ADULTS COMMITTEE

Date:Thursday, 24 May 2018

14:00hr

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

Shire Hall
Castle Hill
Cambridge
CB3 0AP

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

AGENDA

Open to Public and Press

CONSTITUTIONAL MATTERS

1	**Notification of Chairman/woman and Vice-Chairman/Woman** *Councillor Anna Bailey and Councillor Mark Howell were appointed by Council on 15 May 2018 as Chairman and Vice-Chairman respectively for the municipal year 2018-19*	
2	**Apologies for absence and declarations of interest** *Guidance on declaring interests is available at http://tinyurl.com/ccc-conduct-code*	
3	**Minutes – 12th April 2018 and Action Log**	**5 - 14**
4	**Petitions**	

DECISIONS

5	**Finance and Performance Report – Outturn 2017-18**	**15 - 80**

The Adults Committee comprises the following members:

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

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

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

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public. It also welcomes the use of social networking and micro-blogging websites (such as Twitter and Facebook) to communicate with people about what is happening, as it happens. These arrangements operate in accordance with a protocol agreed by the Chairman of the Council and political Group Leaders which can be accessed via the following link or made available on request: http://tinyurl.com/ccc-film-record.

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

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ADULTS COMMITTEE: MINUTES

Date: Thursday 12th April 2018

Time: 2.00pm to 2.30pm

Present: Councillors A Bailey (Chairwoman), S Crawford, K Cuffley, J French, J Gowing (substituting for Cllr Costello), N Harrison, D Wells and G Wilson

Apologies: Councillors Costello, Giles and Howell

76. APOLOGIES AND DECLARATIONS OF INTEREST

There were no declarations of interest.

77. MINUTES – 8 MARCH 2018 AND ACTION LOG

The minutes of the meeting held on 8 March 2018 were agreed as a correct record and signed by the Chairwoman, subject to including Councillor Crawford in the list of those present, and modifying minute 70 by amending the second bullet point under the introduction 'Discussing the amended recommendations, one member' to read: 'pointed out that there had been a cost associated with the consultation exercise, and those who had received the consultation had been given cause to worry about the potential impact of the proposals on themselves or those they cared for; it would have been helpful if the cost of the exercise could have been reported to the Committee'.

The Action Log was noted. In relation to specific actions arising from Minute 64:

- members were advised that work had started on the map of support services for adults, but this was proving a substantial undertaking and would not be ready for circulation until mid-May 2018

- clarification was sought of the explanatory comment on the difference between Cambridgeshire's and Peterborough's per capita expenditure on services covered by the Floating Support Service commissioning review. Members noted that historically, Cambridgeshire and Peterborough had allocated funding differently in several service areas, and it was not possible to transfer funds between local authorities. The Commissioner (Adults) undertook to revisit the explanation; she was asked also to draw attention to any areas where the level of services received by residents differed significantly between Cambridgeshire and Peterborough.

Action required

With the agreement of the Committee, the Chairwoman reordered the agenda to take items 6 and 7, appointments and agenda plan, ahead of the confidential item 5, so that members of the public present could hear as much of the meeting as possible.

78. PETITIONS

No petitions were received.

79. PUBLIC QUESTION

The Chairwoman advised the Committee that a question had been received from Mrs Margaret Ridley, and although it did not relate to any item on the agenda for the meeting, she had agreed to exercise her discretion to allow the question to be put.

Mrs Ridley said that she understood that there was a real problem with people waiting for suitable care arrangements to be made before they could be discharged from hospital, but she was concerned that depositing a frail elderly person in a stranger's spare room was not a safe or appropriate solution. She asked why private discussions were continuing between CareRooms Ltd and officers and members of the County Council without any consideration of the matter by the Adults Committee. The Council should be opening up the discussion to the general public.

The Chairwoman, undertook to reply to the question in writing, and said that only one meeting had taken place with CareRooms Ltd that included Council members, when she and council officers, and one other member, had listened to the plans of the CareRooms Ltd Chief Executive in January 2018. This fell within the ordinary business of the Council, which had a statutory duty to manage the care market. There were no ongoing meetings between Council members and the company being held or planned, and the Council had not made any decision to commission services from CareRooms Ltd. If any such decision were to be proposed, it would be brought to the Adults Committee and would be considered in public.

Councillor Bailey explained that it would not be appropriate for her to answer detailed questions on the CareRooms model. The questions should be asked of the Chief Executive of CareRooms Ltd, who would be happy to meet with the questioner.

The Chairwoman reminded members that she had already responded to a written question from Councillor Crawford to full Council, and undertook to include this response in her written reply to Mrs Ridley. She thanked Mrs Ridley for attending, and expressed the hope that she would leave with a clearer understanding of what was and what was not taking place. Councillor Bailey gave Mrs Ridley her personal assurance that any proposal in relation to CareRooms Ltd would be considered in an open and transparent way.

The question supplied before the meeting and the Chairwoman's written answer, including her answer to the written question at Council on 20 March 2018, are attached to these minutes as Appendix A.

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

It was resolved to note that no appointments to outside bodies were required to be made.

81. AGENDA PLAN

It was resolved unanimously to note the agenda plan, subject to the following changes:

a) add to July's agenda, an item on the Learning Disability Partnership Section 75 and pooled budget arrangements
b) transfer two items from July to September 2018: the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) Annual Report; and the People and Communities Risk Register report
c) add three new items to the agenda for September: Joint working with health – key priorities; Continuing Health Care deep dive; and Learning Disability employment deep dive
d) add an Adult Safeguarding deep dive to the agenda for October 2018
e) decide in September whether further six-monthly updates from CPFT would be required (currently on the agenda plan for December 2018).

The Democratic Services Officer was asked to circulate the revised agenda plan.

Action required

82. EXCLUSION OF PRESS AND PUBLIC

It was resolved unanimously

> that the press and public be excluded from the meeting for the following item of business on the grounds that it contained exempt information under Paragraph 3 of Part 1 of Schedule 12A of the Local Government Act 1972, as amended, and that it would not be in the public interest for this information to be disclosed (Information relating to the financial or business affairs of any particular person (including the authority holding that information)).

83. CARE HOMES DEVELOPMENT WORK STREAM 1 INCREASE TO CURRENT BLOCK CONTRACTS

The Committee received a confidential report outlining the case for increasing residential, residential dementia, nursing and nursing dementia block bed care home provision across Cambridgeshire by increases to current block contracts, and seeking its agreement to specific changes to contracts with current providers.

The Chairwoman thanked the Commissioner (Adults) and the working party for their efforts, and congratulated her on an impressive piece of work.

It was resolved unanimously

> to approve the recommended approach under Workstream 1 of the Care Home Development project to increase the existing block bed contract by 39 beds under current terms and conditions for the duration of the contract (1 plus 2 years).

Chairwoman

APPENDIX A

Text of Mrs Ridley's question submitted in advance of the Adults Committee meeting held on 12th April 2018

We understand that the Adults Committee has made a commitment, with the aid of a working party, to investigate the viability of introducing CareRooms Ltd into Cambridgeshire.

According to the Health Service Journal this "controversial 'CareBnB' firm "was forced to abort its first pilot in Essex after patient groups and social care directors raised safeguarding concerns. We raise two of these concerns below.

1. Safeguarding
It is not clear which patient groups are being targeted. CareRooms states that the discharged patients are relatively fit and that they are only receiving a bed plus meals and that if social care is necessary this will be brought in. If this is the case why then can't the patient receive care at home?
The landlords are not expected to have a health care background and will not receive training in health/social care because CareRooms wishes to avoid the landlords having to be approved by the CQC.
A Cambridgeshire County Council spokesperson told the Hunts Post that the service was an alternative to hospital or care home care. Care home care is usually considered if a patient is thought not to be safe in their own home perhaps because of confusion or the risk of falling. Placing such a patient in a strange environment would make them less safe.
Who will be responsible for responding to concerns from the patient or relatives when things go wrong? Both the County Council and the discharging hospital will have a duty of care to the patient. How is this to be provided and monitored?

2. Involvement of patients' own GP
The patient may be placed away from their GP practice area and although the patient remains 'on the books' there is no requirement for GPs to visit away from the practice area. The 24/7 availability of a video link to a private GP service (Qdoctor) is made out to be a strong selling point. Is the patient expected to register with Qdoctor and does that mean that they are de-registered from their previous GP practice? A GP via a video link is not going to be able to physically examine the patient and therefore he/she should not be prescribing for the patient. A deteriorating patient may therefore have to be moved back to hospital because the video GP cannot treat them and no one from the GP practice will be able to visit.

In the light of these and many other concerns, can the Adults Committee explain why these private discussions are continuing, particularly as they seem to be held without involving the full committee and without any public consultation.

Margaret Ridley Jane Howell

Text of Chairwoman's Reply to Revised Questions from Mrs Ridley, dated 11th April 2018 – CCC Adults Committee

Thank you for your letter sent to me by email on 9th April 2018 and for the questions that you submitted yesterday which have been circulated to Members of the Committee.

It is not usual to take questions about items that are not on the Agenda. However, in the interests of transparency and to clear up any confusion and hopefully allay concerns, I am happy to receive your questions and thank you for bringing them and for attending here today.

I can confirm that only one meeting has been held to date with CareRooms that involved Members of the Council; Cllr Nichola Harrison and myself met with the Chief Executive of CareRooms Paul Gaudin on 16th January 2018 and Council officers were also present. The purpose of the meeting was to listen to Mr Gaudin's plans in developing and launching his business CareRooms. Such a meeting is perfectly within the constitution of the Council. To be clear, there are no ongoing meetings being held or planned between CareRooms and Council Members, including myself as Chairman of the Adults Committee.

As a result of that meeting it was agreed to provide CareRooms with information and insight into the system in Cambridgeshire; it is important to explain that this falls within the ordinary business of the Council which has a statutory duty to manage the care market in Cambridgeshire. The Council is interested in, and in fact needs to explore a range of approaches to facilitating independent living in the community, both for those who we support and those who fund their own care.

Please be assured however, that the Council has not made a decision, and indeed has no immediate plans to commission any services from, or enter into any partnership or contract with CareRooms. If such a plan was forthcoming at any time, you have my absolute assurance that it would come to the Adults Committee for consideration in public.

Because the Council is not planning to use the services of CareRooms, I do not think it would be appropriate for me to answer the detailed content of your questions about how CareRooms is dealing with safeguarding or the involvement of patients' own GPs; these questions all relate to matters of detail of the CareRooms model. CareRooms is an independent private business and should have the opportunity to respond to your questions themselves; it is not for the County Council to do so. I honestly believe these questions are a matter for you to refer to CareRooms and I know that Mr Gaudin would be happy to meet with you to answer your very valid queries.

I have found over the years, that it is always helpful to have an open mind and to listen to people that are looking at different and new solutions to problems. By way of example, we were very interested in our meeting with Mr Gaudin, in the technology based solutions that he is building in to his CareRooms offer, and we immediately saw and felt excited by the potential for the use of similar technological solutions, quite independently from anything to do with CareRooms. From such meetings, new ideas can form.

It may help to refer you to the text of my response to a written question submitted to Council on 20th March 2018, of which Members of this Committee will be aware. I will provide the text of my response in a written reply to you, but you can access both the

question and the response online on the Council's website, and again, I will provide the link for you in my written response.

Thank you again for taking the time to voice your concerns - it is always helpful to hear different points of view and I hope you will leave this meeting with a clear understanding of what is taking place and my personal assurances to you about doing things in an open and transparent way.

Yours sincerely

Anna Bailey

Chairman of the Adults Committee

Response to Written Question at Full Council on 20th March 2018

1. The decision to provide Care Rooms with information and insight into the system in Cambridgeshire falls within the ordinary business of the Council as the local authority has a statutory duty to manage the care market. As the information given to Care Rooms did not represent a change of Council Policy or commit the Council to significant expenditure there is not a requirement to present it to Committee. While at some point, it may be helpful to provide the Committee with information on the Council's involvement, our contact with Care Rooms is very much at an early stage. I can confirm that the County Council has not made a decision to enter into a partnership with Care Rooms. Rather, Cambridgeshire County Council is interested in exploring a range of approaches in terms of the most effective way to promote independent living in the community, both for those who we support and those who fund their own care. Within this context, the Council was approached by CareRooms Chief Executive Paul Gaudin. We have had initial discussions with him about his ideas of delivering home based services, as an alternative to traditional short-term institutional settings, such as care homes or hospitals. The model is at an early stage of development and the Council along with other national and local organisations has offered information and insight into the health and social care landscape. I can confirm that there are no immediate plans for the Council to commission any services from or enter into any partnership with Care Rooms.

2. As indicated in response to the previous question, as this matter falls within the ordinary business of the Council and within the Council's statutory responsibilities, it is clear that there has been no breach of "due process". I can confirm that the Council has not made any decision in relation to entering into a working arrangement with Care Rooms.

3. An initial meeting has taken place between Care Rooms and selected Adult Social Care staff employed by the County Council. Additionally, communication has taken place with the NHS in the form of Cambridgeshire and Peterborough Foundation Trust, concerning the addition of a community nurse to the working group. Cambridgeshire and Peterborough Foundation Trust are receptive to this proposal and are considering the most appropriate representation.

Link to Written Question at Full Council on 20th March 2018 and Response

https://tinyurl.com/CCC-questions-March-2018

ADULTS COMMITTEE

Minutes Action Log

Cambridgeshire County Council

Introduction:

This log captures the actions arising from the Adults Committee up to the meeting on **12 April 2018** and updates Members on progress in delivering the necessary actions.

This is the updated action log as at 15 May 2018

Meeting of 8 March 2018

Minute No.	Report Title	Action to be taken by	Action	Comments	Status
64.	**Joint Commissioning of Floating Support Service**	W Patten	Develop a map of support services for adults to assist members in forming a clear picture of the different services and the overall provision available to support adults	Due to be circulated by the end of April 2018	**Ongoing**
		W Patten	Share the contracts register with members of the Committee	Not in position to share until May.	**Ongoing**
		T Reed	Look into why Cambridgeshire's per capita expenditure on the services covered in the commissioning review appeared to be nearly 50% more than Peterborough's	Cambridgeshire is much bigger geographically than Peterborough, and the scale of funding reflects how these services have been funded historically as existing budgets are being used to procure the new service.	**See 12 April minute 77**

Minute No.	Report Title	Action to be taken by	Action	Comments	Status
65.	**Procurement of care and support services in extra care schemes**	L O'Brien	Report to members whether the Council would retain responsibility for redundancy costs and any deficits on the pension fund for staff employed under the care and support contracts.	The County Council will not be liable for redundancy or deficits on the pension fund for staff employed on this contract. This is because bidders will have received all relevant information to enable them to price their bid to take account of these risks. A Pensions Information Memorandum (PIM) has been produced for this tender. When compiling the PIM, actuaries review the ages, previous service, future working life of staff employed at Ditchburn Place as well as market rates and future risks to the LGPS pension scheme for this staff group, as they are effectively 'ring fenced in the scheme'. The PIM also provides information to bidders on the employer's contribution rate (i.e. they would be expected to pay as the future employer). Finally, the PIM provides the approximate amounts of indemnity i.e. for the value of the bond that the bidder would need to seek. The bond is effectively an insurance policy against the bidder becoming insolvent.	**Completed**
72.	**Adult Social Care Service User and Carers 2017 survey results**	C Bruin	Share action plan arising from survey with members and bring to a later Adults Committee to review progress.	Carers survey- Helen Duncan advised that an action plan has been drafted and some initial actions have been taken to raise awareness of Carers' needs. Practice Guidance for staff has been revised and a reflective practice session will be held with all practitioners. Agenda plan now includes an item to be programmed on progress with the action plan.	**Completed**

Minute No.	Report Title	Action to be taken by	Action	Comments	Status
		C Bruin	If possible, include number of surveys completed as well as percentages in survey results	This has been escalated to Andy Mailer – he will ensure these arrangements are in place for next year's survey.	**Completed**

Meeting of 12 April 2018

Minute No.	Report Title	Action to be taken by	Action	Comments	Status
77.	**Minutes – 8 March 2018 and Action Log**	S Torrance	Further clarification required of the explanation, given in response to Minute 64 above, for the difference in expenditure by Cambridgeshire and by Peterborough on the services covered in the commissioning review.	The figures quoted within the report (£3.1m CCC & £1.12m PCC) relate to the total spend and units across the Floating Support services and the HRS Homelessness Services for both areas. In terms of the homelessness services, for Cambs these are varied with a range of contract values which reflect the level of client complexity they are supporting. This means we aren't comparing like for like services within those figures, which will contribute to the cost discrepancy. The total floating support spend for CCC is £896,389 for 418 units. This includes the general service and the specialist mental health service (the latter aims to provide more support hours to clients that the general service). The total floating support spend for PCC is £56,533 for 40 units. The PCC service provides support to offenders, those with mental health problems and those with substance misuse problems.	

Minute No.	Report Title	Action to be taken by	Action	Comments	Status
81.	**Agenda Plan**	R Yule	Circulate revised agenda plan to members of Committee	Agenda plan circulated by email 27 April.	**Completed**

Agenda Item No: 5

FINANCE AND PERFORMANCE REPORT – OUTTURN 2017-18

To:	**Adults Committee**
Meeting Date:	**24 May 2018**
From:	**Executive Director: People and Communities** **Chief Finance Officer**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable** ***Key decision:*** **No**
Purpose:	**To provide the Committee with the 2017-18 Outturn Finance and Performance report for People and Communities Services (P&C), formerly Children's, Families and Adults Services (CFA).** **The report is presented to provide the Committee with the opportunity to comment on the financial and performance position as at the end of the 2017-18 financial year.**
Recommendations:	**1. The Committee is asked to review and comment on the report** **2. The Committee is asked to recommend to General Purposes Committee that the remaining earmarked reserve within Adults Services is re-approved for 2018/19 (section 3 of the report)**

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1.0 BACKGROUND

1.1 A Finance & Performance Report for People and Communities (P&C), formerly Children, Families and Adults Directorates (CFA) is produced monthly and the most recent available report is presented to the Committee when it meets.

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

1.3 This report is for the whole of the P&C Service, and as such, not all of the budgets contained within it are the responsibility of this Committee. Members are requested to restrict their attention to the budget lines for which this Committee is responsible, which are detailed in Appendix A, whilst the table below provides a summary of the budget totals relating to Adults Committee:

Forecast Variance Outturn (January) £000	Directorate	Budget 2017/18 £000	Actual £000	Outturn Variance £000
444	Adults & Safeguarding	133,087	133,161	73
146	Adults Commissioning (including Local Assistance Scheme)	31,666	31,920	254
0	Communities & Safety - Safer Communities & Partnership	1,561	1,560	-1
590	**Total Expenditure**	**166,314**	**166,641**	**326**
0	Grant Funding (including Better Care Fund, Social Care in Prisons Grant etc.)	-23,051	-23,051	0
590	**Total**	**143,264**	**143,590**	**326**

Please note: Strategic Management – Commissioning, Executive Director and Central Financing budgets cover all of P&C and are therefore not included in the table above.

1.4 **Financial Context**
The Council had overall planned savings of £33.4m in 2017-18, and at year end the overall revenue budget position was an overspend of +£3.8m (1.1%).

2.0 MAIN ISSUES IN THE 2017-18 OUTTURN P&C FINANCE & PERFORMANCE REPORT

2.1 The 2017-18 Outturn Finance and Performance report is attached at Appendix B. At the end of the year, the overall P&C position is an overspend of £6,953k. This is a slightly worse position from the previous forecast reported to Adults Committee in January when the predicted outturn was £6,774k.

Within P&C, despite underspends on a number of areas and delivery of significant savings through transformation the continuing demand pressures, particularly in children's services relating to the rising number of looked after children, have resulted in the overall overspend position at year-end.

Within Adults Services specifically, the position improved by £264k since January with an overall overspend of £326k for the year. The Council has faced significant demand pressures within both Learning Disability and Older People services, partially as a result of increased demand in the NHS and improved performance in reducing delayed transfers of care. Grant funding has been deployed to mitigate these pressures in-year, which have been addressed on a permanent basis through business planning.

Significant work was undertaken during the budget setting process, alongside a number of ongoing workstreams to deliver reductions in costs and required savings in 2018-19. This work includes additional scrutiny on the highest risk budgets and savings via a weekly delivery board.

2.2 **Revenue**

The main changes to the revenue forecast variances within Adults Committee's areas of responsibility since the previous report are as follows:

- In Adults and Safeguarding, the outturn for the Learning Disability Partnership has increased by £488k since January's forecast. Overall this is due to higher than expected demand pressures throughout the year and lower levels of savings than required. A number of packages with large costs were agreed late in the financial year as a result of breakdown in care arrangements and urgently changing need. Where these are permanent packages there will be an impact on spend in the LDP in 2018/19 which has been built into budgets. Overall, over £3.5m of savings were delivered in-year.

- In Adults and Safeguarding, the outturn in the Physical Disability Service was worse than previously forecast. While care costs remained consistent through the year, the level of income secured from the NHS for service-users with health needs has been lower than expected. Work is ongoing to ensure appropriate funding is received.

- In Adults and Safeguarding, the outturn for Adult Mental Health is £228k lower than that reported in January as a result of lower than expected costs, and higher than expected savings delivery, over the last two months of the year

- In Adults and Safeguarding, the outturn on the Strategic Management – Adults line is lower than the previous forecast as a result of further application of one-off grant funding to mitigate pressures elsewhere in the service, as well as an increase in the level of vacancy savings within Adults Services.

2.3 Full detail of the final outturn for all policy lines can been viewed in Appendix B.

2.4 **Capital**

The Capital Programme Board recommended that services include a variation budget to account for likely slippage in the capital programme, as it is sometimes difficult to allocate this to individual schemes in advance. The allocation for P&C's negative budget adjustments has been calculated as follows, shown against the slippage position for 2017/18:

2017/18					
Service	**Capital Programme Variations Budget** **£000**	**Outturn Variance (Close)** **£000**	**Capital Programme Variations Budget Used** **£000**	**Capital Programme Variations Budget Used** **%**	**Revised Outturn Variance (Close)** **£000**
P&C	-10,305	0	0	0%	10,305
Total Spending	-10,305	0	0	0%	10,305

At the end of the 2017/18 financial year the Capital Variation budget has not been utilised. This will be offset with additional borrowing of £10,305k.

2.5 **Performance**

Appendix 7 of the Outturn F&PR contains Performance information.

Of the thirty-eight P&C service performance indicators six are shown as green, two as amber and four are red. Twenty-six have no target and are therefore not RAG-rated.

2.6 **P&C Portfolio**

The major change programmes and projects underway across P&C are detailed in Appendix 8 of the report – none of these is currently assessed as red.

3.0 CARRYFORWARD PROPOSALS: P&C EARMARKED RESERVES IN 2018-19

3.1 The Scheme of Financial Management sets out a process for agreement of one-off funds in addition to the agreed budget to support particular schemes and projects, including enabling pilots and savings plans. These are known as service earmarked reserves and were permitted where Services underspent in previous years and secured political agreement to earmark part of those surpluses to future activity. The Council has moved away from reserves held at Service level, with deficits and surpluses instead handled from across the Council together in a corporate general reserve. Additionally, the transformation fund has been established as the usual route for funding schemes which lead to new ways of working and financial and non-financial benefits. There is an established business case process to bid into the transformation fund. .

3.2 The Scheme of Financial Management sets out that Service Committees will be asked to recommend annual re-approval to the General Purpose Committee

3.3 Although no new service earmarked reserves are being created at this time, there is one previously agreed scheme linked to mental health preventive and community resilience work, where the reserve was intended to fund a three-year contract which comes to an end in 2018/19. £55k of this reserve remains and is intended to be used for the last portion of this contract. Adults Committee is asked to recommend re-approval of this earmarked reserve to GPC.

4.0 2017-18 SAVINGS TRACKER

4.1 As previously reported, the “tracker” report – a tool for summarising delivery of savings – will be made available for Members on a quarterly basis. The tracker as at the end of 2017-18 is included as Appendix C to this report.

4.2 Within the tracker the outturn is shown against the original saving approved as part of the 2017-18 Business Planning process. At the end of 2017-18 total savings of £16,824k were delivered within P&C against the original target of £20,538k. For several proposals the delivery of savings has slipped into 2018/19.

5.0 ALIGNMENT WITH CORPORATE PRIORITIES

5.1 Developing the local economy for the benefit of all

5.1.1 There are no significant implications for this priority.

5.2 Helping people live healthy and independent lives

5.2.1 There are no significant implications for this priority

5.3 Supporting and protecting vulnerable people

5.3.1 There are no significant implications for this priority

6.0 SIGNIFICANT IMPLICATIONS

6.1 Resource Implications

6.1.1 This report sets out details of the overall financial position of the P&C Service.

6.2 Procurement/Contractual/Council Contract Procedure Rules Implications

6.2.1 There are no significant implications within this category.

6.3 Statutory, Risk and Legal Implications

6.3.1 There are no significant implications within this category.

6.4 Equality and Diversity Implications

5.4.1 There are no significant implications within this category.

6.5 Engagement and Consultation Implications

6.5.1 There are no significant implications within this category.

6.6 Localism and Local Member Involvement

6.6.1 There are no significant implications within this category.

6.7 Public Health Implications

6.7.1 There are no significant implications within this category.

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

Appendix A

Adults Committee Revenue Budgets within the Finance & Performance report

Adults & Safeguarding Directorate
Strategic Management – Adults
Principal Social Worker, Practice and Safeguarding
Autism and Adult Support
Carers

Learning Disability Services
LD Head of Services
LD - City, South and East Localities
LD - Hunts & Fenland Localities
LD – Young Adults
In House Provider Services
NHS Contribution to Pooled Budget

Older People's Services
OP - City & South Locality
OP - East Cambs Locality
OP - Fenland Locality
OP - Hunts Locality
Discharge Planning Teams
Shorter Term Support and Maximising Independence
Physical Disabilities

Mental Health
Mental Health Central
Adult Mental Health Localities
Older People Mental Health

Commissioning Directorate
Strategic Management – Commissioning – *covers all of P&C*
Local Assistance Scheme

Adults Commissioning
Central Commissioning - Adults
Integrated Community Equipment Service
Mental Health Voluntary Organisations

Community & Safety Directorate
Safer Communities Partnership

Executive Director
Executive Director - *covers all of P&C*
Central Financing - *covers all of P&C*

Grant Funding
Non Baselined Grants - *covers all of P&C*

From: Martin Wade and Stephen Howarth
Tel.: 01223 699733 / 714770
Date: 19th April 2018

People & Communities (P&C) Service

Finance and Performance Report – Closedown 2018

1. SUMMARY

1.1 Finance

Previous Status	Category	Target	Current Status	Section Ref.
Red	Income and Expenditure	Balanced year end position	Red	2.1
Green	Capital Programme	Remain within overall resources	Green	3.2

1.2. Performance and Portfolio Indicators – March 2018 Data (see sections 4&5)

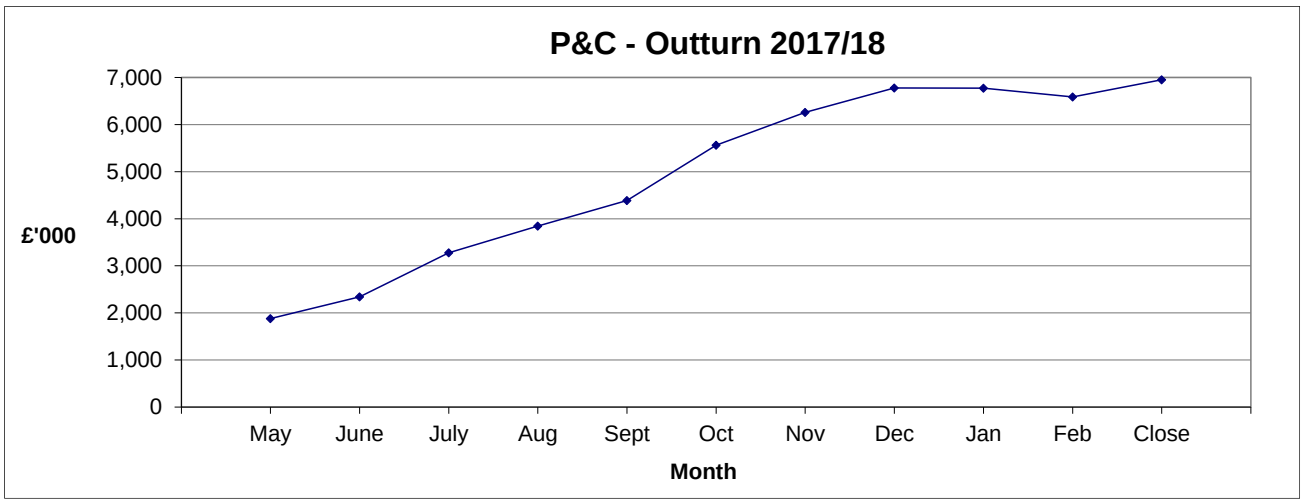
Monthly Indicators	Red	Amber	Green	No Target	Total
Mar Performance (No. of	4	2	6	26	38
Mar Portfolio (No. of indicators)	0	1	5	0	6

2. INCOME AND EXPENDITURE

2.1 Overall Position

Forecast Variance Outturn (Feb) £000	Directorate	Original Budget 2017/18 £000	Budget 2017/18 £000	Actual £000	Outturn Variance £000	Outturn Variance %
252	Adults & Safeguarding	135,238	133,087	133,161	73	0.1%
768	Commissioning	38,792	46,983	47,809	826	1.8%
-172	Communities & Safety	5,047	6,888	6,724	-164	-2.4%
8,262	Children & Safeguarding	103,587	105,723	116,358	10,635	10.1%
-209	Education	19,022	20,014	19,601	-413	-2.1%
-215	Executive Director	494	-107	-369	-262	245.0%
8,687	**Total Expenditure**	**302,182**	**312,588**	**323,283**	**10,695**	**3.4%**
-2,101	Grant Funding	-39,991	-73,022	-76,764	-3,742	5.1%
6,586	**Total**	**262,191**	**239,567**	**6,953**	**6,953**	**2.9%**

The service level finance & performance report for 2017/18 can be found in appendix 1. Further analysis of the forecast position can be found in appendix 2.



2.2 Significant Issues

At the end of Closedown 2017/18, the overall P&C position is an overspend of £6,953k.

As well as making savings through transformation, the service has faced significant demand pressures, particularly in children's services related to the rising number of looked after children, a national trend, and in Learning Disability services. Similarly, as demand increased on the NHS and the acute sector in particular, combined with improved performance in reducing delayed transfers of care from hospital, so did spending levels on Older Adults.

In many cases, planned transformation and demand management strategies delivered significant savings although to a delayed timescale. Financial mitigations were identified across the directorate, in particular a major one-off grant deployment reported against Strategic Management - Adults.

The increase in outturn since last month is £367k. Significant changes are detailed below:

- In Adults and Safeguarding, the outturn on the Strategic Management – Adults line is £532k lower than the previous forecast as a result of further application of one-off grant funding to offset pressures elsewhere in the service.

- In Adults and Safeguarding, the outturn in the Older People locality teams is a £584k higher pressure than was forecast in February. The change is mainly due to increases in care costs over the last six weeks of the year (reflecting trends seen throughout the year) and a higher level of debt adjustments resulting concerted efforts to address outstanding debt ahead of the transfer to the new financial system.

- In Adults and Safeguarding, the outturn in the Physical Disability Service was £97k worse than previously forecast. While care costs have remained lower than expected through the year, the level of income secured from the NHS for service-users with health needs has been lower than expected. Work is ongoing to ensure appropriate funding is received.

- In Adults and Safeguarding, the outturn for Adult Mental Health is £242k lower than that reported in February as a result of lower than expected costs, and higher than expected savings delivery, over the last six weeks of the year.

- In Children and Safeguarding, the Strategic Management outturn has increased by £104k since the position reported in February. Despite over achieving the overall vacancy savings target the final figure was less than previously forecast.

- In Children and Safeguarding, the Children in Care outturn has increased by £227k due to additional unexpected costs from transitional arrangements for a complex case and an increase in in-house fostering placements.

- In Children and Safeguarding, the final Legal Proceedings outturn has increased by £111k due to higher than anticipated costs for February and March due to the number of cases being managed by the service and the increase in presentation of end year invoices by providers.

- In Children and Safeguarding, the final outturn across several of the Dedicated Schools Grant (DSG) funded budgets, including High Needs Top-Up, SEN placements, and Out of School tuition have worsened significantly since previous forecasts. This is as a result of a continuing increase in numbers and complexity of need, alongside a requirement to fund a large number of backdated payments primarily to Post-16 providers. As these budgets are funded from the DSG these pressures are managed as part of the overall DSG rather than impacting on the P&C bottom line.

- In Grant Funding, the Financing DSG contribution has increased to reflect the final contribution to DSG funded services.

2.3 Additional Income and Grant Budgeted this Period

(De Minimis reporting limit = £160,000)

A full list of additional grant income anticipated and reflected in this report can be found in appendix 3.

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

A list of virements made in the year to date can be found in appendix 4.

2.5 Key Activity Data

The Actual Weekly Costs for all clients shown in section 2.5.1-2 are calculated based on all clients who have received a service, are receiving a service, or we plan will receive a service. Some clients will have ceased receiving a service in previous months, or during this month, or we will have assumed an end date in the future.

2.5.1 Key activity data to March 2018 for **Looked After Children** (LAC) is shown below:

	BUDGET				ACTUAL (Mar)				VARIANCE		
Service Type	*No of placements Budgeted*	*Annual Budget*	*No. of weeks funded*	*Average weekly cost per head*	*Snapshot of No. of placements Mar 18*	*Yearly Average*	*Actual Spend*	*Average weekly cost per head*	*Yearly Average budgeted no. of placements*	*Net Variance to Budget*	*Average weekly cost diff +/-*
Residential - disability	1	£143k	52	2,743.20	3	1.24	£169k	2,978.65	0.24	£26k	235.45
Residential - secure accommodation	0	£k	52	0.00	0	0.08	£30k	6,755.00	0.08	£30k	6,755.00
Residential schools	16	£1,160k	52	1,408.53	18	15.77	£1,962k	2,676.81	-0.23	£802k	1,268.28
Residential homes	22	£3,018k	52	2,656.43	39	34.39	£5,708k	3,348.21	12.39	£2,690k	691.78
Independent Fostering	263	£10,304k	52	784.53	270	262.20	£11,098k	830.54	-0.8	£795k	46.01
Supported Accommodation	15	£1,244k	52	1,247.14	28	24.90	£1,829k	1,455.98	9.9	£586k	208.84
16+	25	£608k	52	467.73	7	7.45	£87k	216.77	-17.55	-£521k	-250.96
Growth/Replacement	-	£868k	-	-	-	-	£k	-	-	-£868k	-
Pressure funded within directorate	-	£k	-	-	-	-	£k	-	-	£k	-
TOTAL	342	£17,344k			365	346.03	£20,884k		4.03	£3,540K	
In-house fostering - Basic	212	£2,053k	56	172.89	197	181.75	£1,864k	180.67	-30.25	-£189k	7.78
In-house fostering - Skills	212	£1,884k	52	170.94	197	183.79	£1,681k	186.35	-28.21	-£203k	15.41
Kinship - Basic	40	£439k	56	195.84	45	41.60	£414k	184.01	1.6	-£25k	-11.83
Kinship - Skills	11	£39k	52	68.78	11	10.96	£39k	69.59	-0.04	£k	0.81
In-house residential	5	£556k	52	2,138.07	3	3.35	£495k	2,840.24	-1.65	-£61k	702.18
Growth*	0	-£297k	-	0.00	0	0.00	£k	0.00	-	£297k	-
TOTAL	257	£4,674k			245	226.70	£4,492k		-30.3	-£181k	
Adoption	376	£3,236k	52	165.51	428	407.85	£3,512k	162.95	31.85	£275k	-2.56
Concurrent Adoption	5	£91k	52	350.00	5	3.20	£58k	350.00	-1.8	-£33k	0.00
TOTAL	381	£3,327k			433	411.05	£3,570k		31.85	£243k	
OVERALL TOTAL	980	£25,345k			1043	983.78	£28,946k		5.58	£3,602k	

NOTE: In house Fostering and Kinship basic payments fund 56 weeks as carers receive two additional weeks payment during the Summer holidays, one additional week payment at Christmas and a birthday payment.

*Represented potential growth of in-house foster placements to be managed against the LAC Placements budget but did not occur.

2.5.2 Key activity data to the end of March for **SEN Placements** is shown below:

	BUDGET			ACTUAL (Mar 18)				VARIANCE			
Ofsted Code	*No. of Placements Budgeted*	*Total Cost to SEN Placements Budget*	*Average annual cost*	*No. of Placements Mar 18*	*Yearly Average*	*Total Cost to SEN Placements Budget*	*Average Annual Cost*	*No of Placements*	*Yearly Average*	*Total Cost to SEN Placements Budget*	*Average Annual Cost*
Autistic Spectrum Disorder (ASD)	98	£6,165k	£63k	102	99.04	£6,904k	£68k	4	1.04	£739k	£5k
Hearing Impairment (HI)	3	£100k	£33k	2	2.00	£74k	£37k	-1	-1.00	-£26k	£4k
Moderate Learning Difficulty (MLD)	3	£109k	£36k	8	5.33	£109k	£20k	5	2.33	£k	-£16k
Multi-Sensory Impairment (MSI)	1	£75k	£75k	0	0.00	£0k	-	-1	-1.00	-£75k	£k
Physical Disability (PD)	1	£19k	£19k	5	3.40	£67k	£20k	4	2.40	£48k	£1k
Profound and Multiple Learning Difficulty (PMLD)	1	£41k	£41k	0	0.00	£k	-	-1	-1.00	-£41k	£k
Social Emotional and Mental Health (SEMH)	35	£1,490k	£43k	42	42.35	£2,101k	£50k	7	7.35	£610k	£7k
Speech, Language and Communication Needs (SLCN)	3	£163k	£54k	2	2.00	£89k	£45k	-1	-1.00	-£74k	-£10k
Severe Learning Difficulty (SLD)	2	£180k	£90k	2	2.00	£217k	£108k	0	0.00	£36k	£18k
Specific Learning Difficulty (SPLD)	8	£164k	£20k	7	5.65	£220k	£39k	-1	-2.35	£56k	£18k
Visual Impairment (VI)	2	£64k	£32k	2	2.00	£55k	£28k	0	0.00	-£9k	-£5k
Recoupment	-	-	-	-	-	£106k	-	-	-	£106k	-
TOTAL	157	£8,573k	£55k	172	163.77	£9,942k	£60k	15	6.77	£1,369k	£5k

In the following key activity data for Adults & Safeguarding, the information given in each column is as follows:

- Budgeted number of clients: this is the number of full-time equivalent (52 weeks) service users anticipated at budget setting, given budget available
- Budgeted average unit cost: this is the planned unit cost per service user per week, given the budget available
- Actual service users and cost: these figures are derived from a snapshot of the commitment record at the end of the month and reflect current numbers of service users and average cost

The forecasts presented in Appendix 1 reflect the estimated impact of savings measures to take effect later in the year. The "further savings within forecast" lines within these tables reflect the remaining distance from achieving this position based on current activity levels.

2.5.3 Key activity data to end of March for **Adult Disability and Learning Disability** Services is shown below:

		BUDGET			ACTUAL (Mar 18)				Year End		
Service Type		*Budgeted No. of Service Users 2017/18*	*Budgeted Average Unit Cost (per week) £*	*Annual Budget £000*	*No. of Service Users at End of Mar 18*	*DoT*	*Current Average Unit Cost (per week) £*	*DoT*	*Actual £000*	*DoT*	*Variance £000*
Adult Disability Services	Residential	31	£1,121k	£1,807k	29	↔	£994	↓	£1,676k	↑	-£131k
	Nursing	20	£928k	£965k	22	↑	£960	↓	£1,153k	↓	£188k
	Community	669	£292k	£10,149k	641	↓	£332	↓	£10,098k	↓	-£51k
Total expenditure		**720**		**£12,921k**	**692**				**£12,927k**		**£6k**
Income				-£1,646k					-£1,687k	↓	-£41k
Further savings assumed within forecast										↓	£k
Net Total				**£11,275k**							**-£36k**
Learning Disability Services	Residential	313	£1,386k	£22,560k	307	↓	£1,368	↔	£22,450k	↑	-£110k
	Nursing	8	£2,132k	£887k	7	↔	£1,842	↔	£695k	↓	-£192k
	Community	1,272	£614k	£40,637k	1,282	↓	£650	↑	£44,980k	↑	£4,343k
Learning Disability Service Total		**1,593**		**£64,084k**	**1,596**				**£68,125k**		**£4,041k**
Income				-£2,825k					-£3,452k	↑	-£627k
Further savings assumed within forecast as shown in Appendix 1											0
Net Total				**£61,259k**							**£3,414k**

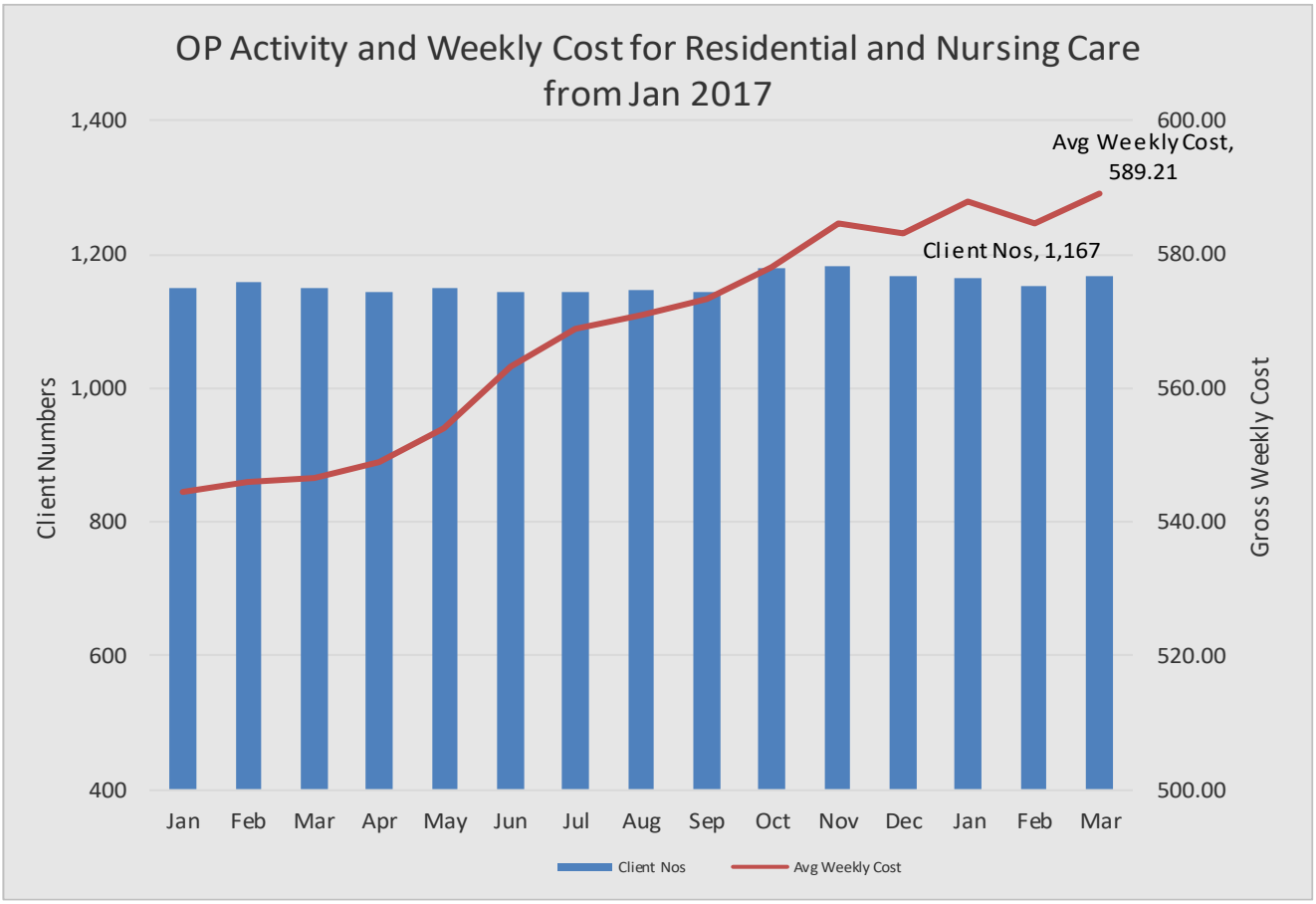
2.5.4 Key activity data to end of March for **Adult Mental Health** Services is shown below:

		BUDGET			ACTUAL (Mar)				Year End		
Service Type		*Budgeted No. of Clients 2017/18*	*Budgeted Average Unit Cost (per week) £'s*	*Annual Budget £000's*	*Snapshot of No. of Clients at End of Mar 18*	*DoT*	*Current Average Unit Cost (per week) £'s*	*DoT*	*Spend £000's*	*DoT*	*Variance £000's*
Adult Mental Health	Community based support	24	£72	£90k	17	↓	£163	↑	£128k	↓	£38k
	Home & Community support	154	£88	£709k	177	↓	£76	↓	£721k	↓	£12k
	Nursing Placement	13	£803	£544k	16	↔	£630	↔	£568k	↑	£24k
	Residential Placement	65	£736	£2,493k	68	↑	£700	↑	£2,514k	↓	£21k
	Supported Accomodation	133	£119	£828k	130	↓	£143	↓	£633k	↓	-£195k
	Direct Payments	20	£235	£245k	13	↔	£252	↑	£183k	↑	-£62k
	Income			-£368k					-£698k		-£330k
Adult Mental Health Total		**409**		**£4,541k**	**421**				**£4,049k**		**-£492k**

Direction of travel compares the current month to the previous month.

2.5.5 Key activity data to the end of March for **Older People** (OP) Services is shown below:

OP Total	BUDGET			ACTUAL (Mar 18)				Year End		
Service Type	***Expected No. of Service Users 2017/18***	***Budgeted Average Cost (per week) £***	***Gross Annual Budget £000***	***Current Service Users***	***D o T***	***Current Average Cost (per week) £***	***D o T***	***Actual £000***	***D o T***	***Variance £000***
Residential	447	£483	£11,593k	455	↑	£508	↑	£12,668k	↓	£1,075k
Residential Dementia	347	£536	£9,984k	378	↑	£552	↑	£10,910k	↓	£926k
Nursing	301	£715	£11,694k	273	↓	£728	↑	£11,350k	↑	-£343k
Nursing Dementia	55	£753	£2,253k	61	↑	£805	↑	£2,187k	↔	-£66k
Respite			£1,303k					£1,234k	↓	-£69k
Community based										
~ Direct payments	248	£173	£2,239k	220	↓	£282	↑	£3,120k	↑	£881k
~ Day Care			£941k					£832k	↓	-£109k
~ Other Care			£4,976k					£4,548k	↓	-£428k
~ Homecare arranged	1,608	*per hour* £15.70	£13,265k	1,251	↓	*per hour* £16.06	↓	£13,543k	↑	£279k
Total Expenditure	3,006		£58,247k	2,638				£60,391k		£2,144k
Residential Income			-£8,306k					-£9,567k	↓	-£1,261k
Community Income			-£8,099k					-£7,575k	↑	£524k
Health Income			-£9k					-£31k	↓	-£21k
Total Income			-£16,415k					-£17,173k		-£758k



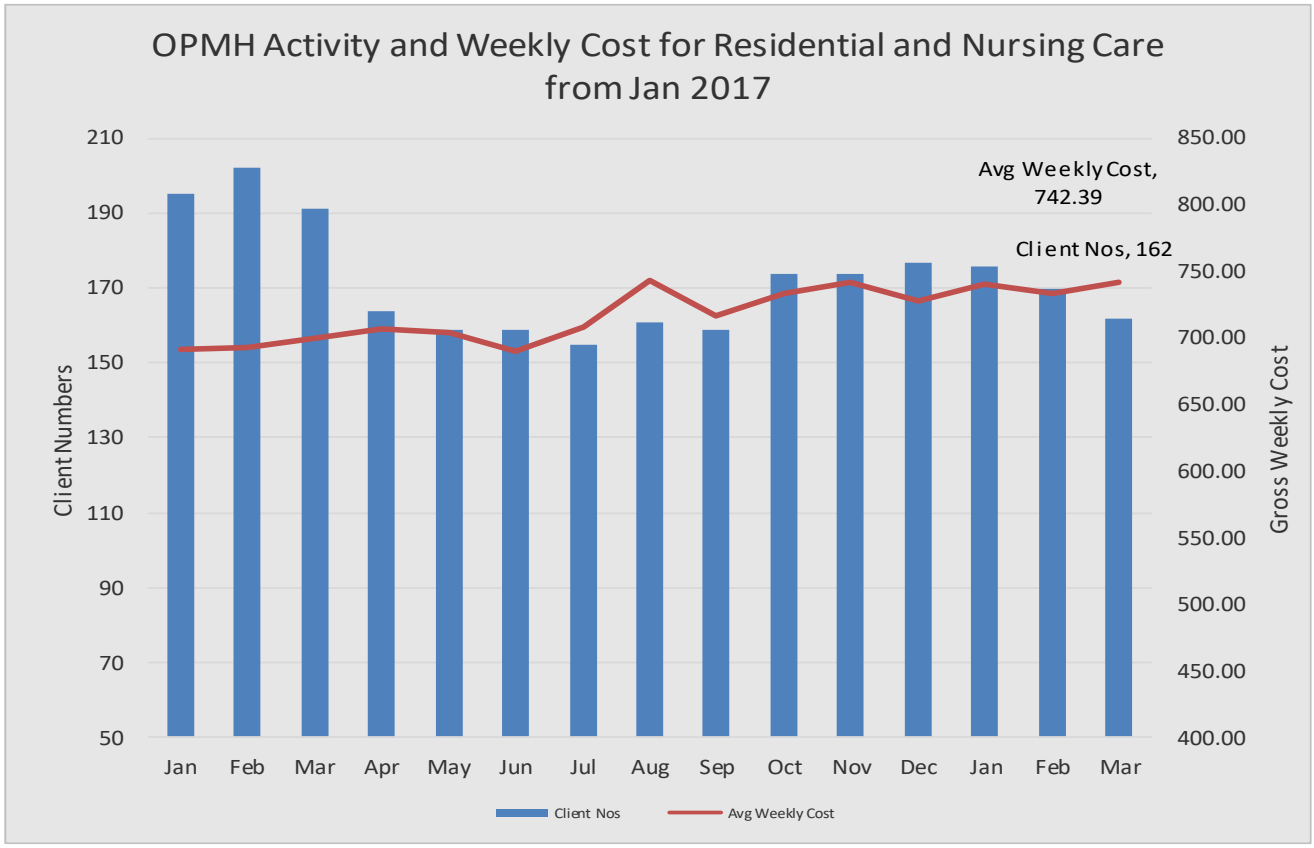
2.5.6 Key activity data to the end of March for **Older People Mental Health** (OPMH) Services is shown below:

For both Older People's Services and Older People Mental Health:

- Respite care budget is based on clients receiving 6 weeks care per year instead of 52.
- Day Care OP Block places are also used by OPMH clients, therefore there is no day care activity in OPMH

Although this activity data shows current expected and actual payments made through direct payments, this in no way precludes increasing numbers of clients from converting arranged provisions into a direct payment.

