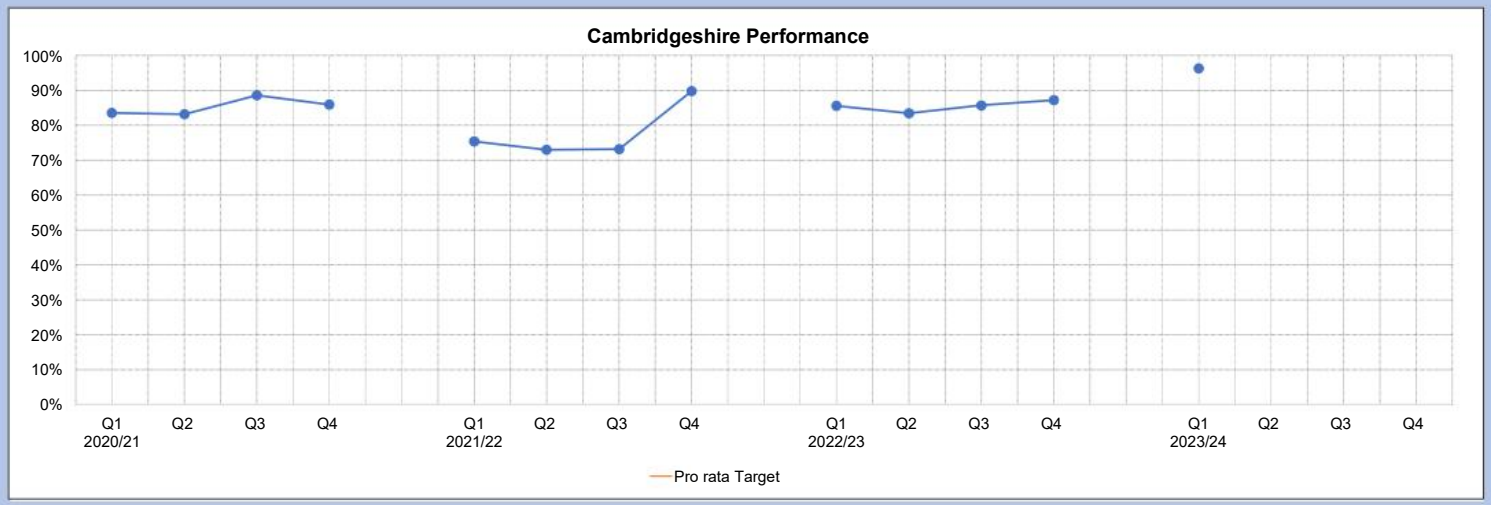
Y = The number of concluded enquiries

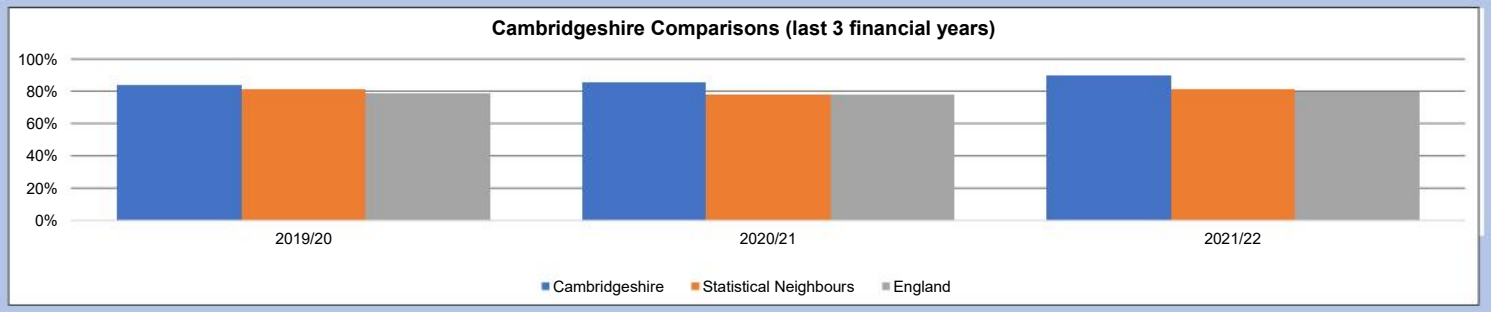
Useful Links

Measures from the Adult Social Care Outcomes Framework from NHS Digital

The local area benchmarking tool from the Local Government Association

The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions:





Commentary

Please note, Q4 data for Cambridgeshire is only provisional and will be updated to reflect statutory returns once published. Annual comparisons with statistical neighbours and England will also be available further to the national publication of statutory data for 2022/23.

Performance in this area continues to be high and comparable with national and statistical neighbour averages.

We continue to have reporting gaps for safeguarding. New dashboards are currently in development meaning not all the data needed to inform these indicators is available for routine use by staff. However, current performance suggests that the Making Safeguarding Personal agenda is fully imbedded in the safeguarding process.

Actions

Data contained in this report will be used to inform a target setting process and targets will be reported from Q4 onwards

Produced on: 05 December 2023

Performance Report

Quarter 2

2023/24 financial year

Adults and Health Committee

Governance & Performance
Cambridgeshire County Council
business.intelligence@cambridgeshire.gov.uk

Key

Data Item	Explanation
Target / Pro Rata Target	The target that has been set for the indicator, relevant for the reporting period
Current Month / Current Period	The latest performance figure relevant to the reporting period
Previous Month / previous period	The previously reported performance figure
Direction for Improvement	Indicates whether 'good' performance is a higher or a lower figure
Change in Performance	Indicates whether performance is 'improving' or 'declining' by comparing the latest performance figure with that of the previous reporting period
Statistical Neighbours Mean	Provided as a point of comparison, based on the most recently available data from identified statistical neighbours.
England Mean	Provided as a point of comparison, based on the most recent nationally available data
RAG Rating	• **Red** – current performance is off target by more than 10% • **Amber** – current performance is off target by 10% or less • **Green** – current performance is on target by up to 5% over target • **Blue** – current performance exceeds target by more than 5% • **Baseline** – indicates performance is currently being tracked in order to inform the target setting process • **Contextual** – these measures track key activity being undertaken, to present a rounded view of information relevant to the service area, without a performance target. • **In Development** - measure has been agreed, but data collection and target setting are in development
Indicator Description	Provides an overview of how a measure is calculated. Where possible, this is based on a nationally agreed definition to assist benchmarking with statistically comparable authorities
Commentary	Provides a narrative to explain the changes in performance within the reporting period
Actions	Actions undertaken to address under-performance. Populated for 'red' indicators only
Useful Links	Provides links to relevant documentation, such as nationally available data and definitions

Indicator 230: Number of new client contacts for Adult Social Care per 100,000 of the population

Return to Index

December 2023

Pro Rata Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
In Development	↑	2150.7	1060.9	Improving

Statistical Neighbour Mean	England Mean	RAG Rating
4477.9	4450.5	In Development

Indicator Description

Effective community prevention and information services should minimise the number of people needing to contact adult social care directly. A marked growth in the number of contacts might show that universal community services are not meeting need. Conversely a marked reduction might suggest that we are not providing the right pathways into adult social care for those who do need it.

This measure only includes requests for support relating to new clients. In line with statutory reporting guidance, the definition of "new" is that the client is not in receipt of any long term support at the time the contact was made.

Calculation:

(X/Y)*100,000

Where:

X = Total number of new requests for support from people aged 18+ as defined by SALT guidance (tables STS001 1a and STS001 1b)

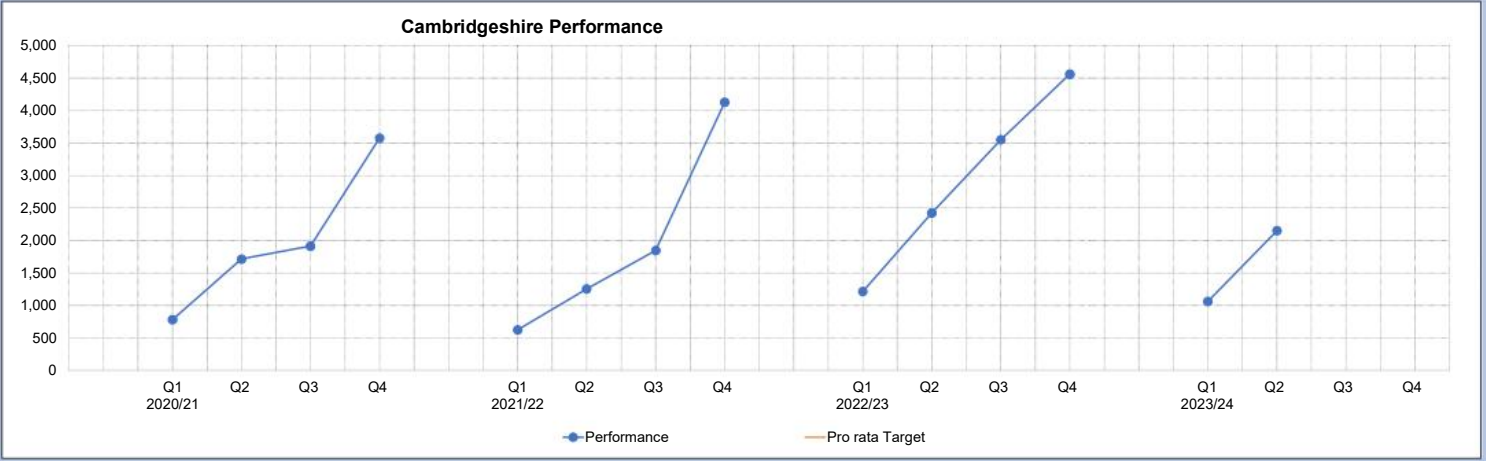
Y = 18+ population

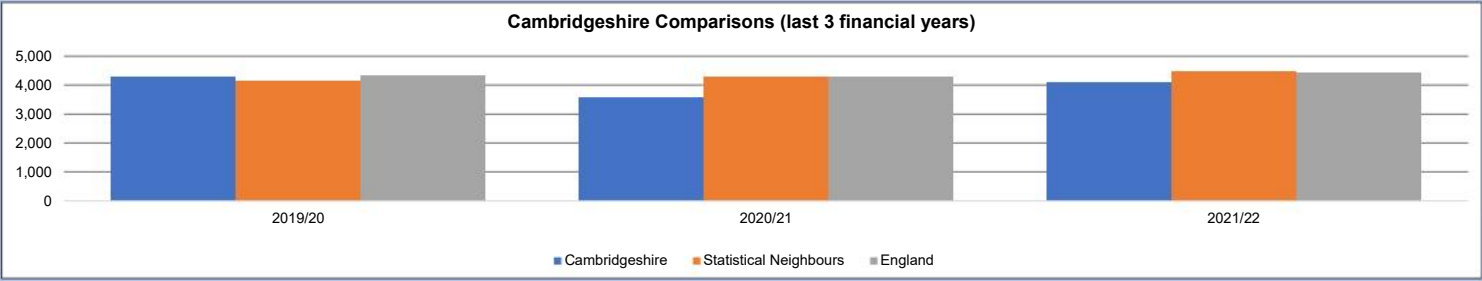
Useful Links

Measures from the Adult Social Care Outcomes Framework from NHS Digital

The local area benchmarking tool from the Local Government Association

The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions:





Commentary

Please note, Q4 data for Cambridgeshire is only provisional and will be updated to reflect statutory returns once published. Annual comparisons with statistical neighbours and England will also be available further to the national publication of statutory data for 2022/23.

New client contacts per 100,000 of population increased across all 4 quarters in 2022/23 compared to 2021/22. The demand continues to grow the lowers number of contacts in covid periods have not been sustainable and currently we are receiving a higher percentage of calls in to ASC requesting for support and remain on par with the equivalent quarters for 2021/22.

Cambridgeshire recorded a higher number of new client contacts in 2022/23 compared to the previous two financial years. In part this is attributable to the new reporting processes implemented in the latter part of the 2021/22 financial year, as well as normal statistical variation. However, there has been a level of increase in new client contacts that is felt to be linked to need in the community (see indicator 231), reflected in the increased numbers of new client assessments for care and support being undertaken (2021/22 monthly average of completed assessments/reassessments: 330, 2022/23 monthly average = 392). Part of the increase in contact numbers may also be due to proactive work with primary care social prescribers to increase awareness of prevention and early intervention services such as lifeline alarms. During the 2022/23 financial year, Cambridgeshire implemented a system to receive electronic referrals from GP and social prescribing systems to improve the referral route and increase the quality of information received.

