CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD

Cambridgeshire County Council

Date:Thursday, 01 February 2018

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

10:00hr

Shire Hall
Castle Hill
Cambridge
CB3 0AP

Committee Rooms 1 & 2, The Guildhall Market Square, Cambridge, CB2 3QJ

AGENDA

Open to Public and Press

1	**Apologies for absence and declarations of interest** *Guidance on declaring interests is available at http://tinyurl.com/ccc-conduct-code*	
2	**Minutes of the meeting on 23 November 2017**	**5 - 14**
3	**Action Log**	**15 - 18**
4	**A Person's Story** Verbal item. To share a person's experiences to provide context to the business of the meeting.	
5	**Draft Suicide Prevention Strategy 2017-20**	**19 - 100**
6	**Feedback on Joint Development Session with Peterborough Health and Wellbeing Board**	**101 - 104**
7	**Better Care Fund Update**	**105 - 122**

8	**A Whole System Approach to Living Well across Cambridgeshire and Peterborough**	**123 - 132**
9	**Sustainability and Transformation Plan Update Report**	**133 - 180**
10	**Forward Agenda Plan**	**181 - 184**
11	**Date of Next Meeting**	

The Cambridgeshire Health and Wellbeing Board comprises the following members:

Councillor Peter Topping (Chairman)

Councillor Margery Abbott Jessica Bawden Sheila Bremner Councillor Mike Cornwell Councillor Angie Dickinson Tracy Dowling Councillor Sue Ellington Stephen Graves Chris Malyon Val Moore Wendi Ogle-Welbourn Dr Sripat Pai Stephen Posey Liz Robin Councillor Joshua Schumann Vivienne Stimpson Ian Walker and Matthew Winn Councillor Samantha Hoy Councillor Claire Richards Councillor Susan van de Ven and Councillor David Wells

Julie Farrow (Appointee)

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

Clerk Name: Richenda Greenhill

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Agenda Item No: 2

CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD: MINUTES

Date: 23 November 2017

Time: 10.00am – 12.10pm

Venue: The Swansley Room, South Cambridgeshire District Council, Cambourne

Present:

Cambridgeshire County Council (CCC)
Councillor P Topping (Chairman),
Councillor S Hoy
Councillor S van de Ven
Councillor D Wells
Councillor J Whitehead (substituting for Councillor C Richards) (until midday)
C Mitchell, Director of Community Services and Integration (substituting for W Ogle-Welbourn, Executive Director, People and Communities) (from 10.20am)
Dr L Robin, Director of Public Health

City and District Councils
Councillors M Abbott (Cambridge City), M Cornwell (Fenland), A Dickinson (Huntingdonshire) and S Ellington (South Cambridgeshire District Council)

Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)
S Bremner and Dr Sripat Pai

Healthwatch
V Moore, Chair

NHS Providers
J Pigg, North West Anglia Foundation Trust (substituting for S Graves)

Voluntary and Community Sector (co-opted)
J Farrow, Chief Executive Officer, Hunts Forum of Voluntary Organisations

Apologies:

J Bawden – Cambridgeshire and Peterborough Clinical Commissioning Group
T Dowling – Cambridgeshire and Peterborough Foundation Trust
S Graves – North West Anglia Foundation Trust (substituted by J Pigg)
C Malyon – Chief Finance Officer, Cambridgeshire County Council
W Ogle-Welbourn – Executive Director, People and Communities, Cambridgeshire County Council (substituted by C Mitchell)
S Posey – Papworth Hospital NHS Foundation Trust
Councillor C Richards – Cambridgeshire County Council 0substituted by Councillor J Whitehead)
V Stimpson – NHS England
I Walker – Cambridge University Hospitals NHS Foundation Trust

33. MEMBERSHIP

The Chairman welcomed Sheila Bremner, Acting Chief Officer at Cambridgeshire and Peterborough Clinical Commissioning Group (CCG), who was joining the Board as one of the CCG's three representatives.

34. ELECTION OF VICE CHAIRMAN/ VICE CHAIRWOMAN

Sheila Bremner was elected as Vice Chair of the Cambridgeshire Health and Wellbeing Board for the remainder of the 2017/18 municipal year.

35. APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST

Apologies were noted as recorded above. There were no declarations of interest.

36. MINUTES OF THE MEETING ON 21 SEPTEMBER 2017

The minutes of the meeting on 21 September 2017 were agreed as an accurate record and signed by the Chairman.

37. ACTION LOG

The Action Log was included in the meeting papers for noting.

38. A PERSON'S STORY

The Chairman welcomed Julie Potter, a senior project worker at Wintercomfort, to the meeting.

Ms Potter explained that two of her colleagues had hoped to attend to share in person their experiences of homelessness in Cambridge, but that due to unforeseen circumstances this had not proved possible. They were though willing for details of their stories to be shared with the Board. Wintercomfort provided a day centre in the middle of Cambridge for the homeless and vulnerably housed. They worked closely with other charities and organisations in the City, sign-posting clients to the support available elsewhere as well as providing direct support. Welfare services focused on enabling people to feel safe and settled through providing access to showers, hot meals, a laundry service and social interaction. This enabled service users to be able to engage with the learning and development opportunities available. However, grant funding tended to focus mainly on the outcomes of the learning and development aspect of their work which meant that other funding streams were needed to support their welfare work. Wintercomfort ran two social enterprises in the catering and cleaning industries which provided service users with a supported transition back to employment.

Ms Potter shared the story of one of her colleagues who had first become involved with Wintercomfort as a service user. He had grown up in a blended family where he had experienced domestic violence. He obtained eight 'O' levels and studied hospitality management at college before leaving to work in various bars and restaurants. In 2011 he suffered a racially motivated attack which led to him losing his job and accommodation and separating from his partner. He 'sofa-surfed', staying for short periods with friends, and slept rough. During this period he experienced both physical and mental health difficulties. He got involved in volunteering and at the end of 2013 he got a home of his own. In 2015 he joined Wintercomfort as an apprentice and when a permanent post became available he was successful in obtaining the

post. His story illustrated how anyone could find themselves experiencing homelessness, but also how they could turn their lives around.

The following points arose in discussion of the person's story:

- A member asked about links between Wintercomfort and health services. Ms Potter stated that the charity had close links with the Cambridge Access Surgery and that they would liaise with service users' GPs where this was appropriate. The dual diagnosis team were also now involved;

- 40% of the staff at Wintercomfort were former service users;

- On average around 80-90 people per day visited Wintercomfort;

- The welfare needs of service users were increasing which was squeezing the time and capacity available to address learning and development needs.

The Chairman thanked Ms Potter for sharing such a powerful story which highlighted how quickly a person's life chances could change. The story also highlighted the links between physical and mental health needs. The Board noted the personal story as context for the remainder of the meeting.

39. HEALTH AND WELLBEING STRATEGY – STAKEHOLDER EVENT

The Board received a report on the event held on 21 September 2017 which had been arranged as part of the Board's work on refreshing its current Health and Wellbeing Strategy. A wide range of stakeholders had been invited to share their views on potential priorities for the Board going forward and the role which it would play. This would be to either:

- **Focus**: the Board initiates and drives new action which is unlikely to be initiated or co-ordinated elsewhere;
- **Watch**: the Board actively monitors that appropriate action is taking place, for example to deliver national priorities or approved local plans;
- **Encourage*:*** the Board encourages other boards or organisations to deliver health and wellbeing outcomes without directly initiating or monitoring the associated actions.

The proposed priority areas for the Board to either 'watch' or 'focus' were:

- Better Care Fund Implementation including demand management, delayed transfers of care and health and social care integration;
- Mental Health;
- Prevention and behaviour change;
- Healthy new housing developments and population growth;
- Addressing health inequalities identified in the Joint Strategic Needs Assessment;
- Working better together and promoting integration.

The Chairman invited feedback from the Board on these proposals to allow officers to work up final recommendations. Specifically, he asked that members focus on those areas which were not already being actively addressed by other organisations or services.

The following points arose in discussion of the report and in response to questions from the Board:

- Members re-stated the importance which they attached to the Board's role in relation to the Better Care Fund and confirmed that this should remain a high priority 'Watch' area;

- Members acknowledged that mental health was a real focus in Cambridgeshire and that a lot of good work was already being done on this by partner organisations and through the Sustainability and Transformation Plan (STP). On this basis it was proposed this should be a 'Watch' area;

- An elected member commented that health inequalities affected the whole of Cambridgeshire in different ways. They could see no evidence that health inequalities were being reduced, especially in the north of the county, and they felt that the Board should concentrate on getting people working together to reduce overall inequality;

- An elected member noted that there had been some initial work on children's and social services for the new community at Northstowe, but that this had fallen into abeyance. They questioned whether the negotiations between developers and the county council in relation to Section 106 money and educational provision could be expanded to include a wider negotiation which included health provision;

- A member commented that they felt that there was a clearer recognition of the need for health and community services in relation to completely new developments than where a new development was attached to an existing village or town. The member felt that a sub-committee or working group looking at inequality in new communities or growing communities might be useful;

- Members noted that planning applications for small housing developments were considered on an individual basis, but that the cumulative effect of these small developments on local health, education and social care services could be significant;

- An elected member commented that homelessness led to poor outcomes and felt that there could be a lack of co-ordination of efforts across districts and the county. They highlighted the frequent co-existence of substance or alcohol addiction and mental health issues and questioned what should be tackled first to improve outcomes. The member felt that there was a need to be more bold in tackling these issues;

- A member commented that health inequalities might be targeted geographically or in response to the needs of particular sections of the population. They felt there was an opportunity to mitigate against inequalities in new communities through infrastructure;

- A member stated that they felt it was important to integrate health and social care provision into new and expanding communities and that this needed to be addressed from the planning stage onward to ensure residents had the services they needed;

- Members noted that the Cambridgeshire and Peterborough Combined Authority was looking at economic inequality in the region and highlighted the significance of the devolution deal going forward;

- The Healthwatch representative stated that patient experience often highlighted frustration with communication regarding their care and emphasised the importance of integration across all of the topics being considered. Patients experienced disruption when integration was poor and information about patient experience could feed into the work being done to address cracks between services;

- A member questioned the proposed use of the term 'encourage' as one of the roles which the Board could play as they felt the work which the Board did needed to have real impact;

- The GP representative stated that GP practices in areas with new developments did not necessarily have the premises or staffing levels needed to accommodate the increased numbers of patients. There were difficulties recruiting staff to fill existing vacancies in some areas, let alone taking on additional staff to meet increased demand. However, there were some innovative solutions emerging including some practices looking to operate a federation model;

- A health service member commented that integration was only helpful if it delivered a specific benefit and suggested that a short mapping exercise might be useful before the Board's next meeting in February to identify where work was already happening or was planned to help identify one or two areas on which to focus;

- A member commented that the new Area Executive Partnerships might provide a new vehicle to pick work up locally and provide feedback to the Board and to the STP.

Summing up, the Chairman stated that the Board had given officers a clear steer that its priorities were health inequalities, including the impact of drug and alcohol misuse on life chances; new and growing communities and housing; and integration. He would work with the Vice Chair and Director of Public Health to work up initial proposals to share with members before decisions were made when the Board met next in February 2018. This work would consider the problems caused by addiction as this fed into so many health issues. The Board had also made clear its wish to identify and focus on areas where it could have a real impact and not duplicate work already being done or planned elsewhere.

It was resolved to:

a) note the feedback from the Health and Wellbeing Stakeholder Event on 21 September 2017;

b) discuss and approve the proposed priorities for a renewed Health and Wellbeing Strategy (2018-21) as outlined in section 4 of the report.

40. SUSTAINABILITY AND TRANSFORMATION PROGRAMME (STP) UPDATE

The Chairman advised the Board that he was revising the order of business to take the Sustainability and Transformation Programme (STP) Update as the next item to accommodate officer commitments elsewhere. He advised members that the report had been received after the statutory deadline for publication and that it had been accepted on the following grounds:

- Reason for lateness: Staffing changes in the Digital Delivery Workstream meant that there was currently no lead officer and this had caused a delay in pulling together the information needed for the report;
- Reason for urgency: The Board had requested that the STP Update report in November should include further information on data sharing and the role that the STP Digital Delivery Group might play in taking forward work on data sharing issues. This was a priority issue for the Board.

The Executive Programme Director for the Fit for the Future programme introduced the report which focused on current thinking and progress on the Accountable Care System (ACS) and the Digital Delivery Group's work on data sharing. The ACS approach was designed to break down organisational boundaries for the benefit of residents. It comprised clinically-led tactical improvements for improving patient care in the short-term with a longer-term system strategy. Significant progress had already been made, including the merger of the Peterborough and Stamford NHS Foundation Trust with the Hinchingbrooke Health Care NHS Trust to form the new North West Anglia Foundation Trust (NWAFT) and the progress made towards relocating Papworth Hospital onto the Cambridge Biomedical Campus.

The Head of Analytics and Evaluation for the Fit for the Future programme provided an update on the Digital Delivery Group (DDG) and data sharing. The leadership and membership of the DDG had recently been reviewed and core pieces of work had been scoped including data sharing and information governance. The benefits of data sharing were widely recognised, but the challenge would be to achieve this in a safe and secure way which complied with statutory requirements. The primary focus of improved data sharing was patient care with a secondary focus on its use for planning purposes. Practical issues to be addressed included the different IT systems used by partner organisations and services.

The following comments were offered in discussion of the report and in response to questions from the Board:

- The NWAFT representative noted the need for all organisations to have a data protection officer (DPO) and asked whether this could be a single data protection officer across all of the organisations covered by the STP. The Head of Analytics and Evaluation stated that this was the ideal time to look at the DPO role and have that discussion and noted that the NWAFT would support this option;
- A member questioned the reference to possible future uses of the Cloud in this context and questioned who would monitor or have access to information and data stored in this way and the potential security issues. The Head of Analytics and Evaluation stated NHS regulations would be adhered to and that only the use of certain Clouds was permitted. There would be dual layer encryption and the access of NHS users would be role-based, tailoring the level of detail which could be seen according to the role of the user;

- Members noted the need to ensure compliance with the General Data Protection Regulation when this came into effect on 25 May 2018;
- A member commented that it would be useful to go back to delivery groups and look at projects which had been delayed to see what the DDG could do to unblock delays and speed up implementation in support of clinical aims;
- The Chairman expressed some surprise that a year into the STP process this work still appeared to be at quite a basic level and asked how the Board could help move things along;
- A member emphasised the importance of patient confidence to their willingness for their data to be stored and shared within the system. The Executive Programme Director stated that there was a need to earn patient trust through consultation and engagement. The General Data Protection Regulation being introduced in May 2018 would move to a specific patient consent model and there was a clear recognition of the need to inform patients and learn lessons from other areas;
- The Healthwatch representative emphasised the importance of promoting a positive message about how data sharing could improve patient care and to encourage a conversation about this. Transparency would be key;
- The Executive Programme Director confirmed that she would be happy to attend the Board's next meeting on 1 February 2018 to provide a further update report. (**Action**: Executive Programme Director)

It was resolved to:

a) note and comment on the report.

41. BETTER CARE FUND UPDATE

The Board received a report providing an update on Cambridgeshire and Peterborough's joint Better Care Fund (BCF) submission and approval status; a six month update on health data in response to a request from the Board in March 2017; an update on progress in delivering the BCF Plan for 2017-19; and information about the Care Quality Commission system reviews proposed for 2018.

The 2017-19 BCF Plan was submitted on 11 September 2017 and following the assurance process it was approved with conditions. These conditions related to the potential risks associated with the major reorganisations taking place across the health and care system in Cambridgeshire and Peterborough. Additional information was requested to ensure that every risk in the Plan had mitigating actions attached to it and to explain the amount of funding included in the 'risk share' element of the Plan. This information had been submitted and officers understood informally that these mitigations had been accepted. Once formally agreed the Plan would graduate to 'approved' status. The Section 75 agreement would then be refreshed and submitted to the Integrated Commissioning Board in December 2017.

The six month update on health data contained at Appendix 2 focused on non-elective admissions, emergency department attendance and delayed transfers of care (DTOCs) to reflect the Board's particular interest in in these issues. Emergency department attendance figures had remained fairly flat, although a slight increase was being seen from August 2017. Work was in hand to address this through the work of the Joint Emergency Team (JET). DTOCs remained a priority issue both for health service providers and the Board. There were some encouraging very recent indications that these figures were beginning to level out or reduce in some cases, but the drive for further and sustained improvement remained unchanged. NHS England

had visited two Trusts to discuss issues and develop action plans to reduce DTOC numbers, including support to implement 'discharge to assess' home-based assessment models. A multi-partner Gold Command had been developed to manage the discharge process for patients with complex needs and to address any issues that might delay their discharge. It was anticipated that this would have a significant impact in managing this group of patients and also those who were assessed as Medically Fit and Ready for Discharge.

The Care Quality Commission (CQC) was currently conducting a national programme of reviews across all aspects of the health and care system. The first series of reviews was currently taking place and a second series was expected in early 2018. It was possible that Cambridgeshire might be included in this second series.

The following comments arose in discussion of the report and in response to questions from Board members:

- Members noted the progress updates contained at Appendix 1 to the report. These were tracked on a monthly basis by the Integrated Commissioning Board and included some projects managed via the Sustainability and Transformation Plan (STP), but monitored through the BCF;
- A Member noted the role of the Board in maintaining an active monitoring role in relation to delivery of the BCF and welcomed the detailed reports provided by officers. Given the major structural reorganisations currently taking place across the health and care system in Cambridgeshire and Peterborough they felt it would be timely to provide an updated structure chart setting out the key roles and responsibilities of the various individuals and organisations responsible for oversight and delivery of the BCF;
  (**Action**: Director of Community Services and Integration)
- A Member commented that it would be interesting to know more about the methodology and focus of the CQC inspections conducted to date. Officers stated that this was already being reviewed and that the findings would be shared with the Board;
  (**Action**: Director of Community Services and Integration)
- Should the CQC visit Cambridgeshire, members might wish to have a briefing session on the most up to date data available;
- An elected member commented that as a newly appointed member of the Board and a lay person, they would find it helpful to be given a steer on where to find the most useful background information on the BCF;
  (**Action**: Director of Community Services and Integration)
- The Director of Public Health reported that the increased activity on DTOCs meant that the proportion of funding allocated for social care packages might need to be increased before the Board met next in February 2018. She sought the agreement of the Board to give her delegated authority to approve some change in the allocation of Improved Better Care Funds (iBCF), if this was required in the event of circumstances changing significantly, in consultation with the Chairman and Vice Chair. Should this delegation need to be used the Director of Public Health would circulate details of the proposed changes to members of the Board for comment.
  (**Action**: Director of Public Health)

  Summing up, the Chairman welcomed the early indications of improvements to DTOC figures, but emphasised the need to maintain this momentum and for the

Board to be assured that BCF funding was being used to drive this improvement. This would remain a key 'watch' area for the Board.

It was resolved to:

a) note and comment on the report and appendices;

b) delegate authority to the Director of Public Health, in consultation with the Chairman and Vice Chair, to approve some change in the allocation of Improved Better Care Funds (iBCF) in the context of changing circumstances, if required.

42. AGENDA PLAN

The Agenda Plan would be circulated to Members outside of the meeting for information and comment.
(**Action**: Democratic Services Officer)

43. DATE OF NEXT MEETING

The Board will meet next on Thursday 1 February 2018 in the Council Chamber at Cambridge City Council, Guildhall, Cambridge.

Chairman
(date)

HEALTH & WELLBEING BOARD ACTION LOG: JANUARY 2018

MINUTE & ITEM TITLE	ACTION REQUIRED / UPDATE	STATUS
Meeting Date: 21 September 2017		
Item 8: Cambridgeshire Annual Public Health Report 2017	To provide Cllr Richards with further information on data relating to educational attainment and those taking free school meals in Cambridge City. **Action: Liz Robin**	**Completed**
	To make the Annual Public Health Report 2017 available to GPs via the NHS Gateway. **Action: Liz Robin**	**Completed**
	To draw the APHR to the attention of the Local Enterprise Partnership. **Action: Liz Robin**	**Completed**
Item 11: Sustainability and Transformation Plan (STP) Update Report	To send a copy of the STP newsletter to Board members to illustrate the tone and content of communication with the wider public. **Action: Aidan Fallon** Updates requested 16.10.17, 08.12.17 &18.01.18.	**On-going**

	To establish whether it would be helpful to arrange a general briefing session on the STP for newer members of the Board. **Action: Richenda Greenhill/ Aidan Fallon** **<u>Update 24.10.17:</u>** Four Board members asked to attend an STP briefing session. This has been arranged for Thursday 14 December 2017 from 12.30-1.30pm at Shire Hall. **<u>Update 11.12.17:</u>** The briefing session on 14 December to be re-arranged as two members unable to attend due to clashes with other meetings.	**On-going**
Item 12: JSNA Core Dataset 2017	To reflect on whether the Board's online presence might be enhanced to better disseminate valuable information such as the JSNA Core Dataset. **<u>Update 07.17.17</u>**: This has been discussed with the County Council communications team who could allocate a web-page to the Health and Wellbeing Board, under the 'Council' section of the website. **Action: Liz Robin**	**On-going**

Meeting Date: 23 November 2017		
Item 40: Sustainability and Transformation Plan Update	To attend the Board's next meeting on 1 February 2018 to provide a further update report. **Action: Catherine Pollard** **<u>Update 11.01.18:</u>** Included on the agenda for the meeting on 1 February 2018.	**On-going**

Item 41: Better Care Fund Update	To provide an updated structure chart setting out the key roles and responsibilities of the various individuals and organisations responsible for oversight and delivery of the BCF. **Action: Cath Mitchell** **Update 22.12.17:** Awaiting documents. These will be forwarded as soon as possible. **Update 11.01.18:** Should be with Democratic Services by close on Monday 15 January. **Update 18.01.18:** Structure chart emailed to all members of the Board.	**Completed**
	To circulate details of the methodology and focus of the CQC inspections conducted to date. **Action: Cath Mitchell** **Update 22.12.17:** Details emailed to all members of the Board on 22.12.17.	**Completed**
	To provide a steer on where new Members would find the most useful background information on the BCF. **Action: Cath Mitchell** **Update 22.12.17:** Information awaited from Geoff Hinkins and Caroline Townsend. **Update 08.01.18**: Details of the Q2 monitoring data for Cambridgeshire and Peterborough's BCF Plans circulated to all members by email. Officers are exploring whether the full BCF documents for Cambridgeshire and Peterborough can be published on-line to provide easy electronic access as the documents are very large. **Update 18.01.18:** The full BCF plan will be published on the Council website and a link sent to all members of the Board. Details awaited.	**On-going**

	To circulate in advance to members of the Board details of any proposed changes to be made to funding allocations by the Director of Public Health under delegated authority, in consultation with the Chairman and Vice Chair. **Action: Liz Robin**	
Item 42: Agenda Plan	To circulate a copy of the Agenda Plan to members of the Board for information. **Action: Richenda Greenhill** **Update 20.12.17:** Copy circulated by email for information 11.12.17.	**Completed**

Agenda Item No: 5

DRAFT SUICIDE PREVENTION STRATEGY 2017-2020

To: **Health and Wellbeing Board**

Meeting Date: **1 February 2017**

From: **Katharine Hartley, Consultant in Public Health**

Recommendations: **The Health and Wellbeing Board is asked to:**

a) Approve the Draft Suicide Prevention Strategy 2017 - 2020 attached at Appendix 1

	Officer contact:		***Member contact:***
Name:	Katharine Hartley	Names:	Councillor Peter Topping
Post:	Consultant in Public Health	Post:	Chairman
Email:	kathy.hartley@peterborough.gov.uk	Email:	Peter.Topping@cambridgeshire.gov.uk
Tel:	01733 207175	Tel:	01223 706398

1. PURPOSE

1.1 The purpose of this paper is to:

a) ensure continuation of suicide prevention work to 2020 through the refresh of the joint Cambridgeshire and Peterborough Suicide Prevention Strategy;
b) review the progress to date from the Suicide Prevention Strategy, 2014 – 2017.

2 BACKGROUND

2.1 Suicide is a major public health issue as it marks the ultimate loss of hope, meaning and purpose to life and has a wide ranging impact on families, communities and society. Suicide is the leading cause of death for younger adults. However, the National Suicide Prevention Strategy – Preventing Suicide in England, states that suicides are not inevitable and many can be prevented, thus supporting a call for action to reduce suicide and the impact of suicide both at national and local level.

2.2 This report proposes a refresh of the joint Peterborough and Cambridgeshire Suicide Prevention strategy (2017-2020) (copy attached at Appendix 1) and includes updates on national and local suicide statistics, initiatives, evidence and forward planning. Incorporated as a main thread throughout the strategy is an ambition towards ZERO Suicide, as agreed through the multi-partner suicide prevention implementation board in 2017. The strategy builds on and supports the National Suicide Prevention Strategy – 'Preventing suicide in England', Dept. of Health 2012.

2.3 The key purpose is to ensure that there is co-ordinated and integrated multi-agency agreement on the delivery of suicide prevention services that is tailored appropriately to local need and is driven by the involvement and feedback from service users. With a focus on Zero suicide, the strategy emphasises the requirement for senior level engagement with all relevant organisations to ensure quality improvement across the pathways of care for suicide prevention.

3. MAIN ISSUES

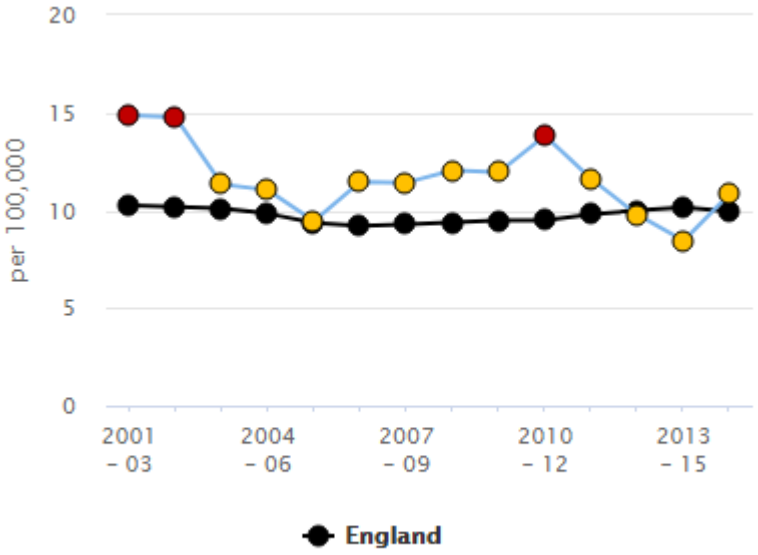
3.1 The six priority areas for suicide prevention in Cambridgeshire and Peterborough with recommendations for actions are set out in the Suicide Prevention Action Plan, developed by the Joint Cambridgeshire and Peterborough Suicide Prevention Implementation Group. This comprises of a partnership of multiple organisations involved in mental health (details at Appendix 2).

3.2 Key points of progress seen since the launch of the 2014 - 2017 suicide prevention implementation plan:

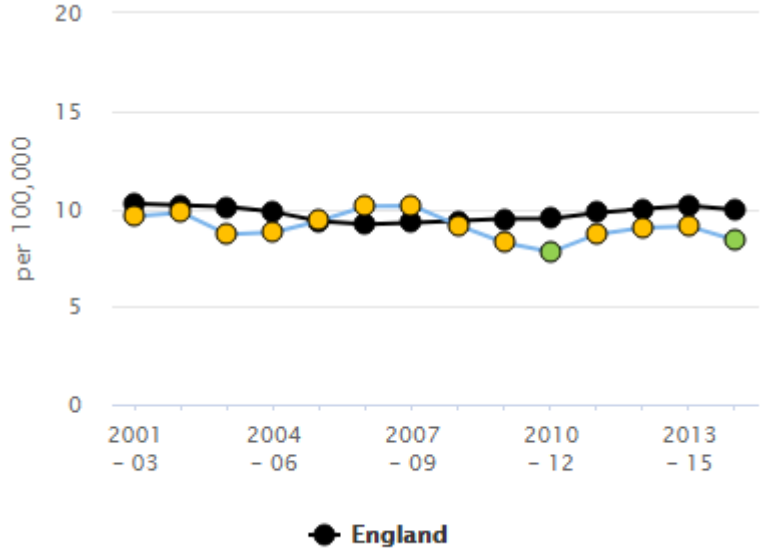
- The suicide rates in Peterborough has decreased since 2010-2012 when the rate was significantly above both the England and East of England rates and is now similar to the England average. The suicide rate in Cambridgeshire has remained similar to or slightly below the England average for the last five time periods.

Suicide rate for Peterborough (top figure) and Cambridgeshire (bottom figure) compared with England – three year rolling averages shown from 2001/03 to 2014/16

Peterborough suicide rate



Cambridgeshire suicide rate



- Development and roll-out of 'STOP Suicide' across Peterborough and Cambridgeshire, including a local suicide prevention website, pledge, training in suicide prevention and campaigns to increase awareness of mental health issues and how to access support.
- Implementation of a 111(2) mental health crisis telephone triage and First Response Service (FRS) that includes a Cambridge 'sanctuary' as a place to feel safe and supported during mental health crisis.
- The construction of safety barriers on Peterborough car parks to prevent suicide
- Community based youth 'face to face' counselling services including a 'drop in' service for young people. The Kooth online counselling service for young people was commissioned in September 2016 to broaden the mental health support available for young people.
- The Stress LESS campaign launched in April 2016, supports young people to manage stress through the exam period.
- Lifeline continued to provide telephone listening support and information to people with mental health concerns 365 days of the year from 7pm -11pm
- Annual audit of suicides with shared learning across the partnership to help focus preventative work
- Keep Your Head (Childrens and Young People's mental health website) has been developed; www.keep-your- head.com This includes a page designed with, and for, GPs. Crisis information and preventive suicide and self-harm information.

3.3 Key new multi-agency initiatives to enhance suicide prevention from 2017:

- The development of a multi-partnership 24 hour Mental health crisis response for children and young people.
- Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) Zero Suicide strategy and action plan, including the following actions:
    - Care planning to ensure that carers, families and significant others are always involved
    - Ensure that every patient has a comprehensive flexible risk management strategy
    - A pathway for the care of patients with drug and alcohol problems that explicitly manages their risk of suicide
    - Ensure that learning from suicide results in sustained improvement
    - Post suicide support by CPFT for families of those who have died due to suicide while under CPFT care
    - CPFT will become the local system leader in the provision of accessible, relevant and up to date information about suicide
    - CPFT will take part in or initiate at least two suicide related research projects a year.
- GP training in suicide prevention. Funding has been secured through the Sustainability and Transformation Plan (STP) for training of GPs across Cambridgeshire and Peterborough in suicide prevention, which will focus on the patient/GP interaction, risk identification, compassion and empathy as well as safety plans and follow-through care.
- Real-time suicide surveillance and enhanced suicide data monitoring. Public health analysts are receiving information on suspected suicides from the police as they occur. This allows information to be assessed for any potential factors that could require action - for example clusters or new methods of suicide. In addition, data is being collated to review suicides, attempted suicides and mental health crisis for the purpose of sharing between agencies and review/monitoring as part of the development towards a learning culture to prevent suicide
- Bereavement support for people affected by suicide - STP funding to set up a reactive support service for people who have been bereaved as a result of suicide. The service is now up and running and is managed by a family liaison officer working with Lifecraft, who offers support to families in the first weeks after bereavement. They also signpost people to follow-up services and peer support groups. Part of this work will be to link with or set-up new peer support groups in Cambridge and Peterborough to support people bereaved due to suicide.
- A new youth counselling service (CHUMS) to support children's mental health and wellbeing
- The development of an adult version of the 'Keep Your Head' website with information on how to access services, self-help resources and information for professionals on mental health issues and illness.
- Zero suicide initiative - This is the overarching ambition for suicide prevention locally and aims to bring all partners together to support the development of a learning culture to drive up quality so that suicide prevention is a priority for each organisation, across the system.

4 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

4.1 The Suicide Prevention Strategy 2017-2020 is relevant to priorities 4 and 6 of the Health and Wellbeing Strategy:

- Priority1: Ensure a positive start to life for children, young people and their families.
- Priority 2: Support older people to be independent, safe and well.
- Priority 3: Encourage healthy lifestyles and behaviours in all actions and activities while respecting people's personal choices.

- Priority 4: Create a safe environment and help to build strong communities, wellbeing and mental health.
- Priority 5: Create a sustainable environment in which communities can flourish.
- Priority 6: Work together effectively.

5 SOURCES

Source Documents	Location
1. National Strategy: Preventing Suicide in England, 2012:	*http://www.dh.gov.uk/health/files/2012/09/Preventing-Suicide-in-England-A-crossgovernment-outcomes-strategy-to-save-lives.pdf*
2. Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives:	*https://www.gov.uk/government/publications/suicide-prevention-thirdannual-report*
3. Cambridgeshire and Peterborough Clinical Commissioning Group Commissioning Strategy for the Mental Health and Well-Being of Adults of Working Age 2013 – 2016	*http://www.cpft.nhs.uk/Downloads/rod%20files/2013_0816_CCG_Adult_MH_Commissionin g_Strategy_2013_FINAL.pdf*
4. JSNA Cambridgeshire – health and wellbeing strategy see:	*http://www.cambridgeshire.gov.uk/info/20116/health_and_wellbeing_board*
5. JSNA Peterborough Mental Health	*http://www.peterborough.gov.uk/pdf/HealthAndSocialCare-JSNA-Mental%20Health.pdf*
6. Suicide Prevention Strategy CPFT 2013-2016 (closed document) – for details please contact author or CPFT	
7. Emotional well-being and mental health strategy for children and young people 2014-2016	
8. Suicides in students	*http://www.ons.gov.uk/ons/about-ons/what-we-do/publicationscheme/published-ad-hoc-data/health-and-social-care/november-2012/index.html*
9. National Confidential Enquiry into Suicide and homicide by people with Mental Health illness – Annual report 2013	*http://www.bbmh.manchester.ac.uk/cmhr/centreforsuicideprevention/nci/reports/AnnualRep ort2013_UK.pdf*
10. Samaritans report –men suicide and society:	*http://www.samaritans.org/sites/default/files/kcfinder/files/Men%20and%20Suicide%20Rese arch%20Report%20210912.pdf*
11. No health without mental health:	*https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215811/dh_1 24057.pdf*
12. Public Health Outcomes Framework	*https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216159/dh_1 32362.pdf*
13. Mental Health Crisis Concordat – Improving outcomes for people experiencing mental 14 health crisis, February 2014.	*https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/28124*

Department of Health	*2/36353 _Mental_Health_Crisis_accessible.pdf*
14. Annual Report of the Chief Medical officer 2013 – Public Mental Health Priorities: Investing in the Evidence	*https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/351629/Annu al_report_2013_1.pdf*
15. Saving Lives: Our Healthier Nation; Department of Health, 1999:	*https://www.gov.uk/government/publications/saving-lives-our-healthier-nation*
16. Detroit model for suicide prevention:	*http://zerosuicide.actionallianceforsuicideprevention.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/PerfectDepressionCarearticles.pdf*
17. ASIST suicide prevention training:	*http://www.chooselife.net/Training/asist.aspx*
18. Mental Health First Aid training England:	*http://mhfaengland.org/*
19. Suicide in primary care in England 2002-2011	*http://www.bbmh.manchester.ac.uk/cmhr/research/centreforsuicideprevention/nci/reports/Sui cideinPrimaryCare2014.pdf*
20. Knapp et al 2011, Mental health promotion and prevention: The economic case.	*http://www.lse.ac.uk/businessAndConsultancy/LSEEnterprise/pdf/PSSRUfeb2011.pdf*
21. The Use and Impact of Applied Suicide Intervention Skills Training (ASIST) in Scotland: An Evaluation Social research: The Scottish Government,	*http://www.chooselife.net/uploads/documents/19-ASISTEvaluationFullReport.pdf*
22. Bickley, H et al 2013; Suicide within two weeks of discharge from psychiatric inpatient care. A case control study Psychiatric Services 2013	*http://ps.psychiatryonline.org/article.aspx?articleID=1673604*
23. Cox et al 2013; Interventions to reduce suicides at suicide hotspots: a systematic review BMC Public Health 2013, 13:214	*http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3606606/pdf/1471-2458-13-214.pdf*
24. Mann et al, 2005 Suicide Prevention Strategies: A systematic Review.	*JAMA. 2005;294(16):2064-2074*
25. Support after a suicide: A guide to providing local services	*https://www.gov.uk/government/publications/support-after-a-suicide-a-guide-to-providinglocal-services*
26. We are in your corner – Samaritans:	*http://www.samaritans.org/media-centre/ourcampaigns/were-your-corner*
27. MHRA – Best practice for the sale of medicines for pain relief -	*http://www.mhra.gov.uk/home/groups/pl-p/documents/websiteresources/con065560.pdf*
28. Hawton K, Bergen H, Simkin S et al (2010) Toxicity of antidepressants: rates of suicide relative to prescribing and non-fatal overdose.	*British Journal of Psychiatry 196: 354-358*
29. 'Help is at hand' a resource for people bereaved by suicide and other sudden, traumatic death	*http://www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf*
30. Preventing Suicide - A Resource for Media Professionals: A resource guide produced by the Department of Mental Health at the World Health Organization in 2000.	*http://www.who.int/mental_health/media/en/426.pdf*

31. Media guidelines for reporting suicide – Samaritans: *32. NHS England and Public Health England 'A call for Action: Commissioning for Prevention' November 2013.* *33. WHO For which strategies of suicide prevention is there evidence of effectiveness*	*http://www.samaritans.org/sites/default/files/kcfinder/files/press/Samaritans%20Media%20G uidelines%202013%20UK.pdf Available at: www.england.nhs.uk* *http://www.euro.who.int/__data/assets/pdf_file/0010/74692/E83583.pdf*

DRAFT Joint Cambridgeshire and Peterborough Suicide prevention strategy

2017-2020

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ORGANISATIONAL SIGNATORIES

To be added

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ACRONYMS AND ABBREVIATIONS

ARC	Advice and Resource Centre
ASIST	Applied Suicide Intervention Skills Training
CAB	Citizens Advice Bureau
CAF	Clinical Assessment Framework
CCG	Clinical Commissioning Group
CEC	Clinical Executive Committee
CMO	Chief Medical Officer
CO	Carbon monoxide
CPFT	Cambridgeshire & Peterborough Foundation Trust
CR/HT	Crisis Resolution/Home Treatment
CREDS	Cambridgeshire Race Equality and Diversity Service
GPs	General Practitioners
ICD10	International Classification of Diseases version 10
LAC	Local Area Coordination
MHFA	Mental Health First Aid
MHRA	Medicines and Healthcare products Regulatory Authority
NICE	National Institute for Health & Clinical Excellence
ONS	Office for National Statistics
PCAS	Peterborough Community Assistance Scheme
QALY	Quality Adjusted Life Year
SCN STP	Strategic Clinical Network Sustainability and Transformation Plans
SUN	Service User Network

CONTENTS – TO BE EDITED FOR FINAL COPY

'Keep your face always to the sunshine and shadows will fall behind you'
Walt Whitman

1. EXECUTIVE SUMMARY AND KEY RECOMMENDATIONS

The Cambridgeshire and Peterborough suicide prevention strategy 2017-2020 is a refresh of the 2014-2017 strategy with updates on national and local suicide statistics, initiatives, evidence and forward planning. Incorporated as a main thread throughout the strategy is an ambition towards ZERO suicide, as agreed through the multi-partner suicide prevention implementation board in 2017. This enhances the work already underway to prevent suicide locally, including 'STOP Suicide' and the 111(2) First Response Service (FRS) for mental health crisis.

The strategy builds on and supports the National suicide prevention strategy – 'Preventing suicide in England, Dept. of Health 2012'[1] but also includes a drive to aim for ZERO suicide, based on the National Zero Suicide Alliance. The key purpose is to ensure that there is co-ordinated and integrated multi-agency agreement on the delivery of suicide prevention services that is tailored appropriately to local need and is driven by the involvement and feedback from service users. With a focus on Zero suicide, the strategy emphasises the requirement for senior level engagement with all relevant organisations to ensure quality improvement across the pathways of care for suicide prevention.

Six priority areas for suicide prevention in Cambridgeshire and Peterborough with recommendations for actions are set out in sections 9-14 and accompanying action plan. A summary of the recommendations is provided below.