OPMH Total	BUDGET			ACTUAL (Mar 18)				Year End		
Service Type	***Expected No. of Service Users 2017/18***	***Budgeted Average Cost (per week) £***	***Gross Annual Budget £000***	***Current Service Users***	***D o T***	***Current Average Cost (per week) £***	***D o T***	***Actual £000***	***D o T***	***Variance £000***
Residential	14	£663	£503k	26	↑	£590	↓	£660k	↓	£156k
Residential Dementia	28	£533	£802k	24	↑	£554	↓	£1,051k	↑	£249k
Nursing	16	£740	£610k	22	↓	£771	↑	£732k	↓	£122k
Nursing Dementia	90	£747	£3,526k	90	↓	£830	↑	£4,231k	↓	£706k
Respite			£10k					£9k	↑	-£1k
Community based										
~ Direct payments	16	£207	£165k	13	↑	£510	↔	£265k	↑	£101k
~ Day Care			£3k					£9k	↓	£6k
~ Other Care			£38k					£50k	↑	£12k
~ Homecare arranged	45	*per hour* £15.95	£546k	52	↑	*per hour* £16.08	↓	£626k	↑	£79k
Total Expenditure	209		£6,204k	227				£7,634k		£1,430k
Residential Income			-£862k					-£902k	↑	-£41k
Community Income			-£244k					-£364k	↑	-£120k
Health Income			£k					-£375k	↓	-£375k
Total Income			-£1,106k					-£1,266k		-£535k



3. BALANCE SHEET

3.1 Reserves

A schedule of the planned use of Service reserves can be found in appendix 5.

3.2 Capital Expenditure and Funding

The 2017/18 Capital spend totaled £85.464m, resulting in a £10.022m overspend as slippage did not meet the anticipated capital variation adjustment. Significant changes in the following schemes have been the major contributory factors to this;

- Fulbourn Primary School; £1,338k accelerated spend as works at the site progressed ahead of the original contractor programme.
- Hatton Park, Longstanton; £306k slippage in 2017/18 due to some fixtures, fittings and ICT budgets not being spent in full during the financial year.
- Meldreth, Primary School: £840k slippage in 2017/18 due to the projects start on site being delayed from November 2017 to February 2018.
- Melbourn Primary; £413k accelerated spend. Project is currently 3 week ahead of schedule.
- Wyton Replacement Primary; £467k accelerated spend as the works on site are progressing ahead of the anticipated schedule.
- Northstowe Secondary School; £494k slippage due to design work commencing later than anticipated to incorporate the SEN provision.
- Bottisham Village College; £1,160k accelerated spend. Contractor made progress significantly ahead of the anticipated schedule of works, with a significant amount of work completed in February 2018.
- Cambridge Additional Places; £1,099k slippage due to two main factors. Delays in the kitchen refurbishment works and a revised completion date of 26 June rather than 29 May 2018 at St Bedes and the Chesterton element of the scheme not starting on site until next financial year.
- Alconbury Secondary and SEN Provision; £720k slippage on the Secondary School element. Design stage has not progressed since the beginning of the financial year as the developer is reviewing the masterplan for Alconbury development and no site has yet been allocated.
- Hampton Gardens Secondary; Final costs confirmed, overspend of £510k, jointly shared with Peterborough City Council. These costs relate to ICT not funded by the ESFA £225k, £75k on the reprogramming of the multi-use games area and £200k access works to the A15.
- Orchard Park Primary early years provision; £341k slippage in 2017/18 as the project is currently on hold pending the outcome of a review.
- LA maintained Early Years Provision; £304k slippage in 2017/18 as progress on
- Condition & Maintenance; £317k overspend is due to higher than expected costs (£197k) for kitchen ventilation works required to meet health and safety standards and projects requiring urgent attention to ensure school remained operational. The remaining £120k is due to urgent works to maintain schools condition.
- Temporary Accommodation; £778k overspend it has been necessary to provide additional mobiles at Spring Common Special School which had required substantial investment (£617k) to make the accommodation suitable.

A detailed explanation of the position can be found in appendix 6.

4. PERFORMANCE

The detailed Service performance data can be found in appendix 7 along with comments about current concerns.

The performance measures included in this report have been developed in conjunction with the Peoples & Communities management team and link service activity to key Council outcomes. The revised set of measures includes 15 of the previous set and 23 that are new. The measures in this report have been grouped by outcome, then by responsible directorate. The latest available benchmarking information has also been provided in the performance table where it is available. This will be revised and updated as more information becomes available. Work is ongoing with service leads to agree appropriate reporting mechanisms for the new measures included in this report and to identify and set appropriate targets.

Four indicators are currently showing as RED:

- **Number of children with a Child Protection (CP) Plan per 10,000 children**

During March we saw the numbers of children with a Child Protection plan decrease from 498 to 477.

The introduction of an Escalation Policy for all children subject to a Child Protection Plan was introduced in June. Child Protection Conference Chairs raise alerts to ensure there is clear planning for children subject to a Child Protection Plan. This has seen a decrease in the numbers of children subject to a Child Protection Plan.

- **The number of Looked After Children per 10,000 children**

In March the number of Looked After Children held at 697. This figure includes 63 UASC, 9% of the current LAC population. There are workstreams in the LAC Strategy which aim to reduce the rate of growth in the LAC population, or reduce the cost of new placements. Some of these workstreams should impact on current commitment.

Actions being taken include:

- A weekly Threshold to Resources Panel (TARP), chaired by the Assistant Director for Children's Services to review children on the edge of care, specifically looking to prevent escalation by providing timely and effective interventions. Decisions and Children's Plans are monitored via a tracker which also takes into account the children's care plan- discussed in the Permanency Monitoring Group.

- A monthly Permanency Monitoring Group (PMG) considers all children who are looked after, paying attention to their care plan, ensuring reunification is considered and if this is not possible a timely plan is made for permanence via Special Guardianship Order, Adoption or Long Term Fostering.

- TARP links with the monthly High Cost Placements meeting, which as of January 2018 started to be chaired by the Assistant Director for Children's Services. The panel ensures that required placements meet the child or young person's needs and are cost effective and joint funded with partners where appropriate.

At present the savings within the 2016/17 Business Plan are on track to be delivered and these are being monitored through the monthly LAC Commissioning Board. The LAC strategy and LAC action plan are being implemented as agreed by CYP Committee.

- **Proportion of Adults with Learning Disabilities in paid employment**

Performance remains low. As well as a requirement for employment status to be recorded, unless a service user has been assessed or reviewed in the year, the information cannot be considered current. Therefore this indicator is also dependent on the review/assessment performance of LD teams – and there are currently 62 service users identified as being in employment yet to have a recorded review in the current year.
(N.B: This indicator is subject to a cumulative effect as clients are reviewed within the period.)

- **Average number of ASC attributable bed-day delays per 100,000 population per month (aged 18+) – YTD**

In February 2018, there were 506 ASC-attributable bed-day delays recorded in Cambridgeshire. For the same period the previous year there were 735 delays – a reduction of 31%. The Council is continuing to invest considerable amounts of staff and management time into improving processes, identifying clear performance targets and clarifying roles & responsibilities. We continue to work in collaboration with health colleagues to ensure correct and timely discharges from hospital.

Delays in arranging residential, nursing and domiciliary care for patients being discharged from Addenbrooke's remain the key drivers of ASC bed-day delays.

5. P&C PORTFOLIO

The P&C Portfolio performance data can be found in appendix 8 along with comments about current issues.

The programmes and projects within the P&C portfolio are currently being reviewed to align with the business planning proposals.

APPENDIX 1 – P&C Service Level Budgetary Control Report

Forecast Variance Outturn (Feb) £'000		Service	Budget 2017/18 £'000	Actual 2017/18 £'000	Outturn Variance £'000	Outturn Variance %
		Adults & Safeguarding Directorate				
-4,403	1	Strategic Management - Adults	-8,880	-13,815	-4,935	56%
82		Principal Social Worker, Practice and Safeguarding	1,316	1,379	63	5%
-130	2	Autism and Adult Support	800	656	-143	-18%
-103		Carers	668	615	-53	-8%
		Learning Disability Services				
-20	3	LD Head of Service	5,625	5,497	-127	-2%
999	3	LD - City, South and East Localities	33,562	34,617	1,055	3%
1,903	3	LD - Hunts & Fenland Localities	27,148	29,028	1,880	7%
56	3	LD - Young Adults	4,258	4,381	123	3%
477	3	In House Provider Services	5,519	5,992	474	9%
0		NHS Contribution to Pooled Budget	-17,113	-17,113	0	0%
		Older People and Physical Disability Services				
467	4	OP - City & South Locality	19,068	19,825	757	4%
-19	4	OP - East Cambs Locality	6,024	6,170	146	2%
291	4	OP - Fenland Locality	9,001	9,295	294	3%
149	4	OP - Hunts Locality	12,411	12,685	275	2%
0		Discharge Planning Teams	2,009	1,990	-19	-1%
51		Shorter Term Support and Maximising Independence	6,781	6,752	-29	0%
61	5	Physical Disabilities	11,685	11,843	158	1%
		Mental Health				
-180	6	Mental Health Central	1,363	1,191	-173	-13%
-154	7	Adult Mental Health Localities	6,008	5,582	-425	-7%
725	7	Older People Mental Health	5,836	6,590	754	13%
252		**Adult & Safeguarding Directorate Total**	**133,087**	**133,161**	**73**	**0%**
		Commissioning Directorate				
-252	8	Strategic Management –Commissioning	2,658	2,324	-334	-13%
-61		Access to Resource & Quality	1,014	943	-71	-7%
-28		Local Assistance Scheme	321	292	-29	-9%
		Adults Commissioning				
160	9	Central Commissioning - Adults	26,700	26,897	197	1%
-30		Integrated Community Equipment Service	711	739	28	4%
41		Mental Health Voluntary Organisations	3,934	3,992	58	1%
		Childrens Commissioning				
-51		Commissioning Services	2,510	2,464	-46	-2%
490	10	Home to School Transport – Special	8,008	8,507	499	6%
500	11	LAC Transport	1,126	1,650	524	47%
768		**Commissioning Directorate Total**	**46,983**	**47,809**	**826**	**2%**

Forecast Variance Outturn (Feb) £'000		Service	Budget 2017/18 £'000	Actual 2017/18 £'000	Outturn Variance £'000	%
		Communities & Safety Directorate				
-40		Strategic Management - Communities & Safety	214	195	-19	-9%
-122	12	Youth Offending Service	1,469	1,347	-121	-8%
-10		Central Integrated Youth Support Services	428	409	-18	-4%
0		Safer Communities Partnership	1,561	1,560	-1	0%
0		Strengthening Communities	436	429	-7	-2%
0		Adult Learning & Skills	2,781	2,785	3	0%
0		Learning Centres	0	-1	-1	0%
-172		**Communities & Safety Directorate Total**	**6,888**	**6,724**	**-164**	**-2%**
		Children & Safeguarding Directorate				
822	13	Strategic Management – Children & Safeguarding	3,969	4,895	926	23%
91		Partnerships and Quality Assurance	1,892	1,978	86	5%
515	14	Children in Care	13,441	14,183	742	6%
-82		Integrated Front Door	2,711	2,630	-81	-3%
0		Children's Centre Strategy	317	330	12	4%
-25		Support to Parents	2,952	2,919	-33	-1%
3,549	15	Looked After Children Placements	17,344	20,884	3,540	20%
585	16	Adoption Allowances	4,406	5,001	595	14%
686	17	Legal Proceedings	1,540	2,337	797	52%
		<u>SEND Specialist Services (0-25 years)</u>				
98	18	SEND Specialist Services	7,739	7,911	172	2%
86		Children's Disability Service	6,467	6,527	60	1%
200	19	High Needs Top Up Funding	13,573	15,747	2,174	16%
1,202	20	Special Educational Needs Placements	8,973	10,342	1,369	15%
53	21	Early Years Specialist Support	965	706	-259	-27%
636	22	Out of School Tuition	1,119	1,939	820	73%
		<u>District Delivery Service</u>				
21		Safeguarding Hunts and Fenland	4,913	4,923	10	0%
-84		Safeguarding East & South Cambs and Cambridge	4,248	4,168	-80	-2%
-32		Early Help District Delivery Service –North	4,309	4,218	-91	-2%
-58	23	Early Help District Delivery Service – South	4,845	4,720	-125	-3%
8,262		**Children & Safeguarding Directorate Total**	**105,723**	**116,358**	**10,635**	**10%**

Forecast Variance Outturn (Feb) £'000		Service	Budget 2017/18 £'000	Actual 2017/18 £'000	Outturn Variance £'000	%
		Education Directorate				
0		Strategic Management - Education	725	683	-42	-6%
-30		Early Years' Service	1,397	1,310	-88	-6%
4		Schools Curriculum Service	58	60	2	3%
90	24	Schools Intervention Service	1,077	1,183	106	10%
-94	25	Schools Partnership Service	753	608	-145	-19%
10		Children's' Innovation & Development Service	185	160	-25	-14%
-125		Teachers' Pensions & Redundancy	2,936	2,898	-38	-1%
		Infrastructure				
4		0-19 Organisation & Planning	3,662	3,634	-28	-1%
0		Early Years Policy, Funding & Operations	90	85	-4	-5%
-68		Education Capital	160	79	-80	-50%
0		Home to School/College Transport – Mainstream	8,972	8,901	-71	-1%
-209		**Education Directorate Total**	**20,014**	**19,601**	**-413**	**-2%**
		Executive Director				
0		Executive Director	416	699	283	68%
-215		Central Financing	-523	-1,069	-546	104%
-215	26	**Executive Director Total**	**-107**	**-369**	**-262**	**245%**
8,181		**Total**	**312,588**	**323,283**	**10,695**	**3%**
		Grant Funding				
-2,101	27	Financing DSG	-40,518	-44,260	-3,742	9%
0		Non Baselined Grants	-32,504	-32,504	0	0%
-2,101		**Grant Funding Total**	**-73,022**	**-76,764**	**-3,742**	**5%**
6,586		**Net Total**	**239,567**	**246,519**	**6,953**	**3%**

APPENDIX 2 – Commentary on Forecast Outturn Position

Narrative is given below where there is an adverse/positive variance greater than 2% of annual budget or £100,000 whichever is greater.

Service	Budget 2017/18	Actual	Outturn Variance	
	£'000	£'000	£'000	%
1) Strategic Management – Adults	**-8,880**	**-13,815**	**-4,935**	**-56%**
Strategic Management – Adults is underspent by £4,935k at the end of 2017/18, which is £532k more underspent than was reported in February. The underspend is due primarily to the re-prioritisation of grant funded activity in response to Adults Services pressures, relating particularly to an increased performance in delayed transfers of care (DTOC), bringing with it an increased need for the delivery of complex packages of care for older people. In addition, throughout the year vacancy savings have been higher than budgeted for, and efficiencies have been made within the Transport service.				
2) Autism & Adult Support	**800**	**656**	**-143**	**-18%**
The Autism and Adult Support Team is -£143k underspent at the end of the year. The underspend is due to lower than expected service-user needs, and efficiencies that have been made in existing care packages as a result of shorter-term interventions being put in place in line with the Transforming Lives approach.				
3) LD – Overall LDP Position	**76,111**	**79,516**	**3,405**	**4%**
At the end of 2017/18, the Learning Disability Partnership is £3,405k over budget overall at year-end, which is a £10k lower than forecast at the end of February. Demand pressures have been higher than expected, despite positive work that has reduced the overall number of people in high-cost out-of-area in-patient placements. New package costs and increases in the costs of existing packages were higher than expected in the final months of 2016/17 and continued to be high in 2017/18 due to increased needs identified at reassessment that we had a statutory duty to meet. Savings under-delivered by £1.4m in-year, as a result of slippage of planned work and a lower level of delivery per case than anticipated. This is partially due to the need to devote energy to fee uplift negotiations with providers, which resulted in uplifts that were within the allocated budget, and difficulties with staff retention. In addition there have been delays in work where for example to progress we need engagement of the NHS outside of Cambridgeshire area. Nevertheless, £3.5m of savings were delivered in-year, which will also make a contribution to 18/19 savings through the full-year effect of cost reductions, and the majority of work not undertaken in 17/18 will be done in 18/19 instead further contributing to planned savings. In-year, the pressure was mitigated by a number of actions, particularly the expansion of the dedicated reassessment and brokerage capacity funded by the Transformation Fund and the sharing of learning and expertise with social work teams to drive additional efficiencies as part of business as usual work. These actions will continue into 18/19, enabling savings delivery to start from a strong position. In House Provider Services had a pressure throughout 17/18 mainly as a result of the level of slippage on staff costs as a result of vacancies not being as high as expected. The provider units have managed with reducing budgets for several years, with a reduction of 6.4% in 2017/18. Staffing levels continue to be reviewed by the units in order to ensure staff members are being used as efficiently as possible, but a minimum level of staffing is required in units to ensure safe service delivery and to meet the regulatory standards of the Care Quality Commission.				

Service	Budget 2017/18	Actual	Outturn Variance	
	£'000	£'000	£'000	%
4) Older People's Services	**46,504**	**47,975**	**1,471**	**3%**

An overspend of £1.471m is reported at year end across Older People's locality budgets. This is a worsening of £583k on the position reported in February.

The cost of care worsened by £191k in the final 6 weeks of the year, despite seeing reductions in the previous 2 months, linked mainly to the efforts to reduced delayed discharges from hospitals. It is also in part due to back-dated loading of some packages, and lower than expected levels of Direct Payments clawed-back as unused, all of which were identified through year-end processes. These should be improved with the introduction of new processes linked to the implementation of ERP Gold and Mosaic. Overall the cost of care was £2.171m over budget for the year, while income from client contributions was £765k higher than budgeted.

Additionally, debt write offs were £173k higher than the allowance made for them in the forecast outturn. The increase in write offs in this period is largely due to a concerted effort to clear outstanding debt before the transfer to ERP Gold.

Staffing budgets overspent by £65k, with £50k of this being in City and South locality. This overspend is due to expenditure on agency staff who are covering vacant posts. The teams are trying to recruit permanent staff to these posts, but continue to suffer from staff shortages in the care market.

Service	Budget 2017/18	Actual	Outturn Variance	
	£'000	£'000	£'000	%
5) Physical Disabilities	**11,685**	**11,843**	**158**	**1%**
The Physical Disabilities team overspent by £158k in 2017/18, increasing by £97k from the February forecast. There has been lower than expected demand during the year leading to an underspend on cost of care, however this has been offset by underachieving savings from both Direct Payment balance recoveries and securing appropriate funding for service users with health needs.				
6) Mental Health Central	**1,363**	**1,191**	**-173**	**-13%**
Mental Health Central underspent by £173k in 2017/18, which is £7k lower than was forecast in February. This is due to an in-year underspend on the Section 75 contract, in addition to the previously reported efficiency on the Section 75 contract value, which was updated in line with the restructure of Mental Health Services undertaken during 2016/17.				
7) Mental Health Services	**11,844**	**12,172**	**329**	**3%**
Mental Health Services overspent by £329k in 2017/18, which is £242k lower than was forecast in February. The underlying overspend on cost of care was £1.061m as the result of demand pressures that have been evident during the course of 2017/18, notably on nursing care. Quality and Assurance panel is well established and CPFT continue to scrutinize packages before funding is approved, but savings delivery was significantly impacted. Savings resulting from securing appropriate funding for service users with health needs have over-achieved, offsetting the cost of care position by £700k, and there was a small overspend on staffing.				
8) Strategic Management - Commissioning	**2,658**	**2,324**	**-334**	**-13%**
Strategic Management Commissioning has underspent by £334k in 2017/18. The Grants to Voluntary Organisations budget underspent by £196k, due to the Home Start/Community Resilience Grant where the re-commissioning of this service ceased in 16/17 (£168k), and a £28k underspend in Small Grants in 2017/18. This therefore reduced the 2017/18 committed expenditure. In addition, as a result of the vacancies held during the Commissioning Directorate restructure and further staff turnover throughout the year, the Commissioning Directorate over-achieved their vacancy saving target by £138k. This was a one-off saving and the expectation is that the Commissioning Directorate will be operating at full capacity during 2018/19.				
9) Central Commissioning – Adults	**26,700**	**26,897**	**197**	**1%**
Central Commissioning – Adults has a pressure of £197k at year-end mainly due to lower than expected income from the NHS for Funded Nursing Care. This is a flat daily rate paid to the Council by the NHS for in-county nursing placements. While the overall number of nursing placements has increased in year, they are proportionately more out-of-county, resulting in lower than expected FNC.				

Service	Budget 2017/18	Actual	Outturn Variance	
	£'000	£'000	£'000	%
10) Home to School Transport –Special	**8,008**	**8,507**	**499**	**6%**
The Home to School Transport – Special Budget is £499k overspent at the end of 2017/18. This is due to a higher than expected number of transport applications from children attending special schools, with an increase of 8% in the number of Cambridgeshire pupils attending Special Schools in the Autumn and Spring Terms of Academic Year 17/18 compared to 16/17, and an 11% increase in pupils with Education, Health and Care Plans (EHCPs) over the same period. While savings have been made through successful routes retenders, savings activities around Independent Travel Training and Personal Transport Budgets (PTB) have not been achieved which further increased the pressure on the budget. Further, savings around an anticipated reduction in pupils with EHCPs have not been achieved due to the increase in pupils with EHCPs				
11) LAC Transport	**1,126**	**1,650**	**524**	**47%**
Looked After Children Transport is 524k overspend at the end of 2017/18. The overall increase in Looked after Children has meant that more children are requiring Home to School Transport. Many of these children are placed out of county and/or at a significant distance away from their schools leading to high transport costs. The anticipated overspend stayed relatively steady throughout the year reflecting the fact that, while there was a significant increase at end of 2016/17 and the start of 2017/18, the overall LAC numbers have only increased slowly throughout the rest of the year.				

Service	Budget 2017/18	Actual	Outturn Variance	
	£'000	£'000	£'000	%
12) Youth Offending Service	**1,469**	**1,347**	**-121**	**-8%**
The Youth Offending Service (YOS) outturn position is an under spend of £121k, a reduction of £1k reported in February. Based on low incidents of secure remand for young offenders in recent years, the YOS remand equalisation earmarked reserve has been reduced, creating a non-recurrent under spend of £90k this year. There was an under spend of £15k against the permanent remand budget. The remaining £16k under spend is across a number of non-pay budgets, including staff training.				
13) Strategic Management – Children & Safeguarding	**3,969**	**4,895**	**926**	**23%**
The Children and Safeguarding Director budget outturn position is an overspend of £926k. The Children's Change Programme (CCP) delivered savings of £669k in 2017/18 by integrating children's social work and children's early help services into a district-based delivery model. However, historical unfunded pressures of £886k still remained. These consisted of £706k around the use of agency staffing and unfunded posts of £180k.The Business Support service pressure of £245k was managed in year and will manage out entirely by 2018/19. Agency need has been reduced based on a 15% usage expectation in 2017/18 but use of agency staff remained necessary to manage current caseloads. All local authorities have agency social workers, many with a much higher % and therefore a budget to accommodate this need is necessary. A further cost of £336k was due to the service not being awarded an expected grant from the DFE, anticipation of this grant had been built in as an income stream and this has now resulted in a shortfall in the required staffing budget. The service also over achieved its vacancy saving target by £336k.				
14) Children in Care	**13,441**	**14,183**	**742**	**6%**
The Children in Care budget outturn position is an over spend of £742k. This is an increase of £227k since last month mainly due to additional unexpected costs for transitional arrangements for a complex case (£174k) and an increase in in-house fostering placements. The 14-25 Teams 1-3 are £268k over budget. The over spend is predominantly due to costs for one young person that is transitioning to adults. We have also seen an increase in the overall number of care leavers in the service by 24% from 260 in April 17 to 322 in March 2018 which has put pressure on budget lines for essential allowances and setting up home costs. The 14-25 Team 4 are £181k over budget. This is predominantly due to delays in the Home Office making decisions about care leavers' adult asylum status, resulting in the need to fund accommodation and expenses for young people pending them being able to work or claim benefits. The final position also includes use of additional funding from DCLG (£100k) to build authorities' resilience and capacity for ongoing support of this cohort. Whilst the additional funding is welcomed the underlying overspend is due to a shortfall between the grant received from the Home Office for former looked after unaccompanied asylum seeking young people who are now over 18 and the costs incurred in supporting them. The local authority has a duty to support this cohort of young people as care leavers. Pending young people being granted an asylum seeking status as young adults, they are not able to claim benefits or obtain housing and require support from the local authority until the Home Office has made a decision.				

Service	Budget 2017/18	Actual	Outturn Variance	
	£'000	£'000	£'000	%
Children In Care continued; Cambridgeshire has seen an increase of 109% in the size of this cohort (from 45 young people to 94) in this financial year as a number of looked after children (including those newly arrived in Cambridgeshire this year) have turned 18. The Supervised Contact team is forecasting to be £322k over budget. This is due to the use of additional relief staff and external agencies. There are currently 201 Supervised Contact Cases which equate to approximately 140 supervised contact sessions a week.				
15) Looked After Children Placements	**17,344**	**20,884**	**3,540**	**20%**
The outturn position is a £3.5m overspend, as reported last month. It is positive that the overall numbers of looked after children increased only slowly throughout the year. This demonstrates that the demand management activity had a positive impact on numbers of looked after children and numbers of external placements. However the composition of placement types and costs indicates that a small but significant number of children were in receipt of very intensive and costly packages of support. The Access to Resources team are working with providers to ensure that support and cost matches need for all children. Overall LAC numbers at the end of March 2018, including placements with in-house foster carers, residential homes and kinship, are 698, 1 more than February 2018. This includes 61 unaccompanied asylum seeking children (UASC). External placement numbers (excluding UASC but including 16+ and supported accommodation) at the end of March are 365, 10 more than reported at the end of February.				

Service	Budget 2017/18	Actual	Outturn Variance	
	£'000	£'000	£'000	%

Looked After Children Placements continued;

External Placements Client Group	Budgeted Packages	28 Feb 2017 Packages	31 Mar 2018 Packages	Variance from Budget
Residential Disability – Children	1	2	3	+2
Child Homes – Secure Accommodation	0	0	0	0
Child Homes – Educational	16	17	18	+2
Child Homes – General	22	37	39	+17
Independent Fostering	263	264	270	+7
Supported Accommodation	15	27	28	+13
Supported Living 16+	25	8	7	-18
TOTAL	**342**	**355**	**365**	**23**

'Budgeted Packages' are the expected number of placements by Mar-18, once the work associated to the saving proposals has been undertaken and has made an impact.

Actions going forward include:

- Weekly panel considering all admissions to care and requests for escalation of resources, attended by Access to Resources and operational managers to ensure that the plans for children remain focussed and those resources are offering the best value for money. This is chaired by the Assistant Director.
- Purchase placements reviews – scrutiny by placement officers and service/district managers to review emergency placements, changes of placements and return home from care planning to ensure that children are in the right placement for the right amount of time. This has resulted in timely and planned endings of high cost placements where appropriate.
- All new admissions to care have to be agreed at Assistant Director or Service Director level.
- Continued provision of the Hub (No Wrong Door) provision working with families preventing admissions to care, and delivery of an all-inclusive team of support for young people with the most complex needs, improving outcomes for young people and preventing use of expensive externally-commissioned services.
- The management of this budget will move to the Commissioning Directorate from April 2018 and will be monitored via the monthly Placement Budget/Sufficiency Strategy meetings.

Longer Term Actions:

A business case that seeks investment to ultimately deliver reductions in overall numbers of children in care and increase the proportion of those remaining in care that are placed with in-house fostering households was approved by General Purposes Committee in December. This includes an independent evaluation that commenced in January 2018 to establish whether the progress of children through the care system and spending too long in care is a factor in the numbers of children in care being higher than statistical neighbours. The first stage of this work has been completed and has informed the wider service development that is being presented to the Children and Young People's Committee in May 2018.

Service	Budget 2017/18	Actual	Outturn Variance	
	£'000	£'000	£'000	%
16) Adoption	**4,406**	**5,001**	**595**	**14%**
The Allowances budget outturn position is an overspend of £595k. Our contract with Coram Cambridgeshire Adoption (CCA) provides for 39 adoptive placements pa. In 2017/18 we required an additional 20 adoptive placements. There was also a need to purchase inter agency placements to manage this additional requirement and ensure our children receive the best possible outcomes. This resulted in an overspend of £351k. The Adoption/SGO allowances pressure of £244k is due to an increase in SGOs over and above our growth forecasts. We have seen an increase of 15% (28 SGOs) in 2017/18 against a planned full year rise of 9%. The increase in Adoption and Special Guardianship orders is however a reflection of the good practice in making permanency plans for children outside of the looked after system and results in reduced costs in the placement budgets.				
17) Legal Proceedings	**1,540**	**2,337**	**797**	**52%**
The Legal Proceedings budget outturn position is an overspend of £797k. This is an increase of £111k from last month which was due to a higher than anticipated increase in costs for February and March due to the number of cases being managed by the service and the increase in presentation of end year invoices by providers. Numbers of care applications increased by 52% from 2014/15 (105) to 2016/17 (160), mirroring the national trend. There are currently 96 open sets of care proceedings. Whilst the numbers of ongoing care proceedings have reduced by around 14% since 1 April 2017 we have consistently had around 100 cases which exceeded the previous year's number of completed legal proceedings and caused significant pressure on the budget. Whilst we are now in a position of having less ongoing sets of care proceedings (and less new applications being issued in Court) legacy cases and associated costs are still working through the system.				

Service	Budget 2017/18	Actual	Outturn Variance	
	£'000	£'000	£'000	%
18) SEND Specialist Services	**7,739**	**7,911**	**172**	**2%**

The SEND Specialist Services outturn position is an overspend of £172k, which is an increase of £74k from last month. This was caused by:

- An increase in the cost of Primary aged pupils without an EHCP, in receipt of an alternative provision package from the SEND District Teams, some of which are supplemented by external tuition agency support due to capacity constraints within the District Teams. These children have either been permanently excluded, are at risk of permanent exclusion or have non in-patient medical needs.
- A shortfall in income generated through the SEND traded service offer. Due to a recruitment delay, we were not able to maximise the level of income generated through the Cambridgeshire Steps programme.
- The cost of providing Educational Psychology services increased at year end due to the use of agency staff to deliver the statutory work of the service
- The cost of providing equipment for children in mainstream settings

Actions going forward:

- We will increase the level of income generated through an expanded traded offer, through the roll out a county-wide, therapeutic approach to behaviour management called Cambridgeshire Steps. A new post will lead on the training and business development of the model across Cambridgeshire and Peterborough. We expect the programmes to reduce challenging behaviour in children with social, emotional and mental health difficulties and those for whom challenging behaviour links to their autism spectrum condition. We also expect that this programme will help to reduce permanent exclusions and to reduce challenging behaviour in children with social, emotional and mental health difficulties and those for whom challenging behaviour links to their autism spectrum condition.
- Informed by the current review of social, emotional and mental health (SEMH) provision, improve the outcomes and target funding to best meet the needs of children and young people locally through a clear and coherent graduated approach. A financially sustainable model that best meets needs in the community and improve outcomes will be introduced
- We will review physical equipment and ICT/ICT equipment criteria and application process for the mainstream equipment budget and will implement a Memorandum of Understanding in relation to equipment needs of children in an education setting and agreed by the Integrated Community Equipment Store Children's Equipment Group.

19) High Needs Top Up Funding	**13,573**	**15,747**	**2,174**	**16%**

Numbers of young people with Education Health and Care Plans (EHCP) in Post-16 Further Education providers continue to increase and as a result the year-end pressure of £2.1m over budget. This budget is funded from the Dedicated Schools Grant (DSG) High Needs Block and for this financial year, this pressure has been managed within the overall available DSG resources.

£147k of this pressure was caused by increasing the level of funding for Speech and Language Therapy. From 2018/19, this work, commissioned jointly with Peterborough City Council, will fully funded at a fixed price. A permanent budget allocation has been identified and as such there will not be a recurrent budget pressure in 2018/19.

Actions going forward:

Through the current Strategic Review of High Needs Provision, we have developed an action plan to ensure longer term financial sustainability of this budget whilst improving outcomes for young people. In summary, the initial focus will be on:

- A review of the current decision making matrix, to ensure it is sufficiently robust and that the right decisions are made at the most appropriate level in the management hierarchy, according to complexity and value. This will include a comparative review of processes and decision making

in other local authorities, including our closest statistical neighbours. We will upskill staff to ensure they are empowered in their decision making and will provide support through an enhanced moderation process

- A review of the Education Health Care Needs (EHCN) Assessment Threshold Guidance to achieve fairness and equity of access to EHCN assessment for children who need it and greater efficiency, effectiveness and transparency in decision making
- A review of the Statutory Assessment Team, to ensure sufficient resource is allocated to undertake monitoring reviews, seeking initially to maximise the amount of SEND reform grant funding that is earmarked to provide capacity to the service. We will ascertain the business need for additional monitoring or standalone unit and attribute the likely saving from this work, by mapping of expected review process including 'deep dive' to ensure top-up funding spent in schools and settings is monitored in the most effective way.
- A comprehensive review of SEN funding for schools and Further Education (FE) colleges. This will include proposals for a tiered funding model for children who have special educational needs, and have needs that require additional support over and above the notional funding in budgets. In full consultation with Cambridgeshire's Schools' Forum, a review of the funding levels (hourly rates) for FE top up funding (Element 3 DSG) including full benchmarking exercise with statistical neighbours is underway. We will seek to develop a new funding model for post-16 and will explore the potential for a tiered funding model for FE colleges.

20) SEN Placements	**8,973**	**10,342**	**1,369**	**15%**

The SEN Placements outturn position is an overspend of £1.4m, which is an increase of £168k from last month. The majority of this increase relates to a lower than expected level of LDP income for one particular young person (c. £50k) and an increase in Recoupment costs (c. £100k).

Overall this budget has seen an increase in pressure from a rise in the numbers of children and young people who are LAC, have an EHCP and have been placed in a 52 week placement. These are cases where the child cannot remain living at home. Where there were concerns about the local schools meeting their educational needs, the SEN Placement budget has funded the educational element of the 52 week residential placement; often these were residential schools given the level of learning disability of the young children, which are generally more expensive.

The SEN Placement budget is funded from the High Needs Block (HNB) element of the Dedicated Schools Grant (DSG).

Actions going forward:

- SEND Sufficiency work is underway to inform future commissioning strategy. This will set out what the SEND need is across Cambridgeshire, where it is and what provision we need in future, taking account of demographic growth and projected needs;
- Three new special schools to accommodate the rising demand over the next 10 years. One school opened in September 2017 with two more planned for 2020 and 2021. Alternatives such as additional facilities in the existing schools, looking at collaboration between the schools in supporting post 16, and working with further education providers to provide appropriate post 16 course is also being explored in the plan;
- SEND Commissioning Strategy and action plan are being developed with a focus on children and young children with SEND in Cambridgeshire accessing mainstream education;
- Work on coordination of reviews for ISEPs to look at returning in to county;
- A full review of all High Needs spend is required due to the ongoing pressures and proposed changes to national funding arrangements;
- All out county placements are in the process of being reviewed and, where appropriate, re-negotiation of packages is taking place; and
- Agree principles for community support/alternative packages of support across all agencies for children and young people up to 25 years who may come under Transforming Care.

Service	Budget 2017/18	Actual	Outturn Variance	
	£'000	£'000	£'000	%
21) Early Years Specialist Support	**965**	**706**	**-259**	**-27%**

The Early Year Access Fund (EYAF) budget underspent by £317k in 17/18, as costs were funded from the new SEN Inclusion Fund (SENIF). For 18/19, the entirety of the EYAF budget has been transferred into the new SENIF budget to assist fund the support costs for 3 and 4 year olds.

In addition, there was a small underspend on the Childcare Access Fund (-£20k), and small overspends on the Children Educated at Home budget (£44k) and the Therapy budget (£34k) following the outcome from Tribunal, where funding for one additional young person was agreed in each instance.

22) Out of School Tuition	**1,119**	**1,939**	**820**	**73%**

The Out of School Tuition outturn position is a £0.8m overspend, which is an increase of £185k from last month. The increase is due to a higher number of children taking up their hours, than previously anticipated and a higher number of children accessing new packages due to breakdown of placement.

Several key themes have emerged throughout the year, which have had an impact on the need for children to receive a package of education, sometimes for prolonged periods of time:

- Casework officers were not always made aware that a child's placement was at risk of breakdown until emergency annual review was called.
- Casework officers did not have sufficient access to SEND District Team staff to prevent the breakdown of an education placement in the same way as in place for children without an EHCP.
- There were insufficient specialist placements for children whose needs could not be met in mainstream school.
- There was often a prolonged period of time where a new school was being sought, but where schools put forward a case to refuse admission.
- In some cases of extended periods of tuition, parental preference was for tuition rather than in-school admission.

There has been an increase in the number of children with an Education Health and Care Plan (EHCP) who are awaiting a permanent school placement. The delay was due to the nature and complexity of the needs of these children. Many of these children are in Key Stage 1 and did not have a permanent placement due to a lack of provision for this cohort of children. In addition, there were a number of children and young people who had a Statement of SEN/EHCP and had been out of school for some time. A smaller cohort of Primary aged children who were permanently excluded, or those with long term medical absence from school, sometimes required external tuition packages when SEND Specialist Teaching capacity is full.

<u>Actions going forward</u>:

- A new process has been established to ensure all allocations and packages are reviewed in a timely way and that there is oversight of moves back into full time school. The transfer of the Out of School Tuition budget to the SEND Services (from November 17) enables more opportunities to use resources differently and to have more cost effective in-house tuition. There have been discussions with the Transformation Team and following the outcomes and recommendations of several large scale provisions and funding reviews, we aim to look at the extension of the existing team in order to prevent placement breakdown more effectively and provide high quality teaching to a smaller number of children who need tuition.
- Immediate interim controls have been placed on access to this budget. Casework officers and Statutory Assessment Team Leaders must request new packages or increases to existing packages with the budget holder. This is vital in order to understand the nature of requests and bring in swift additional support from SEND District Teams. This is not a long term solution and the budget holder is working with the Transformation Team to investigate whether the pump-priming of the SEND District Teams with additional staff could either prevent the breakdown of

placement (and therefore reduce the need for packages of education) or provide in-house tuition at a cheaper rate.

- The current Tuition Provider Framework is up for recommissioning in March 2018. It has been agreed to extend the framework by 12 months in order to give time to look at more sustainable and in-house provision. These decisions and a business case will be formulated using the data and recommendations given through the SEMH Review, High Needs Block Review and SEND Sufficiency Review. The Tuition Provider Contract is zero-based and requires no minimum fulfilment.
- In the short term, it has been agreed to review all cases open to tuition with casework officers as a matter of urgency. This will involve rag rating cases according to confidence that tuition will be ceasing soon (e.g. next steps to a school are in place), safeguarding and financial concerns.

Service	Budget 2017/18	Actual	Outturn Variance	
	£'000	£'000	£'000	%
23) Early Help District Delivery Service - South	**4,845**	**4,720**	**-125**	**-3%**
The Early Help District Delivery Service outturn position is an under spend of £125k. This under spend was mainly the result of vacancy savings accrued from DSG funded posts throughout the year. DSG funded vacancy savings were retained within each individual service and did not contribute towards the Children and Safeguarding Directorate's £1m vacancy savings target for 2017/18. Instead, the DSG-vacancy savings accrued were offset against a number of DSG budget pressures across other services, which allowed for these pressures to be managed within the overall available DSG resources.				
24) Schools Intervention Service	**1,077**	**1,183**	**106**	**10%**
The Schools Intervention Service is £106k overspent at the end of 2017/18. A larger than anticipated number of maintained schools have required Local Authority interventions which has reduced the ability of advisers to trade in order to generate income, resulting in the year-end overspend. There have been further pressures due to a reduction in Service Level Agreement buy-ins from schools for Governor Services.				
25) Schools Partnership Service	**753**	**608**	**-145**	**-19%**
The Schools Partnership Service is £145k underspent at the end of 2017/18. This is primarily due to applying grant funding within the Virtual School. In addition to this there was a small underspend on the Dedicated Schools Grant element of the service.				
26) Executive Director & Central Financing	**-107**	**-369**	**-262**	**245%**
The net outturn position for the Executive Director budget area is a £262k underspend. Nationally, local authorities are currently permitted greater flexibility in use of capital receipts (proceeds from sales of assets) to fund any project that is designed to generate ongoing revenue savings in the delivery of public services and/or transform service delivery to reduce costs. The Council was already making use of this flexibility – and following a recent review a further £193k of eligible expenditure was identified within People & Communities. The remaining underspend resulted from a number of smaller savings achieved across the directorate.				
27) Financing DSG	**-40,518**	**-44,263**	**-3,742**	**9%**
Within P&C, spend of £40.5m is funded by the ring fenced Dedicated Schools Grant. A contribution of £3.74m has been applied to fund pressures on a number of High Needs budgets including Top-up Funding (£2.17m); SEN Placements (£1.36m); Out of School Tuition (£0.82m); less any associated underspends (£0.65m). The total DSG position is currently being finalised and will be reported to Schools Forum in due course. The underlying deficit will then need to be manged as part of the ongoing review of High Needs funding.				

APPENDIX 3 – Grant Income Analysis

The table below outlines the additional grant income, which is not built into base budgets.