Actions

Indicator 231: % of new client contacts not resulting in long term care and support

Return to Index December 2023

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
In Development	↑	88.3%	87.6%	Improving

Statistical Neighbour Mean	England Mean	RAG Rating
91.7%	91.8%	In Development

Indicator Description

This indicator is important to look at in line with indicator 230 as it shows whether change in contact numbers are from people needing long term care, or people whose needs could be met with preventative or low level community support. It helps us understand what might be driving a growth or reduction in contacts.

This measure only includes requests for support relating to new clients. In line with statutory reporting guidance, the definition of "new" is that the client is not in receipt of any long term support at the time the contact was made.

Calculation:

(X/Y)*100

Where:

X = Total number of new requests for support from people aged 18+ as defined by SALT guidance (tables STS001 1a and STS001 1b) that do not result in the need for long term care and support

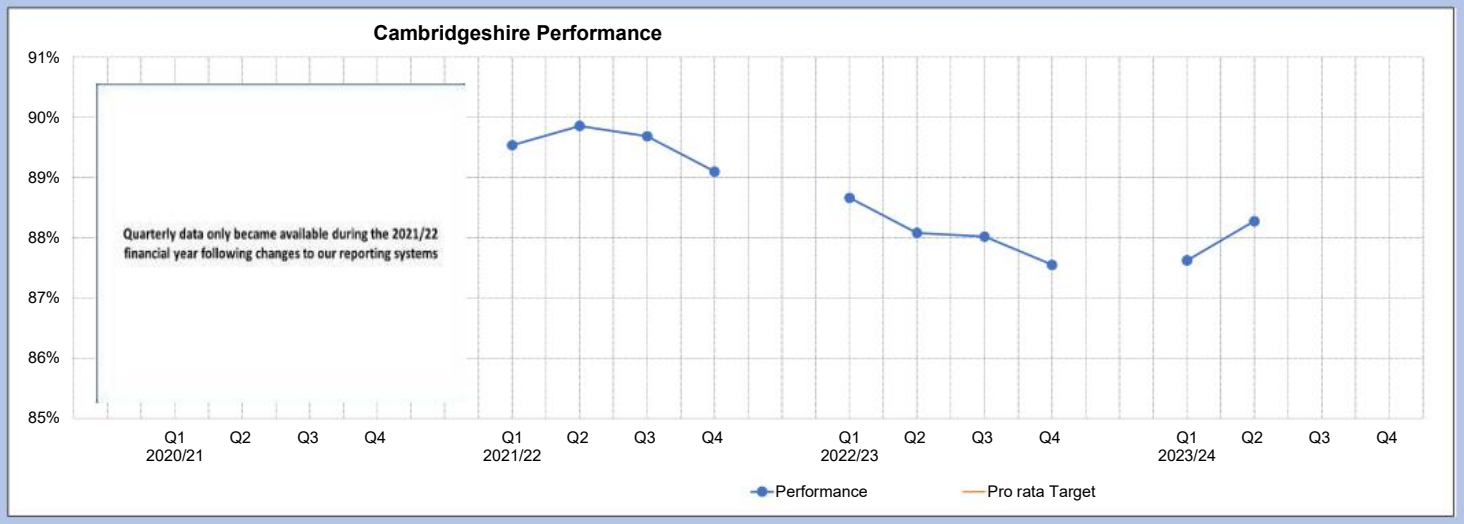
Y = Total number of new requests for support from people aged 18+ as defined by SALT guidance (tables STS001 1a and STS001 1b)

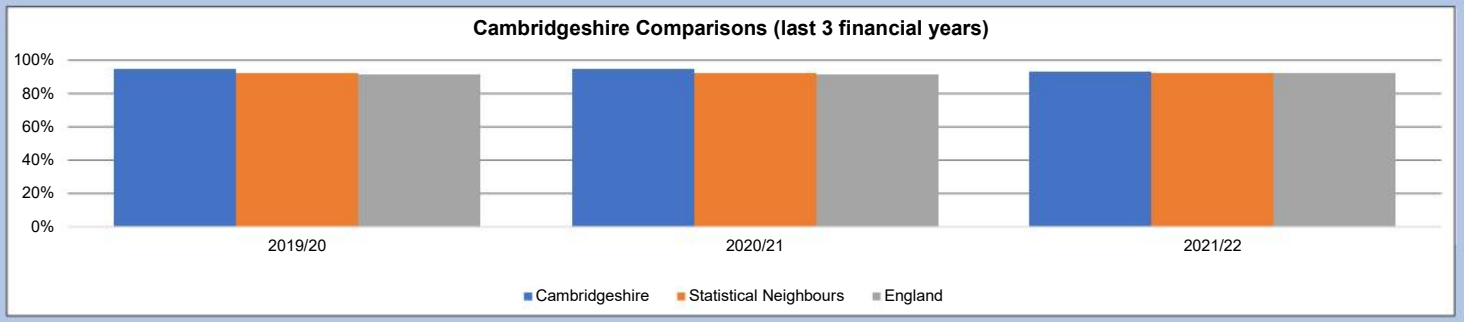
Useful Links

Measures from the Adult Social Care Outcomes Framework from NHS Digital

The local area benchmarking tool from the Local Government Association

The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions:





Commentary

Please note, Q4 data for Cambridgeshire is only provisional and will be updated to reflect statutory returns once published. Annual comparisons with statistical neighbours and England will also be available further to the national publication of statutory data for 2022/23.

The percentage of new client contacts not resulting in long-term care and support has shown a decreasing trend over the last year but has now stabilised around 88%. This figure is slightly higher than the overall percentage for 2021/22 but remains below the equivalent quarter last year. When interpreted in line with indicator 230, which presents slightly less contacts for Q2 2023/24 compared to 2022/23, the overall picture is that the need for Long Term services remains high compared to 2021/22 but has provisionally stabilised in terms of contact numbers and the % progressing to Long Term support.

Actions

Indicator 232: Proportion of people receiving long term support who had not received a review in the last 12 months, % of all people funded by ASC in long-term

Return to Index December 2023

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
In Development	↓	18.3%	19.3%	Improving

Statistical Neighbour Mean	England Mean	RAG Rating
41.3%	45.0%	In Development

Indicator Description

It is a statutory duty to review long term care and support plans at least once a year. Regular reviews can help safeguard from risk, but also support personalisation by continuing to support people to connect to their communities and make the most of the local assets.

Calculation:

(X/Y)*100

Where:

X = Number of people receiving long-term support for over 12 months who had not received a review in the last 12 months

Y = Total number of people receiving long-term support for over 12 months at the end of the period

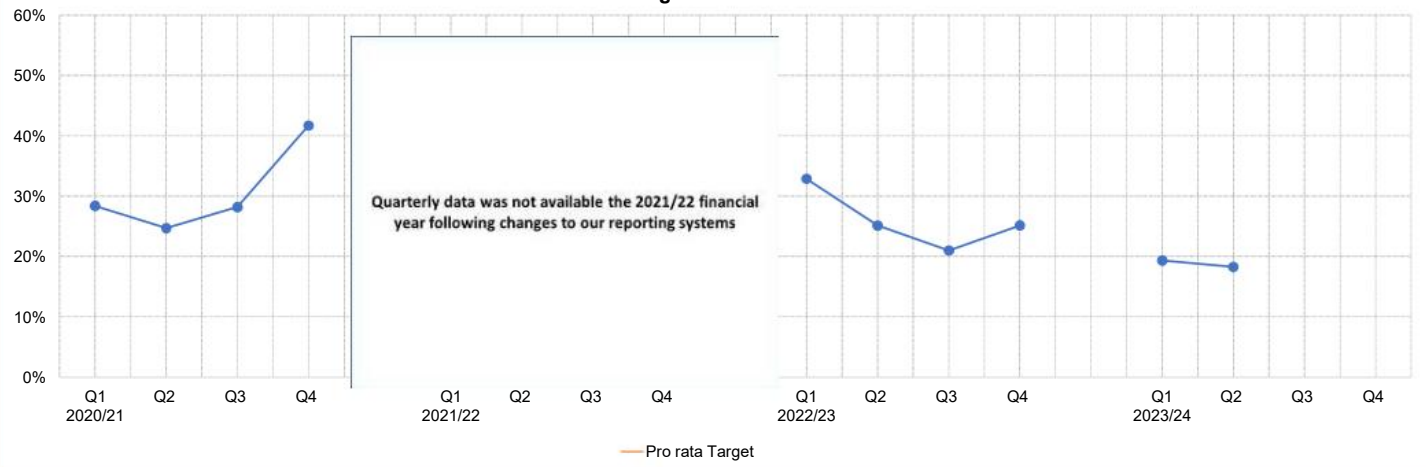
Useful Links

Measures from the Adult Social Care Outcomes Framework from NHS Digital

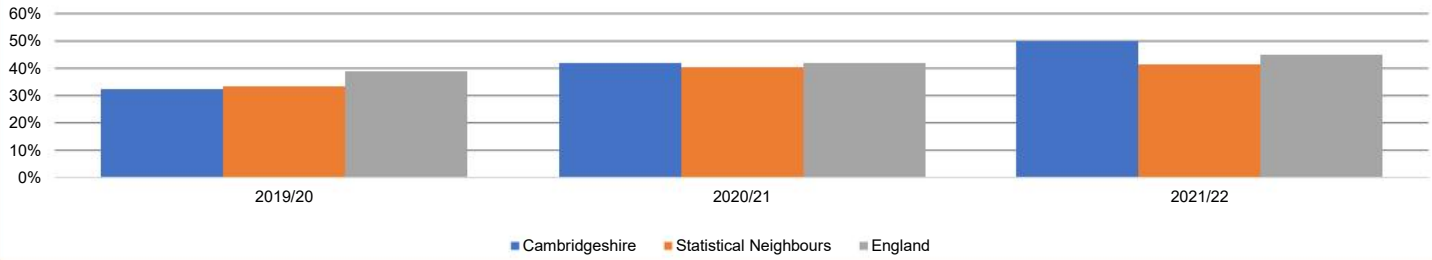
The local area benchmarking tool from the Local Government Association

The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions:

Cambridgeshire Performance



Cambridgeshire Comparisons (last 3 financial years)



Commentary

Please note, Q4 data for Cambridgeshire is only provisional and will be updated to reflect statutory returns once published. Annual comparisons with statistical neighbours and England will also be available further to the national publication of statutory data for 2022/23.

The % of clients at the end of Q2 2023/24 with no review in the last 12 months is the lowest across the last 3 financial years.

During 2022/23, there was a significant level of activity undertaken to clear review backlogs that built up during the pandemic. An external agency was commissioned from March 2022 to work through the backlog of reviews for clients receiving long-term services. This additional capacity significantly increased the number of reviews being completed; in 2021-22 there was an average of 294 reviews completed per month, increasing to an average of 472 reviews for the completed financial year 2022-23.