Table 1 – Summary of suicide prevention priority areas and recommendations for actions

Priority area 1 – Reduce the risk of suicide in high risk groups
Recommendations **1.1** Continue to implement suicide prevention training (STOP suicide and ASIST) to professionals, organisations and individuals in contact with people at risk of suicide. Develop and implement suicide prevention training for GPs **1.2** Continue to develop and tailor suicide prevention resources for professionals, agencies and vulnerable groups **1.3** Continue to raise awareness of STOP suicide and suicide prevention in community settings and to high risk groups **1.4** Ensure access to resources to aid self-help in those at risk of suicide **1.5** Continue to develop integrated, appropriate and responsive services for those at risk of suicide – including pathways for vulnerable groups such as those with co-occurring drug and alcohol and mental health problems. **1.6** Reassess pathways for young people and adults known by mental health services at risk of suicide **1.7** Improve pathways and support for people taken into custody and newly released from custody at risk of suicide

Priority area 2 – Tailor approaches to improve mental health in specific groups

Recommendations

2.1 Continue to work with partners who are delivering the 'Emotional wellbeing and mental health strategy for children and young people' to

- Raise awareness and campaigning around self-harm
- provide access to self-help resources that focus on building resilience in young people
- Raise awareness on preventing bullying
- Assess pathways for support for children who are at risk of self-harm , particularly in vulnerable groups of children and young people – youth offenders, children in care, children under the care of people with mental health problems
- Support initiatives that work with families to address children and young people's mental health

2.3 Promote early interventions to aid prevention of mental health problems that could lead to suicide in particular risk groups.

2.4 Promote training in mental health awareness, particularly with professional groups such as GPs to recognise mental health issues and risk of suicide

Priority area 3 – Reduce access to the means of suicide

Recommendations

3.1 In line with regulations, ensure the removal of potential ligature points – particularly in places of custody and in-patient settings

3.2 Continue to reduce the risk of suicide by jumping from high buildings accessible by the public including multi-storey car-parks and bridges

3.3 Continue work to reduce the risk of suicide on railway lines

3.4 Work with Medicines Management teams at the CCG to ensure safe prescribing of some toxic drugs

3.5 Work with health and care professionals to establish and reinforce safety plans for individuals with mental health problems

Priority area 4 – Provide better information and support to those bereaved or affected by suicide

Recommendations

4.1 Ensure bereavement information and access to support is available to those bereaved by suicide

4.2 Implement a bereavement support service and pathway for those affected by suicide

Priority area 5 - Support the media in delivering sensitive approaches to suicide and suicidal behavior

Recommendations

5.1 Encourage appropriate and sensitive reporting of suicide

- Continue to provide information to professionals on the sensitive reporting of suicide
- Continue to work with local media to encourage reference to and use of guidelines for the reporting

of suicide
Priority area 6 - Support research, data collection and monitoring
6.1 Monitor real-time information on suspected suicides as they occur. Link this information to suicide data provided on a quarterly basis by Cambridgeshire and Peterborough coroners. Include data from the Police on suicides and near suicides. **6.2** Continue to conduct an annual audit of local suicides **6.3** Continue to disseminate current evidence on suicide prevention to all partner organisations **6.4** Evaluate and report on the suicide prevention implementation plan

1.1 Zero Suicide

The ambition towards Zero suicide as the 'backbone' of the strategy requires commitment by organisations and individuals to create a cultural change in suicide prevention as summarised below.

Table 2 – Outline of the zero suicide ambition

Zero Suicide Ambition
Top level (Chief executive) engagement and commitment towards zero suicide for the main organisations involved – CCG, CPFT, PCC, CCC, Police
Improve quality - Create a learning culture not a blaming culture that will review both suicide information and information from people with lived experience to learn lessons and implement good practice.
Review and improve information sharing across agencies involved in the pathway of care of individuals with mental health problems
Strengthen the suicide prevention implementation plan with a stronger emphasis on training, campaigns and initiatives that raise awareness, educate and promote mental health across the population, but with a focus on young people

2. PURPOSE

This document sets out the strategic priorities and recommendations to prevent suicide in Cambridgeshire and Peterborough between 2017 and 2020. Accompanying the strategy is an action plan that is updated from the previous suicide prevention strategy. The action plan is intended to be used as a framework by key stakeholders for implementing the recommendations and for measuring and evaluating suicide prevention outcomes.

Suicide is a major public health issue as it marks the ultimate loss of hope, meaning and purpose to life and has a wide ranging impact on families, communities and society. Suicide is the leading cause of death for younger adults. However, the National Suicide Prevention Strategy – Preventing Suicide in England[1] states that suicides are not inevitable and many can be prevented, thus supporting a call for action to reduce suicide and the impact of suicide both at national and local level.

In line with national guidelines on preventing suicide, and to oversee the implementation of the local strategy, a multi-agency suicide prevention implementation group meets on a quarterly basis with input and membership from many organisations across public, charitable and voluntary sectors, including:

- Cambridgeshire County Council
- Peterborough City Council
- Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) - including CCG GP leads for mental health and commissioning support
- Police
- Coroners
- Cambridgeshire and Peterborough Foundation Trust
- MIND
- Lifecraft
- Service User Engagement Network (SUN)
- MindEd Trust
- Youth Offender service
- Rethink Carers
- Prison and probation service
- Samaritans
- Individuals with lived experience

The strategy is refreshed as a result of the following key considerations:

Nationally

- The National drive to prevent suicide – highlighted by the report "Preventing suicide in England - a cross-government outcomes strategy to save lives HM Government September 2012"[1] with progress reports including the most recent publication 'Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives'[2]
- Public Health England's guidance on 'Local suicide prevention planning - a practice resource'
- National momentum to aim for Zero suicide as described by the Zero Suicide Alliance
- Government commitment to improve mental health - a comprehensive package of measures to transform mental health support in schools, workplaces and communities – as announced in January 2017
- Public Health England Guidelines to develop bereavement support services for those affected by suicide: 'Support after a suicide: a guide to providing local services'

- The findings from the National Confidential Enquiry into Suicide and homicide by people with Mental Health illness – Annual report 2016[8]

Locally

- Suicide prevention is specified in the STP improvement plan within the Primary Care and Integrated Neighbourhoods (PCIN) delivery group, Mental Health Prevention and promotion of mental wellness priority. This stipulates the continued implementation of the suicide prevention strategy and findings of suicide audit.
- The five year forward view on mental health states within the key priorities for investment and focussed work 2016/17 and 2017/18 (primary prevention section): A local focus on Continued implementation of multi-agency suicide prevention strategy and findings of suicide audit (2016/17). By 2020/21 the number of people taking their own lives will be reduced by 10% nationally compared to 2016/17 levels.
- The Peterborough Health and Wellbeing Strategy identified five priorities to improve the health and wellbeing of everyone in Peterborough including 'to enable good child and adult mental health through effective, accessible health promotion and early intervention services'. The suicide prevention strategy includes areas that focus on mental health promotion and early intervention. The findings of the Peterborough JSNA on the mental health and mental illness of adults – 2015/2016 are also considered and help to focus the suicide prevention action plan.
- The development and implementation of a local Mental Health Crisis Concordat Declaration and Action Plan. This work is being led by the Police, but is supported by members across the partnership of organisations including the suicide prevention implementation group. The suicide prevention strategy includes recommendations that link directly to the work developed in the Crisis Concordat Action Plan.
- Feedback consistently received from individuals affected by suicide and local agencies that there is a need for:
    - better support for those bereaved or affected by suicide
    - clearer guidance where to seek help and advice for people who are worried that someone they know might be at risk of suicide, or are presented with somebody threatening suicide
    - improved information sharing across the pathway of care for people at risk of suicide
    - improvements to training for GPs and other health professionals to identify and manage those at risk of suicide

In developing recommendations and action plans for each priority area within the strategy, evidence and information is drawn from national guidance and publications on what is effective in preventing suicide. An emphasis is placed on local needs assessments and intelligence gathered from coroner data. Consultation is made with service users and other organisations or groups including British Transport Police, Probation services, Drug and Alcohol services, Public Health England and Cambridge University Student welfare officers to identify groups at higher risk of suicide and gaps in service provision.

Implementation of the recommendations and action plan are managed by a joint Cambridgeshire and Peterborough Suicide Prevention Implementation Group. Multi-agency working across all sectors, from NHS and mental health professionals to voluntary organisations, will be encouraged in order to utilise expertise from these organisations to implement the proposed initiatives. Continuing engagement with service users and their carers is expected for the successful development, implementation and delivery of initiatives in each priority area. It is envisaged that working groups will be established to address priority areas or particular recommendations and these will report to the joint implementation group. The joint implementation group will be accountable for delivering the strategy and will report progress on a regular basis as part of governance procedures to the Joint Safeguarding Executive and the Health and Wellbeing Boards in Peterborough and Cambridgeshire.

2.1 Outcomes of the implementation of the suicide prevention strategy 2014-2017

The table below lists the progress made to date as a result of the suicide prevention strategy, implementation plan and partnership working since 2014.

Table 3 – Summary of progress of the suicide prevention strategy 2014-2017

Priority area 1 – Reduce the risk of suicide in high risk groups

Suicide Prevention Training

Applied Suicide Intervention Skills Training (ASIST) Training

- Three ASIST trainers trained
- ASIST Courses delivered across Cambridgeshire and Peterborough targeting 'Gate Keeper' roles including those working with migrant communities and bereavement support workers.
- An ASIST course was funded and delivered to peer support workers in Peterborough prison.
- 258 people trained in ASIST between October 2015 and January 2017

Bespoke stop suicide training - Locally developed ½ day STOP suicide course has been developed and delivered. 21 STOP suicide workshops have been delivered reaching 236 people (From Oct 2015 to Jan 2017). These have included sessions with the following:

- CAB
- Three Homeless Charities
- Oasis Community Centre (East European migrants)
- NCS Programme (Peterborough)
- UNISON
- Junior Drs
- Carers Trust
- Cruse
- Colleges (Impington, Homerton, Huntingdon, Ely, Peterborough)

Courses are also offered to the **emergency services** as part of MIND's **Blue Light Activity**.

GP Training in suicide prevention

Funding has been secured through the STP for training of GPs across Cambridgeshire and Peterborough in suicide prevention, which will focus on the patient/GP interaction, risk identification, compassion and empathy as well as safety plans and follow-through care. Training will be implemented from the Autumn 2017

Suicide prevention resources

Since October 2015 the STOP suicide Campaign Makers, partners and other local organisations have helped us to distribute resources to at least 70 different locations across Fenland, Peterborough, Melbourn, Cambridge i.e. pubs, leisure/sport centres, community centres, local shops.

The Blue Light Programme team have also been giving out leaflets to emergency services across Cambs and Peterborough.

In addition, Great Northern agreed to display STOP Suicide resources at its key railway stations from end of July 2016 onwards

A website aimed at promoting mental health in children and young people has been developed – 'Keep Your Head' www.keep-your-head.com This includes a page designed with, and for, GPs. Crisis information and suicide and self-harm information. Wide promotion of this resource has taken place and is continuing.

A directory of Services App (MyHealth App) for the public and a professional directory of services App (Midos) are being developed. These will be available along with the directory of services produced by Lifecraft via 'Keep Your Head'.

The development of an adult version of the 'Keep Your Head' website has been agreed with funding secured from the 'Better Care Fund'. This will be developed from September 2017 with partner organisations and the Service User Network working together to create content.

Awareness raising in suicide prevention

Stop suicide website and pledge

As of January 2017 there were 1,220 personal pledges and 51 organisational pledges for STOP Suicide. In addition, STOP Suicide had 1,343 twitter followers and 394 facebook fans. The STOP suicide website has had 17,598 visitors and 45,047 page views. Approximately **3000** one to one conversations with individuals around the subjects of mental health and suicide since September 2015. The campaign has recruited a total of **10** new Campaign Makers - four in Peterborough, five in Cambridge and one in St Neots.

Promoting suicide prevention across the county:

- 'No Shame In Talking' video on **ITV News Anglia** – Fixers, 5 October 2016 http://www.fixers.org.uk/index.php?module_instance_id=11312&core_alternate_io_han

dler=view_fixer_news_video&data_ref_id=14785&news_data_ref_id=14784&video_no=1 – talk about STOP Suicide

- 'Health Secretary Jeremy Hunt visits Cambridge's 'groundbreaking' mental health services' – **Cambridge News**, 28 October 2016 http://www.cambridge-news.co.uk/news/health/health-secretary-jeremy-hunt-visits-12095230
- **CRC radio** interview – talk about current campaigns, 2 December 2016
- 'Cambridgeshire dad welcomes Theresa May's pledge to 'transform' attitudes to mental health' – **Cambridge News**, 10 January 2017 http://www.cambridge-news.co.uk/news/cambridge-news/cambridgeshire-dad-welcomes-theresa-mays-12431838
- 'Crisis cafes and community clinics among plans to improve mental health services in Cambridgeshire' – **Ely Standard**, 11 Jan 2017 http://www.cambstimes.co.uk/news/crisis_cafes_and_community_clinics_among_plans_to_improve_mental_health_services_in_cambridgeshire_1_4844482
- **Promotion of suicide prevention awareness to coincide with suicide prevention day on September 10th 2016 via a discussion hosted by radio Cambridgeshire**

Develop Integrated services for those at risk of suicide

Vanguard/Crisis Care Concordat work has been successful at creating an integrated mental health team with mental health nurses based in the police control room.

A First Response service (FRS)with crisis telephone number (111 option 2) was established in September 2016 to help prevent people with mental health crisis going to A&E and being admitted or sectioned under section 136 of the mental health act. In addition non health places of safety (sanctuaries) have been established in Peterborough, Cambridge and Huntingdon for people in mental health crisis to access via the FRS. This service has been shortlisted for the Positive Practice in Mental Health Awards in the 'Crisis and Acute Services' category. In addition, the FRS and Sanctuaries have been evaluated by the 'Service User Network' (SUN) against it's 'five values' of Empathy, Honesty, Inclusion, Personalisation and Working Together and have awarded the FRS 3 stars (good rating) and Sanctuaries 4 stars (outstanding).

Data sharing - Information Sharing Agreements are in place across organisations to support the Frequent Attenders CQUIN, in addition to MH and Acute Trusts this includes 111, ambulance service, substance misuse, primary care (Work carried out through the Crisis Care Concordat).

PRISM (enhanced primary care) service for people with mental health problems is in place for many areas across Cambridgeshire. This provides access to support and care for people struggling with mental illness through referral via the GP or through 'step down' from secondary care. The PRISM service is proving effective at reducing referrals to secondary care as people are managed in the community.

Lifeline – continues to offer a free, confidential and anonymous telephone helpline service that is available from 7.00pm – 11.00pm 365 days of the year for Cambridgeshire residents. The

Line provides listening support and information to someone experiencing mental distress or to those supporting someone in distress. Lifeline is hosted by Lifecraft in Cambridge.

Priority area 2 – Tailor approaches to improve mental health in specific groups

Anti-stigma work and mental health promotion targeting specific groups at higher risk

Funding to deliver courses to bar staff in Fenland as well as scoping work to assess feasibility of training barbers/hair dressers. A need for mental health awareness and suicide prevention for men working in the construction industry has been identified (through national data and suicide surveillance) and will be a focus for the anti-stigma/suicide prevention work commissioned from CPSL MIND

Other public engagement events through the 'anti-stigma work:

- Mental Health crisis support for young people event, Cambourne – 22 Sept
- Shelf Help launch, Huntingdon library – 28 Sept
- World Mental Health Day stand at South Cambs Council – 10 Oct
- CCG Development Day stand – 13 October 2016
- HRC Freshers' Fair – 20 October 2016
- Meeting a group of potential Campaign Makers, Wilbrahams Memorial Hall – 1 November
- Hunts Forum AGM stand – 10 November 2016
- Young people's follow up event, Cambourne – 23 November 2016
- Meeting with Cambs Football Association – 12 Jan 2017
- TASC meeting, London – 13 Jan 2017

Children young people anti stigma/bullying in schools

Between October 2015 and January 2017 CPSL Mind have engaged approximately 555 young people via workshops at Hills Road Sixth Form College, Kimbolton School, College of West Anglia, Milton, Oliver Cromwell College, Chatteris, Thomas Clarkson Academy, Wisbech and Ramsey College. Centre 33 have also been delivering mental health awareness sessions in schools. Between September 2016 - March 2017 mental health awareness sessions had taken place in 11 with sessions booked for a further 7 other schools. Across the 11 schools a total of 821 students engaged in the workshops. These sessions aim to challenge stigma and build understanding of mental health.

The Stress LESS campaign launched in April 2016, aiming to support young people to manage stress through the exam period. A range of resources were produced with over 6,500 being downloaded and 2,695 website page views. Over 130 Stress LESS Action plans were made to encourage people to 'Take 5' when revising.

Alongside the campaign a range of workshops are being run to enable school staff to deliver 'Stress LESS' sessions within their schools with pupils. As of Spring 2017 over 21 schools had been involved in this training and a further 90 individuals were being trained over the summer term. These workshops have been expanded to include information on how to respond to a young person in distress (including discussion around self-harm and suicide).

Within schools that engage in the Stress LESS workshops, small grants are available to pupils who have ideas they would like to develop to support the wellbeing of other students. These ideas are taken forward by 'Stress LESS' champions in schools.

A range of training is provided by CPFT to upskill the children and young people's workforce, this includes specific training courses on areas such as responding to self-harm as well as a 14 day CAMH foundation course. There is also tailored training for schools which includes the whole school briefing which offers an introduction to mental health with a focus on the ethos and culture around mental health in schools. Since 2015 there have been 49 schools that have held a whole school briefing, which equates to 1,616 staff.

Tackling self-harm in young people

A self-harm conference was held in 2015 in Cambridgeshire for professionals and locally a guide to 'understanding and responding to self-harm' has been produced and is freely available (download via the Keep Your Head website http://www.keep-your-head.com/CP-MHS/need-help-now/suicide-and-self-harm-support). A self-harm support group for parents has been run by PinPoint with support from local authority teams.

A range of training is provided by CPFT aimed at upskilling the children and young people's workforce in terms of mental health. Self-harm is covered within a number of courses, including specific training on responding to self-harm. This training is free to access for many professionals.

Community based youth counselling services are run across Cambridgeshire and Peterborough, with a bereavement service offered in Cambridgeshire also. These services offer face-to-face counselling and support to young people. The Kooth online counselling service for young people was commissioned in September 2016 to broaden the mental health support available for young people.

Early interventions to prevent suicide

GP training

Funding obtained through STP for suicide prevention training for GPs. Funding is supplemented by CCC Public mental health budget. A bespoke GP training package will be designed and implemented hoping to cover 20-30% of GPs or practices within the next twelve months (from September 2017) – see priority area 1. The training will help to improve GP recognition and management of mental illness and use early intervention techniques to prevent escalation to mental health crisis.

Money management/debt advice - debt prevention work is being funded with care leavers to improve money management skills and ensure vulnerable young people know where to access support if in financial trouble. A contract has also been awarded to support debt prevention and money management support to those with a severe mental illnesses in Cambridgeshire. Both of these pilot projects will be evaluated with a view to expanding provision in the future if successful.

Preventative work in schools (please see priority 2 for further details of training for school staff and mental health awareness sessions with pupils).

In 2017/18 training is being offered to schools staff to develop peer mediation skills. This work aims to support anti-bullying work locally. In addition a range of anti-bullying resources have been developed locally by the PSHE service working together with schools in Cambridgeshire. http://www5.cambridgeshire.gov.uk/learntogether/homepage/352/anti_bullying/

Drop in services for young people in Huntingdon and Peterborough and Cambridge as part of Centre 33 and local authority partnerships. Delivering broad support as well as counselling.

Priority area 3 – Reduce access to the means of suicide

Car park barriers

The 2014-2017 strategy identified a need to reduce access to the means of suicide in Peterborough carparks. There had been a number of suicides from Queensgate car park and incidences of suicide at Northminster car park, both close to the city centre. There is strong evidence for reducing access to the means of suicide in preventing suicide, particularly barriers at sights where suicide has been frequent.

The suicide prevention implementation group along with other parties including the coroner in Peterborough were successful in working with the owners of the Queensgate car parks to reach a decision to erect barriers on all the car parks they operate in the city centre.

Car park barrier construction began in 2015 and was completed in 2017. Following this, barriers have been erected at Northminster car park in Peterborough. There have been no suicides from car parks in Peterborough since the start of the barrier construction.

Suicide prevention on Railways

A range of work is being undertaken nationally as part of the railway Suicide Prevention plan – Samaritans, Network Rail and British Transport Police.

-Samaritans/Network Rail campaign on the railway including printed messages on tickets and posters at stations.

Some local stations are also displaying STOP Suicide resources.

-Staff training has been provided to railway employees to look out for and offer support to people who may be considering taking their own life on the railway (provided by Network Rail nationally).

-Rail505 app – enables other passengers/anybody to report someone they are worried about or to seek help themselves on the railway. https://www.rail505.com/

Safer medicines management

Following Child Death Overview Panel reports there was a communication to GPs regarding safe prescribing to young people, this was also re-circulated.

Priority area 4 – Provide better information and support to those bereaved or affected by suicide

Bereavement support - access to the 'help is at hand' leaflet for people bereaved as a result of suicide:

- Help is at hand booklet shared with Coroners Office (Feb15) and electronically shared with Funeral directors. Information on 'help is at hand' circulated via the GP bulletin in 2015 and 2017.
- Help is at Hand booklets circulated to all GP practices in Cambridgeshire and Peterborough with instructions on how to re-order them.

Establishing a bereavement support service for people affected by suicide

STP Funding was granted in July 2017 to set up a reactive support service for people who have been bereaved as a result of suicide. The service will be managed by a family liaison officer who will offer support to families in the first weeks after bereavement. They will also signpost people to follow-up services and peer support groups. Part of this work will be to set-up SOBS (Survivors of bereavement due to suicide) groups in Cambridge and Peterborough and connect with CRUSE counselling services.

Bereavement support resources

Bereavement support resources are promoted via the Stop Suicide Pledge website and Keep Your Head website. These resources include specific sites for young people who are bereaved.

Priority area 5 - Support the media in delivering sensitive approaches to suicide and suicidal behavior

Communication with Cambridge News on the responsible reporting of suicide, including information advice created by The Samaritans – this was initiated after a suspected suicide incident was poorly reported by the Cambridge News. CCC Coms team have been involved in this work.

Two visits were made to Radio Cambridgeshire to promote the responsible reporting of suicides. Guidelines on suicide reporting were provided to the editor.

Support research, data collection and monitoring

Surveillance: suicide audit

An annual suicide audit was undertaken in 2015 (of deaths in 2014) and 2016 (of deaths in 2015) The audits have helped to shape targeting of local work. The audit will continue to be undertaken annually, with a detailed case review of a sample of files.

Work has been carried out together with the Coroner's Office to improve the standardised regular information received on deaths throughout the year. The quality of the information received has improved.

Surveillance from British Transport Police

Data is received from BTP through an annual report and a warning system (national system).

Local, real-time surveillance system

A local real-time surveillance system has been established – This shares information from Police/Coroner to Public health on suspected suicides as they occur. This information is essential to establish a bereavement support service

The Coroner flags any notable patterns with the group or public health. The surveillance system will also help to identify any concerns in terms of geographic/temporal patterns/clusters.

Suicide rates C&P

The suicide audit for 2014 showed 65 deaths as a result of suicide or unexplained deaths in Cambridgeshire and Peterborough. A similar audit of suicides for 2015 showed there were 66 deaths.

3. NATIONAL CONTEXT

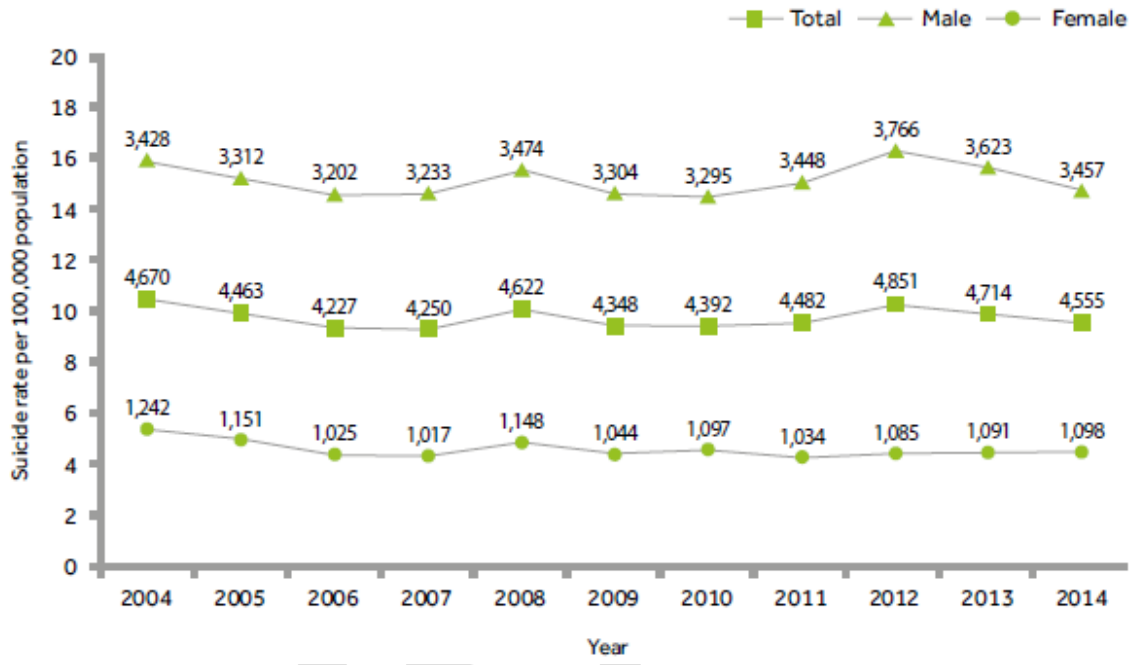
This section reviews and reflects upon nationally available data on suicides in order to place local information on suicides in context. With national reference points that include rates, trends, risk factors, suicide methods and evidence of what works to prevent suicides, a local approach for suicide prevention can be developed. This section summarises key findings from national data on suicides and is intended to be used as a guide to draw comparisons with local data and information presented in section 5.

Suicide is defined in England and Wales as a death with an underlying cause of intentional self-Harm and/or an injury/poisoning of undetermined intent (ICD10 codes X60-X84 - all ages and Y10-Y34 – for ages over 15 years). It is assumed that most injuries or poisonings of undetermined intent are self-inflicted, but there is insufficient evidence to prove that the person intended to take their own life. This assumption however cannot be applied to children due to the possibility that these deaths were caused by other situations – neglect or abuse for example. For this reason, data on suicides in England only include persons aged 15 years and over for deaths from injury of undetermined intent and may under-report deaths as a result of suicide in children.

3.1 Suicide rates and Trends

Data from the Office for National Statistics (ONS) The pattern of suicide since 2004 is a continued fall from previous years, reaching a historical low in 2006 and 2007, a rise in 2008 and 2012, with intervening years being lower, influenced by under-recording of "narrative" verdicts. Suicide rates have reduced since the peak in 2012. Suicide rates are volatile from year to year and are influenced by and reflect social and economic circumstances. Periods of high unemployment or severe economic problems have had an adverse effect on the mental health of the population and have been associated with higher rates of suicide.

Figure 1 – Rates of suicide in the general population in England, by gender.
Number of suicides included on the figure



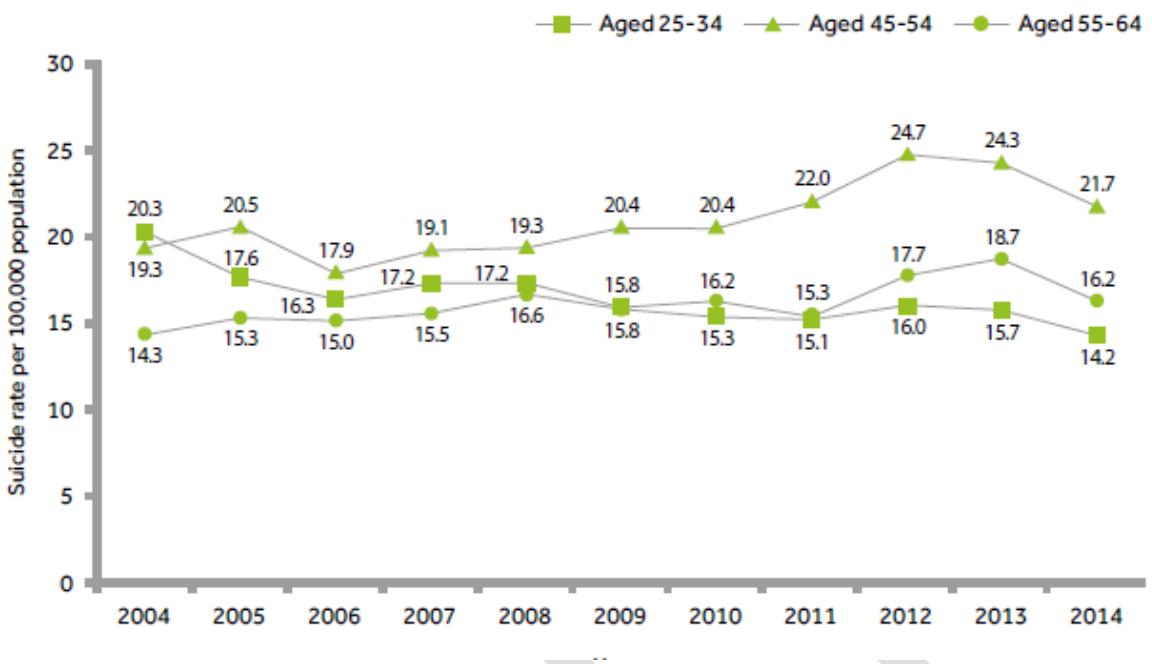
Source: National Confidential Enquiry into Suicide and homicide by people with Mental Health illness – Annual report 2016[8]

3.2 Suicides by sex and age

Suicide in males is currently about three times the rate of suicide in females across all ages in England. Of the total number of suicides in 2014, 3,457 were males and 1,098 were females.

Suicide occurs at all ages, however since 2006 the suicide rate was highest in men between the ages of 45 and 54 years and has increased by 27%. In contrast, the suicide rate in younger men, aged 25-34 has fallen since 2004 by 30% (figure 2). Middle-aged men are recognised as a one of the high-risk groups and should be a focus for suicide prevention strategies. Suicide rates fell in women aged 25-34 and rose in women aged 55-64 years.

Figure 2 – Male suicide rates in the general population in England in those aged 25-34, 45-54 and 55-64



Source: National Confidential Enquiry into Suicide and homicide by people with Mental Health illness – Annual report 2016[8]

3.3 Methods of suicide

National data from the 'National Confidential Inquiry into Suicide and homicide by people with Mental Illness" – Annual report 2016[8] on methods of suicide over the last decade show that the most common methods of suicide were hanging/strangulation, followed by self-poisoning (overdose) and jumping/multiple injuries - mainly jumping from a height or being struck by a train.

Less frequent methods were drowning, carbon monoxide (CO) poisoning, firearms, and cutting/stabbing.

Between 2001 and 2011, there were changes in method of suicide. Suicide deaths by hanging increased, whilst those by self-poisoning and jumping decreased. Of the less common methods, deaths by drowning, carbon monoxide poisoning, and firearms decreased.

3.4 Suicide Risk factors

Preventing Suicide in England, 2012[1] identifies groups of people at higher risk of suicide as follows:

- young and middle-aged men
- people in the care of mental health services, including inpatients
- people with a history of self-harm
- Physically disabling or painful illnesses including chronic pain
- Alcohol and drug misuse
- Stressful life events:
    - Loss of a job
    - Debt
    - Living alone, or becoming socially excluded or isolated
    - Bereavement
    - Family breakdown and conflict including divorce and family mental health problems
    - Imprisonment
- Specific occupational groups, Low skilled male labourers, particularly construction workers, building and finishing trades - plasterers and painters and decorators. Artistic, media and literary occupations presented higher risk, particularly in females. Health professionals and carers were at increased risk as were primary and nursery school teachers

Middle-aged men are identified as one of the high-risk groups and a priority for suicide prevention. A recent report by the Samaritans suggested that middle-aged men, especially those from poorer socio-economic backgrounds are particularly at risk of suicide due to a combination of factors. These include social and cultural changes (for example, rising female employment and greater solo living) that have particularly impacted on the lives of the cohort of men who are now in mid-life[9]

However, the greatest risk of suicide is found in people known to mental health services and particularly in people during the four week period following discharge from psychiatric hospital care[8,21]. It is important that the strategy focuses on identifying weaknesses in the system of care for people with mental health problems and works towards reducing risk in these groups – See section 9 and 9.9 for details.

4. LOCAL CONTEXT

4.1 Local suicide rates

Analysis of suicide rates at a local level for national purposes, uses pooled data on suicides over three year periods to provide a more consistent format to analyse suicide rates and trends when small numbers are given annually. Standardised rates are used in order to make comparisons with other regions.

4.2 Local suicide rates as measured by Public Health Indicator 4.10

The Public Health Outcomes Framework – 2013-2016[11] sets out the opportunities to improve and protect health across the life course and to reduce inequalities in health. The Outcomes Framework includes the Public Health Indicator 4.10 'Suicide Rate' and reflects the importance to keep the

suicide rate at or below current levels.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216159/dh_132362.pdf

A baseline suicide rate (deaths by suicide and injury of undetermined intent) is set for the period 2009-2011 using pooled three year average data. It is expected that each area will report and compare the suicide rate on a yearly basis based upon pooled three year data.

4.3 Trends in local suicide rates

Data on pooled three-year rates for suicide are published on the Public Health Outcomes Framework website: http://www.phoutcomes.info/ and show current indicators as measured against England rates as well as recent trends in suicide rates. . The suicide rate in Peterborough has decreased steadily since 2010-2012 when the rate was significantly above both the England and East of England rates and is now similar to the England average. The suicide rate in Cambridgeshire has remained similar to or slightly below the England average for the last five time periods. When the data for Cambridgeshire is broken down to smaller local authority areas, all districts have recently had rates of suicide which are similar to the England average, although in the past Cambridge City and Fenland have both had periods of statistically higher suicide rates than average. No data is shown for East Cambridgeshire due to small numbers.

Figure 3 – PHOF Indicator 4.10 – Suicide Rate. Directly age-standardised suicide rate per 100,000 for PETERBOROUGH compared with England

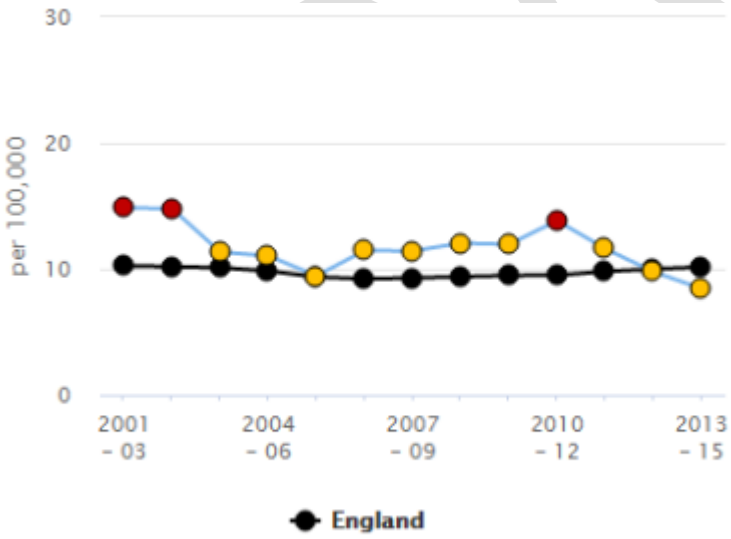


Figure 4 - Peterborough suicide rates (2013 -2015) with nearest CIPFA comparators

4.10 - Suicide rate (Persons) 2013 - 15 — Directly standardised rate - per 100,000

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	14,429	10.1	10.0	10.3
Bedford	–	12	32	7.5	5.1	10.6
Luton	–	10	40	7.7	5.4	10.6
Peterborough	–	-	42	8.4	6.0	11.5
Milton Keynes	–	3	54	8.6	6.3	11.3
Swindon	–	2	53	9.3	6.9	12.2
Coventry	–	4	83	10.0	7.9	12.5
Derby	–	6	65	10.2	7.8	13.0
Bolton	–	5	78	10.7	8.4	13.4
Telford and Wrekin	–	7	50	11.0	8.1	14.5
Oldham	–	11	63	11.0	8.4	14.1
Rochdale	–	8	62	11.2	8.6	14.4
Thurrock	–	1	47	11.3	8.3	15.1
Medway	–	9	83	11.7	9.3	14.5
Bury	–	15	58	12.0	9.1	15.6
Calderdale	–	13	71	12.9	10.1	16.3
Stockton-on-Tees	–	14	68	13.6	10.5	17.3

Although not significantly lower than the England rates, Peterborough has lower suicide rates than most of the CIPFA comparators for the latest data collection time period (2013-2015). Comparators are chosen as nearest and most similar local authority areas in terms of demographics and socio-economic information.

Figure 5 – PHOF Indicator 4.10 – Suicide Rate. Directly age-standardised suicide rate per 100,000 for CAMBRIDGESHIRE compared with England

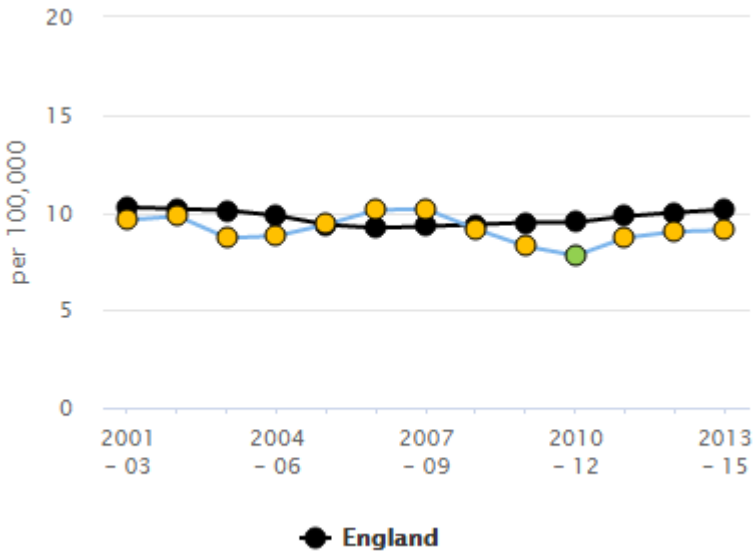


Figure 6 -Cambridgeshire suicide rates with nearest CIPFA comparators

4.10 - Suicide rate (Persons) 2013 - 15 — Directly standardised rate - per 100,000

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	14,429	10.1	10.0	10.3
Hertfordshire	–	14	197	6.6	5.7	7.6
Buckinghamshire	–	7	113	8.5	7.0	10.2
Hampshire	–	8	313	8.7	7.7	9.7
Cambridgeshire	–	-	155	9.1	7.7	10.6
Suffolk	–	5	181	9.3	8.0	10.8
Leicestershire	–	4	164	9.3	7.9	10.9
Oxfordshire	–	1	164	9.4	8.0	10.9
North Yorkshire	–	13	164	10.0	8.5	11.6
West Sussex	–	15	220	10.1	8.8	11.5
Worcestershire	–	6	152	10.1	8.5	11.8
Staffordshire	–	11	240	10.4	9.1	11.8
Essex	–	12	394	10.4	9.4	11.5
Gloucestershire	–	3	171	10.6	9.0	12.3
Northamptonshire	–	9	197	10.6	9.2	12.2
Somerset	–	10	165	11.6	9.9	13.5
Warwickshire	–	2	175	11.8	10.2	13.7

Source: Public Health England (based on ONS source data)

Although not significantly lower than the England rates, Cambridgeshire has lower suicide rates than most of the CIPFA comparators for the latest data collection time period (2013-2015). Comparators are chosen as nearest and most similar local authority areas in terms of demographics and socio-economic information.