Grant	Awarding Body	Expected Amount £'000
Grants as per Business Plan		
Public Health	Department of Health	331
Better Care Fund	Cambs & P'Boro CCG	23,468
Social Care in Prisons Grant	DCLG	319
Unaccompanied Asylum Seekers	Home Office	1,622
Staying Put	DfE	132
Youth Offending Good Practice Grant	Youth Justice Board	531
Crime and Disorder Reduction Grant	Police & Crime Commissioner	127
Troubled Families	DCLG	1,855
Children's Social Care Innovation Grant (MST innovation grant)	DfE	521
Domestic Abuse	DCLG	574
High Needs Strategic Planning Funding	DfE	267
MST Standard	DoH	63
Adult Skills Grant	Skills Funding Agency	2,294
AL&S National Careers Service Grant	European Social Fund	284
Non-material grants (+/- £160k)	Various	116
Total Non Baselined Grants 2017/18		**32,504**

Financing DSG	Education Funding Agency	40,518
Total Grant Funding 2017/18		**73,022**

The non baselined grants are spread across the P&C directorates as follows:

Directorate	Grant Total £'000
Adults & Safeguarding	2,603
Commissioning	21,305
Children & Safeguarding	4,727
Education	21
Community & Safety	3,847
TOTAL	**32,504**

APPENDIX 4 – Virements and Budget Reconciliation

Virements between P&C and other service blocks:

	Eff. Period	£'000	Notes
Budget as per Business Plan		**237,311**	
Multiple Policy Lines	Apr	-292	Corporate Capacity Review (CCR) adjustments
Multiple Policy Lines	Apr	311	Apprenticeship Levy – allocation of budget to meet new payroll cost.
Information Management & Information Technology	Apr	-1,286	Digital Strategy moved to Corporate Services
Multiple Policy Lines	Apr	-293	Savings from organisational structure review within P&C, contribution to corporate target
Adult & Safeguarding	Apr	-52	Court of Protection Client Funds Team transferring to Finance Operations within LGSS
Shorter Term Support and Maximising Independence	May	-10	Transfer from Reablement for InTouch Maintenance to Corporate Services (Digital)
Multiple Policy Lines	May	-1,335	Workforce Development moved to Corporate Services as part of Corporate Capacity review
Safer Communities Partnership	May	-178	DAAT budgets transferred to Public Health Joint Commissioning Unit
Early Help District Delivery Service – North & South	June	-43	Transfer Youth and Community Coordinator budget to Corporate Services per CCR
Education Capital	June	-11	Transfer Property Services from LGSS
LAC Placements	July	2,913	LAC Demography approved by GPC in July
Strategic Management - Adults	July	12	Transfer of Dial a Ride (ETE) to Total Transport (P&C)
Catering & Cleaning Services	Aug	449	Transfer from Education to Commercial and Investment
Adult Early Help	Aug	80	Transfer from Corporate & Customer Services (following review of welfare benefits advice provision)
Adult Learning & Skills	Sept	180	Adult Learning & Skills moved from ETE to Community & Safety
Strategic Management - Children & Safeguarding	Sept	-54	Transfer Budget from CSC Business Support - BSO's to Applications Development Team, within LGSS
Strengthening Communities	Sept-Jan	429	Grants to Voluntary Organisations from Corporate Services
Central Integrated Youth Support Services	Sept	261	Transfer of SCS payroll budget from Corporate services
Childrens' Innovation & Development Service and 0-19 Organisation & Planning	Sept	343	Transfer Trading Units (PCS, ICT, Music and Outdoor Education) to Commercial and Investment
Strategic Management - Commissioning	Oct	382	Healthwatch to Commissioning from Corporate services
Multiple Policy Lines	Dec / Feb	482	Annual staff related Insurance
Physical Disabilities	Jan	-31	Redundancy Savings to Corporate
Budget 2017/18		**239,567**	

APPENDIX 5 – Reserve Schedule

Fund Description	Balance at 1 April 2017	2017/18		Year End Balance 2017/18	Notes
		Movements in 2017/18	Balance at Close 17/18		
	£'000	£'000	£'000	£'000	
General Reserve					
P&C carry-forward	540	-7,493	-6,953	-6,953	Overspend £6,953k applied against General Fund.
subtotal	**540**	**-7,493**	**-6,953**	**-6,953**	
Equipment Reserves					
IT for Looked After Children	133	-69	64	64	Replacement reserve for IT for Looked After Children (2 years remaining at current rate of spend).
subtotal	**133**	**-69**	**64**	**64**	
Other Earmarked Reserves					
Adults & Safeguarding					
Homecare Development	22	-22	0	0	Managerial post worked on proposals that emerged from the Home Care Summit - e.g. commissioning by outcomes work.
Falls prevention	44	-44	0	0	Up scaled the falls prevention programme with Forever Active
Dementia Co-ordinator	13	-13	0	0	Used to joint fund dementia co-ordinator post with Public Health
Mindful / Resilient Together	188	-133	55	55	Programme of community mental health resilience work (spend over 3 years)
Increasing client contributions and the frequency of Financial Re-assessments	14	-14	0	0	Hired fixed term financial assessment officers to increase client contributions as per BP
Brokerage function - extending to domiciliary care	35	-35	0	0	Trialled homecare care purchasing co-ordinator post located in Fenland
Hunts Mental Health	200	0	200	200	Provision made in respect of a dispute with another County Council regarding a high cost, backdated package
Commissioning					
Capacity in Adults procurement & contract management	143	-143	0	0	Continuing to support route rationalisation for domiciliary care rounds
Specialist Capacity: home care transformation / and extending affordable care home capacity	25	-25	0	0	External specialist support to help the analysis and decision making requirements of these projects and tender processes
Home to School Transport Equalisation reserve	-240	296	56	56	A £296k contribution has been made back to reserves to account for 2017/18 having fewer schools days where pupil require transporting
Reduce the cost of home to school transport (Independent travel training)	60	0	60	60	Programme of Independent Travel Training to reduce reliance on individual taxis
Prevent children and young people becoming Looked After	25	-25	0	0	Re-tendering of Supporting People contracts (ART)

Fund Description	Balance at 1 April 2017	2017/18		Year End Balance 2017/18	Notes
		Movements in 2017/18	Balance at Close 17/18		
	£'000	£'000	£'000	£'000	
Disabled Facilities	44	-5	38	38	Funding for grants for disabled children for adaptations to family homes.
Community & Safety					
Youth Offending Team (YOT) Remand (Equalisation Reserve)	150	-90	60	60	Equalisation reserve for remand costs for young people in custody in Youth Offending Institutions and other secure accommodation.
Children & Safeguarding					
Child Sexual Exploitation (CSE) Service	250	-250	0	0	The funding was required for a dedicated Missing and Exploitation (MET) Unit and due to a delay in the service being delivered this went back to GPC to obtain approval, as originally the Child Sexual Exploitation service was going to be commissioned out but now this was bought in house within the Integrated Front Door and this funding was required in 2017/18 to support this function (1 x Consultant Social Worker & 4 x MET Hub Support Workers).
Education					
Cambridgeshire Culture/Art Collection	47	106	153	153	Providing cultural experiences for children and young people in Cambs - fund increased in-year due to sale of art collection
ESLAC Support for children on edge of care	36	-36	0	0	Funding for 2 year post re CIN
Cross Service					
Develop 'traded' services	30	-30	0	0	£30k was for Early Years and Childcare Provider Staff Development
Improve the recruitment and retention of Social Workers (these bids are cross-cutting for adults, older people and children and young people)	78	-78	0	0	This funded 3 staff focused on recruitment and retention of social work staff
Reduce the cost of placements for Looked After Children	110	-110	0	0	Used for repairs & refurb to council properties: £5k Linton; £25k March; £20k Norwich Rd; £10k Russell St; Alterations: £50k Havilland Way Supported the implementation of the in-house fostering action plan: £74k
Other Reserves (<£50k)	149	-43	106	106	Other small scale reserves.
subtotal	**1,423**	**-694**	**728**	**728**	
TOTAL REVENUE RESERVE	**2,096**	**-8,256**	**-6,161**	**-6,161**	

Fund Description	Balance at 1 April 2017	2017/18		Year End Balance 2017/18	Notes
		Movements in 2017/18	Balance at Close 17/18		
	£'000	£'000	£'000	£'000	
Capital Reserves					
Devolved Formula Capital	780	980	1,760	717	Devolved Formula Capital Grant is a three year rolling program managed by Cambridgeshire Schools.
Basic Need	0	32,671	32,671	0	The Basic Need allocation received in 2017/18 is fully committed against the approved capital plan.
Capital Maintenance	0	4,476	4,476	0	The School Condition allocation received in 2017/18 is fully committed against the approved capital plan.
Other Children Capital Reserves	1,448	1,777	3,225	5	£5k Universal Infant Free School Meal Grant c/fwd.
Other Adult Capital Reserves	379	3,809	4,188	56	Adult Social Care Grant to fund 2017/18 capital programme spend.
TOTAL CAPITAL RESERVE	**2,607**	**43,713**	**46,320**	**778**	

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

APPENDIX 6 – Capital Expenditure and Funding

6.1 Capital Expenditure

2017/18					TOTAL SCHEME	
Original 2017/18 Budget as per BP	Scheme	Revised Budget for 2017/18	Actual Spend (Close)	Outturn Variance (Close)	Total Scheme Revised Budget	Total Scheme Forecast Variance
£'000		£'000	£'000	£'000	£'000	£'000
	Schools					
41,560	Basic Need - Primary	38,750	37,434	**-1,316**	274,415	-8,455
26,865	Basic Need - Secondary	29,520	29,810	**289**	219,592	22,259
841	Basic Need - Early Years	1,687	1,042	**-645**	5,442	192
1,650	Adaptations	1,945	1,719	**-227**	3,442	919
248	Specialist Provision	242	12	**-230**	9,810	0
3,000	Condition & Maintenance	3,000	3,316	**317**	27,400	0
1,076	Schools Managed Capital	1,760	3,024	**1,264**	12,022	-664
150	Site Acquisition and Development	150	137	**-13**	650	0
1,500	Temporary Accommodation	1,500	2,278	**778**	15,500	0
2,095	Children Support Services	383	3	**-380**	2,693	75
5,354	Adult Social Care	5,278	5,432	**153**	36,029	0
-6,664	CFA Capital Variation	-10,305	0	**10,305**	-37,825	0
1,533	Capitalisation of Interest Costs	1,533	1,258	**-275**	6,846	0
79,208	**Total CFA Capital Spending**	**75,442**	**85,464**	**10,022**	**576,016**	**14,326**

Basic Need - Primary £8,455k reduction in scheme cost
A total scheme variance of -£8,455k has occurred due to changes since the Business Plan was approved in response to adjustments to development timescales and updated school capacity information. The following schemes have had cost variations since the 2017/18 Business Plan was published;

- Clay Farm (Trumpington Park) Primary; £384k reduction as risk and contingency items not required.
- Fulbourn Primary; £1,215k increase. Detailed planning and design changes have been required to achieve the project and address issues including the severe physical and operational site constraints and drainage restrictions.
- The Shade, Soham; £113k reduction as risk and contingency items not required.
- Wyton Replacement School; £2,773k increase as the scope of the scheme has increased to provide for a 0.5FE extension of the school from 1FE to 1.5FE to ensure it can respond to future demand for places.
- Melbourn Primary; £281k increase due to changes to project scope including works to an early years provision.
- Morley Memorial Primary School; £443k increase due to updating of milestones which were originally undertaken in 2012.
- Fourfields Primary; £2,300k reduction: further analysis of need has identified that this scheme can be removed from the capital programme. This will only impact on future years and not 2017/18.
- Wyton New School; £10,000k reduction further developments involving planning has meant this school can be removed from the capital plan. This will only impact on future years and not 2017/18.

In May 2017 the reductions in scheme cost increased by £419k due to underspends on 2017/18 schemes which were completed and did not require the use of budgeted

contingencies: Godmanchester Bridge (£129k), Fordham Primary (£157k) and Ermine Street Primary at Alconbury Weald (£139k).

In June these reductions were again increased by £628k due to an underspend on the Isle of Ely Primary (£156k) as a result of a contingency not required and reduction in project cost (£472k) for the Barrington Primary School Scheme identified by the milestone 2 report.

In August there was a further reduction of £280k due to contingencies and risk items not being required for Hatton Park School project.

In September an increase of £1,350k occurred due to continued development in the scope of the Gamlingay Primary School scheme.

Basic Need - Primary £1,316k 2017/18 slippage
The following schemes have experienced significant slippage in 2017/18;

- Meldreth Primary incurred slippage of £840k due to the scheme experiencing a delay in the commencement on site from November 2017 to February 2018.
- Barrington Primary School £108k slippage in 2017/18 as the project has been re-phased to achieve a September 2020 completion. As a consequence, anticipated spend on planning and design work is not as great as had been expected this financial year.
- Hatton Park Primary School scheme reporting slippage of £306k due to fixtures, fittings and ICT budgets not being spent in full during the financial year and contingencies not being required.
- Histon Additional Places scheme experienced £125k slippage from December 2017 to January 2018 due to delays in the planning application being approved and an extension of 2 weeks to the tender process.
- Wintringham Park Primary in St Neots has incurred £219k slippage due to design work not progressing as anticipated.
- Gamlingay Primary School scheme experienced £456k slippage in 2017/18 due to the start on site being delayed from January 2018 to late February 2018 as a consequence of the planning process. A transportation report was required before approval granted.
- North West Cambridge Primary incurred £150k slippage in 2017/18 as the associated housing development has not yet commenced therefore the scheme has not progressed to the design and planning stage.
- Pendragon Primary scheme has experienced £150k slippage as the housing development associated with the scheme has not commenced.
- Chatteris New School experienced £208k slippage in 2017/18, the withdrawal of an approved bid by the sponsor to open the new school as a Free School from September 2018 and recent demographics which show the scheme is needed less urgently that originally thought has required the re-evaluation of options for providing the additional places required. The additional places will now be delivered as an extension of the age range at Cromwell Community College and has meant a new design proposal was required and the scheme has not yet progressed beyond the concept design stage

These are offset by £59k accelerated spend in 2017/18 on Bellbird Primary, Sawston scheme. Burwell Primary School has experienced £105k overspend in 2017/18 due to additional costs associated with asbestos removal. Fulbourn Primary School has experienced £1,338k accelerated spend as works are progressing ahead of original contractor programme. Wyton Primary scheme has experienced £467k accelerated spend as the project is progressing better than initially forecast.

Basic Need – Secondary £22,259k increased total scheme cost
A total scheme variance of £22,259k has occurred due to changes since the Business Plan was approved;

- Littleport Secondary and Special School has experienced a £1,059k increase in costs due to additional specialist equipment being required as part of the capital build and further costs associated to planning requirements for the sport centre and land purchase required for the scheme.
- Bottisham Secondary scheme has increased by £2,269k due to works funded by a grant from the Education & Skills Funding Agency (ESFA) being carried out by the Council ahead of receipt of that funding. The school will transfer the budget to the Council to fund this.
- Northstowe Secondary scheme has increased by £19,600k due to the addition of SEN provision of which 40 places are to be funded by the EFSA and also the delivery of community sports provision which will attract S106 funding from South Cambridgeshire District Council.
- Cambourne Village College has experienced an increased scheme cost of £412k for the construction of a performance hall. Funding will be received from the district and parish councils to offset this increase.

Basic Need – Secondary £289k 2017/18 overspend
An in-year overspend for Littleport of £405k and accelerated spend on Trumpington Community College of £384k for IT equipment and final contractor payments, has been offset with slippage on Northstowe Secondary (£494k) due to design work commencing later than anticipated. Alconbury Secondary and SEN scheme has incurred £710k slippage which relates to the secondary school element. The design stage on this project has not progressed since the beginning of the financial year as the developer is reviewing the masterplan for Alconbury development and no site has yet been allocated. Slippage has also occurred on North West Fringe (£350k) as the project has been rephased by 1 year. The project at St Bede's and Chesterton to deliver additional places in Cambridge has slipped by £1,099k due to two main factors. Delays in the kitchen refurbishment works and a revised completion date of 26 June rather than 29 May 2018 at St Bedes and the Chesterton element of the scheme not starting on site until next financial year.

Bottisham Village College has experienced £1,160k of accelerated spend due to revised contractor reports indicating the project is ahead of the scheme's original schedule. Additional costs of £510k have been incurred on Hampton Garden Secondary school, a joint scheme with Peterborough City Council. These costs relate to ICT not funded by the ESFA £225k, reprogramming of the multi-use games area (£75k) and access works to the A15 (£200k).

Basic Need – Early Years £192k increased scheme cost
Increased scheme cost (£592k) to cover identified Early Years commitments. The scheme has subsequently been reduced by £400k as this element has been added in future years to the Morley Memorial Primary School project to undertake the building of Early Years annex as part of this scheme.

Basic Need – Early Years £645k slippage
Orchard Park Primary early years provision has experienced slippage of £341k as the project is currently on hold pending the outcome of a review. Further slippage of £304k has been experienced on the early years project at Peckover, Wisbech.

Adaptations £919k increased total scheme cost
Morley Memorial Primary School has experienced additional total scheme costs of £919k due to the revision of the project which was initially costed in 2012. The additional requirements reflect inflationary price increases and not a change to the scope of the scheme, the further additional £477k is in regard to the Early Years aspect £400k of which has been transferred from the Basic Need – Early Years budget to provide an Early Years annex as part of the scheme.

Adaptations £222k 2017/18 slippage
Morley Memorial Primary School scheme has incurred a slight delay in the start on site that has resulted in £132k slippage in 2017/18. The project will meet its completion date of September 2018. The remaining slippage has occurred at Holme.

Schools Managed Capital £1,264k 2017/18.
Devolved Formula Capital (DFC) is a three year rolling balance and includes £780k carry forward from 2017/18. The total scheme variance of £664k relates to the reduction in 2017/18 grant being reflected in planned spend over future periods. The 2017/18 position relates to schools funded capital of £1,981k which has matching funding to offset the impact. Devolved Formula Capital has a carry forward into 2018/19 of £717k

Condition, Maintenance and Suitability £317k 2017/18 overspend
Condition & Maintenance; £317k overspend is due to higher than expected costs (£197k) for kitchen ventilation works required to meet health and safety standards and projects requiring urgent attention to ensure school remained operational. The remaining £120k is due to urgent works to maintain schools condition.

Temporary Accommodation £778k 2017/18 overspend
It had been anticipated at Business Planning that the current stock of mobiles would prove sufficient to meet demand. Unfortunately, it has proved necessary to provide additional mobiles at Spring Common Special School which had required substantial investment (£617k) to make the accommodation suitable.

P&C Capital Variation

The Capital Programme Board recommended that services include a variation budget to account for likely slippage in the capital programme, as it is sometimes difficult to allocate this to individual schemes in advance. The allocation for P&C's negative budget adjustments has been calculated as follows, shown against the slippage position for 2017/18:

2017/18					
Service	**Capital Programme Variations Budget**	**Outturn Variance (Close)**	**Capital Programme Variations Budget Used**	**Capital Programme Variations Budget Used**	**Revised Outturn Variance (Close)**
	£000	**£000**	**£000**	**%**	**£000**
P&C	-10,305	0	0	0%	10,305
Total Spending	-10,305	0	0	0%	10,305

At the end of the 2017/18 financial year the Capital Variation budget has not been utilised. This will be offset with additional borrowing of £10,305k.

6.2 Capital Funding

2017/18				
Original 2017/18 Funding Allocation as per BP	**Source of Funding**	**Revised Funding for 2017/18**	**Spend – Outturn**	**Forecast Funding Variance - Outturn (Feb)**
£'000		**£'000**	**£'000**	**£'000**
32,671	Basic Need	32,671	32,671	0
4,043	Capital maintenance	4,476	4,476	0
1,076	Devolved Formula Capital	1,760	1,043	-717
3,904	Adult specific Grants	4,188	4,132	-56
17,170	S106 contributions	14,800	11,696	-3,104
0	Early Years Grant	1,443	1,443	0
0	Capitalised Revenue Funding	0	0	0
2,725	Other Capital Contributions	3,804	3,758	-46
26,464	Prudential Borrowing	21,145	35,089	13,944
-8,845	Prudential Borrowing (Repayable)	-8,845	-8,845	0
79,208	**Total Funding**	**75,442**	**85,463**	**10,021**

The overall net impact of the movements within the capital plan a required increase to Prudential Borrowing of £13,944k in 2017/18, this is due to;
£3,104k is S106 funding which has not been received as anticipated, due to timing differences in the delivery of housing development. The remainder is due to in year overspends and capital plan not meeting the capital variation expectation of £10,305k.

£56k Adult Specific grant which is to be carried forward into future years, along with £717k of Devolved Formula Capital which represents the School DFC programme, a rolling three-year programme; and accounts for 16/17 and 17/18 rolled forward funds.

APPENDIX 7 – Performance at end of March 2018

Outcome	Adults and children are kept safe									
Measure	**Responsible Directorate(s)**	**Previous period**	**Target**	**Actual**	**Date of latest data**	**Direction of travel (up is good, down is bad)**	**RAG Status**	**Stat Neighbours**	**England**	**Comments**
% of adult safeguarding enquiries where outcomes were at least partially achieved	Adults & Safeguarding	73.0%	n/a	95.0%	Aug	↑	Improving	n/a	n/a	Performance is improving
% of people who use services who say that they have made them feel safer	Adults & Safeguarding	83.2%	n/a	84.8%	2016/17	↑	No target	n/a	n/a	Performance is improving
Rate of referrals per 10,000 of population under 18	Children & Safeguarding	298.6	n/a	330.1	Mar	↓	**No target**	455.8	548.2	The referral rate is favourable in comparison to statistical neighbours and the England average
% children whose referral to social care occurred within 12 months of a previous referral	Children & Safeguarding	12.54%	20.0%	12.50%	Mar	↑	On Target	22.3%	21.9%	Performance in re-referrals to children's social care is below the ceiling target and is significantly below average in comparison with statistical neighbours and the England average.

Outcome	Adults and children are kept safe									
Measure	**Responsible Directorate(s)**	**Previous period**	**Target**	**Actual**	**Date of latest data**	**Direction of travel (up is good, down is bad)**	**RAG Status**	**Stat Neighbours**	**England**	**Comments**
Number of children with a Child Protection Plan per 10,000 population under 18	Children & Safeguarding	37.1	30.0	35.5	Mar		Off Target	36.93	43.3	During March we saw the numbers of children with a Child Protection plan decrease from 498 to 477. The introduction of an Escalation Policy for all children subject to a Child Protection Plan was introduced in June. Child Protection Conference Chairs raise alerts to ensure there is clear planning for children subject to a Child Protection Plan. This has seen a decrease in the numbers of children subject to a Child Protection Plan.
Proportion of children subject to a Child Protection Plan for the second or subsequent time (within 2 years)	Children & Safeguarding	27.9%	n/a	10.4%	Mar		**No target**	22.5%	18.7%	The rate is favourable in comparison to statistical neighbours and the England average

Outcome	Adults and children are kept safe									
Measure	Responsible Directorate(s)	Previous period	Target	Actual	Date of latest data	Direction of travel (up is good, down is bad)	RAG Status	Stat Neighbours	England	Comments
The number of looked after children per 10,000 population under 18	Children & Safeguarding	51.9	40	51.9	Mar		Off Target	44.9	62	In March the number of Looked After Children held at 697. This figure includes 63 UASC, 9% of the current LAC population. There are workstreams in the LAC Strategy which aim to reduce the rate of growth in the LAC population, or reduce the cost of new placements. Some of these workstreams should impact on current commitment. Actions being taken include: A weekly Threshold to Resources Panel (TARP), chaired by the Assistant Director for Children's Services to review children on the edge of care, specifically looking to prevent escalation by providing timely and effective interventions. Decisions and Children's Plans are monitored via a tracker which also takes into account the children's care plan- discussed in the Permanency Monitoring Group. A monthly Permanency Monitoring Group (PMG) considers all children who are looked after, paying attention to their care plan, ensuring reunification is considered and if this is not possible a timely plan is made for permanence via Special Guardianship Order, Adoption or Long Term Fostering. TARP links with the monthly High Cost Placements meeting, which as of January 2018 started to be chaired by the Assistant Director for Children's Services. The panel ensures that required placements meet the child or young person's needs and are cost effective and joint funded with partners where appropriate. At present the savings within the 2016/17 Business Plan are on track to be delivered and these are being monitored through the monthly LAC Commissioning Board. The LAC strategy and LAC action plan are being implemented as agreed by CYP Committee.

Outcome	Adults and children are kept safe									
Measure	**Responsible Directorate(s)**	**Previous period**	**Target**	**Actual**	**Date of latest data**	**Direction of travel (up is good, down is bad)**	**RAG Status**	**Stat Neighbours**	**England**	**Comments**
Number of young first time entrants into the criminal justice system, per 10,000 of population compared to statistical neighbours	Community & Safety	3.68	n/a	3.23	Q3		**No target**			Awaiting comparator data

Outcome	Older people live well independently									
Measure	**Responsible Directorate(s)**	**Previous period**	**Target**	**Actual**	**Date of latest data**	**Direction of travel (up is good, down is bad)**	**RAG Status**	**Stat Neighbours**	**England**	**Comments**
Number of contacts for community equipment in period	Adults & Safeguarding		n/a				No target	n/a	n/a	New measure, currently in development
Number of contacts for Assistive Technology in period	Adults & Safeguarding		n/a				No target	n/a	n/a	New measure, currently in development
Proportion of people finishing a reablement episode as independent (year to date)	Adults & Safeguarding	57.3%	57%	57.7%	Mar		On Target	n/a	n/a	Performance above target and improving

Outcome	Older people live well independently									
Measure	Responsible Directorate(s)	Previous period	Target	Actual	Date of latest data	Direction of travel (up is good, down is bad)	RAG Status	Stat Neighbours	England	Comments
Average monthly number of bed day delays (social care attributable) per 100,000 18+ population	Adults & Safeguarding	157	114	151	Feb		Off Target	n/a	n/a	In February 2018, there were 506 ASC-attributable bed-day delays recorded in Cambridgeshire. For the same period the previous year there were 735 delays – a reduction of 31%. The Council is continuing to invest considerable amounts of staff and management time into improving processes, identifying clear performance targets and clarifying roles & responsibilities. We continue to work in collaboration with health colleagues to ensure correct and timely discharges from hospital. Delays in arranging residential, nursing and domiciliary care for patients being discharged from Addenbrooke's remain the key drivers of ASC bed-day delays.
Number of Community Action Plans Completed in period	Adults & Safeguarding	104	n/a	98	Feb		No target	n/a	n/a	Performance decreased against the previous period.
Number of assessments for long-term care completed in period	Adults & Safeguarding	158	n/a	183	Mar		No target	n/a	n/a	Performance increased against the previous period.

Outcome	Older people live well independently									
Measure	**Responsible Directorate(s)**	**Previous period**	**Target**	**Actual**	**Date of latest data**	**Direction of travel (up is good, down is bad)**	**RAG Status**	**Stat Neighbours**	**England**	**Comments**
BCF 2A PART 2 - Admissions to residential and nursing care homes (aged 65+), per 100,000 population	Adults & Safeguarding	326.3	564.0	343.2	Mar		On Target	n/a	n/a	The implementation of the Transforming Lives model, combined with a general lack of available residential and nursing beds in the area has continued to keep admissions below national and statistical neighbour averages. N.B. This is a cumulative figure, so will always go up. An upward direction of travel arrow means that if the indicator continues to increase at the same rate, the ceiling target will not be breached.

Outcome	People live in a safe environment									
Measure	**Responsible Directorate(s)**	**Previous period**	**Target**	**Actual**	**Date of latest data**	**Direction of travel (up is good, down is bad)**	**RAG Status**	**Stat Neighbours**	**England**	**Comments**
Victim-based crime per 1,000 of population compared to statistical neighbours (hate crime)	Community & Safety	54.87	n/a	57.59	Q3		**No target**	55.81	69.23	New measure, in development

Outcome	People with disabilities live well independently									
Measure	Responsible Directorate(s)	Previous period	Target	Actual	Date of latest data	Direction of travel (up is good, down is bad)	RAG Status	Stat Neighbours	England	Comments
Proportion of adults with a primary support reason of learning disability support in paid employment (year to date)	Adults & Safeguarding	3.5%	6.0%	3.6%	Mar		Off Target	n/a	n/a	Performance remains low. As well as a requirement for employment status to be recorded, unless a service user has been assessed or reviewed in the year, the information cannot be considered current. Therefore this indicator is also dependent on the review/assessment performance of LD teams – and there are currently 62 service users identified as being in employment yet to have a recorded review in the current year. (N.B: This indicator is subject to a cumulative effect as clients are reviewed within the period.)
Proportion of adults in contact with secondary mental health services in paid employment	Adults & Safeguarding	13.3%	12.5%	13.0%	Feb		On Target	n/a	n/a	Performance at this measure is above target. Reductions in the number of people in contact with services are making this indicator more variable while the numbers in employment are changing more gradually.
Proportion of adults with a primary support reason of learning disability support who live in their own home or with their family	Adults & Safeguarding	76.2%	72.0%	71.2%	Mar		Within 10%	n/a	n/a	Performance is slightly below target

Outcome	People with disabilities live well independently									
Measure	Responsible Directorate(s)	Previous period	Target	Actual	Date of latest data	Direction of travel (up is good, down is bad)	RAG Status	Stat Neighbours	England	Comments
Proportion of adults in contact with secondary mental health services living independently, with or without support	Adults & Safeguarding	81.2%	75.0%	81.5%	Feb		On Target	n/a	n/a	Performance has improved marginally against the previous period.
Proportion of adults receiving Direct Payments	Adults & Safeguarding	23.3%	24.0%	23.6%	Mar		Within 10%	n/a	n/a	Performance is slightly below target
Proportion of carers receiving Direct Payments	Adults & Safeguarding	95.1%	n/a	95.0%	Mar		No target	n/a	n/a	Direct payments are the default option for carers support services, as is reflected in the high performance of this measure.

Outcome	Places that work with children help them to reach their full potential									
Measure	Responsible Directorate(s)	Previous period	Target	Actual	Date of latest data	Direction of travel (up is good, down is bad)	RAG Status	Stat Neighbours	England	Comments
% of EHCP assessments completed within timescale	Children & Safeguarding	100.0%	n/a	91.4%	Mar		No target			Performance remains high despite a fall in comparison to the previous period
Number of young people who are NEET, per 10,000 of population compared to statistical neighbours	Children & Safeguarding	243.5	n/a	260.3	Mar		No target	213.8	271.1	The rate increased against the previous reporting period, however remains favourable compared to the England average.

Outcome	Places that work with children help them to reach their full potential									
Measure	Responsible Directorate(s)	Previous period	Target	Actual	Date of latest data	Direction of travel (up is good, down is bad)	RAG Status	Stat Neighbours	England	Comments
Proportion of young people with SEND who are NEET, per 10,000 of population compared to statistical neighbours	Children & Safeguarding	6.9%	n/a	7.6%	Q4		No target			Performance fell in comparison to the previous reporting period.
KS2 Reading, writing and maths combined to the expected standard (All children)	Education	52.5%	n/a	58.7%	2016/17		No target	61.3%	61.1%	Performance increased but remains below that of our statistical neighbours and the England average.
KS4 Attainment 8 (All children)	Education	51.5%	n/a	47.7%	2016/17		No target	47.5%	46.3%	Performance fell in comparison to the previous reporting period but is above the average for our statistical neighbours and the England average.
% of Persistent absence (All children)	Education	11.0%	n/a	n/a			**No target**	n/a	10.8%	Data currently unavailable - not released at local authority level.
% Fixed term exclusions (All children)	Education	3.5%	n/a	3.7%	Feb		**No target**	-	-	Performance fell slightly in comparison to the previous reporting period.
% receiving place at first choice school (Primary)	Education	91.3%	n/a	93.2%	Sep		No target	n/a	n/a	Performance increased slightly in comparison to the previous reporting period.
% receiving place at first choice school (Secondary)	Education	92.9%	n/a	92.5%	Sep		No target	n/a	n/a	Performance fell slightly in comparison to the previous reporting period.
% of disadvantaged households taking up funded 2 year old childcare places	Education	69.6%	n/a	82.4%	Autumn term 2017		No target	n/a	n/a	Performance increased significantly in comparison to the previous reporting period.

Outcome	Places that work with children help them to reach their full potential									
Measure	Responsible Directorate(s)	Previous period	Target	Actual	Date of latest data	Direction of travel (up is good, down is bad)	RAG Status	Stat Neighbours	England	Comments
Ofsted - Pupils attending schools that are judged as Good or Outstanding (Primary Schools)	Education	82.4%	n/a	82.5%	Feb		No target	89.4%	88.0%	Performance increased slightly in comparison to the previous reporting period, but remains below average in comparison to our statistical neighbours and the England average.
Ofsted - Pupils attending schools that are judged as Good or Outstanding (Secondary Schools)	Education	85.5%	n/a	88.8%	Feb		No target	86.8%	80.5%	Performance increased slightly in comparison to the previous reporting period, and remains above average in comparison to our statistical neighbours and the England average.
Ofsted - Pupils attending schools that are judged as Good or Outstanding (Special Schools)	Education	93.1%	n/a	93.1%	Feb		No target	96.0%	92.9%	Performance remains comparable to the previous reporting period and is above the England average.
Ofsted - Pupils attending schools that are judged as Good or Outstanding (Nursery Schools)	Education	100.0%	n/a	100.0%	Feb		No target	100.0%	98.0%	Performance remains high and is above the England average.

Outcome	The Cambridgeshire economy prospers to the benefit of all residents									
Measure	**Responsible Directorate(s)**	**Previous period**	**Target**	**Actual**	**Date of latest data**	**Direction of travel (up is good, down is bad)**	**RAG Status**	**Stat Neighbours**	**England**	**Comments**
Proportion of new apprentices per 1,000 of population, compared to national figures	Community & Safety		n/a				**No target**			New measure in development
Engagement with learners from deprived wards as a proportion of the total learners engaged	Community & Safety		n/a				**No target**			New measure in development

APPENDIX 8 – P&C Portfolio at end of March 2018

Programme/Project and Lead Director	Brief description and any key issues	RAG
Building Community Resilience Programme: Sarah Ferguson / Elaine Matthews	The Communities and Partnership Committee in Cambridgeshire have signed off an ambitious Delivery Plan, focused around four key priorities. One of these is to accelerate the work to build community resilience, working in partnership to maximize the capacity across the public sector. The Committee will be receiving a report at the end of May which starts to set out some of the key principles for the work. Discussions have started with District Council's and Peterborough, to create a shared community resilience strategy. The Delivery Plan also reflects the cross cutting nature of this Committee and the support it can bring to all service committees. There are key roles for the five Area Champions (elected members taken from the C&P Committee and politically representative of their District), including supporting the recruitment of key workers (Reablement offices, care and foster parents) through community engagement. Nearly £600k is in the process of being allocated to good ideas which are emerging from community and partner organisations to deliver services differently in a way which could reduce spend for the County Council. The Innovate and Cultivate fund is being reviewed in September/ October 2018 with Members, with a view to making recommendations based on the learning from the pilot.	**GREEN**
Children's Centres: Helen Freeman / Sarah-Jane Smedmor	The new Child and Family Centre offer launched at the beginning of April and has been communicated to families, partners, staff and members. An update paper went to CYP committee in March and performance will be reported back to this committee in due course. Work to look at opportunities to align the service offer across Cambridgeshire and Peterborough is now being investigated. This is alongside work with various colleagues across the health centre looking at how better integration with community healthy delivery could improve services for families. This includes work to establish midwifery 'Community Hubs' from Child and Family Centres as part of the Better Births programme.	**GREEN**

Change for Children: Sarah-Jane Smedmor / James Gemmell	The aims of the project are to identify additional opportunities within children's services to ensure that our services are targeted to those in greatest need and towards those that we can ensure experience a de-escalation of need and risk as a result of effective, integrated, multi-agency services delivered in a timely manner. The following options are being explored and monitored; • The viability of a different delivery model for safeguarding services including multi-disciplinary co-located teams that work together to tackle domestic abuse, substance misuse and mental health issues. • Whether the current offer being delivered by the SPACE team can be mainstreamed into the District teams. The SPACE project has now finished- 30.04.18. The women involved are being supported by Early Help and CCA as appropriate. • Review a number of fixed term posts which were created as part of the earlier phases of the CCP to identify if learning / development has been embedded within the District teams • Review of the fostering service and the Hub provision • Review provision in the Integrated Front Door in response to the recent self-assessment and Peer Review • Using technology / different ways of working to increase productivity across the service • Restrict the use of out of hours support provided by external providers (following the introduction of planned out of hours working for District Teams).This review has been undertaken. Much of the planned out of hours support is now provided by Family Workers. However, this is being considered again with Edge of Care Services as a whole within the Change for Children Programme. • Further opportunities to share services with Peterborough CC	**GREEN**

Programme/Project and Lead Director	Brief description and any key issues	RAG
0-19 Commissioning: Janet Dullaghan	The JCU with CCS and CPFT has made good progress to formalise joint commissioning arrangements and work together to identify an exciting programme that will deliver transformation of 0-19 services to an integrated model in line with policy directives, improving the quality of services for children and families. The next step is to prepare the detailed plan which will set out the timescales, and resources for transforming each of the current service specifications within scope against the framework of principles and themes. Theses next steps are to be agreed at the next transformation steering board for CCS/CPFT on 5/04/2018	**GREEN**

Programme/Project and Lead Director	Brief description and any key issues	RAG
Mosaic: Sue Grace / Joanne Hopkins	• Overall programme is on target for go-live for Adult Services on the 1 October subject to the resolution of the risks allocated to LGSS and some interface work to be finished • The Children's work with Mosaic is paused and Children's IT systems will be considered at GPC on 29 May. • The main risks with the programme are the stability of ERP Gold and its potential impact on Mosaic and the provision of the new Disaster Recovery arrangements by LGSS IT which are essential for Mosaic go-live	**GREEN**
Accelerating Achievement: Jon Lewis	Although the achievement of most vulnerable groups of children and young people is improving, progress is slow and the gap between vulnerable groups and other children and young people remains unacceptably wide. Accelerating the Achievement of Vulnerable Groups is a key priority of the Local Authority's School Improvement Strategy 2016-18 and an action plan has been developed. The AA Steering Group is monitoring the implementation of this plan.	**AMBER**

Appendix 3 - P&C Savings Tracker 2017-1

							Planned £000						Forecast £000										
						8,429	-13,297	-3,784	-3,785	-3,491	**-24,357**	-6,828	-2,344	-3,969	-3,683	**-16,824**	7,533						
Reference	**Title**	**Description**	**Committee**	**Transformation Workstream**	**BP Saving or Funnel?**	**Investment 17-18 £000**	**Original Phasing - Q1**	**Original Phasing - Q2**	**Original Phasing - Q3**	**Original Phasing - Q4**	**Original Saving 17-18**	**Current Forecast Phasing - Q1**	**Current Forecast Phasing - Q2**	**Current Forecast Phasing - Q3**	**Current Forecast Phasing - Q4**	**Forecast Saving**	**Variance from Plan £000**	**Saving complete?**	**RAG**	**Direction of travel**	**Forecast Commentary**	**Links with partner organisations**
A/R.6.001	DAAT - Saving from integrating drug and alcohol misuse service contracts	The NHS trust 'Inclusion' provides countywide specialist drug & alcohol treatment services. Currently there are separate treatment contracts for alcohol and drugs. Inclusion have agreed to commence full service integration in 2016-17. This will require fewer service leads employed in management grades and reduces the overall management on-costs in the existing contract agreement. It is also proposed to reduce Saturday clinics and/or move to a volunteer/service user led model for these clinics.	Adults, C&YP	Contracts, commercial & procurement	BP Saving	0	-100	0	0	0	-100	-100	0	0	0	-100	0	Yes	Green	↔	Saving achieved in full in 2017/18	0
A/R.6.101	Recouping under-used direct payment budget allocations for service users	Improving central monitoring and coordination arrangements for direct payments - ensuring budget allocations are proportionate to need and any underspends are recovered.	Adults	Finance & budget review	BP Saving	87	-98	-99	-99	-99	-395	0	0	0	-176	-176	219	No	Red	↑	Direct payment clawbacks lower than the baseline in 17/18 across all services except Learning Disabilities, where the proportion of service-users with a direct payment is higher.	N - except LD: Pooled budget - learning disability partnership
A/R.6.102	Care Act (part reversal of previous saving)	There is a £60k deficit on Care Act funded schemes going into 2017-18, and a further £60k required to fund a new Community Navigators scheme. A saving of £400k was taken from the Care Act funding in 2016-17. Part of this (£120k) will be reversed to fund these schemes now that they are established and ongoing	Adults	Finance & budget review	BP Saving	0	120	0	0	0	120	120	0	0	0	120	0	Yes	Green	↔	Saving achieved	0
A/R.6.111	Supporting people with physical disabilities and people with autism to live more independently	The focus will be on helping people lead independent lives through the Transforming Lives programme and measures approved by Adults Committee in 2016.	Adults	Commissioning	BP Saving	128	-377	-138	-138	-138	-791	-170	-188	-217	-216	-791	0	No	Green	↔	Saving achieved	0
A/R.6.112	Securing appropriate Continuing Healthcare Funding for people with physical disabilities and ongoing health needs	Careful consideration of the needs of people with complex needs to identify where these needs meet the criteria for Continuing Healthcare and full funding by the NHS.	Adults	Finance & budget review	BP Saving	0	-80	-80	-80	-80	-320	-66	-84	-85	-85	-320	0	No	Green	↔	Saving achieved	NHS fund continuing healthcare
A/R.6.113	Specialist Support for Adults with Autism to increase their independence	Recruitment of two full time Support Workers for a twelve month period to work with service users to develop skills and access opportunities such as training or employment that would reduce the need for social care support.	Adults	Adults services	BP Saving	50	-18	-18	-18	-18	-72	-6	-6	-7	-7	-26	46	No	Red	↔	Mitigation work involved expanding the activity of the Workers to other Vulnerable Adults; monitoring the saving against avoided costs and the demographic expectation.	0
A/R.6.114	Increasing independence and resilience when meeting the needs of people with learning disabilities	The focus will be on helping individuals to be independent and resilient through the Transforming Lives initiative, together with policies approved by Adults Committee in 2016. Care and support will focus on developing skills and opportunities, wherever possible, to increase independence. In the short term this may include more intensive support in order to reduce reliance on social care support in the longer term.	Adults	Commissioning	BP Saving	750	-2,307	-74	0	0	-2,381	-953	-582	-382	-84	-2,001	380	No	Red	↔	Lower than expected savings due to slippage on work (due to need to devote energy to provider fee uplift constraint and engagement difficulties with partner organisations) and lower than expected savings per case.	Pooled budget - learning disability partnership
A/R.6.115	Retendering for residential, supported living and domiciliary care for people with learning disabilities	Contracts will be retendered in 2017-18 with the intention of reducing the unit cost of care.	Adults	Contracts, commercial & procurement	BP Saving	0	-63	-63	-102	-103	-331	-71	0	0	0	-71	260	No	Red	↔	Domiciliary care retender has taken place and delivered associated saving. Decision taken to delay retender for supported living and residential frameworks to allow time to undertake detailed analysis of clients and the market to ensure retender is as effective as possible, and won't deliver a saving.	Pooled budget - learning disability partnership
A/R.6.116	Using assistive technology to help people with learning disabilities live and be safe more independently without the need for 24hr or overnight care	New and existing care packages will be reviewed by specialist Assistive Technology and Occupational Therapy staff to identify appropriate equipment which could help disabled people to be safe and live more independently.	Adults	Adults services	BP Saving	186	-53	-53	-54	-54	-214	-52	-9	0	-63	-124	90	No	Red	↑	Level of referrals lower than planned when saving calculated	0
A/R.6.117	Developing a new learning disability care model in Cambridgeshire to reduce the reliance on out of county placements	This work will entail a review of the most expensive out-of-county placements to inform the development of the most cost-effective ways of meeting needs by commissioning new services within county. In particular we know we will need to develop additional in-county provision with the expertise to manage behaviours that may be challenging. By replacing high-cost out of county placements with new in-county provision tailored to our needs we will reduce overall expenditure on care placements.	Adults	Commissioning	BP Saving	0	-58	-47	-35	0	-140	0	0	0	-99	-99	41	No	Red	↑	Most work delayed until 2018/19, with some savings made this year.	Pooled budget - learning disability partnership
A/R.6.118	Review of Health partner contributions to the Learning Disability Partnership	Negotiating with the NHS for additional funding through reviewing funding arrangements, with a focus on Continuing Healthcare and joint funded packages.	Adults	Finance & budget review	BP Saving	0	-500	0	0	0	-500	-500	0	0	0	-500	0	Yes	Green	↔	Saving achieved	NHS funding to pooled budget
A/R.6.121	Managing the assessment of Deprivation of Liberty cases within reduced additional resources	The March 2014 Supreme Court judgment on Deprivation of Liberty requires councils to undertake a large number of new assessments, including applications to the Court of Protection. Funding was made available to increase capacity to undertake best interest assessments and process applications for DoLS. The national demand for staff who are trained as best interest assessors has meant that it has not been possible to deploy all the available funding in this way. This position is not expected to change, and so a saving has been identified against this budget.	Adults	Finance & budget review	BP Saving	0	-100	0	0	0	-100	-100	0	0	0	-100	0	Yes	Green	↔	Saving achieved	0
A/R.6.122	Transforming In-House Learning Disability Services	We will review and make necessary changes to in house services focussed on ensuring that resource is appropriately targeted to provide intensive short term support aimed at increasing independence. We will also Identify where we can work with the independent sector to provide for assessed needs in a different way and consider whether any under-utilitsed services are required for the future.	Adults	Workforce planning & development	BP Saving	0	-375	0	-55	0	-430	-287	0	-56	0	-343	87	No	Red	↔	Restructures phased in two parts through the year, giving only a prt-year effect and delaying some savings until 2018/19.	0
A/R.6.123	Rationalisation of housing related support contracts	In 2016-17 we completed a review of contracted services which support individuals and families to maintain their housing. A contract was terminated in November 2016, with the full-year effect of the associated budget reduction affecting 2017-18.	Adults	Commissioning	BP Saving	0	-58	0	0	0	-58	-58	0	0	0	-58	0	Yes	Green	↔	Saving achieved	0

							Planned £000					Forecast £000										
						8,429	-13,297	-3,784	-3,785	-3,491	**-24,357**	-6,828	-2,344	-3,969	-3,683	**-16,824**	7,533					
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A/R.6.125	Supporting people with learning disabilities to live as independently as possible in adult life	This work has two elements which are focused on managing demand for long term funded services. 1. Work in children's services and in the Young Adults Team will ensure that young people transferring to the LDP will be expected to have less need for services. 2. Working proactively with people who are living at home with carers who are needing increased support to maintain their caring role for whatever reason.	Adults	Adults services	BP Saving	0	-181	-181	-182	-182	-726	-27	-37	-37	-38	-139	587	No	Red	↔	The circumstances of the young people as they reach 18 years old is monitored closely to confirm the level of funding required to meet their needs and to try to anticipate the sustainability of the arrangements. This includes both the home circumstances and the educational arrangements for the young person. This work has led to the forecast overspend.	Pooled budget - learning disability partnership
A/R.6.132	Promoting independence and recovery and keep people within their homes by providing care closer to home and making best use of resources for adults and older people with mental health needs	Reducing the cost of care plans for adults and older people with mental health needs will lead to savings. We aim to reduce residential and nursing care costs and increase the availability of support in the community.	Adults	Adults services	BP Saving	0	-353	-252	-52	-19	-676	-66	-31	73	-189	-213	463	No	Red	↑	Demand for residential and nursing care is increasing across Mental Health services, and although a number of actions have been put in place to increase pace of delivery, there was a significant shortfall against the target.	0
A/R.6.134	Increase in income from Older People and Older People with mental health's client contributions from increased frequency of reassessments	Older people and those receiving elderly mental health services are not always being financially reassessed every year. The council will therefore reassess all clients more regularly to ensure that the full contributions are being collected. This programme has begun in 2016-17 and will continue into 2017-18 to complete.	Adults	Finance & budget review	BP Saving	46	-121	-139	-87	-34	-381	-155	-105	-87	-63	-410	-29	No	Green	↔	Over acheivement of savings in year mainly due to the project starting in January 2017 and acheiving full year impact for the first cohort of clients.	0
A/R.6.140	Helping older people to take up their full benefits entitlements	The council will work with service users to make sure they receive all the benefits to which they are entitled and this is expected to increase service user contributions.	Adults	Finance & budget review	BP Saving	0	-72	-82	-51	-21	-226	0	0	-126	-100	-226	0	No	Green	↔	Monitoring process in place and supplied to OP management team. Welfare benefits advisor team to be re-organised between the Adult Early Help team (CFA) and Financial Assessment team (LGSS) this has only recently been completed creating a delay. Financial Assessment staff have access to DWP database in place as of March.	0
A/R.6.143	Savings from Homecare: re-tendering of home care to develop the market through a number of best practice initiatives including the expansion of direct payments	This proposal will focus specifically on piloting an alternative but complementary approach to home-based care that would try and find alternative and local solutions to traditional homecare - whilst still improving outcomes for service users, promote independence, and achieve savings to the Council. Through the tendering process for home care, the Council will engage potential providers within a price range consistent with achieving this saving. The model also envisages greater efficiency through working across all service user groups including those that that are the responsibility of the CCG.	Adults	Commissioning	BP Saving	0	0	0	-306	0	-306	0	0	-306	0	-306	0	No	Green	↔	Saving achieved	0
A/R.6.145	Using assistive technology to support older people to remain independent in their own homes	The proposal is to invest in and expand the use of Just Checking (or similar) equipment to reduce spending in older people's services. As part of a social care assessment the equipment gives us a full report of a person's movements during a given period allowing us to test whether they are able to go about daily life (eating, washing, dressing, going to the toilet) unaided and to check that overnight they are safe at home. This full picture of a person's daily patterns and movements allows us to say with significantly more accuracy and confidence whether they can or cannot cope independently at home. This additional information and confidence would allow older people, their families and social workers to only make the decision to recommend a move into residential or nursing care where it is absolutely essential. In this way we can reduce care spending overall whilst ensuring we do make provision for those who cannot be independent in their own homes.	Adults	Adults services	BP Saving	110	-187	-134	-27	-10	-358	-166	-155	-27	-10	-358	0	No	Green	↔	Saving achieved	0
A/R.6.146	Expansion of the Adult Early Help Team to minimise the need for statutory care	The Adult Early Help team was established in April 2016 to provide an enhanced first response to people contacting the County Council with social care concerns. The team help people to retain independence, access services and advise on ways in which older people and their carers can organise help for themselves. The goal is to try to resolve issues without the need to wait for a formal assessment or care plan. Through either telephone support or through a face to face discussion, we hope to work with older people to find solutions without the need for further local authority involvement. The intial phase is already resulting in a reduced number of referrals to social care teams. This business case builds on the first phase and proposes continuing the expansion of the Adult Early Help team, so that the team is able to meet more of the need at tier 2, preventing further escalation of need and hence minimising care expenditure. This contributes further savings in 2017-18 as part of the care budget targets in Older People's Services.	Adults	Customer & communities	BP Saving	0	-201	-143	-29	-11	-384	-201	-143	-29	-11	-384	0	No	Green	↔	Saving achieved	0
A/R.6.149	Administer Disability Facilities Grant within reduced overhead costs	At present the County Council invests £300k into the Home Improvement Agencies, which oversee the Disabled Facilities Grants by each of the Districts. The County Council is working in partnership with the District Councils to reduce the cost of the administration of these services. There will be no reduction in the level of grant or service and the intention is to speed up the decision making process.	Adults	Finance & budget review	BP Saving	0	-150	0	0	0	-150	-150	0	0	0	-150	0	Yes	Green	↔	Savings for 2017/18 agreed with District Councils and in the budget - complete.	District Council capital grants via Better Care Fund and central government significantly increased. District Councils engaged in review project
A/R.6.155	Securing appropriate contributions from health to section 117 aftercare.	Careful consideration of the needs of people sectioned under the Mental Health Act to identify joint responsibility and ensure appropriate contributions by the council and the clinical commissioning group to section 117 aftercare.	Adults	Finance & budget review	BP Saving	0	-150	-150	-80	-40	-420	-45	3	10	-701	-733	-313	Yes	Green	↑	Delivery of this saving was re-profiled to accommodate on-going work with the CCG in relation to section 117 and the Joint Commissioning Tool which took place over the first 6 months of the year and was completed in September. Savings delivery exceeded the original target.	NHS funding to section 117 aftercare