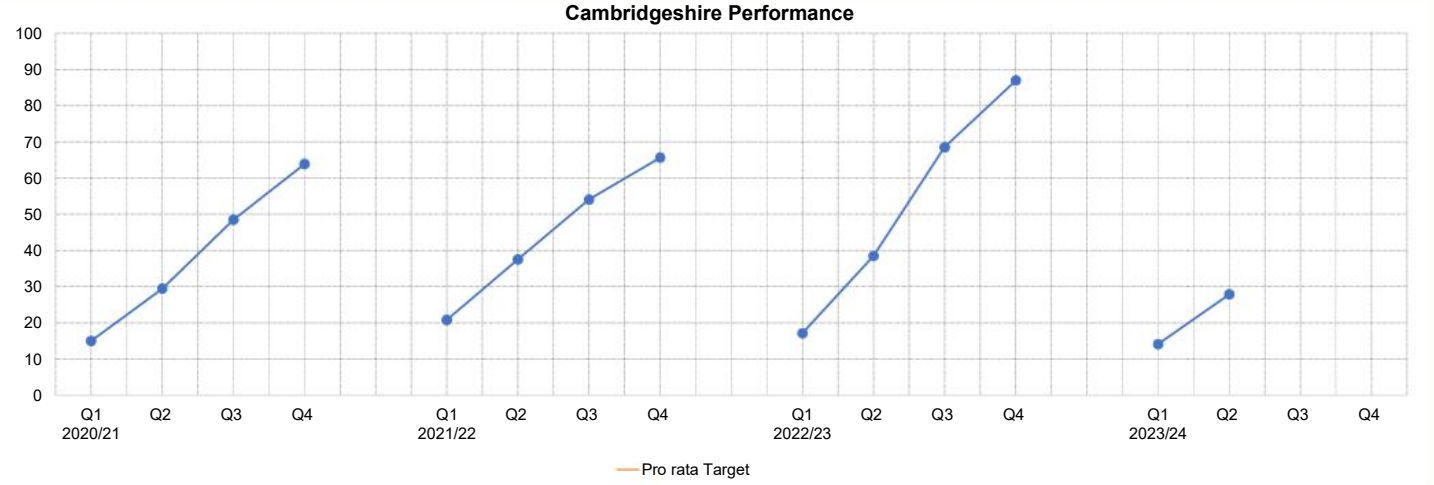
Actions

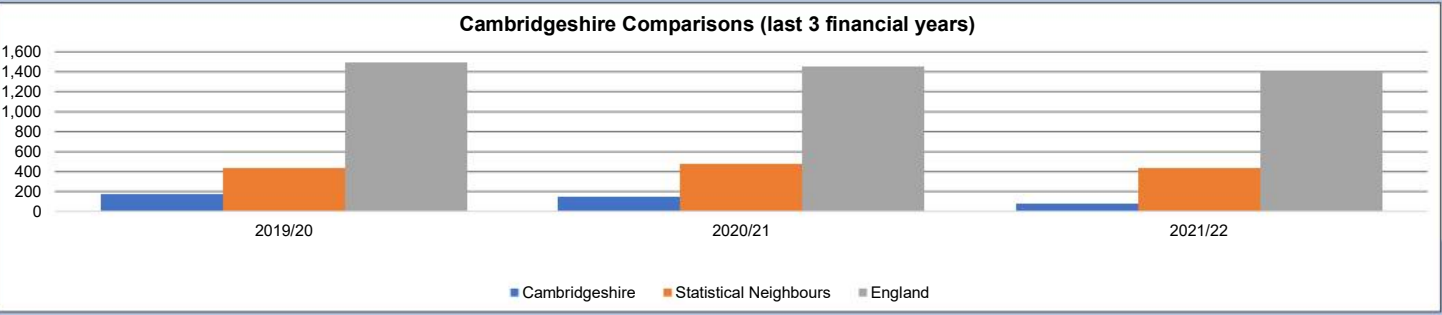
Indicator 233: Number of carers assessed or reviewed in the year per 100,000 of the population

Return to Index December 2023

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
In Development	↑	27.9	14.1	Improving

Statistical Neighbour Mean	England Mean	RAG Rating
440.8	1398.3	In Development





Indicator Description

Reviews are also an important time to make contact with carers to check that they remain able to offer their critical support. Assessments and reviews can be done jointly or separately from the cared for person. It is an opportunity to support carers to continue their caring role but also to plan for the future.

Calculation:

(X/Y)*100,000

Where:

X = Total number of carers with a carers assessment or review in the period

Y = 18+ population

Commentary

Please note, Q4 data for Cambridgeshire is only provisional and will be updated to reflect statutory returns once published. Annual comparisons with statistical neighbours and England will also be available further to the national publication of statutory data for 2022/23.

A move away from carers assessments by default to a more constructive and timely conversation accounts for the lower volume of carers assessments. This should be seen alongside our carers conversation and carers triage activity. During Q2 2023/24 we have completed 152 assessments and reviews. A paper of carers recommissioning is being presented to committee which will set the road map for future carers provision.

Useful Links

Measures from the Adult Social Care Outcomes Framework from NHS Digital

The local area benchmarking tool from the Local Government Association

The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions:

Actions

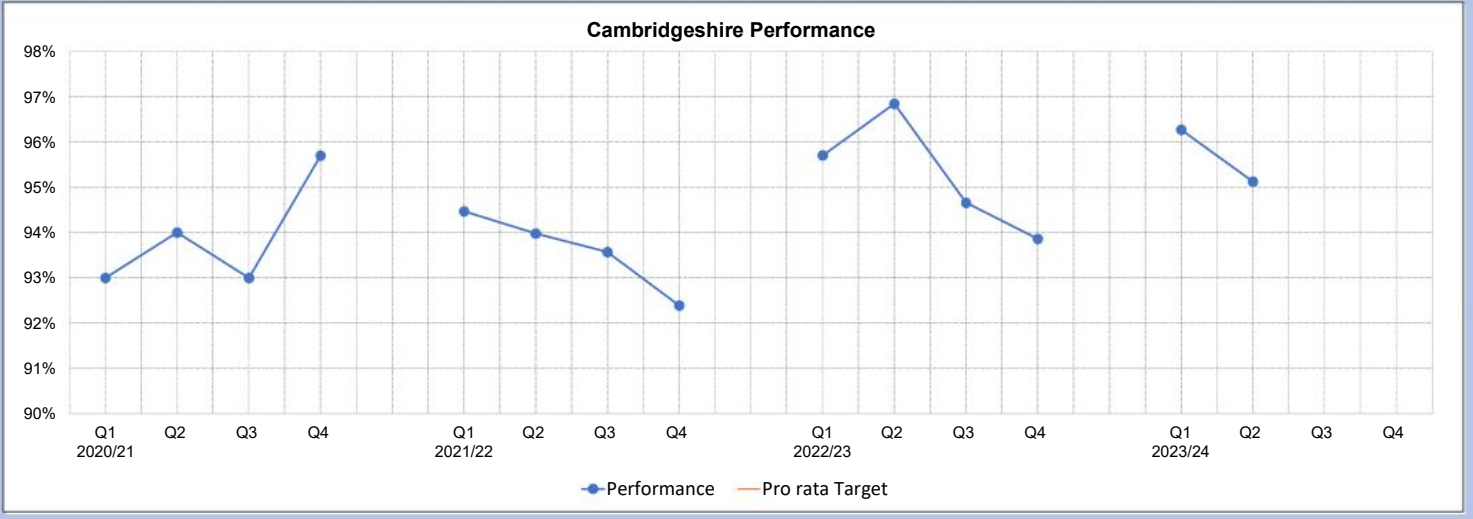
Data contained in this report will be used to inform a target setting process and targets will be reported from Q4 onwards

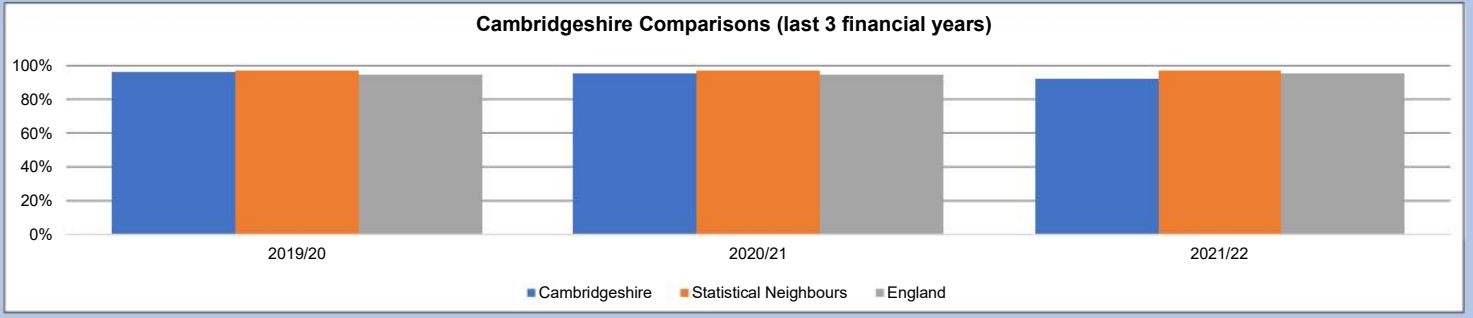
Indicator 105: Percentage of those able to express desired outcomes who fully or partially achieved their desired outcomes

Return to Index December 2023

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
In Development	↑	95.1%	96.3%	Declining

Statistical Neighbour Mean	England Mean	RAG Rating
97.1%	95.4%	In Development





Indicator Description

The Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.

As part of the statutory reporting of safeguarding cases, those adults at risk may be asked what their desired outcomes of a safeguarding enquiry are. Where desired outcomes have been expressed, after completion of the safeguarding enquiry, the achievement of these outcomes is reported. This data is collected as part of the statutory Safeguarding Adults Collection.

This indicator links to indicator 236 and monitors how well we have been able to support the person to achieve the outcomes they wanted from the safeguarding enquiry.

Calculation:

(X/Y)*100

Where:

X = The number of concluded enquiries where outcomes were either achieved or partially achieved.

Y = The number of concluded enquiries where the adult(s) expressed desired outcomes.

Commentary

Performance in this area continues to be high and comparable with national and statistical neighbour averages. The % of fully or partially achieved outcomes for Q2 2023/24 (95%) is slightly lower than for Q2 2022/23 (96%). Overall figures for the number of enquiries where outcomes were expressed and the number with fully or partially achieved outcomes remained fairly stable.

We continue to have reporting gaps for safeguarding. New dashboards are currently in development meaning not all the data needed to inform these indicators is available for routine use by staff.

Useful Links

Measures from the Adult Social Care Outcomes Framework from NHS Digital

The local area benchmarking tool from the Local Government Association

The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions:

Actions

Data contained in this report will be used to inform a target setting process and targets will be reported from Q4 onwards

Indicator 126: Proportion of people using social care who receive direct payments

Return to Index December 2023

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
In Development	↑	17.2%	17.8%	Declining

Statistical Neighbour Mean	England Mean	RAG rating
27.6%	26.7%	In Development

Indicator Description

Direct payments provide people with more choice and control over how they meet their care and support needs.

The scope of this indicator is limited to people who receive long term support only. These include people whose self directed support is most relevant. This will better reflect the council's progress in delivering personalised services for users and carers.

Both measures for self directed support and direct payments have also been split into two. They will focus on users and carers separately. This measure reflects the proportion of people who receive a direct payment either through a personal budget or other means.

Calculation:

(X/Y)*100

X = The number of users receiving direct payments and part direct payments at the end of the period.

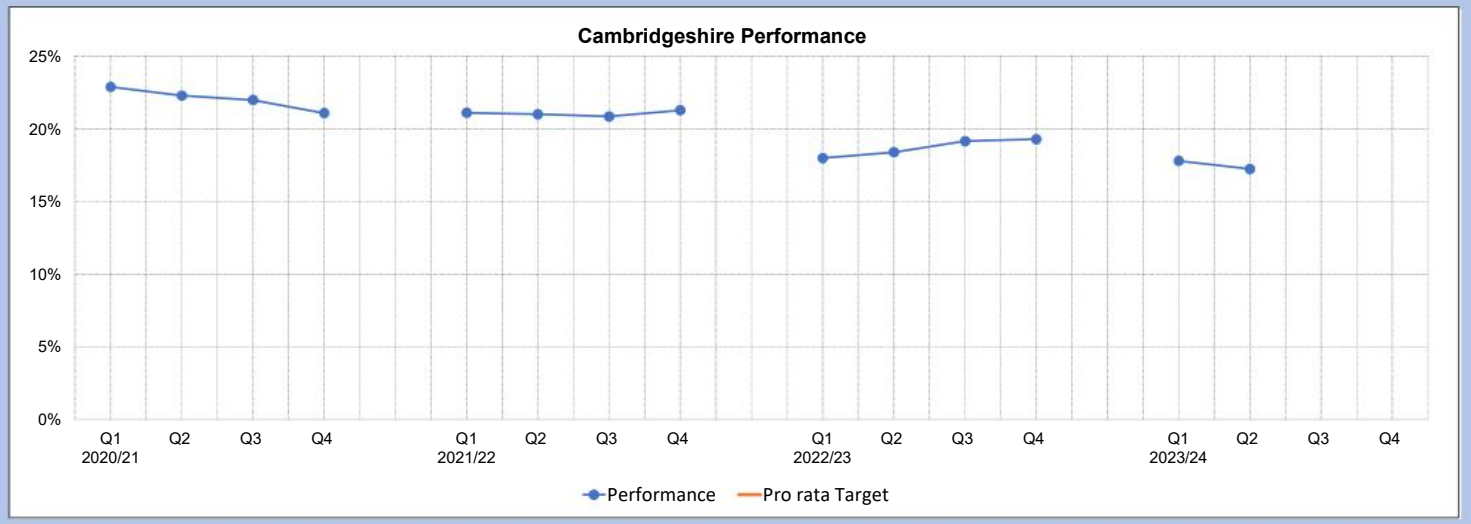
Y = Clients aged 18 or over accessing long term support at the end of the period.