Figure 7 – PHOF Indicator 4.10 – Suicide Rate. Directly age-standardised suicide rate per 100,000 for CAMBRIDGE CITY compared with England

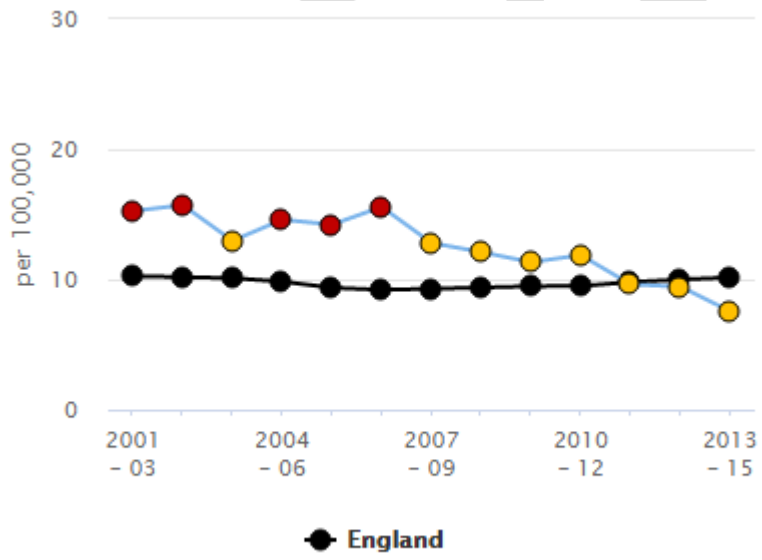


Figure 8 – PHOF Indicator 4.10 – Suicide Rate. Directly age-standardised suicide rate per 100,000 for FENLAND compared with England

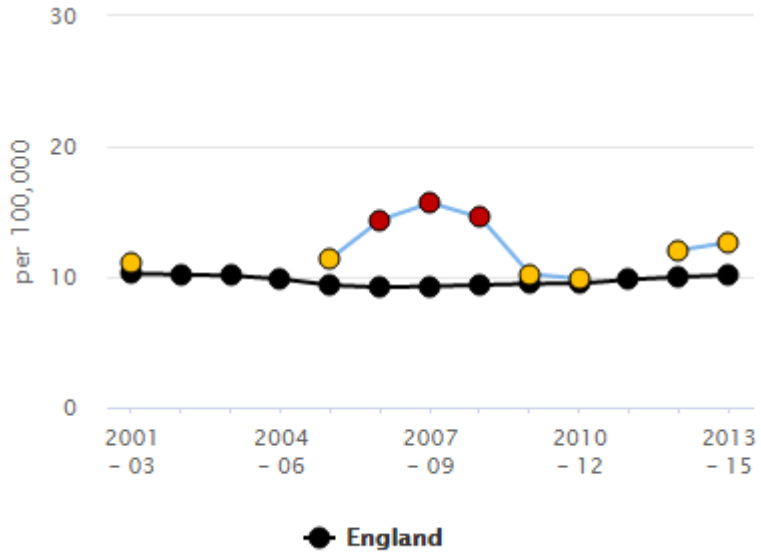


Figure 9 – PHOF Indicator 4.10 – Suicide Rate. Directly age-standardised suicide rate per 100,000 for HUNTINGDONSHIRE compared with England

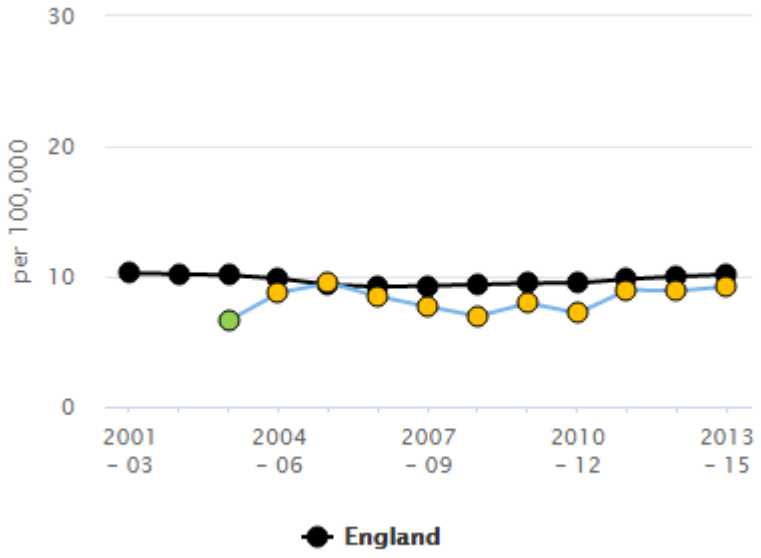
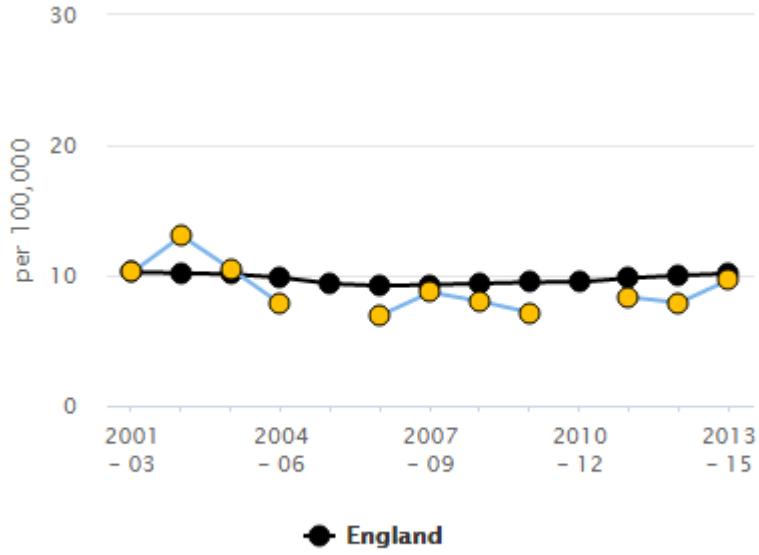


Figure 10 – PHOF Indicator 4.10 – Suicide Rate. Directly age-standardised suicide rate per 100,000 for SOUTH CAMBRIDGESHIRE compared with England



Source: Figure 10 data is taken from The Public Health Outcomes Framework information on indicator 4.10 – suicide rate. Rates are based upon pooled data for the three year periods shown.

Rates are age- standardised and show the number of deaths per 100,000 population from suicide and injury undetermined - ICD10 codes X60-X84 (all ages) and Y10-Y34 (for ages 15 and over) registered in the respective calendar years, aggregated into quinary age bands (0-4, 5-9,…, 85-89, 90+). Counts of deaths for years up to and including 2010 have been adjusted where needed to take account of the ICD-10 coding change introduced in 2011. The detailed guidance on the implementation is available at http://www.apho.org.uk/resource/item.aspx?RID=126245.

4.4 Local annual suicide audit

A recommendation in the 2014-2017 strategy was to conduct a local suicide audit annually for monitoring purposes and to inform the suicide prevention implementation group of any information about concerns, or risk factors that could help focus the prevention work. Two full local suicide audits have taken place so far – for 2014 and 2015 and an audit of suicides for 2016 is expected to be initiated early in 2018. It is important that the annual audit continues, particularly as interventions are focused as a result of audit findings. This will allow data to be gathered to understand effectiveness of interventions and where gaps and need may present. With 'zero suicide' as an overall ambition, the suicide audit will become embedded in the learning culture as case notes are examined for lessons to be learned on a regular basis.

The local suicide audit for 2014 and 2015 showed there were 65 and 66 suicides and unexplained deaths, respectively for these years in Cambridgeshire and Peterborough.

The main findings from the 2014 and 2015 Suicide audits are summarised below. Due to the sensitive nature of the information, details cannot be published.

In Peterborough there were 19 deaths in 2014 and 18 deaths in 2015 classified as suicide or unexplained. The majority of suicides or unexplained deaths were by males (67%). 63% (2014) and

42% (2015) had current or previous contact with mental health services and 30% in 2015 had contact within six months of death with mental health services.

In 2015, there was a noticeably high number of deaths in under 30 year olds in Peterborough and Eastern European populations were overrepresented.

The 2015 audit results for Cambridgeshire & Peterborough showed:

- In males the highest number of deaths was in under 25 year olds and 50-59 year olds.
- In females the age pattern was more mixed, with highest numbers in 30-39 year olds and 70-74 year olds.
- The highest rate locally was in Peterborough, but Fenland and South Cambridgeshire also have high rates compared to the Cambridgeshire and Peterborough average. None of the areas were statistically significantly above that of Cambridgeshire and Peterborough as a whole though.
- Around 30% had been in contact with mental health services within the 6 months prior to death.
- Where a mental illness diagnosis was recorded in the audit records, almost three-quarters mentioned depression, as well as 29% with recorded anxiety.
- Two thirds of people had been in touch with primary care in 2015 or within a maximum of 6 months prior to death.
- 19 people were found to have physical health problems, including 12 with long term conditions (such as diabetes).
- Alcohol misuse was noted in 9 records and 7 mentioned drugs, such as cannabis, cocaine, amphetamine and crystal meth.
- Bereavement was noted in 10 records.

4.5 CPFT Suicide Audit report 2013/14 and 2014/15 data

In 2015, a comprehensive audit on all suicides and possible suicides reported by the CPFT 'Datix' system during the period 2013/14 and 2014/15 was completed by the Trust. This covered suicides and possible suicides of people who have been in contact with care of secondary mental health within twelve months prior to death.

The audit identified 29 deaths in 13/14 with a 3:1 ratio of men to women. 32 deaths were identified in 14/15 with a 1:1 ratio of men to women. Nationally, there is a 3:1 ration of men to women who have died due to suicide, known to mental health services and therefore the 14/15 CPFT data shows a divergence from the national trend.

For men the highest risk factors in both years were being single, unemployed, living alone and experiencing relationship problems. For women, the highest risk factors were being unemployed, and/or experiencing relationship problems. Behavioural risk factors included a history of self-harm and previous suicide attempts.

31% (13/14 data) and 25% (14/15 data) had had contact with CPFT within seven days prior to death. In both years, the majority of suicides were *nCPA* (Care Programme Approach) patients (55% in 2013/14 and 59% in 2014/15).

In 2013/14 14% had been referred to CPFT and were awaiting assessment at the time of death, another 14% had been assessed as not requiring CPFT services, and another 14% had been assessed and refused CPFT services. In 2014/15, the proportion was smaller for those who had been referred to CPFT and were awaiting assessment at the time of death or had been assessed as not requiring CPFT services. However, in 2014/15, 41% had been discharged from CPFT at the time of death.

National data has shown an increase in suicides from CRHT services and as of 2013 there were three times as many suicides in CRHT services as in inpatient care in England. CPFT audit data also reflects this national information.

5. NATIONAL AND LOCAL PUBLICATIONS AND GUIDANCE RELEVANT TO SUICIDE PREVENTION

The local suicide prevention strategy must reflect the latest national information, evidence and guidance on improving mental health and preventing suicide for the population. In addition, the suicide prevention strategy must reflect, support and build upon other local strategies that support mental health. This section summarises the latest national and local publications that underpin the suicide prevention strategy.

5.1 No health without Mental Health

Suicide prevention starts with a better understanding of mental health and improving the mental health of populations, particularly those at high risk of mental health problems. No *health without mental health*, published in 2011[10], is the government's mental health strategy. Published alongside this is an implementation framework to set out what local organisations can do to turn the strategy into reality, what national organisations are doing to support this, and how progress will be measured and reported.

5.2 Cambridgeshire and Peterborough CCG Commissioning Strategy for the Mental Health and Well-Being of Adults of Working Age 2013 – 2016[2]

Our local Commissioning Strategy for the Mental Health and Well-Being of Adults of Working Age provides detailed information on the commissioning intentions and objectives for the next three years. Four key priority areas are identified and within these, priority objectives are listed. Many of the objectives are relevant to suicide prevention in our local area and are listed in table 2 below – extracted from the Commissioning Strategy for the Mental Health and Well-Being of Adults of Working Age 2013 – 2016[2].

Table 4 – Extract from 'the Commissioning Strategy for the Mental Health and Well-Being of Adults of Working Age 2013 – 2016' showing key priority areas and objectives that are relevant to suicide prevention

Key Commissioning Priority Area	Objectives relevant to suicide prevention

1. Prompt Access to Effective Help	• Introduce a **single-point of access** Advice and Resource Centre (ARC) to local mental health services for referrers, carers and service users CCG-wide. • Seek to expand the range of treatment options available – including self-help, online resources, counselling, etc. for people experiencing **mild-to-moderate** mental health problems that could be effectively helped without the need to access specialist mental health services; • Improve the help and support offered throughout the CCG to **offenders** with mental health problems • Ensure more equal access to voluntary sector services throughout the CCG.
2. The "Recovery" Model.	• Improve support for **Carers** and engagement in care planning of loved ones. • Robust **discharge planning** processes • Ensuring there is access to a specialist community-based **forensic** mental health service for former offenders throughout the CCG. • Improved partnership working between primary care, secondary services, and voluntary organisations to strengthen the local response to people who may be at risk of **suicide** • Ensure that there is appropriate **training** in mental health for key stakeholders such as GPs
3. The Inter-Relationship between Physical Health and Mental Health	• Support the introduction of **Liaison Psychiatry** Services at Hinchingbrooke and Peterborough hospitals. • Ensure people with **Dual Diagnosis** promptly receive the help they need for both their mental health and substance misuse problems
4. Improve Our Commissioning Processes	• Ensure that the services we commission are safe, effective and value-for-money

5.3 Preventing suicide in England[1]

Preventing suicide in England is the national strategy intended to reduce the suicide rate and improve support for those affected by suicide. The strategy builds on the successes of the earlier strategy published in 2002. The overall objective of the strategy is to reduce the suicide rate in the general population in England and to better support for those bereaved or affected by suicide. It sets

[1] http://www.dh.gov.uk/health/files/2012/09/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf

out key areas for action and brings together knowledge about groups at higher risk as well as effective interventions and resources to support local action.

The main changes from the previous national suicide prevention strategy are the greater prominence of measures to support families - those who are worried that a loved one is at risk and those who are having to cope with the aftermath of a suicide. The strategy also makes more explicit reference to the importance of primary care in preventing suicide and to the need for preventive steps for each age group.

The Six key areas for actions to prevent suicide are listed as follows:

- Reduce risk of suicide in key high risk groups
- Improve mental health in specific groups
- Reduce access to the means of suicide
- Provide better information and support to those bereaved or affected by suicide
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour
- Support research, data collection and monitoring

The strategy outlines a range of evidence based local approaches and good practice examples are included to support local implementation. National actions to support these local approaches are also detailed for each of the six areas for action.

The inclusion of suicide as an indicator within the Public Health Outcomes Framework - 4.10[11] will help to track national and local progress against the overall objective to reduce the suicide rate.

5.4 Key findings for England from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2016[8]:

This report analyses data on deaths by suicide and undetermined cause in people known to mental health services. Data is compared with that obtained for the general population. Factors leading to or contributing to suicide are analysed and recommendations for service improvements are made as a result of these findings.

The main findings on suicides by people known to mental health services are:

- During 2004-14, 18,172 deaths (28% of suicides in the UK general population) were by people under mental health care
- In the UK in 2014, around 460 patient suicides were recorded - in acute care settings – in-patient and post-discharge care and crisis teams.
- In-patient suicides have continued to fall with a decrease of around 60% during 2004-14. This fall is partly attributed to the removal of ligature points to prevent deaths by hanging but there has been a reduction in suicides on and off the ward by all methods. However, despite this success, there were 62 suicides by in-patients in the England in 2014.
- There are three times as many suicides by patients under the care of the Crisis Resolution Home Treatment service CHRT - in the community, as there are in in-patients.
- Of the patients who died by suicide who were under the care of CRHT services, a third were known by the service for less than one week and a third had recently been discharged from

hospital. 43% of those who died by suicide lived alone. The report suggests that CRHT may not be a suitable setting for their care and raise concerns that CRHT has become the default option for acute mental health care because of pressure on other services, particularly beds.

- Suicide risk is high in the first three months post discharge with highest risk during the first two weeks. Deaths are associated with preceding short term admissions and lack of care planning. However, there has been a fall in post-discharge deaths occurring before first service contact, and this points to a recognition of the need for early follow-up.
- Of the patients who died by suicide, over 50% had a history of alcohol or drug misuse.
- Hanging, followed by self poisoning were the most common methods used for suicide in patients. However, jumping from a height or in front of a train was the third most common method . Suicide prevention initiatives by mental health services should consider how to address the physical safety of their local environment
- Economic challenges were seen to have an impact on patient suicide as 13% of patients who died by suicide had experienced serious financial difficulties in the previous 3 months.
- New migrant status is noted in 5% of patient suicides - people who had been living in the UK for less than five years. 20 deaths over a four year period were recorded in people who were seeking permission to stay in the UK

Recommendations made by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2016[8]

The following table is taken from the National Confidential Inquiry report and lists recommendations for safer patient care to avoid suicide:

Table 5 – Recommendations by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2016[8]

Key elements of safer care in mental health services:

1. Safer wards
   - Removal of ligature points
   - Reduced absconding
   - Skilled in-patient observation
2. Care planning and early follow-up on discharge from hospital to community
3. No 'out of area' admissions for acutely ill patients
4. 24 hour crisis resolution/home treatment teams
5. Community outreach teams to support patients who may lose contact with conventional services
6. Specialised services for alcohol and drug misuse and "dual diagnosis"
7. Multidisciplinary review of patient suicides, with input from family
8. Implementing NICE guidance on depression and self-harm
9. Personalised risk management, without routine checklists
10. Low turnover of non-medical staff

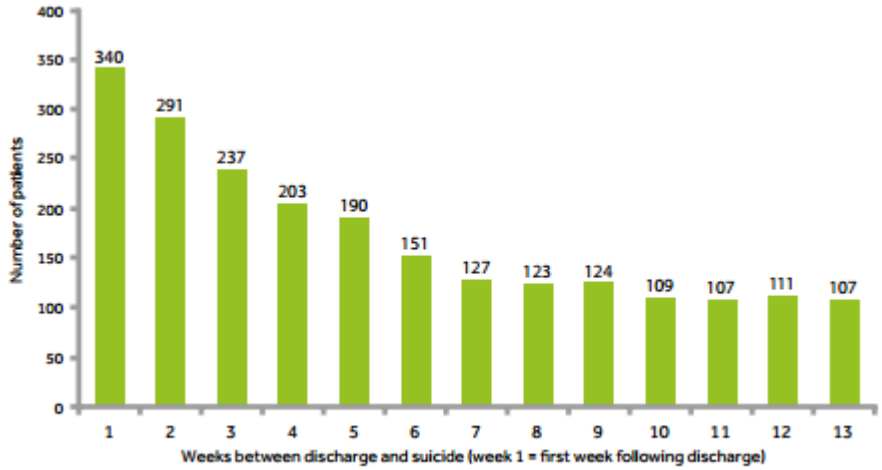
Key elements of safer care in the wider health system:

1. Psychosocial assessment of self-harm patients
2. Safer prescribing of opiates and antidepressants
3. Diagnosis and treatment of mental health problems especially depression in primary care
4. Additional measures for men with mental ill-health, including services online and in non-clinical settings

Source: the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2016[8]

The findings above are used to strengthen recommendations for local interventions as part of the action plan that accompanies this strategy.

Figure 11 - Number of patient suicides by week following discharge, England?, 2004-2014



Source: the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2016[8]

5.5 Cambridgeshire and Peterborough Emotional well-being and mental health draft strategy for children and young people 2014-2016[6]

The suicide prevention strategy takes account of recommendations made in the Cambridgeshire and Peterborough CCG 'Emotional well-being and mental health strategy for children and young people 2014-2016'. This document recognises that the mental health and wellbeing of children and young people is everybody's business and by partnership working, more efficient use of resources to provide the right intervention at the right time to the right people will result.

The specific areas for action listed in this draft strategy are:

1. The commissioning of mental health services will be outcome-focussed, maximising the capacity of statutory and voluntary sector organisations
2. Mental health support will be everyone's business, all partners will understand the role they can play and support will be co-ordinated, integrated, evidence based and cost effective.
3. There will be clear pathways of care across agencies, with the right level of expertise and a shared professional knowledge
4. Services will be available for all levels of need, maximising the opportunities for early intervention and prevention, whilst also providing for those with severe and enduring mental health problems
5. Ensure that children and young people's mental health needs are identified early and support is easy to access and prevents problems getting worse
6. Standardised principles of practice will be adopted across all organisations

5.6 Mental Health Crisis Concordat – Improving outcomes for people experiencing mental health crisis – February 2014[12]

The Mental Health Crisis Care Concordat is a national agreement between 22 national bodies involved in the care and support of people in crisis and includes health, policing, social care, housing, local government and the third sector. The concordat sets out how partners will work together to ensure that people receive the help they need when they are in mental health crisis.

The Concordat focuses on four main areas:

- **Access to support before crisis point** – making sure people with mental health problems can access help 24 hours a day and are taken seriously.
- **Urgent and emergency access to crisis care** – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
- **Quality of treatment and care when in crisis** – people are treated with dignity and respect, in a therapeutic environment.
- **Recovery and staying well** – preventing future crises by ensuring that people are referred to appropriate services.

Although the Crisis Care Concordat focuses on the responses to acute mental health crises, it also includes a section on prevention and intervention. This strategy includes and reflects some of the key messages and recommendations from the concordat, aiming to reinforce a commitment by partners to work together in preventing and managing crises. To this end, members of the suicide prevention strategic group will support the development of the mental health crisis care concordat declaration and action plan to ensure a joined-up approach to effective crisis management and prevention.

5.7 Annual Report of the Chief Medical Officer 2013 – Public Mental Health Priorities: Investing in the Evidence

The report from the Chief Medical officer focuses on epidemiology and the quality of the evidence base for public mental health and includes a chapter on suicide prevention[13]. The report highlights the recent increase in both the suicide and self-harm rates (since 2006/7), and suggests that the economic recession is the most likely cause for the increase. The risk of suicide in the year following self-harm is much greater than that of the general population. In addition, risk of suicide is high in people who are admitted for psychiatric treatment and remains high in the immediate post-discharge period. However, around three quarters of suicides occur in people not known to psychiatric services.

Suicide prevention should be based on evidence of what is effective. To improve safety of mental health services, access to 24 hour crisis services, policies for patients with dual diagnoses (drug/alcohol problems in combination with mental illness) and multidisciplinary reviews after suicide are effective strategies. Suicide prevention in the general population should focus on restricting of access to means of suicide, population approaches to reduce depression and improvements in detecting and managing psychiatric disorders with increased voluntary sector and internet based support. It is also recommended that work is carried out with media and internet providers to ensure responsible reporting of suicide. Self-harm should be followed up with a psychosocial assessment and access to psychological therapy upon discharge and screening for dual

diagnoses. Importantly, it is recommended that surveillance should be in place to ensure that information about changes and trends in suicides are identified to enable public health action.

This strategy learns from the recommendations made in the CMO report, and this is reflected in the details contained within the accompanying action plan.

6. LOCAL ACTIVITY TO PREVENT SUICIDE - MAPPING SUICIDE PREVENTION SERVICES PROVIDED IN CAMBRIDGESHIRE AND PETERBOROUGH

It is important to understand the current services and pathways with regard to suicide prevention in order to form a map of available interventions with which to identify any gaps and weaknesses in the system. A summary of the available services is provided in the following sections:

6.1 Services for people with mental health problems

NHS Cambridgeshire and Peterborough CCG currently commissions services for people with mental health problems on a pathway basis from the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT). In addition, NHS Cambridgeshire and Peterborough CCG along with Cambridgeshire County Council and Peterborough City Council commission mental health services from a range of local independent and voluntary sector organisations. Some mental health services are commissioned as part of the mental health Crisis care work that includes Police. In addition, there are voluntary sector organisations that provide mental health support in Cambridgeshire and Peterborough with funding outside the statutory sector.

- Cambridgeshire and Peterborough Foundation Trust (CPFT) Locality Teams; Psychosis, Affective Disorders, Assertive Outreach
- **Improving Access to Psychological Therapies (IAPT)** services (through CPFT) – providing psychological or talking therapies for people experiencing common mental health problems. **Group Therapy Centre** (http://www.grouptherapycambridge.org.uk/) in Cambridge and **Oakdale** in Peterborough - commissioned by Cambridge & Peterborough NHS to provide therapy groups for local people experiencing emotional and mental health worries.
- Acute Care Pathway (including crisis resolution and home treatment (CRHT) and Psychiatric Intensive Care Pathway). The acute pathway may include contact with liaison psychiatry services
- **111 (option 2)** mental health crisis telephone line with First Response Service (FRS) support into the community.
- Community **Sanctuaries** (in Cambridge, Peterborough and Huntingdon) for people to be referred to by the FRS if in mental health crisis
- **CAMEO** (NHS service that provides specialised assessment, care and support to young people experiencing a first episode of psychosis)
- **Lifecraft** – a user-led organisation for adults in the Cambridge area who have experience of mental health difficulties in their lives. Lifecraft offers a wide range of free services to help and support its' Members in their wellbeing and recovery. Lifecraft have produced a Mental

Health Handbook that serves as a directory of services for people with mental health problems

- **Lifeline** is provided for people in Cambridgeshire and offers telephone support to people experiencing mental health crisis
- Cambridgeshire, Peterborough and South Lincolnshire Mind (**CPSL MIND) -** provide a wide range of services across the county to support those recovering from mental health challenges, promote positive mental health and tackle mental health-related stigma and discrimination within our communities. CPSL MIND also hosts the STOP Suicide campaign and website
- **Talking therapies** are available through 3Ts to 11-17 year olds. This will shortly be changing (1st January 2018) and the service will be expanding to include provision for under 11s in Peterborough. In Peterborough the service will cater for up to 18 year olds, in Cambridgeshire the service will go up to 25 year olds.
- Drop in counselling sessions for children and young people run by **Centre 33**. This is provided on Saturdays 11am -1pm in Cambridge, on Thursdays 2pm-5pm in Wisbech, on Monday 4pm -6pm and Thursday 4pm – 7pm in Ely, on Thursday, 4pm-7pm in Huntingdon and 'Here Now' Drop-in on Fridays, 2-5pm at Central Library, Peterborough
- **Kooth** (www.kooth.com) - an online counselling and emotional well-being platform for children and young people (aged 11-25), accessible through mobile, tablet and desktop. Kooth users have access to trained counsellors available until 10pm, 365 days a year, peer-to-peer support through moderated forums, and a range of self-help materials
- **Keep Your Head website** for children and young people - http://www.keep-your-head.com/ - provides information on mental health and wellbeing, including services that are available as well as self-help guides and professional resources
- **Centre 33** offers a range of support for young people (up to the age of 25) in Cambridgeshire. They can help with a range of issues from housing, to family problems and bullying.

6.2 Independent and Voluntary Sector Services

Voluntary sector organisations play a significant role in local mental health service provision, often for people who may struggle to access the "mainstream" services

- **Cambridge and Peterborough Samaritans** - provide confidential emotional support to people in distress or despair in the local area. Support is provided over the telephone or by email. Cambridge Samaritans in Emmanuel St takes callers at the door from 10am until 10.30pm. Peterborough Samaritans in Lincoln Rd, Millfield takes callers at the door on Mondays (10am - 4pm) and all other days from 7am – 4pm.
- **PINPOINT** (https://www.pinpoint-cambs.org.uk/) offers parent-to-parent support for children with additional needs including mental health problems, particularly around self-harm
- **Choices** in Cambridge - Offers a confidential counselling service in Cambridge and surrounding areas for women and men whose lives are affected by childhood sexual abuse. - https://www.choicescounselling.co.uk/
- **Relate** relationship counselling

- **The Richmond Fellowship -** a specialist employment service providing support for people recovering from mental health problems to find paid employment, voluntary work, education and training or to retain their current employment
- **Rethink Carers -** The Cambridge and the Peterborough and Fenland Groups help the carers of those with severe and enduring psychotic illnesses including schizophrenia
- **Bereavement services – CRUSE bereavement** - provide bereavement support to anyone who needs it. This includes a Cambridge based group specifically for people affected by suicide.

6.2 Gap analysis in suicide prevention service provision – information from the 2014-2017 strategy

Service user feedback is crucial in determining where the gaps in service provision lie for suicide prevention across Cambridgeshire and Peterborough

NHS Cambridgeshire and Peterborough CCG Commissioning Strategy for the Mental Health and Well-Being of Adults of Working Age 2013 – 2016[2] consulted with service users, carers, HealthWatch, GPs and the Patient Experience Team to identify gaps in service provision relevant to suicide prevention as follows:

- Raising awareness and mental health promotion to ensure better access to services, and linking between physical and mental health services. Make the best use of existing campaigns to raise awareness
- Improved information and services for carers
- Improved crisis support
- Prompt access to appropriate services
- Prompt and appropriate response by services – particularly in crisis
- acknowledge the role of carers in supporting people with severe and enduring mental illness
- Commissioners and providers review practice to ensure recipients of mental health support services always have details of who they can contact when in distress 24 hours a day.
- greater emphasis throughout services upon prevention, early intervention, support and self-management
- prompt access for GPs to obtain advice and effective help for patients presenting at surgeries in distress or “crisis”
- partnership working across local service providers (including the voluntary sector) in order that patients receive an integrated and seamless service across all interfaces

These issues were used to inform the suicide prevention implementation plan 2014-2017. Some of the needs are being addressed through workplans initiated in the last few years and details can be found in the implementation plan and summary of suicide prevention work to date. However, many of the needs are still relevant and additional needs are identified through consultation work through the suicide prevention implementation group

- Access to sanctuaries during mental health crisis in all areas of Cambridgeshire, including an unmet need in Fenland

- Better working relationships between and across the statutory services and third sector agencies to ensure sharing of information and timely and appropriate response to those requiring mental health support and crisis resolution
- Faster access to therapy, particularly for those with depression.
- Support for drug and alcohol users with mental health problems who do not meet the threshold for treatment under the dual diagnosis pathway
- Walk in centres – there is a lack of walk in voluntary centres that offer support and help to people at risk of suicide. Cambridge has Lifecraft and Centre 33 (for people aged below 25 years). No similar walk in centres exist in Fenland, Peterborough or Huntingdon.
- Bereavement support services for people bereaved as a result of suicide
- Mental health promotion targeted to men at higher risk of suicide
- Online information for adults with mental health problems – self-help resources and services that are available (similar to the children and Young people's Keep Your Head site)

7. A STRATEGIC LOCAL PARTNERSHIP APPROACH TO SUICIDE PREVENTION IN PETERBOROUGH AND CAMBRIDGESHIRE

In line with National guidelines on preventing suicide, and in recognition that an effective local public health approach is fundamental to suicide prevention**,** a multi-agency local suicide prevention group was established to provide input and recommendations to develop and refresh this strategy. The group is formed from partner organisations and stakeholders and includes representatives from the NHS – GPs and clinical commissioners, public health, mental health trusts, police, coroners and charitable organisations –such as The Samaritans, Lifecraft and CPSL MIND (see section 2 for details). An important aspect to developing a local strategy for suicide prevention will be engagement with 'service users' – those who have been affected by suicide or at risk of suicide. With service user input and feedback, the strategy should reflect what is needed and what would work to minimise suicide risk in the population.

Note: service user and stakeholder consultations on this strategy and action plan are scheduled for December 2017 and January 2018

8. THE ZERO SUICIDE AMBITION

There has been national and local interest to embrace what is termed as a 'zero suicide initiative'. Zero suicide was conceived through the 'Detroit model' for suicide prevention[15], which has been successful in America - creating a cultural shift in how patients with mental health problems are cared for with the emphasis on an ambition to achieve a zero rate of suicides as a core responsibility of the 'caring' organisations. The core principles and values of the 'Detroit model' are based on six dimensions and ten rules for perfect care:

Table 6 – Six dimensions and ten rules of perfect care according to the 'Detroit Model'

Six Dimensions of Perfect Care	**Ten rules of perfect care**
1. Safe	1. Care is relationships

2. Effective 3. Patient Centred 4. Timely 5. Efficient 6. Equitable	2. Care is customised 3. Care is Patient centred 4. Share knowledge 5. Manage by Fact 6. Make safety a system priority 7. Embrace transparency 8. Anticipate patient needs 9. Continually reduce waste 10. Professionals Cooperate

Nationally, the Zero Suicide Alliance (http://zerosuicidealliance.com/) was launched in November 2017. This focuses on improving support for people contemplating suicide by raising awareness of and promoting FREE suicide prevention training which is accessible to all.

The suicide prevention group has also agreed to endorse the Detroit principle to aim to work towards zero suicides in our local area. This will form the overarching principle for all suicide prevention as outlined in this strategy. Zero suicide requires high level commitment by all partner organisations and support by individuals to drive through the cultural change required to make this a success.

A Workshop in July 2017 consulted key stakeholders on the zero suicide ambition and what this means locally to support the suicide prevention implementation plan. The themes that emerged are presented in the box below.

As Cambridgeshire and Peterborough have already established the 'STOP suicide campaign' , which is now recognised widely across the county and has the support of all major organisations involved in mental health care, the ambition towards 'zero suicide' will not be viewed as a new initiative but embedded as the core principle for the local strategy and STOP suicide campaign. In addition, the Cambridgeshire and Peterborough suicide prevention implementation group will endorse and promote the national Zero Suicide Alliance initiative through the partnership.

Table 7 – Local goals for the zero suicide ambition

Zero Suicide Ambition – Main goals for implementation locally
Top level (Chief executive) engagement and commitment towards zero suicide for the main organisations involved – CCG, CPFT, PCC, CCC, Police
Improve quality at the organisational level- Engagement with organisational workforce to create a learning culture not a blaming culture. Part of this process will involve reviewing both suicide information and information from people with lived experience to learn lessons and implement good practice.
Improve quality at the individual level – win over 'hearts and minds' for zero suicide so it is at the forefront of peoples' minds during day to day organisational business and becomes part of life.

Review and improve information sharing across agencies involved in the pathway of care of individuals with mental health problems Strengthen the local STOP suicide campaign and suicide prevention implementation plan with a stronger emphasis on campaigns and initiatives that raise awareness, educate and promote mental health across the population, but with a focus on young people Promote the Zero Suicide Alliance resources and information including free online training in suicide prevention

9. SUICIDE PREVENTION PLAN

The zero suicide ambition will provide the main thread for suicide prevention and its work will be embedded in all areas within the plan. The suicide prevention plan is divided into six priority areas based upon the national guidance 'Preventing suicide in England, 2012[1]:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behavior
6. Support research, data collection and monitoring.

In tackling each priority area, evidence and information is taken from national guidance and publications on what is effective in preventing suicide, but an emphasis is placed on local needs and information gathered from the suicide audit and stakeholders that identify groups at higher risk of suicide and gaps in service provision. In all areas there will be encouragement of multi-partnership working across all sectors from NHS and mental health professionals to voluntary organisations that will utilise expertise from these organisations to implement the proposed initiatives. Continuing engagement between the dedicated members of the Cambridgeshire and Peterborough suicide prevention group and service users and their carers is essential for the successful design, development, implementation and delivery of initiatives in each priority area.

The plan includes recommendations from the CPFT zero suicide strategy and cross reference to the Trust's strategy and action plan will be made to ensure a joined up and comprehensive approach to suicide prevention locally.

Each priority area is discussed in detail and recommendations for action are made in the following sections of this strategy document.

10. PRIORITY 1 - REDUCE THE RISK OF SUICIDE IN KEY HIGH-RISK GROUPS

Data presented in 'Preventing suicide in England[1]' identified particular groups at higher risk of suicide – see section 3.4. It is important to compare and contrast the high risk groups identified nationally with local data on suicides as well as local information based upon health and wellbeing

needs assessment in order to focus suicide prevention resources appropriately to those in greatest local need.

10.1 Identifying People at higher risk of suicide

The suicide prevention strategic group includes Peterborough and Cambridgeshire coroners who are providing comprehensive local suicide data to the group on a regular basis. Analysis of the local data on suicides has enabled the identification of local suicide risk factors and emerging issues. In particular, men from Eastern European migrant populations – Polish and Lithuanian nationals residing in Peterborough and Fenland regions are emerging as a high risk group for suicide. In addition, unemployment, bereavement, drug or alcohol use are factors that have been recognised through the local suicide audits as potential risk factors. Groups of people, such as middle aged men (particularly those working in building and construction or IT), people in custody, gypsies and travellers and homeless are also identified as at increased risk of mental health issues and suicide.

Cambridge has a higher proportion of students in the population compared with similar sized cities as it is home to both the university of Cambridge and Anglia Ruskin University. Although the risk of suicide in the Cambridge student population has not been established, ONS data has shown a substantial increases in both male and female suicides in the student population from 2007-2011[7]

Based upon the evidence above of people at high risk of suicide both nationally and locally, the following groups of people will form the basis for targeted interventions (table 3):

Table 8 - Groups at high risk of suicide – Cambridgeshire and Peterborough

- New migrants – Polish and Lithuanian people
- People in contact with mental health services – including people recently discharged from psychiatric hospital care
- Unemployed people and those in financial difficulties
- Students
- Middle-aged men
- Gypsies and travellers
- Young offenders
- People in custody
- People who self-harm and have had a history of self-harm
- Alcohol/drug users
- Bereaved people and those bereaved by suicide
- Veterans
- Gay, lesbian, transsexual people
- Children with mental health problems at risk of self-harm

The strategy recognises that individuals may fall into two or more high-risk groups. Conversely, not all individuals in the group will be vulnerable to suicide. Other risk factors, such as loneliness, social circumstances and physical illness, must also be considered within the wider context or risk *Preventing suicide in England, Department of Health, 2012*[1]

10.2 Creating tools and resources to aid suicide prevention in high risk groups

The evidence base for suicide prevention highlights particular interventions that have been shown as effective in reducing risk or raising awareness of suicide. The best suicide prevention strategies use a combination of tools and interventions.

Based on the evidence of what is effective in preventing suicide, the following tips have been developed to aid the development of the suicide prevention strategy:

- Emphasise self-help and provide solutions for self-help
- Emphasise that suicide is preventable - there are preventative actions individuals can take if they are having thoughts of suicide or know others who are at risk of suicide.
- The impact of mental illness and substance abuse as risk factors for suicide can be reduced by access to effective treatments and strengthened social support.
- Don't glorify or romanticize suicide or people who have died by suicide. Vulnerable people, especially young people, may identify with the attention and sympathy garnered by someone who has died by suicide.
- Teach people how to tell if they or someone they know may be thinking of harming themselves and how to protect them from this harm.

10.3 Recommendations to prevent suicide in high risk groups

This strategy reflects what is known from the evidence base on suicide prevention and uses knowledge of local gaps in service provision to make the following recommendations for actions in preventing suicide in high risk groups:

1. Suicide prevention training – for professionals and other front-line workers in contact with vulnerable groups at risk of suicide
2. Develop suicide prevention resources for professionals in contact with vulnerable groups and for self-help
3. Promote awareness raising campaigns to prevent suicide
4. Ensure integrated, appropriate and responsive services to those at risk of suicide
5. Reassess pathways for people known by mental health services at risk of suicide – ensure follow-up provision of care upon discharge from services.
6. Improve pathways and support for offenders and people taken into custody at risk of suicide.

Each of these recommendations for action is discussed in detail below, highlighting how they will reach out to the target groups at high risk of suicide across Cambridgeshire and Peterborough

10.4 Recommendation 1.1 - Suicide Prevention Training

The recommendation is to enable mental health and suicide prevention training throughout Cambridgeshire and Peterborough for professional groups and third sector organisations in regular contact with adults who are at risk of suicide. The training will equip people in recognising the signs and symptoms of mental health problems and suicidal behaviour in people they encounter through

the work they do. Moreover, it will give them the skills and confidence to respond appropriately to affected individuals – to support and refer them appropriately.

From 2017 -2020 suicide prevention training will continue after initial funding in 2014 from the Strategic Clinical Network. This helped to set-up the local STOP suicide initiative, that included training. From 2015, funding for suicide prevention training was provided by Cambridgeshire County Council (CCC) with support funding from Peterborough City Council (PCC) to continue the work of the STOP Suicide initiative. MIND in Peterborough and Cambridgeshire with support from Lifecraft in Cambridge deliver the suicide prevention training on behalf of the partnership.

Training in suicide prevention aims to reach beyond "traditional" models of suicide prevention by engaging with a much wider range of agencies, including voluntary organisations and faith groups who are likely to come into contact with the two thirds of suicides who are not in contact with mainstream mental health services.

Suicide prevention training is provided from a recognised and evidence-based source such as 'Applied Suicide Intervention Skills Training' **(**ASIST)[16]. ASIST is a two-day suicide prevention course that aims to help both professionals and lay people to become more willing, ready and able to recognise and help persons at risk of suicide. ASIST is intended as 'suicide first-aid' training, and is focused on teaching participants to recognise risk and learn how to intervene effectively to reduce the immediate risk of suicide. A study by the London School of Economics estimated the cost-effectiveness of implementing ASIST training to GPs and concluded that the cost per QALY (Quality Adjusted Life Year) saved was £1,573 – extremely cost effective in terms of medical interventions

A bespoke, half day 'STOP suicide' suicide prevention training course has been developed by MIND and Lifecraft and is offered as an alternative to the two day ASIST training.

In addition, Cambridgeshire County Council continues to support Mental Health First Aid (MHFA)[17] training, in order to promote general mental health awareness in professional groups and organisations likely to be in contact with people with a broad range of mental health needs is recommended.