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A/R.6.157	Increase in income from Older People and Older People with Mental Health's client contributions following a change in Disability Related Expenditure	Following a comparative exercise, the Adults Committee agreed a change to the standard rate of disability related expenditure (DRE) during 2016. This means that additional income is being collected through client contributions. This line reflects the 'full-year' impact of this change, reflecting that the new standard rate is applied at the planned point of financial assessment or reassessment for each person.	Adults	Finance & budget review	BP Saving	0	-53	-38	-22	-6	-119	-53	-38	-22	-6	-119	0	No	Green	↔	Implemented following policy change in 2016. Achievement in 2017/18 is through full year effect (existing clients did not start adjustment until January, and will be picked up through scheduled financial assessment reviews). Monitoring process in place through to OP management team.	0
A/R.6.159	Efficiencies from the cost of Transport for Older People	Savings can be made through close scrutiny of the expenditure on transport as part of care packages in Older People's Services to ensure that travel requirements are being met in as cost efficient a way as possible.	Adults	Commissioning	BP Saving	0	-25	-25	-25	-25	-100	0	-16	-16	-16	-48	52	No	Red		Three areas of efficiencies identified were not sufficient to make the saving. Changes made will have some positive impact on 2018/19, and transport will remain under review.	0
A/R.6.160	Ensuring joint health and social care funding arrangements for older people are appropriate	We have been working with NHS colleagues to review continuing health care arrangements including joint funding, with a view to ensuring that the decision making process is transparent and we are clearer about funding responsibility between social care and the NHS when someone has continuing health care needs. Several cases has been identified where potentially health funding should be included or increased based on a review of needs.	Adults	Finance & budget review	BP Saving	0	-196	-143	-89	-36	-464	-106	0	-138	-130	-374	90	No	Red		To achieve the baseline CHC savings each year as well as continue with last year's permanent saving and make this year's saving requires the team to complete decision support tool that save £1.541m this year. Savings to date are £1.074m across the OP&MH directorate. Our progress is constrained by the pace and effectiveness of the CCG in completing the CHC process. Pace of delivery is expected to increase as these constraints are resolved.	0
A/R.6.161	Managing the Cambridgeshire Local Assistance Scheme within existing resources	The Adults Committee has considered several proposals on how to deliver the Cambridgeshire Local Assistance Scheme (CLAS). The contingency budget previosuly held for CLAS has now been removed, as is no longer required to support the redesigned service.	Adults	Finance & budget review	BP Saving	0	-163	0	0	0	-163	-163	0	0	0	-163	0	No	Green	↔	The contract was already let and so the saving was been delivered.	0
A/R.6.163	Ensuring homecare for adults with mental health needs focuses on supporting recovery and piloting peer support delivered through the Recovery College	Savings will be achieved through reproviding homecare services for adults with mental health needs and helping people to return to independence more quickly.	Adults	Adults services	BP Saving	0	-75	-75	-60	-40	-250	-38	-28	-2	0	-68	182	No	Red	↔	Savings delivery is behind profile, and although actions were put in place to increase the pace of delivery, there was a shortfall against target at year end.	0
A/R.6.164	Reablement for Older People - Improving effectiveness to enable more people to live independently	Development of the Reablement Service to ensure it promotes independence and reduces the costs of care by being directed at the right people. Changes to the way the service operates will release additional capacity, allowing it to work with more people, achieve better outcomes and so reduce demand and cut costs. It is proposed that within existing staffing levels we can increase the number of people receiving a reablement service and increase the number of people for whom the reablement intervention is ended without the need for ongoing care or with a reduced need for ongoing care. To achieve this we will improve team structures and working practices and ensure the cases referred to the service are appropriate, where there is good potential for people to live independently again.	Adults	Adults services	BP Saving	0	-93	-67	-42	-17	-219	0	0	0	0	0	219	No	Red		Work underway to ensure that the service can measure the avoided cost as a result of the involvement and to avoid double counting with AEH. Key risk around pull towards mainstream provision. Activity data suggests a reduction in the number of clients going through reablement, 124 fewer instances of reduced care or managing completly independantly has led to a significant reduction in savings and we have therefore not made any of the targetted savings during 2017-18.	0
A/R.6.165	Enhanced Occupational Therapy Support to reduce the need for double-handed care	The Double-Up Team was set up as a 'spend to save' initiative in 2013 based on evidence from other local authorities. Initially set up as a pilot project, it was endorsed as part of the County Council's prevention agenda, the implementation of Transforming Lives and the requirements of The Care Act. The team consists of two Senior Occupational Therapists (OTs) and two OT Technicians employed directly by the County Council. The team's remit is to focus on the review of service users to assess whether it is possible to either: • Reduce existing double-up packages of care to single-handed care OR • Prevent single-handed care packages being increased to double-up This team is currently based outside of the existing mainstream OT service to ensure focus on the delivery of actions that will benefit the recipients whist returning a saving direct to the Council. Through the actions of the existing team, savings from the Councils homecare budget were generated in the region of £1.1m in 2015-16 and are on track to achieve a similar figure in the current financial year. This business case proposes the expansion of the service through the recruitment of an additional two OT workers so they can share learning and benefits associated with the current model to other settings (further details are listed in the 'scope' section of this document) as well as providing additional review capacity.	Adults	Adults services	BP Saving	90	-132	-94	-19	-7	-252	-42	-124	-36	-16	-218	34	No	Amber	↑	Overall 40% of reductions cases assessed by the team led to an actual reduction in the cost of the service user's placement. The team also prevented the need for double handed care in 79% of preventions cases they assessed. The preventions equate to an estimated avoided cost of £753k.	Alongside mainstream occupational therapy service provided within community (CPFT) and hospitals based OTs
A/R.6.167	Voluntary Sector Contracts for Mental Health Services	Renegotiation of a number of voluntary sector contracts for mental health support has resulted in lower costs to the Council whilst maintaining levels of service provision for adults with mental health needs. The reductions have been discussed and negotiated with the providers impacted, and they have factored this into their own business planning. On-going investment by the Mental Health service in the voluntary and community sector remains over £3.7m	Adults	Finance & budget review	BP Saving	0	-130	0	0	0	-130	-130	0	0	0	-130	0	Yes	Green	↔	Delivered	0
A/R.6.168	Establish a review and reablement function for older people with mental health needs	Redirect support workers within the Older People Mental Health team to provide a review and reablement function for service users in receipt of low cost packages (under £150 per week).	Adults	Adults services	BP Saving	0	-20	-25	-15	-9	-69	-4	-1	0	0	-5	64	No	Red	↔	Savings delivery is behind profile, and although actions were put in place to increase the pace of delivery, there was a shortfall against target at year end.	0

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A/R.6.169	Better Care Fund improvement	Each year the Council and the local NHS agree a Better Care Fund plan, this includes an element for social care services. Given the uplift in the BCF allocation in 2016-17 and an anticipated further increase in 2017-18 the Council will negotiate that a greater share of BCF monies are focused on provision of social care services. This supports the local NHS.	Adults	Finance & budget review	BP Saving	0	-930	0	0	0	-930	0	0	-930	0	-930	0	Yes	Green	↔	On track	The Better Care Fund is a pooled budget with the NHS
A/R.6.170	OP contractual & demand savings (including respite beds) 6.170	Retendering of contracts in 2016-17 has presented the opportunity to reduce our block purchasing of respite beds, following under-utilisation and unused voids in previous arrangements. Use of spot purchasing for respite will be monitored. Additionally, as trends have continued towards supporting fewer people overall in 2016-17 it has been possible to reflect this cost reduction in a further small saving on demographic allocations.	Adults	Commissioning	BP Saving	0	-450	0	0	-100	-550	-450	0	0	0	-450	100	No	Red		Full delivery of respite block saving resulting from 2016/17 retendering, but demand pressures across OP locality budgets means that full delivery of this saving is not expected.	0
A/R.6.201	Staffing reductions in Commissioning Enhanced Services	Review of Commissioning across CFA.	C&YP	Workforce planning & development	BP Saving	0	0	0	-107	0	-107	0	0	-107	0	-107	0	No	Green	↔	Saving was delivered as part of the Commissioning restructure.	0
A/R.6.202	Children's Change Programme: Changes to Management Structure in Children's Services	The Children's Change Programme is reviewing and transforming the system of children's services across early help, safeguarding and protection teams. Phase 1 of the programme will realise savings from staffing by deleting duplication and simplifying processes. Specifically, we will integrate social work and early help services into a district-based delivery model, unifying services around familiar and common administrative boundaries so they can align with partners better; and reducing the number of team manager level posts required.	C&YP	Workforce planning & development	BP Saving	0	-619	0	0	0	-619	-283	0	0	0	-283	336	No	Red	↔	Pressure of £336k was due to the service not being awarded an expected grant from the DFE, because anticipation of this grant had been built in to the budget as an assumed income stream. This resulted in a shortfall in the required staffing budget in 2017/18. Pressure was offset by additional vacancy savings; £1.,34m forecast against £1m target. Residual pressure will be managed out in 2018/19 as part of the next stage of Children's Change programme.	0
A/R.6.203	Amalgamating Family Support Services	Amalgamation of Specialist Family Support Service Family Support Workers in localities to produce better efficiency and subsequently a reduction of associated relief staff costs.	C&YP	Workforce planning & development	BP Saving	0	-50	0	0	0	-50	-50	0	0	0	-50	0	No	Green	↔	Savings Achieved in 2017/18	0
A/R.6.205	Children's Social Care Support for young people with complex needs	Prevention of placement or family breakdowns by providing outreach support and the provision of a consistent wrap-around support for young people with complex needs to avoid the use of costly external residential provision that may not meet need.	C&YP	Children's services	BP Saving	497	0	-135	-181	-243	-559	-10	-197	-154	-12	-373	186	No	Red	↔	Shortfall in 2017/18 due to delayed start of The Hub but still forecasting ability to meet total savings over the next two years.	0
A/R.6.210	Home to School Transport (Special)	Most children and young people with Statements of SEND and Education, Health and Care (EHC) plans do not require special transport arrangements. Wherever possible and appropriate, the child or young person with SEN should be treated in the same way as those without. e.g. in general they should walk to school, travel on a public bus or rail service or a contract bus service or be taken by their parents. They should develop independent travel skills which should be assessed at each Annual Review. The majority of children/ young people of statutory school age (5-16) who have a Statement of Special Educational Need (SSEN) will attend their designated mainstream school. Only if, as detailed in their SSEN/EHC Plan, a child or young person has a special educational need or disability which ordinarily prevents them from either walking to and from school or accessing a bus or rail service or contract bus service, will they be eligible for free transport. With effect from 1 September 2015, the Council stopped providing free transport for young people with SEND over the age of 16, except those living in low income families. In addition to the £396k of savings in this business case, there are two separate invest to save proposals which are being funded by CFA underspend and ETE capital funding (Meadowgate footpath and Independent Travel Training) which relate to home to school transport (special). There is less likelihood of achieving savings from 2018-19 onwards as these are more reliant on a reduction in the number of children on EHC plans. The ability to make considerable savings from 2018-19 onwards is based on increased in-county education provision and reduction in EHC Plans due to more need being met within mainstream provision, both of which are needed to reduce the number of pupils requiring transport - even with demographic increase in population. We plan to achieve savings through a	C&YP	Children's services	BP Saving	0	-124	-123	-123	-123	-493	-40	-40	-301	-36	-417	76	No	Amber		While this savings target was not be met in full, thethe majority of it was. Savings were made due to a successful tender round and an ongoing scrutiny of contract services to ensure that Council delivers the most efficient and cost effective school transport services.	0
A/R.6.213	LAC Inflation Savings	Award inflation at 0.7% rather than 1.7%	C&YP	Commissioning	BP Saving	0	-31	-31	-31	-31	-124	-124	-23	-23	-22	-192	-68	No	Green	↑	The saving overachieved based on the fee uplifts awarded throughout 17/18.	0
A/R.6.214	Moving towards personal budgets in home to school transport (SEN)	The Personal Transport Budget (PTB) is a sum of money that is paid to a parent/carer of a child who is eligible for free school travel. The cost of a PTB would not be more than current transport arrangements. A PTB gives families the freedom to make their own decisions and arrangements about how their child will get to and from school each day. Monitoring and bureaucracy of PTBs is kept to a minimum with parents not being expected to provide evidence on how the money is spent. However, monitoring of children's attendance at school is done and PTBs are removed if attendance falls below an agreed level.	C&YP	Contracts, commercial & procurement	BP Saving	0	-58	-58	-58	-58	-232	0	0	0	0	0	232	No	Red		No savings were made through this proposal in 2017/18. While some parents took up the option of a PTB, a focused, strictly time-limited review will be undertaken to determine whether a greater level of savings could be achieved in future years by making changes to the scheme and relaunching it in 2018/19	0

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A/R.6.215	Adaptation and refurbishment of Council Properties to reduce the unit cost of placements	Two properties owned by Cambridgeshire County Council have become vacant, or are becoming vacant over the coming months. This presents an opportunity to increase the capacity for in-county accommodation the Council has for children who are looked after and to contribute to the savings arising from the unit cost of placements. Refurbishment of the properties will take place to make these buildings fit for purpose.	C&YP	Commissioning	BP Saving	0	-141	-140	-141	-140	-562	0	-13	-52	-34	-99	463	No	Red		The original saving was predicated on a 12 month period for each of these placements. Due to issues with handing the properties over in a fit state the timescales for opening the homes slipped from April 17 to August 17. As a result of the lead times needed to progress the project, part of the saving will be pushed to 18/19 (a saving of -£55k is forecast to be delivered in 18/19). Not all the beds are occupied currently and the team continue to review placements in order to identify suitable young children to move into the properties.	0
A/R.6.216	Pathways to access contraception and sexual health services for priority groups	To provide intermediate level training to 100 staff from targeted services in residential children's homes, drug and alcohol services, adult mental health services, the Youth Offending Service, the 18-25 team and Domestic Violence Adviser team. We will purchase 12 contraception boxes for offices of services attending training for use with clients	C&YP	Commissioning	BP Saving	0	-185	0	0	0	-185	0	0	0	0	0	185	No	Red	↔	0	0
A/R.6.217	Enhanced intervention service for children with disabilities	Establish an Enhanced Intervention Service in Cambridgeshire. The purpose of the team would be to reduce the number of children with disabilities placed in out of county residential homes, to enable children to safely live with their family and access education in their local area.	C&YP	Commissioning	BP Saving	120	-29	-48	-48	-49	-174	0	0	-144	-33	-177	-3	No	Green	↔	Notional savings achieved. Currently working with seven young people with complex needs who are at risk of exclusion or education breakdown requiring a move to an out of area residential school placement. In each case the children are still at home or in local placement and there is a reduced level of anxiety for the child, their families and support network. One child previously worked with did go into a placement. There is a pressure on the project to provide services for many other young people, and this is showing services gaps and practice learning needs in a way that is helpful to the service overall.	0
A/R.6.218	SPACE Programme – helping mothers to prevent repeat removals	The Space Programme works to engage with mothers who have had their baby permanently removed from their care, with the aim of reducing the likelihood of it happening again. The programme works with mothers and their partners where appropriate, to help them understand the range of issues they face and which may have contributed to their child becoming permanently removed in the first place. In partnership with other agencies, the programme works to promote positive relationships, self esteem and confidence and assertiveness, whilst encouraging access to universal and specialist services that can help mothers live healthier lives. The programme has been funded by CFA reserves from October 2015 to March 2017 and works on the assumption that the programme prevents six babies entering foster care in 2017-18 and 2018-19 as a result of the intervention work that's taken place in 2015-16 and 2016-17. Outcome data for the programme is currently being prepared and reviewed and options to secure permanent funding to sustain this work are being explored.	C&YP	Children's services	BP Saving	0	-111	0	0	0	-111	0	0	0	-111	-111	0	No	Green	↑	Saving Achieved	0
A/R.6.219	Systemic family meetings to be offered at an earlier stage to increase the number of children being diverted from LAC placements	Change the referral criteria for systemic family meetings so they take place with families at an earlier stage - at the point just before beginning a child protection plan. This would enable us to work with a larger group of 390 children at Child Protection level, rather than 240 at court proceedings level.	C&YP	Commissioning	BP Saving	148	-115	-115	-115	-116	-461	-115	-115	-115	-143	-488	-27	No	Green	↔	Notional savings achieved. Q4 savings quantified against benchmark data. The additional capacity enables the clinical team to operate at capacity as per the unit model. The focus is on ensuring wider family networks are identified as part of care solutions and emergency placements are reduced because the wider family can step in. the children and young people are identified according to researched risk factors for a trajectory of going into care, and carefully audited, to ensure the interventions making a difference are unique to this work.	0
A/R.6.220	Increase the number and capacity of in-house foster carers	Reduce spending on foster placements from external carer agencies by increasing the capacity of the in-house service.	C&YP	Commissioning	BP Saving	0	-48	-49	-49	-49	-195	-62	-161	-108	-8	-339	-144	No	Green	↔	Savings target exceeded by £144k (offsetting shortfall in Supported Lodgings A/R.6.241 savings target).	0
A/R.6.221	Link workers within Adult Mental Health Services	Two Link Workers will embed a Think Family approach in adult mental health services and increase access to preventative and early help services to keep families together wherever possible.	C&YP	Commissioning	BP Saving	84	0	0	0	0	0	0	0	0	0	0	0	No	0	↔	No savings planned for 17/18	0
A/R.6.222	Independent travel training for children with SEND	Proposal to introduce Independent Travel Training (ITT) for young people with SEND to help them cope with the often more complex journeys required to access further education. Once trained and assessed to be safely able to travel independently, we will no longer have to provide home to school transport for these young people.	C&YP	Children's services	BP Saving	0	-24	-24	-24	-24	-96	0	0	0	0	0	96	No	Red		No savings were achieved through this proposal in 2017/18 as implementation was delayed. A small working group has been established to develop an action and implementation plan to deliver savings in 2018/19.	0
A/R.6.225	Alternative model of delivery for school catering and cleaning [EI]	A new way of providing school catering and cleaning as either a joint venture or a partnership with another provider is at an advanced stage. A minimum of £50K has been set as a project priority.	C&YP	Workforce planning & development	BP Saving	0	-13	-13	-12	-12	-50	0	0	0	0	0	50	No	Red	↔	C&I has considered future plans for this function.	0

							Planned £000					Forecast £000										
						8,429	-13,297	-3,784	-3,785	-3,491	**-24,357**	-6,828	-2,344	-3,969	-3,683	**-16,824**	7,533					
Reference	**Title**	**Description**	**Committee**	**Transformation Workstream**	**BP Saving or Funnel?**	**Investment 17-18 £000**	**Original Phasing - Q1**	**Original Phasing - Q2**	**Original Phasing - Q3**	**Original Phasing - Q4**	**Original Saving 17-18**	**Current Forecast Phasing - Q1**	**Current Forecast Phasing - Q2**	**Current Forecast Phasing - Q3**	**Current Forecast Phasing - Q4**	**Forecast Saving**	**Variance from Plan £000**	**Saving complete?**	**RAG**	**Direction of travel**	**Forecast Commentary**	**Links with partner organisations**
A/R.6.227	Strategic review of the LA's ongoing statutory role in learning	A programme to transform the role of the local authority in education in response to national developments such as the 2016 Education White Paper, and the local context, (e.g. the increasing number of academies and the educational performance of schools) has been started. This has four strands - the LA's core duties, traded services, local authority-initiated Multi-academy Trusts and the recruitment and retention of school staff. Early work has identified savings from reducing core funding by discharging the Education Advisor function with two f.t.e. staff, one funded centrally and one traded; Mathematics, English and Improvement advisers to be fully traded from 2017-18; Primary advisers to be part traded from 2017-18 and fully traded from 2018-19; Senior Advisers to be part traded; and a reduction in the intervention budget, supporting only maintained schools where we have a statutory responsibility to do so. The Education Advisers will generate a £10k surplus in 2018-19.	C&YP	Workforce planning & development	BP Saving	0	-67	-68	-67	-68	-270	-180	-25	-35	-30	-270	0	No	Green	↑	These savings have been met in full through grant funding and reduction in intervention budget	0
A/R.6.230	Reduction in Heads of Service	Reduce the number of Heads of Service in the Learning directorate from six to five in line with the reduction in staffing and changing role of the Directorate.	C&YP	Workforce planning & development	BP Saving	0	-80	0	0	0	-80	-60	0	0	0	-60	20	No	Green	↔	Head of Service for CID appointed as interim resulting in slight underachievement in 2017/18. Permanent role still planned for deletion.	0
A/R.6.234	Home to School Transport (Mainstream)	The 2017-18 saving is made up of the summer term changes to post 16 and spare seats charging policy, implemented in 2016-17. As a result of a decision taken by SMT, all services are now required to absorb the impact of the general growth in population and no demography funding will be allocated for this purpose. This represents £598k for this budget. Full year savings of £438k from route retendering (which normally would be offered as savings) will instead be diverted to meet this pressure, with the remainder secured through a programme of route reviews.	C&YP	Contracts, commercial & procurement	BP Saving	0	-70	0	0	-24	-94	-70	0	0	-24	-94	0	No	Green	↔	Full saving achieved in 2017/18	0
A/R.6.236	Business Support	Development and implementation of course booking and customer feedback systems and new ways of working will enable us to reduce our business support capacity.	C&YP	Workforce planning & development	BP Saving	0	-51	0	0	0	-51	-51	0	0	0	-51	0	Yes	Green	↔	Saving achieved	0
A/R.6.238	Virtual Beds	Tender for 16 Block Distributed Purchasing (Flexi Beds).	C&YP	Commissioning	BP Saving	0	0	-23	-83	-99	-205	0	0	0	0	0	205	No	Red	↔	Decision taken not to take this proposal forward. Alternative proposals are being progressed.	0
A/R.6.239	Review of top 50 placements	Monthly review by panel of the top 50 most expensive external placements, with the objective of reducing placement costs wherever possible.	C&YP	Commissioning	BP Saving	0	-81	-81	-81	-81	-324	0	-23	-127	-254	-404	-80	No	Green		The saving is based on a review of the high cost placements that were undertaken during 17/18 . 'Top 50' meetings took place to ensure regular review of high cost placements in order to secure further savings. There were also Purchased Placement review meetings established that were held by Placements Officers and Group Managers to review high cost placements that were made in an emergency and ensuring those were adequately reviewed. It should also be noted that where a placement price reduced, the saving was quantified over a 12 month period. Therefore any changes midway through the financial year resulted in an element of the saving being pushed back into 18/19.	0
A/R.6.240	Negotiating placement fees	Negotiate the costs of external placements for Looked After Children.	C&YP	Commissioning	BP Saving	0	-17	-18	-17	-18	-70	-5	-5	-17	-50	-77	-7	No	Green		Savings were negotiated on an adhoc basis either at point of placement (for placement moves) or by reducing high cost packages. The team will continue to negotiate with providers where possible.	0
A/R.6.241	Foster carers to provide supported lodgings	Delivery of 10 new supported lodging placements	C&YP	Commissioning	BP Saving	0	0	-22	-65	-65	-152	0	0	0	0	0	152	No	Red	↔	Shortfall of savings based on availability of supported lodgings carers. Carers that have been approved have taken placements from elsewhere and not from the LAC Placements budget as anticipated.	0
A/R.6.242	Reducing fees for Independent Fostering Agency placements	Reduce fees for Independent Fostering Agency (IFA) placements	C&YP	Commissioning	BP Saving	0	-30	-30	-3	-3	-66	-17	-12	0	0	-29	37	No	Red		Meetings continue to be arranged with providers, contracts and placements to support negotiations in order to try and secure further savings in this area.	0
A/R.6.243	Children's Change Programme: Hawthorns, FGC, PIP & Misc	Restructure of Children's Services through the Children's Change Programme, to be reinvested to support the revised structure (see proposal A/R.5.004).	C&YP	Children's services	BP Saving	1,595	-1,595	0	0	0	-1,595	-1,595	0	0	0	-1,595	0	Yes	Green	↔	Saving Achieved	0
A/R.6.244	Total Transport	This is an updated proposal, in light of the data and experience gained through Phase 1 of the Total Transport pilot, which was implemented in the East Cambridgeshire area at the start of September 2016. By investing in staff and by extending the use of smartcard technology, the Council will be able to deliver more efficient mainstream school transport services, matching capacity more closely with demand. The intention is to secure financial savings whilst ensuring that all eligible pupils continue to receive free transport with reasonable but efficient travel arrangements.	C&YP	Commissioning	BP Saving	132	-180	0	-290	-370	-840	0	-134	-336	-370	-840	0	No	Green	↑	Saving fully achieved in 2017/18	0
A/R.6.245	Cambridgeshire Race, Equality and Diversity Service (CREDS)	The de-delegation received by the Cambridgeshire Race, Equality and Diversity Service (CREDS) from maintained primary schools in 2017-18 will reduce as a consequence of the large number of recent and forthcoming academy conversions. This reduction in funding will require a restructure of the service, including staffing reductions.	C&YP	Workforce planning & development	BP Saving	0	-125	0	0	0	-125	-125	0	0	0	-125	0	No	Green	↔	Balanced budget achieved in 2017/18	0

							Planned £000						Forecast £000										
						8,429	-13,297	-3,784	-3,785	-3,491	**-24,357**	-6,828	-2,344	-3,969	-3,683	**-16,824**	7,533						
Reference	**Title**	**Description**	**Committee**	**Transformation Workstream**	**BP Saving or Funnel?**	**Investment 17-18 £000**	**Original Phasing - Q1**	**Original Phasing - Q2**	**Original Phasing - Q3**	**Original Phasing - Q4**	**Original Saving 17-18**	**Current Forecast Phasing - Q1**	**Current Forecast Phasing - Q2**	**Current Forecast Phasing - Q3**	**Current Forecast Phasing - Q4**	**Forecast Saving**	**Variance from Plan £000**	**Saving complete?**	**RAG**	**Direction of travel**	**Forecast Commentary**	**Links with partner organisations**
A/R.7.101	Early Years subscription package	Proposal to develop Early Years subscription package for trading with settings.	C&YP	Children's services	BP Saving	0	0	0	-28	0	-28	0	0	-28	0	-28	0	No	Green	↔	Saving achieved	0
A/R.7.103	Education ICT Service	Increase in trading surplus through expanding out-of-county provision.	C&YP	Children's services	BP Saving	0	-25	-25	-25	-25	-100	-25	-25	-25	-25	-100	0	No	Green	↔	Saving fully achieved in 2017/18	0
A/R.7.104	Cambridgeshire Outdoors	Increase in trading surplus through cost reduction and external marketing.	C&YP	Children's services	BP Saving	0	-12	-13	-13	-12	-50	-4	-4	-4	-5	-17	33	No	Red	↑	While some additional income was achieved increased costs have resulted in an underachievement of this income target. Work is ongoing to address this for 2018/19.	0
A/R.7.105	Admissions Service	Increase in trading surplus through an increased use of automated systems.	C&YP	Children's services	BP Saving	0	-3	-3	-3	-1	-10	-3	-3	-3	-1	-10	0	No	Green	↔	Saving fully achieved in 2017/18	0
A/R.7.106	Reduction in income de-delegated from Schools to CREDS	The de-delegation received by the Cambridgeshire Race, Equality and Diversity Service (CREDS) from maintained primary schools in 2017-18 will reduce as a consequence of the large number of recent and forthcoming academy conversions. This reduction in funding will require a restructure of the service, including staffing reductions.	C&YP	Workforce planning & development	BP Saving	0	30	30	30	35	125	30	30	30	35	125	0	No	Green	↔	Balanced budget achieved in 2017/18	0

							Planned £000					Forecast £000											
						8,429	-13,297	-3,784	-3,785	-3,491	**-24,357**	-6,828	-2,344	-3,969	-3,683	**-16,824**	7,533						
Reference	**Title**	**Description**	**Committee**	**Transformation Workstream**	**BP Saving or Funnel?**	**Investment 17-18 £000**	**Original Phasing - Q1**	**Original Phasing - Q2**	**Original Phasing - Q3**	**Original Phasing - Q4**	**Original Saving 17-18**	**Current Forecast Phasing - Q1**	**Current Forecast Phasing - Q2**	**Current Forecast Phasing - Q3**	**Current Forecast Phasing - Q4**	**Forecast Saving**	**Variance from Plan £000**	**Saving complete?**	**RAG**	**Direction of travel**	**Forecast Commentary**	**Links with partner organisations**
C/R.5.304	Neighbourhood Cares (Buurtzorg)	Piloting a radically different model of social work in Cambridgeshire informed by the latest thinking developed locally through the Transforming Lives project, innovation being led by other local authorities and in particularly by the successful Buurtzory model of community care in Holland.	GPC	Adults services	Funnel	656	0	0	0	0	0	0	0	0	0	0	0	No	0	↔	Manager appointed. No savings target in 2017/18	0
C/R.5.313	Enhanced Response Service - Assistive Technology Phase 2	Following the agreement of GPC to the Assistive Technology proposals (Phase 1) in September 2016 a further business case has been developed to establish an enhanced assistive technology response service to reduce/delay/minimise admissions to hospital and funded care.	GPC	Adults services	Funnel	393	-14	-63	-112	-161	-350	0	0	0	0	0	350	No	Red	↔	Recruitment to the Enhanced Response Service is ongoing and will be fully operational later in the year. Some part-year savings are expected to accrue during 2017/18. A forecast for this funnel saving will be entered once activity information becomes available.	Savings likely for partner organisations: -reducing non-elective admissions to acute hospitals -reducing ambulance call-outs
C/R.5.319	ASC/OP investment required to manage demand and reduce cost to serve	To include: - OP Home Care - OP Accommodation - Crisis Response - Section 117 - Lifetime Costs: use of upfront spending to reduce the total lifetime costs of service users with long term needs	GPC	Adults services	Funnel	3,357	0	0	0	0	0	0	0	0	0	0	0	No	0	↔	£500k tranformation funding has been approved for draw-down in 2017/18 in respect of appointing an external provider to help the Council shape and deliver an ambitious change programme across all adult social care client groups.	0
CFA.F.01	Assessment of Prisoners	Take 100k from this budget as the demand is lower than expected	Adults	Adults services	Funnel	0	0	-50	0	0	-50	0	-50	0	-50	-100	-50	No	Green	↑	The sum identified has been removed from the budget and there are currently no concerns around deliverability, although this assumes that the budget is similar to last year. The grant received is £318.7k, £1k higher than budgeted.	0
CFA.F.02	Total Transport	Establish a team to deliver the Total Transport Pilot.	C&YP	Children's services	Funnel	0	0	0	0	0	0	0	0	0	0	0	0	No	0	↔	0	0
CFA.F.03	Learning Disability Reviews	Additional savings on Learning Disability Reviews - investment for Project Assessment Team shown in 6.114 above	Adults	Adults services	Funnel	0	-1,480	-342	-342	-455	-2,619	0	0	0	0	0	2,619	No	Red		Slippage	0
CFA.F.04	Learning Disability In House	Stretch target	Adults	Adults services	Funnel	0	0	0	0	-70	-70	0	0	0	0	0	70	No	Red		0	0
CFA.F.05	Learning Disability Proposal	Out of Area Repatriation savings	Adults	Adults services	Funnel	0	0	0	-130	-130	-260	0	0	0	0	0	260	No	Red	↔	0	0
CFA.F.06	Better Care Fund	Further reduction in the transformation fund in excess of the number at A/R.6.169	Adults	Adults services	Funnel	0	0	-220	0	0	-220	0	0	0	0	0	220	No	Red	↔	Delivery considered unlikely given CCG opening position on BCF negotiation.	0
CFA.F.08	Home to School Transport	2016/17 underspend should be ongoing as agreed at CFA Delivery Board	C&YP	Children's services	Funnel	0	-200	0	0	0	-200	0	0	0	0	0	200	No	Red	↔	0	0
CFA.F.09	Non-Residential Protected Income Allowances	The Council continue to allow the current levels of protected income in the financial assessment. This would mean that all benefit income increases would be absorbed in the financial contribution however, the service user would not receive a reduced amount of protected income disregard.	Adults	Finance & budget review	Funnel	0	0	0	0	0	0	0	0	0	0	0	0	No	0	↔	This proposal now forms part of the 2018/19 Business Plan, and savings delivery will be subject to the outcome of the formal consultation process.	0
CFA.F.10	LDP - Residential to Supported Living	Potential has been identified to work with residential providers to consider whether some provision could be converted into supported living arrangements. This approach can be beneficial for all parties with a lower cost of care for providers and commissioners and service users having access to additional flexible income as a result of changes to benefit entitlements	Adults	Commissioning	Funnel	0	0	0	0	0	0	0	0	0	-11	-11	-11	No	0		0	0
CFA.F.13	Normal limit on the cost of domiciliary care	0	Adults	Adults services	Funnel	0	0	0	0	-50	-50	0	0	0	0	0	50	No	Red		Saving relates to a policy change, whereby service users who are in receipt of domiciliary care that costs more than the 'normal' cost of a residential placement would be charged the difference between the 'normal cost' and their care package cost, in addition to any existing client contribution. It is thought the change in policy can be implemented in 2017/18, but this depends what processes it needs to go through. On further analysis it was decided to remove the saving expectation due to the unpredictable and irregular surges in demand in our challenged market meaning that there are too many days where we need to spend significantly more than the normal limit to and if we were challenged we couldn't provide care home placements at that price.	0
CFA.F11	LDP Inflation	Expected underspend on inflation allocation due to provider uplift restrictions	Adults	Adults services	Funnel	0	0	0	0	0	0	0	0	0	-200	-200	-200	No	0	↔	Expected underspend on inflation allocation due to provider uplift restrictions	0
CFA.F12	Underspends in PD and AAT	0	Adults	Adults services	Funnel	0	0	0	0	0	0	0	0	0	-289	-289	-289	No	0	↔	Surplus in budget at budget prep due mainly to full-year effect of 16/17's savings, net of any emerging pressures on demography (in PD)	0

Agenda Item No: 6

ADULTS POSITIVE CHALLENGE PROGRAMME

To:	**Adults Committee**
Meeting Date:	**24th May 2018**
From:	**Service Director: Adults and Safeguarding**
Electoral division(s):	**All**
Forward Plan ref:	*Key decision:* **No**
Purpose:	**To provide an update on the work on the Adults Positive Challenge Programme, following the previous update to Committee in January 2018.** **To seek endorsement from Committee to the proposed scope and approach for the programme.**
Recommendations:	Adults Committee is asked to:

a) Comment on and endorse the new mission for adult social care as described in 2.2.1

b) Comment on and endorse the work to date on the Adults Positive Challenge Programme and the opportunities identified

c) Approve the engagement of iMPOWER consultancy to support delivery the rapid implementation priorities as set out in section 2.1.2.

d) Endorse the proposal to go forward to General Purposes Committee for further investment from the Transformation Fund to facilitate delivery of the programme

e) Endorse the proposals set out in section 2.2.4 for the scope of the programme, specifically that it is a whole-Council initiative, led by the Adults Committee but supported by all directorates and committees

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1. BACKGROUND

1.1 Through the Adults Positive Challenge Programme, the County Council has set out to design a new service model for Adult Social Care which will continue to improve outcomes whilst also being economically sustainable in the face of the huge pressure on the sector.

1.2 Through investment from the Council's Transformation Fund, a consortium of Capgemini and iMPOWER was appointed to support an initial discovery phase of the programme which has included a baseline analysis, development a new vision and identification of opportunities for the improvement, efficiency and further transformation. iMPOWER have also carried out a similar discovery phase in Peterborough City Council. At the end of phase one this investment has given us:

- a rigorous review of the current operating model with an analysis of impact against cost to serve;
- a baseline assessment of all Adult Social Care services;
- identification of a new vision and outline model for Adult Social Care;
- an Outline Business Case which identifies areas of opportunity with the potential to deliver up to £49 million of savings, through initial investment, whilst driving up outcomes for citizens of Cambridgeshire and Peterborough;
- detailed proposals for a 'fast forward' phase across Cambridgeshire and Peterborough.

1.3 The initial discovery phase has evidenced that the Cambridgeshire system is already broadly efficient and effective. The quality of outcomes for services users in Cambridgeshire was found to be in line with national average, despite a lower than average level of expenditure. The analysis also found that the Transforming Lives Programme has made progress in encouraging a proactive, preventative and personalised approach to care and highlighted that a larger proportion of service users in Cambridgeshire are supported to live independently at home rather than in residential or 24 hour care settings.

1.4 The baseline assessment also highlighted that more work is needed to embed the focus on independence and that several key challenges are driving the need for a new approach – specifically:

- a substantial supply capacity challenge in the current care workforce;
- continuing increases in demand from a growing and aging population;
- a combination of demand growth and inflationary pressure leading to a substantial budget deficit in the coming years;
- limited digital tools and inadequate use of data causing productivity losses in staff time and impacting on the frequency and quality of case reviews.

2.3 Building on this initial work, the consortium has now delivered an Outline Business Case which describes the opportunity areas, new ways of working and service models which could maximise their potential. Cambridgeshire County Council and Peterborough City Council carried out the discovery phase of work as two distinct programmes. It is proposed that in line with the agreed principles of the Shared and Integrated Services Programme future phases will be planned and implemented as one programme across both councils.

2. CURRENT POSITION

2.1 Immediate opportunities

2.1.1 In response to the need to strike a balance between the strategic elements of the Adults Positive Challenge Programme with the financial imperative to deliver transformation at pace, it is necessary to develop a programme of operational work streams that will be implemented immediately, in parallel with the development of the longer term, large-scale strategic opportunities and changes identified by the consortium.

2.1.2 To support the Council with the immediate opportunities, iMPOWER have commenced a short-term programme of 'fast forward' activity that will take place between May and August 2018. This programme of activity is designed to progress the discrete operational opportunities identified in the Outline Business Case for all client groups, and maintain momentum for the wider programme. The scope of this work is currently being refined and developed in the context of a neighbourhood or 'place based' approach, and with a priority focus on ensuring the immediate work addresses the 2018/19 Business Plan pressure of £1m. The programme of activity will be delivered and implemented in a flexible way to enable the Council to maximise all opportunities for success throughout the programme. The areas that are proposed are:

- Changing the conversation we have with individuals and communities through a redesign of communication and engagement tools and systems (Website, fact sheets, letters, etc.)
- Practice Development with staff and managers
- Strengthening the Assistive Technology offer – strengthening work already started in this area
- Clarification of discharge support pathways and communication
- Detailed planning of longer term, strategic work streams including commissioning by outcomes and the neighbourhood or place based approach

2.1.3 The total cost of the 'Fast Forward' phase is likely to be around £240k which will be funded through previously agreed Transformation Funding in Cambridgeshire, contribution from Peterborough City Council and a new bid to the Cambridgeshire Transformation Fund of around £120k. A detailed proposal and Transformation Fund bid is being developed to go to General Purposes Committee in July.

2.2 Strategic Programme

2.2.1 The fundamental principle of the strategic change is a model which is based on *putting choice and independence directly into the hands of individuals and communities*. The new model will be driven by the neighbourhood or place based approach, and success will mean that citizens have greater independence and better outcomes with reduced state intervention by:

- addressing citizens' needs early on to prevent them from escalating - working in partnership with communities and health partners, to share information, act as one care workforce & be proactive;
- empowering individuals to do more for themselves - providing them with the resources, tools and local support network to make it a reality; and

- building self-sufficient and resilient communities - devolving more preventative care & support resources at a neighbourhood level and enabling individuals to spend their long term care budget within their community.

2.2.2 The Outline Business Case produced by the consortium has identified twelve specific opportunities that will support delivery of the vision, and work is now underway to develop and refine these opportunities across Cambridgeshire and Peterborough. This will be through the development of detailed business cases that will full explore the scale of opportunity available and the case for investment. The opportunity areas are:

1. Customising Care – embedding further the person / community-centred practice, commenced in Transforming Lives.
2. Neighbourhood Based Support Model – the establishment of operational teams located within working as part of a specified local community building on the learning and linking in to the evaluation of the Neighbourhood Cares pilot.
3. Outcome-based Commissioning and stimulation of new care models – commissioning by outcomes and a more significant focus on developing and expanding the care market.
4. Support for Carers – giving equal weight to support for carers and for service users to minimise the risk of carer breakdown.
5. Digital engagement and self-management – utilising digital platforms and tools to improve engagement.
6. Online Marketplace – establishment of a new, online marketplace for care, equipment and support to reduce dependency on the Council.
7. Targeted Reablement and Enablement – expanding reablement provision to new cohorts of people that might benefit from intensive, goal-focussed support.
8. Technology Enabled Care (TEC) – making better use of technology to manage demand, taking advantage of cutting edge technology and working with technology companies to develop new products in response to care need requirements.
9. Discharge Pathways – a clear focus on behaviours and relationships within the discharge model to instil a mind-set of 'returning home'.
10. Intelligent use of Data – making better use of data at both a micro and macro level to make better decisions, support clients and support front-line staff to access the information they need to work more effectively.
11. Improve Finance Pathways – ensuring the finance pathways and processes support people to self-serve and support commissioning.
12. Information sharing and a digitally-mobile workforce – provision of a connected and holistic citizen-view.

2.2.3 Work is underway to develop the detailed business cases necessary to fully realise the potential financial impact of the long-term Adults Positive Challenge Programme. The Outline Business Case indicates an investment of £4.8m could yield cumulative savings of £49.5m during 2018-2023. However a final, detailed business case and investment bid will be presented to General Purposes Committee in September 2018 for consideration.

2.2.4 Although the focus of the work to date has very much been around adults services, the Outline Business Case demonstrates clearly that this transformation will be a key priority and focus for teams across the whole Council. Senior Responsible Officers from across different Council Directorates will be appointed to lead different parts of the programme to

ensure distributed leadership, and resource to deliver change will come from all parts of the organisation and external sources.

2.2.5 Throughout the Adults Positive Challenge Programme, transformation support will be aligned across Cambridgeshire County Council and Peterborough City Council in line with the commitment made by both Councils as part of the shared services agenda to work together where it is in the interests of both organisations to do so.

2.2.6 The Adults Positive Challenge Programme will be embedded within the broader strategic health and social care agenda in Cambridgeshire, and will seek to maximise the opportunities available to drive forward health and social care reform as part of the wider system and through the Combined Authority's Public Service Reform programme.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

There are no significant implications for this priority.

3.2 Helping people live healthy and independent lives

The entirety of the Adults Positive Challenge Programme supports the need to shift social care practice away from long-term support towards more preventative support and advice, which will support people to live healthier and more independent lives – as described throughout the paper

3.3 Supporting and protecting vulnerable people

Safeguarding vulnerable adults is central to the purpose of Adult Services. As the service's focus encompasses more preventative activities and less long-term care support, ensuring that risk is managed effectively and arrangements are in place to support appropriate safeguarding of vulnerable adults will continue to be essential.

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

Resource implications are described in section 2.1.2.

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

There are no significant implications in this category.

4.3 Statutory, Legal and Risk Implications

As outlined in section 2, we do not anticipate any change to statutory or legal duties as a result of this programme nor do we anticipate any greater level of risk. The new model is expected to be both safer and higher quality.

4.4 Equality and Diversity Implications

There are no significant implications in this category.

4.5 Engagement and Communications Implications

There are no significant implications from this paper but the programme will entail a significant programme of engagement and communication as it develops

4.6 Localism and Local Member Involvement

There are no significant implications in this category.

4.7 Public Health Implications

There are no significant implications in this category

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

Source Documents	Location
Committee Report January 2018	***Adults Committee Report Jan 2018***

Agenda Item No: 7

CAMBRIDGESHIRE AND PETERBOROUGH DEMENTIA STRATEGIC PLAN

To:	**Adults Committee**
Meeting Date:	**24 May 2018**
From:	**Executive Director: People and Communities**
Electoral division(s):	**ALL**
Forward Plan ref:	*Key decision:* **No**
Purpose:	To outline the strategic plan for improving outcomes, experience and the cost effectiveness of services for people living with dementia and their carers as a national and local priority.
Recommendation:	The Committee is asked to approve the Strategic Plan so that the improvement in outcomes, experience and cost effectiveness in dementia care across Cambridgeshire and Peterborough can be delivered.

	Officer contact:		***Member contacts:***
Name:	**Fiona Davies**	Names:	Cllr Bailey/Cllr Howell
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1. BACKGROUND

1.1 Using the national Well Pathway for Dementia, the Dementia Strategic Plan presents a vision for dementia care in Cambridgeshire and Peterborough and the key outcomes to be delivered. It summarises the current status of dementia care, identifying strengths and opportunities for improvement and likely future demand and the actions known to be required to improve outcomes over the two years from 2018/19. It aims to ensure that the best use of resources is made and to identify significant gaps in services and any investment required. The work on cost effectiveness will be undertaken in the context of the current pressure on public sector resources with the aim being to identify opportunities for service redesign and reinvestment to deliver the required improvements.

2. THE STRATEGIC PLAN

2.1 Dementia is a syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is disturbance which can affect memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgement i.e. cognitive impairment. However, not all cognitive impairment is caused by one of the dementias i.e. they are not all progressive. The scope of the Strategic Plan is confined to progressive cognitive impairment/dementias. Therefore, it includes Alzheimer's disease, dementia with Lewy Bodies and cardio-vascular dementias and Mild Cognitive Impairment (MCI).

2.2 The Strategic Plan was developed by the Older People's Mental Health (OPMH) Delivery Board, which is made up of representatives of the voluntary sector including carer representatives and representatives of people living with dementia, Cambridgeshire County Council (CCC), Peterborough City Council (PCC), Peterborough and Cambridgeshire Clinical Commissioning Group (CCG) commissioners, and Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) who work primarily with older people living with dementia and their carers. However, they also care for people with early onset dementia i.e. those under age 65 years.

2.3 The Plan is based on the outcomes of engagement with a variety of individuals employed by both statutory and voluntary sector organisations across the Cambridgeshire and Peterborough health and social care system during 2016 and 2017. It was finalised following engagement on the draft Strategic Plan from September to October 2017. This included a Survey Monkey Questionnaire that was circulated using existing networks and engagement events with representative groups including:

- The Older People's Partnership Boards: Cambridgeshire and Peterborough
- The Ageing Well Strategy Board
- The Carers' Trust: Carers' Group
- The STP: Clinical Advisory Group
- The Peterborough Living Well Partnership

2.4 The Plan aims to achieve equity of access, assessment, treatment, support and outcomes across the area. It also aims to prevent or delay the onset of dementia. Overall, the aim is to ensure the cost effectiveness of dementia care and to maximise the use of resources available to meet health and social care needs in relation to dementia and other conditions across the area. It describes how the Older People Mental Health (OPMH) Delivery Board plans to work with its partners to achieve the vision for dementia. These are summarised in action plans for each of the Pillars and Cross Cutting Themes of the Well Pathway for Dementia (see Appendix 1). The Executive Summary is attached for reference (Appendix 2). The full Strategy document is attached as Appendix 5.

2.5 The work that will be done to develop the business case requested by the Sustainability and Transformation Partnership (STP) is also described within the Plan. This will be completed during the Autumn 2018 with implementation of the agreed improvements to take place from 1 April 2019.

2.6 Gaps and improvements that can be made across the dementia pathway in Cambridgeshire and Peterborough have been identified. The most significant gaps have been identified as:

- Early intervention and support including information, advice and guidance and advance care planning – primarily provided by the voluntary sector.
- The infrastructure required to support the development of dementia friendly communities and environments – primarily provided by the voluntary sector/also in primary care
- Support to maximise quality of life whilst living with dementia - for individuals living with dementia and their carers.
- Capacity to support people intensively to remain at home at times of crisis and/or enhanced need (service provided by Dementia Intensive Support Team (DIST)).
- Psychological treatment for people following diagnosis and in specialist dementia inpatient care.
- The seamlessness and co-ordination of care across both mental and physical health clinicians, teams and organisations.
- Management of dementia and quality of care in care homes.
- Personalised care planning and support.
- Specialist assessment, treatment and support for people diagnosed with early onset dementia[1].

2.7 Gaps in non-progressive dementias such as those that are caused by substance misuse or brain damage have been identified. However, responsibility for delivery of services for these groups rests with a variety of individuals, teams and organisations which are beyond the usual networks of those working with the progressive dementias. Having given the matter considerable thought, the OPMH Delivery Board decided to highlight these gaps but to recommend that other networks address the issues with their support and advice if required.

[1] This document contains key issues identified within the needs assessment undertaken to inform the Strategic Plan. The detail is contained in 'Early Onset Dementia, Needs Assessment', October 2017.

2.8 The County Council has a key role to play in addressing each of the priorities above - arising from the Care Act. Qualified Social Workers and Support Workers seconded to CPFT as part of the integrated mental health service are responsible for care planning and support and are for ensuring that this is personalised. These staff, and those employed within Early Help teams are responsible for ensuring that information, advice, guidance and appropriate signposting, including referral for diagnosis, is provided as early in the course of the disease as possible. Social Workers and the Commissioning Teams are responsible for ensuring access to good quality housing and accommodation, including care homes. The County Council also has responsibility for carer assessment and support and for supporting the development of dementia friendly communities and environments. In addition, the Council has a responsibility to work effectively with partners in the NHS, the voluntary sector and with people living with dementia and their carers to deliver care that is co-ordinated and seamless.

2.9 A core data set to monitor quality, outcomes has been developed and will be refined as part of the work to implement the Strategic Plan. These are based upon the Memory Service National Accreditation Programme quality standards and the reporting requirements of NHS and social care organisations. In addition to the need to report on core national and local activity, performance and outcomes this data set will enable the system to monitor the improvements that are of the greatest importance to people living with dementia and their carers. Achievement of this ambition will be supported by the alignment of the Personal Care and Support Planning initiative with the development of the dementia pathway.

3. NEXT STEPS

3.1 The Plan has been signed off by all the Boards necessary except for Peterborough Cabinet and the Health and Wellbeing Board. The processes to secure sign off are underway and near completion.

3.2 The Plan draws together work to improve outcomes for people living with dementia and their carers that was already underway and the work needed to address the additional gaps in care and support and opportunities for improvement identified as it was developed. Implementation of both is already underway as implementation is an iterative and evolving process.

3.3 A detailed implementation plan has been developed with Task and Finish Workstreams established led by key individuals from across the health and care system. Responsibility for delivery lies with the Dementia Steering Group, the project group established to ensure delivery and ultimately with the OPMH Delivery Board which reports to the Ageing Well Strategy Board and the MH Strategy Group. Cath Mitchell, Director of Integration, Cambridgeshire and Peterborough is the Senior Responsible Officer with overall responsibility for delivery.