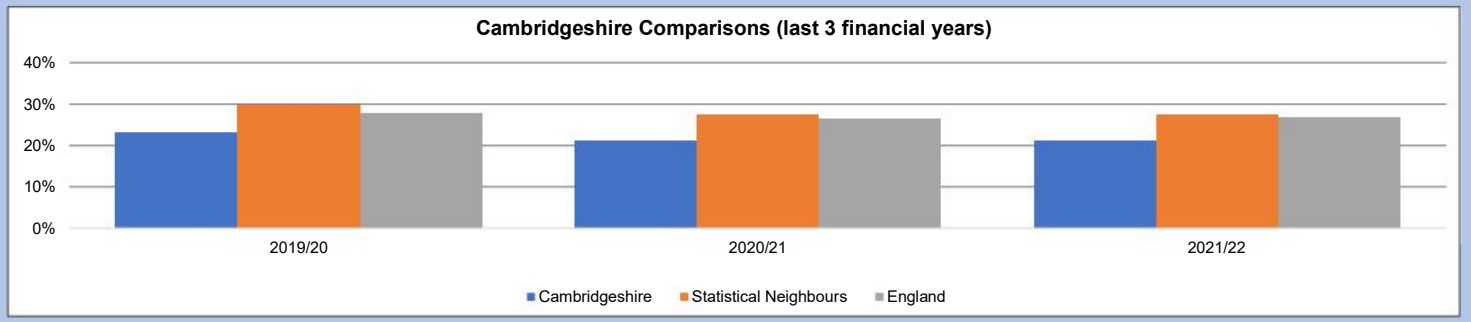
Useful Links

Measures from the Adult Social Care Outcomes Framework from NHS Digital

The local area benchmarking tool from the Local Government Association

The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions:





Commentary

Please note, Q4 data for Cambridgeshire is only provisional and will be updated to reflect statutory returns once published. Annual comparisons with statistical neighbours and England will also be available further to the national publication of statutory data for 2022/23.

The percentage of people receiving direct payments in Q2 2023/24 continues to be low, reflecting the challenge in making direct payments an attractive solution. The general decrease in performance across the last year compared to 2021/22 is mostly driven by an increase in the number of people using social care rather than the number of people receiving direct payments, which has remained relatively stable (828 at the end of Q4 2021/22 compared to 808 at the end of the latest quarter). The alternative options like individual service funds are being explored to increase choice of control to Adults receiving care in the community.
Our work with Community Catalyst around micro enterprises seeks to build more opportunities for people to use direct payments to access care and support opportunities local to them.
The council has recently introduced Individual Service Funds, a personal budget managed by a provider of the persons choice rather than held by themselves. This alongside the work to develop place based micro-enterprises within the Care Together programme should help to build on the range of options available.

Actions

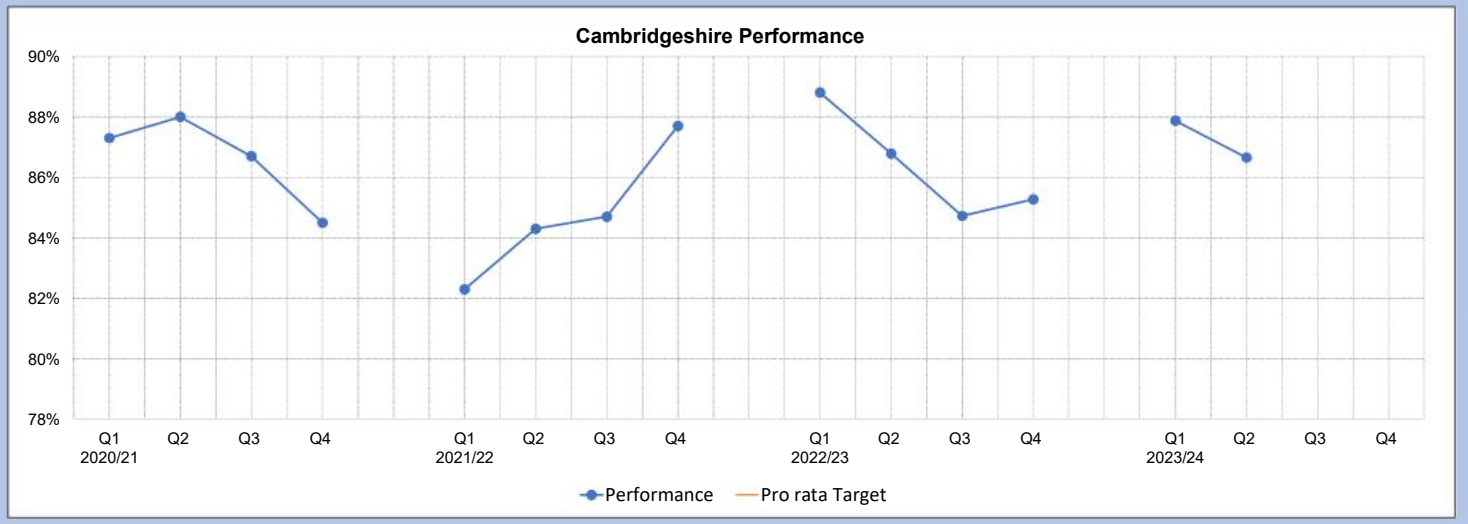
Data contained in this report will be used to inform a target setting process and targets will be reported from Q4 onwards. We now have a programme manager in place to oversee the work to increase direct payments and hopefully this will support progress to begin to deliver a noticeable impact.

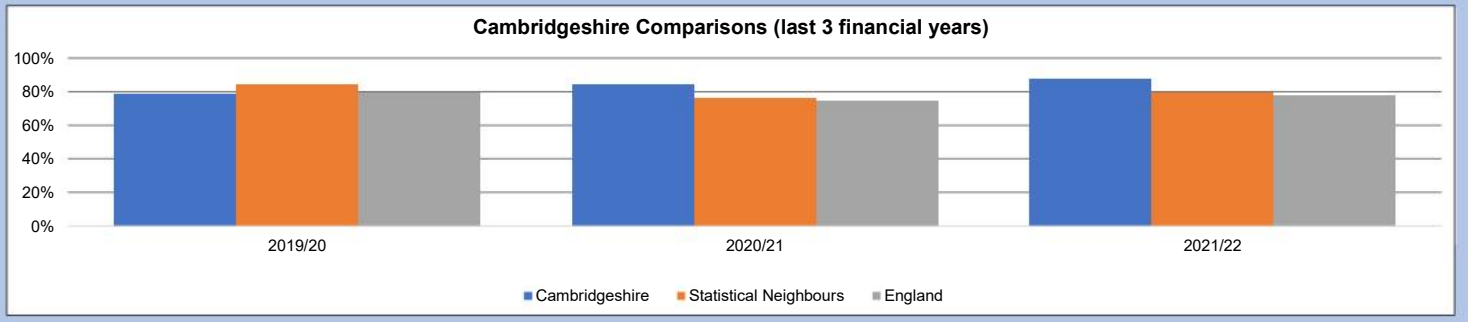
Indicator 140: Proportion of people receiving reablement who did not require long term support after reablement was completed

Return to Index December 2023

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
In Development	↑	86.7%	87.9%	Declining

Statistical Neighbour Mean	England Mean	RAG Rating
79.3%	77.6%	In Development





Indicator Description

This indicator shows the proportion of new clients who received short term services during the year, where no further request was made for ongoing support. Reablement support has best results for those who can be prevented from requiring long term care and support. However, it can also benefit people in receipt of long-term care and support by supporting improvement and enhancing their level of independence. Setting a target too high on this indicator can be a perverse incentive to reduce the service for those with more complex needs. A target should be set that reflects a balance of use. This indicator can be viewed alongside the trends on new clients with long term service outcomes (indicator 231) to ensure that more complex cases are not being diverted straight into long term care.

Short term support is designed to maximise independence. Therefore, it will exclude carer contingency and emergency support. This stops the inclusion of short term support services which are not reablement services.

Calculation:

(X/Y)*100

Where:

X = Number of new clients where the sequel to "Short Term Support to maximise independence" was "Ongoing Low Level Support", "Short Term Support (Other)", "No Services Provided - Universal Services/Signposted to Other Services", or "No Services Provided - No identified needs".

Y = Number of new clients who had short term support to maximise independence. Clients with a sequel of either early cessation due to a life event, or who have had needs identified but have either declined support or are self funding are not included in this total.

Commentary

Please note, Q4 data for Cambridgeshire is only provisional and will be updated to reflect statutory returns once published. Annual comparisons with statistical neighbours and England will also be available further to the national publication of statutory data for 2022/23.

The proportion of people not requiring long-term support after a period of reablement remains high compared to the national and statistical neighbour average. Q2 2023/24 has decreased showing the complexity of cases coming through needing further support following a short-term intervention.

Useful Links

Measures from the Adult Social Care Outcomes Framework from NHS Digital

The local area benchmarking tool from the Local Government Association

The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions:

Actions

Data contained in this report will be used to inform a target setting process and targets will be reported from Q4 onwards

Indicator 234: % total people accessing long term support in the community aged 18-64

Return to Index December 2023

Target	Direction for Improvement	Current Month	Previous Month	Change in Performance
In Development	↑	90.8%	90.7%	Improving

Statistical Neighbour Mean	England Mean	RAG Rating
82.4%	84.7%	In Development

Indicator Description

We want people to be supported in a community setting whenever that is best for them. Community settings include sheltered housing and extra care housing. Residential and nursing homes are the right choice for those with the most complex needs but good performance on this indicator should reflect partnership working with housing to provide alternatives for housing with support. Using an indicator that splits ages helps monitor equity between client groups.

Calculation:

(X/Y)*100

Where:

X = Total number of people accessing long-term support in the community aged 18-64

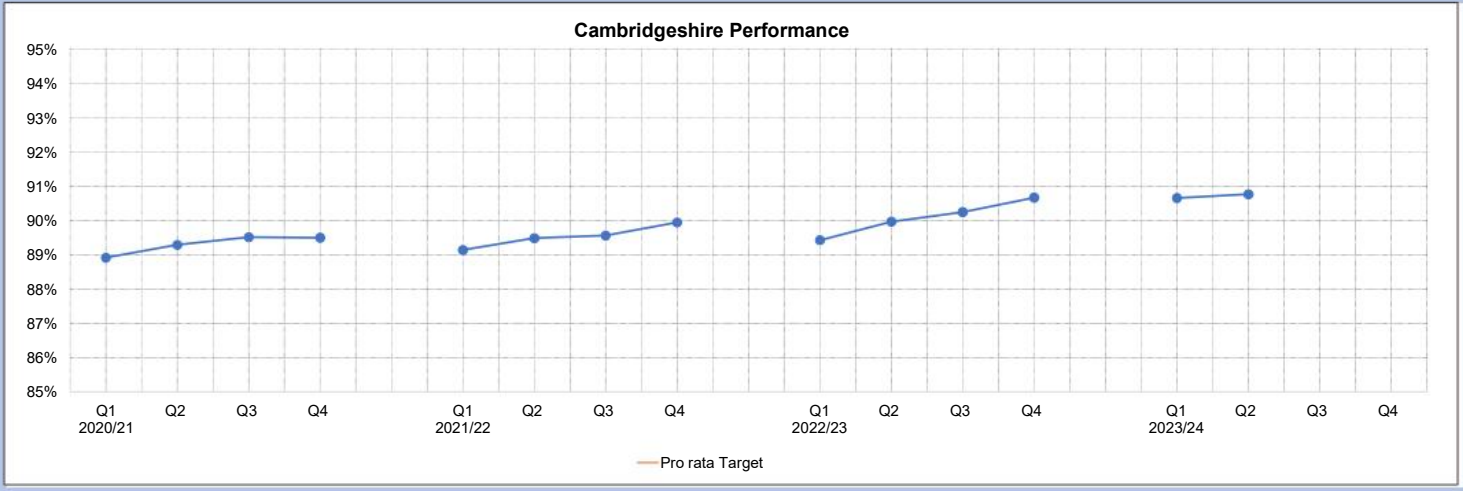
Y = Total number of people accessing long-term support aged 18-64

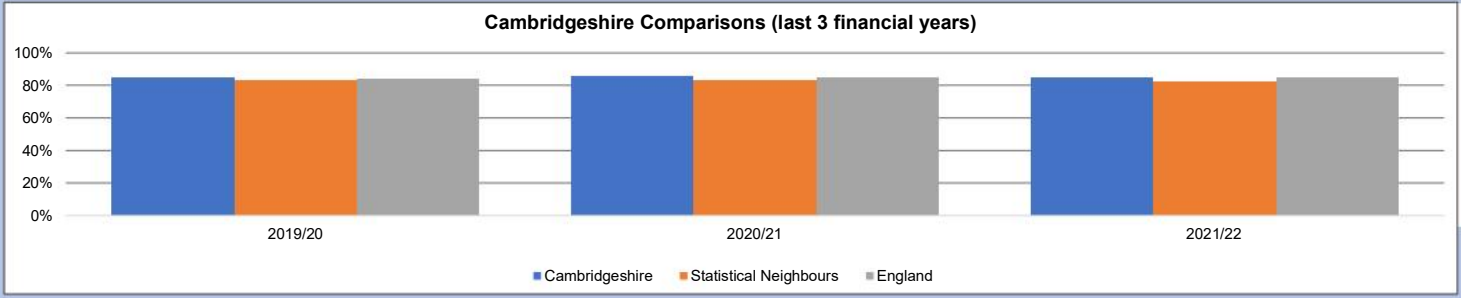
Useful Links

Measures from the Adult Social Care Outcomes Framework from NHS Digital

The local area benchmarking tool from the Local Government Association

The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions:





Commentary

Please note, Q4 data for Cambridgeshire is only provisional and will be updated to reflect statutory returns once published. Annual comparisons with statistical neighbours and England will also be available further to the national publication of statutory data for 2022/23.