CPFT also offer suicide prevention training as do Samaritans and free online suicide prevention training is available through the Zero Suicide Alliance.

Suicide prevention training will be targeted to individuals and organisations who are most likely to encounter people at risk of suicide, with priorities given to people working with those with recognised risk locally, for example, Eastern European migrants or men working in the building/construction industry.

In order to create a culture that encourages an understanding and appreciation of the roles and responsibilities of other agencies, suicide prevention training, where possible will be offered to mixed groups of professionals. This would promote partnership working between agencies and deliver consistent messages on suicide prevention across the professional groups. Mixed groups will also facilitate a better understanding of each other's roles and responsibilities when dealing with people in crisis.

GP Training in suicide prevention

Funding has been secured through the STP with some support from CCC and PCC for training of GPs across Cambridgeshire and Peterborough in suicide prevention. GPs are most likely to have contact with people at risk of suicide in many of the 'high risk' categories listed in Table 3.The 2015 audit of suicides and deaths from undetermined intent for Cambridgeshire and Peterborough found that two thirds of people had been in touch with primary care in 2015 or within a maximum of 6 months prior to death. Suicide prevention training for GPs can potentially enable greater identification of those at risk, and earlier referral to evidence based treatment services (Suicide in primary care in England 2002-2011[18]. Training will focus on the patient/GP interaction, risk identification, compassion and empathy as well as safety plans and follow-through care. Training will be implemented from late 2017.

10.5 Recommendation 1.2 - Develop suicide prevention resources for professionals in contact with vulnerable groups and for self-help

Different professional groups and organisations with direct contact with people at risk of suicide will have differing responsibilities towards these people. Often there is a lack of clarity or understanding about what is appropriate in terms of responding to a person who may be suicidal or in signposting that person to sources of self-help. In order to bridge this gap, it is recommended that resources be developed for professional groups and organisations that will act as protocols and provide signposting information in any circumstances where professionals are in contact with people at risk of suicide. Resources will help to empower organisations with information to help vulnerable people in mental health crisis. Examples of suicide prevention protocols for GPs and for people working for MIND are provided in Appendix 1

A variety of resources and information was developed and collated as a result of the 2014-2017 suicide prevention implementation plan. These included the development and promotion of the STOP suicide initiative, including the STOP suicide website: http://www.stopsuicidepledge.org/. The development of the local 'Keep Your Head' website with resources and information aimed at young people, their carers and professionals: http://www.keep-your-head.com/CP-MHS. Wide promotion of the Crisis (111/2) service has been undertaken by the partnership. The suicide bereavement support leaflet has been distributed via GPs, police, coroners and will be promoted on a regular basis.

There has been support and agreement by partners involved in suicide prevention work to create an adult version of the 'keep your head' website, which will contain information, resources and self-help guides for people experiencing mental health problems or suicidal thoughts. This work will be initiated in the Autumn of 2017, with funding in place to support (through the Better Care Fund).

A directory of services has been produced by Lifecraft in Cambridge and a professional and service user App (MiDos and MyHealth), are being created to contain information about mental health support and services with funding through the Mental Health Delivery Board. These will be promoted through the various websites mentioned above.

An opportunity exists to work with professionals to develop care plans for people known by mental health organisations to ensure up-to-date self-help resources and contact information is included to help prevent escalation of mental health problems into crisis. This can be facilitated through the proposed GP training.

10.6 Recommendation 1.3 – Awareness-raising campaigns and the Cambridgeshire and Peterborough Pledge to reduce suicide

The 2014-2017 suicide prevention strategy recommended the development of a range of awareness raising initiatives and campaigns in collaboration with service users through focus group feedback. Service users representing particular high-risk or hard to reach groups should be sought to ensure resources and advocacy services are developed appropriately. Resources will need to be translated into other languages, including Polish and Lithuanian and be culturally appropriate if they are to reach out to all vulnerable groups.

In addition the development of the 'Cambridgeshire and Peterborough STOP suicide Pledge' to reduce suicide was recommended. The pledge is intended to raise awareness in individuals and organisations about responding to the risk of suicide by encouraging self-help and helping others. Development and roll-out of the 'Peterborough and Cambridgeshire Pledge' to reduce suicide was initially supported by funding from the SCN Pathfinder programme and is now receives continuing support and funding from CCC and PCC.

As of January 2017 there were 1,220 personal pledges and 51 organisational pledges for STOP Suicide. In addition, STOP Suicide had 1,343 twitter followers and 394 facebook fans. The STOP suicide website has had 17,598 visitors and 45,047 page views. Approximately 3000 one to one conversations with individuals around the subjects of mental health and suicide since September 2015. The campaign has recruited a total of 10 new Campaign Makers - four in Peterborough, five in Cambridge and one in St Neots.

The Samaritans run a national campaign 'We're in your corner' that raises awareness of the issue of men and suicide and encourages these men to seek help – see https://www.samaritans.org/media-centre/our-campaigns/were-your-corner. It would be beneficial for local campaigns targeted at reducing suicide in men (such as STOP suicide) work with the Samaritans to share idea and resources in order to maximise benefits.

Continuing support for campaign work and promotion of the STOP suicide pledge is recommended.

It is recommended that awareness-raising will be supported by promotion of 'World Suicide Prevention Day' each year on September 10th and world 'mental health awareness day on October 10th in addition to local initiatives throughout the year.

10.7 Recommendation 1.4 – Aspire to develop integrated, appropriate and responsive services to those at risk of suicide

This work is the backbone to suicide prevention with an aspiration to create a seamless pathway of care that has no cracks for people to fall between. Service improvement and driving up quality of care is the key theme behind the zero suicide ambition. A first step to achieving this is to create a culture of learning across the system. Learning from case reviews of suicides is recommended as a pilot but also learning from people with 'lived experience' to determine what works as well as what has gone wrong.

The last year has seen the implementation of initiatives to improve the pathway of care for people in mental health crisis (through the work of the Crisis Care Concordat partnership). The suicide prevention strategy endorses and continues to support this work:

- Continue support for Integrated Mental Health teams – Mental health nurses in police control rooms
- Continue support for Crisis 111(2), First Response Service and the continuing roll-out of sanctuaries or places of safety in the community for people in mental health crisis to use.
- Ensure suicide prevention initiatives link to Crisis Concordat work and include pathways of care for people pre crisis, during crisis and post crisis
- Develop and expand data sharing agreements and protocols (see recommendation 1.6 below)

A recent audit of drug and alcohol related deaths highlighted the high rate of mental health problems in people who have died as a result of drug and/or alcohol abuse. Likewise, the suicide audit highlighted drug and/or alcohol problems in a proportion of deaths. It is clear that there are gaps in services that do not cater sufficiently for people who do not meet the thresholds for a 'dual diagnosis' of concurrent drug/alcohol abuse and severe mental illness. These may be people who are substance or alcohol users with common mental health disorders such as depression. They may be treated for their substance use but their mental health needs are overlooked. A recommendation in this strategy is to encourage and facilitate systems that allow engagement with other services where appropriate – particularly with drug and alcohol teams.

Other recommendations in this section include:

- The development of guidance for GPs and primary care – resources, sign posting and self-referral as well as safety plans and links with PRISM
- Develop bereavement support services for those affected by suicide – see Recommendation 4.1
- Improve data sharing between agencies– The Vanguard and Concordat work has required data sharing protocols. Data flow following a bereavement is being reviewed.
- Continue work to map and update pathways and ensure all partners are aware of contacts and resources for self-help as well as pathways and how they operate
- Encourage professionals and organisations to work together in identifying gaps and opportunities in pathways to prevent suicide – particularly at points where services meet when a person is transferred from one service to another

10.8 Recommendation 1. 6 - Reassess pathways for people known by mental health services at risk of suicide

Approximately 30% of people who die as a result of suicide are known to the mental health services. People recently discharged from psychiatric care are the group with the highest risk of suicide, particularly within the first two weeks post discharge[8]. A retrospective case control study showed that 55% of suicides by people known by psychiatric services, died within a week of discharge from a psychiatric unit[21]. The study concluded that factors associated with increased suicide risk during this period included hospitalization of less than 1 week, recent adverse events, older age, and comorbid psychiatric disorders. Factors associated with decreased risk included patients receiving enhanced

aftercare. Based on these findings, work should be conducted in partnership with CPFT to identify gaps or weaknesses and areas for improving the care of people upon discharge from psychiatric care.

To assess and improve pathways of care for people known to mental health services, it will be important to work in partnership with CPFT, through the CPFT zero suicide strategy group and the Mental Health Crisis Care Concordat Working group. To this end, the following are recommended:

- Ensure Crisis Concordat work aligns with this priority area. Pathways of care to be assessed include those pre crisis, during crisis and post crisis. Explore models for strong community and joined-up support at locality level for people pre and post crisis as part of the 'Neighbourhood model'.
- Assess pathways to ensure that information is shared across agencies in the patient's best interest
- Assessment of pathways for people who are discharged from psychiatric care. This would include ensuring that careful and effective careplans and follow-up arrangements are in place. Link with PRISM as a 'step down' or 'step up' process in community settings. Ensure that carers, families and significant others are always involved in care planning, including the identification and mitigation of risk.
- Ensure that every CPFT patient has a comprehensive flexible risk management strategy that results from a specific risk focused conversation and that the strategy is consulted, considered and reviewed at every contact.
- Ensure that CPFT patients who's mental state is deteriorating are picked up early and offered objective review and increased support
- Engage with Rethink Carers group – for carers of people with mental health illnesses – understand concerns about pathways of care and provide information to carers in order to support them in their care role for someone at risk of suicide
- Engage with service users to establish the strengths and weaknesses in pathways of care in response to crisis – including a review of the use of Police section 136 and the use of places of safety
- Encourage development of pathways that are comprehensive and organised around the patient – particularly where organisations meet during transition points – acute sector transition into the community, for example
- Enable ongoing support for people with mental health issues and for those people in the community who do not meet the threshold for secondary mental health services – through links with PRISM. CPFT will ensure that it has a pathway for the care of patients with drug and alcohol problems that explicitly manages their risk of suicide and provides them with more not less active treatment

10.9 Recommendation 1.7 - Improve pathways and support for people taken into custody and newly released from custody at risk of suicide.

Prisoners and people taken into custody have been identified as a group with specific requirements due to the nature of the crisis that has increased their risk of suicide. To this end, the following is proposed:

- Liaise with NHS England and Public Health England to work with probation, prison and police staff to understand the screening risk assessment procedure at court and upon reception of prisoners and people taken into custody to include risk of suicide/self-harm.
- In partnership with NHS England, liaise with prison managers to promote the use of prison listeners to prevent suicide.
- Assess pathways of care for people in police custody and working with NHS England, assess pathways of care for people in prisons at risk of suicide. Review self-help advice and information, screening and risk assessment upon reception into custody
- Promote access to the Samaritans in custody suites.
- Continue to support suicide prevention training of prison staff and prison listeners (section 9.4).
- Promote access to support from drug and alcohol services for people in custody with mental health and drug/alcohol problems.
- Assess discharge pathways for people who have been in custody, including a review of care plans for people with mental health problems. Recognise the need to promote joined-up services with an understanding of the roles and responsibilities of other organisations including the probation service.

11 PRIORITY 2 - TAILOR APPROACHES TO IMPROVE MENTAL HEALTH IN SPECIFIC GROUPS

The Preventing Suicide in England strategy identified specific groups of people for whom a tailored approach to their mental health is necessary if their suicide risk is to be reduced:

- children and young people, including those who are vulnerable such as looked after children, care leavers and children and young people in the youth justice system
- survivors of abuse or violence, including sexual abuse
- veterans
- people living with long-term physical health conditions
- people with untreated depression;
- people with autism or Asperger's spectrum disorders
- people who are especially vulnerable due to social and economic circumstances
- people who misuse drugs or alcohol
- lesbian, gay, bisexual and transgender people; and
- Black, Asian and minority ethnic groups and asylum seekers.

The Cambridgeshire and Peterborough CCG Commissioning Strategy for Mental Health and Well-being of Adults of Working Age 2013-2016[2] sets out an implementation plan with four themes as follows:

Theme 1 – Easier and prompt access to effective help

This includes a section on addressing the barriers to access to 'main stream' services for marginalised groups

Theme 2 – The Recovery Model

Theme 3 – The inter-relationship between physical health and mental health

Theme 4 – Improve our commissioning processes

The National publication 'No health without mental health' 2011 set out six mental health objectives:

- More people will have good mental health – this included a statement to continue to work to reduce the national suicide rate
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm – includes fewer people self-harming and safeguarding children and young people and vulnerable adults
- Fewer people will experience stigma and discrimination

11.1 Recommendations to improve mental health in specific groups

Recommendation 2.1 Assess pathways of care for children and adults who self-harm

Emergency admissions for self-harm in young people remains a concern in Cambridgeshire and Peterborough with data showing rates of admission above those for England and the East of England. It will be important to work in partnership highlight strengths, gaps and weaknesses within the pathways of care for children and adults who self-harm and identify areas for improvement, particularly with respect to follow-up care for people discharged from services.

- Monitor admissions to the Accident and Emergency departments for self-harm to assess any impact on service developments. Repeat admissions of people who self-harm would be particularly useful to monitor as the strategy should focus on the best interventions to prevent repeat episodes of self-harm
- assess pathways for support for children who are at risk of self-harm , particularly in vulnerable groups of children and young people – youth offenders, children in care, children under the care of people with mental health problems
- Promote the 'Keep Your Head' website for children and young people to professionals including liaison psychiatry to highlight resources and directory of services for self-help and signposting
- Develop an adult version of the 'Keep Your Head'website to contain information about resources, services and self-help guidance for people with mental health problems
- Ensure follow-up care plans are robust for people discharged from services
- Assess plans for people who self-harm if mental health services are not involved. Link this work to the PRISM service (Enhanced primary care service for people with mental health issues).

11.2 Recommendation 2.2 Work with partners who are developing the 'Emotional wellbeing and mental health strategy for children and young people' to promote the following:

- Continue to raise awareness and campaigning around self-harm

- Continue to provide access to self-help resources that focus on building resilience in young people, including the 'Keep Your Head' website
- Continue work that raises awareness and develops resources aimed at preventing bullying and promoting mental wellbeing in schools and colleges- see 'beat bullying' teaching resources – www.beatbullying.org/dox/resources.html
- Support and promote the projects that work with families to address self-harm, for example Pinpoint.
- Develop a 24 hour crisis response for children.

11.3 Recommendation 2.3 – Promote early interventions to aid prevention of mental health problems that could lead to suicide

Prevention interventions to promote good mental health and avoid decline towards suicidal tendencies are essential to this strategy:

- Review access to support in the community before crisis situations arise.
- Work with communities and community liaison teams to raise awareness of sources of help, for example, debt management, relationship counselling, housing organisations parent/children centres
- Promote Information and provide training to health professionals including GPs and health visitors to encourage use of signposting, advice and self-help resources (through the Keep Your Head websites, for example
- Engage with service users and public to understand gaps in service provision and focus efforts on improving the system to support individuals where appropriate
- Review the potential to provide a tangible presence of a mental health drop-in facility in Peterborough city centre

11.4 Recommendation 2.4 - Promote training in Mental Health Awareness

For detailed information – see section 9.4. Continue to roll-out training that promotes mental health awareness and prevention of mental health problems that could lead to suicide. Implementation of bespoke training packages in mental health awareness and suicide prevention began in 2014. This work is continuing to be funded as well as additional training in suicide prevention aimed at GPs. Training for General Practice staff should include awareness around risk assessment for mental health issues by assessing patient histories, particularly around a past history of self-harm.

12 PRIORITY 3 - REDUCE ACCESS TO THE MEANS OF SUICIDE

The 2014-2017 strategy reported that the most common method for suicide was hanging but there was considerable concern about information on deaths as a result of multiple injuries associated with falling from height from car parks in both Peterborough and Cambridge. The strategy made clear recommendations to help address these issues but vigilance is still required and more work can be done as follows:

12.1 Recommendation 3.1 – In line with regulations, ensure the removal of potential ligature points – particularly in places of custody and in-patient settings

Most suicides are the result of hanging. It is therefore important to remove potential ligature points in places likely to have people at high risk of suicide – including places of custody, prisons and hospitals in line with national regulations and guidance - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/117555/safer-detention-guidance-2012.pdf
http://www.rcpsych.ac.uk/pdf/AIMS-PICU%20Standards%20-%20Second%20Edition%20-%20FINAL%20new%20template.pdf

Regular audit of potential ligature points should continue as good practice in places of safety including psychiatric hospitals and places of custody taking into account recommendations made by coroners.

12.2 Recommendation 3.2 Reduce the risk of suicide by jumping from high buildings accessible by the public including multi-storey car parks

Preventing access to the means of suicide by physical barriers in locations where people may choose to jump is one of the most effective mechanisms for preventing suicide[22,23]. There is no evidence to suggest that people will find an alternative mechanism for suicide if one method is made inaccessible[23]

The suicide prevention implementation group fully endorses the erection of barriers at all multi-storey car parks in Cambridge and Peterborough to ensure safety by preventing access to any area with a sheer drop that could lead to a suicide attempt. This would make a clear statement and showcase Peterborough and Cambridge as places that take positive steps to prevent suicide.

The suicide prevention implementation group is delighted with progress to date; barriers have been erected on all the Queensgate shopping centre car parks in Peterborough. No deaths have been reported as a result of jumping from car parks since the work began to construct the barriers. In Cambridge, the Queen Anne car park in Cambridge should to be reviewed in terms of protective measures to prevent people from jumping from the building.

Training in suicide prevention has been provided to staff working at both Peterborough and Cambridge shopping centres by the Samaritans. Similar training should be considered for all staff working in the multi-storey car parks in Peterborough and Cambridge.

12.3 Recommendation 3.3 – Reduce the risk of suicide on railway lines

A range of work is being undertaken nationally as part of the railway Suicide Prevention plan – involving Samaritans, Network Rail and British Transport Police. There have also been local initiatives to support this work:

- Samaritans/Network Rail campaign on the railway includes printed messages on tickets and posters at stations. Some local stations are also displaying Stop Suicide resources.
- Staff training has been provided to railway employees to look out for and offer support to people who may be considering taking their own life on the railway (provided by Network Rail nationally).
- The Rail505 app – enables other passengers/anybody to report someone they are worried about or to seek help themselves on the railway. https://www.rail505.com/

Continuing implementation of these initiatives is supported by this strategy

In addition, the annual suicide audit will be used to assess whether there are any 'black spots' for suicide on railway lines locally. An assessment of any requirements for physical barriers should be made at any location with heightened risk of suicide.

12.4 Recommendation 3.4 – Work with Medicines Management team at the CCG to ensure safe prescribing of some toxic drugs

Self-poisoning accounts for about a quarter of deaths by suicide in England and is the second most common method for suicide in men and women. Safe prescribing regulations were introduced in 1998 to limit the size of packs of paracetamol, salicyates and their compounds sold over the counter, supported by guidance on best practice in the sale of pain relief medication (MHRA, 2009[25]).

The National Institute for Health and Clinical Excellence (NICE) will be developing a quality standard on safe prescribing, as part of a library of approximately 170 NHS Quality Standards covering a wide range of diseases and conditions.

The suicide prevention implementation group should work with the CCG Medicines Management team chief pharmacist to ensure that there is a focus on suicide prevention as part of implementation of forthcoming NICE guidance – quality standard on safe prescribing. Further consideration needs to be given to the prescribing of some toxic drugs, where safer alternative medicines are available[26]

Promotion of suicide prevention through pharmacies and with pharmacists is recommended to raise awareness of suicide risk due to some forms of prescription medication.

12.5 Recommendation 3.5 - Whenever possible, medical professionals should be reinforcing safety plans for individuals with mental health problems

Promote the adoption of personal safety plans for people with mental health illness, or who have previously suffered from mental illness and/or are at risk of suicide as identified by GPs and other health professionals. This includes those who have never been in Secondary Care services.

Personal safety plans are essential as part of the process of care and need to cross over organisational boundaries and be person held. There is an opportunity to promote the use of safety plans with GPs and other health professionals through the suicide prevention training from the autumn of 2017 (funded with STP money). Included in the safety plan is an assessment of access to means of suicide and dialogue should be promoted between the health professional and patient about how to eliminate access to the means of suicide. This should include exploring and adopting best models for reducing hanging in the community.

Educational resources and information for GPs will continue to be disseminated by engagement with GP leads and clinical networks through the CCG.

13 PRIORITY 4 - PROVIDE BETTER INFORMATION AND SUPPORT TO THOSE BEREAVED OR AFFECTED BY SUICIDE

It was recognized in the 2012 Preventing Suicide in England strategy that bereavement by suicide was an area poorly covered by previous suicide prevention strategies.

Public Health England have published a suite of recent guidelines on supporting people after suicide. These highlight the need for change to ensure all suicide prevention strategies include postvention (activities for people bereaved by suicide to support their recovery and prevent adverse outcomes). The guidelines include several case studies of reactive approaches to postvention support as well as information on how to implement and evaluate similar initiatives.
https://www.gov.uk/government/publications/support-after-a-suicide-a-guide-to-providinglocal-services
Locally, no specific bereavement support service exists for people and families who have been affected by suicide. Bereavement is in itself a risk factor for suicide and a conservative estimate is that 10 people are directly affected by each suicide death. Friends and relatives of people who die by suicide have a 1 in 10 risk of making a suicide attempt after their loss. When compared with people bereaved through other causes, those bereaved by suicide are also at an increased risk of psychiatric admission and depression.

There are several bereavement charities and organisations, some of which specialize in helping those affected by suicide.

- CRUSE – a charity dealing with bereavement in general – supported by the CCG
- Survivors of bereavement by suicide
- Compassionate Friends – a charity dedicated to helping families of children who have died

In addition, The 'Help is at hand' booklet produced by the Department of health[27] is designed for people affected by the loss of a loved one through suicide.

13.1 Recommendations to support those who are bereaved and bereaved as a result of suicide

Recommendation 4.1 Ensure bereavement information and access to support is available to those bereaved by suicide

Funding has been approved through the Systems Transformation Programme (STP) to implement a local, county wide suicide bereavement support service (approved in July 2017). A pathway will be developed so that bereaved individuals will be asked whether they would like to be contacted by a support officer upon initial contact (usually by a police informing the family of the death by suicide of a loved one). If they consent to be contacted, this information will be passed to the family support officer and they will make contact with the family or bereaved individual within the first week after bereavement to offer support and signposting to services (such as CRUSE a charity to help bereaved people) and self-help resources. It may be important to ascertain whether there are any other individuals outside the family context (friends, colleagues for example) who may be affected by the suicide.

The bereavement support service will also help facilitate the setting up of local 'Survivors of Bereavement due to Suicide (SOBS) groups, that will be run as friendship or 'peer support' groups for people affected by suicide.

Information for those bereaved as a result of suicide will continue to be made available through professionals and other organisations in first contact with bereaved people (Police Officers, coroners, GPs, death registration professionals and funeral directors).

- Continue to distribute 'help is at hand' leaflets to these professionals.
- Provide details of local bereavement charities if not included in 'help is at hand' leaflet. A local bereavement support leaflet should be developed to signpost people to locally available services and resources for self-help. This should be provided to individuals who have been affected by suicide.

The families of people who have died as a result of suicide who are known to mental health services may be particularly vulnerable after bereavement. It will be important to review and map the processes in place to ensure that appropriate support is available to families and close contacts after bereavement. Any gaps in the services should be highlighted and recommendations made to improve outcomes.

14 PRIORITY 5 - SUPPORT THE MEDIA IN DELIVERING SENSITIVE APPROACHES TO SUICIDE AND SUICIDAL BEHAVIOR

It is known that the reporting of suicides by the media can promote other suicides – particularly using the same method or at the same location and that responsible reporting of suicide or reduced reporting can decrease suicides at 'hotspot' locations[28].

There are media guidelines on the reporting of suicide from 'The Samaritans'[29] that set out clear instructions and recommendations on what an article should contain when it reports a death by suicide.

14.1 Recommendation 5.1 – Encourage the appropriate and sensitive reporting of suicide

- Ensure all professionals in contact with the media are aware of guidelines for reporting suicide. Some professionals such as coroners and police may be contacted by journalists after a suicide in order to obtain details for an article to report the suicide.
- Continue to work with local media to encourage reference to and use of guidelines for the reporting of suicide. Work with Communications teams within the local authorities to encourage responsible reporting of suicide by the local newspapers.
  Highlight the following:
    - Media guidelines produced by Samaritans
    - Encourage a positive report on the deceased person
    - Do not sensationalise the suicide or suicide method
    - Protect bereaved families from intrusion – press complaints commission
    - Use of language by the media - Avoid referring to suicide in the headline of a story – it is more sensitively reported in the body of the story.

- Avoid terms such as “successful”, “unsuccessful”, or “failed”.

15 PRIORITY 6 - SUPPORT RESEARCH, DATA COLLECTION AND MONITORING

Suicide prevention relies on information about local suicides to determine who is at risk of suicide and where and how suicides happen locally. This data is important in order to focus resources. It is also important to monitor local suicides and reports of self-harm by assessing up-to-date information. This will enable appropriate response to any changes in rates of suicides and self-harm and will help to understand the impact of implementing the recommendations set out in this strategy.

To this end, the following recommendations are made:

15.1 Recommendation 6.1 Continue to collect detailed suicide data on a quarterly basis and carry out an annual audit of local suicides

Data should continue to be collected from Cambridgeshire and Peterborough coroners and include information on age, sex, nationality, occupation, marital status, contact with mental health services, contact with primary care services and in particular services in two weeks prior to death, place of death, resident address, method of suicide.

A suicide audit will be conducted on an annual basis and used to inform development of initiatives targeted to people at risk locally. The information contained in the audit will also be used as part of the evaluation process for this strategy.

Real-time suicide surveillance has been implemented that sends information on suspected suicides as they occur from police to public health. This enables the suicide prevention implementation group to react if necessary to any concerns, for example linked suicides, or suicide in young people that may affect other young people at school or colleges.

In addition, and as part of the Zero suicide ambition, it is proposed that a sample of suicide case files be reviewed on a quarterly basis to learn lessons and identify preventative actions that could be implemented locally.

All data is held securely by public health analysts as part of the suicide prevention partnership.

In addition to the above, CPFT will ensure they have a comprehensive, clinically rich, searchable data set collating every suicide of a patient in contact with the trust. The data from this database will be freely available to staff, patients and carers and actively used to educate staff patients and carers.

15.2 Recommendation 6.2 Disseminate current evidence on suicide prevention to all partner organisations

As evidence emerges on the best practice interventions and measures to reduce the risk of suicide, there should be a mechanism for ensuring that this is disseminated to all partner organisations working to prevent suicide. This may be facilitated through the suicide prevention group meetings with an assigned person responsible for checking the evidence base on a regular interval.

15.3 Recommendation 6.3 Coroners should notify the Suicide Prevention Strategic Group about inquest evidence that suggests patterns and suicide trends and evidence for service development to prevent future suicides

Coroners are best placed to review and assess evidence during the year as inquests to suicides occur. This may provide opportunities to identify concerns about local suicides – patterns or trends, for which action may be required. In addition, coroners may highlight concerns about services or opportunities to improve services where failings have occurred.

16 EVALUATION – HOW WILL WE KNOW WE ARE MAKING PROGRESS? Recommendation 6.4 - Evaluate and report on the suicide prevention implementation plan

Evaluation is an important component to this strategy and will provide essential information and evidence on what is effective in suicide prevention and what areas require more work or are ineffective.

A set of Key Performance Indicators will be developed to monitor the progress against the strategy and aligned with the suicide prevention implementation plan 2017 - 2020.

Public health outcome indicator 4.10[11] expects suicide rates to be reported annually based on three year rolling average rates for local populations. A baseline has been set as the average rate of suicides for the period 2009-2011 and this should be used to compare future statistics and the impact of implementing this strategy.

Evaluation should also include surveys of various groups for effectiveness of particular actions or interventions.

- Survey of GPs
- Survey of mental health professionals
- Survey of people trained in suicide prevention
- Survey of service users

Soft data should be used as part of the evaluation – data collected by each implementation sub-group. For example; actions taken, resources disseminated or used and numbers of people reached by the initiative.

16.1 RESOURCES FOR IMPLEMENTING INITIATIVES TO PREVENT SUICIDE AND SUSTAINABILITY

The implementation of the strategy will require a mixture of input and work from partner organisations, cultural and organisational change and funding for the delivery of specific initiatives.

Implementation of the recommendations and action plan will be managed by a joint Cambridgeshire and Peterborough Suicide Prevention Implementation Group. Multi-agency working across all sectors, from NHS and mental health professionals to voluntary organisations, will be encouraged in order to utilise expertise from these organisations to implement the proposed initiatives.

Continuing engagement with service users and their carers is expected for the successful development, implementation and delivery of initiatives in each priority area.

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27. Hawton K, Bergen H, Simkin S et al (2010) Toxicity of antidepressants: rates of suicide relative to prescribing and non-fatal overdose. *British Journal of Psychiatry* 196: 354-358
28. 'Help is at hand' a resource for people bereaved by suicide and other sudden, traumatic death http://www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf
29. Preventing Suicide - A Resource for Media Professionals: A resource guide produced by the Department of Mental Health at the World Health Organization in 2000. http://www.who.int/mental_health/media/en/426.pdf
30. Media guidelines for reporting suicide – Samaritans: http://www.samaritans.org/sites/default/files/kcfinder/files/press/Samaritans%20Media%20Guidelines%202013%20UK.pdf
31. NHS England and Public Health England 'A call for Action: Commissioning for Prevention' November 2013. Available at: www.england.nhs.uk
32. WHO For which strategies of suicide prevention is there evidence of effectiveness http://www.euro.who.int/__data/assets/pdf_file/0010/74692/E83583.pdf

APPENDIX 1

Examples of Suicide Prevention Protocols for specific professional groups

1. **Suicide Prevention Pathway developed by Peterborough MIND -**Peterborough and Fenland Mind Suicide Protocol

Who should you call is you are faced with a Suicidal Person (SP)?

Rarely a SP may behave out of control on in a way suggesting harm to themselves or others. If this is the case you should call the Police on 999. See *point 1* if this is the case

Normally the SP will speak of thoughts or plans of suicide alone and appear distressed. If this is the case see *point 2* for the key questions you need to ask

Point 1
The police are able to detain someone under the Section 136 of the Mental Health Act if they believe the SP to have a 'mental disorder' and are in need of immediate need of care and control.

They will first remove the SP to a place of safety, preferably a hospital or police station where they will be held until approved by an Approved Mental Health Professional. One or two doctors will also assess the SP for up to 72 hours.

Point 2
If you feel the person is distressed and can be spoken through what they are experiencing you should stay calm, show interest and concern, not show judgement or shock. You should be positive that the right help they can feel better.

You should then encourage them to see their GP as a matter of priority whilst still addressing non-medical concerns. The agreed response you need here is for the person to let you contact their GP. The SP may suggest this is pointless but nevertheless it should be the first port of call unless consent is firmly withheld. If you are given

Point 3
If the SP refuses for you to get in contact with their GP then you must respect their request for confidentially. You should then offer the SP a 'Feeling on the Edge' leaflet and tell them they can return to you if they decide they want help from the service to access their GP. The expectations to this strict rule are (a) Imminent threat of self- harm, then call the police (b) Vulnerable Adult such as Dementia, Learning Disability or Abused Domestic Violence when a SOVA approach is required

Point 4
If you are given consent you should then ring the GP and explain to the receptionist who you are, who the SP is and why you are calling. They should use a password (perhaps a Suicide Prevention Alert) and ask to speak to the Duty GP.
The GP will speak to you and they should use their professional judgement and personal knowledge to decide on the best pathway which will often result to a same day appointment. If the GP cannot speak to you immediately then you are to ask for a ring back and an urgent same day appointment for the SP.

If the surgery is uncooperative or unresponsive and you feel they are still carrying the risk then they should log the experience and feedback to the Administrators as a possible Quality Issue and also ring ARC for assistance.

DRAFT Joint Cambridgeshire and Peterborough Suicide Prevention Three Year Action Plan

2017-2020

The joint Cambridgeshire and Peterborough suicide prevention three year action plan accompanies the refresh of the Joint Suicide Prevention Strategy (2017-2020) and builds upon the work undertaken between 2014-2017. The action plan is a working document and will be adjusted and updated as work proceeds to implement the recommendations.

Implementation of the strategy according to the action plan will be the responsibility of partner organisations as described in the suicide prevention strategy. A joint Cambridgeshire and Peterborough Suicide Prevention implementation group oversees the implementation of the action plan and will report progress to the Health and Wellbeing Board and Joint Safeguarding Executive Board.

The 4 key organizations responsible for the commissioning and/or provision of mental health services – Cambridgeshire and Peterborough Clinical Commissioning Group (CCG), Cambridgeshire County Council (CCC), Peterborough City Council (PCC) and the Cambridgeshire and Peterborough Foundation Trust (CPFT) have committed to putting achievement of the zero suicide ambition at the heart of mental health care – commissioning and delivery - in Cambridgeshire and Peterborough. While the Suicide Prevention Implementation Group brings together partners responsible for delivering the Plan and for reporting progress with delivery, a number of Boards and Groups will support the group to achieve delivery including the Adult Mental Health Joint Commissioning Group, the MH Delivery Board (Cambridgeshire and Peterborough Crisis Concordat Group) and the OPMH Delivery Board.

The joint suicide prevention strategy document provides detail for each recommendation and should be used for cross-reference when implementing the action plan.

Funding to support recommendations and actions will depend upon on-going support from the partner organisations.

DETAILED ACTION PLAN FOR SUICIDE PREVENTION

Recommendation	Actions	Timescale	Suggested performance measure	Responsibility/Involvement of partners	Progress to date Rating
Priority 1 - Reduce the risk of suicide in high risk groups					
Recommendation 1.1 - Suicide Prevention Training	Continue ASIST and STOP suicide training as follows: ● ASIST courses delivered to individuals and priority organisations identified (as agreed in contract with CPSL MIND)– ensuring training reaches out to people working or in contact with the most vulnerable or hard-to-reach groups at risk of suicide ● STOP suicide courses delivered with agreed target for participation ● Evaluation of training effectiveness – at the end of each course (by survey) and follow-up.	Ongoing delivery of ASIST and STOP suicide training Evaluation of training – on an annual basis	Numbers of people trained List of organisations receiving training and numbers of staff trained within each organisation- 80% satisfaction with training	CPSL MIND – STOP Suicide	ASIST Courses delivered across Cambridgeshire and Peterborough targeting 'Ga Keeper' roles Update required Evaluation forms are completed by participants and feedback is collected following courses
	Develop and deliver GP suicide prevention training programme (funded through STP with support from CCC	GP training in suicide prevention from Autumn 2017 for one year	Survey Numbers of GPs trained Survey of outcomes Data on suicides lined to practices	CPSL MIND STP Funding Public Health oversight	
	Training supported by Samaritans	Ongoing		Samaritans	Update required

	Continue delivery of MHFA through workplace health – funded by CCC (Cambridgeshire only	Ongoing		Public Health	Update required.
Recommendation 1.2 – Develop suicide prevention resources for professionals in contact with vulnerable groups and for self-help	**Resources and information** • Collect and collate available resources and a directory of services • Promote and update the directory of services –through existing apps/websites e.g. Keep your Head, MyDOS, MyHealth and STOP suicide • Provide access to resources and information – via the STOP suicide and Keep Your Head (CYP) website - Link to partner organisations and resources/information – MindEd, Zero Suicide Alliance, NSPA, Lifecraft • develop an adult version of 'Keep Your Head' website with information and resources for signposting and self-help	Ongoing updates and maintenance to STOP suicide and Keep Your Head (CYP)websites – Keep Your Head (adult version) - Launch and Comms 2018 Spring 2018 onwards – GP training with promotion of resources for signposting and self-help as well as development of care plans	Website visitor statistics and monitoring – including resource pages 'hits' Directory of services developed and used by partner organisations Feedback from GP training and bereavement support service – including leaflets disseminated	CPSL MIND – STOP suicide resources Public Health SUN – KYH websites	Stop Suicide website stats KYH stats KYH adult launch
	Continue to promote the 111(2) FRS/Sanctuary service through multiple media connections. Include promotion to BME communities, using the FRS video in other languages		Awareness of FRS/111(2) service	Crisis Care Concordat	
Recommendation 1.3 – Awareness-raising campaigns and promote the Cambridgeshire and Peterborough STOP	• Continue work by STOP suicide to use public events and other community opportunities to promote the STOP suicide pledge and raise awareness of suicide prevention	Ongoing through contract with CPSL MIND for STOP suicide	Number of individuals signing pledge Number of organisations signing pledge	CPSL MIND STOP suicide Link with	STOP Suicide data update Samaritans – local update

Suicide pledge to reduce suicide	• Make use of partnership working when targeting campaigns - Samaritans and STOP suicide share idea and resources in order to maximise benefits. • Continue to Identify localities for specific awareness raising and special events such as suicide prevention day (10th September) and world mental health awareness day (10th October) • Explore use of social media in awareness raising • Include suicide prevention in other health awareness campaigns • Include awareness raising and suicide prevention material in bulletins that are sent out to GPs		Possible survey to assess awareness in the community	Samaritans' 'We're in your corner' campaign targeted at men Partnership group for world MH awareness day	
Recommendation 1.4 –Aspire to develop integrated, appropriate and responsive services for those at risk of suicide	**CRISIS CARE - 111(2) FRS/Sanctuaries** Integrated Mental Health teams – Mental health nurses in police control rooms Ensure suicide prevention initiatives link to Crisis Concordat work and include pathways of care for people pre crisis, during crisis and post crisis	Ongoing	Statistics on FRS/sanctuary use Emergency admissions Ambulance conveyances due to MH crisis Consider an audit of information sharing protocols, once agreed	Crisis Concordat partnership Ensure partnership support	Vanguard/Crisis Care Concordat work including: -Integrated Mental Health Team – mental health nurs based in the police control room. This work undertook a rang of mapping and pathways work in terms of crisis support.