3.4 The County Council will have a key role in supporting the OPMH Delivery Board to deliver the Strategic Plan. In particular to:

i) Support the proposal to develop Dementia Friendly Communities, working closely with District Councils and leading as a County Council and identifying

Dementia Champions. The possibility that Area Champions could support and help to progress this work is currently being explored.

ii) Support the proposal to encourage organisations across Cambridgeshire and Peterborough to become Dementia Friendly and lead by example by exploring how and then committing to what would be required for the County Council to become Dementia Friendly. There are 3 key ways in which an organisation can become dementia friendly:

1. Make customer service more dementia-friendly
2. Improve the physical environment
3. Provide practical support and deal with difficult situations effectively

3.5 Two of the key risks to delivery of the Strategic Plan are currently rated amber. Mitigating actions are in place to address them:

- **Risk 1:** Insufficient capacity within OPMH commissioning and provider organisations to deliver a complex programme of work with the detailed level of analysis necessary to achieve the outcomes required.
- **Risk 2:** The need to for system wide participation in delivery of the strategy.

The third risk relating to resourcing the facilitation of the care pathways workshops has been resolved.

4. ALIGNMENT WITH CORPORATE PRIORITIES

4.1 Developing the local economy for the benefit of all

There are no significant implications for this priority.

4.2 Helping people live healthy and independent lives

See wording under 3.1 above

4.3 Supporting and protecting vulnerable people

See wording under 3.1 above

5. SIGNIFICANT IMPLICATIONS

5.1 Resource Implications

There are no immediate resource implications within the Strategic Plan. However, the aim is to improve the use of resources and to identify gaps in the current pathway and to address the implications of the inevitable increase in demand for dementia care and support arising from the 86% (n=8,100) increase in the numbers of people living with dementia in Cambridgeshire and Peterborough to 2031. The Plan will identify proposals for service redesign and may lead to the development of business cases for additional investment for consideration by the Cambridgeshire County Council and Peterborough City Council. The CCG/Strategic Transformation Partnership. Proposals for redesign and/or investment will be developed January –

September 2018, with a business case/s developed September to December 2018
.
It is likely that resources in terms of staff time (primarily time for training) and investment in training and minor adaptations to physical environments will be required in order to progress the proposals relating to making the County Council a Dementia Friendly organisations, if it is agreed that this should be pursued. The current proposal is to explore what would be required and identify the potential cost.

5.2 **Procurement/Contractual/Council Contract Procedure Rules Implications**

No immediate implications.

5.3 **Statutory, Legal and Risk Implications**

No immediate implications.

5.4 **Equality and Diversity Implications**

The Plan will have a positive impact on: age, disability, race, religion/belief, pregnancy and maternity (for those in caring roles), rurality and deprivation. It has a neutral impact on gender reassignment, sex, sexual orientation, and marriage and civil partnership. There are no negative impacts.

5.5 **Engagement and Communications Implications**

The Plan was developed by the OPMH Delivery Board that has wide representation of key organisations involved in the delivery and commissioning of dementia care and support. Individuals within and the organisations represented were consulted. There were monthly consultations and engagement throughout the period when the Plan was developed at the scheduled meetings. Members of the Committee are as follows:

- PCC/CCC MH Commissioning Team
- C&P CCG:
- CPFT
- Alzheimer's Society
- Carers' Trust
- Peterborough LEP
- Councillor Lamb
- Ageing Well Strategy Board
- STP: PCIN
- Older People's Partnership Boards: Peterborough and Cambridgeshire
- Cambridgeshire ASC Teams
- Peterborough ASC Teams

The Plan has now been signed off by:

- The OPMH Delivery Board: 17.01.18
- The Ageing Well Strategy Board: 16.01.18 (subject to approval of the Plan by the OPMH Delivery Board)
- PCC/CCC Joint Commissioning Board: 14.02.18

- STP: PCIN:01.03.18
- STP: CAG: 15.03.18
- CCG: CEC: 27.03.18
- CPFT: Executive Team: 27.03.18 (approval by the Trust Board is not required)

Sign off by the following is planned April – June 2018:

- STP: HCE
- CCG: GB
- CCC: Adults Committee
- PCC: Health and Wellbeing Board
- CCC: Health and Wellbeing Board

No further consultation needed to finalise the Plan. As the Plan is implemented there will be significant and ongoing engagement and consultation with all stakeholders.

5.6 **Localism and Local Member Involvement**

The development of Dementia Friendly Communities (DFCs) are key to the national dementia strategy and are also included as a key strand within the Cambridgeshire and Peterborough Dementia Strategic Plan. Increasing the number of DFCs is a key outcome from the pre-and post-diagnostic support workstream. This workstream has been identified as having the biggest gap in terms of what is needed to provide cost effective care and support for people living with dementia and their carers in Cambridgeshire and Peterborough. Support for, and involvement of, Members in the development of DFCs would make a significant contribution to this (see 3.4 above). District Councils are also key to this workstream and plans to engage with and involve them in this work are included in the action plan.

5.7 **Public Health Implications**

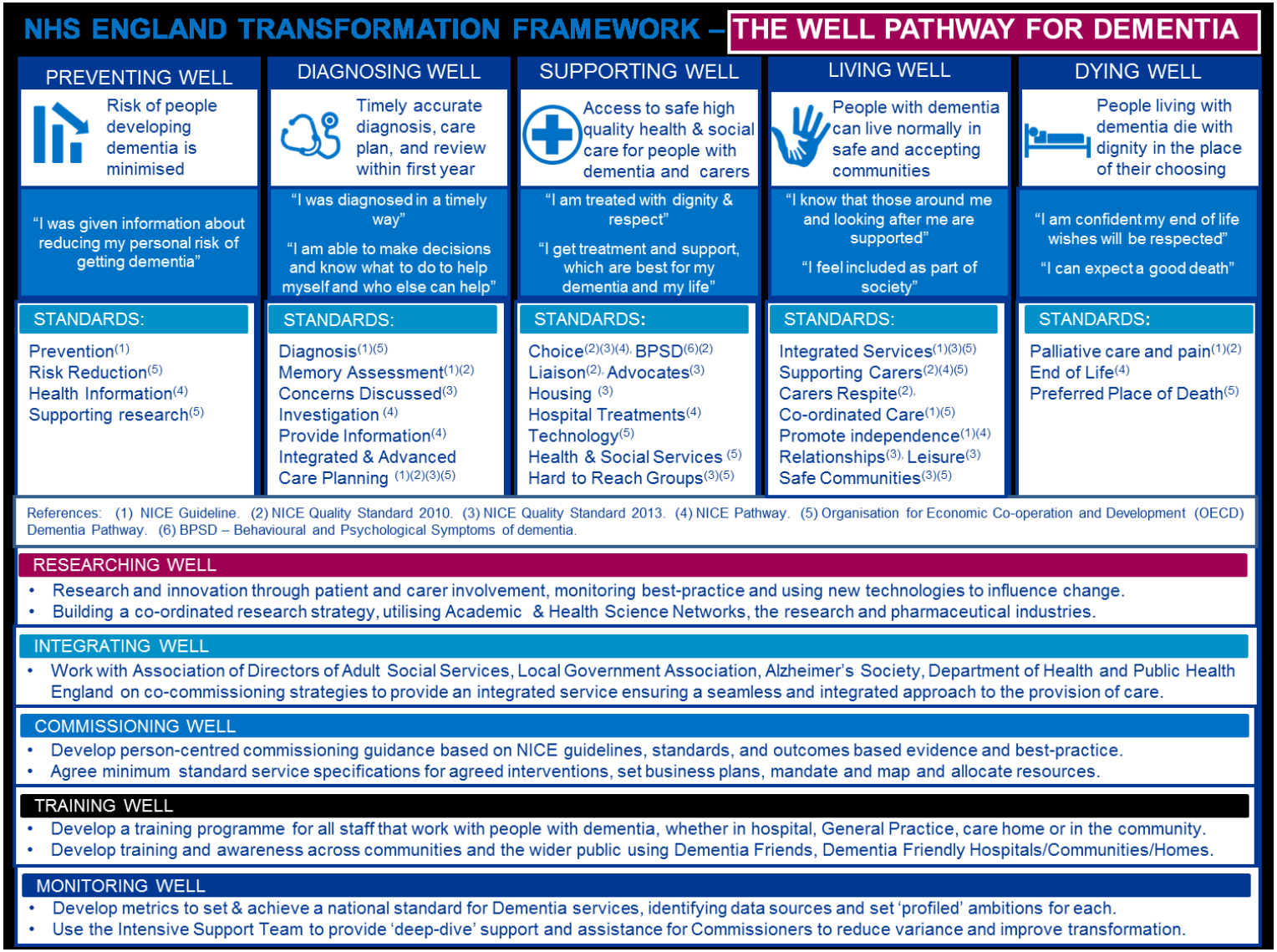
Prevention is one of the 5 Dementia Well Pathway Pillars. There is a Prevention workstream and action plan within the plan. These summarise and pull together the components of the Public Health Strategy that relate to dementia. There are therefore no specific implications of the Strategic Plan for Public Health, although the Plan highlights the importance of prioritising and progressing this work.

Implications	**Officer Clearance**
Have the resource implications been cleared by Finance?	Yes Tom Kelly
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by Finance?	Yes Tom Kelly
Has the impact on statutory, legal and	No

risk implications been cleared by LGSS Law?	Name of Legal Officer:
Have the equality and diversity implications been cleared by your Service Contact?	Yes Oliver Hayward
Have any engagement and communication implications been cleared by Communications?	Yes
Have any localism and Local Member involvement issues been cleared by your Service Contact?	No
Have any Public Health implications been cleared by Public Health	Yes Katie Johnson

Source Documents	**Location**
Cambridgeshire Public Health Strategy 2015 – 18	Public Health, Shire Hall, Cambridge
Apart from the above, the main sources were local activity and finance data (operational) and national strategy documents: • Dementia: The NICE/SCIE Guidelines on Supporting People with Dementia and their Carers in Health and Social Care, NICE/SCIE, 2006	https://www.scie.org.uk/publications/misc/dementia/dementia-fullguideline.pdf?res=true
• National Dementia Strategy, DH 2009	https://www.gov.uk/government/publications/living-well-with-dementia-a-national-dementia-strategy
• Prime Minister's Challenge on Dementia: 2020, DH, 2015	https://www.gov.uk/government/publications/prime-ministers-challenge-on-dementia-2020
• Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset, NICE, 2015	https://www.nice.org.uk/guidance/ng16

Appendix 1: The Well Pathway for Dementia[2]



[2] https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/03/dementia-well-pathway.pdf , online, accessed: 05.07.17

Appendix 2

Cambridgeshire & Peterborough All Age Dementia Strategic Plan 2018 - 2023

Dementia: Everybody's Business: better outcomes for people living with dementia and their carers

Executive Summary

Cambridgeshire and Peterborough
Older People's Mental Health Delivery Board
January 2018

Cambridgeshire and Peterborough CCG, Cambridgeshire County Council and Peterborough City Council, Cambridgeshire and Peterborough NHS Foundation Trust, Cambridgeshire University Hospitals NHS Foundation Trust, North West Anglia NHS Foundation Trust, The Alzheimer's Organization, The Carers' Trust, Care Network

EXECUTIVE SUMMARY

Improving experience and outcomes for people living with dementia and their carers is a national priority. The Cambridgeshire and Peterborough Sustainability and Transformation Partnership (STP) which brings together leaders of health and social care organisations across the health and social care system to ensure that services are effective and efficient, has identified improving outcomes and experience for people living with dementia and their carers as a key priority for 2018/19 and beyond.

This Strategic Plan has been developed by the Older People's Mental Health (OPMH) Delivery Board to deliver that improvement. The Plan aims to address the needs of people of all ages living with dementia[3] and mild cognitive impairment[4] and their carers living in Cambridgeshire and Peterborough. It also aims to prevent or delay the onset of dementia and to identify ways that individuals and communities can be supported to improve the quality of life of people living with dementia as they go about their lives.

The Plan relates specifically to dementia. A definition of dementia has been agreed by those involved in dementia across the Cambridgeshire and Peterborough health and social care system:

> Dementia is a syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgement.[5]'

It can be caused by a number of progressive neurodegenerative diseases, including Alzheimer's disease, frontotemporal dementia, vascular disease, Parkinson's disease and Huntington's disease. Not all cognitive impairment is due to dementia.

Mild cognitive impairment (MCI) is also included within the scope of the Strategic Plan because, whilst people with MCI are at higher risk of developing dementia, it is not possible or appropriate to make a positive diagnosis of dementia at the point when MCI is identified. It is important that people with MCI are identified, in particular to distinguish them so that they are not misdiagnosed with dementia. To do so would give a large number of people a diagnosis of a progressive terminal neurodegenerative disease which they do not have, and which may never develop**.** This would be inappropriate and unhelpful, causing unnecessary distress for individuals and their families. MCI can be defined as:

> A condition where an individual has cognitive deficits beyond those expected for their age and education, but which are not significant enough to interfere with their daily activities[6].

[3] A syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgement.[3]'

[4] A condition where an individual has cognitive deficits beyond those expected for their age and education, but which are not significant enough to interfere with their daily activities[4].

[5] The ICD-10 Classification of Mental and behavioural Disorders, clinical descriptions and diagnostic guidelines' World health organisation 1992 ISBN 92 4 154422

[6] Petersen RC, Smith GE, Waring SC, Ivnik RJ, Tangalos EG, Kokmen E (1999). "Mild cognitive impairment: clinical characterization and outcome". Arch. Neurol. 56 (3): 303–8.

Services for people with cognitive impairment that results from brain damage of a non-progressive nature are not included within the scope of the Strategic Plan because responsibility for commissioning and provision lies with a variety of organisations, groups and individuals beyond the boundaries of dementia commissioning and provision. However, it is essential that it is noted that there are gaps in services for people with non-progressive cognitive impairment. This issue has been drawn to the attention of STP leaders and commissioners by the Older People's Mental Health (OPMH) Delivery Board as part of its work to develop the Strategic Plan. Members of the Delivery Board are happy to provide assistance to those addressing these needs.

The case for prioritising the care and support of people living with dementia and their carers in Cambridgeshire and Peterborough is strong:

- Dementia affects the older population in significant numbers – an estimated 670,000 people in England[7] and 8,600[8] in Cambridgeshire and Peterborough.
- There is a considerable economic cost associated with the disease estimated at £23 billion a year, which is predicted to triple by 2040. This is more than the cost of cancer, heart disease and stroke[9].
- An estimated 25% of hospital beds are occupied by people with dementia.
- Hospital stays of people with dementia are approximately 1 week longer than average[10].
- 75% of people living in care homes have dementia[11].
- Dementia is the leading cause of death for women[12].
- It is estimated that the number of people living with dementia in Cambridgeshire and Peterborough will increase from 8,600 to 16,110 (7,510/86%) between 2016 and 2031. Action therefore needs to be taken to:
    i) Do everything possible to prevent and delay the onset of dementia to slow the growth in numbers of people living with dementia.
    ii) Ensure that the best use of the resources available is in order to manage the resulting increase in demand.
- Improving awareness and understanding of dementia will enable people living with dementia and their carers to live more comfortably with their families and communities.
- If dementia is diagnosed early in its course, appropriate support can be provided in the present, and as the disease progresses, reducing the incidence of avoidable crises and interventions, improving experience and outcomes whilst also releasing resources for investment in other health and social care interventions.
- Across Cambridgeshire and Peterborough there is a desire to improve experience and outcomes for people who access any health and social care services.

The main thrust of national strategy is to ensure that people living with dementia are supported to live at home with their families for as long as possible. Early diagnosis and intervention including access to information, advice and guidance, advance care planning that is personalised, timely access to specialist assessment and treatment, and effective support for carers are key

[7] The Prime Minister's Challenge on Dementia, DH, 2020

[8] Public Health England, 2016

[9] Commissioning for Value: Mental health and dementia pack, Public Health England, January 2017

[10] The Prime Minister's Challenge on Dementia, DH, 2020//5 Year Forward View, DH, 2015

[11] The Prime Minister's Challenge on Dementia, DH, 2020/5 Year Forward View, DH, 2015

[12] The Prime Minister's Challenge on Dementia, DH, 2020/5 Year Forward View, DH, 2015

components of the strategy. Promoting better awareness and understanding of dementia amongst communities and businesses is essential if people living with dementia and their carers are to live and participate comfortably in their communities. Based on the work of the Alzheimer's Society, national strategy includes programmes to increase awareness through the development of dementia friendly communities and environments. There is much that can be done to prevent dementia by tackling key risk factors such as smoking, excess weight and physical inactivity. Overall, the aim is:

> **To enable people living with dementia to live independently for longer and to enjoy being part of their community[13] and to keep them healthier for longer and out of hospital[14].**

A vision for people living with dementia and their carers in Cambridgeshire and Peterborough has been agreed:

> ***We will work hard to prevent people in Cambridgeshire and Peterborough from acquiring dementia and ensure that those living with and affected by dementia receive compassionate, expert care and support, that is right for them to live positive and fulfilling lives …. we will support and empower them to take part in, and contribute to, the families and communities in which they live and work[15].***

Gaps and improvements that can be made to all of the above in Cambridgeshire and Peterborough have been identified through the work to develop the Strategic Plan. However, the biggest gaps identified are in:

- Early intervention and support including information, advice and guidance and advance care planning – primarily provided by the voluntary sector.
- The infrastructure required to support the development of dementia friendly communities and environments – primarily provided by the voluntary sector.
- Support to maximise quality of life whilst living with dementia - for individuals living with dementia and their carers.
- Capacity to support people intensively to remain at home at times of crisis and/or enhanced need (service provided by Dementia Intensive Support Team (DIST)).
- Psychological treatment for people following diagnosis and in specialist dementia inpatient care.
- The seamlessness and co-ordination of care across both mental and physical health clinicians, teams and organisations.
- Personalised care planning and support.
- Specialist assessment, treatment and support for people diagnosed with early onset dementia[16].

Addressing these gaps has been prioritised within the Strategic Plan. The Plan describes how the OPMH Delivery Board plans to work with its partners to achieve the vision for dementia using the

[13] Dementia Implementation Guide, DH, 2017

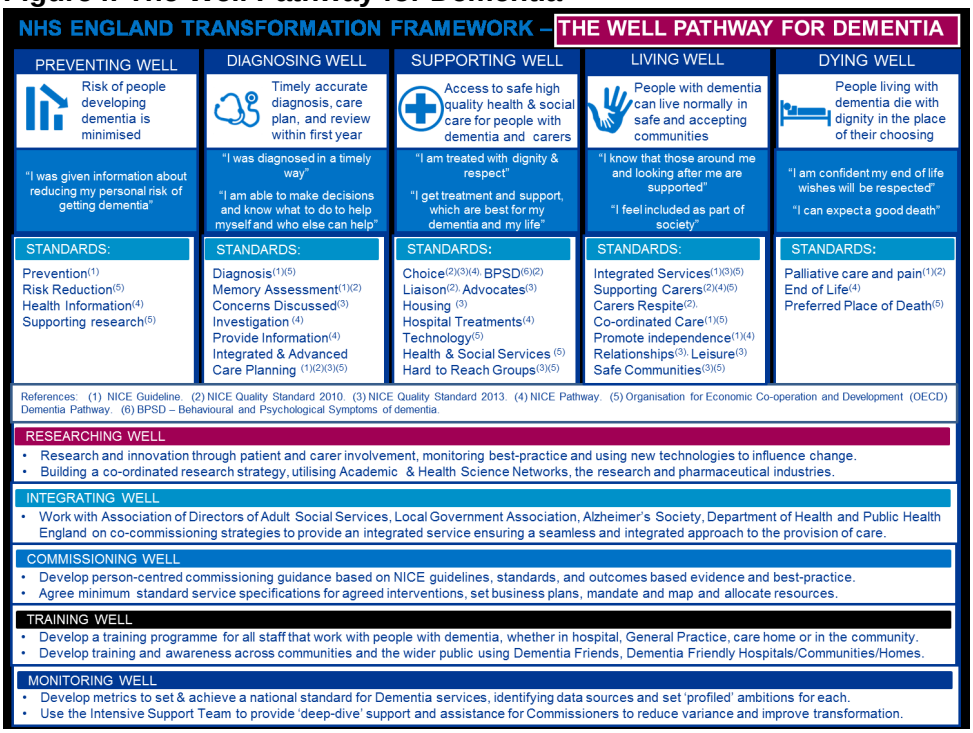
[14] The Five Year Forward View Implementation Guide, 2017-19, DH 2017

[15] Adapted from Dementia UK's Strategy

[16] This document contains key issues identified within the needs assessment undertaken to inform the Strategic Plan. The detail is contained in 'Early Onset Dementia, Needs Assessment', October 2017.

pillars and cross-cutting themes of the Well Pathway for Dementia which provides a framework for delivery of the national dementia strategy as its basis. (See Figure i below).

Figure i: The Well Pathway for Dementia[17]



The aim is to ensure that delivery of the services under each pillar of the Well Pathway are effective and efficient and developed in line with national and local good practice. To achieve this, action plans to improve outcomes from the services under each of the Pillars and Cross Cutting Themes has been developed. (See Section 3.2). These are summarised in Table 1 below. The Strategic Plan aims to deliver the following outcomes:

- Prevention of the onset of dementia where this is possible.
- People living with dementia are supported to live safely for longer within the community and with their carers.
- Improved accessibility to, and consistency of, assessment, treatment and support for people living with dementia and their carers across Cambridgeshire and Peterborough.
- Increased choice and control for people living with dementia and their carers - at all stages of the disease.
- Improved outcomes and experience of services for people living with dementia and their carers at all stages of the disease and wherever they live i.e. at home, in care homes and when admitted to hospital..
- Well co-ordinated care that addresses physical and mental health and social care needs in a seamless way.
- Crises and avoidable admission to inpatient dementia services and acute hospitals are reduced.
- Better understanding and awareness of dementia within communities
- Better use of resources/value for money.

[17] https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/03/dementia-well-pathway.pdf , online, accessed: 05.07.17

A key objective of the Strategic Plan is to reduce costs where possible, releasing resources for investment in new/improved services and/or for investment in other key areas of need.

Investment, capacity, activity and performance across the health and social care system in dementia diagnosis, assessment, treatment and support is not fully understood. The Plan aims to develop this understanding in order to identify opportunities for improved performance, outcomes and reduced cost in order to enable investment to address gaps in services and support. Improvement will be achieved primarily by ensuring early diagnosing, intervention and effective community based, reducing expenditure on more expensive specialist interventions in line with national guidance for CCGs[18] and Local Authorities on cost effectiveness. Finally, the gap between current investment, improvements required and the increase in capacity necessary to match the likely increase in the numbers of people living with dementia will be identified. All of this will be brought together in a business case to the STP and to Peterborough City Council (PCC) and Cambridgeshire County Council (CCC).

A core data set to monitor quality, outcomes and activity based on the Memory Service National Accreditation Programme (MSNAP) quality standards, the reporting requirements of NHS and social care organisations has been developed and will be refined as part of the work to implement the Strategic Plan. Notwithstanding the need to report on core national and local activity, performance and outcomes, the key driver for the development of these outcomes will be to monitor the things that are of the greatest importance to people living with dementia and their carers.

Delivery of the Strategic Plan constitutes a major programme of work. A high level timeline for delivery of the actions/milestones required 2017 – 2019 has been developed to support delivery (See Figure ii below). An assessment of the risks to delivery of the Strategic Plan has been made with the following risks being identified:

- **Risk 1:** Insufficient capacity within OPMH commissioning and provider organisations to deliver a complex programme of work with the detailed level of analysis necessary to achieve the outcomes required
- **Risk 2:** Insufficient resources available across the system to support the analysis required
- **Risk 3:** Lack of resources to support external facilitation for the development of the care pathway

At the time of completion of the Strategic Plan (January 2018), these are rated amber with mitigating actions in place to address them.

[18] Next Steps on the NHS Five Year Forward View, DH, 2017

Table i: Summary of the Cambridgeshire and Peterborough Dementia Well Pathway Action Plans

Strategic Plan: Section	Pillar/Cross Cutting Theme and Standard	Key Objective 1	Key Objective 2	Key Objective 3	Key Objective 4
3.2.1	***Preventing Well*** ***The risk of people developing dementia is minimised: "I was given information about my personal risk of getting dementia"***	To build strategy to include evidence-based and equitable primary, secondary and tertiary prevention efforts across the life course.	To incorporate dementia risk reduction into current long-term disease approaches and unique messaging.		
3.2.2	***Diagnosing Well*** ***Timely accurate diagnosis, care plan, and review within first year. "I am diagnosed in a timely way. I am able to make decisions and know what to do to help myself and who else can help".***	To increase the dementia diagnosis rate.	To develop a robust pathway that meets the standards within NICE guidelines and MSNAP with protocols agreed between the Memory Assessment Service, GPs, older people's services and the voluntary sector, including protocols that ensure that advance planning is established consistently across Cambridgeshire and Peterborough (includes assessing the feasibility of commissioning a Memory Assessment Service that meets the standards required to achieve MSNAP accreditation).		
3.2.3	***Supporting Well*** ***Access to safe high quality health and social care for people with dementia and their carers. "I am treated with dignity and respect. I get treatment and support which are best for my dementia and my life."***	To develop a robust dementia pathway within which there is an action plan that supports improvement/achievement of the standards within NICE guidelines and MSNAP consistently across Cambridgeshire and Peterborough that relate to Living Well (includes assessing the feasibility of commissioning	To work with Acute providers to develop a plan for ongoing improvement in the quality of care for people with dementia when in hospital.	To improve awareness of and access to dementia care for hard to reach groups	To ensure that the quality of care of people living with dementia in care homes meets the Care Quality Commission requirements and best practice.

Strategic Plan: Section	Pillar/Cross Cutting Theme and Standard	Key Objective 1	Key Objective 2	Key Objective 3	Key Objective 4
		a Memory Assessment Service that meets the standards contained within NICE guidelines and MSNAP; as a minimum, standards relating to advance planning must be achieved).			
3.2.4	***Living Well*** ***People with dementia can live normally in safe and accepting communities. "I know that those around me and looking after me are supported. I feel included as part of society."***	To ensure geographical consistency in relation to Dementia Friendly Communities and Dementia Friendly Environments across Cambridgeshire and Peterborough	To ensure that people living with dementia have access to community based support that is robust and consistent across Cambridgeshire and Peterborough	To establish a robust infrastructure of support for carers that is consistent across Cambridgeshire and Peterborough	
3.2.5	***Dying Well*** ***People living with dementia die with dignity in the place of their choosing. "I am confident my end of life wishes will be respected. I can expect a good death."***	To improve the quality of care and support and outcomes at end of life for people living with dementia and their carers			
3.2.6	**Early Onset Dementia**	To ensure that people living with early onset dementia and their carers have access to robust assessment, treatment and support.			
3.2.7	***Researching Well***	To ensure that every patient with a diagnosis of dementia is given the opportunity to participate in dementia research.	To evaluate the impact of the Dementia Strategic Plan		

Strategic Plan: Section	Pillar/Cross Cutting Theme and Standard	Key Objective 1	Key Objective 2	Key Objective 3	Key Objective 4
3.2.8	**Integrating Well**	To ensure that care is seamless, addressing physical and mental health and social care needs in an holistic and cost effective way			
3.2.9	**Commissioning Well**	To improve the commissioning and leadership for health and social care commissioning.	To ensure that best use of resources is made.	To ensure that services are effectively commissioned.	
3.2.10	**Training Well**	To ensure that staff across the Cambridgeshire and Peterborough health and social care system are involved in and inform the development of and are trained in the operation of the integrated dementia pathway.			
3.2.11	**Monitoring Well**	To improve understanding of activity, performance and outcomes for people living with dementia and their carers in Cambridgeshire and Peterborough.	To develop a set of indicators of quality that include experience of services and support and outcomes for people living with dementia and their carers related to dementia across the Cambridgeshire and Peterborough health and social care system		

Appendix 3

Dementia Friendly Communities: Briefing Note[19][20]

A dementia-friendly community is a city, town or village where people with dementia are understood, respected and supported.

In a dementia-friendly community people will be aware of and understand dementia, so that people with dementia can continue to live in the way they want to and in the community they choose.

Why are dementia-friendly communities important?

Dementia-friendly communities are vital in helping people live well with dementia and remain a part of their community.

Too many people affected by dementia feel society fails to understand the condition they live with, its impact or how to interact with them. That's why people with dementia sometimes feel they need to withdraw from their community as the condition progresses.

In fact, over a third of people with dementia told us that they have felt lonely recently. More than a quarter of carers we surveyed said they felt 'cut off from society' too.

This isn't okay. People affected by dementia still have an incredible amount to offer to their community. If appropriately supported, they can continue to play an active and valuable role even years after diagnosis.

Who can help make their community dementia-friendly?

Everyone. From governments and local shops, to book clubs and churches, we all have a part to play in creating communities where people with dementia feel active, engaged and valued.

People affected by dementia have the most important role in any dementia-friendly community. By sharing their experiences and connecting with others, they ensure that communities keep the needs of people affected by dementia at the heart of everything they do.

[19] https://www.alzheimers.org.uk/info/20115/making_your_community_more_dementia-friendly/341/how_to_become_a_recognised_dementia-friendly_community, accessed: 04.04.18

[20] https://www.alzheimers.org.uk/info/20115/making_your_community_more_dementia-friendly/337/what_is_a_dementia-friendly_community, accessed: 04.04.18

How to become a recognised dementia-friendly community

Our Dementia Friendly Communities recognition scheme celebrates the work of dementia-friendly communities across the country.

Many communities have received formal recognition for being dementia-friendly[21].

If you'd like to get involved, here's what you'll need to do.

Step one: Get a group together

Dementia-friendly communities work best when they're led by local people. Join with other interested people locally to form your 'steering group.' Some communities choose to form a Local Dementia Action Alliance.

Step two: Agree a leader

This person will oversee the group and make sure the community is making progress. They aren't expected to do everything themselves, but can coordinate the group's activity.

They'll also be Alzheimer's Society's key contact for the community, receiving support from our Dementia Friendly Communities Officers.

Step three: Raise awareness

People in your community need to understand dementia before they can take dementia-friendly actions. There are lots of ways you can raise awareness, such as:

- Becoming Dementia Friends
- Accessing Alzheimer's Society training
- Running lessons in schools

Step four: Involve people affected by dementia

Before you can start taking action, you'll need to hear the experiences of people affected by dementia where you live. You could do this by:

- Inviting people with dementia to join your group
- Visiting services, such as Memory Cafés
- Hosting a community event

Step five: Tell the world

You're doing something amazing, so make sure your community knows about it. It's a great way to get more people on board and to celebrate your successes.

[21] There are currently 328 DFCs in England and Wales

You could consider:

- Sharing news on social media
- Writing a press release for your local newspaper
- Taking part in community events and fayres

Step six: Identify areas for local action

Taking action is the most important part of any dementia-friendly community. You don't have to tackle everything at once. Speaking to local people with dementia can help you identify what your priorities should be.

We suggest using the BSI PAS1365: A code of practice for dementia-friendly communities to help you. This guide offers eight key areas for action and some suggested actions for communities:

- arts, culture, leisure and recreation
- businesses and shops
- children, young people and students
- community, voluntary, faith groups and organisations
- emergency services
- health and social care
- housing
- transport

Step seven: Monitor your progress

Now you've got the ball rolling, you'll need to plan how you'll measure your progress. Many communities host regular meetings to share their updates on their actions, but you can choose what's right for you.

As a recognised community, we'll want to know how you're getting on 6 months after your application. You'll then keep us up-to-date with a yearly assessment. However you can update your progress as much as you want over the year.

Step eight: Apply for recognition

Your community is ready to apply to our Dementia Friendly Communities recognition scheme. We want to hear how you've achieved the steps above and, more importantly, what your future plans are. Apply now:

- Communities in England and Wales
- Communities in Northern Ireland

Need more help?

- Read more about the recognition process and our criteria online.
- Email our Dementia Friendly Communities team at DementiaFriendlyCommunities@alzheimers.org.uk

Appendix 4

Becoming a Dementia Friendly Organisation: Briefing Note[22]

Three ways your organisation can help people affected by dementia

1. Make your customer service more dementia-friendly
2. Improve the physical environment
3. Provide practical support and deal with difficult situations effectively

1. Make your customer service more dementia-friendly

Good customer service can be key to helping somebody to live well with dementia. Here are a few tips to help your organisation deliver a more dementia-friendly service.

Offering understanding and reassurance

Someone with dementia may find it difficult to process information. They may feel disorientated and struggle to answer simple questions or take in what you are saying. In the later stages, they may be confused about what they are doing and make mistakes.

You can assist a person with dementia by:

- Allowing the person to take their time.
- Understanding how they might be feeling.
- Being friendly and smiley.
- Considering their feelings and responding to the emotions they are expressing.
- Asking direct questions. For example, 'Is there someone you would like me to call?' rather than 'What would you like me to do?'

Communicating clearly

A person with dementia may not understand what you are doing or remember what you have said. Treat them respectfully by addressing them in conversation, as well as any partner or carer they may be with.

The below guidance is vital when communicating with someone who is experiencing difficulties associated with dementia.

Body language and physical contact

[22] https://www.alzheimers.org.uk/info/20116/making_organisations_more_dementia-friendly/355/three_ways_your_organisation_can_help_people_affected_by_dementia, accessed, 04.04.18

- Make eye contact.
- Make sure that your body language and facial expressions match what you are saying.
- Never stand too close or stand over someone to communicate.
- Do not cover your mouth. The person should be able to see your face clearly.

Talking

- Speak clearly and calmly.
- Use short, simple sentences.
- Speak at a slightly slower pace.
- Avoid speaking sharply or raising your voice.
- Don't talk about people with dementia as if they are not there or talk to them as you would to a young child.

Listening

- Listen carefully to what the person is saying, and give them plenty of encouragement.
- If you haven't understood fully, tell the person what you have understood and check with them to see if you are right.
- If possible, use visual clues – write your message down if the person is able to read and use objects or pictures to help the person understand. For example, show the person photographs of meals they can choose from.

For more information, please see page 20 of our Dementia-friendly business guide, which gives detailed advice on how you can help people affected by dementia.

2. Improve the physical environment

Places that are noisy, busy or that have sounds that might be distracting can make people with dementia uneasy. They may not recognise colours, faces or objects or have problems with spatial awareness.

- Objects that are shiny, patterned or reflective can cause people with dementia to mistake what they are seeing.
- Features such as lighting, mirrors, shadows, steps and patterned walls and floors might cause problems for some people with dementia.
- Be aware of environments that are noisy or dark, and if you can, provide a quiet place where it is easier to offer one-to-one assistance.
- What is obvious to you may not be so to them.

For more information, please see our Physical environments checklist on page 81 of our Dementia-friendly business guide.

3. Provide practical support and deal with difficult situations effectively

Whatever sector your organisation is in, you should be providing appropriate practical support for people affected by dementia. A small action may make a significant difference to someone and help them to continue living safely and comfortably in the community.

The following actions are just some of the steps you can take.

- If someone can't remember how to do something, offer to show them how to do it. As much as possible, do the task with them and not for them. Break down tasks into smaller tasks, supporting them along the way.
- Be patient, especially if you are asked to repeat yourself.
- If someone cannot remember significant information, for example their address or PIN, make sure you are aware of your organisation's alternative procedures that will help them access the service or information they require (E.g. Being able to sign for purchases). If your organisation doesn't have these processes in place perhaps you could suggest developing them (E.g. A 'no hurry check-out').

Cambridgeshire & Peterborough All Age Dementia Strategic Plan 2018- 2023

Dementia: Everybody's Business: better outcomes for people living with dementia and their carers

Cambridgeshire and Peterborough

Older People's Mental Health Delivery Board

January 2018

Cambridgeshire and Peterborough CCG, Cambridgeshire County Council and Peterborough City Council, Cambridgeshire and Peterborough NHS Foundation Trust, Cambridgeshire University Hospitals NHS Foundation Trust, North West Anglia NHS Foundation Trust, The Alzheimer's Organization, The Carers' Trust, Care Network

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[1] https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/03/dementia-well-pathway.pdf , online, accessed: 05.07.17

[2] PHE Dementia Profile

Glossary

Admiral Nurse		Nurses who provide specialist dementia support to families, working alongside people living with dementia and their families, helping them to live more positively with dementia by providing one-to-one support, expert guidance and practical solutions to the challenges they face
AIMS	**Acute Inpatient Mental Health Services**	A set of standards for Acute Inpatient Mental Health Services developed by the Royal College of Psychiatrists.
AWSB	**The Ageing Well Strategy Board**	A Clinical Community of the STP CAG which aims review, and make recommendations to improve the quality and outcomes of health and care services for older people across the Cambridgeshire and Peterborough STP footprint
CAG	**Care Advisory Group**	A sub-committee of the STP Board whose main purpose is to contribute to the overall delivery of STP objectives arising from the Fit for the Future programme, by reviewing care model design. See also HCE and STP below.
CAMTED-OP	**Cambridge Training Education and Development-Older People**	A countywide specialist multi-disciplinary training team offering training to a range of providers e.g. care homes, home care providers and acute hospitals in the areas of dementia care and functional mental health.
CCC	**Cambridgeshire County Council**	The countywide part of the two tier authority structure in providing local government services including adult social care services.
CCG	**Clinical Commissioning Group**	Clinically-led statutory NHS organisations created following the Health and Social Care Act in 2012 replacing Primary Care Trusts on 1 April 2013 responsible for the planning and commissioning of health care services to a particular area e.g. Cambridgeshire and Peterborough.
CQC	**Care Quality Commission**	The independent regulator of health and social care in England that aims to ensure that health and social care services are safe, effective, compassionate, high-quality care and that encourages providers to develop and improve quality.
Community Services Delivery Board		The multi-agency/-disciplinary group of people involved in improvement of outcomes and experience for adults aged 18 – 65 years.
CPFT	**Cambridgeshire and Peterborough NHS Foundation Trust**	The NHS provider of integrated physical and mental health services for adults and older people; specialist mental health and learning disability services; children and young people's mental health services; children's community services (Peterborough); social care.
CRHT	**Crisis Resolution and Home Treatment Team**	Specialist mental health teams commissioned to help people though short-term mental health crises by providing intensive treatment and support outside hospital, ideally in their own homes.
CUH	**Cambridge University Hospital**	Cambridge University Hospital NHS Foundation Trust: NHS Provider of local acute/general hospital services and a range of national specialist services.

DAA	**Dementia Action Alliance**	A group of businesses who meet together on a regular basis and encourage action at a local level
DCa	**Dementia Café**	A service provided by Alzheimer's Society for people with dementia, their carers and families providing a safe, comfortable and social environment for people to share experiences and ideas, get advice from trained members of staff and form friendships.
DCh	**Dementia Champions**	Individuals who are trained to deliver dementia awareness sessions as well as working with local employers to become more dementia friendly.
Dementia		A syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgement.[3]'
DFC	**Dementia Friendly Community**	A group/network that already exists and seeks to make itself more dementia friendly internally – can be a geographical location e.g. a village, or a network e.g. a chain of supermarkets or faith community
DiADeM	**Diagnosis of Advanced Dementia Assessment Tool**	A tool developed by the Yorkshire and Humber Dementia Strategic Clinical Network, and supported by Alzheimer's Society to support GPs to diagnose dementia in people living with advanced dementia in care homes.
DIST	**Dementia Intensive Support Team**	Specialist dementia workforce within the Cambridgeshire and Peterborough Crisis Resolution and Home Treatment service.
DTOCs	**Delayed Transfers of Care**	A discharge from hospital of an individual who is fit for discharge that is delayed – often due to lack of availability of appropriate health or social care services/support.
DRC	**Dementia Resource Centre**	Alzheimer's Society provided service providing information, advice and support to people living with dementia and their carers.
Fit for the Future		A set of priorities agreed by health and care leaders/organizations across Cambridgeshire and Peterborough, aimed at improving the population's health and wellbeing within a defined financial envelope.
GPwSI	**General Practitioner with a Special Interest**	A GP who has a special interest in a specific condition/disease etc and who takes the lead in this area and advises on behalf of colleagues.
HCE	**Health and Care Executive**	Organisations from across the system have agreed to work together, taking joint responsibility for improving the population's health and wellbeing within a defined financial envelope. The purpose of the HCE is to provide strong, collective leadership to this process. The HCE's main purpose is to commission and oversee a programme of work that will deliver the Fit for the Future priorities.
Herbert Protocol		A scheme being introduced by West Yorkshire Police and other agencies which encourages carers

[3] The ICD-10 Classification of Mental and behavioural Disorders, clinical descriptions and diagnostic guidelines' World health organisation 1992 ISBN 92 4 154422

		to compile useful information which could be used in the event of a vulnerable person going missing.
HH	**Hinchingbrooke Hospital**	A small district general hospital run by North West Anglia NHS Foundation Trust in Hinchingbrooke near Huntingdon, Cambridgeshire serving the Huntingdonshire area.
KLOE	**Key Lines of Enquiry**	A set of prompts and indicators developed by the Care Quality Commission to assess the performance of health and social care organisations
LA	**Local Authority**	An organization that is officially responsible and has specific statutory responsibilities for the public services and facilities in a particular area.
MCI	**Mild Cognitive Impairment**	A condition where an individual has cognitive deficits beyond those expected for their age and education, but which are not significant enough to interfere with their daily activities[4].
MSNAP	**Memory Service National Accreditation Programme[5]**	A set of standards and criteria associated with Memory Services for dementia developed by the Royal College of Psychiatrists, drawn from key national policy and guidance documents related to dementia assessment, diagnosis including pre- and post- diagnostic support.
Neighbourhood Team		The physical and mental health care hub of the local community for over 65-year olds and adults requiring community services. Provided by CPFT, They work closely with GPs, primary care, social care and the third and independent sector to provide joined-up responsive, expert care and treatment.
PCC	**Peterborough City Council**	A unitary authority providing all local government services to the people of Peterborough and its surrounding areas.
PCH	**Peterborough City Hospital**	The acute general district hospital run by North West Anglia NHS Foundation Trust serving the Peterborough city, north Cambridgeshire, areas of east Northamptonshire and Rutland.
PCSP	**Personalised Care and Support Planning**	An approach that aims to transform the experience of care and support from largely reactive, i.e. responding when something goes wrong, to a more helpful proactive service, centred on the needs of each individual patient. It recognise the assets and value that patients, carers and communities can bring to help deliver more effective, person-centred and sustainable care for people with long-term conditions
NHS	**National Health Service**	Public provider of health care paid for from taxation and free at the point of care
NICE	**National Institute for Clinical Excellence**	Provides guidance, advice, quality standards and information services for health, public health and social care. Also contains resources to help maximise use of evidence and guidance.
No.	**Number**	Standard abbreviation for 'number'.
OPMH	**Older People's Mental Health services**	Mental health services commissioned/provided for adults aged over 65 years.

[4] Petersen RC, Smith GE, Waring SC, Ivnik RJ, Tangalos EG, Kokmen E (1999). "Mild cognitive impairment: clinical characterization and outcome". Arch. Neurol. 56 (3): 303–8.

[5] Memory Services National Accreditation Programme (MSNAP) – Standards for Memory Services, CCQI221, Royal College of Psychiatrists, 5th edn, 2016

SCIE	**Social Care Institute for Excellence**	An independent charity and improvement agency for the care and health sectors.
SDU	**Service Delivery Unit**	An overarching team established by system partners to oversee and support the delivery of the STP.
STP	**Sustainability and Transformation Partnership**	A partnership of senior leaders across the health and social care system in Cambridgeshire and Peterborough health and social care leaders working together to return the area to financial, clinical and operational sustainability through the Fit for the Future programme.

EXECUTIVE SUMMARY

Improving experience and outcomes for people living with dementia and their carers is a national priority. The Cambridgeshire and Peterborough Sustainability and Transformation Partnership (STP) which brings together leaders of health and social care organisations across the health and social care system to ensure that services are effective and efficient, has identified improving outcomes and experience for people living with dementia and their carers as a key priority for 2018/19 and beyond.

This Strategic Plan has been developed by the Older People's Mental Health (OPMH) Delivery Board to deliver that improvement. The Plan aims to address the needs of people of all ages living with dementia[6] and mild cognitive impairment[7] and their carers living in Cambridgeshire and Peterborough. It also aims to prevent or delay the onset of dementia and to identify ways that individuals and communities can be supported to improve the quality of life of people living with dementia as they go about their lives.

The Plan relates specifically to dementia. A definition of dementia has been agreed by those involved in dementia across the Cambridgeshire and Peterborough health and social care system:

> Dementia is a syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgement.[8]'

It can be caused by a number of progressive neurodegenerative diseases, including Alzheimer's disease, frontotemporal dementia, vascular disease, Parkinson's disease and Huntington's disease. Not all cognitive impairment is due to dementia.

Mild cognitive impairment (MCI) is also included within the scope of the Strategic Plan because, whilst people with MCI are at higher risk of developing dementia, it is not possible or appropriate to make a positive diagnosis of dementia at the point when MCI is identified. It is important that people with MCI are identified, in particular to distinguish them so that they are not misdiagnosed with dementia. To do so would give a large number of people a diagnosis of a progressive terminal neurodegenerative disease which they do not have, and which may never develop**.** This would be inappropriate and unhelpful, causing unnecessary distress for individuals and their families. MCI can be defined as:

[6] A syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgement.[6]'
[7] A condition where an individual has cognitive deficits beyond those expected for their age and education, but which are not significant enough to interfere with their daily activities[7].
[8] The ICD-10 Classification of Mental and behavioural Disorders, clinical descriptions and diagnostic guidelines' World health organisation 1992 ISBN 92 4 154422

A condition where an individual has cognitive deficits beyond those expected for their age and education, but which are not significant enough to interfere with their daily activities[9].

Services for people with cognitive impairment that results from brain damage of a non-progressive nature are not included within the scope of the Strategic Plan because responsibility for commissioning and provision lies with a variety of organizations, groups and individuals beyond the boundaries of dementia commissioning and provision. However, it is essential that it is noted that there are gaps in services for people with non-progressive cognitive impairment. This issue has been drawn to the attention of STP leaders and commissioners by the Older People's Mental Health (OPMH) Delivery Board as part of its work to develop the Strategic Plan. Members of the Delivery Board are happy to provide assistance to those addressing these needs.

The case for prioritising the care and support of people living with dementia and their carers in Cambridgeshire and Peterborough is strong:

- Dementia affects the older population in significant numbers – an estimated 670,000 people in England[10] and 8,600[11] in Cambridgeshire and Peterborough.
- There is a considerable economic cost associated with the disease estimated at £23 billion a year, which is predicted to triple by 2040. This is more than the cost of cancer, heart disease and stroke[12].
- An estimated 25% of hospital beds are occupied by people with dementia.
- Hospital stays of people with dementia are approximately 1 week longer than average[13].
- 75% of people living in care homes have dementia[14].
- Dementia is the leading cause of death for women[15].
- It is estimated that the number of people living with dementia in Cambridgeshire and Peterborough will increase from 8,600 to 16,110 (7,510/86%) between 2016 and 2031. Action therefore needs to be taken to:
    i) Do everything possible to prevent and delay the onset of dementia to slow the growth in numbers of people living with dementia.
    ii) Ensure that the best use of the resources available is in order to manage the resulting increase in demand.
- Improving awareness and understanding of dementia will enable people living with dementia and their carers to live more comfortably with their families and communities.

[9] Petersen RC, Smith GE, Waring SC, Ivnik RJ, Tangalos EG, Kokmen E (1999). "Mild cognitive impairment: clinical characterization and outcome". Arch. Neurol. 56 (3): 303–8.
[10] The Prime Minister's Challenge on Dementia, DH, 2020
[11] Public Health England, 2016
[12] Commissioning for Value: Mental health and dementia pack, Public Health England, January 2017
[13] The Prime Minister's Challenge on Dementia, DH, 2020//5 Year Forward View, DH, 2015
[14] The Prime Minister's Challenge on Dementia, DH, 2020/5 Year Forward View, DH, 2015
[15] The Prime Minister's Challenge on Dementia, DH, 2020/5 Year Forward View, DH, 2015

- If dementia is diagnosed early in its course, appropriate support can be provided in the present, and as the disease progresses, reducing the incidence of avoidable crises and interventions, improving experience and outcomes whilst also releasing resources for investment in other health and social care interventions.
- Across Cambridgeshire and Peterborough there is a desire to improve experience and outcomes for people who access any health and social care services.