The percentage of clients accessing long term support in the community aged 18-64 has remained relatively static over the last 12 months but increased slightly to 90.77% in Q2 2022/23. The overall number of community-based clients has also increased, from 2243 in Q2 2022/23 to 2360 in Q2 2023/24. Increasing need for long term services in general and community clients specifically has been experienced throughout the last year for 18-64 clients.

Actions

Data contained in this report will be used to inform a target setting process and targets will be reported from Q4 onwards

Indicator 235: % total people accessing long term support in the community aged 65 and over

Return to Index December 2023

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
In Development	↑	61.9%	60.7%	Improving

Statistical Neighbour Mean	England Mean	RAG rating
59.3%	62.4%	In Development

Indicator Description

We want people to be supported in a community setting whenever that is best for them. Community settings include sheltered housing and extra care housing. Residential and nursing homes are the right choice for those with the most complex needs but good performance on this indicator should reflect partnership working with housing to provide alternatives for housing with support. Using an indicator that splits ages helps monitor equity between client groups.

Calculation:

(X/Y)*100

Where:

X = Total number of people accessing long-term support in the community aged 65 and over

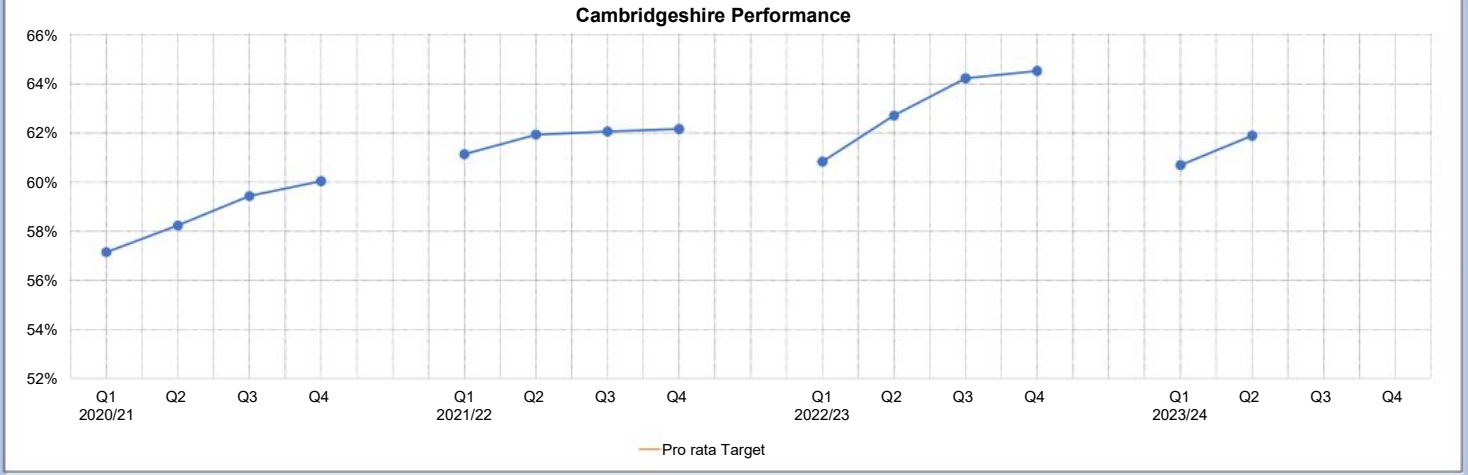
Y = Total number of people accessing long-term support aged 65 and over

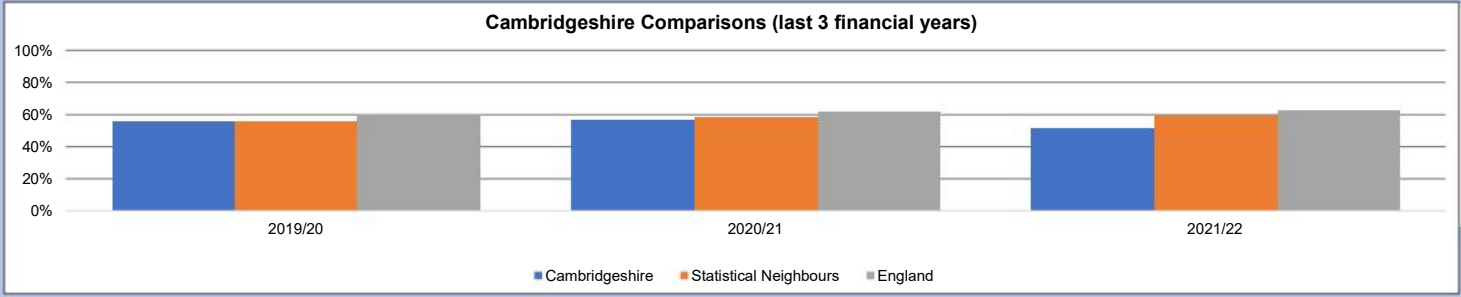
Useful Links

Measures from the Adult Social Care Outcomes Framework from NHS Digital

The local area benchmarking tool from the Local Government Association

The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions:





Commentary

Please note, Q4 data for Cambridgeshire is only provisional and will be updated to reflect statutory returns once published. Annual comparisons with statistical neighbours and England will also be available further to the national publication of statutory data for 2022/23.

The percentage of clients aged 65+ accessing long term support in the community had increased during 2022/23 but has now dropped to a comparable rate with last year (62% in Q2 2022/23, 61% in Q2 2023/24). The number of clients receiving long term support and support in the community specifically have both increased marginally in the last 12 months.

Actions

Data contained in this report will be used to inform a target setting process and targets will be reported from Q4 onwards

Indicator 236: Percentage of Cases where Making Safeguarding Personal (MSP) questions have been asked

Return to Index December 2023

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
In Development	↑	96.0%	96.4%	Declining

Statistical Neighbour Mean	England Mean	RAG Rating
81.6%	79.7%	In Development

Indicator Description

It is important when undertaking a safeguarding enquiry that the person to whom it relates is engaged and is able to say what they want as an outcome, where they have capacity to do so. This indicator monitors how well we are involving people in this way.

Calculation:

(X/Y)*100

Where:

X = The number of concluded enquiries where the adult or adult's representative was asked what their desired outcomes were

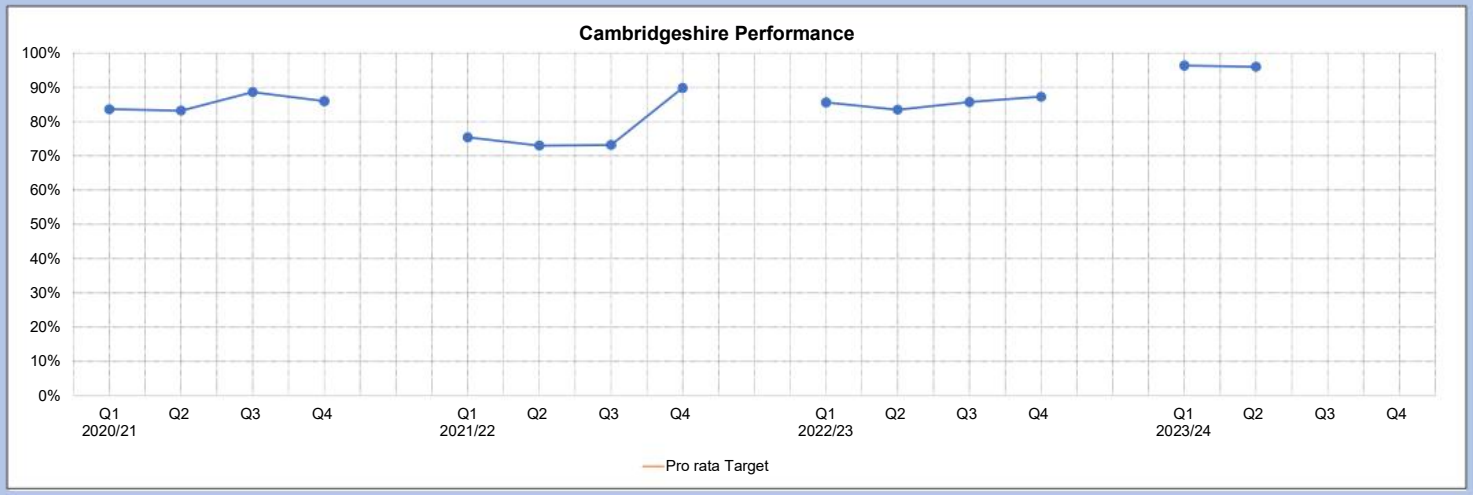
Y = The number of concluded enquiries

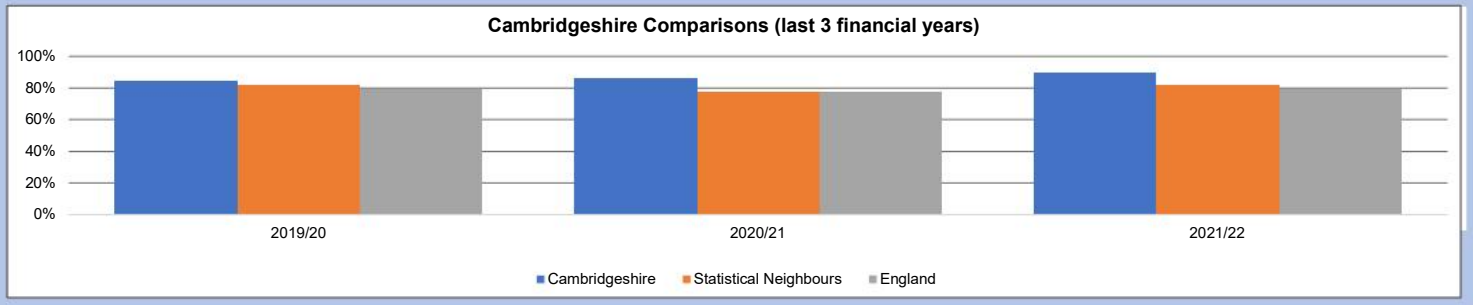
Useful Links

Measures from the Adult Social Care Outcomes Framework from NHS Digital

The local area benchmarking tool from the Local Government Association

The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions:





Commentary

Please note, Q4 data for Cambridgeshire is only provisional and will be updated to reflect statutory returns once published. Annual comparisons with statistical neighbours and England will also be available further to the national publication of statutory data for 2022/23.

Performance in this area continues to be high and comparable with national and statistical neighbour averages (96% in Q2 of 2023-24)

We continue to have reporting gaps for safeguarding. New dashboards are currently in development meaning not all the data needed to inform these indicators is available for routine use by staff. However, current performance suggests that the Making Safeguarding Personal agenda is fully imbedded in the safeguarding process.

Actions

Data contained in this report will be used to inform a target setting process and targets will be reported from Q4 onwards

Indicator 229: Percentages of safeguarding enquiries where risk has been reduced or removed

Return to Index December 2023

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
In Development	↑	88.5%	91.7%	Declining

Statistical Neighbour Mean	England Mean	RAG Rating
92.0%	91.2%	In Development

Indicator Description

This indicator tracks the effectiveness of safeguarding enquiries in reducing or removing risk. It should be viewed alongside indicators 236 and 105, which reflect the desired outcomes of the person at risk. This is to ensure that there is not a perverse incentive to go against the person's wishes and eliminate risk when that person has capacity to decide on a level of risk that is acceptable to them.