	Continue Lifeline – telephone support for people with mental health problems 6pm-11pm		Information on numbers of callers	Lifecraft and Lifeline Carole Morgan	Update on use
	Support the development of systems that allow engagement with other services where appropriate – particularly with drug and alcohol teams	January 2018 onwards through CPFT strategy		Link with CPFT zero suicide strategy drug/alcohol Susie Talbot	
	Ensure that GPs receive core training in suicide prevention (See Recommendation 1.1) and ensure development of guidance for primary care – resources, sign posting and self-referral as well as safety plans and links with PRISM	May 2018 onwards	Evaluation surveys Numbers of GPs trained Information resources distributed to GPs	GP training – CPSL MIND	
	CPFT ZERO SUICIDE ACTION Ensure that every patient has a comprehensive flexible risk management strategy that results from a specific risk focused conversation and that the strategy is consulted, considered and reviewed at every contact	See CPFT Zero suicide action plan		CPFT Neil Winstone/Nicky Asplin	CPFT to provide update to group
	Work with the Joint Safeguarding Executive to monitor delivery and develop an improvement plan to achieve the outcomes required	To be developed in 2018		Fiona Davies Kathy Hartley Zero suicide T&F group	
Recommendation 1. 6 - Reassess pathways for people known by mental health services at risk of suicide	**Link to learning through the ZERO suicide ambition.** Create a culture of learning to drive up quality across the system 1. Develop a regular forum whereby organisations can bring cases and learning to share with partners – to ensure actions and recommendations are made to drive up quality of care	Scoping this work for delivery during 2018 Will require additional resources to implement	Data dashboard for monitoring suicides and MH crisis Monitor reporting by the two forums Review of cases, actions,	All partners Work with CPFT Zero suicide Task and finish group to scope and develop both groups	-Sharing data – continued work as a system to improv data sharing and establish agreements. Vanguard wor and Concordat work has required data sharing protocols. Data flow

	Pathways of care to be assessed include those pre crisis, during crisis and post crisis. 2. Develop a forum or forums for people with 'lived experience', service users, community organisations and others to come together or submit feedback on 'what works well' as well as 'what could be improved'. This forum should link with (1) above to feedback across the partnership and drive up quality across the system Assessment of pathways for people who are discharged from psychiatric care and A&E care/liaison psychiatry – Continue to engage with service users to establish the strengths and weaknesses in pathways of care in response to crisis – including the FRS service and Sanctuaries		recommendations and follow-through Assess use of Section 136 and places of safety GP training evaluation – referrals, awareness of services and avoiding CRISIS Consider an audit of Care plans in place for people discharged from services	Link to Safeguarding Exec and Safeguarding boards Link to drug and alcohol services Engagement with service users and carers through (SUN Carers groups) the mental health stakeholders group – quarterly meetings across Cambridgeshire and Peterborough	following a bereavement now being reviewed.
	Develop information sharing processes This may be required in order to develop the learning culture (above) CPFT to review all the ISA's in place or ISA's being established to support MH crisis care pathway and explore how information could be further shared shared between organisations (Cambridgeshire Information Sharing Framework)	Ongoing		CRIS care concordat CPFT Public health	Real-time suicide surveillance between police and PH Crisis Care Concordat: Information Sharing Agreements are in place across organisations to support the Frequent Attenders CQUIN, in additi to MH and Acute Trusts thi

	review of care plans and information contained within care plan, including consent to share information between agencies				includes 111, ambulance service, substance misuse, primary care.
	CPFT ZERO SUICIDE ACTION Ensure that carers, families and significant others are always involved in care planning including the identification and mitigation of risk. Whenever this proves immediately unachievable carers, families and significant others will know why and how their involvement will be made possible.	New workstream		CPFT to update Anna Tuke - lead	Link to CPFT Zero Suicide Acti plan
	Develop 24 hour crisis response for children.			Crisis Care Concordat – Modestas CPFT	
	Explore models for community and joined-up support at locality level for people post crisis – and ongoing support for people with mental health issues in the community who do not meet the threshold for secondary mental health services - link with the PRISM service	Ongoing		Crisis Care Concordat PRISM Lifecraft CPSL MIND	
Recommendation 1.7 - Improve pathways and support for people taken into custody at risk of suicide and for people newly released from custody.	Link with prisons and Offending, Prevention and Management Strategic Needs Assessment - understand the screening risk assessment procedure at court and upon reception of prisoners and people taken into custody (including police custody) to include risk of suicide/self-harm. ● Continue to work with prison managers to promote and train peer support 'prison listeners'.	Ongoing work with police, prisons and probation	Reduction in suicides in people in custody – baseline 2009-2011 Suicide audit of case files to ensure inclusion of people released from custody	Police, probation, Samaritans and custody staff as members of the suicide prevention implementation group	ASIST course funded for pe supporters in Peterborough prison. A number of issues were highlighted as part of the Substance Misuse JSNA (criminal justice section) an support is being given to th upcoming needs assessmer being undertaken by the Office of the Police and Crime Commissioners Offic

	• Broaden and promote access to the Samaritans in custody suites and in courts by raising awareness and supporting partnerships, learning from good practice • Promote access to support from drug and alcohol services for people in custody with mental health and drug/alcohol problems. Raise awareness and promote partnership working • Assess discharge pathways for people who have been in custody, including a review of care plans for people with mental health problems. Work with probation and other services to ensure safe release from prison		Prisons and Offending, Prevention and Management Strategic Needs Assessment Numbers of police custody, prison staff and prison listeners trained in suicide prevention	NHS England to lead on suicide prevention initiatives in prisons with support from the suicide prevention implementation group Engagement with Public Health England for support	Work is being done to look into issues around transfer health information at point of entry to prison.
Priority 2 - Tailor approaches to improve mental health in specific groups					
Recommendation 2.1 Work in partnership with CPFT to assess pathways of care for children (10-24 year olds) and adults who self-harm	• Raise awareness and promote campaigns to address self-harm • provide access to self-help resources that focus on building resilience in young people - Signpost CYP to 'Keep Your Head' website and directory of services at the point of contact • Review the use of follow-up care plans for people discharged from services • Assess plans for people who self-harm if mental health services are not involved	Ongoing work linked with pathway design for suicide prevention and Emotional well-being and mental health group for children and young people.	Report on pathways available to children and adults who self-harm Including recommendations for improvements Admission rates for self –harm reported to suicide prevention group	CPFT and Emotional well-being and mental health group for children and young people Safeguarding Boards	-Directory of services – Kee Your Head (includes specifi information on self-harm) and MyHealth app. -Public Health are currently reviewing self-harm admissions data to establis if there are any data reporting errors (Cambs). - Providing a psycho social assessment and safety plan for Emergency Department (ED) patients

	• Review resources to help people who self-harm or have a history of self-harm, for example; 'Harmless' http://www.harmless.org.uk A national organisation based in Nottingham Commissioning of Kooth and expansion of face-to-face counselling services for young people.		Trends in admission rates recorded		Self-harm support groups f parents have been run by PinPoint and support from Locality Teams (Cambs). Training delivered by CPFT (free of charge) – understanding and responding to self-harm.
Recommendation 2.2 Work with partners who are developing the 'Emotional wellbeing and mental health strategy for children and young people*	• raise awareness and develop resources aimed at preventing bullying in schools and colleges • assess pathways for support for children who are at risk of self-harm , particularly in vulnerable groups of children and young people – youth offenders, children in care, children under the care of people with mental health problems	Ongoing work	Data on self-harm in children Training delivered for emotional wellbeing support of children Partnership working to deliver resources and awareness raising – Number of workshops and events run and feedback obtained Achieve zero suicides in children	Partnership within Emotional Wellbeing board and safeguarding children board Sharif and Andy Jarvis to provide updates	
Recommendation 2.3 Promote early interventions to aid	Prevention interventions to promote good mental health and avoid decline towards suicidal tendencies.		Consider survey of service users and the public to assess	Suicide Prevention	-Broader range of information provided

prevention of mental health problems that could lead to suicide	• Promote 'Keep Your Head' website for CYP to raise awareness and promote early interventions and signpost to support • Develop 'Keep Your Head' adult website to raise awareness of sources of help, for example, debt management, relationship counselling, housing organisations parent/children centres • Training and Information to health professionals including GPs and health visitors to promote resources and advice services • Engage with service users and public to understand gaps in service provision and focus efforts on improving the system to support individuals where appropriate	Ongoing and continuing work on 'Keep Your Head' CYP Autumn 2017 – development of 'Keep Your Head' adult mental heal website Debt and money management services to be developed from Sept 2017 Ongoing preventative work in schools	awareness of prevention resources.	implementation group to lead -	through counselling service (advice). -In 17/18 there will be debt management (preventative work funded with care leavers as well as those wit mental illnesses in Cambridgeshire. -Preventative work in schoo includes training to improv understanding of Mental Health in teaching/pastoral staff. Aiding identification o those who need support. Drop in services for young people in Huntingdon and Peterborough and Cambrid as part of Centre 33 and loc authority partnerships. Delivering broad support as well as counselling.
Priority 3 – Reduce access to the means of suicide					
Recommendation 3.1 – In line with regulations, ensure the removal of potential ligature points – particularly in places of custody and in-patient settings	• CPFT audit of ligature points and other suicide risks in inpatient settings and residential care settings in line with regulations • Audit of ligature points in places of custody	This is ongoing - on a yearly basis	Audit of potential ligature points is conducted annually in inpatient wards and places of custody	CPFT lead for inpatient audit Police lead for audit of police custody suites	

	• Share information on identifying potential ligature points between agencies (CPFT, Coroners, Police and Prisons)		Potential ligature points removed or made safe	NHS England lead for audit in prisons	
Recommendation 3.2 – Reduce the risk of suicide by jumping from high buildings and bridges accessible by the public including multi-storey car-parks	• Advocate for construction of barriers on bridges and buildings where evidence shows high risk of suicide • Work with police and highways England to reduce risk on bridges where suicides and threatened suicides have occurred	Ongoing work	Achieve zero suicides at car parks in Cambridge and Peterborough Aim for zero suicides from bridges over highways in the area	Police/Coroner/public health	Barriers erected at Queensgat shopping centre and Northminster car park in Peterborough
Recommendation 3.3 – Reduce the risk of suicide on railway lines in Cambridgeshire and Peterborough	• Support the national railway Suicide Prevention plan and initiatives by British Transport Police to reduce suicides on railways • Use the annual suicide audit to assess whether there are any 'black spots' for suicide on railway lines locally. An assessment of any requirements for physical barriers should be made at any location with heightened risk of suicide. • Continue to promote STOP suicide at local railway stations	Ongoing work	Training of rail staff in suicide prevention Posters available to aid self-help in railway locations Achieve zero suicides on railway lines	Samaritans, Helen Whyeman – data Link with British Transport Police	-Samaritans/Network Rail campaign on the railway including printed messages on tickets and posters at stations. -Some local stations are als displaying Stop Suicide resources. -Staff training has been provided to railway employees to look out for and offer support to people who may be considering taking their own life on the railway (provided by Network Rail nationally). -Rail505 app – enables othe passengers/anybody to report someone they are worried about or to seek

					help themselves on the railway. https://www.rail505.com/
Recommendation 3.4 – Work with Medicines Management team at the CCG to ensure safe prescribing of some toxic drugs	• contact the CCG medicines management team chief pharmacist to ensure quality standards on safe prescribing. Further consideration needs to be given to the prescribing of some toxic drugs, where safer alternative medicines are available. (Hawton et al 2010) • Promotion of suicide prevention through pharmacies and with pharmacists is recommended to raise awareness of suicide risk due to some forms of prescription medication.		Prescribing data to reflect safe prescribing guidance	TBC Chief pharmacist at the CCG	-Following Child Death Overview Panel reports there was a communication to GPs regarding safe prescribing to young people, this was also re circulated.
Recommendation 3.5 - Whenever possible, medical professionals should be reinforcing safety plans for individuals with mental health problems	Education and training for health professionals including General Practice staff on use of personal safety plans for patients with mental health problems. This includes plans for those who have never been in secondary care services – see section 1.1 – GP training	Ongoing through training of professional staff and GP training in suicide prevention	Number of GPs trained Consider an audit of safety plans	CPFT and CPSL MIND	Some training of GPs and mental health specialists through the training offered b CPSL MIND and CPFT
Priority 4 – Provide better information and support to those bereaved or affected by suicide					
Recommendation 4.1 - Ensure bereavement information and access to support is available to those bereaved by suicide	Develop and implement a bereavement support service for people affected by suicide. Establish peer support groups or develop links with existing peer support groups – CRUSE and SOBS	November 2017 – November 2018 Funding approved through STP to create a bereavement support	Help is at hand leaflets are available to police, coroners, funeral directors and GP practices	Lifecraft to lead bereavement support service implementation	Bereavement support service began in December 2017 and is currently receiving referrals

	Ensure availability of 'Help is at hand booklet 'for those bereaved as a result of suicide (GP surgeries, coroners offices, police and funeral directors). Create and disseminate a local bereavement support leaflet to signpost people to services and self-help support information.	service for people affected by suicide. Ongoing distribution of help is at hand resources Ongoing development and roll-out of peer support groups – CRUSE, Compassionate Friends group in Cambridge Bereavement support group in Peterborough	Bereavement support service in place. Number of contacts made. Evaluation by follow-up survey	CRUSE run a peer support group in Cambridge Rosie Wilson runs a 'compassionate friends' group in Cambridge for parents affected by suicide Helen Pope organises a peer support group in Peterborough	Help is at Hand bookle circulated to all GP practices in Cambridgeshire and Peterborough with instructions on how to re-order them.
Priority 5 - Support the media in delivering sensitive approaches to suicide and suicidal behavior					
Recommendation 5.1 –Encourage appropriate and sensitive reporting of suicide	Continue to liaise with local media to encourage reference to and use of guidelines for the reporting of suicide. Ensure the involvement of Comms teams in LAs and CCG.	Ongoing work initiated in 2014. Ad hoc contact with local media	Sensitive and responsible reporting of suicide by local media based on Samaritans guidelines	TBC	
Priority 6 - Support research, data collection and monitoring					
Recommendation 6.1 Collect detailed suicide data on a quarterly basis from Cambridgeshire and Peterborough coroners and carry out an annual audit of	Form sub-group to ensure data collection and audit. Suicide and mental health dashboard to be developed Audit on a yearly basis to report changes to suicide numbers, methods, demographics, risk factors.	On-going quarterly collection of data and full audit on a yearly basis On-going real-time suspected suicide surveilance	Public Health Indicator 4.10 – Baseline period = 2009-2011 Achieve 10% reduction in suicide rate by 2020	Public health – Helen Wyeman Coroners Police CPFT BTP	Data is now received from BTP through an annual report and a warning system (national system).

local suicides	Report on suicide rates in relation to public health outcome: 'Reduce the rate of suicide in the population As part of the zero suicide ambition – consider reviewing a sample of suicide case files on a quarterly basis to create a culture of learning		Suicide statistics on three year rolling basis		A local real-time surveillance system ha been established – Th shares information fro Police/Coroner to Pub health on suspected suicides as they occur
Recommendation 6.2 Disseminate current evidence on suicide prevention to all partner organisations	Ensure membership of implementation groups by all partners with correspondence list kept up to date for sharing resources Link with NSPA	On-going sharing of information with partner organisations	Implementation group meeting minutes and email records	Public health to lead, collate and ensure dissemination of evidence	Relevant national publications and evidence is circulated via group distribution list.
Recommendation 6.3 Coroners should notify the Suicide Prevention Strategic Group about inquest evidence that suggests patterns and suicide trends and evidence for service development to prevent future suicides	Ongoing updates to the suicide prevention strategic group by the coroners as required	Ongoing	Data is sent on a quarterly basis to public health lead analyst in Cambridgeshire	Coroners to lead – liaising with the Suicide Prevention Strategic Group	The Coroner flags any notable patterns with the group or public health. The 'real time' surveillance system w also help with this in terms of geographic/temporal patterns.
Recommendation 6.4 Evaluate and report on the suicide prevention implementation plan	Evaluation methods created for each area of suicide prevention as listed in the recommendations above. Evaluation of suicide audit data – changes to suicide methods or risk of suicide. Changes to rates of suicide	Report to Health Committee and HWB as requested	Collation and analysis of any evaluation and survey data Analysis of suicide audit data	Public Health to lead	See columns above

			Evaluation and outcomes from all recommendations listed above		
ZERO SUICIDE AMBITION ACTIONS	Ensure that suicide prevention and the zero suicide ambition is supported by effective commissioning and delivery approaches including: embedding suicide prevention in strategic and operational plans of CPFT, CCG, CCC and PCC, included in contracts – organizations commissioned will be required to sign up to the Strategy inc. the Zero suicide and suicide prevention strategy and develop and report against action plans to support their commitment.	New Initiative		Fiona Davies to lead To be discussed at Safeguarding Executive Board	

* When referring to 'children and young people', the definition from the emotional wellbeing and mental health of children strategy is used; "all children and young people and their families in Cambridgeshire and Peterborough, from conception to their 18th birthday or their 25th year if disabled or have complex needs".

This is a live action plan that was last updated in January 2018.

Agenda Item No: 6

FEEDBACK ON THE JOINT DEVELOPMENT SESSION WITH CAMBRIDGESHIRE AND PETERBOROUGH HEALTH AND WELLBEING BOARDS

To: **Health and Wellbeing Board**

Meeting Date: **1 February 2018**

From: **Director of Public Health**

Purpose: **To provide the Health and Wellbeing Board with an update from the joint development session with Peterborough and Cambridgeshire Health and Wellbeing Boards, held on 23 January 2018.**

Recommendations: **The Health and Wellbeing Board is asked to:**

a) **note the content of the update report;**
b) **agree to holding a joint meeting with Peterborough Health and Wellbeing Board to further develop the priority areas identified in the development session.**

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1. PURPOSE

1.1 To provide the Cambridgeshire Health and Wellbeing Board (HWB) with an update on the joint development session held between both Cambridgeshire and Peterborough Health and Wellbeing Boards on the 23rd January 2018.

1.2 Health and wellbeing boards (HWBs) are forums where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. A significant number of HWBs are now beginning to play a genuine leadership role across local health and care systems.

1.3 The session was facilitated by Andrew Cozens, an associate from the Local Government Association (LGA), with a clear purpose around:-

- Understanding the HWBs accountabilities are.
- Understanding the work of both HWBs
- Sharing both HWBs priority areas
- Considering if there is value in joining up some of the work of both HWBs
- Agree future ways of working

2 BACKGROUND

2.1 The theme of the development session was to examine how combining the expertise of both Boards would support identifying wider solutions to shared challenges, including increased demand and scarce resources. The session examined how the Boards could work together collaboratively on shared priorities.

2.2 Board members were provided with an overview of the Cambridgeshire and Peterborough Joint Strategic Needs Assessment Core Dataset (2018). Key areas of commonality for both Cambridgeshire and Peterborough HWBs were identified as follows:

- Growing Populations
- New Housing Development Sites
- Ageing Populations
- Health inequalities
- Rising demand including mental health

2.3 Opportunities for joint working were also identified through both the boards Health and wellbeing strategies.

Peterborough HWB Strategy Sections	**Cambridgeshire HWB strategy developing priorities**
Health and wellbeing through the life course.	Mental Health, Prevention
Creating a healthy environment	Population growth and new developments
Tackling health inequalities	Health inequalities including homelessness, drug and alcohol
Working together effectively	Integration of health and social care services.

3. MAIN ISSUES

3.1 Key themes for working together were identified by participants around:

- Integrated solutions (not just integrated services) and the collective impact of the Board membership
- A focus on place based integration and on commonality of need.
- Prevention – working through outcomes and priorities including mental health and early years.
- Population Growth - including new communities, healthy new developments, and the impact on demand and resource requirements.

3.2 The session further explored how we can develop these priorities practically across Cambridgeshire and Peterborough. In regards to integration it was emphasised that the HWB Board was a place where holistic integration of solutions and outcomes around the root causes of issues could be considered, not just the integration of services.

In regards to population growth and in particular new developments it was suggested that a unit of shared expertise was needed to ensure that there was a shared understanding from health commissioners, providers, planners of housing and population growth, and that the key parties involved in planning new developments were talking to the right people.

Prevention is a clear focus in both HWB strategies and within the Sustainability and Transformation Plan (STP). It was suggested the focus for the HWBs could be around identified priorities for children and young people's emotional well-being as well as drug and alcohol misuse. The approach could be more of a strategic overview addressing any blocks identified by existing partnership groups.

The place based discussion included identifying places or groups within the population, where people's experience of health and wellbeing is less good and working with local communities in an asset based approach to address local needs. There was some discussion over the role of the new Living Well Partnerships in aiding this process.

4 Recommendation

4.1 Collective ways of working were also discussed as a way the boards could be strengthened to better enable local people to have improved health and reduce health inequalities.

A suggested approach was for both the Health and Wellbeing Boards to consider a joint meeting in which further work on the key themes identified in 3.1 would be discussed and a joint action plan could be agreed.

5 SOURCES

Source Documents	Location
None	

Agenda Item No: 7

BETTER CARE FUND UPDATE

To: **Health and Wellbeing Board**

Meeting Date: **1 February 2018**

From: **Cath Mitchell, Director of Transformation and Delivery: Community Services and Integration**

Recommendations: **The Health and Wellbeing Board is asked to:**

a) note and comment on the report and appendices.

	Officer contact:	***Member contact:***
Name:	Geoff Hinkins	Name: Councillor Peter Topping
Post:	Transformation Manager	Position: Chairman, Cambridgeshire Health and Wellbeing Board
Email:	Geoff.hinkins@cambridgeshire.gov.uk	Email: Peter.Topping@cambridgeshire.gov.uk
Tel:	01223 699679	Tel: 01223 706398 (office)

1. BACKGROUND

1.1 The Better Care Fund (BCF) creates a joint budget to help health and social care services to work more closely together in each Health & Wellbeing Board Area. The BCF came into effect in April 2015. The 2017/19 plan is the third Cambridgeshire BCF Plan. Following agreement from the Health and Wellbeing Board, it is the first joint Cambridgeshire and Peterborough Plan. Two separate pooled budgets are to be maintained in line with statutory requirements.

1.2 This report and its appendices provide an update on Cambridgeshire and Peterborough's joint BCF submission and approval status; and on progress in delivering the Cambridgeshire and Peterborough BCF Plan for 2017-19.

2. BCF PLAN UPDATE

2.1 Cambridgeshire and Peterborough submitted their joint Better Care Fund plan on 11 September 2017. Following a request for additional information, Cambridgeshire was formally notified that its plan was approved on 22 December 2017. The approval letter noted that the plan meets all Better Care Fund requirements, and the focus should now be on delivery. This formal notification gives partners permission to develop the full Section 75 partnership agreement that sets the legal framework for the pooled BCF budget; the County Council and Clinical Commissioning Group (CCG) are now developing this agreement.

2.2 Pending formal approval of Cambridgeshire and Peterborough's plan, partners have continued to work together to deliver the Better Care Fund plan; progress on delivery is reported regularly to the Integrated Commissioning Board (ICB), an officer group that monitors the BCF on behalf of both Cambridgeshire and Peterborough Health and Wellbeing Boards. The Delivery plan progress report considered by the ICB at its December meeting is attached as Appendix A. The Quarter 3 update report submitted to NHS England (covering performance from October to December) is attached as Appendix B.

3.0 DELAYED TRANSFERS OF CARE UPDATE

3.1 Delayed Transfers of Care (DTOC) have remained a significant challenge in Cambridgeshire and Peterborough throughout the third quarter of 2017/18. Through the Better Care Fund, partners invested in a number of immediate initiatives to support delivery of the ambitious national DTOC target of 3.5% of bed days by November. Initiatives include:

3.2 **Dedicated Social Worker to support Self-Funding Service Users at Addenbrookes**

Whilst the number of delayed transfers of care for self-funders at Addenbrookes is relatively low, the length of each delay is significant. A large proportion of delays relate to self-funders with more complex needs who may require assessment for ongoing support or placement following discharge from hospital. This often requires completion of further statutory assessments placing increasing pressure on existing resource. In

order to reduce delays within this area, a dedicated Social Worker has been recruited to support self-funding service users with more complex needs through the discharge process.

3.3 **Transfer of Care**

To support a coordinated, system wide approach to managing transfer of care, Cambridgeshire County Council (CCC) will be recruiting Social Worker Strategic Discharge Leads aligned to Addenbrookes and Hinchingbrooke to support discharge pathways into the community, helping to embed the new Discharge to Assess model.

3.4 **Admission Avoidance within Locality Teams**

An increase in demand and the need to ensure all packages of care are based on Care Act compliant assessments, which takes longer than a standard review, has led to a significant level of outstanding reviews across Locality Teams. Overdue reviews create a significant risk of hospital admissions placing further pressure on DTOC, and increased costs of care post admission. CCC are have recruited additional resource to ensure a focused effort on reducing this backlog is undertaken in order to reduce the impact this could have on DTOC and increased spend due to increases in care need over the winter period.

3.5 **Domiciliary Care Provision**

The new Home and Community Support Contract has commenced. This approach has enabled CCC to take a consistent approach to commissioning domiciliary care provision across all service areas including Older People and Physical Disabilities, Mental Health, Learning Disabilities, Continuing Healthcare and Children's Community Services. The tender exercise has been successful in increasing the number of providers delivering homecare services on behalf of CCC, and is therefore expected to support an incremental increase in capacity and a centralised brokerage service has also been implemented to provide oversight and management of capacity across the County. Due to limited market capacity and a significant increase in demand there have been significant challenges which brokerage and CCC are working with the system to mitigate.

3.6 **Homecare and Discharge Cars**

CCC will continue to commission a Discharge and Transition Car service, as part of the Home and Community Support Contract. This service will prioritise hospital discharge in providing interim domiciliary care provision where there is lack of capacity in the mainstream domiciliary care contract. This service will be provided for up to six weeks to support management of DTOC, and will be managed by the centralised Homecare Brokerage Team to ensure available provision is maximised.

3.7 **Reablement Provision**

A specialist recruiter has been commissioned to work with PCC and CCC to support increasing reablement capacity by 20%. This will include dedicated recruitment to additional Reablement Support Worker and Social Worker posts. A number of these posts have now been recruited to, and a recruitment campaign for remaining posts is ongoing. As part of this work, CCC are also running recruitment fairs, promotional campaigns and working in partnership with JobCentre Plus to proactively identify potential candidates. Whilst the majority of Social Worker, Coordinator and Administrative roles have been recruited to, attracting Reablement Support Worker

applicants has proven challenging due to current market conditions and the demographics of Cambridgeshire. CCC are currently exploring options to mitigate the challenges.

3.8 **Short Term Reablement Beds**

To support ongoing management of winter pressures, CCC will continue to commission existing short-term reablement beds at Doddington Court. In addition to this, a number of other reablement beds will be commissioned for 6 months to ensure the reablement team have available to capacity to enable early intervention to reduce the demand for higher cost placements across the service and support hospital discharge flow across the county throughout this winter. These have now been implemented, with 2 additional beds also being identified within the South of the County which are due to go live next week.

3.9 **Discharge to Assess (D2A) Pathway**

CCC is working with Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) and the wider system to support implementation of the D2A STP business case. The phase one Single Point of Coordination (SPOC) has been established and is operating across all three Cambridgeshire and Peterborough acute trusts. The long-term design of the model and SPOC is on-going and will build on good examples of practice across the system.

3.10 **Continuing Health Care (CHC) 4Q Hospital Discharge Pathway**

A three month pilot has been implemented to introduce a hospital pre-screening tool (4Q test) to prevent assessment related discharge delays. The pilot went live across all three acute trusts during November and December and a three month evaluation is planned.

3.11 **Community Equipment & Assistive Living Technology**

Community Equipment and Assistive Living Technology Services will continue to give priority to hospital discharge in deploying equipment to support high-risk support packages to both community and residential settings to manage risks and reduce the likelihood of readmission and manage DTOC pressures.

In addition to activities funded through the Improved Better Care Fund (IBCF), the CCC Assistive Technology Team will also be piloting Telecare Enabled Discharge. This pilot will aim to engage individuals in using assistive living technology to meet their support needs and maximise their independence as early as possible on discharge from hospital. This should ultimately enable each individual to achieve a sustainable recovery, reducing future readmissions and preventing an increase in the cost of care.

3.12 **Trusted Assessor Model**

Under the wider Better Care Fund Programme, CCC are engaging in development of a trusted assessor model to reduce delayed transfers of care for individual awaiting a care home placement on discharge from hospital.

4. ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

The Better Care Fund is relevant to priorities 2, 3, 4 and 6 of the Health and Wellbeing Strategy:

- Priority 2: Support older people to be independent, safe and well.
- Priority 3: Encourage healthy lifestyles and behaviours in all actions and activities while respecting people's personal choices.
- Priority 4: Create a safe environment and help to build strong communities, wellbeing and mental health.
- Priority 6: Work together effectively.

5. Source Documents

Source Documents	**Location**
None.	

Focus Area	Key Area	Description	Governance & Delivery			Project Status		Timescale	Progress update	key Risks / Issues	last updated
			Primary Governance	Accountable Officer (SRO) & Agency	Operational Leads	Current Project Stage	RAG Status				
Prevention & Early intervention	**Community Equipment, DFG, Assistive Tech**	Integrating AT with neighbourhood teams - Integrating AT with Primary Care - Deploy monitoring equipment - Enhanced response service - Review network of call centres / monitoring hubs - Increasing reach of AT - Integrating AT geographically and across user groups	Integrated Commissioning Board	Cath Mitchell, CCG	Operational Lead: Diana Mackay	DEVELOP	Pending	Approach fully scoped and implementation plan developed - December 2017 Implementation of new approaches: March 2018	we currently have an integrated community equipment service (ICES) across C&P. Work has been ongoing to identify the future provision for the ICES and to strengthen assistive technology. The DFG Joint Grants Policy continued to develop to ensure a consistent approach to appropriate conversations (re suitability of an adaptation or alternative options) and adaptations for residents across the county in order to improve outcomes for people in need of housing support across Cambridgeshire and Peterborough.		Dec-17
	Ageing Well: Falls Prevention	- Develop and implement a falls prevention mass media campaign - Enhance and expand CPFT strength and balance exercise rehabilitation - Enhance/establish specialist falls prevention health trainer service in Cambridgeshire and Peterborough - Strengthen falls prevention delivery and integration in the community - Develop, and implement Fracture Liaison Services (FLS) across Cambridgeshire and Peterborough acute trusts - Public health falls prevention coordinator to lead, co-ordinate, monitor and evaluate the implementation of the programme and facilitate system-wide integration	STP:PCIN Delivery Group	Katie Johnson, Public Health	Project Lead: Helen Tunster Clinical Lead: Jackie Riglin HR Lead: Sarah Dunlevy / Tara Sutton Comms Lead: Mark Cole Finance Lead: Tracy Shepherd / Clare Andrews	DEPLOY	On Track	1. Falls primary prevention campaign: 01/01/18 - 27/8/18 2. Enhancement and expansion of strength and balance training provision: 01/10/17 - 8/1/18 3a. Enhancement of Falls Prevention Health Trainer Service - Peterborough: 19/06/17 - 8/1/18 3b. Enhancement of Falls Prevention Health Trainer Service - Cambridgeshire: 19/6/17 - 8/1/18 4. Strengthening falls prevention delivery and integration in the community: 1/4/17 – 7/11/17 5. Development and implementation of Fracture Liaison Service: 1/9/17 – 1/4/18	**Performance** KPI / Overall Target / Monthly Target / Monthly actual Number of multifactorial falls assessments by (i) Neighbourhood teams: TBC by CPFT Dec 17 / TBC by CPFT Dec 17 / St Ives data expected Dec 17 Number of multifactorial falls assessments by (ii) Falls prevention trainers: 218 / 18 / Go live Jan 18 Emergency hospital admission for injury due to falls in people aged 65+: TBC by SDU / TBC by SDU / Data expected Jan 18 Emergency hospital admission for fractured neck of femur in people aged 50+: TBC by SDU / TBC by SDU / Data expected Jan 18 Emergency hospital admission for fractured neck of femur including fragility #: TBC by SDU / TBC by SDU / Data expected Jan 18 **Key Meetings/ Next Steps** Interview therapy assistants (2nd recruitment) and specialist health trainer (Cambs) — Oct: - — Nov: Completed therapy assistants 23rd Nov — Dec: Heath Trainer: 5th Dec Train CPFT staff in Huntingdonshire locality — Oct: - — Nov: Not completed on time — Dec: Due by W/C 18th Continue contract negotiations for FPHT service in Peterborough — Oct: Not completed on time — Nov: Not completed on time — Dec: Due by W/C 4th Winter message campaign completed — Oct: - — Nov: - — Dec: Due by W/C 11th Start comms plan for full Falls campaign — Oct: - — Nov: - — Dec: Due by 12th	**Key Project Risks/ Issues** • FPHT contract may take longer than planned to agree. Escalated internally to Director of Public Health actions being taken. • Further issues identified with falls documentation on CPFT's systmOne after go live. Issues raised with IT support. Will be escalated within CPFT if not resolved urgently. **DG Escalations** No escalations to PCIN	Nov-17
	Ageing Well: Stroke prevention / Atrial Fibrillation	Develop and deliver programme for patients on the AF register not currently receiving anticoagulation. Targeted opportunistic case finding	STP:PCIN Delivery Group	Sue Watkinson, CCG	Project Lead: Jackie Brisbane Clinical Lead: Amrit Takhar Comms Lead: Helen McPherson Finance Lead: Neil Williamson	DELIVER	Slippage	Scoping/Design: 06/03/17 – 17/04/17 Delivery Lead-Time: April to end June 2017 Works/Installation/Commissioning: April to end of June 2017 Practical Completion/"Go Live"3: End of June 2017 Post-Project Evaluation: January 2018	**KPIs** / **Target overall** / **Monthly Target** / **Actual** Number of signed SLAs: 30 / 30 / 30 No of practises with Grasp AF installed: 30 / 30 / 30 No of practises ready for data extraction: 30 / 30 / 29 Flu clinic participation: 7 practises / 7 / 6 No of AF patients Diagnosed: / / TBC Number of newly diagnosed patients starting Anticoagulation (2495 per year baseline): 381 additional per year / 32 / TBC Dec **Key Meetings/ Next Steps** Baseline data extracted — Oct: Not completed on time — Nov: W/C 27th Nov — Dec: Ongoing Newly diagnosed AF patients to have GP clinical review to determine intervention (support offered by AF Clinical lead) — Oct: - — Nov: W/C 27th Nov — Dec: Ongoing Review existing patient caseloads in practices to determine if any need anti-coags now. — Oct: - — Nov: Not completed on time — Dec: W/C 4th Dec	**Key Project Risks/ Issues** • Delay in collection of baseline data means that patients on current caseload have not been reviewed in September - November leading to a risk of reduction in savings. • SRO reviewing savings profile. The issue of data collection has now been resolved and the savings slippage will be determined once actual savings have been quantified so no actions for PCIN.	Nov-17
	VCS Joint commissioning	Mapping existing provision and identify opportunities for joint commissioning Develop strategic plan with partners to roll out joint commissioning	Integrated Commissioning Board	Cath Mitchell, CCG	CCG: Gill Kelly PCC/CCC: Oliver Hayward	DEVELOP	Slippage	1st phase Joint Commissioning Plan to include: March 2018 1. Process for co-production agreed and people identified 2. Set up VCS reference group 3. commissioners' total VCS & community resilience building spend, activity & contracts mapped 4. joint outcomes framework developed & agreed 5. return on investment assessment tool / process developed 6. develop costed plans to achieve outcomes - building on H&WB Strategies and informed by Wellbeing Summit outputs 7. incorporation into other plans system wide plans as relevant e.g. BCF, Council, STP 8. Agree governance to oversee plan implementation 9. Identify further investment opportunities Single Wellbeing Network commenced: December 2017	Building on the Joint Commissioning Principles established during 2016/17, the existing arrangements are in the process of being reviewed by the CCG and the Councils, to develop joint outcomes and plans. The two separate C&P Wellbeing Networks merged into a single network in September 2017 to strengthen the co-ordination of and support for wellbeing services and VCS activity across Cambridgeshire and Peterborough to build in more support will be provided for vulnerable adults before they require the support of statutory services.		Nov-17
Community services & MDT	**MDT Case Management**	Stratified Patient List: Developing effective interventions to support frail older people and adults with long term conditions/disability is establishing a robust mechanism to identify these patients who are at risk (case finding). Joint Care Plan:co-produce a shared care plan, which will quickly inform professionals of agreed care plans Integrated System Pathway to admission and discharge: Ensure an integrated pathway from early identification of need, through intermediate care provision to long term care support and supported early discharge Patient Based Information Sharing: MDT working systems to share patient data and appropriate information governance will be developed to ensure seamless care and reducing the need for the patient to tell their story more than once	STP:PCIN Delivery Group	John Martin, CPFT	Project Lead: Laura Searle Clinical Lead: Rhiannon Nally / Ben Underwood HR Lead: Cathy Mayes Comms Lead: Andrea Grosbois Finance Lead: Tracy Shepherd	DEPLOY	Slippage	Phased roll out of case management to non-Trailblazer sites: to commence April//May 17. Pseudonymised tool for case finding rolled out: to commence August 2017. Joint Care Plan developed: January 2018. Frailty tool training implemented: to commence September 2017. Patient held record/information sharing approach implemented: March 2018.	**Top Achievements** 1. Letter sent to all trailblazing practices to communicate data extraction start date of 6th November, further information and process map. 2. Confirmation of all but 2 of the new staff start dates. First group of staff attended local induction 07/11/17. 3. Unfilled vacancies re-advertised with a closing date of 17/11/17. Interviews took place 24/11/17. **Areas of focus** • First run of data was run by MDT coordinators on 6th November 2017. Ongoing focus. • Kings Hall space situation still a priority. Potential to lease additional space by subletting. • MDT coordinator meeting with practices to agree the process they wish to follow in case finding, with the trailblazer teams.	**Project Risk** • Estates: Kings Hall: Will not be ready by go live date and a plan B has not yet been confirmed. Suggestion of use of Oaktree. Room, IT and parking details as yet unconfirmed. CPFT needs to be clarified urgently. **DG Escalations** • Data required from practices on EMIS. Can the CCG support this via the Primary Care Information Team (PCIT)?	Nov-17

Focus Area	Key Area	Description	Governance & Delivery			Project Status		Timescale	Progress update	key Risks / Issues	last updated
			Primary Governance	Accountable Officer (SRO) & Agency	Operational Leads	Current Project Stage	RAG Status				
DTOC / HIC	**8 HIC Model**	Delivery of the 8 HIC to manage discharges, supporting the system to deliver the 3.5% DTOC target. Including: - Early discharge planning (Elective & Emergency) - Systems to monitor patient flow - Multi-disciplinary / Multi-Agency Discharge - Home First / Discharge to Assess - Seven Day Servoce - Trusted Assessor - Focus on Choice - Enhancing Health in Care Homes	A&E Delivery Boards (NWAFT & CUH)	Refer to DTOC Plans	Refer to DTOC Plans	DEPLOY	On Track	Refer to DTOC Plans	Reablement: recruitment is progressing well to support a 20% increase in reablement capacity. A number of appointments have been made, with further recruitment initiatives planned. Additional reablement step down bed capacity has been commissioned at Clayburn Court and will there will be a phased implementation from mid January. Moving and Handling Coordinator: this post is now based with the Transfer of Care Team with a view to support embedding integrated approaches to equipment and assistive technology to support discharge and this post was in place from the 16th October and initial outcomes are being monitored. A falls response pilot went live with Cross Keys Homes in November 2017. Transfer of Care: two new social worker posts have been based in the acute from 23rd October (Admissions Avoidance Social Worker and Social Care Strategic Discharge Lead). A new Continuing Healthcare pathway (4Qs) 3 month pilot was launched in NWAFT during November and additional social worker and discharge planning nurse capacity to support this is in place. An evaluation of the 4Q pilot is in planning. Trusted Assessor: a care home trusted assessor pilot is being implemented with South Lincolnshire County Council and LINCA. Communications have been undertaken with the local care homes to ensure appetite and buy in. The service launched in December with one Trusted Assessor post in place within PCH. A second trusted assessor post is due to come on line shortly, enabling delivery of a 6 day service. Home Care: a regular meeting with home care providers is now fully operational to support joint working and capacity building.	If there in insufficient intermediate care provision in the community to manage appropriate discharges, then reablement effectiveness may be impacted. Risk of recruitment to large number of ICW and reablement support worker posts across the system Capacity at end of d2a pathway needs to be in placed, or will impact on patient flow.	Dec-17
Information, Communication and Advice	**Information, Communication & Advice**	Deliver a trusted source of 'one version of the truth', enabling information and advice provided to customers to be consistent, accurate and comprehensive; regardless of the point of access.	Integrated Commissioning Board	Charlotte Black, PCC/CCC	CCG: Nigel Gausden PCC: Tina Hornsby CCC: Ed Strangeways CVS: Louise Porter	DEVELOP	On Track	1 Stage 1 - LGA Funded Demonstrator / Proof of Concept Develop MIDOS test environment: 08/09/2017 Test MIDOS: 15/09/2017 Produce Stage 1 evaluation - proof of concept report: November 2017 2 LIP Search Platform Development - Go Live Go Live: March 2018 3 Directory of Services Development March 2018 4 Front End Search Functionality March 2018	The persona development and lead researchers report has been finalised. The Data Standards have been developed The working group has now been reformed as the Information and Data Standards Quality Group with a remit of the ongoing monitoring and embedding of compliance with standards across the partnership. LGA funded MiDOS test demo has been developed and tested. Evaluation report and toolkit being drafted. Next steps: develop approach and plan for moving to a live system wide solution.	If the cost of IT solution that meets the requirements of the specification is overly prohibitive, then this will impact on the ability to deliver a system wide solution. - Score 9	Nov-17
iBCF Housing	**Investing in Housing for vulnerable groups**	1. commit funds to enable acquisition of property. 2. property purchase. 3. accommodation available. 4. clients move in. 5. care plans review. 6. Savings available	Integrated Commissioning Board	Oliver Hayward, PCC/CCC	CCC: Richard O'Driscoll PCC: Nigel Harvey Whitten CCG: Cath Mitchell	DEVELOP	Slippage	1. Agree principles / prepare Business Case Mid August 2017 2. Start to source property (to meet time-line) August 2017 onwards 3. Property (accommodation) available Mid February 2018 4. Clients move in and benefits start to be realised. Mid March 2018	Financial arrangements being finalised. Initial properties identified.	Delays in finalising financial arrangements	Dec-17

Better Care Fund Template Q3 2017/18

Guidance

Overview

The Better Care Fund (BCF) quarterly monitoring template is used to ensure that Health and Wellbeing Board areas continue to meet the requirements of the BCF over the lifetime of their plan and enable areas to provide insight on health and social integration.

The local governance mechanism for the BCF is the Health and Wellbeing Board, which should sign off the report or make appropriate arrangements to delegate this.

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, as below:

Data needs inputting in the cell

Pre-populated cell

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.

If required, the row heights can be adjusted to fit and view text more comfortably for the cells that require narrative information. Please note that the column widths are not flexible.

The details of each sheet within the template are outlined below.

Checklist

1. This sheet helps identify the data fields that have not been completed. All fields that appear as incomplete should be complete before sending to the Better Care Support Team.
2. It is sectioned out by sheet name and contains the description of the information required, cell reference (hyperlinked) for the question and the 'checker' column which updates automatically as questions within each sheet are completed.