The main thrust of national strategy is to ensure that people living with dementia are supported to live at home with their families for as long as possible. Early diagnosis and intervention including access to information, advice and guidance, advance care planning that is personalised, timely access to specialist assessment and treatment, and effective support for carers are key components of the strategy. Promoting better awareness and understanding of dementia amongst communities and businesses is essential if people living with dementia and their carers are to live and participate comfortably in their communities. Based on the work of the Alzheimer's Society, national strategy includes programmes to increase awareness through the development of dementia friendly communities and environments. There is much that can be done to prevent dementia by tackling key risk factors such as smoking, excess weight and physical inactivity. Overall, the aim is:

> **To enable people living with dementia to live independently for longer and to enjoy being part of their community[16] and to keep them healthier for longer and out of hospital[17].**

A vision for people living with dementia and their carers in Cambridgeshire and Peterborough has been agreed:

> ***We will work hard to prevent people in Cambridgeshire and Peterborough from acquiring dementia and ensure that those living with and affected by dementia receive compassionate, expert care and support, that is right for them to live positive and fulfilling lives …. we will support and empower them to take part in, and contribute to, the families and communities in which they live and work[18].***

Gaps and improvements that can be made to all of the above in Cambridgeshire and Peterborough have been identified through the work to develop the Strategic Plan. However, the biggest gaps identified are in:

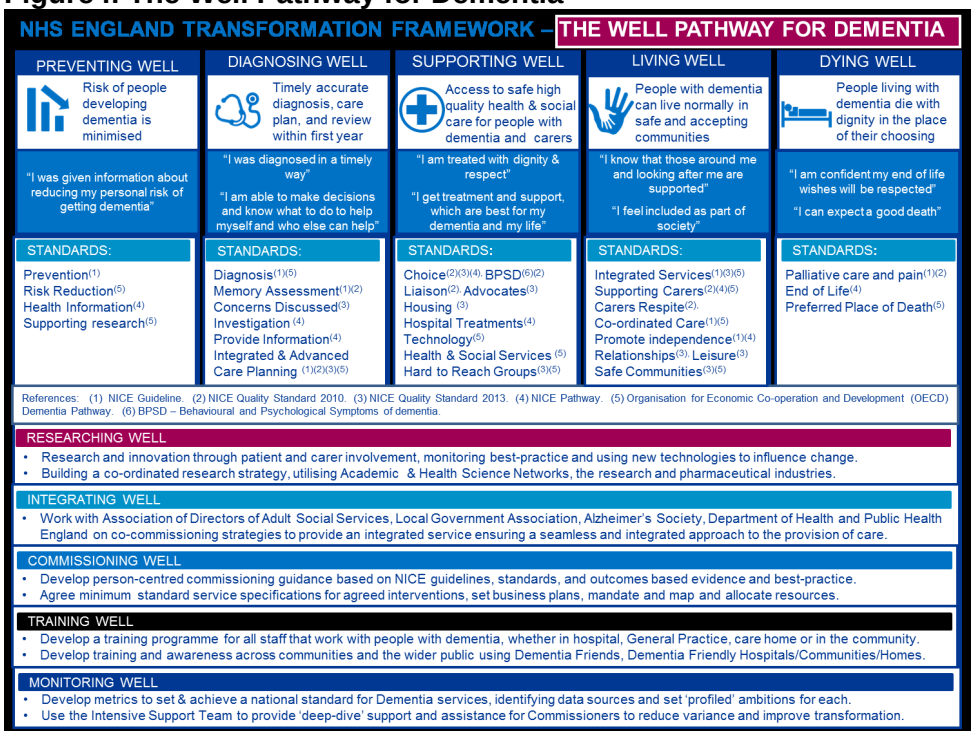
- Early intervention and support including information, advice and guidance and advance care planning – primarily provided by the voluntary sector.

[16] Dementia Implementation Guide, DH, 2017
[17] The Five Year Forward View Implementation Guide, 2017-19, DH 2017
[18] Adapted from Dementia UK's Strategy

- The infrastructure required to support the development of dementia friendly communities and environments – primarily provided by the voluntary sector..
- Support to maximise quality of life whilst living with dementia - for individuals living with dementia and their carers.
- Capacity to support people intensively to remain at home at times of crisis and/or enhanced need (service provided by Dementia Intensive Support Team (DIST)).
- Psychological treatment for people following diagnosis and in specialist dementia inpatient care.
- The seamlessness and co-ordination of care across both mental and physical health clinicians, teams and organizations.
- Personalised care planning and support.
- Specialist assessment, treatment and support for people diagnosed with early onset dementia[19].

Addressing these gaps has been prioritised within the Strategic Plan. The Plan describes how the OPMH Delivery Board plans to work with its partners to achieve the vision for dementia using the pillars and cross-cutting themes of the Well Pathway for Dementia which provides a framework for delivery of the national dementia strategy as its basis. (See Figure i below).

Figure i: The Well Pathway for Dementia[20]



[19] This document contains key issues identified within the needs assessment undertaken to inform the Strategic Plan. The detail is contained in 'Early Onset Dementia, Needs Assessment', October 2017.

[20] https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/03/dementia-well-pathway.pdf , online, accessed: 05.07.17

The aim is to ensure that delivery of the services under each pillar of the Well Pathway are effective and efficient and developed in line with national and local good practice. To achieve this, action plans to improve outcomes from the services under each of the Pillars and Cross Cutting Themes has been developed. (See Section 3.2). These are summarised in Table 1 below. The Strategic Plan aims to deliver the following outcomes:

- Prevention of the onset of dementia where this is possible.
- People living with dementia are supported to live safely for longer within the community and with their carers.
- Improved accessibility to, and consistency of, assessment, treatment and support for people living with dementia and their carers across Cambridgeshire and Peterborough.
- Increased choice and control for people living with dementia and their carers - at all stages of the disease.
- Improved outcomes and experience of services for people living with dementia and their carers at all stages of the disease and wherever they live i.e. at home, in care homes and when admitted to hospital..
- Well co-ordinated care that addresses physical and mental health and social care needs in a seamless way.
- Crises and avoidable admission to inpatient dementia services and acute hospitals are reduced.
- Better understanding and awareness of dementia within communities
- Better use of resources/value for money.

A key objective of the Strategic Plan is to reduce costs where possible, releasing resources for investment in new/improved services and/or for investment in other key areas of need.

Investment, capacity, activity and performance across the health and social care system in dementia diagnosis, assessment, treatment and support is not fully understood. The Plan aims to develop this understanding in order to identify opportunities for improved performance, outcomes and reduced cost in order to enable investment to address gaps in services and support. Improvement will be achieved primarily by ensuring early diagnosing, intervention and effective community based, reducing expenditure on more expensive specialist interventions in line with national guidance for CCGs[21] and Local Authorities on cost effectiveness. Finally, the gap between current investment, improvements required and the increase in capacity necessary to match the likely increase in the numbers of people living with dementia will be identified. All of this will be brought together in a business case to the STP and to Peterborough City Council (PCC) and Cambridgeshire County Council (CCC).

[21] Next Steps on the NHS Five Year Forward View, DH, 2017

A core data set to monitor quality, outcomes and activity based on the Memory Service National Accreditation Programme (MSNAP) quality standards, the reporting requirements of NHS and social care organisations has been developed and will be refined as part of the work to implement the Strategic Plan. Notwithstanding the need to report on core national and local activity, performance and outcomes, the key driver for the development of these outcomes will be to monitor the things that are of the greatest importance to people living with dementia and their carers.

Delivery of the Strategic Plan constitutes a major programme of work. A high level timeline for delivery of the actions/milestones required 2017 – 2019 has been developed to support delivery (See Figure ii below). An assessment of the risks to delivery of the Strategic Plan has been made with the following risks being identified:

- **Risk 1:** Insufficient capacity within OPMH commissioning and provider organisations to deliver a complex programme of work with the detailed level of analysis necessary to achieve the outcomes required.
- **Risk 2:** The need for system wide participation to successfully deliver the Strategic Plan.
- **Risk 3:** Lack of resources to support external facilitation for the development of the dementia care pathway.

At the time of completion of the Strategic Plan (January 2018), these are rated amber with mitigating actions in place to address them.

Table i: Summary of the Cambridgeshire and Peterborough Dementia Well Pathway Action Plans

Strategic Plan: Section	Pillar/Cross Cutting Theme and Standard	Key Objective 1	Key Objective 2	Key Objective 3	Key Objective 4
3.2.1	**Preventing Well** The risk of people developing dementia is minimised: "I was given information about my personal risk of getting dementia"	To build strategy to include evidence-based and equitable primary, secondary and tertiary prevention efforts across the life course.	To incorporate dementia risk reduction into current long-term disease approaches and unique messaging.		
3.2.2	**Diagnosing Well** Timely accurate diagnosis, care plan, and review within first year. "I am diagnosed in a timely way. I am able to make decisions and know what to do to help myself and who else can help".	To increase the dementia diagnosis rate.	To develop a robust pathway that meets the standards within NICE guidelines and MSNAP with protocols agreed between the Memory Assessment Service, GPs, older people's services and the voluntary sector, including protocols that ensure that advance planning is established consistently across Cambridgeshire and Peterborough (includes assessing the feasibility of commissioning a Memory Assessment Service that meets the standards required to achieve MSNAP accreditation).		
3.2.3	**Supporting Well** Access to safe high quality health and social care for people with dementia and	To develop a robust dementia pathway within which there is an action plan that supports improvement/achievement of the standards within NICE	To work with Acute providers to develop a plan for ongoing improvement in the quality of care for people with dementia when in hospital.	To improve awareness of and access to dementia care for hard to reach groups	To ensure that the quality of care of people living with dementia in care homes meets the Care Quality Commission

	their carers. “I am treated with dignity and respect. I get treatment and support which are best for my dementia and my life.”	guidelines and MSNAP consistently across Cambridgeshire and Peterborough that relate to Living Well (includes assessing the feasibility of commissioning a Memory Assessment Service that meets the standards contained within NICE guidelines and MSNAP; as a minimum, standards relating to advance planning must be achieved).			requirements and best practice.
3.2.4	**Living Well** People with dementia can live normally in safe and accepting communities. “I know that those around me and looking after me are supported. I feel included as part of society.”	To ensure geographical consistency in relation to Dementia Friendly Communities and Dementia Friendly Environments across Cambridgeshire and Peterborough	To ensure that people living with dementia have access to community based support that is robust and consistent across Cambridgeshire and Peterborough	To establish a robust infrastructure of support for carers that is consistent across Cambridgeshire and Peterborough	
3.2.5	**Dying Well** People living with dementia die with dignity in the place of their choosing. “I am confident my end of life wishes will be respected. I can expect a good death.”	To improve the quality of care and support and outcomes at end of life for people living with dementia and their carers			
3.2.6	**Early Onset Dementia**	To ensure that people living with early onset dementia and their carers have access to			

		robust assessment, treatment and support.			
3.2.7	**Researching Well**	To ensure that every patient with a diagnosis of dementia is given the opportunity to participate in dementia research.	To evaluate the impact of the Dementia Strategic Plan		
3.2.8	**Integrating Well**	To ensure that care is seamless, addressing physical and mental health and social care needs in an holistic and cost effective way			
3.2.9	**Commissioning Well**	To improve the commissioning and leadership for health and social care commissioning.	To ensure that best use of resources is made.	To ensure that services are effectively commissioned.	
3.2.10	**Training Well**	To ensure that staff across the Cambridgeshire and Peterborough health and social care system are involved in and inform the development of and are trained in the operation of the integrated dementia pathway.			
3.2.11	**Monitoring Well**	To improve understanding of activity, performance and outcomes for people living with dementia and their carers in Cambridgeshire and Peterborough.	To develop a set of indicators of quality that include experience of services and support and outcomes for people living with dementia and their carers related to dementia across the Cambridgeshire and Peterborough health and social care system		

1 Introduction

In this Section, the scope, including the definition of dementia adopted by the Cambridgeshire and Peterborough health and social care community, rationale for the development of a Strategic Plan for dementia, the vision and aims are described.

1.1 Rationale

Improving experience and outcomes for people living with dementia and their carers is a national priority. The Sustainability and Transformation Partnership (STP) brings together leaders of health and social care organisations across the Cambridgeshire and Peterborough health and social care system to ensure that services are effective and efficient. The STP has identified improving outcomes for people living with dementia and their carers as a key priority for 2018/19 and beyond. This means that dementia will be given significant focus by leaders of organisations responsible for the commissioning and delivery of health and social care.

There are numerous reasons for prioritising the care and support of people living with dementia and their carers in Cambridgeshire and Peterborough. The key reasons are:

- Dementia affects the older population in significant numbers – an estimated 670,000 people in England[22] and 8,600[23] in Cambridgeshire and Peterborough.
- There is a considerable economic cost associated with the disease estimated at £23 billion a year, which is predicted to triple by 2040. This is more than the cost of cancer, heart disease and stroke[24].
- An estimated 25% of hospital beds are occupied by people with dementia.
- Hospital stays of people with dementia are approximately 1 week longer than average[25].
- 75% of people living in care homes have dementia[26].
- Dementia is the leading cause of death for women[27].
- It is estimated that the number of people living with dementia in Cambridgeshire and Peterborough will increase from 8,600 to 16,110 (7,510(86%)) between 2016 and 2031. Action therefore needs to be taken to:
    iii) Do everything possible to prevent and delay the onset of dementia to slow the growth in numbers of people living with dementia.

[22] The Prime Minister's Challenge on Dementia, DH, 2020
[23] Public Health England, 2016
[24] Commissioning for Value: Mental health and dementia pack, Public Health England, January 2017
[25] The Prime Minister's Challenge on Dementia, DH, 2020//5 Year Forward View, DH, 2015
[26] The Prime Minister's Challenge on Dementia, DH, 2020/5 Year Forward View, DH, 2015
[27] The Prime Minister's Challenge on Dementia, DH, 2020/5 Year Forward View, DH, 2015

iv) Ensure that the best use of the resources available is in order to manage the resulting increase in demand.

- Improving awareness and understanding of dementia will enable people living with dementia and their carers to live more comfortably with their families and communities.
- If dementia is diagnosed early in its course, appropriate support can be provided in the present, and as the disease progresses, reducing the incidence of avoidable crises and interventions, improving experience and outcomes whilst also releasing resources for investment in other health and social care interventions.

Across Cambridgeshire and Peterborough there is a desire to improve experience and outcomes for people who access any health and social care services.

1.2 Scope of the Strategic Plan and Definition of Dementia

A definition of dementia that will underpin the Strategic Plan and work to improve delivery and outcomes has been agreed by those involved in dementia across the Cambridgeshire and Peterborough health and social care system:

> Dementia is a syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgement.[28]'

The syndrome of dementia can be caused by a number of progressive neurodegenerative diseases, including Alzheimer's disease, frontotemporal dementia, vascular disease, Parkinson's disease and Huntington's disease. Not all cognitive impairment is due to dementia. Mild cognitive impairment (MCI) can be defined as:

> A condition where an individual has cognitive deficits beyond those expected for their age and education, but which are not significant enough to interfere with their daily activities[29].

It is important that those with MCI are identified, in particular to distinguish them so that they are not misdiagnosed with dementia. Whilst people with MCI are at higher risk of developing dementia, it is not possible or appropriate to make a positive diagnosis of dementia at the point when MCI is identified. To do so would give a large number of people a diagnosis of a progressive terminal neurodegenerative disease which they do not have, and which may never develop**.** This would be inappropriate and unhelpful, causing unnecessary distress for individuals and their families.

[28] The ICD-10 Classification of Mental and behavioural Disorders, clinical descriptions and diagnostic guidelines' World health organisation 1992 ISBN 92 4 154422

[29] Petersen RC, Smith GE, Waring SC, Ivnik RJ, Tangalos EG, Kokmen E (1999). "Mild cognitive impairment: clinical characterization and outcome". Arch. Neurol. 56 (3): 303–8.

Onset of dementia is around age 40 years. The incidence at this age is very low. However, it doubles with every 5 year increase in age and by age 65 – 69 years, the incidence in the general population is approximately 2%. By age 85 years the incidence rises to approximately 20%.

The agreed definition of dementia specifically excludes stable cognitive impairment that results from brain damage of a non-progressive nature, including head injury, single vascular events (e.g. stroke), learning disability or cognitive impairment arising from alcohol misuse. The Strategic Plan does not directly address the needs of this group of people. However, it is important to note that there are gaps in services for many of these groups across Cambridgeshire and Peterborough. The OPMH Delivery Board has drawn this issue to the attention of STP leaders and commissioners as part of the work to develop the Strategic Plan. Its members are keen to provide assistance and will do so to those addressing these needs on request.

In summary, the Strategic Plan includes people of all ages living with dementia, mild cognitive impairment who live and receive services in the Cambridgeshire and Peterborough area, and their informal carers. It is important to note that, although the delivery of most strands of the strategic plan will be overseen by the OPMH Delivery Board, some strands are, and will be best managed elsewhere e,g. the early onset dementia workstream will be managed by adult mental health services through the Community Services Delivery Board.

1.3 Vision

Working with people living with dementia and their carers and others involved in dementia care across Cambridgeshire and Peterborough, members of the OPMH Delivery Board have agreed a vision for people living with dementia and their carers:

> ***We will work hard to prevent people in Cambridgeshire and Peterborough from acquiring dementia and ensure that those living with and affected by dementia receive compassionate, expert care and support, that is right for them to live positive and fulfilling lives …. we will support and empower them to take part in, and contribute to, the families and communities in which they live and work[30].***

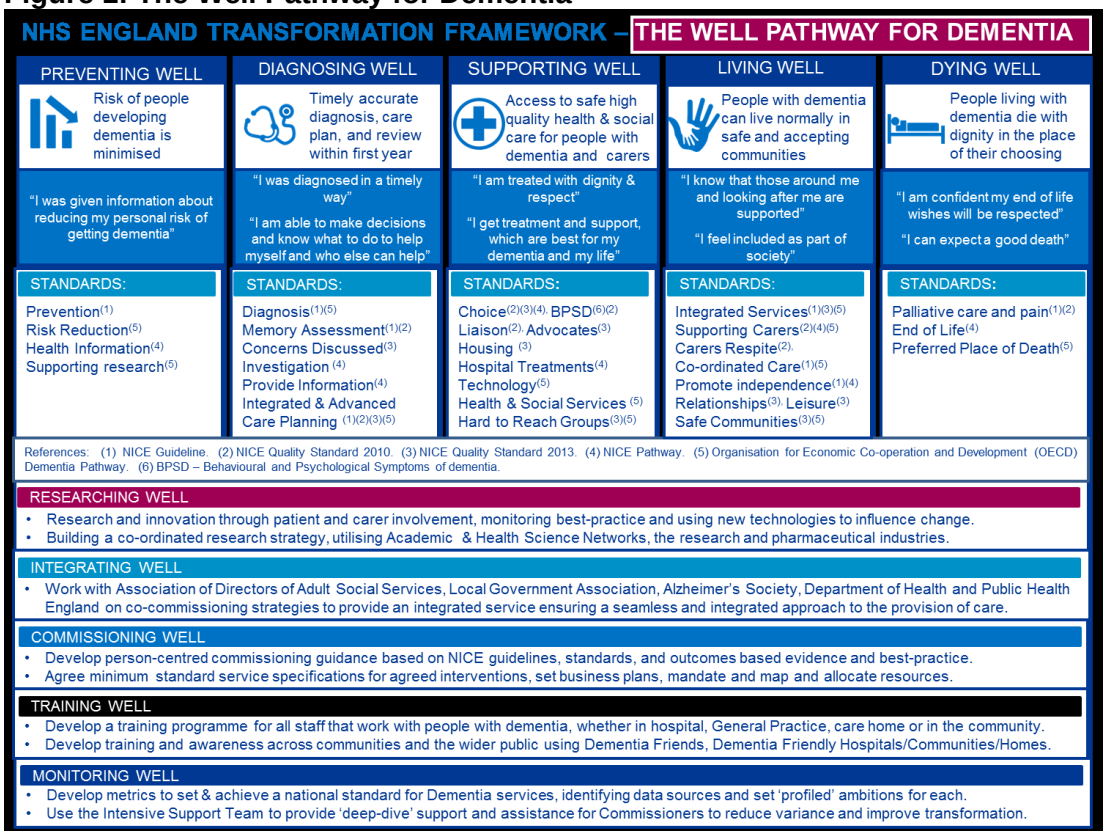
Dementia impacts on cognition, physical and mental health and wellbeing and has an increasing impact on the ability of the individual to function. Because it occurs more frequently in later life, people living with dementia may also be diagnosed with other physical conditions and/or be physically frail. Access to specialist assessment, treatment and support is essential. In order to be effective, assessment, treatment and support provided by a

[30] Adapted from Dementia Uk's Strategy

variety of agencies working in both specialist mental and physical health services must be identified and met in a co-ordinated way.

The Well Pathway for Dementia provides a framework for delivery of the national dementia strategy and provides the basis of the Strategic Plan. (See Figure 1 below).

Figure 1: The Well Pathway for Dementia[31]



The objective is to ensure that delivery of the services under each pillar of the Well Pathway are effective and efficient and developed in line with national and local good practice. To achieve this, action plans to improve outcomes from the services under each of the Pillars and Cross Cutting Themes has been developed. The action plans are summarised in Table 1 below.

[31] https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/03/dementia-well-pathway.pdf , online, accessed: 05.07.17

Table 1: Summary of the Cambridgeshire and Peterborough Dementia Well Pathway Action Plans

Strategic Plan: Section	Pillar/Cross Cutting Theme and Standard	Key Objective 1	Key Objective 2	Key Objective 3	Key Objective 4
3.2.1	**Preventing Well** The risk of people developing dementia is minimised: "I was given information about my personal risk of getting dementia"	To build strategy to include evidence-based and equitable primary, secondary and tertiary prevention efforts across the life course.	To incorporate dementia risk reduction into current long-term disease approaches and unique messaging.		
3.2.2	**Diagnosing Well** Timely accurate diagnosis, care plan, and review within first year. "I am diagnosed in a timely way. I am able to make decisions and know what to do to help myself and who else can help".	To increase the dementia diagnosis rate.	To develop a robust pathway that meets the standards within NICE guidelines and MSNAP with protocols agreed between the Memory Assessment Service, GPs, older people's services and the voluntary sector, including protocols that ensure that advance planning is established consistently across Cambridgeshire and Peterborough (includes assessing the feasibility of commissioning a Memory Assessment Service that meets the standards required to achieve MSNAP accreditation).		
3.2.3	**Supporting Well** Access to safe high quality health and social care for people with dementia and their carers. "I am treated with	To develop a robust dementia pathway within which there is an action plan that supports improvement/achievement of the standards within NICE guidelines and MSNAP	To work with Acute providers to develop a plan for ongoing improvement in the quality of care for people with dementia when in hospital.	To improve awareness of and access to dementia care for hard to reach groups	To ensure that the quality of care of people living with dementia in care homes meets the Care Quality Commission

	dignity and respect. I get treatment and support which are best for my dementia and my life."	consistently across Cambridgeshire and Peterborough that relate to Living Well (includes assessing the feasibility of commissioning a Memory Assessment Service that meets the standards contained within NICE guidelines and MSNAP; as a minimum, standards relating to advance planning must be achieved).			requirements and best practice.
3.2.4	**Living Well** People with dementia can live normally in safe and accepting communities. "I know that those around me and looking after me are supported. I feel included as part of society."	To ensure geographical consistency in relation to Dementia Friendly Communities and Dementia Friendly Environments across Cambridgeshire and Peterborough	To ensure that people living with dementia have access to community based support that is robust and consistent across Cambridgeshire and Peterborough	To establish a robust infrastructure of support for carers that is consistent across Cambridgeshire and Peterborough	
3.2.5	**Dying Well** People living with dementia die with dignity in the place of their choosing. "I am confident my end of life wishes will be respected. I can expect a good death."	To improve the quality of care and support and outcomes at end of life for people living with dementia and their carers			
3.2.6	**Early Onset Dementia**	To ensure that people living with early onset dementia and their carers have access to robust assessment, treatment and support.			

3.2.7	**Researching Well**	To ensure that every patient with a diagnosis of dementia is given the opportunity to participate in dementia research.	To evaluate the impact of the Dementia Strategic Plan		
3.2.8	**Integrating Well**	To ensure that care is seamless, addressing physical and mental health and social care needs in an holistic and cost effective way			
3.2.9	**Commissioning Well**	To improve the commissioning and leadership for health and social care commissioning.	To ensure that best use of resources is made.	To ensure that services are effectively commissioned.	
3.2.10	**Training Well**	To ensure that staff across the Cambridgeshire and Peterborough health and social care system are involved in and inform the development of and are trained in the operation of the integrated dementia pathway.			
3.2.11	**Monitoring Well**	To improve understanding of activity, performance and outcomes for people living with dementia and their carers in Cambridgeshire and Peterborough.	To develop a set of indicators of quality that include experience of services and support and outcomes for people living with dementia and their carers related to dementia across the Cambridgeshire and Peterborough health and social care system		

As part of the work relating to each pillar and cross cutting theme will be to identify the strengths and the potential for improvement across the dementia pathway in greater detail. Through the development of the care pathway under Integrating Well, these findings will be drawn together. In its turn, development of the care pathway will inform the work on each area. It will also offer the opportunity for immediate and ongoing improvement.

Dementia has been identified by the STP as the pilot area for Personalised Care and Support Planning (PCSP). Review. In order to ensure that dementia care and support is driven by the individual living with dementia and their carers, the work on the dementia care pathway has been aligned to the PCSP project.

The Strategic Plan aims to deliver the following improvements to experience and outcomes for people living with dementia and their carers in line with national and local strategies:

- Prevention of the onset of dementia where this is possible.
- People living with dementia are supported to live safely for longer within the community and with their carers.
- Improved accessibility to, and consistency of, assessment, treatment and support for people living with dementia and their carers across Cambridgeshire and Peterborough.
- Increased choice and control for people living with dementia and their carers - at all stages of the disease.
- Improved outcomes and experience of services for people living with dementia and their carers at all stages of the disease and wherever they live i.e. at home, in care homes and when admitted to hospital..
- Well co-ordinated care that addresses physical and mental health and social care needs in a seamless way.
- Crises and avoidable admission to inpatient dementia services and acute hospitals are reduced.
- Better understanding and awareness of dementia within communities
- Better use of resources/value for money.

1.4 Delivering the Plan

The Strategic Plan has been developed and will be delivered by the Older People's Mental Health Delivery Board (OPMH Delivery Board). This Board is made up of commissioners and statutory and non-statutory providers and representatives of people who access dementia care and their carers and families across the area. It is accountable to the Clinical Advisory Group (CAG) and the Health Care Executive (HCE) of the STP. Those responsible for delivering the action plans developed under the Well Pathway are accountable to the organisations that employ them for delivery of the specific actions and workstreams agreed.

Delivery of the Strategic Plan constitutes a major programme of work. A high level timeline for delivery of the actions/milestones required 2017 – 2019 is included in Figure 2 below.

Figure 2: Dementia Strategic Plan: Timeline 2017- 2019

	2017			2018												2019		
	Oct	**Nov**	**Dec**	**Jan**	**Feb**	**March**	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
STP Sign Off: Strategic Plan		i) Primary Care Innovation Network	i) Clinical Advisory Group ii) Clinical Executive Committee	i) Health Care Executive														
OPMH Delivery Board: Well Pathway and Cross Cutting Themes: Action Plans	i) Strategic Plan: Engagement	i) Complete Strategic Plan ii) Review OPMH Delivery Board membership	i) Establish Task and Finish Groups and initiate actions ii) Review OPMH Delivery Board membership	i) All Task and Finish Groups established.	i) Task and Finish Group delivery against the agreed actions and timelines	i) Task and Finish Group delivery against Action Plans										i) Review of Action plans and planning: 2019/20		i) Action Plans finalised and implementation 2019/20 initiated
				Memory Assessment Service Self-Assessment against MSNAP standards		i) Memory Assessment Service identification of gaps and input to business case ii) Memory Assessment Service development of an Improvement Plan against items that relate to internal operation							i) STP Decision to work towards MSNAP accreditation					
OPMH Delivery Board: Development of Care Pathway and Business Case		i) Define project scope and agree outcomes ii) Agree timeline and initiate work	i) Plan and set up workshops	i) Hold workshops to review and develop pathway ii) Agree action plans and Implement required changes in a planned way where possible iii) Develop business case iv) Secure sign off													i) Secure final sign off	
				i) Identify and quantify opportunities for improvement		i) Develop business case												
STP Sign Off: Pathway and Business Case				Updates to Primary Care Innovation Network, Clinical Advisory Group Clinical Executive Committee as required										i) Primary Care Innovation Network	i) Clinical Advisory Group ii) Clinical Executive Committee		i) Health Care Executive	

2 Context and Drivers for Change

In this Section, the strengths and potential for improved outcomes and experience for people living with dementia and their carers are identified, along with areas where more information is needed to understand current performance and the overall effectiveness and efficiency of the dementia pathway. The epidemiology of dementia and the current and likely future demand for dementia care are described, along with a summary of national and local strategy that relates to dementia. Benchmarked data published by NHS England and by Public Health England (PHE) is combined with local data about performance, activity and investment in acute and community physical and mental health services and the views of managers, practitioners and commissioners involved in dementia care as well as of people living with dementia and their families and carers. This provides the basis for the gap analysis through which the current strengths and opportunities for improved outcomes for people living with dementia and their carers is identified.

Diagnosis, assessment, treatment and support for people aged 18 to 65 years has been identified as a significant gap in local provision. As part of the work to develop the Strategic Plan, a needs assessment was undertaken by the Cambridgeshire and Peterborough Public Health Department. The report provides a robust overview of the likely numbers of people living with early onset dementia and the current status of services. In order to provide a clear picture of the needs of this group and the action required to address them, the needs assessment is included at Appendix 1 and is referenced at appropriate places in this document.

2.1 National Context and Drivers for Change [32]

2.1.1 The Prevalence of Dementia

Dementia in People Aged 18 - 65 Years: Early Onset Dementia

It estimated that there are approximately 42,325 people with early-onset dementia in the UK. They represent around 5% of the 850,000 people with dementia[5]. Early onset dementia is seen in slightly more men than women (21,519 men and 20,806 women), a male: female gender ratio of 1.03 to 1.00[33].

[32] This section is supported by an appendix which shows the tables and charts referred to in this section.
[33] This document contains key issues identified within the needs assessment undertaken to inform the Strategic Plan. The detail is contained in 'Early Onset Dementia, Needs Assessment', October 2017.

Globally, there are 47.5 million with dementia, which is predicted to rise to 150 million by 2050[i]. Global costs are estimated to be £356 billion (equivalent to 1% of global GDP). [ii] In the UK, it is estimated there are 850,000 people living with dementia. This will rise to 1 million by 2025 and 2 million by 2050. 62% of people with dementia are female and 38% are male. Dementia is the leading cause of death among women in the UK with 31,850 deaths a year[iii]. There are around 21 million people in England with a close friend or family member with dementia. It is estimated that 1 in 3 people will care for a person with dementia in their lifetime. Half of these people will be employed when they are required to care and it is thought that some 66,000 people have already cut their working hours to care for a family member, whilst 50,000 people have left work altogether. There is a considerable economic cost associated with the disease estimated at £26.3 billion a year, with an average cost of £32,250 per person[iv]. This is more than the cost of cancer, heart disease and stroke. Costs are predicted to triple by 2040.

2.1.2 The National Dementia Strategy

The key elements of the national strategy for dementia can be summarised under the 5 pillars and 5 cross cutting themes of the Well Pathway for Dementia developed from the National Dementia Strategy[34], publications such as The Prime Minister's Challenge on Dementia 2020 and the 2015 NICE Dementia Guidelines[35]. These provide the overarching structure and aims are the backbone of this Strategic Plan. (See Figure 1 above).

The main thrust of national strategy is to ensure that people living with dementia are supported to live at home with their families for as long as possible. Early diagnosis and intervention, advance care planning, timely access to specialist assessment and treatment and effective support for carers are key components of the strategy. Promoting better awareness and understanding of dementia amongst communities and businesses is essential if people living with dementia and their carers are to live and participate comfortably in their communities. Based on the work of the Alzheimer's Society, national strategy includes programmes to increase awareness through the development of dementia friendly communities and environments. There is much that can be done to prevent dementia by tackling key risk factors such as smoking, excess weight and physical inactivity.

2.1.3 Guidelines and Best Practice in Dementia

In 2006, the National Institute for Clinical Excellence (NICE) and Social Care Institute for Excellence (SCIE) published joint guidelines on dementia[36]. These address prevention,

[34] Living Well With Dementia: a national dementia, DH, 2009
[35] Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset, NICE, 2015
[36] Dementia: supporting people with dementia and their carers in health and social care, CG42, November 2006, last updated: September 2016, NICE, https://www.nice.org.uk/guidance/cg42

diagnosis, assessment and management of dementia in health and social care and include recommendations relating to Alzheimer's disease. The guidelines have informed the Strategic Plan and will be accessed as required during implementation. They can be accessed at: https://www.nice.org.uk/guidance/cg42. There are additional guidelines relating to dementia e.g. Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset[37].

The Memory Service National Accreditation Programme (MSNAP)[38] provides a quality framework for Memory Services. The standards aim to enable Memory Services to evaluate themselves against a set of agreed standards based on best practice and guidance defined by the Royal College of Psychiatrist (RCP) and including the NICE/SCIE guidelines[39]. Although the primary focus is Memory Services, the standards address the treatment and support that should be available following diagnosis:

- Management
- Resources available to support assessment and diagnosis
- Assessment and diagnosis
- Ongoing care management and follow up
- Pharmacological interventions
- Psychosocial interventions

This means that the standards and quality indicators that relate to both the Memory Service and parts of the dementia pathway that are beyond it. They therefore provides a framework across the assessment, treatment and support parts of the care pathway.

A key outcome from the work to develop the Strategic Plan is agreement that the MSNAP standards provide a useful framework to support the improvement of outcomes for people living with dementia and their carers, and therefore that CPFT should work with partners across Cambridgeshire and Peterborough to achieve MSNAP accreditation. In order to achieve this, co-ordination across the Diagnosing Well, Supporting Well and Living Well pathways will be required. Undertaking this self-assessment will be one of the first steps in the implementation of the Strategic Plan.

2.1.4 Cost Effectiveness in Dementia Care

Both the 2015 5 Year Forward View[40] and The Prime Minister's Challenge on Dementia, 2020[41] make the case for improving dementia assessment, treatment and support. The case made is as follows:

[37] Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset, NG16, October 2015, https://www.nice.org.uk/guidance/ng16
[38] Memory Assessment Service National Accreditation Programme (MSNAP): Standards for Memory Services, 5th edn., Pub.No. CCQI221 Royal College of Psychiatrists, 2016
[39] Dementia: supporting people with dementia and their carers in health and social care, CG42, November 2006, last updated: September 2016, NICE, https://www.nice.org.uk/guidance/cg42
[40] The Five Year Forward View, DH, 2015
[41] The Prime Minister's Challenge on Dementia 2020, DH, 2015

- Dementia affects the older population in significant numbers (670,000 people in England)
- There is a considerable economic cost associated with the disease estimated at £23 billion a year, which is predicted to triple by 2040. This is more than the cost of cancer, heart disease and stroke[42].
- An estimated 25% of hospital beds are occupied by people with dementia
- Hospital stays of people with dementia are approximately 1 week longer than average
- 75 percent of people living in care homes have dementia
- Dementia is the leading cause of death for women

Whilst it is possible to demonstrate a direct return on investment or the impact of a change in service delivery clearly, there are many improvements to services that are made for which the direct impact cannot easily be quantified. This is particularly the case in relation to preventative measure and ensuring that there is early identification and support for people experiencing a specific disorder or condition. However, on occasion, this can be addressed e.g. by applying the experience of an individual to others with the same condition and/or the impact of an intervention for one condition to another.

There is specific evidence that effective community based care reduces cost and improves outcomes e.g. the health and care economy in the West Midlands has estimated that significant reduction in the need for more specialist, expensive health and social care resources, intervention and home-based care is estimated as having the potential to save £38 million through the reduction in acute hospital admissions (700 per annum), shorter lengths of hospital stay (25% reduction) and less use of high cost intensive interventions[43]. This finding can be applied to Cambridgeshire and Peterborough in general and to dementia in particular.

In the section on mental health in the Five Year Forward View, the benefit of early intervention in mental health, including dementia, is made:

> There is now good evidence that tackling some major mental health problems early reduces subsequent problems, improves people's life chances, and also saves money for the wider economy[44].

An evaluation of the Alzheimer's Society Dementia Advisor Services indicated a significant return on investment, with every £1 invested in such post-diagnosis support resulting in nearly £41 worth of benefits[45].

[42] Commissioning for Value: Mental health and dementia pack, Public Health England, January 2017
[43] NHS West Midlands, 2010
[44] Next Steps on the NHS Five Year Forward View, DH, 2017.
[45] Dementia advisers: A cost-effective approach to delivering integrated dementia care, Alzheimer's Society, 2016

As a result of the above findings, one of the priorities for the NHS in England for 2017-19 is to free up 2000 – 3000 hospital beds with responsibility for this lying with NHS Improvement/NHS England and Local Authorities. The required action includes reducing delays caused by delays in accessing health commissioned community services and social care services.

The need and opportunity to improve the cost effectiveness of care informs Government guidance for CCGs relating to dementia and the delivery of care in general[46]. The guidance requires improvement in the dementia diagnosis rate so that intervention can be made early in the course of an individual's illness. The main thrust of the guidance for all conditions, including dementia, is to seek improved outcomes and cost effectiveness by making improvements in the following areas:

1. Integrated care:
    b. Integrated care around the patient with primary, community and hospital services working effectively together (vertical integration)
    c. Long term partnerships with patients as opposed to episodic care
    d. Management of systems/networks of care – not just organisations – networked care (horizontal integration)
    e. Partnership with Local Authorities with collective responsibility for resources, population health and keeping people healthier for longer
    f. Partnership with other partners sharing responsibility for resources and keeping people healthier for longer
    a. Improved assessment, treatment and support for people with long term conditions, of which dementia is one.
    b. Improved out of hospital care with much greater priority being given to this within the NHS
2. Increasing the value out of medicines and pharmacy
3. Improving support for carers
4. Population health management: and prevention
    a. Improved prevention
    b. Enhanced patient activation and supported self-management for long term conditions
    c. Manage avoidable demand
    d. Reduce unwarranted variation in line with the Right Care Programme

Overall, the main outcomes sought for people with dementia and their carers is improvement in quality of life for both with the key objective being:

> **To enable people living with dementia to live independently for longer and to enjoy being part of their community[47] and to keep them healthier for longer and out of hospital[48].**

[46] Next Steps on the NHS Five Year Forward View, DH, 2017
[47] Dementia Implementation Guide, DH, 2017
[48] The Five Year Forward View Implementation Guide, 2017-19, DH 2017

If this outcome is not achieved with dementia being poorly managed, expensive health and social care resources will be needed to manage avoidable deterioration or crises and the experience and quality of life of people living with dementia and their carers will be poor.

2.2 Local Context

2.2.1 The Number of People Living with Dementia in Cambridgeshire and Peterborough

The Number of People Aged Under 65 Years Living with Dementia in Cambridgeshire and Peterborough

It is estimated that, in 2016, 123 men and 87 women (210 individuals) across Cambridgeshire and Peterborough had early onset dementia and that this would increase to 123 men and 87 women (246 individuals) by 2036. It is important to note that the definition used by the Alzheimer's Society report included Alcohol excess on their definition, so this is likely to have increased estimates. However, it still gives an indication of the current and increasing need for services to serve these people and their families. A recent local study indicated that the incidence of dementia in a population is slightly higher than national estimates. This means that the real number of people living with early onset dementia may be slightly higher. See Appendix 1 for more detail. .

The Number of People Aged Over 65 Years Living with Dementia in Cambridgeshire and Peterborough

Prevalence is a measure of the proportion of a population that has a condition at a specific point in time. We do not know the true number of people with dementia in Cambridgeshire and Peterborough due to people living with the condition who have not been diagnosed as having dementia. This means that we have to use ways to estimate the number of people with dementia in Cambridgeshire and Peterborough. Using estimates of the prevalence of dementia in a population, it is possible to estimate the number of people living with dementia.

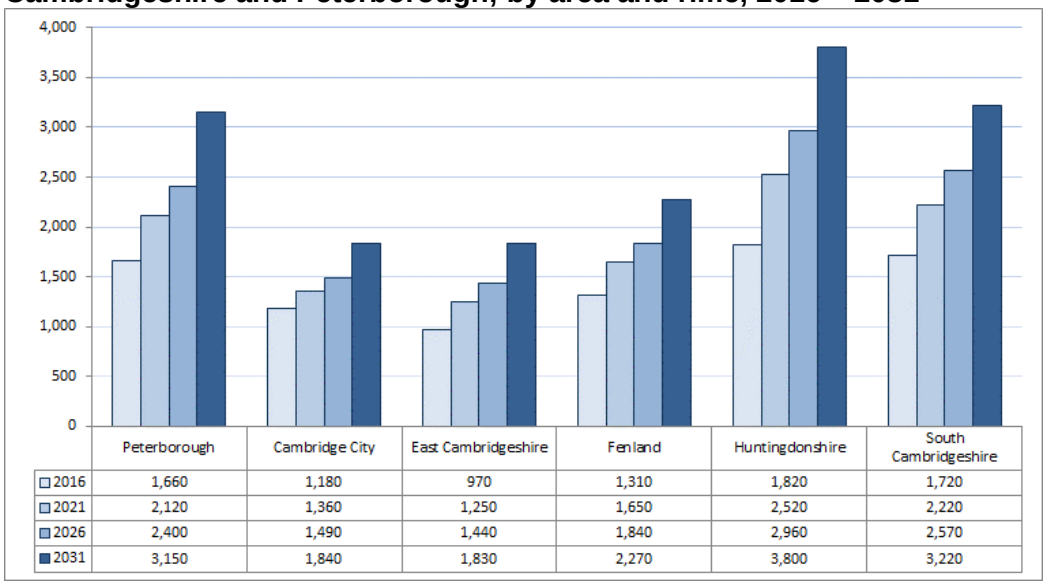
The Cognitive Function and Ageing Study (CFAS) (I and II) provides contemporary estimates of dementia prevalence based on a study of dementia in six geographical areas of England (including Cambridgeshire) over the past two decades[v]. The authors found a 'cohort' effect whereby later-born populations seem to have a lower risk of prevalence dementia than those born earlier in the past century. It was thought that this might be partly due to work on modifiable risk factors for dementia. This study therefore suggests that previous estimates of dementia have slightly over-estimated future prevalence of dementia. However, we know that the population in Cambridgeshire and Peterborough is getting older. The latest population forecasts estimate that there will be 220,000 people over the age of 65

by the year 2031, with a higher proportion of these older people being over 85 (18%). This will inevitably impact the number of people living with dementia in the area because the incidence of dementia doubles with every 5 year increase in age. The increase in age profile of the local population will significantly outweigh any benefit from a cohort effect as described in CFAS II where the incidence of dementia in the population was shown to have decreased, with the likely net result that the number of people living with dementia will increase. Dementia in the older population is also more likely to be comorbid with other conditions. Where there is co-morbidity, dementia is a single, though powerful, contributor towards greater frailty and its attendant increase in complex health and social care usage.

Applying the CFAS prevalence estimates to the Cambridgeshire and Peterborough population, it is estimated that in 2016, there were 7,000 people living with dementia in Cambridgeshire and 1,660 in Peterborough in 2016, a total of 8,660 aged over 65 years across the area. These figures do not include those with early onset dementia.

Figure 3 below shows how prevalence varies across Cambridgeshire and Peterborough and how it is expected to change over time. This shows that the number of people living with dementia is expected to increase by 86% over the next 15 years, from 8,660 to 16,110. It also shows that Huntingdonshire and South Cambridgeshire have the highest number of people living with dementia, and East Cambridgeshire and Cambridge City have the lowest number.

Figure 3: Estimates of the Number of people (aged 65+) living with Dementia in Cambridgeshire and Peterborough; by area and rime, 2016 – 2031[49]



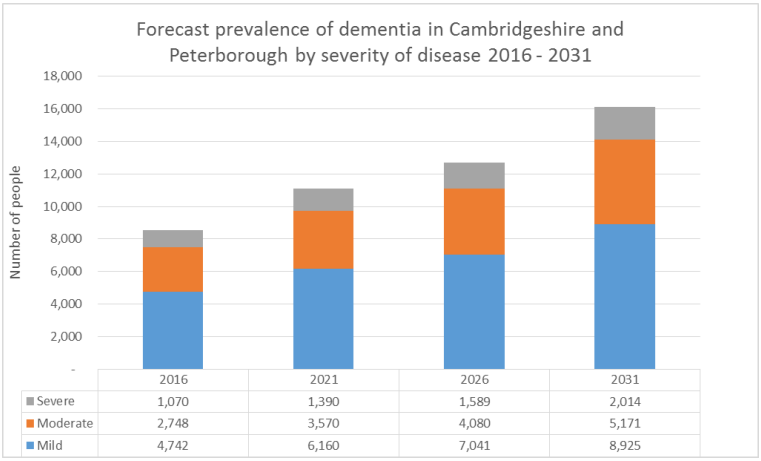
	Peterborough	Cambridge City	East Cambridgeshire	Fenland	Huntingdonshire	South Cambridgeshire
2016	1,660	1,180	970	1,310	1,820	1,720
2021	2,120	1,360	1,250	1,650	2,520	2,220
2026	2,400	1,490	1,440	1,840	2,960	2,570
2031	3,150	1,840	1,830	2,270	3,800	3,220

Dementia is a progressive illness from which there is no currently recovery. At different stages in this progression, the needs of people with dementia and their carers change. The changes that people experience have led to 3 groupings – mild, moderate and severe. In order to plan to assess, treat and support people effectively, it is necessary to understand

[49] Calculated using CFAS II prevalence estimates applied to local population forecasts (2015 based)

the numbers of people likely to be in each group. The Alzheimer's Society expert Delphi consensus statement estimates that 55.4% of people with late onset-dementia have mild dementia, 32.1% have moderate dementia and 12.5% have severe dementia. Applying these proportions to the dementia prevalence estimates in Cambridgeshire and Peterborough for 2016 to 2031 gives us an idea about the number of people living with mild, moderate and severe dementia (See Figure 4 below). It shows that, in 2016, there were an estimated 4,742 people (aged 65+) with mild dementia, 2,748 with moderate dementia and 1,070 with severe dementia in Cambridgeshire and Peterborough.

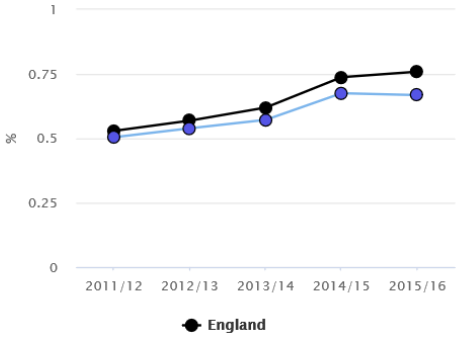
Figure 4: Forecast Prevalence of Dementia by Severity of Disease (Aged 65+), Cambridgeshire and Peterborough, 2016 – 2031



The recorded dementia prevalence provides an indication of the concentration, within a population, of the number of people who have been diagnosed and who are now living with the condition. The following data has been extracted from the Public Health England (PHE) Fingertips Dementia Profiles[vi] and are based on the number of people with dementia recorded on their practice register within a CCG, as a proportion of people (all ages) registered at each GP practice within a CCG.

The data for Cambridgeshire and Peterborough is presented in Figures 3 and 4 above. The data show that there were 4,593 people recorded as having dementia in Cambridgeshire in 2015/16 (a prevalence of 0.7%) and 1,254 people recorded as having dementia in Peterborough (a prevalence of 0.6%). The difference between these numbers and the estimated numbers of people living with dementia indicate that there are a significant number of people in Cambridgeshire and Peterborough who have dementia but remain undiagnosed. Diagnosis of dementia will be explored further in Section 3. Figures 5 and 6 below also show that the recorded prevalence of dementia has increased between 2011/12 and 2015/16 in both Cambridgeshire and Peterborough.

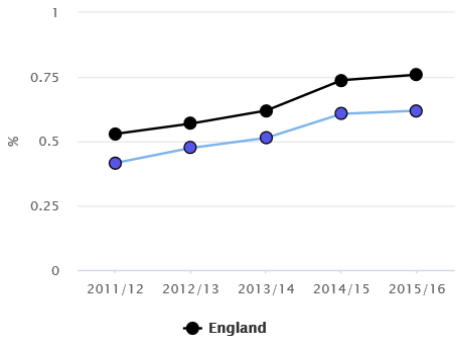
Figure 5: Recorded Prevalence of Dementia (All Ages), Cambridgeshire, 2011/12 – 2015/16[50]



Period		Count	Value	Lower CI	Upper CI	East of England	England
2011/12	●	3,213	0.5	0.5	0.5	0.5	0.5
2012/13	●	3,486	0.5	0.5	0.6	0.6	0.6
2013/14	●	3,762	0.6	0.6	0.6	0.6	0.6
2014/15	●	4,538	0.7	0.7	0.7	0.7	0.7
2015/16	●	4,593	0.7	0.6	0.7	0.8	0.8

Source: Quality Outcomes Framework (QOF), NHS Digital

Figure 6: Recorded Prevalence of Dementia (All Ages), Peterborough, 2011/12 – 2015/16[51]



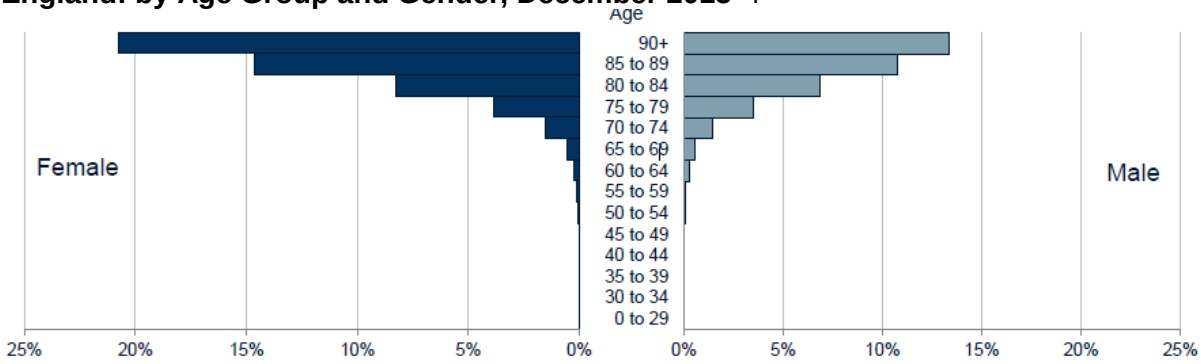
Period		Count	Value	Lower CI	Upper CI	East of England	England
2011/12	●	764	0.4	0.4	0.4	0.5	0.5
2012/13	●	890	0.5	0.4	0.5	0.6	0.6
2013/14	●	983	0.5	0.5	0.5	0.6	0.6
2014/15	●	1,189	0.6	0.6	0.6	0.7	0.7
2015/16	●	1,254	0.6	0.6	0.7	0.8	0.8

Source: Quality Outcomes Framework (QOF), NHS Digital

:

It is also possible to use data to see how recorded dementia prevalence varies with age and gender; this is shown in Figure 7 below, which presents national data from GP records (the Quality Outcomes Framework. It shows that dementia is more common in women than men, and prevalence increases with age.