Calculation:

(X/Y)*100

Where:

X = The number of enquiries where the risk had been reduced or removed when the enquiry concluded

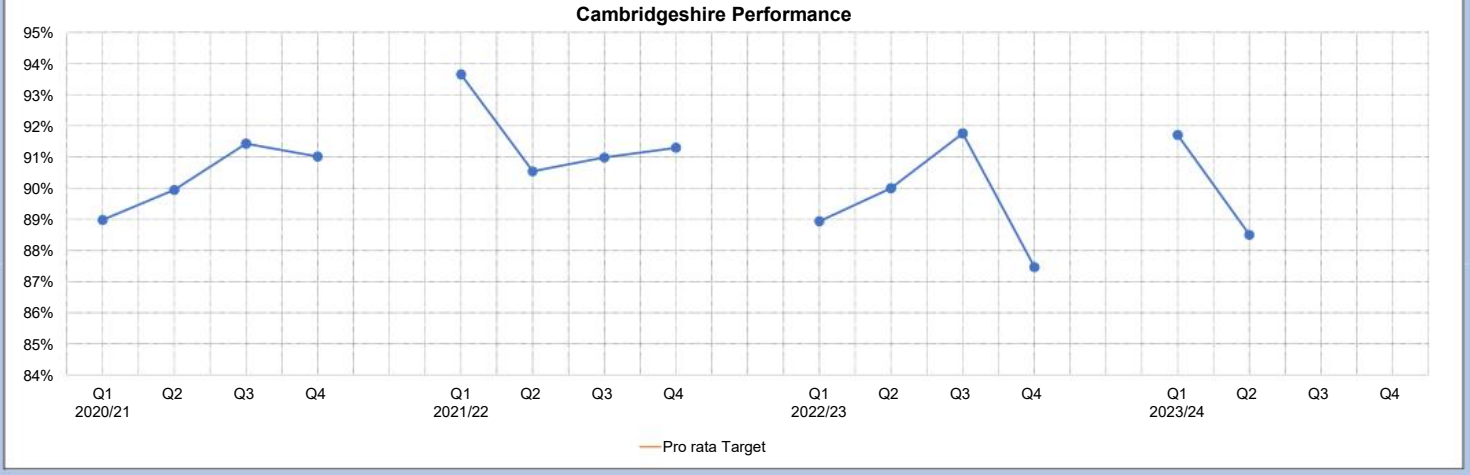
Y = The number of concluded enquiries where a risk was identified

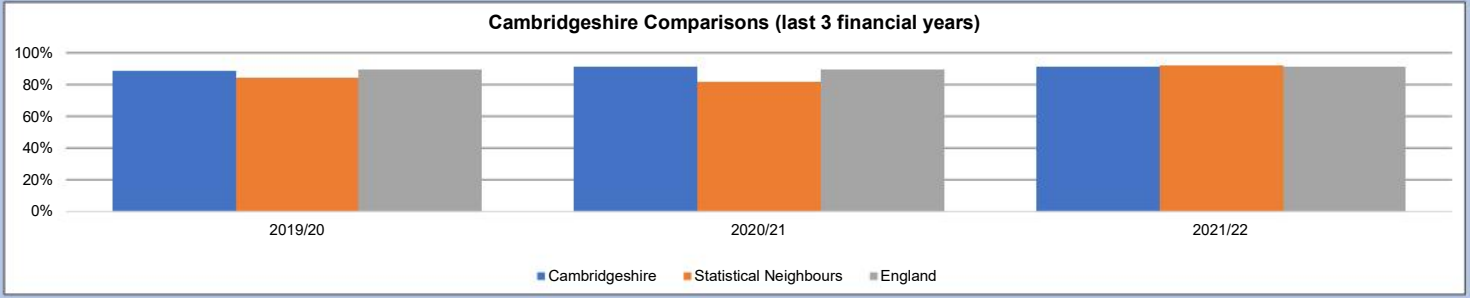
Useful Links

Measures from the Adult Social Care Outcomes Framework from NHS Digital

The local area benchmarking tool from the Local Government Association

The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions:





Commentary

Please note, Q4 data for Cambridgeshire is only provisional and will be updated to reflect statutory returns once published. Annual comparisons with statistical neighbours and England will also be available further to the national publication of statutory data for 2022/23.

We have been consistent is our approach and have been managing risk well and in over 88% of safeguarding cases risk is removed or reduced. Safeguarding pathways are being revisited to increase the number of S42's to give further considerations to risks.

Actions

Data contained in this report will be used to inform a target setting process and targets will be reported from Q4 onwards

Adults and Health Policy and Service Committee Agenda Plan

Published 1 December 2023

Notes

The definition of a key decision is set out in the Council's Constitution in Part 2, Article 12.
* indicates items expected to be recommended for determination by full Council.
+ indicates items expected to be confidential, which would exclude the press and public.

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

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

Committee date	Agenda item	Lead officer	Reference if key decision	Timings	Deadline for reports	Agenda despatch date
14/12/23	All Age Carers Service Tender	A Bourne/ A Betts-Walker	2023/088		01/12/23	06/12/23
	Commissioning Prevention in Primary Care	V Thomas	2023/058			
	Primary Care Commissioning and Procurement Governance	V Thomas	2023/020			
	Fall Prevention Strategy	E Smith / H Tunster	Not applicable			
	Finance Monitoring Report	J Hartley	Not applicable			
	Adults - Performance Monitoring Report – Quarter 2	V Thomas A Reddy	Not applicable			
	Public Health Risk Register	J Atri	Not applicable			
	Health Scrutiny items					

Committee date	Agenda item	Lead officer	Reference if key decision	Timings	Deadline for reports	Agenda despatch date
	NHS Workforce Development: Primary Care and Nursing Workforce	C Iton, Chief People Officer, ICS	Not applicable			
	Improving health outcomes for people with learning disabilities	C Anderson, Chief Nursing Officer, ICS	Not applicable			
	Health scrutiny work plan	R Greenhill	Not applicable			
	Health scrutiny recommendations tracker	R Greenhill	Not applicable			
25/01/24	Business Planning - Scrutiny and overview of Adults and Health proposals	P Warren Higgs/ J Atri	Not applicable		12/01/24	17/01/24
07/03/24	Re-commissioning Sexual and Reproductive Health Services	Val Thomas	2024/005		23/02/24	28/02/24
	Re-commissioning Behaviour Change Services	Val Thomas	2024/010			
	Care Together - Place Based Homecare Phase 1	J Melvin / A Belcheva	2024/006			
	Occupational Therapy Section 75 Agreement with CPFT	D Mackay	2024/007			
	Future Accommodation Programme	L Sparks	2024/008			
	Block Bed Tender (T3)	L Hall	2024/014			
	Finance Monitoring Report	J Hartley	Not applicable			
	Adults - Performance Monitoring Report – Quarter 3	A Reddy	Not applicable			

Committee date	Agenda item	Lead officer	Reference if key decision	Timings	Deadline for reports	Agenda despatch date
	Health - Performance Monitoring Report – Quarter 3	V Thomas	Not applicable			
	Risk Register	D Revens	Not applicable			
	Health Scrutiny items					
	Approval process for responses to NHS Quality Accounts 2023/24	R Greenhill	Not applicable			
	Health scrutiny work plan	R Greenhill	Not applicable			
	Health scrutiny recommendations tracker	R Greenhill	Not applicable			
25/04/24 Reserve Date					12/04/24	17/04/24
27/06/24	Finance Monitoring Report	J Hartley			14/06/24	19/06/24
	Adults - Performance Monitoring Report – Quarter 4	A Reddy	Not applicable			
	Health - Performance Monitoring Report – Quarter 4	V Thomas	Not applicable			
	Health Scrutiny items					
	Health scrutiny work plan	R Greenhill	Not applicable			
	Health scrutiny recommendations tracker	R Greenhill	Not applicable			
19/09/24 Reserve					06/09/24	11/09/24

Committee date	Agenda item	Lead officer	Reference if key decision	Timings	Deadline for reports	Agenda despatch date
Date						
10/10/24	Finance Monitoring Report	J Hartley			27/09/24	02/10/24
	Adults - Performance Monitoring Report – Quarter 1	A Reddy	Not applicable			
	Health - Performance Monitoring Report – Quarter 1	V Thomas	Not applicable			
	Health Scrutiny items					
	Health scrutiny work plan	R Greenhill	Not applicable			
	Health scrutiny recommendations tracker	R Greenhill	Not applicable			
12/12/24	Finance Monitoring Report	J Hartley			29/11/24	04/12/24
	Adults - Performance Monitoring Report – Quarter 2	A Reddy	Not applicable			
	Health - Performance Monitoring Report – Quarter 2	V Thomas	Not applicable			
	Health Scrutiny items					
	Health scrutiny work plan	R Greenhill	Not applicable			
	Health scrutiny recommendations tracker	R Greenhill	Not applicable			
23/01/25	Business Planning - Scrutiny and overview of Adults and Health proposals	P Warren Higgs/ J Atri	Not applicable		10/01/25	15/01/25

Committee date	Agenda item	Lead officer	Reference if key decision	Timings	Deadline for reports	Agenda despatch date
06/03/25	Finance Monitoring Report	J Hartley			21/02/25	26/02/25
	Adults - Performance Monitoring Report – Quarter 3	A Reddy	Not applicable			
	Health - Performance Monitoring Report – Quarter 3	V Thomas	Not applicable			
	Health Scrutiny items					
	Health scrutiny work plan	R Greenhill	Not applicable			
	Health scrutiny recommendations tracker	R Greenhill	Not applicable			
19/06/25	Finance Monitoring Report	J Hartley			06/06/25	11/06/25
	Adults - Performance Monitoring Report – Quarter 4	A Reddy	Not applicable			
	Health - Performance Monitoring Report – Quarter 4	V Thomas	Not applicable			
	Health Scrutiny items					
	Health scrutiny work plan	R Greenhill	Not applicable			
	Health scrutiny recommendations tracker	R Greenhill	Not applicable			

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

Adults and Health Committee Training Plan 2022/23

Below is an outline of topics for potential training committee sessions and visits for discussion with the new Adults and Health Committee.

The Adults & Health Committee induction recording can be sent to Members by contacting democraticservices@cambridgeshire.gov.uk

Date	Timing	Topic	Presenter	Location	Notes	Attendees
On Request **Monday 20th June 2022** Amundsen House 10.00 – 12.00 Scott House 13.00 – 15.00	1 day or 2 half days	**CCC** Overview of the Adult Social Care Customer Journey including Prevention & Early Intervention Services and Long-Term Complex Services. At this session you will start the day at Amundsen House and be introduced to our Prevention & Early Intervention services, where many of our customers start their journey. You will have the opportunity to listen into live calls and get to know more about Adult Early Help, Reablement and Technology. In the afternoon, you will visit our Social Work Teams for Older People and the Learning Disability partnership in Scott House and have the opportunity to experience case work.	Head of Prevention & Early intervention, Head of Assessment & Care Management, Social Work Teams	Amundsen House & Scott House	**ASC Session:** Maximum attendance of 4 Members & can be arranged on request	Attended by Cllr Richard Howitt Cllr Susan van de Ven Cllr Claire Daunton (am only) Cllr Graham Wilson

Friday 11th November 2022 10am - 4pm		**PCC** Overview of the Adult Social Care Customer Journey including Prevention & Early Intervention Services and Long-Term Complex Services.	Operations Manager and Head of Housing & Health Improvement	Sand Martin House		Cllr John Howard
Thursday 21st September 2023 (reserve committee date)	2.00pm to 5.00pm	Health Scrutiny training and development session	David McGrath, Link UK LTD	Red Kite Room, New Shire Hall* *Members are encouraged to attend the session in person if possible, but a Zoom link will be available if needed	Open to all members and substitute members of A&H	**Scrutiny Training** Cllr Howitt Cllr van de Ven Cllr Howell Cllr Costello Cllr Hay Cllr Slatter Cllr Daunton Cllr Black Cllr Seeff Cllr Bulat Cllr Shailer Cllr Dr Nawaz - FDC Cllr Horgan - ECDC Cllr Garvie – SCDC **Social Value Development Session** As above but apologies from Cllr Daunton and Slatter and plus Cllr Goodliffe.

To be scheduled Jan/Feb 2024		How care packages - are worked out (in terms of need), - Are costed, - And the payments for which are agreed with service users, - Are invoiced to service users	Kirsten Clarke Service Director, Adult Social Care			

Please note that the training plan will be reviewed in light if the new Executive Director: Adults, Health and Commissioning taking up post in June 2023.