3. The checker column will appear “Red” and contain the word “No” if the information has not been completed. Clicking on the corresponding “Cell Reference” column will link to the incomplete cell for completion. Once completed the checker column will change to “Green” and contain the word “Yes”
4. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
5. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Complete Template'.
6. Please ensure that all boxes on the checklist tab are green before submission.

1. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.

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

2. National Conditions & s75 Pooled Budget

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Integration and Better Care Fund planning requirements for 2017-19 continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/wp-content/uploads/2017/07/integration-better-care-fund-planning-requirements.pd
This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met within the quarter and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to contact their Better Care Manager.

In summary, the four national conditions are as below:
National condition 1: A jointly agreed plan
Please note: This also includes onfirming the continued agreement on the jointly agreed plan for DFG spending
National condition 2: NHS contribution to social care is maintained in line with inflatior
National condition 3: Agreement to invest in NHS-commissioned out-of-hospital services
National condition 4: Implementation of the High Impact Change Model for Managing Transfers of Care

3. National Metrics

The BCF plan includes the following four metrics: Non-Elective Admissions, Delayed Transfers of Care, Residential Admissions and Reablement. As part of the BCF plan for 17/19, planned targets have been agreed for these metrics.
This section captures a confidence assessment on meeting these BCF planned targets for each of the BCF metrics.

A brief commentary is requested for each metric outlining the challenges faced in meeting the BCF targets, any achievements realised and an opportunity to flag any Support Needs the local system may have recognised where assistance may be required to facilitate or accelerate the achievement of the BCF targets.

As a reminder, if the BCF planned targets should be referenced as below:
- Residential Admissions and Reablement: BCF plan targets were set out on the BCF Planning Template
- Non Elective Admissions (NEA): The BCF plan mirrors the CCG Operating Plans for Non Elective Admissions except where areas have put in additional reductions over and above these plans in the BCF planning template. Where areas have done so and require a confirmation of their BCF NEA plan targets, please write into england.bettercaresupport@nhs.net
- DToC: The BCF plan targets for DToC for the current year 17/18 should be referenced against the agreed trajectory submitted on the separate DToC monthly collection template for 17/18.
The progress narrative should be reported against this agreed monthly trajectory as part of the HWB's plan

When providing the narrative on challenges and achievements, please also reflect on the metric performance trend when compared to the quarter from the previous year - emphasising any improvement or deterioration observed or anticipated and any associated comments to explain.
Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

4. High Impact Change Model

The BCF National Condition 4 requires areas to implement the High Impact Change Model for Managing Transfer of Care. Please identify your local system's current level of maturity for each of the eight change areas for the reported quarter and the planned / expected level of maturity for the subsequent quarters in this year.

The maturity levels utilised are the ones described in the High Impact Changes Model (link below) and an explanation for each is included in the key below:
Not yet established - The initiative has not been implemented within the HWB area
Planned - There is a viable plan to implement the initiative / has been partially implemented within some areas of the HWB geograph
Established - The initiative has been established within the HWB area but has not yet provided proven benefits / outcome
Mature - The initiative is well embedded within the HWB area and is meeting some of the objectives set for improvement
Exemplary - The initiative is fully functioning, sustainable and providing proven outcomes against the objectives set for improvemen
https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-model

Where the selected maturity levels for the reported quarter are 'Mature' or 'Exemplary', please provide further detail on the initiatives implemented and related actions that have led to this assessment.

For each of the HICM changes please outline the challenges and issues in implementation, the milestone achievements that have been met in the reported quarter and any impact to highlight, and any support needs identified to facilitate or accelerate the implementation of the respective changes.

Hospital Transfer Protocol (or the Red Bag Scheme):
The template also collects updates on areas' implementation of the optional 'Red Bag' scheme. Delivery of this scheme is not a requirement of the Better Care Fund, but we have agreed to collect information on its implementation locally via the BCF quarterly reporting template.
Please report on implementation of a Hospital Transfer Protocol (also known as the 'Red Bag scheme') to enhance communication and information sharing when residents move between care settings and hospital.
Where there are no plans to implement such a scheme please provide a narrative on alternative mitigations in place to support improved communications in hospital transfer arrangements for social care residents.

Further information on the Red Bag / Hospital Transfer Protocol:
A quick guide is currently in draft format. Further guidance is available on the Kahootz system or on request from the NHS England Hospital to Home team. The link to the Sutton Homes of Care Vanguard – Hospital Transfer Pathway (Red Bag) scheme is as below:
https://www.youtube.com/watch?v=XoYZPXmULHE

The HICM maturity assessment (particularly where there are multiple CCGs and A&E Delivery Boards (AEDBs)) may entail making a best judgment across the AEDB and CCG lenses to indicatively reflect an implementation maturity for the HWB. However, the AEDB lens is a more representative operational lens to reflect both health and social systems. Where there are wide variations in their maturity levels, making a conservative judgment is advised. Please note these observed wide variations in the narrative section on 'Challenges'.
Also, please use the 'Challenges' narrative section where your area would like to highlight a preferred approach proposed for making this assessment, which could be useful in informing design considerations for subsequent reporting.

5. Narrative

This section captures information to provide the wider context around health and social integration.
Please tell us about the progress made locally to the area's vision and plan for integration set out in your BCF narrative plan for 2017-19. This might include significant milestones met, any agreed variations to the plan and any challenges.

Please tell us about an integration success story observed over reported quarter highlighting the nature of the service or scheme and the related impact.

Better Care Fund Template Q3 2017/18

1. Cover

Version 1

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Cambridgeshire
Completed by:	Geoff Hinkins
E-mail:	geoff.hinkins@cambridgeshire.gov.uk
Contact number:	01223 699679
Who signed off the report on behalf of the Health and Wellbeing Board:	Wendi Ogle-Welbourn

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

Complete

	Pending Fields
1. Cover	0
2. National Conditions & s75 Pooled Budget	0
3. National Metrics	0
4. High Impact Change Model	0
5. Narrative	0

Better Care Fund Template Q3 2017/18

2. National Conditions & s75 Pooled Budget

Selected Health and Well Being Board: Cambridgeshire

Confirmation of National Conditions		
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:**
1) Plans to be jointly agreed? (This also includes agreement with district councils on use of Disabled Facilities Grant in two tier areas)	Yes	
2) Planned contribution to social care from the CCG minimum contribution is agreed in line with the Planning Requirements?	Yes	
3) Agreement to invest in NHS commissioned out of hospital services?	Yes	
4) Managing transfers of care?	Yes	

Confirmation of s75 Pooled Budget			
Statement	**Response**	**If the answer is "No" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:**	**If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)**
Have the funds been pooled via a s.75 pooled budget?	No	Due to the delays associated with the national NHS England assurance process the local secton 75 pooled budget agreement for 2017-19 is being finalised.	31/03/2018

Better Care Fund Template Q3 2017/18

3. Metrics

Selected Health and Well Being Board: Cambridgeshire

Metric	Definition	Assessment of progress against the planned target for the quarter	Challenges	Achievements	Support Needs
NEA	Reduction in non-elective admissions	Data not available to assess progress	Full Q3 NEA performance data was not available at the time of writing. NEAs in November and December totaled 10,145 against a full Q3 target of 15,217. Indicative full	Continued roll out of falls prevention programme of work, stroke prevention (Atrial Fibrillation)	None identified
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target	Self-funders continue to present a pressure to the system which is difficult to predict.	Despite an increase in admissions in the first two quarters, at the end of Quarter 3 there were a total of 234 care home admissions year. Therefore it is currently	None identified
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Data not available to assess progress	Data to assess progress will be available by the end of January and can be shared with the regional BCF manager once available.	Clear plans, supported by the iBCF funding to increase reablement capacity by 20% and improve domiciliary provision across the market have improved reablement	None identified
Delayed Transfers of Care*	Delayed Transfers of Care (delayed days)	Not on track to meet target	The system continued to report high levels of DTOC in Q3. Full Q3 delayed bed days published data was not available at the time of writing. Indicative local monitoring	There is a clear DTOC trajectory and plan in place to support delivery of the 3.5% target. A number of key initiatives were introduced in Q3, which should	Continued peer sharing of good practice examples / learning from other areas, to support effective high impact change implementation across the system.

** Your assessment of progress against the Delayed Transfer of Care target should reflect progress against the monthly trajectory submitted separately on the DToC trajectory template*

Better Care Fund Template Q3 2017/18

4. High Impact Change Model

Selected Health and Well Being Board: Cambridgeshire

		Maturity assessment				Narrative			
		Q2 17/18	Q3 17/18 (Current)	Q4 17/18 (Planned)	Q1 18/19 (Planned)	If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	Challenges	Milestones met during the quarter / Observed impact	Support needs
Chg 1	**Early discharge planning**	Mature	Mature	Mature	Mature	1. Emergency admissions have discharge dates set which whole hospital are committed to delivering 2. Early discharge dates including	DTOC pressures across the system due to demand and market capacity and increased frailty.	Redesigned CHC hospital discharge pathway (4Qs) implemented in acute as a 3 month pilot. Impact to be reviewed in Q4.	None identified
Chg 2	**Systems to monitor patient flow**	Plans in place	Established	Established	Established		Real time system flow across the whole health and care system.	SHREWD established and in place to monitor acute patient flow.	None identified
Chg 3	**Multi-disciplinary/multi-agency discharge teams**	Plans in place	Plans in place	Established	Established		Delays in agreeing iBCF funding to support some of the key initiatives has impacted on implementation progress of newly funded initiatives (e.g. new posts in the Transfer of Care Team - e.g.	D2A single point of coordination continues to be enhanced. Expansion of d2a agreed and being mobilised. Local acute MDT hub in operation as part of the d2a SPOC. Further development for	None identified
Chg 4	**Home first/discharge to assess**	Plans in place	Plans in place	Established	Established		N/A	D2A system wide single point of coordination established in Q2. Local acute MDT hub in operation as part of the d2a SPOC. Expansion of d2a agreed and is being mobilised. Further	None identified
Chg 5	**Seven-day service**	Not yet established	Not yet established	Plans in place	Plans in place		The need to understand fully the financial and staffing challenges associated with 7DS provision, including impact/cost analysis to ensure resources are targeted most appropriately.	N/A	None identified
Chg 6	**Trusted assessors**	Not yet established	Plans in place	Established	Established		Engagement and buy in from care homes.	Implementation model agreed with key partners. Refinement and approach to implementation being planned, which will include key learning from Peterborough pilot.	Learning and sharing from other areas to ensure maximise opportunity and overcome any issues/challenges quickly.
Chg 7	**Focus on choice**	Established	Established	Mature	Mature		Staff training and confidence to implement the Choice Policy effectively within their practice.	Choice Policy agreed and implemented within acute.	None identified
Chg 8	**Enhancing health in care homes**	Established	Established	Mature	Mature		Slight increase in hospital admissions from care homes locally - reasons being investigated.	All vacancies for Care Home Educators filled and links with care homes well established.	None identified

Hospital Transfer Protocol (or the Red Bag Scheme) Please report on implementation of a Hospital Transfer Protocol (also known as the 'Red Bag scheme') to enhance communication and information sharing when residents move between care settings and hospital.									
		Q2 17/18	**Q3 17/18 (Current)**	**Q4 17/18 (Planned)**	**Q1 18/19 (Planned)**	**If there are no plans to implement such a scheme, please provide a narrative on alternative mitigations in place to support improved communications in hospital transfer arrangements for social care residents.**	**Challenges**	**Achievements / Impact**	**Support needs**
UEC	**Red Bag scheme**	Established	Mature	Mature	Established		N/A	Implemented in Q2. Positive feedback from both EEAST/Care Homes regarding the availablity of care plans/forms/kit for patients when needing an admission	None identified

Better Care Fund Template Q3 2017/18

5. Narrative

Selected Health and Wellbeing Board: Cambridgeshire

Remaining Characters:	13,981

Progress against local plan for integration of health and social care

Progress against local plan for integration of health and social care
During Q3 formal NHS England approval was received for the local BCF 2017-19 Plan and the associated Section 75 pooled budget agreement is being finalised. A key focus in Q3 has been the development of a robust delivery plan and BCF outcomes dashboard, which has been closely aligned with the STP.

Delivery of the BCF initatives has progressed within Q3 and the below provides an update on the key developments:

Prevention & Early Intervention
Objective: to establish and implement approaches that prevent or delay the need for more intensive health and social care services, or, proactively promote the independence of all older people and adults with long-term conditions (LTCs).

Key intervention programmes and progress include:

Falls prevention: This project is implementing a comprehensive, standardised, and integrated falls prevention pathway across the CCG and

Please tell us about the progress made locally to the area's vision and plan for integration set out in your BCF narrative plan for 2017-19. This might include significant milestones met, any agreed variations to the plan and any challenges.

Remaining Characters:	19,121

Integration success story highlight over the past quarter

Key areas of success during Q3 include:

• NHS England approval of our Better Care Fund Plan 2017-19.
• Development of robust BCF delivery plans and an outcome measurement dashboard, aligned with local STP metrics.
• Good progress on whole system falls project – building on results of pilot
• Implementation of the Stroke prevention Atrial Fibrillation project, which has rolled out ECG equipment to support the identification of patients in flu clinics. Service Level Agreements have been signed by 22 GP practices.
• High Impact Changes: good progress to implement the local iBCF DTOC plans to support delivery of the high impact changes. A number of good practice initiatives went live in Q3, including Social Care Discharge Lead post, additional Transfer of Care Team (TOCT) social worker posts to support discharge and enhanced reablement and intermediate care provision.

Please tell us about an integration success story observed over the past quarter highlighting the nature of the service or scheme and the related impact.

Better Care Fund Template Q3 2017/18

Checklist

[<< Link to Guidance tab]

Complete Template

1. Cover

	Cell Reference	Checker
Health & Wellbeing Board	C8	Yes
Completed by:	C10	Yes
E-mail:	C12	Yes
Contact number:	C14	Yes
Who signed off the report on behalf of the Health and Wellbeing Board:	C16	Yes

Sheet Complete:	Yes

2. National Conditions & s75

	Cell Reference	Checker
1) Plans to be jointly agreed?	C8	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements?	C9	Yes
3) Agreement to invest in NHS commissioned out of hospital services?	C10	Yes
4) Managing transfers of care?	C11	Yes
1) Plans to be jointly agreed? If no please detail	D8	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements? If no please detail	D9	Yes
3) Agreement to invest in NHS commissioned out of hospital services? If no please detail	D10	Yes
4) Managing transfers of care? If no please detail	D11	Yes
Have the funds been pooled via a s.75 pooled budget?	C15	Yes
Have the funds been pooled via a s.75 pooled budget? If no, please detail	D15	Yes
Have the funds been pooled via a s.75 pooled budget? If no, please indicate when	E15	Yes

Sheet Complete:	Yes

3. Metrics

	Cell Reference	Checker
NEA Target performance	D7	Yes
Res Admissions Target performance	D8	Yes
Reablement Target performance	D9	Yes
DToC Target performance	D10	Yes
NEA Challenges	E7	Yes
Res Admissions Challenges	E8	Yes
Reablement Challenges	E9	Yes
DToC Challenges	E10	Yes
NEA Achievements	F7	Yes
Res Admissions Achievements	F8	Yes
Reablement Achievements	F9	Yes
DToC Achievements	F10	Yes
NEA Support Needs	G7	Yes
Res Admissions Support Needs	G8	Yes
Reablement Support Needs	G9	Yes
DToC Support Needs	G10	Yes

Sheet Complete:	Yes

4. HICM

	Cell Reference	Checker
Chg 1 - Early discharge planning Q3	F8	Yes
Chg 2 - Systems to monitor patient flow Q3	E9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q3	F10	Yes
Chg 4 - Home first/discharge to assess Q3	F11	Yes
Chg 5 - Seven-day service Q3	F12	Yes
Chg 6 - Trusted assessors Q3	F13	Yes
Chg 7 - Focus on choice Q3	F14	Yes
Chg 8 - Enhancing health in care homes Q3	F15	Yes
UEC - Red Bag scheme Q3	F19	Yes
Chg 1 - Early discharge planning Q4 Plan	G8	Yes
Chg 2 - Systems to monitor patient flow Q4 Plan	G9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q4 Plan	G10	Yes
Chg 4 - Home first/discharge to assess Q4 Plan	G11	Yes
Chg 5 - Seven-day service Q4 Plan	G12	Yes
Chg 6 - Trusted assessors Q4 Plan	G13	Yes
Chg 7 - Focus on choice Q4 Plan	G14	Yes
Chg 8 - Enhancing health in care homes Q4 Plan	G15	Yes
Chg 1 - Early discharge planning Q1 18/19 Plan	H8	Yes
Chg 2 - Systems to monitor patient flow Q1 18/19 Plan	H9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q1 18/19 Plan	H10	Yes
Chg 4 - Home first/discharge to assess Q1 18/19 Plan	H11	Yes
Chg 5 - Seven-day service Q1 18/19 Plan	H12	Yes
Chg 6 - Trusted assessors Q1 18/19 Plan	H13	Yes
Chg 7 - Focus on choice Q1 18/19 Plan	H14	Yes
Chg 8 - Enhancing health in care homes Q1 18/19 Plan	H15	Yes
Chg 1 - Early discharge planning, if Mature or Exemplary please explain	I8	Yes
Chg 2 - Systems to monitor patient flow, if Mature or Exemplary please explain	I9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams, if Mature or Exemplary please explain	I10	Yes
Chg 4 - Home first/discharge to assess, if Mature or Exemplary please explain	I11	Yes
Chg 5 - Seven-day service, if Mature or Exemplary please explain	I12	Yes
Chg 6 - Trusted assessors, if Mature or Exemplary please explain	I13	Yes
Chg 7 - Focus on choice, if Mature or Exemplary please explain	I14	Yes
Chg 8 - Enhancing health in care homes, if Mature or Exemplary please explain	I15	Yes
UEC - Red Bag scheme, if Mature or Exemplary please explain	I19	Yes
Chg 1 - Early discharge planning Challenges	J8	Yes
Chg 2 - Systems to monitor patient flow Challenges	J9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Challenges	J10	Yes
Chg 4 - Home first/discharge to assess Challenges	J11	Yes
Chg 5 - Seven-day service Challenges	J12	Yes
Chg 6 - Trusted assessors Challenges	J13	Yes
Chg 7 - Focus on choice Challenges	J14	Yes
Chg 8 - Enhancing health in care homes Challenges	J15	Yes
UEC - Red Bag Scheme Challenges	J19	Yes
Chg 1 - Early discharge planning Additional achievements	K8	Yes
Chg 2 - Systems to monitor patient flow Additional achievements	K9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Additional achievements	K10	Yes
Chg 4 - Home first/discharge to assess Additional achievements	K11	Yes
Chg 5 - Seven-day service Additional achievements	K12	Yes
Chg 6 - Trusted assessors Additional achievements	K13	Yes
Chg 7 - Focus on choice Additional achievements	K14	Yes
Chg 8 - Enhancing health in care homes Additional achievements	K15	Yes
UEC - Red Bag Scheme Additional achievements	K19	Yes
Chg 1 - Early discharge planning Support needs	L8	Yes
Chg 2 - Systems to monitor patient flow Support needs	L9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Support needs	L10	Yes
Chg 4 - Home first/discharge to assess Support needs	L11	Yes
Chg 5 - Seven-day service Support needs	L12	Yes
Chg 6 - Trusted assessors Support needs	L13	Yes
Chg 7 - Focus on choice Support needs	L14	Yes
Chg 8 - Enhancing health in care homes Support needs	L15	Yes
UEC - Red Bag Scheme Support needs	L19	Yes

Sheet Complete:	Yes

5. Narrative

	Cell Reference	Checker
Progress against local plan for integration of health and social care	B8	Yes
Integration success story highlight over the past quarter	B12	Yes

Sheet Complete:	Yes

Agenda Item No: 8

A 'WHOLE SYSTEM' PARTNERSHIP APPROACH TO HEALTH AND LIVING WELL ACROSS CAMBRIDGESHIRE AND PETERBOROUGH

To: **Health and Wellbeing Board**

Meeting Date: **1 February 2018**

From: **Mike Hill**
Director, Health and Environmental Services, South Cambridgeshire District Council/ District Support Officer

Recommendations: **The Health and Wellbeing Board is asked to:**

a) **Comment on the draft Living Well Concordat and Living Well Area Partnership Terms of Reference;**
b) **Seek formal agreement from their respective Councils and organisations to signing up to the 'Living Well Concordat'.**

	Officer contact:		***Member contact:***
Name:	Mike Hill	Names:	Councillor Peter Topping
Post:	Director, Health and Environmental Services, South Cambridgeshire District Council/ District Support Officer	Position	Chairman
Email:	Mike.Hill@scambs.gov.uk	Email:	Peter.Topping@cambridgeshire.gov.uk
Tel:	01954 713229	Tel:	01223 706398

1. PURPOSE

1.1 To seek the Health & Wellbeing Board's comments on draft Living Well Area Partnership Terms of Reference and a "Living Well Concordat" to support a commitment to a "whole system approach" to health and wellbeing across Cambridgeshire and Peterborough.

2 BACKGROUND

2.1 The King's Fund paper, "Population Health Systems: Going Beyond Integrated Care" argues that "Improving population health is not just the responsibility of health and social care services, or of public health professionals…it requires co-ordinated efforts across population health systems…Making this shift will require action and alignment across a number of different levels, from central government and national bodies to local communities and individuals."

2.2 The NHS Five Year Forward View recognises the role of health organisations in ill-health prevention and lifestyle support. This aligns strongly with public services and local government's role delivering on the "wider determinants of health" including economic prosperity, housing, community safety & protection, education & skills, socio-economic inequalities, and public health.

2.3 The joint Health & Care Executive (HCE) and Public Service Board (PSB) has concluded that there are huge opportunities for closer working between the 18 organisations across Cambridgeshire & Peterborough comprising health commissioners, health providers, and local authority, community & voluntary and public service organisations. These opportunities were based on:

a) Serving shared people in a shared place
b) Shared "enablers" including workforce, skills, estate and ICT challenges
c) Similar financial sustainability challenges
d) A willingness to get better at working together
e) A history of policy initiatives designed to promote integrated working
f) Multiple shared programmes and projects (for example the Sustainability and Transformation Partnership (STP) and the Better Care Fund (BCF))
g) Commitment to building community resilience

2.4. The Cambridgeshire Health & Wellbeing Board Development session in March 2017 session asked officers to redesign current partnership delivery arrangements to improve efficiencies (less meetings), reduce duplication (join-up delivery and governance arrangements) and embed a "shared people and place-based" approach to delivering health & wellbeing outcomes for residents.

2.5. This paper outlines for discussion an approach to joining-up actions across the Health and Care Executive (HCE) and Public Services Board (PSB) organisations to improve Cambridgeshire & Peterborough's "Population Health System" working. Key changes proposed are:

a) **Collective Leadership & Governance** HCE & PSB, with the addition of the Community Voluntary Service (CVS), have now aligned their current meetings schedule every quarter to form a "whole system" programme sponsoring group to manage governance and oversee joint delivery.

b) **Living Well Area Partnerships** The formation of 4 “Shared people and place-based” delivery groups is underway, covering Peterborough, Huntingdonshire, East Cambridgeshire & Fenland, and Cambridge City & South Cambridgeshire. These will form the “go-to” meetings to build relationships, take operational decisions to translate agreed policy into “on-the-ground” change, and ensure benefits are realised for local residents and communities. They will replace current Local Health Partnerships and CCG Area Executive Partnerships which will cease. Opportunities will be explored to also merge with Community Safety Partnership meetings.

c) **Aligning Budgets & Resources** Better use will be made of the huge, combined “mainstream” staff and budgets each Partner has, with clear links into STP, BCF and other funding streams.

5. The 4 Living Well Area Partnerships footprints are based on joining-up on current District Council boundaries. It is proposed that the 4 footprints are kept under local review to ensure no barriers to effective working are created with health system operational areas.

6. The Living Well Area Partnerships will report into the joint HCE / PSB Chief Executives’ meeting to provide strategic leadership, planning and resourcing. The joint HCE / PSB meeting will agree papers to go forward to the Health & Wellbeing Boards.

7. Formal decision-making and scrutiny will remain with individual partners and their legal responsibilities. The Cambridgeshire and the Peterborough Health & Wellbeing Boards will continue to provide partnership leadership and agreement and reflect a genuine partnership with health and other organisations.

8. Membership of the Boards will comprise key local organisations engaged in the partnership delivery of health & wellbeing outcomes. This Membership will be kept under review to ensure the Partnerships are effective.

9. Draft Terms of Reference for the Living Well Area Partnerships are attached at Appendix 1 for the Board’s comments.

10. To show commitment to the “Whole System Population Approach” to joint working, all partners are asked to seek their individual organisations’ formal sign-up to the Living Well Concordat. This will streamline governance by replacing the multiple current MoUs and partnering commitments variously in existence. A draft “Living Well Concordat” is provided at Appendix 2 for discussion.

Resource Implications

11. The new Living Well Area Partnerships will reduce the number of meetings that Councillors and officers must attend by joining-up and replacing Local Health Partnership and Area Executive Partnership meetings. It is anticipated that arrangement of Living Well Area Partnership meetings will be undertake by District Councils with existing resources.

5 SOURCES

Source Documents	Location
King's Fund paper, "Population Health Systems: Going Beyond Integrated Care" The NHS Five Year Forward View	Contact: M Hill Mike.Hill@scambs.gov.uk 01954 713229

Living Well Partnership

Terms of Reference

Purpose

To provide operational leadership of a "whole system" partnership approach to the local delivery and implementation of "living well" health and wellbeing improvements, care model designs, service improvements and savings opportunities identified at a system level in Health & Wellbeing Strategy, Public Health Priorities, Sustainability & Transformation Plan, and Better Care Fund.

Principles

Living Well Partnerships (LWP) will add value by working together and joining-up areas of common interest by:

1. Understanding the health and wellbeing needs and outcomes of its local populations of all ages, related to e.g. access to services, wider determinants of health, health and wellbeing in its widest sense.

2. Demonstrating successful delivery through effective programme and performance management of Health and Wellbeing Board, System Transformation Partnership and Better Care Fund system-wide priorities, plus local initiatives, ideas and priorities.

3. Ensure agreed outcomes are delivered, taking into account local relationships, local residents' needs, and differing local strengths, assets and priorities.

4. Focusing on aligning and better using partners' "mainstream" resources.

5. Support the General Practice Forward View and Mental Health Forward View strategies at a local level through co-ordination and connection with local initiatives

Accountabilities

1. Improve patient experience and outcomes on the ground for local people by overseeing the adoption, design and integrated local implementation of system-wide health improvement and wellbeing priorities.

2. Provide operational leadership, and stakeholder, clinical, and professional expertise to local partner organisations to enable them to join-up and improve integration of partnership contributions to improving the health and wellbeing of our "shared people" in our "shared place".

3. Develop and own local delivery plans, adopting a programme management approach to the monitoring and reporting of local delivery progress, risks, and resident and patient benefits realisation.

4. To support delivery of strategies and projects delegated from the following Boards; Integrated Commissioning Board, Health & Wellbeing Board, Public

Health Reference Group, Public Services Board/Health Care Executive, Accident & Emergency Delivery Boards, System Transformation Partnership Delivery Boards, Joint Commissioning Unit for Children and Young People, and Crime and Disorder Partnership to ensure joined-up delivery.

5. Report quarterly to the Health and Wellbeing Board and the Joint Meeting of the Health Care Executive and Public Service Board.

6. Develop and oversee delivery of a local engagement and communication plan, and ensure partners get information to the right people at the right time through an effective information sharing system.

7. Provide a forum that can facilitate learning and sharing good practice about what each partner does and can do.

8. Encourage a partnership response to address gaps in service and identified need and where necessary, to minimise any associated impact.

Meeting arrangements

Notice of Meetings
Meetings of the LWP will be convened by local Districts to arrange the venue, clerking and recording of meetings. Agenda-setting teleconference to take place each month with key partners.

Chairmanship
Health representative preferred by Partners

Meeting Frequency
Every 1/2 months, based on business need, including receiving a full Programme Board report every quarter.

Membership
As a minimum, the Living Well Partnerships will comprise Senior Officers or substitutes from:

Core Group:
Patient Representatives
Healthwatch
Relevant CCG Director of Transformation
Local GP representatives or Primary Care Management Lead
NHS Foundation Trusts (relevant to local area)
Cambridgeshire and Peterborough NHS Foundation Trust
Cambridgeshire County Council / Peterborough City Council
District Council representatives
Public Health representative
Cambridgeshire Community Services
Pharmacists representative
Community & Voluntary Sector rep

As required:
Police, Fire & Rescue, East of England Ambulance Trust
Other partners as relevant.

Conflicts of Interest
Members of the LWP will be required to declare any conflicts of interest.

Reporting / Governance
Living Well Partnerships will report to the joint Health Care Executive/Public Services Board on a quarterly basis. The Health Care Executive/Public Services Board will agree reports to be sent to individual Partner's governance processes and to Health & Wellbeing Boards.

Status of Reports/Meeting
LWP meetings will not be public meetings. Agendas and minutes will be published.

Impact on Other Boards
Living Well Partnerships will replace separate Local Health Partnership and Area Executive Partnership meetings, both of which will end.

Equality statement
Members of the Living Well Partnership will ensure that these terms of reference are applied in a fair and reasonable manner that does not discriminate on such grounds as race, gender, disability, sexual orientation, age, religion or belief.

Review of Terms of Reference
The Terms of Reference will be reviewed on a bi-annual basis, or sooner if required.

Approval

Author: (name and role:	
Approved by	
Date approved:	

Cambridgeshire & Peterborough "Living Well" Partnership Charter

Our Shared Ambition & Commitment

Local residents in new and existing communities across Cambridgeshire and Peterborough will maintain and improve their physical and mental health & wellbeing, supported by joined-up, sustainable, prevention and treatment services, delivered in local "Place-based" partnerships, now and in the future.

We commit to taking a "whole system, population health", partnership approach to making an impact on and delivering health outcomes for local residents and communities, recognising that preventing ill-health, improving health, and supporting residents "living well" is not just the responsibility of health professionals, but requires co-ordinated efforts, influencing, action and alignment across central and local government, health services, local communities and individuals.

Partnership Principles & Behaviours

1. We will take a "People & Place-based" approach, working with and through local communities to support them "living well", building on their skills, strengths, resilience and local knowledge, to make an impact and deliver real outcomes.
2. We are all equal partners (not just "consultees"), joining-up and balancing clinical, prevention, and community solutions, valuing the contribution we each bring to our residents and communities.
3. We will share and join-up our resources for the benefit of local residents, just as those residents expect us to.
4. We will take a "public purse, whole system" approach to funding our work, avoiding unfair subsidisation and cost-shunting.
5. We respect and acknowledge the different organisational, legal, contractual, decision-making and political arrangements impacting on partners and will look to find ways to use these as strengths to underpin our partnership working.
6. Not all partners will be able to do everything at the same time. However, those that can, will; those that cannot will not stop those that can.
7. We will challenge each other to improve our services and partnership working, sharing and embedding learning.
8. We will take creative advantage of established, mainstream resources, structures and processes to deliver outcomes and influence the future, eliminating duplication and bureaucracy.

Signatories

To:	**Health and Wellbeing Board**
Meeting Date:	**01 February 2018**
From:	**Sustainability & Transformation Plan (STP) Update Report**
	Presented By:
	Catherine Pollard, Executive Programme Director Cambridgeshire & Peterborough System Delivery Unit
	Aidan Fallon, Head of Communication & Engagement Cambridgeshire & Peterborough System Delivery Unit
Recommendation:	**The Health and Wellbeing Board is asked to note this update report**

	Officer contact:
Name:	Aidan Fallon
Post:	Head of Communications & Engagement (C&P STP)
Email:	Aidan.fallon1@nhs.net
Tel:	07970 195351

1. PURPOSE

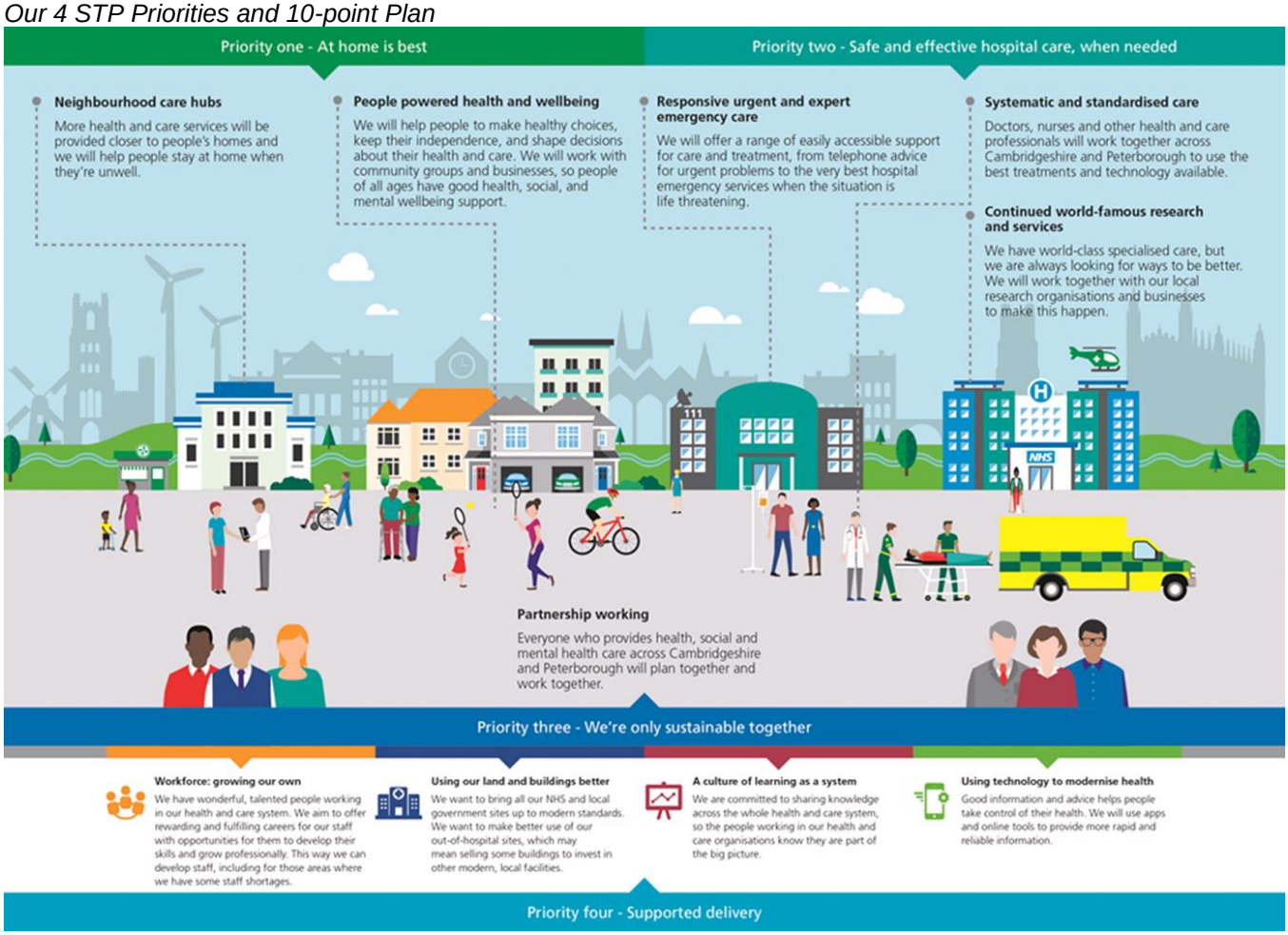
1.1 The purpose of this report is to meet the request from the Health & Wellbeing Board for an update on the Sustainability & Transformation Plan.

2. BACKGROUND

2.1 The local health system in Cambridgeshire & Peterborough agreed a single Sustainability and Transformation Partnership (STP) plan for 2016 – 2021, which was approved by NHS England (NHSE) and NHS Improvement (NHSI) and was published in October 2016.

2.2 The STP set out an ambitious 10-point plan around four priorities for change (See Infographic Below): At home is best; safe and effective hospital care, when needed; we're only sustainable together; and supported delivery. This paper summarises the progress made to date in seeking to achieve these four priorities as well as outlining what's ahead for 2018.

Our 4 STP Priorities and 10-point Plan



2.3 NHSE published the *Next Steps on the NHS Five Year Forward* View in March 2017, which reviewed the progress made since the launch of the NHS Five Year Forward View in October 2014 and set out a series of practical and realistic steps for the NHS to deliver a better, more joined-up and more responsive NHS in England. The Next Steps document outlined that, from April 2017, all NHS organisations must form Sustainability and Transformation Partnerships and establish an STP Board drawn from constituent organisations, including appropriate non-executive, general practice, and local government participation. This paper outlines the revised governance arrangements that are currently being approved by the partner NHS organisations and the Board is asked to note these revised arrangements.

3. PROGRESS MADE IN THE FIRST YEAR OF THE STP

3.1 Priority 1: At home is best

3.1.1 Through the Primary Care and Integrated Neighbourhood (PCIN) Delivery Group, we have focussed on universal adoption of evidenced based practice for people with long-term conditions, including people with mental health needs. This has led to the investment of £1m in respiratory, stroke prevention and falls prevention services. We have also been awarded £1.9m diabetes funding from the national bids.

3.1.2 As a specific example, a Suicide Prevention service went live in December 2017, which is aimed at reducing the likelihood of suicides through providing GP training and the appointment of a bereavement officer to support those who have been affected by the suicide of a loved one, as these are at greater risk of suicide. It is expected that both aspects of this service will utilise existing services such as PRISM (enhanced primary care service for people with mental health problems) to ensure the right support is being accessed by those who need it. Scoping has also begun on the current wraparound services with a view to establishing peer support groups.

3.2 Priority 2: Safe and effective hospital care, when needed

3.2.1 The focus in 2017/18 has been on addressing avoidable hospital admissions and reducing length of stay in hospital by creating more community based services and capacity to care for people in more appropriate settings. This work is being driven mainly through the Urgent & Emergency Care (UEC) Delivery Group.

3.2.2 We have invested £2m to expand our Joint Emergency Team (JET) with more than 70 additional staff and, as of the end of December, almost 50 job offers have been made with approximately 20 new staff in post. The latest audit on JET utilisation confirmed that admission avoidance has increased from 42% (July to September 2017), to 54% in October 2017.

3.2.3 The Discharge to Assess service was established and focusses on people in hospital who are at a point where care and assessment can safely be continued in a non-hospital setting and they do not require an acute hospital bed, but may still require care services. The principle is to provide short term, funded support for patients so they can be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person. To deliver Discharge to Asses, we are investing over £4.8m in 2017/18 to recruit 155 additional posts (mainly Integrated Care Workers) and the creation of a single point of coordination.

3.2.4 We are investing £0.7m to establish a Stroke Early Supported Discharge (ESD) service which has, from January 2018, started to provide both intensive stroke discharge support and home-based neuro rehabilitation. The operational model will result in therapy staff rotating between hospitals, the community based neuro rehabilitation teams and the stroke ESD team. This will result in an enhanced and multidisciplinary team with better joint working and communication across the patient pathway. We are currently recruiting to 35 additional posts to provide this service, which goes live in the south of the county this month (January 2018) and in the north of the county in the spring.

3.2.5 The Care Advisory Group (CAG) has also endorsed clinical strategies on Cardiology, Cancer, Asthma and Musculoskeletal. These strategies are now being turned into Business Cases, in preparation for a phased implementation. Seven additional triage models have gone live so far this year across the system and a business case to support cancer patients in the community, reduce unnecessary admissions to hospital and improve patient care and experience was approved.

3.3 Priority 3: We're only sustainable together

3.3.1 In November 2016, the system created a System Delivery Unit (SDU), which currently comprises of approximately 22 staff to oversee and support delivery of the STP. The SDU launched an STP Programme Cycle in June 2017, which provided a clear and consistent structure to frame the various processes across the STP to ensure appropriate accountability across the 'lifecycle' of the STP improvement projects.

3.3.2 In early 2017, we moved from the planning phase to the delivery phase of the STP. We put in place STP programme arrangements, with a delivery governance structure to ensure effective implementation. Both our governance and working structures includes clinicians and other front-line staff from system partners as well as patient and public representation. To ensure all transformation is consistently clinically led, we are establishing Clinical Communities to lead priority areas for service redesign, including Ageing Well, Cardiology and Respiratory. Each community has a clinical chair and membership from across the clinical pathway (including primary care and patients).