Figure 7: Recorded Dementia Prevalence, Percentage of Registered GP Patients: England: by Age Group and Gender, December 2015[52].



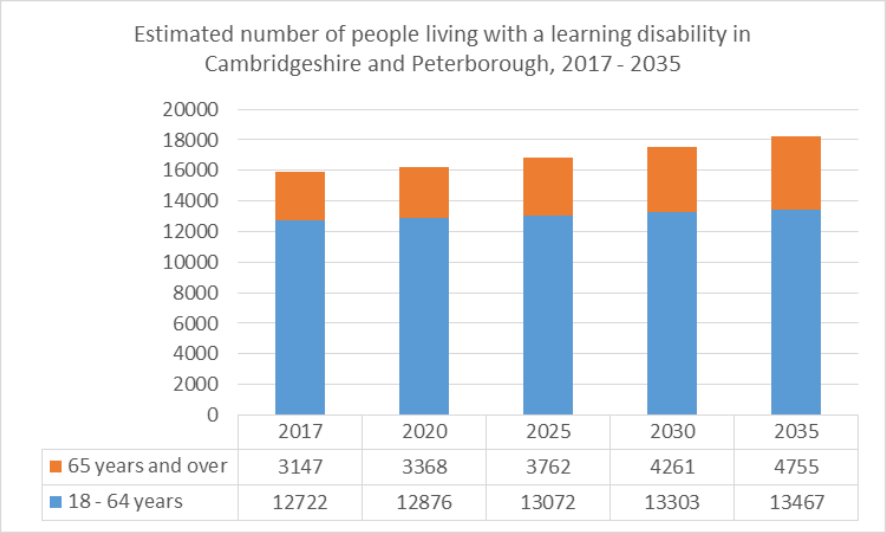
People with learning disabilities are at increased risk of developing dementia as they age; an estimated 1 in 5 people with a learning disability who are over the age of 65 will develop

[50] *PHE Dementia Profile*
[51] *PHE Dementia Profile*
[52] *Quality and Outcomes Framework Data, HSCIC, www.hscic.gov.uk/pubs/qofdemdec15*

dementia. People with learning disabilities who develop dementia are more likely to do so at an earlier age. This is particularly true for people with Down's Syndrome. It is estimated that a third of people with Down's Syndrome develop dementia in their 50s.[vii]

Figure 8 below shows that the number of older people in Cambridgeshire and Peterborough living with a learning disability is expected to increase by 51% over the next 18 years, from 3,147 in 2017 to 4,755 in 2035.

Figure 8: The Estimated Number of People Living with a Learning Disability in Cambridgeshire and Peterborough, 2017 – 2035[53]



The most common cause of dementia is Alzheimer's disease. Other possible causes include vascular dementia, Lewy Body disease and other Parkinsonian syndromes and various forms of frontotemporal lobar degeneration. A large number of rarer conditions can cause dementia including infectious causes such as HIV or CJD and hereditary conditions such as Huntington's disease. The most common cause of dementia in younger people remains Alzheimer's disease, though other rare causes cause proportionately more cases compared to late onset disease. In Cambridgeshire there are 11.5 cases of dementia per 100,000 person years for those aged 45-64 of which 4.2 are Alzheimer's, 3.5 frontotemporal dementia and 0.8 Huntington's disease[54].

Evidence is increasing suggesting that the majority of cases in very late life are secondary to mixed disease, hence a rise in diagnosis of cases of 'mixed dementia'. Commissioning of disease specific pathways, for example for Parkinson's disease needs explicit consideration of how dementia in these patients is identified and managed to avoid clinical gaps appearing. Mild Cognitive Impairment (MCI) describes a condition where cognition is impaired but function is intact. People with MCI are an important group as they are at increased risk of developing dementia (at a rate of c10% per year). However it is important to differentiate them from those with dementia, as not all will deteriorate and develop full

[53] www.pansi.org.uk
[54] http://www.neurology.org/content/71/19/1496.short

blown disease. Whilst they are at high risk, they are not simply those with 'early' dementia and represent a large mixed bag of cases where accurate identification is important, estimates of the prevalence of this condition range from 3-19% in the over 65s.. A further important group, often neglected in commissioning, are those who have significantly impaired cognition and function secondary to a specific insult and whose condition may not be progressively declining. These include those with chronic impairment secondary to stroke or alcohol use.

2.2.2 Local Strategic Context

The local strategic context for this strategy is provided by the priorities of the Cambridgeshire and Peterborough Sustainability and Transformation Partnership[55] (STP). The strategic objectives of partner organisations – commissioners and providers - within the STP are increasingly aligned to the STP strategic priorities and therefore the STP priorities provide a summary of the strategic direction and objectives of local statutory and non-statutory health and care organisations. These priorities are summarised in Figure 9 below.

Figure 9: Cambridgeshire and Peterborough Sustainability and Transformation Plan Priorities for Change: 10 Point Plan

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

2.3. Dementia Services in Cambridgeshire and Peterborough

2.3.1 Overview

Dementia services are made up of community and acute physical and mental health and social care services. Although there are areas of average to good performance,

[55] Cambridgeshire and Peterborough CCG, Cambridgeshire County Council, Peterborough City Council, Cambridgeshire Community Services NHS Trust, Peterborough and Stamford Hospitals NHS Foundation Trust, Hinchingbrooke Healthcare NHS Trust, Cambridge University Hospitals NHS Foundation Trust, Cambridgeshire and Peterborough NHS Foundation Trust, Papworth Hospital NHS Foundation Trust

improvement is needed in a number of key areas. The improvements required include both changes to and development of specific services under each of the Well Pathway Pillars. In addition, there is a need for a much more clearly defined care pathway. This would improve both the accessibility of services and co-ordination of care across organisations and between professional groups. In addition, much closer working with people living with dementia and their carers is needed both to identify the changes that will make the biggest impact on both experience of, and outcomes from care.

2.3.2 Specialist Dementia Services

Across Cambridgeshire and Peterborough there are well established dementia services. These are commissioned by the CCG, CCC and PCC and provided by CPFT which provides:

- Assessment, diagnosis, post-diagnostic support, care and treatment of people newly diagnosed with dementia: Memory Services.
- Care and treatment of people with moderate and severe dementia.
- Acute hospital liaison dementia services in Cambridge University Hospital (CUH), Hinchingbroke Hospital Care Trust (HH) and Peterborough City Hospital (PCH).
- Dementia Intensive Support Teams (DIST) for people with dementia in crisis as part of a Crisis Resolution and Home Treatment (CRHT) service.
- In-patient assessment and treatment for people with severe, complex and challenging dementias.
- Dementia training and education in acute hospitals and care homes: CAMTED-OP
- Admiral Nurses
- Dementia carers support

As well as providing access to diagnosis, assessment and support following diagnosis, the Memory Services offer access to Dementia Advisors who provide support around the time of diagnosis and a Dementia Support Service which provide ongoing support and advice. Both services are integrated within the Memory Service but are provided by the Alzheimer's Society.

Most CPFT clinical staff are based in locality teams where they are part of the multidisciplinary team and many staff work across a wider patient group than just those with a diagnosis of dementia. People who are assessed by the Memory Services as being sub-diagnosis i.e. with mild cognitive impairment will be referred back to their GP who will monitor and refer back to CPFT for further assessment as necessary e.g. if there is a deterioration in the individual's health. . Referral may also be to Adult Social Care for assessment of social care needs. The four Memory Services across Cambridgeshire and Peterborough are described in Table 2 below.

Table 2: Memory Services in Cambridgeshire and Peterborough

Peterborough and Borders	Provided in the Dementia Resource Centre (DRC) by clinical staff who outreach from the locality mental health team as well as from the locality base. The DRC is in purpose build dementia friendly building separate from the Integrated Care Team (Locality Team) and has space for groups and activities and has a café and drop in centre.
Cambridge	Located in Brookfields with the Integrated Care Team.
Huntingdon	Located in Hinchingbrooke Hospital with the Integrated Care Team.
East Cambridgeshire and Fenlands	Located in Doddington with the Integrated Care Team with clinics in Wisbech and Ely.

There has been additional investment in Crisis Resolution and Home Treatment services (CRHT) for older people with mental health problems with the establishment and expansion of the Dementia Intensive Support Team (DIST) within the CRHT. The CRHT provides rapid and intensive community input, including treatment of behavioural and psychiatric symptoms of dementia and delirium, prevention of avoidable admissions and support to carers and for those in crisis in their own home and in residential and nursing homes. Expanded hours and increased staffing resources have enabled the DIST service to support 429 people with dementia in 2015/16.

2.3.3 Acute Hospitals and the Community and Primary Care Health and Social Care Services

Primary care, community and acute hospital services have a critical role to play in the diagnosis, assessment and treatment of people living with dementia and their carers. This is particularly the case for older people living with dementia who are most likely to either be physically frail or to have more than one physical health condition. The services provided are described in detail elsewhere. However, of particular relevance to this Strategic Plan are GPs, the Community Neighbourhood Teams provided by CPFT, Adult Social Care Teams and the range of health and social care and voluntary sector services designed to prevent admission to Acute Hospital and/or to facilitate discharge when treatment is complete.

The CCG provides the Care Home Support Team, a team of nurses who act as care home facilitators. The team prioritises which care homes to work with based on areas that homes may need assistance with. This includes the areas of end of life planning and end of life care planning after death. The facilitators use quality improvement training, advice and signposting to empower care home staff to implement the change ideas. They also use external agencies to help identify where practice is sub optimal. In End of Life this is identified by the Hospice at Home Teams, the Community Palliative Nurses and the Acute Palliative Nurses as well as the End of Life facilitators within CPFT. The facilitators work with the Care Homes to improve their practice and identify the support available to them.

2.3.4 The Voluntary Sector

Voluntary sector organisations are commissioned to provide information, guidance and care and support for people diagnosed with dementia, their carers, families and the communities in which they live. The key voluntary sector organisations that are involved with dementia are:

- **The Carers' Trust:** provides support for carers across all client groups, including dementia.
- **Making Space:** provides specialised support for carers with mental health problems.
- **The Alzheimer's Society:** provides a wide range of information, advice and support available for people living with dementia and their carers, including advocacy, dementia advisers, dementia cafés, activities, information and peer support. In Peterborough, support is provided through the DRC. In Cambridgeshire the services are provided alongside the Memory Services provided by CPFT. The Alzheimer's Society also supports the development of Dementia Friendly Communities and Environments.

Although these services are seen overall to be appropriate and of good quality services are not commissioned consistently across Cambridgeshire and Peterborough.
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2.3.5 The Independent Sector

The independent sector are commissioned to provide home care, residential and nursing home and home/domiciliary care to meet the needs of people who are eligible for support by the Councils and/or CCG.

2.3.6 Investment in Dementia Care

Further work is needed to understand the total health and social care investment in dementia care across Cambridgeshire and Peterborough. This work will be completed as part of the work to develop and review the dementia care pathway to 30.09.18.

2.4 Gap Analysis

Benchmarked data published by NHS England and by Public Health England along with local activity data relating to the performance of acute and community services and specialist mental health services was analysed included in Sections 2.4.1 and .2.4.2 below. The data published by Public Health England was chosen over the Right Care data for the final analysis because it enabled differentiation in performance in Cambridgeshire and Peterborough because this assisted with identifying plans and prioritising areas for improvement. The data provided is from Public Health England unless otherwise indicated.

This information was supplemented by local performance data from monitoring undertaken by health and social care services.

This analysis was combined with a summary of the views of stakeholders - managers, practitioners and commissioners in statutory, voluntary and independent sector organisations, and people living with dementia and their families and carers. The summary was developed using the outcomes of engagement events undertaken over the previous 2 years, information collected routinely during service delivery and commissioning processes and engagement events arranged specifically to allow a wide range of stakeholders to review and input to the Strategic Plan. The findings provide the basis for identification of the priorities for improvement and are therefore summarised under the headings for each of the Well Pathway pillars and cross cutting themes in Sections 3.2. The full gap analysis is included at Appendix 1.

3 Our Vision, Priorities and Actions

In this section, the findings from Section 2 are drawn together and prioritised action plans for improvement against each of the Well Pathway pillars and cross cutting themes are identified. The structure for each section is the same. However, as each section has been written by the lead for that specific aspect of dementia, there is some inconsistency in styles of writing within this part of the Strategic Plan.

3.1 Our Vision

Members of the OPMH Delivery Board worked with stakeholders to agree a vision for dementia in Cambridgeshire and Peterborough:

> ***We will work hard to prevent people in Cambridgeshire and Peterborough from acquiring dementia and ensure that those living with and affected by dementia receive compassionate, expert care and support, that is right for them to live positive and fulfilling lives …. we will support and empower them to take part in, and contribute to, the families and communities in which they live and work.***
>
> *Adapted from Dementia UK's Strategy*

3.2 Our Priorities

3.2.1 Preventing Well

The Standard

The risk of people developing dementia is minimised: "I was given information about my personal risk of getting dementia"

The standard includes the following parts of the Well Pathway:

- Prevention
- Risk reduction
- Health information
- Supporting research

Overview

There is clear evidence that a number of modifiable risk factors, including smoking, physical inactivity and obesity, increase an individual's risk of developing dementia. The prevalence of these risk factors varies across Cambridgeshire and Peterborough, with a general pattern

of higher rates of harmful health behaviours seen in Peterborough and Fenland. There is an opportunity to use recent guidance published by NICE and Public Health England (PHE) to take public health action to reduce these risk factors and incorporate messages of dementia risk reduction into existing programmes of work.

Best Practice and Guidelines

The Blackfriars Consensus[56]: The Blackfriars Consensus (2014) makes the case for concerted action to reduce people's risk of dementia by supporting them to live healthier lives and manage pre-existing conditions that increase their risk of dementia.

NICE Guidance (NG16) 'Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset'[57]: Guided by evidence reviews conducted by The Cambridge Institute of Public Health, NICE recently published guidance on mid-life approaches to delay or prevent the onset of dementia, disability and frailty in later life. It sets out the case for promoting a healthy lifestyle to reduce the risk of or delay the onset of dementia. The guidelines also highlight that there is emerging evidence on the importance of psychosocial risk factors throughout life such as loneliness, isolation and depression. The recommendations within the guidelines make it clear that risk reduction is complex and requires multiagency action.

Public Health England Guidance: The most recent guidance on the effect of midlife risk factors on dementia from Public Health England[58] is based on a review conducted by the Personal Social Services Research Unit which found evidence that the following risk factors in mid-life are associated with an increased risk of dementia later in life:

- Physical inactivity in mid-life is highly prevalent and increases the risk of all-cause dementia: people inactive in midlife have more than double the risk of dementia in old age than those who are physically active.
- Current smoking increases the risk of all-cause dementia: the risk of dementia in old age is slightly higher for smokers in midlife than for non-smokers, but past smoking is not associated with an increased all-cause dementia risk.
- Diabetes increases the risk of all-cause dementia; while the samples in several reviews include older people, there are some original studies specifically from midlife which suggest that people with diabetes have around 2.5 times the risk of onset of dementia in old age.

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[56] Blackfriars Consensus on promoting brain health: reducing risks for dementia in the population (2014). Public Health England & the UK Health Forum and Public Health England. Available from: http://nhfshare.heartforum.org.uk/RMAssets/Reports/Blackfriars%20consensus%20%20_V18.pdf

[5757] National Institute for Health and Care Excellence (2015) Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset. NICE guideline (NG16)

[58] Read S, Wittenberg R, Karagiannidou M, Anderson R & Knapp M at the Personal Social Services Research Unit, London School of Economics and Political Science on behalf of Public Health England (2017). The Effect of Midlife Risk Factors on Dementia in Older Age. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/633096/effect_of_midlife_risk_factors_on_dementia_in_older_age.pdf.

- Hypertension in mid-life increases the risk of all-cause dementia: people with hypertension in midlife are at slightly greater risk of dementia in old age
- Obesity in mid-life increases the risk of all-cause dementia: people who are obese have around 1.6 times the risk of onset of dementia in old age
- Depression increases the risk of all-cause dementia; while the samples in several reviews include older people, there are studies specifically for midlife depression which suggest that people with depression in midlife are at slightly greater risk of dementia in old age.
- Mental activities in mid-life are associated with a lower risk of dementia in later life: for example, higher complexity of working with data among lower educated people in midlife can roughly halve the risk of dementia in old age.

In addition to the above guidance which focuses on mid-life risk factors, Public Health England have published an evidence-based resource for local authorities and commissioners on changing risk behaviours and promoting cognitive health in older adults[59]. The report uses the findings of three systematic reviews which examine the evidence on the effectiveness of interventions aimed at reducing unhealthy behaviours in older people, whether these result in the prevention or delay of cognitive decline or dementia, and any barriers or facilitators to success. The guidance concludes that:

> There is evidence that changes in health behaviour in older age can have beneficial effects on cognitive function in the short term although no intervention studies to date have reported longer term impact on the prevention or delay of dementia onset.'

It summarises the available evidence for a number of risk factors (including diet, physical activity, cognitive stimulation and social isolation) and recommends that efforts should focus on developing and implementing guidance, policies and interventions to reduce smoking and alcohol consumption across the population, including in older adults.

Modelling of the potential of primary prevention by Norton et al[60]: In 2015, Norton et al reported that a third of Alzheimer's cases worldwide might be attributable to potentially modifiable risk factors. Alzheimer's disease incidence might be reduced through reduction in seven risk factors: diabetes mellitus, midlife hypertension, midlife obesity, physical inactivity, depression, smoking and low educational attainment. It was estimated that by 2050, if these seven risk factors were reduced by 10%, 170,000 (8.8%) of UK cases of Alzheimer's disease could be prevented. If these seven risk factors were reduced by 20%, 314,000 (16.2%) of predicted cases could be averted. We have applied these potential reductions in prevalence through primary prevention to the Cambridgeshire and Peterborough population. Table 3 below shows the estimated number of cases of Alzheimer's disease that could be prevented through effective reductions in these seven risk factors. A 20% reduction across

[59] Lafortune L, Kelly S, Olanrewaju O, Cowan A & Brayne C at the Cambridge Institute of Public Health on behalf of Public Health England (2016). Changing risk behaviours and promoting cognitive health in older adults – an evidence-based resource for local authorities and commissioners. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/571471/changing_risk_cognitive_health_report.pdf

[60] Norton S, Matthews FE, Barnes DE, Yaffe K, & Brayne C (2014). Potential for primary prevention of Alzheimer's disease: an analysis of population-based data. *The Lancet Neurology*. 13:788-94.

these seven risk factors could prevent 3,067 (9.2%) of Alzheimer's disease across Cambridgeshire and Peterborough by 2036.

Table 3: Impact of a 10% and 20% Reduction in the Risk Factors for Dementia Per Decade on the Estimated Number of Cases of Dementia in Cambridgeshire and Peterborough

Indicator	2016 %	2021 %	2026 %	2031 %	2036 %
% reduction in prevalence of dementia resulting from a 10% reduction per decade in the relative prevalence of the 7 risk factors	0.0	2.4	4.6	6.8	8.8
% reduction in prevalence of dementia resulting from a 20% reduction per decade in the relative prevalence of the 7 risk factors	0.0	4.8	9.2	12.9	16.2
Indicator	**2016** No.	**2021** No.	**2026** No.	**2031 No.**	**2036 No.**
Reduction in number of cases of dementia with 10% reduction in risk factors	0	-267	-585	-1,095	-1,666
Reduction in number of cases of dementia with 20% reduction in risk factors	0	-534	-1169	-2,078	-3,067
Number of people with dementia if a 10% reduction in risk factors is achieved	8,560	10,850	12,130	15,010	17,260
Number of people with dementia if a 20% reduction in risk factors is achieved	8,560	10,590	11,540	14,030	15,860

Specific NICE guidance includes NG 16 Dementia, disability and frailty in later-life – mid-life approaches to delay or prevent onset[2].

Local Data

The following data is taken from the Public Health England Dementia Profiles (see Section 2.2.1 for further detail about the indicators and data source).

- Smoking prevalence in adults is below the national average in Cambridgeshire 15.2% but just above in Peterborough at 17.6%.
- In Cambridgeshire, 25.3% of adults are physically inactive which is lower than the national average. In Peterborough, 34.3% of adults are physically inactive which is higher than the national average.
- In Cambridgeshire 63.2% of adults are overweight or obese – this is less than the national average. In Peterborough, 70.8% of adults are overweight or obese which is greater than the national average.
- In Cambridgeshire 9.6% and in Peterborough 10.4% of the eligible population had received their NHS health check.

Key Objectives

Key Objective 1: Build strategy to include evidence-based and equitable primary, secondary and tertiary prevention efforts across the life course.
Key Objective 2: Incorporate dementia risk reduction into current long-term disease approaches and unique messaging.

Measuring Success:

The ultimate aim of this strand of work is to reduce the prevalence of dementia through efforts to tackle modifiable risk factors across the life course, with a focus on mid-life. However, the latest PHE report on dementia prevention states that a reduction in some risk factors, for example smoking, affects mortality as well as dementia incidence. People who change behaviours in middle age may experience considerably improved life expectancy. It is, therefore, possible that while they may gain a reduced risk of onset of dementia at a given age, for example in their seventies, their lifetime risk of onset of dementia may rise and be higher than if they had not changed their behaviours. In addition, there are challenges to measuring the true prevalence of dementia in a given area (see Section 3.2.2. below Diagnosing Well for more information). It will therefore be appropriate to measure success of this pillar of work using process measures (e.g. inclusion of dementia prevention messages in behaviour change training) and measures of health behaviours in the population. In addition, the evidence base for dementia prevention, especially on targeting unhealthy behaviours in older people, should continue to be monitored to inform the development of this area of work.

Action Plan

Action	Further information	Measures of success	Lead	Timescales
1.1 Continue delivery of public health strategy and interventions that aim to support people to lead healthy lifestyles throughout their life course, including: - **Stopping smoking;** - **Being more physically active;** - **Reducing their alcohol consumption;** - **Adopting a healthy diet;** - **Achieving and/or maintaining a healthy weight.**	• This work is coordinated by the Health Improvement Team within public health with services being commissioned by the public health Joint Commissioning Unit. • Integrated lifestyle services (including weight management and smoking cessation) are provided by Everyone Health in Cambridgeshire and Solutions for Health in Peterborough. • This links with implementation of the older people's primary prevention JSNAs.	KPIs of integrated lifestyle services and prevalence of health behaviours (e.g. smoking, physical inactivity, excess weight)	Public health (Core public health business overseen by health improvement lead Consultant)	Ongoing
1.2 Work with public health commissioners and local providers to ensure that these	• NHS Health Checks already include messages around preventing dementia. • Work with colleagues in the Health Improvement Team and Joint Commissioning Unit in public health and the healthy lifestyle	Effective inclusion of dementia risk reduction messages in healthy lifestyle interventions and the	Public health (Senior Public Health Manager –	Jan to June 2018

healthy lifestyle interventions include messages around dementia risk reduction.	providers (Everyone Health in Cambridgeshire and Solutions for Health in Peterborough) to understand current practice and implement inclusion of messages about dementia risk reduction in healthy lifestyle interventions. • Link with the Cambridgeshire and Peterborough Diabetes Prevention Programme to ensure messages of dementia prevention are included within the programme.	diabetes prevention programme.	Older People)	
1.3 Raise awareness about how the risk of dementia can be reduced by keeping physically and mentally healthy using public health campaigns.	• Ensure messages about dementia risk reduction are included in local public health campaigns that act to promote healthy lifestyles. • This will include local campaigns in Cambridgeshire, the Healthy Peterborough campaigns and pharmacy public health campaigns. • Dementia prevention will be included as a quality standard in the public health communications strategy.	Effective inclusion of dementia risk reduction messages in all relevant public health campaigns.	Public health (Communications Lead)	Ongoing
1.5 Work with commissioners and providers to ensure Healthy Conversation Skills and Behaviour Change training includes messages around dementia risk reduction.	• Public health are currently working with the CCG to develop a programme of healthy conversation skills training. • Behaviour change training is delivered by Everyone Health. • Target training to appropriate frontline staff e.g. social care, voluntary sector organisations.	Effective inclusion of dementia risk reduction messages in behaviour change training and healthy conversation skills training.	Public health (Lead for health coaching)	Jan to June 2018
1.6 Continue delivery of work place health programme with employers across Cambridgeshire and Peterborough which aims to support employees to lead healthy lifestyles.	• The Workplace Health Programme is currently delivered by Living Sport. • Provision includes Mental Health First Aid Lite Training and Health Champion Training alongside tailored advice and support networks for employers. • Messages about dementia risk reduction and supporting those with dementia in the workplace can be included as part of support network content.	Effective inclusion of dementia risk reduction messages in the workplace health.	Public health (Work place health lead)	Ongoing
1.7 Work with colleagues through the Older People's	• Review the evidence base for secondary and tertiary prevention of dementia.	Evidence base is used to design and deliver messages on diagnosis to enable	Public health (Senior Public Health	April to September 2018

Mental Health Board to identify the current provision of secondary and tertiary prevention (including healthy lifestyle advice and signposting to lifestyle services) and address any identified gaps.	• Link with the strategy lead for diagnosing well pathway to understand current practice.	effective secondary prevention where appropriate.	Manager – Older People)	

3.2.2 Diagnosing Well

The Standard

Timely accurate diagnosis, care plan, and review within first year. "I am diagnosed in a timely way. I am able to make decisions and know what to do to help myself and who else can help".

This standard includes the following parts of the Well Pathway:

- Diagnosis
- Memory assessment
- Concerns discussed
- Investigation
- Provide information
- Integrated and advance care planning

Best Practice and Guidelines

MSNAP[61] provides a quality framework for Memory Assessment Services. The standards aim to enable Memory Assessment Services to evaluate themselves against a set of agreed standards based on best practice and guidance defined by the Royal College of Psychiatrist and including the National Institute for Clinical Excellence (NICE) guideline, Dementia: supporting people with dementia and their carers in health and social care[62]. Although the primary focus is Memory Assessment Services, the standards address the treatment and support that should be available following diagnosis:

- Management
- Resources Available to Support Assessment and Diagnosis
- Assessment and diagnosis
- Ongoing care management and follow up
- Pharmacological interventions
- Psychosocial interventions

This means that the Standards include items that feature under the Supporting Well and Living Well Pillars of the Well Pathway. MSNAP includes a set of quality indicators relating to key aspects of the Pathway. (Appendix xx). They will therefore be used to underpin the development of the pathway that are defined under Diagnosing Well, Living Well and Supporting Well.

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[61] Memory Assessment Service National Accreditation Programme (MSNAP): Standards for Memory Assessment Services, 5th edn., Pub.No. CCQI221 Royal College of Psychiatrists, 2016

[62] Dementia: supporting people with dementia and their carers in health and social care, CG42, November 2006, last updated: September 2016, NICE, https://www.nice.org.uk/guidance/cg42

Local Data

National guidelines relating to Diagnosing Well, are contained within Dementia: Supporting people with dementia and their carers in health and social care[63]. MSNAP[64] incorporates these guidelines into a set of standards that give more detailed guidance relating to diagnosing dementia and supporting individuals and their carers pre- and post diagnosis. It also includes standards that aim to enable people living with dementia and their carers to participate and live independently in their communities, as well as standards relating to ongoing care management and follow up, pharmacological and psychosocial interventions. MSNAP[65] includes a set of quality indicators and therefore provides a basic quality framework for both Memory Assessment Services and the wider dementia care pathway.

The overall aim of the national dementia guideline and MSNAP is to enable people to live independently and safely at home for as long as possible, avoiding crises and hospital admission wherever possible. The aim of these guidelines is therefore to ensure diagnosis as early in the course of the illness as possible in order to ensure that there is access to the information, advice, guidance that people need to make choices and take control of their care. It also aims to ensure that treatment and support needs are identified and addressed early, and that advance care planning takes place so that individuals' needs and wishes are addressed in a way that is in accordance with their wishes as the disease progresses.

The gap analysis showed that the diagnosis rate for Cambridgeshire is slightly below average - 62.7% against the national target (67%). However, Peterborough performs well when compared with the rest of the county with a diagnosis rate of 78.4%. However, there is significant variation in diagnosis rates between GP practices. Stakeholders identified access to and speed of diagnosis as a strength in local provision. The following gaps/opportunities for improvement were identified:

- Advance care planning so that crises, avoidable admission to hospital is minimised, particularly in the event of a carer being unable to care temporarily and plans are made for end of life
- Case finding in care homes.

These gaps will be addressed through the Key Objectives identified below. In addition, the Memory Assessment Service will work towards MSNAP accreditation.

Key Objectives:

Key Objective 1: To increase the rate of diagnosis of dementia

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[63] Dementia: supporting people with dementia and their carers in health and social care, CG42, November 2006, last updated: September 2016, NICE, https://www.nice.org.uk/guidance/cg42

[64] Memory Assessment Service National Accreditation Programme (MSNAP): Standards for Memory Assessment Services, 5th edn., Pub.No. CCQI221 Royal College of Psychiatrists, 2016

[65] Memory Assessment Service National Accreditation Programme (MSNAP): Standards for Memory Assessment Services, 5th edn., Pub.No. CCQI221 Royal College of Psychiatrists, 2016

Key Objective 2: To develop a robust dementia pathway within which there is an action plan that is supporting improvement/achievement of the standards within NICE guidelines and MSNAP with protocols, agreed between the Memory Assessment Service, GPs, older people's services and the voluntary sector consistently across Cambridgeshire and Peterborough, (includes assessing the feasibility of commissioning a Memory Assessment Service that meets the standards required to achieve MSNAP accreditation; as a minimum, standards relating to advance planning must be achieved).

Action Plan

Key Objective 1: To increase the dementia diagnosis rate.				
Objective	**How Improvement will be Measured**	**Timescale**	**Action Required**	**Lead**
1.1 To ensure that the waiting time for and rate of diagnosis in Cambridgeshire so that it at least exceed the national targets (6 weeks and 67%)	Diagnosis rate across Cambridgeshire: Target: exceed national target: 67% Peterborough: Target: at least maintain current rate: 79% Waiting time for diagnosis: achieve 18 weeks referral to assessment (KLOE)	**31.03.19**	i) Engagement/work with GP practices: Cambridgeshire ii) Ensure that all GPs have received recent training on dementia diagnosis (in hand through CAMTED-OP) (KLOE) iii) Ensure that all GPs and primary care staff have received training in dementia within minority ethnic communities (KLOE)	CPFT Clinical Lead (OPMH) with CCG Clinical Lead (OPMH)
1.2 Ensure consistency in diagnosis rates within Cambridgeshire and Peterborough, reducing variation.	Diagnosis rate across Cambridgeshire: Target: exceed national target: 67% Peterborough: Target: at least maintain current rate: 79% Waiting time for diagnosis: achieve 18 weeks referral to assessment (KLOE)	**31.03.20**	i) Engagement/work with GP practices: Cambridgeshire and Peterborough ii) Ensure that every practice is using the Data Quality Toolkit to cleanse data re:patients with dementia (http://www.necsu.nhs.uk (KLOE) iii) Ensure that every practice is using the DiADeM tool in care homes (KLOE)	CPFT Clinical Lead (OPMH) with CCG Clinical Lead (OPMH)
1.3 Increase the rate of diagnosis of dementia in care homes	Rate of diagnosis of dementia in residential and nursing homes	**31.03.20**	i) Roll out use of the Dementia Case Finding Tool for Care Homes ii) Develop a system for measuring the rate of dementia diagnosis in care homes	CPFT Clinical Lead (OPMH) with CCG Commissioner (OPMH)
Key Objective 2: To develop a robust pathway that meets the standards within NICE guidelines and MSNAP with protocols agreed between the Memory Assessment Service, GPs, older people's services and the voluntary sector, including protocols that ensure that advance planning is established consistently across Cambridgeshire and Peterborough (includes assessing the feasibility of commissioning a Memory Assessment Service that meets the standards required to achieve MSNAP accreditation).				
Objective	**How Improvement will be Measured**	**Timescale**	**Action Required**	**Lead**
2.1 Ensure that the Memory Assessment Service achieves the closest fit possible with NICE dementia guidelines as reflected in the MSNAP	Aspirational: Memory Assessment Service achieves MSNAP accreditation meeting 100% Of MSNAP Type 1 standards Memory Assessment Service meets 80% of MSNAP Type 2 standards	**30.09.21**	i) Undertake a gap analysis, including Memory Assessment Service self-assessment against the MSNAP standards, prioritising advance care planning as part of the work to revise the dementia care pathway: e.g. everyone diagnosed with dementia is referred to a	CCG Clinical Lead (OPMH) with CPFT Clinical Lead (OPMH)

standards within the resources available as part of the work to develop a robust dementia pathway; at a minimum the standards relating to advance planning must be achieved.	Memory Assessment Service meets 60% of MSNAP Type 3 standards Alternative to the above: there is clarity about the standards that can/can't be met by the Memory Assessment Service and an action plan with SMART objectives that will support improved outcomes for people living with dementia and their carers % of people who have an advance care plan within 8 weeks of diagnosis % of people who receive a diagnosis following assessment and start treatment within 6 weeks (KLOE) % referrals for assessment at a Memory Service that receive a diagnosis of dementia (KLOE)		voluntary sector organization for information, advice, guidance and support following diagnosis: 30.06.18 ii) Assess resources required to achieve accreditation and undertake a cost/benefit analysis: 30.09.18 iii) Develop a business case for improvement of the dementia pathway: 30.09.18 iv) Seek approval for the proposed improvements and investment required from each organization and the STP: 31.12.18 v) Implement the agreed improvements to the dementia pathway: 01.04.19	
2.2 Assess the gap between current dementia services and the MSNAP standards and determine the improvement and investment that may be required to achieve MSNAP accreditation		**31.03.19** **31.03.20** **30.09.20**	i) Secure STP agreement to consider working towards the commissioning of Memory Assessment Service MSNAP accreditation : 31.01.18 ii) Assessment/self-assessment of performance of current Memory Assessment Service and related pathway against MSNAP standards as part of the development of the multi-agency/multi-disciplinary care pathway with key stakeholders: 30.09.18 iii) STP decision re: investment/actions required to achieve the MSNAP standards included in the business case for the STP Dementia business case based on ii) above: 31.03.19	CPFT Clinical Lead (OPMH) with CCG Commissioner (OPMH)

			iv) Decision re: attainment of MSNAP accreditation: 31.01.20 v) CPFT/Commissioner Agreement of standards to be attained and monitored from 01.04.20: 31.03.20	

3.2.3 Supporting Well

The Standard

Access to safe high quality health and social care for people with dementia and their carers. "I am treated with dignity and respect. I get treatment and support which are best for my dementia and my life."

The standard includes the following parts of the Well Pathway:

- Choice
- Behavioural and Psychological Symptoms of Dementia
- Liaison
- Advocates
- Housing and accommodation
- Hospital treatments
- Technology
- Health and social services
- Hard to reach groups

Best Practice and Guidelines

The guidelines relating to Living Well, are contained within Dementia: Supporting people with dementia and their carers in health and social care[66]. Standards relating to ongoing care management and follow up, pharmacological and psychosocial interventions included in the MSNAP standards apply to assessment, treatment and support in Cambridgeshire and Peterborough because the Memory Assessment Service undertakes diagnosis and initial care planning, but then discharges cases to primary care where no further assessment and treatment is required at the time, or to the Community Mental Health Teams where further assessment, treatment and care planning is required to meet identified needs for treatment and support. (See Section 3.2.2, Diagnosing Well: Best Practice and Guidelines above.).

The national guideline also includes a standard relating to inpatient dementia services, stating that as far as possible, dementia care should be community-based, but that psychiatric inpatient admission may be considered in certain circumstances, including if an individual is severely disturbed and needs to be contained for his or her own health and/or the safety of others or if assessment in a community setting is not possible e.g. if the individual has complex physical and psychiatric problems. It states that as far as possible dementia care services should be community-based, but psychiatric inpatient admission may be considered in certain circumstances, including if an individual is severely disturbed and

[66] Dementia: supporting people with dementia and their carers in health and social care, CG42, November 2006, last updated: September 2016, NICE, https://www.nice.org.uk/guidance/cg42

needs to be contained for his or her own health and/or the safety of others or if assessment in a community setting is not possible e.g. if the individual has complex physical and psychiatric problems.

Local Data

Through the gap analysis, the following strengths were identified:

- Management of dementia in acute hospital (Right Care).
- Early work undertaken in relation to meeting the needs of people from minority groups with dementia.
- Percentage of patients whose care was reviewed at least annually by GPs (Right Care).
- The mortality rate for people with dementia in Cambridgeshire and Peterborough is slightly lower than the England average at 845 per 100,000 people.

Gaps:

- Sufficient capacity in voluntary sector services to enable access.
- The availability of transport to access services.
- Advance care planning so that crises, avoidable admission to hospital is minimised, particularly in the event of a carer being unable to care temporarily and plans are made for end of life.
- The availability of care at home, particularly in more rural areas.
- Pressure on the cost of nursing home care in Cambridgeshire as an affluent area.
- Access to nursing home care for those with the most complex needs, particularly on discharge from hospital.
- Dementia care in residential care and nursing homes.
- Assessment, treatment and support for people with early onset dementia.

Key Objectives

Key Objective 1: To develop a robust dementia pathway within which there is an action plan that supports improvement/achievement of the standards within NICE guidelines and MSNAP consistently across Cambridgeshire and Peterborough that relate to Living Well (includes assessing the feasibility of commissioning a Memory Assessment Service that meets the standards contained within NICE guidelines and MSNAP ; as a minimum, standards relating to advance planning must be achieved).
Key Objective 2: To ensure geographical consistency in relation to Dementia Friendly Communities and Dementia Friendly Environments across Cambridgeshire and Peterborough.
Key Objective 3: To improve awareness of and access to dementia care for hard to reach groups.
Key Objective 4: To ensure that the quality of care of people living with dementia in care homes meets the Care Quality Commission requirements and best practice.

Action Plan

Key Objective 1: To develop a robust dementia pathway within which there is an action plan that supports improvement/achievement of the standards within NICE guidelines and MSNAP consistently across Cambridgeshire and Peterborough that relate to Living Well (includes assessing the feasibility of commissioning a Memory Assessment Service that meets the standards contained within NICE guidelines and MSNAP; as a minimum, standards relating to advance planning must be achieved).				
Objective	**How Improvement will be Measured**	**Timescale**	**Action Required**	**Lead**
1.1 Ensure that the Memory Assessment Service achieves the closest fit possible with NICE dementia guidelines as reflected in the MSNAP standards within the resources available as part of the work to develop a robust dementia pathway; at a minimum the standards relating to advance planning must be achieved.	Aspirational: Dementia Pathway meets the MSNAP accreditation meeting 100% Of MSNAP Type 1 standards Memory Assessment Service meets 80% of MSNAP Type 2 standards Memory Assessment Service meets 60% of MSNAP Type 3 standards. Aspirational: Dementia Pathway fully meets the standards contained within the Nice Guidelines. A care pathway between organisations with a key role in dementia across the health and social care system in place. Protocols in place between services across the care pathway e.g. the Memory Assessment Service, GPs, older people's services and the voluntary sector consistently across Cambridgeshire and Peterborough. Alternative to the above: there is clarity about the standards that can/can't be met by the Memory Assessment Service and an action plan with SMART objectives that will support improved outcomes for people living with dementia and their carers. % of people who have an advance care plan within 8 weeks of diagnosis.	**30.09.21**	i) Identify and seek agreement to the core standards within the NICE dementia guidelines that relate to Living Well and Supporting Well that should be met as a minimum across Cambridgeshire and Peterborough: 31.03.18 ii) Link the outcome of i) above with the requirements for MSNAP accreditation. iii) Undertake a gap analysis between services currently commissioned and the minimum and full standards identified in ii) above, including Memory Assessment Service self-assessment: 31.03.18 iv) Identify opportunities for improved outcomes and efficiency, quantify and develop an implementation plan, including the potential offered by community pharmacy: 30.09.18 v) Assess the additional investment required to achieve the key as part of the review of the dementia pathway and undertake a cost/benefit analysis: 30.09.18 vi) Develop a business case for improvement of the dementia pathway if/as appropriate: 30.09.18 vii) Seek approval for the proposed improvements and investment required from each organization and the STP: 31.12.18 viii) Implement the agreed improvements to the dementia pathway: 01.04.19	CCG Clinical Lead (OPMH) with CPFT Clinical Lead (OPMH), CCG Commissioner (OPMH), CCC/PCC Commissioner, (MH)

	Determine cost/benefit of moving to a functional/organic rather age based (under/over 65 yrs) approach to mental health services. Services are commissioned to provide effective pre-and post diagnostic support The Alzheimer's Society is commissioned to provide pre- and post diagnostic support (KLOE)			
1.2 To determine the impact of the likely increase in the number of people living with dementia in Cambridgeshire and Peterborough and the action needed to meet likely additional demand	Over time: capacity meets demand so that KPIs continue to be met	**31.03.22/ 31.03.27/ 31.03. 32**		CCG Clinical Lead (OPMH) with CPFT Clinical Lead (OPMH), CCG Commissioner (OPMH), CCC/PCC Commissioner, (MH)
Key Objective 2: To work with Acute providers to develop a plan for ongoing improvement in the quality of care for people with dementia when in hospital.				
Objective	**How Improvement will be Measured**	**Timescale**	**Action Required**	**Lead**
2.1 To improve patient and carer experience and outcomes of Acute Hospital care	All acute hospitals meet the standards for a dementia friendly environment	31.03.22	i) Establish a Task and Finish Group/s to identify, prioritise and deliver the improvements required in Acute Hospital care, including ensuring meeting the requirements of providing a Dementia Friendly Environment and carer/ patient experience and timely discharge to an appropriate setting (See Key Objective 2, 3.2.4 below): 31.03.18 ii) Identify the gaps in investment required: 30.09.18 iii) Undertake a cost benefit analysis and include in the dementia business case: 31.12.18 iv) Develop an action plan/s to include improving understanding of the experience and outcomes of people diagnosed with dementia through	CCG Commissioner (OPMH)/CCG Clinical Lead (OPMH)/ Acute Hospital Clinical and Managerial Leads

			improved coding of dementia (See 3.2. below): 31.09.18	
2.2 To ensure that admission to Acute Hospital occurs only when medically necessary	i) Reduction in no. of avoidable admissions to Acute hospital care ii) Reduction in no. of avoidable admissions to specialist dementia Inpatient Care	31.03.22	i) Establish a Task and Finish Group/s ?? include in the workstream for Key Objective 1,1.1 above: 31.03.18 ii) Include as a key objective within 1.1 i. (above) and include within the dementia business case: 31.12.18 iii) Include as a key objective under Integrating Well: 31.03.22	CCG Commissioner (OPMH)/CCG Clinical Lead (OPMH)/ Acute Hospital Clinical and Managerial Leads
2.3 To improve understanding of the experience and outcomes of people diagnosed with dementia in Acute Hospital care	i) Robust coding of dementia as primary and secondary reason for admission	31.03.19	i) Include in the work of the Acute Hospitals Task and Finish Groups. Also see Monitoring Well (Section 3.2.12 below).	CCG Commissioner (OPMH)/CCG Clinical Lead (OPMH)/ Acute Hospital Clinical and Managerial Leads
Key Objective 3: To improve awareness of and access to dementia care for hard to reach groups				
Objective	**How Improvement will be Measured**	**Timescale**	**Action Required**	**Lead**
3.1 Develop an action plan that addresses priorities building on recent work on cultural variation in understanding of, and approach to dementia to improve engagement with hard to reach groups.	i) An increase in the no. and % of people from hard to reach groups diagnosed with dementia ii) An increase in the no. and % of people from hard to reach groups dementia care	31.03.20	i) Set up a task and finish group to improve access to, and outcomes from dementia care, building on the research undertaken 2016/17: 31.01.18 ii) Work with key stakeholders to identify priority groups for improved access to dementia care: 30.09.18 iii) Review the findings of the work on cultural variance in approach to dementia services by ethnic minorities and develop an action plan to address the priorities identified under ii) above: 30.09.18 iv) Identify the investment required and undertake a cost/benefit analysis for inclusion in the dementia business case: 30.09.18 v) Deliver the improvements that can be achieved with minimal/no investment: 31.3.20	CCC/PCC Commissioner (MH) and CPFT Clinical Lead

			vi) Implement the action plan according to the outcome of the business case: 31.3.20	
Key Objective Four: To ensure that the quality of care of people living with dementia in care homes meets the Care Quality Commission requirements and best practice.				
Objective	**How Improvement will be Measured**	**Timescale**	**Action Required**	**Lead**
4.1 To ensure that standards of care for people living with dementia in care homes across Cambridgeshire and Peterborough improve, at least achieving the minimum standards in Care Homes[67]	i) An increase in the % of care homes that are rated outstanding and good ii) A reduction in the % of care homes that a rated inadequate or requires improvement iii) All homes will achieve the minimum required to achieve the dementia care standards including: i) Appropriate prescribing. ii) Effective advance planning. iii) An increase in the percentage of people living with dementia in care homes who have the same access to NHS assessment, treatment and support as people in the general population; ultimately 100% achievement of this objective. To include: a) A reduction from 22% in the percentage of people living in care homes who have difficulty accessing mental health services.. b) An increase in the rate of referral into psychological therapies for people over 65 years. c) A reduction in the % of avoidable admissions to acute hospitals. d) Determine whether an increase in the rate of contact with secondary MH services ??	30.09.17 and 31.03.20	i) Establish a task and finish group to develop an action plan and oversee improvement. ii) Review and secure agreement to the targets proposed under 'How improvement will be measured'. iii) Agree a set of standards for dementia in care homes in Cambridgeshire and Peterborough. iv) Work with The Care Homes Support Team and care homes to support care homes to follow a programme of continuous improvement using evidence based guidance prioritising: a) Improvement of recruitment, retention and training of care home staff. b) Leadership. c) Defining the care pathway within the home, including working with NHS services – Primary Care and CPFT inc. Admiral Nurses to improve access to assessment, treatment and support, reduce avoidable use of acute hospital services, develop information sharing agreements/protocols and ensuring regular review of care plans within care homes (KLOE) d) Identify gaps in services/resources and develop business case to be part of the wider dementia business case.	CCG commissioner (OPMH) and CCC/PCC Commissioner (MH) and CPFT lead

[67] The Fundamental Standards in Care Homes, Care Quality Commission, accessed 21.12.17, https://www.cqc.org.uk/what-we-do/how-we-do-our-job/fundamental-standards

	including inpatient stays would improve outcomes/experience for people living with dementia and their carers or whether the current low rate of admission reflects a well developed community based dementia assessment and treatment service. iv) Improvement in performance against standards for end of life (see Dying Well section 3.2.5). Decrease in the use of bank and agency staff in care homes	30.09.17		

3.2.4 Living Well

The Standard

People with dementia can live normally in safe and accepting communities. "I know that those around me and looking after me are supported. I feel included as part of society."