GLOSSARY OF TERMS / TEAMS ACROSS ADULTS & COMMISSIONING

More information on these services can be found on the Cambridgeshire County Council Website: https://www.cambridgeshire.gov.uk/residents/adults/

ABBREVIATION/TERM	NAME	DESCRIPTION
COMMON TERMS USED IN ADULTS SERVICES		
Care Plan	Care and Support Plan	A Care and Support plans are agreements that are made between service users, their family, carers and the health professionals that are responsible for the service user's care.
Care Package	Care Package	A care package is a combination of services put together to meet a service user's assessed needs as part of a care plan arising from a single assessment or a review.
DTOC	Delayed Transfer of Care	These are when service users have a delay with transferring them into their most appropriate care (ie; this could be from hospital back home with a care plan or to a care home perhaps)
KEY TEAMS		
AEH	Adults Early Help Services	This service triages requests for help for vulnerable adults to determine the most appropriate support which may be required
TEC	Technology Enabled Care	TEC team help service users to use technology to assist them with living as independently as possible
OT	Occupational Therapy	
ASC	Adults Social Care	This service assesses the needs for the most vulnerable adults and provides the necessary services required
Commissioning	Commissioning Services	This service provides a framework to procure, contract and monitor services the Council contract with to provide services such as care homes etc.
TOCT	Transfer of Care Team (sometimes Discharge Planning)	This team works with hospital staff to help determine the best care package / care plan for individuals being discharged from hospital back home or an appropriate placement elsewhere
LDP	Learning Disability Partnership	The LDP supports adults with learning disabilities to live as independently as possible
MASH	Multi-agency Safeguarding Hub	This is a team of multi-agency professionals (i.e. health, Social Care, Police etc) who work together to assess the safeguarding concerns which have been reported

MCA DOLs Team	Mental Capacity Act Deprivation of Liberty Safeguards (DOLS)	When people are unable to make decisions for themselves, due to their mental capacity, they may be seen as being 'deprived of their liberty'. In these situations, the person deprived of their liberty must have their human rights safeguarded like anyone else in society. This is when the DOLS team gets involved to run some independent checks to provide protection for vulnerable people who are accommodated in hospitals or care homes who are unable to no longer consent to their care or treatment.
PD	Physical Disabilities	PD team helps to support adults with physical disabilities to live as independently as possible
OP	Older People	OP team helps to support older adults to live as independently as possible
Provider Services	Provider Services	Provider Services are key providers of care which might include residential homes, care homes, day services etc
Reablement	Reablement	The reablement team works together with service-users, usually after a health set-back and over a short-period of time (6 weeks) to help with everyday activities and encourages service users to develop the confidence and skills to carry out these activities themselves and to continue to live at home
Sensory Services	Sensory Services	Sensory Services provides services to service users who are visually impaired, deaf, hard of hearing and those who have combined hearing and sight loss
FAT	Financial Assessment Team	The Financial Assessment Team undertakes assessments to determine a person's personal contribution towards a personal budget/care
AFT	Adult Finance Team	The Adult Finance Team are responsible for loading services and managing invoices and payments
D2A	Discharge to Assess	This is the current COVID guidance to support the transfer of people out of hospital.

Carers Triage	Carers Triage	A carers discussion to capture views and determine outcomes and interventions such as progress to a carers assessment, what if plan, information, and/or changes to cared for support
DP	Direct Payment	An alternative way of providing a person's personal budget
DPMO	Direct Payment Monitoring Officer	An Officer who audits and monitors Direct Payments
Community Navigators	Community Navigators	Volunteers who provide community-based advice and solutions

GLOSSARY OF TERMS / TEAMS ACROSS PUBLIC HEALTH

ABBERVIATION/TERM	DESCRIPTION
Common Terms Used in Public Health	
Accreditation	The development of a set of standards, a process to measure health department performance against those standards, and some form of reward or recognition for those agencies meeting the standards.
Assessment	One of public health's three core functions. The regular collection, analysis and sharing of information about health conditions, risks, and resources in a community. Assessment is needed to identify health problems and priorities and the resources available to address the priorities.
Assurance	One of the three core functions in public health. Making sure that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services. The services are assured by encouraging actions by others, by collaboration with other organisations, by requiring action through regulation, or by direct provision of services.
Bioterrorism	The intentional use of any microorganism, virus, infectious substance, or biological product that may be engineered as a result of biotechnology, or any naturally occurring or bio-engineered component of any such microorganism, virus, infectious substance, or biological product, to cause death disease, or other biological malfunction in a human, an animal, a plant, or another living organism in order to influence the conduct of government or to intimidate or coerce a civilian population
Capacity	The ability to perform the core public health functions of assessment, policy development and assurance on a continuous, consistent basis, made possible by maintenance of the basic

	infrastructure of the public health system, including human, capital and technology resources.
Chronic Disease	A disease that has one or more of the following characteristics: it is permanent, leaves residual disability, is caused by a non-reversible pathological alteration, requires special training of the patient for rehabilitation, or may be expected to require a long period of supervision, observation or care.
Clinical Services/Medical Services/Personal Medical Services	Care administered to an individual to treat an illness or injury.
Determinants of health	The range of personal, social, economic and environmental factors that determine the health status of individuals or populations
Disease	A state of dysfunction of organs or organ systems that can result in diminished quality of life. Disease is largely socially defined and may be attributed to a multitude of factors. Thus, drug dependence is presently seen by some as a disease, when it previous was considered to be a moral or legal problem.
Disease management	To assist an individual to reach his or her optimum level of wellness and functional capability as a way to improve quality of health care and lower health care costs.
Endemic	Prevalent in or peculiar to a particular locality or people.
Entomologist	An expert on insects
Epidemic	A group of cases of a specific disease or illness clearly in excess of what one would normally expect in a particular geographic area. There is no absolute criterion for using the term epidemic; as standards and expectations change, so might the definition of an epidemic, such as an epidemic of violence.
Epidemiology	The study of the distribution and determinants of diseases and injuries in human populations. Epidemiology is concerned with the frequencies and types of illnesses and injuries in groups of people and with the factors that influence their distribution.
Foodborne Illness	Illness caused by the transfer of disease organisms or toxins from food to humans.
Health	The state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity. Health has many dimensions-anatomical, physiological and mental-and is largely culturally defined. Most attempts at measurement have been assessed in terms of morbidity and mortality
Health disparities	Differences in morbidity and mortality due to various causes experience by specific sub-populations.
Health education	Any combination of learning opportunities designed to facilitate voluntary adaptations of behaviour (in individuals, groups, or communities) conducive to health.

Health promotion	Any combination of health education and related organizational, political and economic interventions designed to facilitate behavioural and environmental adaptations that will improve or protect health.
Health status indicators	Measurements of the state of health of a specific individual, group or population.
Incidence	The number of cases of disease that have their onset during a prescribed period of time. It is often expressed as a rate. Incidence is a measure of morbidity or other events that occur within a specified period of time. See related prevalence
Infant Mortality Rate	The number of live-born infants who die before their first birthday per 1,000 live births.
Infectious	Capable of causing infection or disease by entrance of organisms (e.g., bacteria, viruses, protozoan, fungi) into the body, which then grow and multiply. Often used synonymously with “communicable
Intervention	A term used in public health to describe a program or policy designed to have an effect on a health problem. Health interventions include health promotion, specific protection, early case finding and prompt treatment, disability limitation and rehabilitation.
Infrastructure	The human, organizational, information and fiscal resources of the public health system that provide the capacity for the system to carry out its functions.
Isolation	The separation, or the period of communicability, of known infected people in such places and under such condition as to prevent or limit the transmission of the infectious agent.
Morbidity	A measure of disease incidence or prevalence in a given population, location or other grouping of interest
Mortality	A measure of deaths in a given population, location or other grouping of interest
Non-infectious	Not spread by infectious agents. Often used synonymously with “non-communicable”.
Outcomes	Sometimes referred to as results of the health system. These are indicators of health status, risk reduction and quality of life enhancement.
Outcome standards	Long-term objectives that define optimal, measurable future levels of health status; maximum acceptable levels of disease, injury or dysfunction; or prevalence of risk factors.
Pathogen	Any agent that causes disease, especially a microorganism such as bacterium or fungus.
Police Power	A basic power of government that allows restriction of individual rights in order to protect the safety and interests of the entire population
Population-based	Pertaining to the entire population in a particular area. Population-based public health services extend beyond medical treatment by targeting underlying risks, such as tobacco, drug and alcohol use; diet and sedentary lifestyles; and environmental factors.
Prevalence	The number of cases of a disease, infected people or people with some other attribute present during a particular interval of time. It often is expressed as a rate.

Prevention	Actions taken to reduce susceptibility or exposure to health problems (primary prevention), detect and treat disease in early stages (secondary prevention), or alleviate the effects of disease and injury (tertiary prevention).
Primary Medical Care	Clinical preventive services, first contact treatment services and ongoing care for commonly encountered medical conditions.
Protection	Elimination or reduction of exposure to injuries and occupational or environmental hazards.
Protective factor	An aspect of life that reduces the likelihood of negative outcomes, either directly or by reducing the effects of risk factors.
Public Health	Activities that society does collectively to assure the conditions in which people can be healthy. This includes organized community efforts to prevent, identify, pre-empt and counter threats to the public's health.
Public Health Department	Local (county, combined city-county or multi- county) healthy agency, operated by local government, with oversight and direction from a local board of health, which provides public health services throughout a defined geographic area.
Public Health Practice	Organisational practices or processes that are necessary and sufficient to assure that the core functions of public health are being carried out effectively.
Quality assurance	Monitoring and maintaining the quality of public health services through licensing and discipline of health professionals, licensing of health facilities and the enforcement of standards and regulations.
Quarantine	The restriction of the activities of healthy people who have been exposed to a communicable disease, during its period of communicability, to prevent disease transmission during the incubation period should infection occur.
Rate	A measure of the intensity of the occurrence of an event. For example, the mortality rate equals the number who die in one year divided by the number at risk of dying. Rates usually are expressed using a standard denominator such 1,000 or 100,000 people.
Risk Assessment	Identifying and measuring the presence of direct causes and risk factors that, based on scientific evidence or theory, are thought to directly influence the level of a specific health problem.
Risk Factor	Personal qualities or societal conditions that lead to the increased probability of a problem or problems developing.
Screening	The use of technology and procedures to differentiate those individuals with signs or symptoms of disease from those less likely to have the disease.
Social Marketing	A process for influencing human behaviour on a large scale, using marketing principles for the purpose of societal benefit rather than for commercial profit.

Social Norm	Expectations about behaviour, thoughts or feelings that are appropriate and sanctioned within a particular society. Social norms can play a powerful role in the health status of individuals.
Standards	Accepted measure of comparison that have quantitative or qualitative value.
State Health Agency	The unit of state government that has leading responsibility for identifying and meeting the health needs of the state's citizens. State health agencies can be free standing or units of multipurpose health and human service agencies.
Surveillance	Systematic monitoring of the health status of a population.
Threshold Standards	Rate or level of illness or injury in a community or population that, if exceeded, call for closer attention and may signal the need for renewed or redoubled action.
Years of Potential Life lost	A measure of the effects of disease or injury in a population that calculates years of life lost before a specific age (often ages 64 or 75). This approach places additional value on deaths that occur at earlier ages.
Health and Care Organisations in Cambridgeshire & Peterborough	
CAMHS	Community Child and Adolescent Mental Health Services https://www.mind.org.uk/information-support/for-children-and-young-people/understanding-camhs/?gclid=EAIaIQobChMIr_P53PKW8QIV_4FQBh1GmgBYEAAYASAAEgI2Q_D_BwE
CAPCCG	Cambridgeshire and Peterborough Clinical Commissioning Group https://www.cambridgeshireandpeterboroughccg.nhs.uk
CCC	Cambridgeshire County Council https://www.cambridgeshire.gov.uk
CCS	Cambridgeshire Community Services NHS Trust http://www.cambscommunityservices.nhs.uk/
CHUMS	Mental Health & Emotional Wellbeing Service for Children and Young People http://chums.uk.com/
CPFT	Cambridgeshire and Peterborough NHS Foundation Trust (Mental health, learning disability, adult community services and older people's services) http://www.cpft.nhs.uk/
CQC	Care Quality Commission (The independent regulator of health and social care in England) http://www.cqc.org.uk/
CUH	Cambridge University Hospitals NHS Foundation Trust (Addenbrooke's and the Rosie) https://www.cuh.nhs.uk

EEAST	East of England Ambulance Service NHS Trust http://www.eastamb.nhs.uk
HH	Hinchingbrooke Hospital (Provided by North West Anglia NHS Foundation Trust – NWAFT) https://www.nwangliaft.nhs.uk
HUC	Herts Urgent Care (provide NHS 111 and Out of Hours) https://hucweb.co.uk/
ICS	Integrated Care Systems
Helpful NHS Terminology Links	
https://www.nhsconfed.org/acronym-buster	The NHS uses a number of acronyms when describing services this acronym buster may be of some help.
https://www.kingsfund.org.uk/audio-video/how-does-nhs-in-england-work	The Kings Fund have produced a good video explaining how the NHS in England works. The Kings Fund website in general contains many resources which you may find helpful.
https://www.england.nhs.uk/learning-disabilities/	NHS terms used in the field of disabilities
https://www.thinklocalactpersonal.org.uk/Browse/Informationandadvice/CareandSupportJargonBuster/	Think Local Act Personal jargon buster search engine for health and social care.