3.3.3 To meet the requirements of the *Next Steps on the NHS Five Year Forward View*, we established, in shadow form, an STP Board in August 2017, made up of NHS system Chairs and Chief Executives, as well as social services local authority colleagues. The system governance arrangements and documentation have, therefore, needed to be reviewed and revised to ensure that the STP Board is reflected as well as the necessary changes to the structures for delivering the STP. The STP Board endorsed a revised Memorandum of Understanding and Governance Framework on the 30 November 2017 and these are attached at Appendix 1 and 2.

3.3.4 The Health & Wellbeing Board is asked to note that, although the Memorandum of understanding has been updated, there has been no change to the appendix containing Local Authority signup.

3.4 Priority 4: Supported delivery

3.4.1 We face a number of challenges to make sure we have the right numbers of the right staff in the right care location. To address these challenges, we have developed a system-wide five-year workforce strategy.

3.4.2 We continue to recruit to a range of new county-wide jobs to enable us to deliver our new and expanded community based patient services (see 3.1 and 3.2 above), and meet our staffing needs. Our recent recruitment successes to system-wide services include:

- Falls prevention services have 4 new staff.
- Heart failure services have made 8 job offers.
- Diabetes services have made 18 job offers.
- 392 apprentices have been recruited in 2016/17, and we have a target to recruit a

further 550 apprentices in 2017/18.

3.4.3 We have not made as much progress as we would have liked on working together to realise the potential digital technology offers us, and to overcome information sharing barriers that could improve patient care and experience. To address this, we have recruited a Technology & Information Advisor to lead the system-wide digital agenda, together with a newly appointed clinical lead for digital. We have also re-established a Digital Delivery Group comprising all the system partners and who's role is to drive the digital agenda. This group will meet for the first time in February 2018.

4. LOOKING AHEAD TO 2018

4.1 Over the past year, the system has made significant progress in establishing infrastructure for system working, strengthening relationships for working across organisational boundaries and making investments collectively in out-of-hospital care. While this work has yet to lead to the required reductions in demand for urgent care services and improvement in our financial situation, the STP Board has confirmed their commitment to continuing to adopt the beneficial behaviours of an accountable care system. With the encouragement of NHS England and NHS Improvement, we will continue to evolve how we deliver transformation through working in partnership. This also aligns to the Health & Wellbeing Board's Strategic Priority for 2018-2021 to *work better together and promote integration*.

4.2 To improve our operational and financial sustainability in 2018, we need to increase A&E performance to 95%, reduce Delayed Transfers of Care (DTOC) to 3.5% and achieve our financial control totals. This is going to require a different approach to delivery – we must:

- Focus on a small number of areas to make a step-change in integrated working and really innovate, based on where it will make the biggest difference;
- Choose some quick-wins to celebrate success and build confidence;
- Learn from examples of success, for example:
  i. Deaths from cardiovascular disease in the north of the county have significantly reduced;
  ii. Integrated working across health and the local authority in children's services;
- Seek national recognition and funding for areas where we are already uniquely strong – cardiology and cancer;
- Be realistic in our ambitions, using data to give us credibility in our negotiations with the regulators – on the money and on the timing of National Must Dos;
- Recognise how differently we'll be asking out staff to work, which means we must invest the time and effort as leaders for setting out the vision for doing so, and providing the necessary support;
- Tailor approaches to local area's assets and needs;
- Embed prevention in every project in line with the Health & Wellbeing Board's strategic priority for 2018-2021 on *prevention and behaviour change*; and
- Be brave.

4.3 Our emerging areas of focus are:
- *Four areas of innovation* –
  i. Supporting primary care by accelerating new models of working at scale and addressing workload challenges.
  ii. Integrated (urgent) care, enabled by community care for the elderly.
  iii. Elective demand management for MSK and through advice & guidance.
  iv. Digital, including information governance, *data lakes* and collaboration;

- *Three areas for national recognition* – Cardiology, Cancer and Digital; and
- *Two quick wins* – Shared Services (likely to be collaboration around estates and Workforce (including exploring collaboration around bank & agency, apprenticeships and international recruitment).

4.4 The areas of focus listed above are not the sum total of work to be undertaken by system partners – we will continue with 'business as usual' improvement programmes to reduce the system costs of care or take forward local strategic initiatives, for example, the relocation to New Papworth (Autumn 2018).

4.5 Moreover, to ensure we balance focus on a small number of system solutions with the breadth of challenge we face, given our financial pressures, we must revisit how we resource transformation (through pooling project support and continuing to make system investments), how we remove any financial disincentives, and how we build a culture of delivery. We will also have to revisit how the system structured to see how it can be streamlined when considered alongside other governance and working arrangements.

5. CONCLUSION

5.1 The Health & Wellbeing Board is asked to note and comment on this STP update report.

6 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

6.1 The STP is relevant to all of the Health and Wellbeing Board's Strategic priorities for 2018-2021:

1) Better Care Fund Plan Implementation;
2) Mental health;
3) Prevention and Behaviour Change;
4) Healthy new housing developments and population growth;
5) Addressing health inequalities identified in the Joint Strategic Needs Assessment; and
6) Working better together and promoting integration.

Appendix 1: *STP Memorandum of Understanding*

Appendix 2: STP Governance Framework

Fit for the Future
Working together to keep people well

Cambridgeshire and Peterborough Sustainability and Transformation Partnership

Memorandum of Understanding

Cambridgeshire and Peterborough Health and Care System

November 2017

Memorandum of Understanding: Cambridgeshire & Peterborough Health and Care System – a Partnership for implementing the Sustainability and Transformation Partnership

Date effective: **[Date to be confirmed]** Signatories 'The partners', the CEOs/Accountable Officers and Chairs of:

1. NHS Cambridgeshire and Peterborough Clinical Commissioning Group (C&PCCG)
2. Cambridgeshire University Hospital NHS Foundation Trust (CUHFT)
3. Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
4. Cambridgeshire Community Services NHS Trust (CCS)
5. North West Anglia NHS Foundation Trust (NWAngliaFT)
6. Papworth Hospital NHS Foundation Trust (Papworth)
7. Peterborough City Council (PCC): (CEO & HWB Chair) – Appendix 1 only
8. Cambridgeshire County Council (CCC): (CEO & HWB Chair) – Appendix 1 only

In future, others may wish to join or become more formally affiliated with the partnership embodied in this MOU, including East of England Ambulance Trust, Cambridge University Health Partners, NHS England Specialised Commissioning, GP Federations, practices or third sector organisations.

Introduction

Purpose: The local health economy within Cambridgeshire & Peterborough CCG has agreed a single Sustainability and Transformation Partnership (STP) plan for 2016 – 2021, which has been approved by NHSE and NHSI. The STP has been developed with front-line staff and patients, building from an evidence for change that had widespread public and patient involvement. The plan envisages widespread changes to how care is delivered to local people, with far greater emphasis on care being delivered in or close to home, and standardisation of necessary in-hospital care in line with best and most efficient practice. In the small number of instances where changes to the location of services are proposed, there will be formal consultation with the public, following close informal engagement.

In order to deliver this plan and return the system to financial balance, we must manage risk (financial, operational, quality and reputational) through a number of jointly agreed commitments (outlined below) to which the Partners have agreed. The most important of which relate to a new set of behaviours from the System Partners, in order to build long-standing trusting relationships that replicate those of an accountable care system.

Scope: Each of the respective partner organisations have clearly defined accountabilities and responsibilities in line with statute. This MOU describes principles of behaviour and action which pertain to the implementation of the Sustainability and Transformation Partnership. Therefore, this MOU pertains only to those areas of work which have been agreed, by each individual partner organisation, as system improvement areas. The MOU does not relate to individual partners' decisions but to any possible interactions those may have with other partner organisations. Partners are expected to actively engage with each other. Individual major decisions should be raised at the STP Board and Health and Care Executive (HCE) so that the impact on other organisations can be considered.

How this document relates to local authorities, their executive officers and members is described further in Appendix 1

Longevity: The term of the MOU is linked to the anticipated time required to implement the STP, therefore it is expected to expire on 31st March 2021, unless a decision is taken to extend it beyond this. If, during the intervening period, as confidence builds, the responsibility for System decisions are delegated to the STP Board (some decisions may be delegated to HCE), this MOU and the associated Terms of Reference for all relevant System groups will be amended. While, at no stage, can the powers of the STP Board or HCE supersede those of statutory bodies, this MOU nevertheless reflects the minimum level of partnership required to implement the STP.

Commitment 1: One ambition: the STP sets out a five plus year plan to return Cambridgeshire and Peterborough (C&P) to financial, clinical and operational sustainability by developing the beneficial behaviours of an accountable care system, and thereby addressing the underlying drivers of the current system deficit. This means acting as a single executive leadership team, and operating under an aligned set of incentives to coordinate System improvements for the benefits of local residents and healthcare users by:

- Supporting local people to take an active and full role in their own health
- Preventing health deterioration and promoting independence
- Using the best, evidence-based, means to deliver on outcomes that matter
- Focussing on what adds value (and stopping what does not)

Such organisational altruism is fully congruent with Partners' duties to the public and is necessary to return each organisation individually to financial balance.

The Partners accept collective responsibility for delivering the plan in its totality. Together, we own the opening risk and agree that the plan, whilst challenging, is deliverable. However, in practice, the Partners recognise external influences and pressures each is subject to. We commit to honest, transparent, and mutual support of each other's position in circumstances where we may be able to help others and influence the view of regulators or external assurance bodies regarding the primacy of System sustainability entailed in this plan and the joint commitment to it.

Our immediate priorities will be agreed collectively and reflect local Health and Wellbeing strategies, together with addressing clinical and operational pressures. However, given resources are scarce, priority will be accorded to projects with the greatest expected return on investment and/or fixing what is most broken – for example high levels of non-elective beddays per capita and high proportions of beds being occupied by patients whose discharge is delayed. The highest impact projects will be properly resourced with the Partners' best people. We will not try to do too many things at once, even though there are many aspects of our health and care system which need improving.

Commitment 2: One set of behaviours: the Partners recognise the scale of change implied by this MOU and the STP. The partners agree that cultural change applies from the STP Board and Board level to front-line staff. By signing this MOU, all Partners agree explicitly to exhibit the beneficial behaviours of an accountable care system. In particular, Partner organisations collectively agree to:

- People first: solutions that best meet the needs of today and tomorrow's local residents and healthcare users must be the guiding principle on which decisions are made. This principle must over-ride individual or organisational self-interest. Embedding the voice and views of service users in service improvement will be key to ensuring this principle is not forgotten.

- Collective decision-making: Chairs, CEOs, SROs and clinical leads have dedicated time *face-to-face* to build trusting relationships, improve mutual understanding and to take shared strategic decisions together. As system leaders, Partners will work together with integrity and the highest standards of professionalism, for example by:
    - Not undermining each other.
    - Speaking well of and respecting each other.
    - Behaving well, especially when things go wrong.
    - Keeping our promises – small and large.
    - Speaking with candour and courage.
    - Delivering on promises made.
    - Seeing success as collective.
    - Sticking to decisions once made.

- Common messaging: there is a consistent set of messages we tell our patients and our staff about why we need to work together, what benefits it will bring and how we are doing it, although how the story is told will be tailored to the audience. Each partner organisation will take full responsibility for making sure their staff are well briefed on system improvement work, drawing from system messages and materials.
- Open book: finance (cost and spend), activity and staffing data are shared between all parties transparently and in a timely manner. This data is held independently by the System Delivery Unit. On a monthly basis actual financial positions of each organisation will be shared with the STP Board and HCE (and bi-partite, as required), with explicit transparency about performance against expected cost saving and demand management trajectories. The purpose of this sharing is to support collaborative problem-solving.

Commitment 3: One long-run plan: The Partners are committed to implementation at pace. By end of 2018/19, the Partners will have achieved the following:

- *Home is best:* fully staffed integrated Neighbourhood Teams will be operational across C&P, providing a proactive and seamless service. General practices will have received support from Partners to be sustainable. Social care will be functionally integrated. The first phase of the prevention strategy will have been implemented.
- *Safe & effective hospital care*: hospital flow will be improved, with a reduction in annual growth rates in non-elective admissions, a fall in bed occupancy and Delayed Transfers of Care (DTOC). Common pathway designs will be in place across all three general acute sites for frailty, stroke, ophthalmology, orthopaedics, ENT and cardiology. All acute services (including fragile ones such as emergency medicine, acute paediatrics, stroke, and others) will be clinically sustainable seven days a week. People will receive consistent urgent and emergency care in the right place, as quickly as possible. More routine urgent and planned care will be managed, with support, within community and primary care, for example by being able to access consultants' opinions without referral.
- *Sustainable together:* We will exploit our collective buying power to get reduced prices, through a common approach to Procurement. The west Pathology Hub will be operational. The merger of Peterborough and Stamford Hospitals NHS Foundation Trust and Hinchingbrooke Healthcare NHS Trust will be fully embedded, and the start of consideration of other organisational consolidation will have commenced. Papworth will have successfully moved onto the Cambridge Biomedical Campus.
- *Enablers:* There will be a single 10-year plan for estates and workforce, a five-year plan for the digital roadmap, and a quality improvement (learning) culture. Local community estates are being modernised. Our workforce recruitment, retention and

reported staff satisfaction will be improved. The first new roles will be in the training pipeline. Patient records securely accessible by any clinician anywhere, where appropriate and relevant to patient care, and a person level linked data set will form the foundation for population health improvement analytics. Staff will have been trained in a common C&P improvement methodology and will have been involved in a system wide improvement project.

Taken together, the Partners believe that these actions give the system the best possible chance of returning to financial balance by 2021. However, capturing the savings opportunities identified will require certain assumptions to be true – for example achieving sustainable DTOC levels consistently below 2.5%. Addressing structural system deficits by securing additional system income by, for example, MFF recalculations and specific structural deficit funding (PFI support, CCG allocation increases, etc.) will also be key to system financial balance.

In many cases bringing about the changes envisaged by the STP can only be achieved with the support of local people and staff, including on occasion, through formal consultation. Therefore, the exact shape of the solutions may change to reflect the feedback and views of local people and staff, the STP is a starting point not fixed destination.

Commitment 4: One programme of work: The HCE will be accountable to the STP Board for delivery of the STP, as such, all System projects will be agreed by the HCE, and under the supervision of a Delivery/Enabling Group. HCE will agree what needs to be done to what end, by who, by when – be they projects done independently or as a System.

- The agreed Delivery Plan identifies the following work streams to be done as a System:
    i. Integrated Neighbourhoods: translating the proactive and preventative care schematic into operational practice, supporting sustainable general practice
    ii. Urgent and Emergency Care: achieving best practice non-elective bed-days per capita
    iii. Planned Care: standardising referral and treatment protocols in line with best practice
    iv. Children, Young People and Maternity: holistic, family-centred care, in line with iThrive, the maternity taskforce and peri-natal mental health
    v. Shared services (including estates): minimising the costs of over-heads
    vi. Digital: implementing the local Digital Roadmap, sharing data and information in a manner consistent with local and national policies and consent
    vii. Workforce: leadership, planning, skills development, recruitment and retention
    viii. General Practice Forward View (GPFV)
- The proposed split of work between System and organisational business will be agreed by the HCE, with new work not starting without HCE ratification.
- The proposed split of System work between what is undertaken once across C&P, and what is undertaken on an area basis will be according to:
    - Phase of project life cycle: design projects must be done once across C&P
    - Locus of relationships: delivery projects should be local where vertical relationships dominate, and C&P wide where horizontal (across acutes) relationships dominate, and
    - Subsidiarity: change happens bottom up, and neighbourhoods across C&P differ significantly.
- Each System project will have a named Senior Responsible Officer (SRO) (Exec level) who is accountable for delivery of the project.
- Each System project will have a delivery objective – a savings, activity shift or quality improvement target (or a combination) and delivery date. Some System projects will have an agreed investment plan.

- The collective impact of System projects will be measured against an agreed definition of success.

Commitment 5: One budget: in line with developing the positive behaviours of an accountable care system, and in recognition of the fact that one organisation's decisions about the level of service may impact another's costs, the Partners agree they will collectively focus on activities that take cost out, make agreed investments in order to save elsewhere, and move deficits to where they should most appropriately fall. System costs may be reduced by activity reductions and by unit cost reductions, and we recognise that all System Partners can influence both. Acting in this way requires:

- Financial incentive design: two year contracts for 2017/18 and 2018/19 contracts will neutralise perverse financial incentives and aim to return the C&P System to financial balance. The Partners agree that the key aim of any incentives will be to focus on addressing the drivers of the system deficit. Financial incentive design options ***may***, therefore, include a combination of:
    - the inclusion of multilateral loss/gain sharing arrangements, for some aspects of C&P CCG commissioned activity;
    - a single System control total which has been negotiated with regulators;
    - alignment of all quality based payments to delivering System priorities (including CQUINs and following agreement with primary care, changes to local enhanced services and/or a local substitute for the QOF);
    - a suspension of non-value adding adjustments to basic cost and volume arrangements such as fines, marginal rates and 30 day readmissions rule (noting that some of these funds currently cover the costs of some community services, which would need alternative funding to be agreed if the services are to continue);
    - a cost plus based approach to local prices for service developments (eg ambulatory care)

  Within this framework and in recognition of the importance of gathering timely and accurate cost data, providers will be paid for the activity they under-take, against an agreed activity trajectory, and commissioners will be responsible for taking decisions about what services can be provided affordably, in line with their legal duties. Due to the lack of incentive to do more activity, even where this would be desirable as it would reduce overall system costs, block contracts should be avoided for all services.
- All parties will exhibit win-win-win behaviours (for patients, providers and commissioners) – any financial recovery plans will be approached as *System* financial recovery plans.
- Contract mechanics for 2017/18 and 2018/19: the least required effort will be dedicated to contract negotiations, with early collective CEO engagement to agree key investment priorities and risk sharing parameters at the outset (rather than at the end). Contract management meetings will be replaced with place or care programme based financial assurance, performance and planning meetings.
- Commissioning intentions will be based on a clinically led, evidence-based and person-focussed appraisal of how best to meet local people's need. Once developed, Partners will discuss openly within HCE any new service developments, closures or relocations prior to public and staff engagement and consultation as required. The HCE and the System Delivery/Enabling Groups will be the fora for agreeing commissioning intentions, including those of the Joint Commissioning Unit.
- Financial and operational plans will be aligned across health and social care: the Partners agree to plan finances and operational capacity together, neutralising any

inclination to cost shift or not invest in one part of the system to save elsewhere. This will involve working from common assumptions, producing plans for regulators that are not works of fiction and doing our best to ensure there are no in-year surprises. Where appropriate, this will also include greater use of pooled budgets between NHS and council commissioners, which will be determined on a case by case basis.

- Savings: Savings will be calculated on the basis of resource utilisation across the entire patient pathway, including all points of care and Partner organisations – thereby capturing direct and indirect savings. Delivery/Enabling Groups will track savings against pre-determined trajectories in a robust and timely manner, with the Executive Programme Director's guidance and SDU support. A named SRO for each project is responsible for making sure savings trajectories are met and/or securing recovery proposals where implementation is not on track.
- Investment: A System Investment Fund (SIF) for system wide investments has been established and is made up of contributions from Partners. In 2017/18 it is likely that due to cash constraints top-up funding will be required and that a System bid to NHS England will be made. Decisions on how to spend this System wide investment and re-investment pot will be taken collectively via an approved gateway process and the Investment Committee. Analysis will be undertaken first to ensure existing resources cannot be safely redeployed/or productively improved before investment can be made. The SIF will come from any STF funds, recycled savings and the CCG's 1% hold-back.

Commitment 6: One set of governance arrangements: the STP Board and the groups reporting to it (HCE, Care Advisory Group, System Delivery Board, Financial Performance and Planning Group, Investment Committee, Clinical Communities and Delivery/Enabling Groups) will be the vehicle through which System business is conducted. All existing arrangements will either be dissolved or aligned.

As much business, as possible that pertains to the system will be conducted via the system governance described in STP Governance Framework. However, it is recognised and accepted that some decisions will need to be referred back to Partners' Boards/Governing Bodies for ratification. Given this may add time before implementation can commence, the limits to the STP Board and HCE's powers must be anticipated, and accommodated in planning. The STP Governance Framework describes decision making processes and roles and responsibilities of individual groups and organisations in detail.

Commitment 7: One delivery team: resources are in place to deliver the STP. This means:

- System Delivery Unit: A new SDU led by an Independent Chair and Executive Programme Director will be created from October 2016. The Independent Chair and Executive Programme Director will be invited to attend Partners' Boards regularly to provide updates on the STP. The SDU will have a budget agreed by HCE (delegated by the STP Board) to employ staff, funded jointly by NHS Partners (see Appendix 2). The SDU will be responsible for:
    - Finance, Evaluation & Analytics
    - System Strategy, Planning and Development

  The System Delivery Unit is primarily envisaged as adding much needed analytics, project management, quality improvement, problem solving capacity to the system and coordinating of assurance to NHS England/NHS Improvement. However, it will be responsible for giving assurance to the STP Board that the STP plan and its future modifications is being appropriately delivered, on budget and to planned timelines.
- Alignment of resources: We recognise the scale of change required to deliver the STP, and all Partners commit to align our staff and, by prior HCE agreement, funds to deliver these changes. This may include prioritising the availability of staff for STP planning and

implementation, the voluntary secondment/loan of staff and other such pragmatic arrangements – in recognition that delivering the STP is essential to each organisation's individual sustainability strategy. Through the delivery planning process, each prioritised project will be allocated staff, from across Partners. These, 'aligned' staff will be expected to dedicate the bulk of their time to the system work – with up front negotiations about what may need to be stopped as a result. SROs and if necessary Delivery/Enabling Group chairs will be expected to escalate to the employer if they feel staff are not being released as agreed. The employing Partner will be expected to rectify the situation within two weeks. The SDU will make transparent the relevant WTE contributions (clinical and managerial) from each Partner organisation, to ensure the burden of effort is fairly shared.

- Assets: in addition to Partners' employees we agree there are other assets which can help deliver the STP, including local communities and Health and Wellbeing Boards. Partners will explore how existing relationships with the Universities, Charitable trusts, local business, informal carers and other public services (like the Fire Service) can be exploited for the benefit of the System. All Partners will highlight opportunities for leveraging these assets for the benefit of the System and will represent the System's interests as well as their own.
- Skills development: where our staff do not have the required skills and expertise to deliver the scale and nature of the change required, we will recognise and address this. It's important that our people are in the right roles.

Commitment 8: One assurance and risk management framework.

- Crucial to strengthening trust and creating a sense of shared accountability, will be evolving the HCE from a forum for making strategic decisions, to one where Partners can be assured of the delivery of System wide improvements. The System Delivery Unit is responsible for monitoring implementation of the STP plan and giving such assurance to the HCE about delivery of the plan. The SDU will provide timely, and regular reporting to the STP Board, HCE, Care Advisory Group, System Delivery Board, Financial Performance and Planning Group, Investment Committee, Clinical Communities and Delivery/Enabling Groups to give mutual assurance that the Delivery plan is on track. A small number of new monitoring dashboards will be developed by the SDU for this purpose, subject to the agreement of the HCE and/or relevant Delivery/Enabling Group chair. In exceptional circumstances, new data items may be collected, but the default presumption is that existing data items will be used (even if these are not normally shared beyond organisations). Once the data collection is agreed, accurate data will be supplied on time.
- Inevitably, things will not go as planned, and there are already many risks that planned impacts will not be realised. Some of these risks will be best managed individually, but many can only be effectively managed by the Partners together. The Partners therefore agree that mitigations will be more effective if they are done together. Transparency around risk/risk mitigation is non-negotiable. Whilst it is difficult to specify in advance the actions that may be required to address risks to delivering the STP, we agree about the process:
    - A STP Programme Risk Register maintains emerging risks to both the agreed delivery plan and agreed mitigations;
    - Care Advisory Group, System Delivery Board, Financial Performance and Planning Group, Investment Committee, Clinical Communities and Delivery/Enabling Groups are required to adhere to the STP's Assurance Framework and Risk Register.
    - Project SROs are expected to deliver all actions to the pre-agreed time-table of milestones – repeated risks and issues regarding process delays due to poor project management and oversight, which are within the control of the SRO will

be escalated by the Executive Programme Director to the employing CEO via the System Delivery Board.

- For the purposes of this agreement, risk is not narrowly defined; examples include reputational, clinical, governance, performance against targets and financial risks.
- Select risks will be reviewed by Boards each month in accordance with the STP's Risk Assurance Framework.

Appendices

1. Local Authorities and the C&P Sustainability and Transformation Plan.
2. SDU Financing: Funding split (%); Initial budget for the SDU; legally binding arrangements for sharing SDU costs (expected and unexpected)

CAMBRIDGESHIRE AND PETERBOROUGH
SUSTAINABILITY AND TRANSFORMATION PROGRAMME
MEMORANDUM OF UNDERSTANDING

Appendix 1: Local Authorities and the C&P Sustainability and Transformation Plan

Introduction

- The local health economy within the Cambridgeshire & Peterborough Clinical Commissioning Group area has agreed a single Sustainability and Transformation Plan (STP) for 2016 – 2021, which has been approved by NHS England and NHS Improvement.

- All partners share an ambition to return the health and care system in Cambridgeshire and Peterborough to financial, clinical and operational sustainability, coordinating System improvements for the benefits of local residents and healthcare users by:
  - Supporting local people to take an active and full role in their own health
  - Promoting health, preventing health deterioration and promoting independence
  - Using the best, evidence-based, means to deliver on outcomes that matter
  - Focussing on what adds value (and stopping what doesn't)

  Cambridgeshire County Council (CCC) and Peterborough City Council (PCC) are key stakeholders in the development and delivery of the STP and will act as partners in the STP by working together to find solutions to ensure that healthcare, public health and social care services are aligned. However the Councils will only be able to do this in line with their statutory responsibilities, democratic and constitutional duties in the local authorities' governance arrangements

- The Cambridgeshire District and City Councils, which are members of the Cambridgeshire Health and Wellbeing Board, exercise a number of relevant functions including housing, land use planning, leisure services etc, which may also align to the wider STP Programme, and which are subject to their own democratic and constitutional arrangements.

- All partners across local authorities and the NHS are expected to support local Health and Wellbeing Strategies and Better Care Fund Plans. NHS partners will ensure that STP delivery is aligned with these wider partnership strategies and plans.

- An agreed set of behaviours and principles has been developed in order for CCC, PCC and the wider local authority membership of the HWB Board to support (and be supported) in the contribution to and delivery of the STP.

- These behaviours and principles outline how CCC, PCC and the wider local authority HWB Board membership will work together with the Health system, whilst adhering to their statutory duties and democratic and constitutional duties in the local authorities' governance arrangements

Key Behaviours:

CCC, PCC and the wider local authority Health and Wellbeing Board membership recognise the scale of change required to deliver the STP and that cultural change applies from leadership level to front line staff.

CCC, PCC and the wider local authority Health and Wellbeing Board membership will continue to build and promote trusting relationships, mutual understanding and where feasible take decisions together with the health system.

CCC and PCC representatives on the Health and Care Executive (HCE) will take full responsibility for making sure their staff are well briefed on system improvement work, drawing from system messages and materials. The HCE will ensure that relevant system messages and materials are shared with the wider HWB Board membership.

All members of the Health Care Executive and the Health and Wellbeing Boards will support and promote system behaviours for the benefit of local residents and healthcare users including:

- Working together and not undermining each other
- Behaving well, especially when things go wrong
- Engaging in honest and open discussion
- Keeping our promises – small and large
- Seeing success as collective
- Carrying through decisions once made

Key Principles:

The key principles of local authorities working with partners to deliver the STP plan are:

- Commitment to implementation at pace
- Use collective commissioning and buying opportunities to improve delivery outcomes and/or system savings
- Where appropriate, HCE representatives and other senior local authority officers to act as if part of a single executive leadership team, to coordinate system improvements for the benefits of local residents in line with the STP.
- Influence the view of regulators and external assurance bodies regarding the primacy of System sustainability enshrined in the STP and the joint commitment to it.
- Highlight and work to prevent cost shunting to other partners, subject to statutory requirements on both partners. (This should not preclude negotiation of agreements on pooled funding for specific services or areas of work).
- Adopt an invest to save approach

- Share information on new major service developments, savings, closures or relocations, and more generally share information in a timely manner when needed to support development of partnership business cases and savings plans. This should comply with existing information sharing agreements and protocols.

- Align human, financial, estate and digital resources to deliver these changes where this adds value, delivers people-centred outcomes and saves money.

Democratic requirements and local authority governance

- CCC and PCC will participate in the Health and Care Executive (HCE) arrangements through their senior officer representatives acting as non-voting members of the HCE. This arrangement will recognise that local authority policy and financial decisions are subject to the constitutional decision making arrangements within their respective authorities, with are led by elected Councillors.

- CCC, PCC and Cambridgeshire District and City Councils will also participate in and support the STP through their local Health and Wellbeing Boards and shared programme management arrangements. Again, this arrangement will recognise that local authority policy and financial decisions are subject to the constitutional decision making arrangements within their respective authorities, which are led by elected Councillors.

- Local authorities support the commitment to longer-term planning, but the Partners recognise that local authorities are subject to democratic governance. Therefore the LAs must reserve the right to change their priorities in accordance with the priorities of their elected Councils

- CCC, PCC and wider local authority HWB Board membership cannot commit to sharing the opening financial risk in the STP, given that local authorities have a statutory requirement to balance their budgets and cannot operate at a deficit. Likewise, NHS partners are not expected to commit to meeting the financial risk of meeting statutory social care requirements.

- CCC and PCC have a particular statutory requirement to scrutinise proposals for NHS service changes as elected representatives of their communities, and must ensure the independence and integrity of those arrangements.

- The role of all Councillors to represent the views of their local constituents and speak up on their behalf is recognised. Councillors have a unique responsibility of advocacy with respect to their constituents. Nothing in this memorandum should undermine that.'

Signed on behalf of Cambridgeshire County Council and Peterborough City Council:

Gillian Beasley ..... Date: 12/1/17

Fit for the Future
Working together to keep people well

Cambridgeshire and Peterborough Sustainability and Transformation Partnership

Governance Framework
November 2017

NHS Cambridgeshire and Peterborough Clinical Commissioning Group
NHS Cambridge University Hospitals NHS Foundation Trust
NHS Cambridgeshire and Peterborough NHS Foundation Trust
NHS Cambridgeshire Community Services NHS Trust
NHS North West Anglia NHS Foundation Trust
NHS Royal Papworth Hospital NHS Foundation Trust
Peterborough City Council
Cambridgeshire County Council

Contents

1. Introduction

1.1 This Framework describes arrangements intended to provide a foundation of good corporate governance, enabling the Sustainability and Transformation Partnership (STP) to implement changes in the way that NHS services will be planned, delivered and experienced in Cambridgeshire and Peterborough. The Framework incorporates the milestones for delivering the STP for Cambridgeshire and Peterborough over the next five years, linked to the NHS Five Year Forward view.

1.2 The STP is formed from the following NHS and partner organisations across Cambridgeshire and Peterborough:

NHS Cambridgeshire and Peterborough Clinical Commissioning Group
Cambridgeshire University Hospital NHS Foundation Trust
Cambridgeshire and Peterborough NHS Foundation Trust
Cambridgeshire Community Services NHS Trust
North West Anglia NHS Foundation Trust
Papworth Hospital NHS Foundation Trust
Cambridgeshire County Council
Peterborough City Council
Local General Practices
East of England Ambulance Service NHS Trust

1.3 Cambridgeshire County Council and Peterborough City Council participate in the STP with the intention to align their public health and social care services in an integrated way. The Councils will participate in the STP through their representatives recognising that their policy and financial decisions are subject to the constitutional arrangements within their respective authorities. The Councils also have a particular requirement to scrutinise proposals for NHS service changes as elected representatives of their communities and must ensure the independence and integrity of those arrangements. The role of the City Council and the district councils exercise a number of relevant housing, planning and other functions, which may also align to this Programme.

1.4 The Sustainability and Transformation Partnership is supported by NHS Improvement and NHS England.

1.5 This Framework sets out the governance arrangements that the STP will adhere to in delivering its functions. It describes how the STP will operate, confirms those matters reserved to individual organisations for decision, describes the various Boards through which the health partners operate and where certain powers of those Boards will be delegated to the STP Board or in turn to the Health and Care Executive (HCE).

1.6 The STP Board is made up of the partner organisations Chairs and Chief Executives who are jointly responsible for ensuring delivery of the STP. The partner organisations will participate in the decision-making processes of the

STP Board to the extent that they are delegated authority by their respective organisations.

Patient and stakeholder engagement is key to shaping the work required to deliver STP. The STP Board will receive regular reports about engagement activities that have taken place with the public and with stakeholders.

2. Sustainability and Transformation Partnership

2.1 The STP exists to identify and drive delivery of strategic changes to the Cambridgeshire and Peterborough NHS health and care system that will both improve outcomes for local people, support the population to become healthier and ensure that services are financially sustainable. The STP will also oversee delivery of transformation across the system.

2.2 The Governance Framework applies to the whole lifecycle of the STP.

3. Corporate Governance Framework

3.1 This Framework describes the governance arrangements that have been established to ensure that the STP will operate to deliver its role and functions. It describes how the STP will operate, the decision-making process and how certain powers will be delegated from the STP's national health statutory organisations to the STP Board and its associated sub-committees and workstreams.

3.2 This Framework will be approved by the Boards Governing Bodies and local authority Committees/Cabinets of all partner organisations, and will be reviewed on a regular basis.

4. Principles for Good Governance

4.1 All members of the STP will observe the highest standards of probity in relation to the stewardship of public funds, the management of the STP, and the conduct of its business.

4.2 All members of the STP will adhere to the seven Nolan principles underpinning public office:

- **Selflessness:** holders of public office should take decisions solely in terms of public interest. They should not do so in order to gain financial or other material benefits. In addition, the NHS Commissioning Board will act as a role model to the clinical commissioning system and the NHS as a whole, in adopting and maintaining excellent standards of propriety for themselves, their family and their associates;
- **Integrity:** holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties;

- **Objectivity:** in carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards or benefits, holders of public office should make choices on merit;
- **Accountability:** holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office;
- **Openness:** holders of public office should be as open as possible about all their decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands;
- **Honesty:** holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest; and
- **Leadership:** holders of public office should promote and support these principles by leadership and example.

5. Aims

5.1 Through this Governance Framework, the STP aims to;

- maximise the effectiveness of the STP;
- ensure all partner organisations referred to in Section 1.2 meet their statutory obligations;
- ensure effective stewardship of public funds; and
- be a model of excellence in corporate governance by adopting the highest standards of business conduct.

6. Accountability and Leadership

6.1 The STP is accountable to the statutory organisations of the Cambridgeshire and Peterborough system described in Section 1.2 above, and to the associated regulatory authorities described in Section 1.4 above.

6.2 The STP is committed to openness and transparency in its work, in support of its accountability to patients and public. To that end, public meetings of the Boards, Governing Bodies and local authority committees/cabinets of each organisation are held regularly, and members of the public are welcome to attend and observe these meetings.

6.3 The STP will demonstrate its accountability through:

- Adhering to the Governance Framework, Memorandum of Understanding and STP Assurance Framework.
- Publishing the Sustainability and Transformation Partnership plan.
- Publishing other relevant documentation.
- Working within the Freedom of Information Act Policy.
- Commitment to the Living Well Partnership concordat.

6.4 The STP is committed to putting patients and the public at the heart of its decision-making, and is actively pursuing a wide range of communications and engagement mechanisms to support this commitment.

6.5 The STP Accountable Officer is accountable to the STP Board.

7. Roles and Responsibilities

7.1 Individual Organisations

Each individual organisation being a Member of the STP remains at all times accountable for its own activity and decisions.

7.2 Officers from Individual Organisations

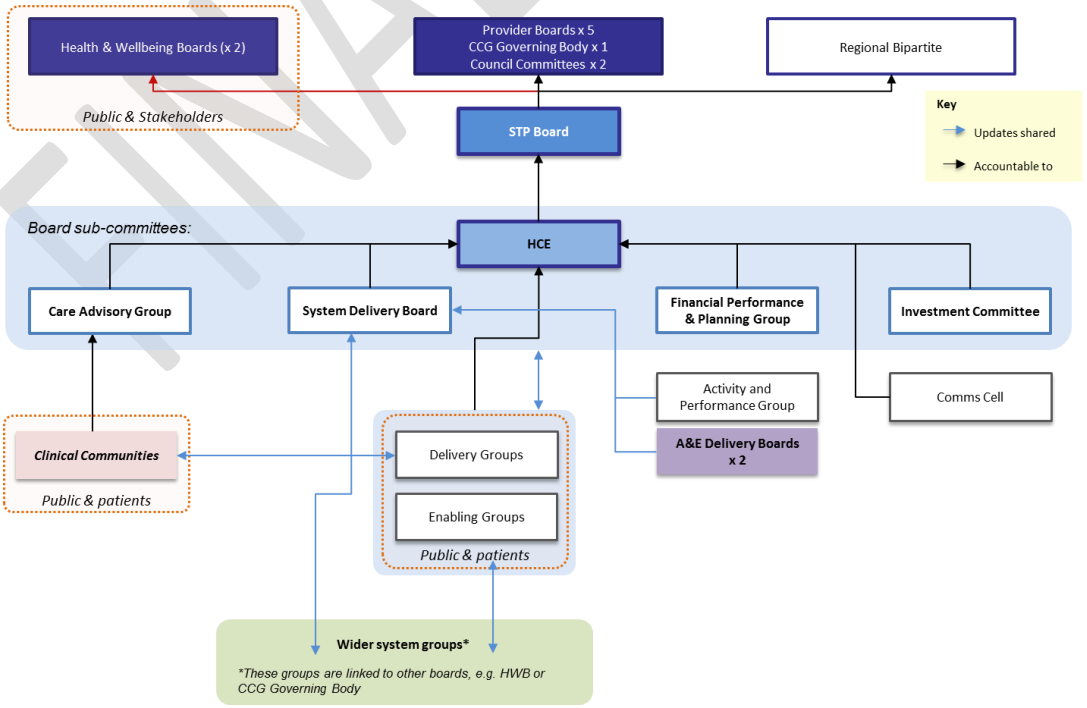
Members need to ensure that they have all necessary delegated permissions to bind the authority on whose behalf they act when making decisions. They must ensure that they adhere to all internal processes when making those decisions.

7.3 System Delivery Unit

The System Delivery Unit (SDU) has been established to oversee, on behalf of the HCE, a programme of work to deliver the STP. The SDU is accountable to the Accountable Officer.

8. Organogram

8.1 The governance structure for the STP is shown below:



8.2 STP Board

The role of the STP Board is described below:

- To focus on the medium and long-term strategy of the STP and answer the 'big' questions, to set the vision for Cambridgeshire and Peterborough's population based on health needs, and ensure the programme is structured to enable this to be delivered.
- To share an ambition to return the health and care system in Cambridgeshire and Peterborough to financial, clinical and operational sustainability by 2021 through developing the beneficial behaviours of an accountable care system.
- To influence the view of regulators or external assurance bodies regarding the primacy of system sustainability entailed in this plan and the joint commitment to it.
- To support and promote system behaviours, as set out in the Memorandum of Understanding, for the benefit of local residents and healthcare users including:
    - Working together and not undermining each other
    - Behaving well, especially when things go wrong
    - Engaging in honest and open discussion
    - Keeping our promises -small and large
    - Seeing success as a collective
    - Carrying through decisions once made
- To provide objective, 'third party' oversight and to act as 'critical friends' to the HCE in order to ensure that the STP's objectives are achieved including holding the HCE to account for the following, as delegated to the STP Board by the relevant Statutory Bodies:
    - Delivery of the STP, through the System Delivery Board which reports to HCE on an exceptional basis.
    - Ensuring that robust accountability, delivery and reporting arrangements are in place.
    - Ensuring the Cambridgeshire and Peterborough STP has in place, and is adhering to, collective governance arrangements including:
        I. a Memorandum of Understanding setting out how organisations will work together to deliver the STP;
        II. a Governance Framework clearly defining the roles and responsibilities of key groups and describing how they interrelate, and;
        III. a risk assurance framework and register.
- To recognise where an individual organisation is standing in the way of a necessary local change or failing to meet their duties of collaboration and seek to address and resolve this; where this is not possible, to escalate the issue to NHS England and NHS Improvement.
- To ensure the system works together to give a common message to service users and the general public; and is inclusive in its work.
- To promote the requirement to complete impact assessments for commissioning and decommissioning of services are completed.
- To foster working collaboratively with Partners, Local Authority and Combined Authority.

8.3 Health and Care Executive

The role of the Health and Care Executive is described below:

- To be collectively responsible for the development and implementation of the Cambridgeshire and Peterborough STP.
- To function as a single executive leadership team, operating under an aligned set of incentives to coordinate action for the benefits of local residents and healthcare users.
- To enact the positive behaviours of an accountable care system.
- To agree common messages to enable one story to be told to staff and patients about why we need to work together, what benefits it will bring and how we are doing it.
- To be honest, transparent, and mutually supportive of the positions of each organisation represented.
- To identify innovation and good practice, and ensure effective diffusion across the system.
- To be accountable to provider Boards, the CCG Governing Body and specified council committees.
- To engage with the Health and Wellbeing Boards for Cambridgeshire and Peterborough in regard to the delivery of the STP.
- To hold to account the following sub-groups of the STP Board, as delegated by the STP Board:
  - Care Advisory Group
  - Financial Performance and Planning Group
  - Investment Committee
  - System Delivery Board
- To hold to account the following delivery vehicles:
  - Clinical Communities
  - Delivery and Enabling Groups
- To determine areas of development and service reconfiguration for the Cambridgeshire and Peterborough health and care system from 2016 through to 2020; to lead a process to prioritise these areas.
- To determine which service change projects need to be done, by whom and by when (be they system change projects or independent change projects within the CCG or provider organisations); to ratify any proposed new work before it can start.
- To sign off all system projects to;
  - ensure that they are allocated to a Delivery or Enabling Group or System group, and;
  - ensure that system projects are assigned an executive level SRO.
- To prioritise projects across the system balancing need to deliver maximum impact quickly with the need to adequately resource each project.
- To report progress and provide assurance to the Regional Bipartite that the STP delivery plan is on track.

- To resolve issues locally, but where this is not possible to escalate unresolved issues to NHS Improvement and NHS England through an agreed Bipartite meeting process.
- Through the chairs of the Delivery/Enabling Groups liaise with and support the Delivery/Enabling Groups as required, providing information, advice and recommendations as appropriate.
- To adhere to the principles described in the STP's Memorandum of Understanding.
- To adhere to the STP's Assurance Framework; this requires the group to maintain a risk register, to review this at every meeting and to review and seek to resolve risks escalated from the other groups in the STP structure.

8.4 Care Advisory Group

The role of the Care Advisory Group is described below:

- To receive and critically review strategies and business cases to improve or transform population health from the groups in the STP structure:
  - Review and comment on care model design proposals from groups in the STP structure. This will require:
    I. Assessing impact on the local population, patients and carers, the overall STP objectives and deliverability.
    II. Considering implications for other groups in the STP structure and cross-cutting themes, and ensuring that proposals are congruent and complementary.
  - Maintain an oversight of the proposals from all groups in the STP structure and ensure alignment between them.
  - Ensure that proposals are developed to address maximising both population health and patient benefit. Aim to reach consensus on all proposals to be submitted to the HCE and where this is not achievable, clearly articulate the relative merits of alternative proposals.
  - Promote care model design proposals that are operationally and financially sustainable.
- To provide overall clinical advice and expertise to the STP, making recommendations to the HCE.
  - Jointly, with the Financial Performance and Planning Group, oversee the completion of business cases, providing clinical assurance.
  - To give clinical assurance, if necessary by drawing on wider expertise outside of the CAG to future iterations of the Cambridgeshire and Peterborough five–year STP and its component parts.
  - Provide other groups involved in the Sustainability and Transformation Partnership with clinical advice and information as necessary, including Quality Impact Assessments for both new business plans and proposed disinvestments.
  - To provide clinical guidance in the design and interpretation of quality and inequality impact assessments required for all current and new service re-design.
- To review progress towards implementation.
  - Report progress using all necessary and agreed analytic methodology to the HCE using an agreed reporting format.

- Provide reports using all necessary and agreed analytics, as requested, to members of the SDU.
- Report risks and issues to the HCE, escalating any unresolved areas
- Resolve issues locally, but where this is not possible to escalate unresolved issues to the HCE through an agreed process.
- Where necessary to provide clinical narrative for the interpretation of health analytic metrics used to monitor service provision and implementation of new models of care.
- Give advice to communications teams concerning the clinical accuracy of publicity and information available to the public and to the health and social care workforce.

- To evaluate service outcomes.
  - Review the evaluation of the new model of care and all relevant services to ensure the original service model and strategy and has been achieved and make recommendations to Health and Care Executive on the future service model.
- To advise on the medium and long-term care/clinical model in the STP.
  - Provide strategic direction; contribute to the vision for improving health and well-being within the STP.
  - Where necessary require Clinical Communities in the STP structure to develop plans to address those new initiatives and present the conclusion, where agreed, to HCE for consideration.
  - To make recommendations for future innovation in service delivery, clinical or translational research that will impact on population and individual health outcomes for the system.
- To adhere to the principles described in the STP's Memorandum of Understanding.
- To adhere to the STP's Assurance Framework; this requires the group to maintain a risk register, to review this at every meeting and to review and seek to resolve risks escalated from the other groups in the STP structure.

8.5 System Delivery Board

The role of the System Delivery Board is described below:

- Tactical and operational decision making:
  - On behalf of the Health & Care Executive, to take decisions that address blocks to progress raised by the Delivery/Enabling Groups and wider STP groups to ensure they remain on track to deliver;
    - I. an agreed programme of system improvements or transformations, and;
    - II. the national 'must dos' held by the STP (including but not limited to: urgent & emergency care; general practice; mental health; cancer; planned care; estates, back office & clinical support services; digital; children's services and maternity; and workforce).
  - To receive updates from the Activity and Performance Group on system activity and financial performance. Where these updates suggest the programme of work is not having the intended impact, the System Delivery Board will work to establish if the agreed programme

of work is sufficient to meet agreed trajectories, and to make recommendations to HCE as required.
    - To work in partnership with CAG, FPPG and Investment Committee to ensure the appropriate balance is found between devolving autonomy and maintaining accountability.
- Operational delivery:
    - To provide collective system leadership and pace-setting for the Delivery Groups and Enabling Groups on behalf of HCE.
    - To offer support, trouble-shooting and constructive challenge to Delivery Groups (including clinical communities who are leading design), and Enabling Groups.
    - To ensure;
        I. all work in design, develop, deploy and deliver phases is meeting critical path milestones;
        II. the Delivery Groups, Enabling Groups, A&E Delivery Boards and system wide groups are cognisant of inter-dependencies between them and these are well managed;
        III. projects in the deploy and deliver phases have the anticipated impact, in line with business case implementation trajectories, and;
        IV. lessons are learnt and shared of what has gone well and what has gone less well.
    - To re-prioritise SDU and system resourcing across projects, balancing the need to deliver maximum impact quickly with the need to adequately resource each project.
    - To sign off a single methodology (captured in the STP Ways of Working document) for project management and programme monitoring.
    - To receive updates from the Integrated Commissioning Board, as relevant.
    - To, by exception, escalate to HCE for resolution, risks and issues escalated by Delivery Groups and Enabling Groups.
    - To receive and sign-off the delivery updates to be received by HCE and the STP Board, and any submissions relating to STP wide delivery to the national regulators.
- Governance:
    - To adhere to the principles described in the STP's Memorandum of Understanding.
    - To report progress and provide assurance to the Health and Care Executive that the STP delivery plan is on track.
    - To provide updates to the Health and Care Executive, STP Board and Bipartite on the delivery of the system improvements and transformations and the National Must Do's.
    - To ensure the Delivery Groups, Enabling Groups, A&E Delivery Boards and wider STP Programme groups commissioned by the HCE;
        I. are working to deliver one or more of the areas identified in the STP plan;
        II. are appropriately resourced;

III. have identified clear outcomes, targets for activity shifts, quality changes or financial savings/growth, timescales for delivery, and agreed associated projects;
IV. are on track to deliver the changes set out above within the agreed timescale, and;
V. report on progress against an agreed set of metrics, and report risks and issues.

- Risk management:
  - To adhere to the STP's Risk Assurance Framework.
  - To ensure that progress, risks and issues are tracked and reported using the agreed methodology.
  - To resolve, or oversee the resolution, of Delivery/Enabling Group risks and issues escalated by other groups in the STP structure. Where this is not possible to escalate unresolved issues to the Health and Care Executive.

8.6 Financial Performance and Planning Group

The role of the Financial Performance and Planning Group is described below:

- To advise the Health and Care Executive (HCE) on system financial sustainability.
- To monitor and report on the financial risks to the implementation of the STP.
- To oversee submission of national financial submissions on behalf of the STP.
- To develop a framework for contracting and incentives, aligning planning assumptions, quality assuring savings and investment proposals and tracking savings progress.
- To monitor and report on the system performance against key national/local metrics.
- To maintain an overview of the delivery and benefits realisation of Cost Improvement Plans (CIP), Quality Innovation Productivity and Prevention (QIPP) and transformation plans.
- To consider and approve business cases for the use of significant system wide financial investments.
- To liaise with non-NHS stakeholders to the STP.
- To report progress to the HCE using an agreed reporting format.
- To resolve issues locally, but where this is not possible to escalate unresolved issues to the HCE through an agreed process.
- To monitor the SDU budget.
- To adhere to the principles described in the STP's Memorandum of Understanding.
- To adhere to the STP's Assurance Framework; this requires the group to maintain a risk register, to review this at every meeting and to review and seek to resolve risks escalated from the other groups in the STP structure.

8.7 Investment Committee

The role of the Investment Committee is described below:

- To ensure that Business Cases submitted for consideration are supported and agreed by NHS and Local Authority.
- To develop criteria against which Business Cases will be assessed.
- To assess and evaluate all Business Cases submitted to the Committee against agreed investment criteria.
- In assessing Business Cases, have due regard to the system's agreed priorities and other pipeline investment cases currently under development, acknowledging that the investment fund cannot finance every case.
- To decide, based on assessment against agreed investment criteria whether to recommend the case for immediate funding in full, or in part, at a later date, subject to further information or not at all.
- To report on a regular basis to the HCE on the level of the System Investment Fund (SIF) committed and uncommitted.
- To review Marginal Rate Emergency Tariff (MRET) funded scheme Business Cases, and decide whether these should be recommended to the HCE for continued funding, or whether these funds should be reinvested in the SIF for other schemes.
- In regards to the Better Care Fund, ensuring there is a process for sharing Business Cases proposals where there are implications for both health and social care.
- To adhere to the principles described in the STP's Memorandum of Understanding.

8.8 Clinical Communities

The role of the Clinical Communities is described below:

- Design clinical strategy and required service changes
    - Review the current patient pathway and identify areas for improvement.
    - Redesign patient pathways covering all elements of patient's care (prevention, emergency care, elective care and primary/community care and where appropriate end of life care) to improve;
        I. Clinical effectiveness and safety
        II. Patient experience
        III. Population health
        IV. Financial sustainability
    - Identify required service improvements, service changes and commissioning arrangements to deliver new model of care and patient pathway
    - Identify clinical, operational and financial outcomes and Key Performance Indicators (KPIs) to enable meaningful evaluation of service changes that are implemented.
    - Accept the financial savings opportunities proposed by the CCG as part of their annual planning as the level of ambition towards which they will work towards.

  - Work closely with finance colleagues to develop an outline business case to (estimate) initial financial outcomes and identify resources required (revenue, capital and non-financial). Make every effort to identify how the redesign, change or improvement can be done within existing resources by working differently.
  - Present clinical strategy and recommended service changes to CAG for approval.
- Review quality and performance.
  - Review benchmarking data, including RightCare, Getting It Right First Time (GIRFT) and relevant national policies, guidance and best practice for specified clinical areas.
  - Review current service clinical performance, clinical indicators and outcomes across the whole patient pathway, including public health, primary, community care and acute care.
  - Review population needs assessments where available, and undertake population needs assessment where not already available for specified clinical areas.
  - Identify innovation and good practice.
  - Implement (tactical improvements/ quick wins).
  - Plan and implement services improvements that are within the gift of the community's members to implement without permission and in line with the STP's governance arrangements.
  - Refine continuously improvements until fully embedded in usual care.
- Evaluate service outcomes.
  - Review the evaluation of the new model of care and all relevant services to ensure the original service model and strategy and has been achieved and make recommendations to Health and Care Executive on the future service model.
  - Review the evaluation of the clinical outcomes against the agreed KPIs to determine whether patient experience, outcomes and financial sustainability has improved as planned and make recommendations to Health and Care Executive on the future service model.
  - Present findings, learning and recommendations to wider STP group via CAG.
- Work collaboratively with stakeholders
  - Demonstrate evidence of patient/carer and public involvement (PPI).
  - Develop systems for accessing patient/carer and public involvement and opinion on specific issues, with support from the STP PPI leads.
  - Review and audit the level of patient/carer feedback, reporting to the Care Advisory Group with support from the STP PPI lead.
  - Engage with Public Health, Local Authorities and the joint Strategic Needs Assessment.
  - Engage with similar clinical networks, NHSE and Specialist Commissioning to share best practice and information.
  - Develop strong working partnerships with the Clinical Senate; the East of England Academic Health Science Networks (AHSNs), Cambridge University Health Partners and the Medical School, NHSE and I), and Local Education and Training Boards (LETBs).
- Operate in accordance with the STP's agreed ways of working

- Work in accordance with the STP's agreed 'ways of working' and programme cycle.
- Adhere to the principles described in the STP's Memorandum of Understanding.
- Adhere to the STP's Assurance Framework.

8.9 Delivery and Enabling Groups

The role of the Delivery and Enabling Groups is described below:

- To contribute to the overall delivery of the STP objectives by ensuring that the quality improvements and financial opportunities identified in the STP realised.
- To be responsible for setting up and ensuring the implantation (including savings realisation) of projects to meet the STP objectives.
- To oversee the delivery of a portfolio of STP projects in order to realise financial savings and achieve quality improvement.
- To improve patient experience and outcomes.
- To provide expertise to support transformational change.
- To monitor progress and risks, and report this as appropriate.
- To establish and oversee Development Groups, that will work up business cases for approval, and Deployment Groups, that will take forward business cases once approved.
- To lead a process to evaluate projects once Deployment is complete, and share the learning from this.
- To adhere to the principles described in the STP's Memorandum of Understanding.
- To adhere to the STP's Assurance Framework.

8.10 Activity and Performance Group

The role of the Activity and Performance Group is described below:

- To review and discuss activity and performance across the system in a non-contractual environment.
- To feedback trends and key insights into Delivery/Enabling Groups and Clinical Communities, which may form part of evaluations.
- To provide reports to the System Delivery Board.
- To recommend and help develop future priorities based on activity and performance levels.
- To compare local and national data sets to answer specific requests by regulators.
- To adhere to the principles described in the STP's Memorandum of Understanding.
- To adhere to the STP's Assurance Framework.

8.11 A&E Delivery Boards

The role of the A&E Delivery Boards is described below:

- To ensure urgent care needs are dealt with in the most appropriate setting by the most appropriate services (which in many cases should not be in A&E departments or acute hospital beds).
- To provide a vehicle for strong and visible front-line clinical leadership and resident/patient involvement.
- To promote a culture of continuous quality improvement.
- To oversee improvement projects that require locality tailoring for successful implementation.
- To deliver nationally mandated improvement initiatives and core responsibilities to lead to A&E recovery.

8.12 System Groups

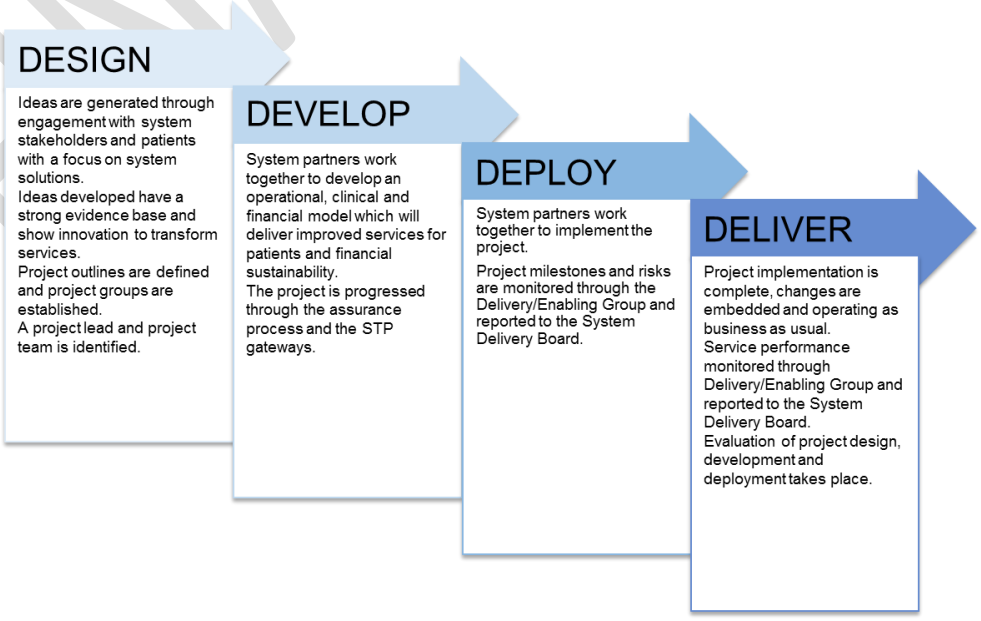
There are a number of aligned workstreams and partner groups which also support the STP such as the *Joint Commissioning Unit, Integrated Commissioning Board and Living Well Area Partnerships.*

9. Delivering the STP

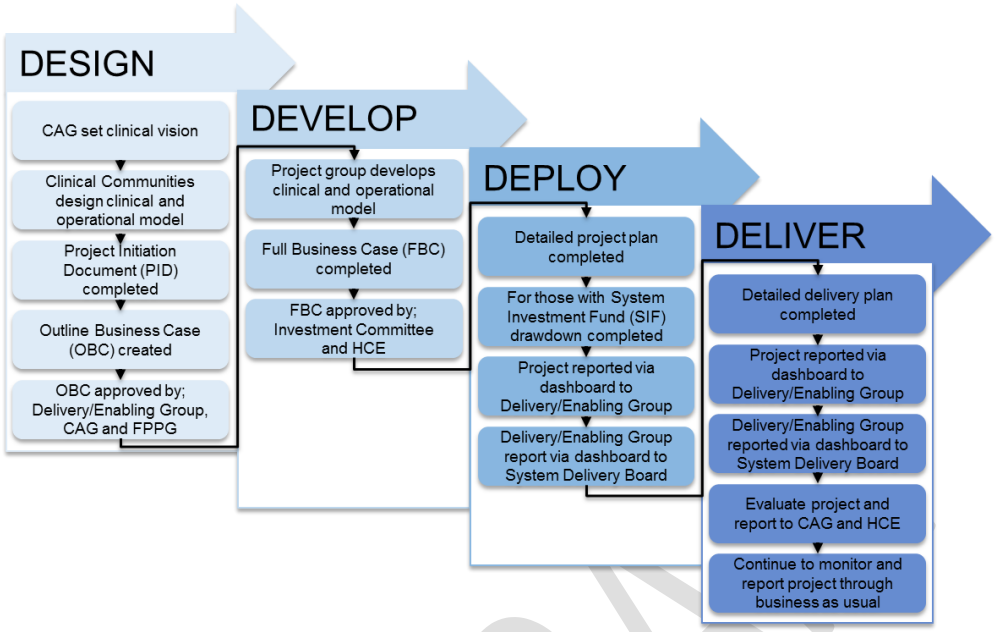
9.1 Overview

As the STP moves from planning into implementation and delivery it is apparent that there needs to be a clear and consistent structure to frame the various processes across the STP to reduce confusion and ensure appropriate accountability across the 'lifecycle' of the STP improvement projects. To support this the SDU has developed a suite of guidance documents and tools which will assist all parties understand at each stage in the improvement project's life (Design, Develop, Deploy and Deliver). This is outlined in the STP Programme Cycle.

The diagram below describes what happens at each stage in an improvement project's life:



The diagram below demonstrates how a project moves through each stage:



9.1.1 Decision Making

Decision making remains with each organisation until/unless authority is delegated to the STP Board or in turn to the Health and Care Executive. All decision-making across the STP will therefore be taken under the Scheme of Delegation set out in the tables below. Urgent Decisions are covered in Section 9.10 below.

In the context of the decision-making process, the following applies:

Endorse – to support decisions that have been made across the STP
Approve – to approve decisions/documentation (in line with Statutory Duties and Functions of all Organisations across the STP)

The decision-making process for the implementation phase of the STP is split into three categories:

1. Proposals that require funding from the STP System Investment Fund
2. Proposals that require local investment (from the CCG, provider organisations or council
3. Proposals that do not require any investment

A summary of these processes appears on the following page. More detail about each process is available in the STP Programme Cycle and Ways of Working document.

Summary of the governance approach for the approval of project proposals

Key GATEWAY 1 | GATEWAY 2

		(1) Governance approach for projects requiring funding from the STP System Investment Fund (SIF)	(2) Governance approach for projects requiring investment from the CCG, provider organisations or council only	(3) Governance approach for projects that do not require any investment
Outline Business Case Stage	Set Clinical Vision	CAG	CAG	CAG
	Approve vision	HCE	HCE	HCE
	Approve Gateway Proposal	Delivery Group	Delivery Group	Delivery Group
	Approve Proposals	CAG | FPPG	CAG | FPPG	CAG | FPPG
Full Business Case Stage	Develop Full Business Case/Final Proposal	Delivery Group Delivery Groups must ensure sign off (e.g. from the CCG CEC, Provider Boards or someone with delegated authority) is achieved before cases proceed to the IC	Delivery Group Delivery Groups must ensure sign off (e.g. from the CCG CEC, Provider Boards or someone with delegated authority) is achieved before cases proceed to the IC	Delivery Group Delivery Groups must ensure sign off (e.g. from the CCG CEC, Provider Boards or someone with delegated authority) is achieved before cases proceed to the IC
	Evaluate Full Business Case	Investment Committee		
	Approve Full Business Case/ Final Proposal (where investment is required) or Agree Final Proposal is in line with STP (where no investment is required)	HCE	HCE	HCE
	Final Sign off (where investment is required) or Approve Final Proposal Case (where no investment is required)	Appropriate formal sign off from relevant local organisation(s)	Appropriate formal sign off from relevant local organisation(s)	Appropriate formal sign off from relevant local organisation(s)

9.2 Matters Reserved to the Boards, Governing Bodies and Local Authority Committees/Cabinet of Statutory Organisations across the lifecycle of the STP

Table 1 summarises the decisions reserved to the CCG Governing Body.

Table 1 – Schedule of Matters reserved to CCG Governing Body
To approve the overarching Options and Consultation Document

Table 2 summarises those matters which have been reserved to the Boards of NHS Organisations.

Table 2 – Schedule of Matters reserved to the Boards, Governing Bodies of Statutory NHS Organisations
To approve system-wide planning intentions on an annual basis
To approve options for future organisational form
To approve individual QIPP and CIP plans over the lifecycle of the STP
To approve in principle, the Sustainability and Transformation Partnership plan and agree delegated Chair's Action/Urgent Decisions (for CCG Governing Body)
To formally endorse sustainable medium-term options for service reconfiguration
To approve the overarching Governance Framework
To endorse the overarching Options and Consultation Document

Table 3 summarises those matters which are reserved to the Local Authority Committees/Cabinet.

Table 3 – Schedule of Matters reserved to Local Authority Committees/Cabinet
To approve social care and public health service aspects of system-wide planning intentions on an annual basis.
To formally approve the social care and public health service aspects of a Sustainability and Transformation Partnership plan
To approve the overarching Governance Framework

9.3 Matters Delegated to the STP Board

Table 4 summarises those matters have been delegated to the STP Board by the relevant Statutory Bodies.

Table 4 – Schedule of Matters Delegated to the STP Board and its members	
Matters Delegated	**Delegated to**
To focus on the medium and long-term strategy of the STP	STP Board
To ensure that the system has in place a process for working towards an Accountable Care System	STP Board

To hold the HCE account to commission and oversee the Sustainable and Transformation Partnership programme of work that will, by the end of 2018/19 have delivered on home is best, safe and effective hospital care, sustainable together and enablers	STP Board
To hold the HCE account for delivery of the STP	STP Board
To hold the HCE to account for ensuring that accountability and reporting arrangements are in place.	STP Board
To hold the HCE to account for ensuring the Cambridgeshire and Peterborough STP has in place, and is adhering to, collective governance arrangements.	STP Board
To determine the nature of a formal vote	Chair
To approve STP Board minutes	STP Board
To provide written notice of dates, times and locations of meetings of the STP Board	Secretariat

9.4 Matters Delegated to the Health and Care Executive

Table 5 summarises those matters have been delegated to the Health and Care Executive by the STP Board.

Table 5 – Schedule of Matters Delegated to the Health and Care Executive and its members*	
Matters Delegated	**Delegated to**
To commission and oversee the Sustainable and Transformation Partnership plan of work that will, by the end of 2018/19 have delivered on home is best, safe and effective hospital care, sustainable together and enablers	Health and Care Executive
To determine areas of development and service reconfiguration for the Cambridgeshire and Peterborough health and care system from 2016 through to 2020; to lead a process to prioritise these areas	Health and Care Executive
To determine which service change projects need to be done, by whom and by when (be they system change projects or independent change projects within the CCG or provider organisations); to ratify any proposed new work before it can start.	Health and Care Executive

To sign off all system projects and ensure that they are allocated to a Delivery Group/Enabling Group.	Health and Care Executive
To ensure the workstreams/work programmes commissioned by the HCE are working to deliver one or more of the areas identified in the table above, are appropriately resourced, have identified clear outcomes, targets for activity shifts, quality changes or financial savings/ growth, timescales for delivery, and agreed associated projects, are on track to deliver the changes set out above within the agreed timescale and report on progress against an agreed set of metrics, and report risks and issues	Health and Care Executive
To prioritise projects across the system balancing the need to deliver maximum impact quickly with the need to adequately resource each project	Health and Care Executive
To resolve, or oversee the resolution, of risks and issues escalated by the groups accountable to the HCE	Health and Care Executive
To report progress and provide assurance to the Regional Bipartite that programme delivery is on track	Health and Care Executive
To resolve issues locally, but where this is not possible to escalate unresolved issues to NHS Improvement and NHS England through an agreed Bipartite meeting process	Health and Care Executive
To oversee a process for agreeing commissioning intensions	Health and Care Executive
To engage with individual Boards, Governing Bodies and Local Authority Cabinet/Committees on the implementation of the STP	Health and Care Executive
To engage with Health and Wellbeing Boards on the implementation of the STP.	Health and Care Executive
To approve business cases to support delivery of the STP	Health and Care Executive
To review and endorse recommendations made via the Investment Committee.	Health and Care Executive
To manage the risks associated with overall delivery of the STP	Health and Care Executive
To determine the need for Urgent Decisions in discussion with the Chair and Programme Director	Chair
To determine the nature of a formal vote	Chair

To approve HCE minutes	Health and Care Executive
To provide written notice of dates, times and locations of meetings of the HCE	Secretariat

** Representation by local authority officers on the Health Executive will be limited to relevant social care and public health services within the remit of their delegated authority from their respective Council. Any key decisions will be subject to the constitutional process which applies to the Committee Chair/Vice Chair or Cabinet Portfolio Holder responsible for that function.*

9.5 Matters Reserved to the Care Advisory Group

Table 6 summarises those matters have been delegated to the Care Advisory Group by the STP Board.

Table 6 – Schedule of Matters Delegated to the Care Advisory Group and its members	
Matters Delegated	**Delegated to**
To commission, receive and critically review information and reports from the Delivery and Enabling Groups.	Care Advisory Group
To provide overall clinical advice and expertise to the Sustainability and Transformation Partnership, making recommendations to the Health and Care Executive	Care Advisory Group
To report progress using all necessary and agreed analytic methodology to the Health and Care Executive using an agreed reporting format.	Care Advisory Group
To make recommendations for future innovation in service delivery.	Care Advisory Group
To review business cases at 'Outline Business Case' stage and make recommendations about whether or not they should proceed.	Care Advisory Group
To endorse Investment Committee initial proposals to be developed into full business cases.	Care Advisory Group
To determine the nature of a formal vote.	Chair
To approve CAG minutes.	Care Advisory Group
To provide written notice of dates, times and locations of meetings of the CAG.	Secretariat

9.6 Matters Reserved to the System Delivery Board

Table 7 summarises those matters that have been delegated to the System Delivery Board by the STP Board.

Table 7 – Schedule of Matters Delegated to the System Delivery Board and its members	
Matters Delegated	**Delegated to**
To sign off methodology and a small number of monitoring dashboards developed by the SDU for monitoring programme delivery	System Delivery Board
To review the performance of the STP, by monitoring the delivery of workstreams/work programmes, against an agreed set of programme metrics and using the agreed methodology	System Delivery Board
To ensure that progress, risks and issues are tracked and reported using the agreed methodology	System Delivery Board
To receive and sign-off reports from the SDU that the STP plan, and its future modifications, is being appropriately delivered	System Delivery Board
Through the Chairs of the Delivery/Enabling Groups to liaise with and support the Delivery/Enabling Groups as required, providing information, advice and recommendations as appropriate	System Delivery Board
To resolve, or oversee the resolution, of risks and issues escalated by the groups accountable to the HCE	System Delivery Board
To determine the nature of a formal vote	Chair
To approve System Delivery Board minutes	System Delivery Board
To provide written notice of dates, times and locations of meetings of the System Delivery Board	Secretariat

9.7 Matters Reserved to the Financial Performance and Planning Group

Table 8 summarises those matters that have been delegated to the Financial Performance and Planning Group by the STP Board.

Table 8 – Schedule of Matters Delegated to the Financial Performance and Planning Group and its members	
Matters Delegated	**Delegated to**
To advise the Health and Care Executive on system financial sustainability	Financial Performance and Planning Group
To oversee submission of national financial submissions on behalf of the STP	Financial Performance and Planning Group
To develop a framework for contracting and incentives, aligning planning	Financial Performance and Planning Group

assumptions, quality assuring savings and investment proposals and tracking savings progress	
To monitor and report on the system performance against key national/local metrics	Financial Performance and Planning Group
To maintain an overview, the delivery and benefits realisation of CIP, QIPP and transformation plans	Financial Performance and Planning Group
To consider and endorse business cases for the use of significant system wide financial investments	Financial Performance and Planning Group
To report progress to the Health and Care Executive using an agreed reporting format	Financial Performance and Planning Group
To resolve issues locally, but where this is not possible to escalate unresolved issues to the Health and Care Executive through an agreed process	Financial Performance and Planning Group
To endorse Investment Committee initial proposals to be developed into full business cases	Financial Performance and Planning Group
To monitor the SDU budget	Financial Performance and Planning Group
To determine the nature of a formal vote	Chair
To approve Financial Performance and Planning Group minutes	Financial Performance and Planning Group
To provide written notice of dates, times and locations of meetings of the Financial Performance and Planning Group	Secretariat

9.8 Matters Reserved to the Investment Committee

Table 9 summarises those matters that have been delegated to the Investment Committee and its members by the STP Board.

Table 9 – Schedule of Matters Delegated to the Investment Committee and its members	
Matters Delegated	**Delegated to**
To develop the criteria against which business cases will be assessed	Investment Committee
To evaluate business cases submitted to the committee against the criteria	Investment Committee
To ensure that all business cases submitted for consideration are supported and agreed by all significantly affected local health and social care organisations (supported by the SDU)	Investment Committee

To decide, based on the assessment against agreed Investment criteria, and system priorities whether to recommend the case for immediate funding in full, or in part, or at a later date where other cases due for presentation are thought to need priority	Investment Committee
Have due regard to the system agreed priorities and other pipeline investment cases currently under development, acknowledging that potentially not all cases can be funded based on the resources available	Investment Committee
To review MRET funded scheme business cases, and make recommendations to the Health and Care Executive for continued funding, or whether it believes these funds should be reinvested in the investment pot for other schemes	Investment Committee
To determine the nature of a formal vote	Chair
To approve Investment Committee minutes	Investment Committee
To provide written notice of dates, times and locations of meetings of the Investment Committee	Secretariat

9.9 Matters Reserved to the Clinical Communities

Table 10 summarises those matters that have been delegated to the Clinical Communities and their member by the Care Advisory Group.

Table 10 – Schedule of Matters Delegated to the Clinical Strategy Groups and its members	
Matters Delegated	**Delegated to**
To review quality and performance	Clinical Communities
To design clinical strategy and required service changes	Clinical Communities
To review and monitor service outcomes	Clinical Communities
To work collaboratively with stakeholders	Clinical Communities
To operate in accordance with the STPs agreed ways of working	Clinical Communities
To determine the nature of a formal vote	Chair
To approve Clinical Communities minutes	Clinical Communities
To provide written notice of dates, times and locations of meetings of the Clinical Strategy groups	Secretariat

9.10 Matters Reserved to the Delivery and Enabling Groups

Table 11 summarises those matters that have been delegated to the Delivery and Enabling Groups and its members by the Health and Care Executive.

Table 11 – Schedule of Matters Delegated to the Delivery and Enabling Groups and its members	
Matters Delegated	**Delegated to**
To improve patient experience and outcomes	Delivery and Enabling Groups
To provide expertise to support transformational change	Delivery and Enabling Groups
To oversee the delivery of a portfolio of projects in order to realise financial savings and quality improvement	Delivery and Enabling Groups
To monitor progress and risks, and report this as appropriate	Delivery and Enabling Groups
To develop final Business Cases for submission to Investment Committee	Delivery and Enabling Groups
To determine the nature of a formal vote	Chair
To approve Delivery/Enabling Group minutes	Delivery and Enabling Groups
To provide written notice of dates, times and locations of meetings of the Delivery/Enabling Group	Secretariat

9.11 Matters Reserved to the A&E Delivery Board

Table 12 below summarises those matters that have been delegated to the A&E Delivery Board and its members.

Table 12 – Schedule of Matters Delegated to the A&E Delivery Board and its members	
Matters Delegated	**Delegated to**
To improve patient experience and outcomes in relation to emergency care	A&E Delivery Board
To provide expertise to support transformational change	A&E Delivery Board
To oversee the delivery of a portfolio of projects in order to realise financial savings and quality improvement	A&E Delivery Board
To deliver five mandated improvement initiatives	A&E Delivery Board
To deliver the nationally mandated core responsibilities to lead A&E recovery	A&E Delivery Board
To receive assurance that the following nationally mandated core responsibilities are being delivered by the UEC Delivery Group	A&E Delivery Board

To monitor progress and risks, and report this as appropriate	A&E Delivery Board
To determine the nature of a formal vote	Chair
To approve A&E Delivery Board minutes	A&E Delivery Board
To provide written notice of dates, times and locations of meetings of the A&E Delivery Board	Secretariat

9.12 Urgent Decisions

Due to the nature of the business cycle of individual organisations, there may be a requirement for Urgent Decisions to be taken. In these circumstances, Urgent Decisions should be;

- discussed by the Health and Care Executive and taken by the Chair of the Health and Care Executive, in consultation with the Chair, Chief Executive and Director of Finance (or their equivalent roles) in each partner organisation;
- required to be taken by the Councils as a result of any decision exercised by the HCE are subject to the individual council's constitutional arrangements, and;
- be recorded appropriately and reported to the partner organisations for formal ratification at the next available meeting.

9.13 Conflicts of Interests

The STP will ensure that all Conflicts of Interests are managed in line with NHS Statutory Guidance:

- A register of personal, professional and organisational conflicts of interest will be maintained for all members of the STP by the STP's Secretariat.
- Those in attendance will be asked to declare their personal, professional and organisational conflicts of interest. Where any members of the STP have a material interest, they should either be excluded from relevant parts of meetings, or join in the discussion but not participate in the decision making itself (i.e., not have a vote).
- The Chair of the relevant meeting has responsibility for deciding whether there is a conflict of interest and the appropriate course of corresponding action. In making such decisions, the chair may wish to consult a member of a Governing Body or Board in the system who has responsibility for issues relating to conflicts of interest.
- All decisions, and details of how any conflict of interest issue has been managed, should be recorded in the minutes of the meeting.

9.14 Dispute and Conflict Resolution

Any issues that cannot be resolved locally will be referred to the regional Bipartite.

10. Risk Management

The STP Assurance Framework provides detail on how the STP Board will manage and monitor risks in relation to delivery of the STP programmes of work or projects. It also describes the accountability arrangements. An overarching risk register which will be overseen by the STP Board and shared with the individual partner organisations.

11. Cycle of Business

The STP has developed a cycle of business which will align with the individual organisation's business cycles/decision-making processes. Consideration to a monthly cycle of formal business for statutory boards and governing bodies has been considered as part of the process. The STP Programme Cycle and Ways of Working documents describe this in more detail.

12. Reporting Arrangements

The SDU will prepare reports relating to STP delivery for system partners.

CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD
FORWARD AGENDA PLAN

MEETING DATE	ITEM	REPORT AUTHOR	
22 March 2018 10.00am, Fenland District Council, March			
	Apologies and Declarations of Interest	Oral	**Reports to Richenda Greenhill by Friday 9 March 2018**
	Minutes of the Meeting on 1 February 2018	Richenda Greenhill	
	Action Log Update	Richenda Greenhill	
	Person's Story		
	Draft Health and Wellbeing Strategy Update	Dr Liz Robin	
	Better Care Fund: Update	Geoff Hinkins	
	Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation Programme: Update	Catherine Pollard	
	Forward Agenda Plan	Richenda Greenhill	
	Date of Next Meeting		
31 May 2018 10.00am, Kreis Viersen Room, Shire Hall, Cambridge			
	Notification of the Chairman/ Chairwoman	Oral	**Reports to Richenda Greenhill by Friday 18 May 2018**
	Election of a Vice Chairman/ Chairwoman	Oral	
	Apologies and Declarations of Interest	Oral	
	Minutes of the Meeting on 22 March 2018	Richenda Greenhill	
	Action Log Update	Richenda Greenhill	

MEETING DATE	ITEM	REPORT AUTHOR	
	Person's Story		
	Better Care Fund: Update	Geoff Hinkins	
	Cambridgeshire and Peterborough Dementia Strategy	Fiona Davies	
	Safeguarding Adults Board Annual Report 2017/18	Russell Wate	
	Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation Programme: Update	Catherine Pollard	
	Forward Agenda Plan	Richenda Greenhill	
	Date of Next Meeting		
26 July 2018, 10.00am, venue tbc			
	Apologies and Declarations of Interest	Oral	**Reports to Richenda Greenhill by Friday 13 July 2018**
	Minutes of the Meeting on 31 May 2018	Oral	
	Action Log Update	Richenda Greenhill	
	Person's Story	Oral	
	Better Care Fund: Update	Geoff Hinkins	
20 September 2018, 10.00am, venue tbc			
	Apologies and Declarations of Interest	Oral	**Reports to Richenda Greenhill by Friday 7 September 2018**
	Minutes of the Meeting on 26 July 2018	Oral	
	Action Log Update	Richenda Greenhill	
	Person's Story	Oral	
	Better Care Fund: Update	Geoff Hinkins	

MEETING DATE	ITEM	REPORT AUTHOR	
22 November 2018, 10.00am, Kreis Viersen Room, Shire Hall, Cambridge			
	Apologies and Declarations of Interest	Oral	**Reports to Richenda Greenhill by Friday 9 November 2018**
	Minutes of the Meeting on 20 September 2018	Oral	
	Action Log Update	Richenda Greenhill	
	Person's Story	Oral	
	Better Care Fund: Update	Geoff Hinkins	
31 January 2019, 10.00am, Kreis Viersen Room, Shire Hall, Cambridge			
	Apologies and Declarations of Interest	Oral	**Reports to Richenda Greenhill by Friday 18 January 2019**
	Minutes of the Meeting on 22 November 2018	Oral	
	Action Log Update	Richenda Greenhill	
	Person's Story	Oral	
	Better Care Fund: Update	Geoff Hinkins	
28 March 2019, 10.00am, venue tbc			
	Apologies and Declarations of Interest	Oral	**Reports to Richenda Greenhill by Friday 15 March 2019**

MEETING DATE	ITEM	REPORT AUTHOR	
	Minutes of the Meeting on 31 January 2019	Oral	
	Action Log Update	Richenda Greenhill	
	Person's Story	Oral	
	Better Care Fund: Update	Geoff Hinkins	
30 May 2019, 10.00am, venue tbc			
	Notification of the Chairman/ Chairwoman	Oral	**Reports to Richenda Greenhill by Friday 17 May 2019**
	Election of a Vice Chairman/ Chairwoman	Oral	
	Apologies and Declarations of Interest	Oral	
	Minutes of the Meeting on 31 January 2019	Oral	
	Action Log Update	Richenda Greenhill	
	Person's Story	Oral	
	Better Care Fund: Update	Geoff Hinkins	

Updated: 24.01.18