Health Scrutiny Work Plan December 2023

To:	Adults and Health Committee
Meeting Date:	14th December 2023
From:	Executive Director of Strategy and Partnerships
Electoral division(s):	All
Key decision:	No
Forward Plan ref:	n/a
Outcome:	To produce a health scrutiny work plan for 2024/25 which reflects members' priorities, is prioritised against agreed scrutiny objectives and which is able to respond to emerging local or national events
Recommendation:	The Committee is recommended to: a) review and comment on the current Health Scrutiny Work Plan attached at Appendix 1. b) provide feedback on the potential criteria for prioritising health scrutiny topics attached at Appendix 2. c) agree to use the afternoon of 25th January 2024 for a health scrutiny work planning workshop.

Officer contact:
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1. Background

1.1 The Health Scrutiny Work Plan sets out the Adults and Health Committee's future work programme in relation to the discharge of its health scrutiny function.

1.2 Member review of the Health Scrutiny Work Plan at each committee meeting:

i. enables members to satisfy themselves that the Work Plan continues to reflect the Committee's priorities
ii. allows the programme to be amended to respond to any emerging issues which the Committee feels would benefit from scrutiny
iii. supports a broad-based Member-led approach

1.2.1 It was agreed in June 2023 that the Work Plan should be reviewed during the Committee's afternoon health scrutiny sessions when co-opted members are present, rather than in the morning session as part of the Committee's agenda plan.

2. Main Issues

2.1 The current Health Scrutiny Work Plan is attached at Appendix 1 for review and comment.

2.2 Looking forward, the aim is to develop an annual work programme which is informed by input from key sources including:

a) Cambridgeshire County Council's Strategic Framework 2023-28, which sets out the Council's ambitions
b) Committee members and Spokes
c) NHS Provider Quarterly Liaison Groups
d) Senior officers
e) Healthwatch
f) The Voluntary and Community Sector
g) Local residents
h) The Care Quality Commission
i) The Integrated Care Board

2.3 A long-list of potential topics is being collated which can then be assessed by members against agreed scrutiny objectives to prioritise items for inclusion in the 2024/25 Work Plan. The topics which have been suggested so far are attached at Appendix 2.

2.4 The Centre for Governance and Scrutiny (CfGS) says that work programming is about looking at the right topics, at the right time and in the right way. To deliver this it is proposed to create a framework of planned work which reflects the Council's ambitions and members' priorities, aligns with key dates for local providers and commissioners (for example, the publication of the local Integrated Care Board's accounts and annual report and milestones in the re-development of Hinchingbrooke Hospital etc), while retaining the agility to add topics in-year in response to local or national events.

2.5 Potential criteria for prioritising topics are attached at Appendix 3, and member feedback on this would be welcome.

2.6 It is proposed to hold a workshop on the afternoon of Thursday 25th January (reserve committee date) for members to discuss and prioritise the 2024/25 workplan. This would include identifying any topics which they might want to progress through a rapid review or task and finish group.

2.6 Contact has been made with Peterborough City Council at officer level with a view to sharing learning on local health services, aligning work where this would add value and avoiding duplication of scrutiny activity where possible.

3. Alignment with ambitions

3.1 Net zero carbon emissions for Cambridgeshire by 2045, and our communities and natural environment are supported to adapt and thrive as the climate changes

There are no significant implications for this ambition.

3.2 Travel across the county is safer and more environmentally sustainable

There are no significant implications for this ambition.

3.3 Health inequalities are reduced

The following bullet point sets out details of implications identified by officers:

- Health scrutiny offers an opportunity for the Council to offer constructive challenge to NHS system partners around the measures they have in place to address health inequalities, and to identify and share examples of learning and best practice.

3.4 People enjoy healthy, safe, and independent lives through timely support that is most suited to their needs

The following bullet point sets out details of implications identified by officers:

- Health scrutiny can identify and promote examples of best practice by NHS providers and commissioners which are of benefit to local residents. It can also examine and challenge areas of practice where concerns have been raised and make recommendations to service providers.

3.5 Helping people out of poverty and income inequality

There are no significant implications for this ambition.

3.6 Places and communities prosper because they have a resilient and inclusive economy, access to good quality public services and social justice is prioritised

There are no significant implications for this ambition.

3.7 Children and young people have opportunities to thrive

- Health scrutiny supports the delivery of quality health care for all of Cambridgeshire's residents, including children and young people. The Adults and Health Committee invites representatives of the Children and Young People Committee to join relevant health scrutiny sessions and to take part in the discussions.

4. Significant Implications

4.1 Resource Implications
There are no significant implications within this category.

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

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

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

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

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

4.7 Public Health Implications
There are no significant implications within this category.

4.8 Climate Change and Environment Implications on Priority Areas:
There are no significant implications within this category.

5. Source documents

5.1 None

Adults and Health Policy and Service Committee
Health Scrutiny work plan

Updated: 10th November 2023

Committee date	Agenda item	Lead organisation/s	Deadline for reports	Agenda despatch date
14/12/23	NHS workforce development: Primary Care and Nursing Workforce	C Iton, Chief People Officer ICS	01/12/23	06/12/23
	Improving health outcomes for people with learning disabilities	C Anderson, Chief Nursing Officer, ICS		
	Health Scrutiny Recommendations Tracker	R Greenhill		
	Health Scrutiny Work Plan	R Greenhill		
25/01/24	**Development session**		TBC	17/01/24
Provisional	*Health scrutiny work programme 2024/25*	*R Greenhill*		
Provisional	*Committee training or briefing session*	*TBC*		
07/03/24	Approval process for responses to NHS Quality Accounts 2023/24	R Greenhill	TBC	28/02/24
	Health Scrutiny Recommendations Tracker	R Greenhill		
	Health scrutiny work programme 2024/25	R Greenhill		

Committee date	Agenda item	Lead organisation/s	Deadline for reports	Agenda despatch date
25/04/24 Reserve Date	**Development session**		TBC	17/04/24
Provisional	*Committee training or briefing session*	*TBC*		
27/06/24			TBC	19/06/23
19/09/24 Reserve Date			TBC	11/09/24
Provisional				
10/10/24			TBC	02/10/24
12/12/24			TBC	04/12/24
23/01/25			TBC	15/01/24

Committee date	Agenda item	Lead organisation/s	Deadline for reports	Agenda despatch date
06/03/25			TBC	26/02/25
19/06/25			TBC	11/06/25

Adults and Health Policy and Service Committee
Potential Health Scrutiny topics 2024/25

1. Strategic
    i. Shared Care Record Phase 2 (including social care records): Being scoped between now and end of December 2023. Possible scrutiny item in March or May/ June, depending on progress
    ii. Waiting lists for elective care
    iii. Winter planning 2024
    iv. Communication – making people aware of the services available and how to access them/ digital accessibility. This has been a recurring theme in several scrutiny sessions during the past year
    v. Structures for delivery of primary care services: Delivery of services by a range of healthcare professionals/ virtual wards and hybrid service delivery models/ digital delivery

2. Operational
    i. Mental health support – access to crisis medicines/ community support/ access to secure beds – Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
    ii. East of England Ambulance Service Trust (EEAST): Last CCC scrutiny 21.12.21
    iii. Cambridge University Hospitals NHS Foundation Trust (CUH) – Care Quality Commission (CQC) inspection of maternity services. Rated as Requires Improvement (report 04.09.23).
    iv. Pharmacy provision
    v. Dentistry
    vi. Residential care homes, in relation to the scope for health promotion and preventative measures to avoid health deterioration; how these considerations could be embedded at the earliest stages of planning new care homes; and the facilities which could be made available to benefit the wider community.
    vii. Children's mental health: Scrutinised previously 17.03.22 and 05.10.22. Potential lines of enquiry might include how this is supported by local health service providers; the role and availability of residential care locally; the health service support available locally to children and young people who self-harm; and an analysis following Cllr Hoy's motion to Council - 25th January 2022 about the lack of children's mental health provision to compare the situation then and now.
    viii. Autism diagnosis and pathways for older girls: Proposed as a potential area for future scrutiny in discussion of children and young people's access to mental health support in 05.10.22].
    ix. Addressing health inequalities: Potential lines of enquiry: A comparative look at health facilities and provision in different districts, disparities and inequalities and how to address those; pre-disposing factors; does decentralisation support work to address health inequalities.
    x. Tacking obesity: Potential lines of enquiry: Prescribing and bariatric surgery; tacking obesity in children and young people; how much consultant or primary care time was being used for private care.
    xi. North West Anglia NHS Foundation Trust's role in the work being done by the North Place Partnership.
    xii. Re-development of Hinchingbrooke Hospital. ICS partners have been undertaking work to review the services required at the new hospital and would welcome the opportunity to share the detail of this work and the outcomes with the committee, and to discuss the approach to engagement. Likely timing March – June 2024

Potential criteria for prioritising health scrutiny topics

1. Scrutiny is likely to result in improvements in health provision for local people

2. The topic aligns with the Council's Ambition 3: Health inequalities are reduced

3. The topic aligns with the Council's Ambition 4: People enjoy healthy, safe and independent lives through timely support that is most suited to their needs

4. The topic aligns with the Council's Ambition 7: Children and young people have opportunities to thrive

5. The topic aligns with the Joint Strategic Needs Assessment and recommendations approved by the Cambridgeshire and Peterborough Health and Wellbeing Board and Integrated Care Partnership Board on 20th October 2023: 2023 Joint Strategic Needs Assessment.

6. The topic has been identified as an area of concern or one where scrutiny could add value by the Care Quality Commission or local partners or stakeholders

7. The topic is of concern to local people and attracting high levels of public dissatisfaction, evidenced through public consultation/ councillors' casework/ media attention.

8. A service is performing above expectations, attracting high levels of public satisfaction and/ or maximising the use of resources in innovative and potentially transferable ways, evidenced through public consultation/ councillors' casework/ media attention.

Adults and Health Committee

Health Scrutiny Recommendations Tracker

Purpose:
To record the recommendations made by the Adults and Health Committee in the discharge of its health scrutiny function, and their outcomes.

Meeting 29th June 2023

Report title	Officer/s responsible	Recommendation/s	Outcomes	Status
Shared Care Records	K Russell Surtees, ICS/ CPFT	Digitisation in relation to social care was identified as a key issue, and the committee asked to see timetables on that outside of the meeting. The Committee welcomed the assurances given that there would be no commercial exploitation of patient data, and emphasised the need to be clear how people could opt out.	The Shared Care Record Phase 2 (including social care records) is being scoped. This work should be completed by the end of December 2023, and an update on timetables will be provided then together with details of how people can opt out.	In progress
Access to GP Primary Care Services	N Briggs, ICS	A copy of the Committee's conclusions was sent to the Chief Finance Officer at the Integrated Care System (ICS) on 23rd August 2023. The Committee requested that a copy of the ICS report on lessons learnt from the experience at Priors Field be provided once the review was completed.	The report is expected to go to the Integrated Care Board in January 2023, and a copy will be provided then.	In progress

Meeting 5th October 2023

Report title	Officer/s responsible	Recommendation/s	Outcomes	Status
Cambridgeshire and Peterborough Integrated Care Board Finance Report	R Greenhill	The Democratic Services Officer was given delegated authority to send the Committee's conclusions to the Chief Finance Officer at the Integrated Care System, in consultation with the Chair and Vice Chair of the Adults and Health Committee.	The minute of the discussion was sent on 23rd October 2023.	Completed
Cambridgeshire and Peterborough Integrated Care System (ICS) Winter Plan 2023/24	R Greenhill	A Rapid Review Group was established comprising Councillors Black, Costello and Daunton to meet with the report author and follow up the lines of questioning identified at the Committee's pre-meet and that review. The Democratic Services Officer was given delegated authority to provide feedback to the Integrated Care System following this meeting at the direction of the Rapid Review Group and in consultation with the Adults and Health Committee Spokes.	Progress was delayed due to the report author being unavailable. A meeting has been arranged instead with the Chief Executive Officer and the Executive Director for Performance and Assurance at the ICS on 8th December 2023.	In progress