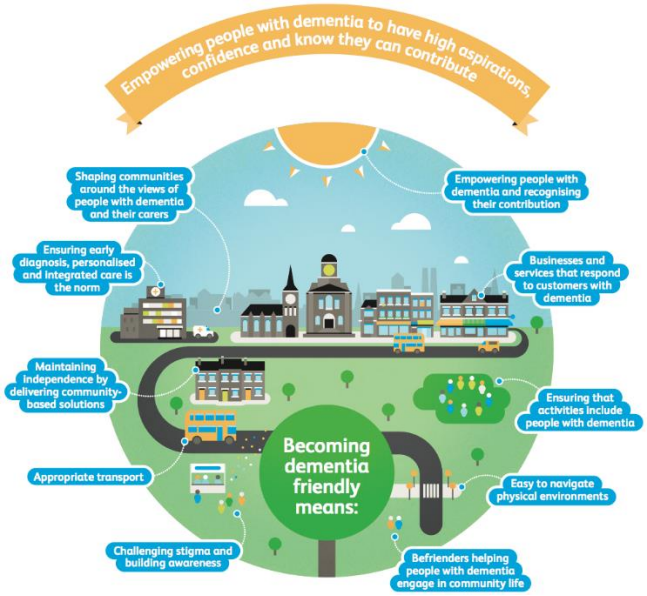
The standard includes the following parts of the Well Pathway:

- Integrated services
- Supporting carers
- Carers' respite
- Co-ordinated care
- Promote independence
- Relationships
- Leisure
- Safe communities

Best Practice and Guidelines

The guidelines relating to Living Well, are contained within Dementia: Supporting people with dementia and their carers in health and social care. Standards relating to the provision of information, advice and guidance ongoing care management, pre- and post-diagnostic counselling and support and advance care planning that relate to Supporting Well are included in the MSNAP standards because following diagnosis the Memory Assessment Service discharges those people who have no need for further assessment and treatment is required at the time, back to their GPs with advice about the support available in the community. The national guideline also includes a standard relating to inpatient dementia services. Additional good practice includes support based on the work of the Alzheimer's Society which recommends approaches to promoting awareness of dementia and building individual and community resilience to help communities and organisations become dementia friendly. Initiatives include Dementia Cafes, Dementia Friendly Communities, Dementia Champions, Dementia Environments and the development of Dementia Action Alliances to support this across communities and wider networks e.g. regional/national organisations and communities of interest. (See Figure 10 below).

Figure 10: Becoming Dementia Friendly[68]



[68] Alzheimer's Society

Local Data

Strengths:

- Dementia friendly communities
- The Dementia Resource Centre in Peterborough which provides a focus for dementia support

Gaps:

- Geographical consistency and capacity in relation to the Dementia Resource Centres (commissioned in Peterborough but not in Cambridgeshire and insufficient capacity and potential for development in Peterborough)
- Geographical consistency in relation to Dementia Friendly Communities
- Geographical consistency in relation to Dementia Friendly Environments
- Information, advice, guidance and support for carers so that they can continue caring when they wish to do so.
- Carer-reported quality of life score for people caring for someone with dementia: Cambridgeshire is slightly higher than the England average (7.7) at 7.9 and the Peterborough average score is significantly lower than the England at 6.7
- The proportion of adult carers who feel that they have as much social contact as they would like: Cambridgeshire is approximately in line with the national average of 38.6%, whilst Peterborough is significantly lower at 29.7%.
- Carer assessment and support

Key Objectives

Key Objective 1: To ensure geographical consistency in relation to Dementia Friendly Communities and Dementia Friendly Environments across Cambridgeshire and Peterborough.

Key Objective 2: To ensure that people living with dementia have access to community based support that is robust and consistent across Cambridgeshire and Peterborough

Key Objective 3: To ensure that support for carers is robust and consistent across Cambridgeshire and Peterborough

Action Plan

Key Objective 1: To ensure geographical consistency in relation to Dementia Friendly Communities and Dementia Friendly Environments across Cambridgeshire and Peterborough				
Objective	**How Improvement will be Measured**	**Timescale**	**Action Required**	**Lead**
1.1 To support the Dementia Action Alliances, Dementia Friends, Dementia Champions, Dementia Friendly Communities and those currently signed up to working towards providing Dementia Friendly Environments	Increase in no. of Dementia Friendly Communities increases across Cambridgeshire and Peterborough Increase in no. of Dementia Action Alliances across Cambridgeshire and Peterborough		i) Commissioners and the Alzheimer's Society to work with District Councils to find ways of supporting the current Dementia Friendly Communities and Dementia Action Alliances while the work to develop the care pathway is undertaken: 31.03.19: Strengthen the network of Dementia Action Alliance and Dementia Friendly Communities working with the District Councils to formalise the existing networks (this is an enabling objective that appears in the Living Well part of the Strategy; Undertake an option appraisal in order to determine the best way to provide a resource for the provision of information, advice and guidance assessing the cost/benefits of the Cambridgeshire and Peterborough Dementia Resource Centre and Wellbeing Network models.	**CCC/PCC Commissioner (MH)/CCG Commissioner (OPMH)**
1.2 Within the work to develop the dementia care pathway, to determine the potential and cost/benefit of supporting an increase in the number of Dementia Friends, Dementia Champions, Dementia Friendly Communities and	There is an increase in the no/% the adult population who are Dementia Friends across Cambridgeshire and Peterborough year on year There is an increase in the no./% people/the adult population Dementia Champions across Cambridgeshire and Peterborough year on year There is an increase in the no. of Dementia Friendly Communities across Cambridgeshire and Peterborough year on year		i) See Section 3.2. 3 Key Objective 1, (1.i) above ii) MH Commissioners support the 4 key statutory organisations across Cambridgeshire and Peterborough – CPFT, CCC, PCC, CCG – to work towards becoming Dementia Friendly: 31.03.19	**CCC/PCC Commissioner (MH)/CCG Commissioner (OPMH)**

organisations currently signed up to and working towards providing dementia friendly environments	There is an increase in the no./% organisations that are signed up to becoming and working towards Dementia Friendly Environments across Cambridgeshire and Peterborough year on year			
1.3 To work with Primary Care at scale and the emerging GP Federations to meet the basic requirements in relation to Dementia Friendly Practices Environments as outlined in the Forward View for Primary Care to include exploring how the GP with a Special Interest (GPwSI) can enhance outcomes for people living with dementia and their carers	No./% dementia friendly GP practices (KLOE) An increase in no./% dementia friendly GP practices All GP practices have achieved more than the minimum standard (locally agreed standard) for a Dementia Friendly Practice	**31.03.20**	**i)** Establish a task and finish group: 31.01.18 ii) Review national best practice to determine the minimum local requirement to qualify as a Dementia Friendly Practice: 30.04.18 iii) Undertake a gap analysis in relation to achievement of the minimum local requirement to qualify as a Dementia Friendly Practice: 30.09.18 iv) Identify the investment required and the cost/benefit of achieving the minimum local requirement to qualify as a Dementia Friendly Practice: 30.09.18 v) Build the findings of i) – iv) above into the business case for improvement in dementia outcomes: 31.10.18	**CCG Commissioner (OPMH)/CCG Clinical Lead (OPMH)**
1.4 To work with Primary Care at scale and the emerging GP Federations to build on 2.3 above to achieve more than the minimum requirement for Dementia Friendly Environments as outlined in the	All GP practices have an action plan which supports improvement in the attainment the standards required of a Dementia Friendly Practice	**31.03.21**	i) According to the outcome of 1.3 above, follow the same process	**CCG Commissioner (OPMH)/CCG Clinical Lead (OPMH)**

Forward View for Primary Care				
1.5 To ensure that Acute Trusts exceed the basic requirements for Dementia Friendly Environments	(KLOE) No./% of Acute Trusts that meet the standards for Dementia Friendly Environments (KLOE) All Acute Trusts have achieved more than the minimum standard for a Dementia Friendly environment			
Key Objective 2 To ensure that people living with dementia have access to community based support that is robust and consistent across Cambridgeshire and Peterborough **Key Objective 3: To establish a robust infrastructure of support for carers that is consistent across Cambridgeshire and Peterborough**				
Objective	**How Improvement will be Measured**	**Timescale**	**Action Required**	**Lead**
3.1 To ensure that people living with dementia have access to community based support that is robust and consistent across Cambridgeshire and Peterborough	Reduction in no./% admissions to residential and nursing home care Reduction in average LOS in residential and nursing home care Reduction in no./% avoidable admission to Acute Hospital care Reduction in average LOS in acute hospital Reduction in no./% presentations at Accident and Emergency Departments that do not lead to admission An increase in community resources - voluntary sector and communities – for people living with dementia and their carers	**31.03.21**	i) Establish a task and finish group to assess the extent to which the needs of people living with dementia are being met and to address any gaps 31.01.18 ii) Identify and determine the action needed to address the key gaps in support for, identifying any gaps, including considering developing a hub and spoke model of support e.g. extending the Dementia Resource Centre or building on the Carers' hub and spoke model. iii) Determine whether there is a need to improve housing options for people living with dementia including for people who are self-funders e.g. extra care housing, sheltered housing; initiate a review and implement recommendations as appropriate and progress/implement the findings. . iv) Determine whether there is a need to improve housing options for people living with dementia including for people who are self-funders e.g. extra care housing,	**CCG Commissioner (OPMH)/CCC/PCC Commissioner (MH)/ Director of Integration (CPFT)**

	An increase in the no. and % of carers of people with dementia receiving services advice or information An increase in awareness and use of community/voluntary sector resources by people living with dementia who self-fund support An increase in capacity and use of independent living and supported accommodation for people living with dementia e.g. sheltered housing, extra care housing An increase in the use of assistive technology		sheltered housing; initiate a review and implement recommendations as appropriate and progress/implement the findings. . v) Initiate an action plan arising from ii) above as necessary. vi) Determine the investment needed and the cost/benefit of addressing the identified gaps. vii) Include unmet needs in the business case for dementia (See 3.2.3 (1.i) above: 31.12.18.	
3.2 To ensure that the gaps in support for carers are being addressed: Carers and family members have access to the following: **i) Individual/group psychoeducation** **ii) Peer support groups tailored to the needs of the person they are caring for i.e. stage of dementia** **iii) Support, information, advice and guidance by telephone and through the internet** **iv) Support, information advice**	Reduction in length of stay of people with dementia in residential and nursing home care Reduction in no./% avoidable admissions* and length of stay of people with dementia to Acute Hospital care Reduction in no./% presentations* and length of stay of people with dementia at Accident and Emergency Departments that do not lead to admission An increase in the no. and % of carers of people with dementia receiving services advice or information An increase in the no. and % of carers or people with dementia accessing and receiving psychological therapies	**31.03.21**	i) Establish a task and finish group 31.01.18 ii) Through the task and finish group, develop and begin to deliver a prioritised work plan that will improve outcomes for carers of people living with dementia are being met including identification of key gaps and the actions and develop a business case (see 3.2.3 (1.i)) above if necessary to address any gaps (aimed at delivering improvement in 3.2.i – vii: 30.09.18 (Training for carers will be one of the priorities). To include learning from work to improve outcomes for carers of people with other needs e.g. cancer and developing more effective processes for gathering and responding to feedback of care from local carers. iii) Agree how carer experience and outcomes will be monitored/measured e.g. as part of the care pathway/personalised	**CCG Commissioner (OPMH)/CCC/PCC Commissioner (MH)/ Director of Integration (CPFT)**

and guidance pre- and post diagnosis **v) Training about dementia, services and benefits, communications and problem solving in the care of people with dementia** **vi) Psychological therapy including cognitive behavioural therapy to address psychological distress** **vii) Carers have access to support and activities:** **i) With the person they care for** **ii) Without the person they care for** **viii) Improve processes for receiving and addressing feedback (positive and negative) from carers**.	Any carer who is suddenly no longer able to care is offered an 72 hours support Friends and Families Tests: NHS Trusts Carer surveys/feedback: PCC and CCC % CCG funding used to support carers (KLOE) An increase in % CCG funding used to support carers		care planning and support development build seeking and recording carer feedback into the pathway.	
3.3 To improve access to appropriate options for respite care, including transport, short breaks accompanied by access to meaningful activity	An increase in the no. and % of carers of people with dementia being supported to continue caring with an appropriate offer of respite care Eligible carers are able to access respite care that responds to their individual needs/wishes in respect of breaks from caring:		i) Establish a task and finish group: 31.01.18 ii) Review current provision against carers' needs: 30.06.17 iii) Include proposals for improved access to respite care in the business case developed under 3.2.3 (1.i) above.	**CCG Commissioner (OPMH)/CCC/PCC Commissioner (MH)/ Director of Integration (CPFT)**

for the individual living with dementia	i) Transport ii) Short breaks People living with dementia have access to meaningful activities during a short break			
3.4 To support carers following the death of the individual they cared for	Following the death of the person they cared for carers have access to: i) Peer support groups ii) Support from voluntary sector ii) Psychological therapy iii) Bereavement services		i) Establish a task and finish group: 31.01.18 ii) Review current provision against carers' needs: 30.06.17 iii) Include proposals for improved access to respite care in the business case developed under 3.2.3 (1.i) above.	**CCG Commissioner (OPMH)/CCC/PCC Commissioner (MH)/ Director of Integration (CPFT)**

3.2.5 Dying Well

The Standard

People living with dementia die with dignity in the place of their choosing. "I am confident my end of life wishes will be respected. I can expect a good death."

Overview

NICE guidance includes advice on adopting a palliative approach to dementia care and ensuring that people with dementia have equal access to palliative care services.

Palliative care is for people living with a terminal illness where a cure is no longer possible. It is for people diagnosed with any terminal condition or for people who have a complex illness and need their symptoms controlled. Palliative care aims to treat or manage pain and other physical symptoms. It will also help with any psychological, social or spiritual needs. Treatment will involve medicines, therapies, and any other support that specialist teams believe will help their patients. It includes caring for people who are nearing the end of life.

End of life care is an important part of palliative care for people who are nearing the end of life. End of life care is for people who are considered to be in the last year of life and aims to help people live as well as possible and to die with dignity. It also refers to treatment during this time and can include additional support, such as help with legal matters. The aim is to help everyone affected by the diagnosis achieve the best quality of life. A person with dementia might receive palliative care alongside particular treatments, therapies and medicines, such as chemotherapy or radiotherapy.

Providing optimal palliative care to patients with dementia requires excellent co-ordination and communication across the whole system: between primary and secondary care; between secondary care organisations; between health and social care; and, between these and the voluntary care and third sectors. It is key to have systems in place to facilitate communication and a cultural environment whereby all professionals involved in the care of people with dementia and their families have the knowledge appropriate to their role to promote and provide good quality palliative care (including end of life care).

Provision of best care in the last months, weeks and days of life can be guided by knowledge of individuals' wishes and preferences. Opportunities to explore and communicate wishes and support future care plans should be taken at all stages from diagnosis forward. More formal processes such as advance decisions/refusals and Powers of Attorney for health, welfare and finances should be flagged up early, with advice given where necessary on how to produce and register these, so that they can be successfully enacted at the appropriate time. Closer links between specialist and non-specialists in end of

life and dementia care across disciplines should be fostered to promote and share best practice.

Stakeholders identified the following strengths:

- The percentage of people over 65 with dementia dying in hospital is comparatively low compared to the England average (25% v 30% England average (Figures 10 & 21))
- The percentage of people over 65 with dementia dying in their usual place of residence is higher than the England average (74% v 69% England average (Figures 10 & 21))
- The percentage of people over 65 with dementia dying in a care home is higher than the England average (63% v 59% England average (Figures 10 & 21))
- A local audit found that the standard of end of life care was very high in Addenbrookes Hospital (evidence was not collated for other local hospitals)

The following gaps were identified:

- Advanced care planning for those dying with dementia is minimal. (A local audit demonstrated that only 11% of those dying with dementia had any form of advanced care planning)
- Preferred place of death is not recorded frequently for end of life. However, dying in preferred place was found not to be a top priority (in a population based study only 34% ranked 'dying in preferred place' as their top care-related priority and this can often change as end of life is approached)
- End of life care training relevant to people with dementia is not consistent across the patch

Improving end of life care has been identified as a key priority by Cambridgeshire and Peterborough STP. The National End of Life Intelligence network (NEnd of lifeIN) profiles indicate that in Cambridgeshire and Peterborough approximately 6,700 die each year. The total number of deaths has remained fairly constant from 2014/15 until present day with a small decrease in 2015/16.

In Cambridgeshire and Peterborough in 2015/16 26.7% of people died in [69]their own homes. This percentage is the highest compared to other most similar CCGs and is significantly higher than the national average. However, 41.9% of people die in hospital, 5.9% in a hospice and 23% in a care home[70].

In comparison, in Cambridgeshire and Peterborough in 2015, of over 65s with Dementia dying, 10.8% died in [71]their own homes, higher than the national average (8.9%). However, 24.8% of people died in hospital and 62.9% in a care home (Figures 10 & 21).

[70] British Social Attitudes Survey: http://bsa-30.natcen.ac.uk/media/36320/bsa_30_dying.pdf

The percentage dying in hospital is lower than the England wide percentage (30%) but shows that there are a large number of admissions at the end of life for people with dementia. A number of these admissions may have been avoidable with high quality future care planning and provision of support and expertise in end of life care in the community.

Population-based studies of preferences for place of death indicate that over 60% of people in general (including those who were not facing life-threatening illness at the time) would prefer to die at home. Whilst this has been an important driver for improving end of life care at home, the 'place of death' is not necessarily the highest priority for everybody. In a population-based study involving just under 10,000 adults across England, only 34% ranked 'dying in preferred place' as their top care-related priority: the rest were split fairly evenly between the other two options of 'having as much information' as they wanted and 'choosing who makes decisions' about their care.

In the 2012 British Social Attitudes survey, 60% of those who stated that they would prefer to die at home would change their mind if sufficient support from family, friends or social and medical professionals were not available. The need to be pain free (24%) came a close second to the presence of family and friends (28%), in terms of the most important aspects of their end of life care. The general conclusion, is that we do not know the proportion of UK patients that would prefer to die at home. What we do know is that, from surveys of the general public, given the opportunity and the right support, most people would prefer to die at home (Hoare et al, 2015). We also know that preferences can often change as a person approaches end of life.

Best Practice and Guidelines

The needs of people with dementia at the end of life are comparable to those of people with cancer with physical, social, financial and spiritual support required: a major difference is that the palliative phase of dementia may go on for several years. Many people with dementia however do not get the end of life care that they need, with pain, in particular, undertreated near the end of life.

In 2009, the Department of Health set out a national dementia strategy. The end of life objective in the strategy was simply "Improve end of life care for people with dementia". This should result in two outcomes:

- People with dementia and their carers will be involved in planning end of life care
- Services will consider people with dementia when planning local end of life services.

NICE guidelines on supporting people with dementia and their carers explicitly recommend that:

'Dementia care should incorporate a palliative care approach from the time of diagnosis until death. The aim should be to support the quality of life of people with dementia and to enable them to die with dignity and in the place of their choosing, while also supporting carers during their bereavement, which may both anticipate and follow death.

Specifically NICE guidance includes:

- Adopting a palliative approach to dementia care

- Ensuring that people with dementia have equal access to palliative care services
- Good communication between teams when a person with dementia is nearing the end of life
- Encouraging people with dementia to eat and drink by mouth for as long as possible
- Individual assessment of the need for antibiotics at the end of life for a person with dementia with a fever
- Care facility policies to reflect the unlikely success of CPR in patients with advanced dementia
- Resuscitation decisions to take place in accordance with the Mental Capacity Act taking into account an individual's stated wishes and preferences where available.

In 2014 a white paper, defining optimal palliative care for older people with dementia, identified 11 domains in which 57 recommendations were made. The eleven domains include:

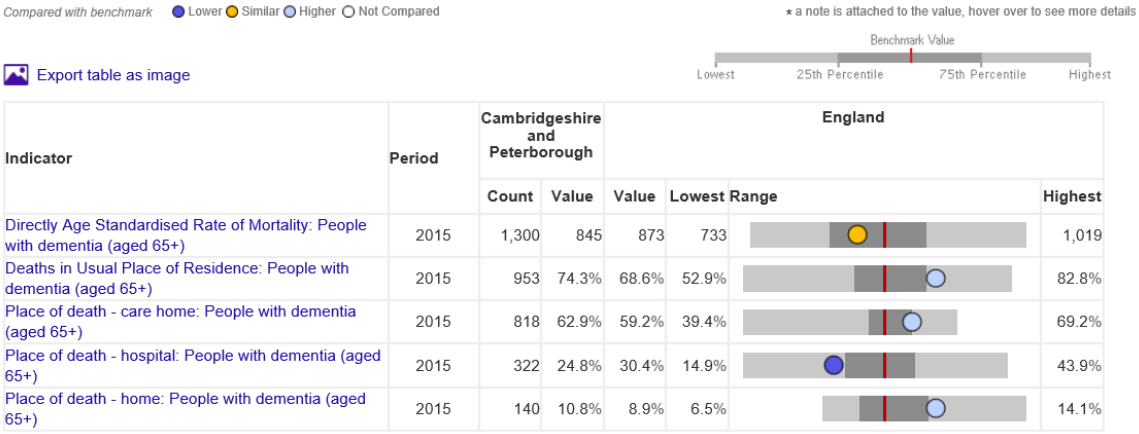
- Applicability of palliative care – dementia can be regarded as a terminal condition
- Person-centred care, communication and decision making – decision making should stem from the patient's perspectives
- Setting care goals and advance planning – makes planning proactive
- Continuity of care – there should be no interruptions even with transfer
- Prognostication and timely recognition of dying – advanced care planning principles
- Avoiding overly aggressive, burdensome or futile treatment – treatment should take into account care goals and the stage of dementia
- Optimal treatment of symptoms and providing comfort – a holistic approach to treatment of symptoms is paramount
- Psychosocial and spiritual support – includes emotional support, spiritual support and ensuring a comfortable environment
- Family care and involvement – families may need support throughout the trajectory
- Education of the healthcare team – education is required for the whole healthcare team in applying a palliative care approach
- Societal and ethical issues – patients and their carers should have equitable access to palliative care and support as for other terminal diseases

The two domains that received the highest endorsement during a Delphi process were 'person centred care, communication and shared decision making' and 'optimal treatment of symptoms and providing comfort'. Advance care planning, continuity of care, education of the healthcare team and continuity of care were also identified as priority areas.

Local Data

Cambridgeshire and Peterborough generally performs well in terms of the place of death for people with dementia. It has higher than average proportion of people dying in their usual place of residence, at home and in care homes, and a lower than average proportion of people dying in hospital. (See Figure 11 below).

Figure 11: Spine Chart Showing Performance of the Cambridgeshire and Peterborough STP Area against the England Average for a Range of 'Dying Well' dementia indicators, 2015[72]



Indicator	Period	Cambridgeshire and Peterborough		England			
		Count	Value	Value	Lowest	Range	Highest
Directly Age Standardised Rate of Mortality: People with dementia (aged 65+)	2015	1,300	845	873	733		1,019
Deaths in Usual Place of Residence: People with dementia (aged 65+)	2015	953	74.3%	68.6%	52.9%		82.8%
Place of death - care home: People with dementia (aged 65+)	2015	818	62.9%	59.2%	39.4%		69.2%
Place of death - hospital: People with dementia (aged 65+)	2015	322	24.8%	30.4%	14.9%		43.9%
Place of death - home: People with dementia (aged 65+)	2015	140	10.8%	8.9%	6.5%		14.1%

A recent local audit of end of life care for people with dementia dying at the local Cambridge acute hospital, Addenbrookes Hospital, based on the relevant white paper recommendations found that of the 40 patients dying between June and December 2015, the standard of end of life care was very high when approaching death had been recognised. However, for only 11% of the patients was there any documentation of advance care planning including preference for place of care. (Three patients had advance care planning, one had Lasting Power of Attorney arrangements in place.) Few patients had documentation in their community records regarding resuscitation discussions/decisions and none of the case notes evidenced discussion about alternative plans to hospital admission on presentation to A&E.

A further analysis was made of those patients known to the local Community Services and Mental Health Provider, Cambridgeshire & Peterborough Foundation Trust (CPFT) (24/40). Only 21% of these had any documented discussion about advance care planning, which was all related to lasting powers of attorney for finance. Another study analysed the clinical notes of a cohort of 20 patients admitted to Denbigh (specialist dementia) ward in CPFT in 2016. Of the 20 admissions, only seven had documented discussions related to future care planning. (One patient had discussed advance care planning, six had discussed Lasting Powers of Attorney.) This was despite 5 of the 20 patients being within one year of death and two dying within weeks of the admission. This suggests that the key issue is whether discussions take place at all on End of Life planning rather than if the plans are communicated. Having end of life conversations is difficult. Conversations need to be held early on in dementia before cognitive powers decline. However, those with early dementia may not wish to hold such conversations. Creating the opportunity to discuss advance care planning at the right time is key.

[72] PHE Dementia Profile

Training

Training in end of life care for people with dementia is active in the region, but is neither co-ordinated nor consistent. Staff have varying degrees of awareness of approaching end of life. Currently, non-specialists in dementia care receive little training in end of life care. End of life dementia training is being delivered in the Community Trust by a team comprising liaison psychiatry and palliative care based in Cambridge. There are also pockets of training taking place across the system by different organisations. High quality dementia training is currently being delivered by CAMTED-OP and an end of life facilitator in the Peterborough area who deliver a one day course in end of life care in dementia available to CPFT staff; this is run on a small scale with very little funding. A review of education and training programmes across the system would identify any duplication and gaps. There may be areas of duplication but more likely there are large gaps in access to focused training.

The 2017 dementia business case, that is currently being implemented, aims to increase provision of training on dementia awareness, including training on end of life planning for people with dementia. Through the implementation of the business case, the aim is that more staff will be trained to provide improved care and support for people with dementia and their carers in preparation for end of life.

Key Objectives

Key Objective 1: To improve the quality of care and support and outcomes at end of life for people living with dementia and their carers

- To improve care of people with dementia and their families toward the end of life across care settings, thereby reducing futile interventions and avoiding non-essential hospital admissions
- To improve quality of life at the end of life stage for people with dementia and their carers by being more likely to die in their place of choice.
- To enhance links between palliative care and dementia care.
- To ensure that people with dementia have a personal care and support plan.
- To ensure that patients and their families have been fully involved in the development of the plan, the decisions and have their choices recorded.
- To ensure that all people in CPFT dementia units and/or their families have had a DNAR conversation and that the decision is recorded in their plan.
- To ensure that care plans for people with dementia contain end of life planning with preferred place of care, including alternative plans to hospital admission where appropriate.
- To ensure access by all relevant professionals to personal care and support plans.
- To avoid unnecessary admissions for people with dementia towards the end of life.
- To provide education, training and support for care and health professionals to increase their general skill base for supporting people with dementia in planning for end of life care.
- To strengthen the interface with voluntary sector organisations, primary care, acute trusts and social care organisations.
- To increase the end of life training given to care homes.

Action Plan

Key Objective 1: To improve the quality of care and support and outcomes at end of life for people living with dementia and their carers				
Improvement Required	**How Improvement will be Measured**	**Action Required**	**Timescale**	**Lead**
1.1 Improve care and quality of life of people with dementia and their families at end of life	% with personal care and support plans % Care plans that include Advanced life (end of life) care plans % that have reviews of their care plans conducted on increasing frequency plan according to trigger points being reached	i) Ensure links with C&P END OF LIFE Strategy work Embed future care planning including end of life care planning in routine practice in all settings ii) Train and empower professionals/ carers/ individuals to have conversations about end of life and dying well: Conversations about dying should be able to happen at any stage, in particular, at the early stages by all sector professionals and encourage people to think about advance care plans (consider specifically END OF LIFE dementia support worker) Health care professionals will offer discussion about future care preferences (including end of life care wishes) as a routine part of dementia post diagnostic support iii) Proactive review of future care plans throughout the care pathway both routinely and at trigger points e.g. re referral into services, hospital admission, at times of crisis or when deteriorating functional status is recognised. iv) Trigger points for review need to be identified v) Promotion of advance care planning and legal processes e.g. Power of Attorney across the system; deliver a local awareness and promotion campaign on planning for the future, working alongside local charities e.g. Age UK, Alzheimer's society, Dying Matters	**31.03.20**	**CCG Commissioner (OPMH)/CPFT Lead**

Key Objective 1: To improve the quality of care and support and outcomes at end of life for people living with dementia and their carers				
Improvement Required	**How Improvement will be Measured**	**Action Required**	**Timescale**	**Lead**
1.2 Improve care planning for end of life	Care plans contain preferred place of dying Treatment options and future care decisions plan to include CPR status, culturally sensitive information, spiritual information Powers of Attorney in place Carer what-if plans in place and carer information included	i) Develop core contents of personal care and support plan to include: Preferred place of dying DNAR information Culturally sensitive information Spiritual information and/or requests powers of attorney Carer information	**31.03.19**	**CCG Commissioner (OPMH)/CPFT Lead**
1.3 Ensure that end of life care plans are accessible to those who need to understand them	Health and care professionals' access to treatment options and future care decisions plan	i) Electronic and paper systems to capture future care preferences and plans so they can be shared widely across the system and acted on when appropriate (END OF LIFE Dashboard already in existence). This will be especially important when patients are acutely deteriorating and acute hospital admission may be considered ii) Consider how the plans can be integrated so that they follow patients through the system	**31.03.19**	**CCG Commissioner (OPMH)/CPFT Lead**
1.4 Ensure that those involved in caring for people with dementia and their carers at end of life are appropriately educated and trained.	% of care professionals trained to provide improved care and support for people with dementia and their carers towards the end of life Estimate of avoided admissions at end of life through various measures % of people with dementia dying in their usual place of residence compared to national statistics	i) Upskill care professionals across the disciplines to support and provide end of life care to patients and their families, working alongside specialist colleagues where needed (part of dementia business case being implemented in 2017/18) ii) Care home staff are being trained in END OF LIFE as part of the Care Home Support Team's remit Potential extension or consolidation of the DIST team to support care of advanced dementia including end of life care. iii) Train staff to support these developments, working closely with colleagues in elderly care	**31.03.19**	**CCG Commissioner (OPMH)/CPFT Lead**

Key Objective 1: To improve the quality of care and support and outcomes at end of life for people living with dementia and their carers				
Improvement Required	**How Improvement will be Measured**	**Action Required**	**Timescale**	**Lead**
		and palliative care and local promotion of future care planning.		
1.5 Deliver additional improvements in end of life care and quality of life of people with dementia and their families	Carer/service user feedback % of deaths who are on END OF LIFE register % offered to go on GP palliative care register % that have reviews of medication conducted on increasing frequency plan according to trigger points being reached	i) Review feedback and use to improve end of life care ii) Ensure patients are placed on END OF LIFE register iii) Ensure patients are placed on Palliative care register where appropriate iv) Encourage pharmacists to be pro-active in discussing medication changes that could be needed with prescribers	**31.03.20**	**CCG Commissioner (OPMH)/CPFT Lead**

3.2.6 Early Onset Dementia[73]

The Standard

Diagnosis, access, assessment, treatment and support should be consistent for people of all ages living with dementia and their carers. (Locally agreed standard)

Local Context

Specialist assessment, treatment and support for people with early onset dementia was identified as the biggest single gap in dementia care across Cambridgeshire and Peterborough.

Key Objectives

Key Objective 1: To ensure that people living with early onset dementia and their carers have access to robust assessment, treatment and support. Also See Appendix 1

[73] Early Onset Dementia Needs Assessment: Cambridgeshire and Peterborough, October 2017

Action Plan

Key Objective 1: To ensure that people living with early onset dementia and their carers have access to robust assessment, treatment and support.				
Improvement Required	**How Improvement will be Measured**	**Action Required**	**Timescale**	**Lead**
1.1 Establish a Task and Finish group to deliver the recommendations made in the Early Onset Dementia Needs Assessment.	A Task and Finish Group established. Recommendations that can be achieved within existing resources delivered. A service specification developed. A business case produced. Improved experience and outcomes for people living with early onset dementia and their carers.	i) Confirm that leadership should come from adult mental health services. ii) Finalise and implement the action plan including: a) Update CPFT's webpage with an accurate description of support currently available. b) Establish consistent recording within health and social care services to ensure accurate estimates of service burden are obtained. iii) Develop a service specification and business case.	**31.03.18** **31.03.19** **30.09.18**	CPFT Clinical Lead/ CCG Commissioner MH/CCC/PCC Commissioner (MH)

3.2.7 Researching Well

Local Context

The following strengths in relation to Researching Well were identified:

- CPFT has a very active programme of clinical trials which allows patients to access the latest potential treatments for dementia if they wish.
- There is a strong research base across the health and social care community in Cambridgeshire and Peterborough. This includes a strong research base for dementia.

Key Objectives

Key Objective 1: To ensure that every patient with a diagnosis of dementia is given the opportunity to participate in dementia research[74]**.**
Key Objective 2: To evaluate the impact of the Dementia Strategic Plan.

[74] This is an objective of the National Institute for Health Research Join Dementia Research programme of which CPFT is a member organisation https://www.joindementiaresearch.nihr.ac.uk/

Action Plan

Objective 1: To ensure that every patient with a diagnosis of dementia is given the opportunity to participate in dementia research.				
Objective	**How Improvement will be Measured**	**Action Required**	**Timescale**	**Lead**
1.1 Include the opportunity to participate in dementia research for all those given a diagnosis of dementia in the care planning process.	No./% patients signed up to 'Join Dementia Research No./% patients taking part in CRN funded research projects No. active CRN funded projects Improved experience and outcomes for people living with dementia and their carers (see Section 5 below)	i) Incorporate in the dementia pathway/Memory Service operational policy.	31.03.19	CPFT Clinical Lead (OPMH)/CCG Commissioner (OPMH)/CCC/PCC Commissioner (MH)
Objective 2: To evaluate the impact of the Dementia Strategic Plan				
2.1 Identify options for evaluation of the impact of the Strategic Plan.	The impact of the Strategic Plan is evaluated/quantified.	i) Consider options for evaluating the impact of the Strategic Plan including the possibility of undertaking a longitudinal study of dementia in Cambridgeshire and Peterborough. ii) Progress the preferred option/s.	31.03.19	CPFT Clinical Lead (OPMH)/CCG Commissioner (OPMH)/CCC/PCC Commissioner (MH)

3.2.8 Integrating Well

Local Context

Ensuring that care is co-ordinated with physical and mental health and social care needs assessed and addressed in a seamless way and that statutory and voluntary sector services across community, primary and secondary health and social care staff work together within a clearly defined care pathway was identified as the biggest opportunity for improvement arising from the gap analysis. The objective is to ensure that people living with dementia are supported to live at home for as long as possible. Delivery requires that a detailed multi-agency pathway (process map) from pre-diagnosis to end of life is agreed for adults of all ages for each of Cambridgeshire and Peterborough with the core processes the same but reflecting local differences in infrastructure.

The opportunity afforded by the development of the integrated care pathway includes improvement to both outcomes and cost effectiveness. A gap analysis will be completed and plans to address the gaps will be developed. The gap analysis will include an assessment of the need/potential to shift investment to the front end of the pathway i.e. to community based services. The estimated changes in numbers of people living with dementia will be included, with a 3 to 10 year projection of the impact of any likely changes in demand being factored in. Proposals to achieve this objective will be developed and agreed jointly by commissioners and providers through the process of developing care pathways. It is therefore essential that representatives from specialist mental health services and community services are involved – across health and social care. This includes involving frontline staff.

Key Objectives

Key Objective 1: To ensure that care is seamless, addressing physical and mental health and social care needs in an holistic and cost effective way.

Action Plan

Key Objective 1: To ensure that care is seamless, addressing physical and mental health and social care needs in an holistic and cost effective way				
Objective	**How Improvement will be Measured**	**Timescale**	**Action Required**	**Lead**
1. To ensure that health and social care staff work effectively together and with the voluntary sector and community to identify and meet the physical and mental health and social care needs of people living with dementia and their carers.	Dementia care pathways/services are informed by/compliant with the evidence base for dementia Improved system-wide performance in dementia care, experience and outcomes (see Section 5 below) Improved experience and outcomes for people living with dementia and their carers (see Section 5 below) Clearly defined multi-agency care pathways agreed and in place .	31.03.19	i) Define project scope and agree desired outcomes ii) Agree timeline and initiate work programme iii) Plan and set up workshops to include people living with dementia and their carers iv) Hold workshops to review and develop pathway v) Agree action plans and implement required changes in a planned way where possible vi) Develop business case vii) Secure STP sign off viii) Ensure that the local dementia network is linked to and supported by the regional/national clinical network (KLOE) See also Section 3.2.5 above.	**CCG Commissioner (OPMH)/CCC/PCC Commissioner (MH)/OPMH Clinical Lead (OPMH**
2. Deliver the agreed improvements to multi-professional/agency working	Improved system-wide performance in dementia care, experience and outcomes (see Section 5 below) Improved experience and outcomes for people living with dementia and their carers (see Section 5 below)	01.04.19 – 31.03.22	**i)** Initiate implementation of work programme ii) Embed the roles of community pharmacists and opticians in the pathway iii) Monitor and review progress	**CCG Commissioner (OPMH)/CCC/PCC Commissioner (MH)/OPMH Clinical Lead (OPMH)**
3. Develop standard information sharing practices between primary and secondary care, particularly around diagnosis (KLOE)	Data can be shared to the extent that effective multi-disciplinary/agency working is not severely impacted Information sharing protocols between primary and secondary care are in place (particularly around diagnosis) KLOE	31.03.20	i) Develop multi-agency information sharing agreements/protocols for dementia based on system-wide agreements ii) Embed the information sharing agreement/protocol for dementia in the newly developed care pathways	

	Information sharing protocols between statutory and non-statutory organisations are in place (particularly around diagnosis) Information sharing protocols with carers are in place		iii) Ensure that practices review their registers using other measures as specified within KLOE.	

3.2.9 Commissioning Well

Local Context

Effective health and social care commissioning and leadership in dementia care was identified as a gap in dementia care.

Key Objectives

Key Objective 1: To improve the commissioning and leadership for health and social care commissioning.

Action Plan

Key Objective 1: To improve the commissioning and leadership for health and social care commissioning.				
Objective	**How Improvement will be Measured**	**Timescale**	**Action Required**	**Lead**
1.1 To establish effective arrangements established for aligned (joint) health and social care commissioning of dementia care	Leads for commissioning of dementia care identified in CCG and CCC and PCC. CCG, CCC and PCC dementia leads involved in and attending the OPMH Delivery Board regularly. CCG, CCC and PCC dementia leads appropriately leading/involved in decision making within the OPMH Delivery Board. Clear leadership re: distribution of resources across the pathway and improvements made. Improved system-wide performance in dementia care, experience and outcomes (see Section 4 below) Improved experience and outcomes for people living with dementia and their carers (see Section 4 below)	**31.03.18**	i) Confirm lead for OPMH commissioning in CCG and PCC/CCC ii) Establish Joint Commissioning Group (OPMH) agreeing Terms of Reference, including aims, objectives for joint/aligned commissioning, governance arrangements, membership etc. iii) Embed the commissioning activities arising from the Strategic Plan within the work plan for the Group	**CCG Director for Integration/ PCC/CCC Assistant Director (Commissioning)**
1.2 Build on the current strong partnerships to ensure a collaborative approach with stakeholders through the OPMH Delivery Board and the Ageing Well Strategy Group in the delivery of the Strategic Plan.	Agencies – statutory and voluntary and independent sector - across the dementia pathway – physical and mental health and social care are and/or have been actively involved in the delivery of the Strategic Plan. People living with dementia, their carers and members of communities are and/or have been actively involved in the delivery of the Strategic Plan.	31.03.19	i) Ensure commissioning leadership for delivery of the Strategic Plan and OPMH Delivery Board.	**CCG Director for Integration/ PCC/CCC Assistant Director (Commissioning)**

	Improved system-wide performance in dementia care, experience and outcomes (see Section 4 below) Improved experience and outcomes for people living with dementia and their carers (see Section 4 below)			
Key Objective 2: To ensure that best use of resources is made.				
2.1 Identify and review health and social care investment in dementia care.	Improved system-wide performance in dementia care, experience and outcomes (see Section 4 below) Improved experience and outcomes for people living with dementia and their carers (see Section 4 below). Improved cost effectiveness/use of resources	31.03.19	i) Refine current understanding of health and social care investment in dementia care including investment in: a) Voluntary sector. b) Specialist mental health services (CPFT). c) Acute hospitals. d) Residential and nursing home care. .(31.05.18) ii) Support, monitor and pull together the findings from the dementia workstreams to support recommendations for overall improvement in outcomes, experience and cost effectiveness. (30.09.18) iii) Develop a business case based on ii) above. (31.12.18)	**CCG Commissioner (OPMH)/CCC/PCC Commissioner (MH)/OPMH Clinical Lead (OPMH)**
Key Objective 3: To ensure that services are effectively commissioned.				
3.1	Improved system-wide performance in dementia care, experience and outcomes (see Section 4 below) Improved experience and outcomes for people living with dementia and their carers (see Section 4 below). Improved cost effectiveness/use of resources	31.03.19	i) In partnership with providers, undertake a joint (health and social care) review of current service specifications: a) Voluntary sector. b) Specialist mental health services (CPFT). c) Acute hospitals. d) Residential and nursing home care. Taking into account the findings from the dementia workstreams. (31.12.18) ii) Respecify the above services. (31.12.18)	**CCG Commissioner (OPMH)/CCC/PCC Commissioner (MH)/OPMH Clinical Lead (OPMH)**

3.2.10 Training Well

Local Context

A gap in training in cross-agency/pathway working was identified. This is primarily because of the lack of an integrated care pathway in the first place.

Key Objectives

Key Objective 1: To ensure that staff across the Cambridgeshire and Peterborough health and social care system inform the development of and are trained in the operation of the integrated dementia pathway.

When the integrated care pathway has been agreed, implementation must include training of staff in working across agencies to ensure that people living with dementia and their carers are diagnose early and provided with assessment and treatment early in the course of their illness and on an ongoing basis as the disease progresses. This requirement will be included in the business case. A first step is to ensure that staff at the frontline are involved in the development of the integrated care pathway.

Action Plan

Key Objective 1: To ensure that staff across the Cambridgeshire and Peterborough health and social care system inform the development of and are trained in the operation of the integrated dementia pathway.				
Objective	**How Improvement will be Measured**	**Timescale**	**Action Required**	**Lead**
1. To provide training for staff to support implementation of the integrated care pathway.	Frontline staff across the health and social care system have been involved in the development of the integrated dementia pathway. Frontline staff across the health and social care system have been involved in the ongoing development and review of the integrated dementia pathway Improved system-wide performance in dementia care, experience and outcomes (see Section 5 below) Improved experience and outcomes for people living with dementia and their carers (see Section 5 below)	31.03.19 and 31.03.122	i) Involve frontline staff in the development of the integrated care pathway. ii) Involve frontline staff in the identification of training needs to support implementation of the integrated care pathway iii) Involve frontline staff in the ongoing development of the integrated care pathway.	**CCG Commissioner (OPMH)/CCC/PCC Commissioner (MH)/OPMH**

Further develop the knowledge and expertise of staff in both the physical and mental health aspects of dementia care, delivery of a fully integrated multi-agency/multi-disciplinary approach and the range of services and support available for people diagnosed with dementia and their carers. This will be underpinned by the improvements identified through the work on Local Priority 1.

3.2.11 Monitoring Well

Local Context

Gaps were identified in the following areas:

- Detailed understanding of activity relating to dementia in acute hospitals e.g. where dementia is not the main reason (primary diagnosis) for admission.
- Detailed monitoring of activity, finance and outcomes relating to dementia within and across statutory services – health and social care
- Agreement to work towards the MSNAP and to adoption of the related quality indicators (Appendix xx).

Key Objectives

Key Objective 1: To improve understanding of the activity, performance and outcomes for people living with dementia and their carers.

Key Objective 2: To develop a set of indicators of quality that include experience of services and support and outcomes for people living with dementia and their carers related to dementia across the Cambridgeshire and Peterborough health and social care system.

Action Plan

Key Objective 1: To improve understanding of the activity, performance and outcomes for people living with dementia and their carers.				
Objective	**How Improvement will be Measured**	**Action Required**	**Timescale**	**Lead Organization/ Individual**
1.1 Agree and monitor a set of indicators/outcomes that monitor what is important to people living with dementia and their carers and integrate these with 1.2 below.	A set of indicators identified by people living with dementia and their carers. Improved experience and outcomes for people living with dementia and their carers	i) Specify this as an outcome from the process of development of the a dementia care pathway	31.12.18	CCG Commissioner (OPMH)/CCG Clinical Lead (OPMH)/CCC/PCC Commissioner (MH),
1.2 Develop a system wide set of performance indicators for dementia base on the MSNAP standards and that meet the requirements for reporting of the NHS and Councils.	A system-wide data set that supports monitoring of achievement of the MSNAP standards and meets the national for dementia is in place and being monitored Improved system-wide performance in dementia care, experience and outcomes Improved experience and outcomes for people living with dementia and their carers (see Section 1.1. above)	i) Set up a task and finish group to develop and implement a set of high level performance indicators with the SDU ii) Monitor and report on performance against the agreed indicators to key Boards and organisations iii) Refine/develop the data set	31.12.18	CPFT Clinical Lead/ CCG Commissioner (OPMH)/CCC/PCC Commissioner (MH),
1.3 Work with the acute hospital trusts in Cambridgeshire and Peterborough to increase understanding of acute hospital utilisation by people with dementia including improve identification and recording of people with a primary and secondary diagnosis of dementia.	Validity of reporting of primary and secondary diagnoses of dementia reflects activity More appropriate use of Acute Hospital care by people with dementia More appropriate use of Specialist Mental Health/Dementia care by people with dementia	i) Assess the validity of current reporting of primary/secondary diagnoses in Acute Hospital settings ii) Address the gaps/make the necessary improvements iii)Monitor and report on performance against the agreed indicators to key Boards and organisations iv) Refine/develop the data set	31.12.18	CCG Commissioner (OPMH)/Acute Hospital Dementia Lead/s

Key Objective 2: To develop a set of indicators of quality that include experience of services and support and outcomes for people living with dementia and their carers related to dementia across the Cambridgeshire and Peterborough health and social care system.				
2.1 Review the core health and social care data set identified within the Strategic Plan to develop a prioritised set of indicators that supports effective monitoring of the delivery and outcomes of dementia care.	A set of indicators agreed by commissioners, practitioners, people living with dementia and their carers that monitor what is important to service users and carers as well as what is required for local and national monitoring. Routine monitoring of the agreed data set in place with processes to address exceptions in place	i) Set up a task and finish group (will also include monitoring financial performance). ii) Review the proposed data set and agree data collection/monitoring processes. iii) Monitor performance and outcomes and address exceptions. iv) Identify key issues to inform the business case. v) Support the other Task and Finish Groups as they progress their plans and develop business cases.	31.12.18	CCG Commissioner (OPMH)/CCG Clinical Lead (OPMH)/CCC/PCC Commissioner (MH),

4 Performance and Outcomes and Impact of the Strategic Plan and Risk Assessment

In this section, the intended impact and benefits arising from implementation of the action plans and the outcome of the Council and CCG Equality Impact Assessments are summarised. The risks to delivery of the Strategic Plan are also summarised.

4.1 Outcomes and Performance

The Strategic Plan aims to deliver the following improvements to experience and outcomes for people living with dementia and their carers in line with national and local strategies:

- Prevention of the onset of dementia where this is possible.
- People living with dementia are supported to live safely for longer within the community and with their carers.
- Improved accessibility to, and consistency of, assessment, treatment and support for people living with dementia and their carers across Cambridgeshire and Peterborough.
- Increased choice and control for people living with dementia and their carers - at all stages of the disease.
- Improved outcomes and experience of services for people living with dementia and their carers at all stages of the disease and wherever they live i.e. at home, in care homes and when admitted to hospital..
- Well co-ordinated care that addresses physical and mental health and social care needs in a seamless way.
- Crises and avoidable admission to inpatient dementia services and acute hospitals are reduced.
- Better understanding and awareness of dementia within communities
- Better use of resources/value for money.

Overall, the outcome sought for people with dementia and their carers is improvement in outcomes and experience for both with the key objective being:

> **To enable people living with dementia to live independently for longer and to enjoy being part of their community[75] and to keep them healthier for longer and out of hospital[76].**

[75] Dementia Implementation Guide, DH, 2017
[76] The Five Year Forward View Implementation Guide, 2017-19, DH 2017

A core data set to monitor quality, outcomes and activity based on the MSNAP quality standards, the reporting requirements of NHS, including KLOE, and social care organisations has been developed as part of the process of developing this Strategic Plan. This will be developed and refined as part of the work to implement the Plan. Notwithstanding the need to report on core national and local activity, performance and outcomes, the key driver for the development of these outcomes will be to monitor the things that are of the greatest importance to people living with dementia and their carers. Monitoring of these indicators, and identification of the additional indicators and measures needed to monitor performance and outcomes will be initiated during the first year of implementation of the Strategic Plan.

4.2 Financial Impact

The actions and plans outlined in the Strategic Plan aim to both improve the experience and outcomes for people living with dementia and their carers. Most of these are based on strategies and interventions that have been shown to improve the cost effectiveness of dementia care. The aim during the first year of the plan is to apply national and local evidence and experience of service improvement to identify and quantify the potential to improve cost effectiveness across the physical and mental health and social care pathway in order to develop a business case to the STP to support improved outcomes and cost effectiveness. The potential for such improvement lies within the following:

- Reduction in no./% of crises.
- Reduction in avoidable admission to inpatient dementia services and acute hospitals.
- Reduction in no./% presentations to Accident and Emergency Departments that do not lead to an admission.
- Reduction in no./% of people living with dementia who die in hospital.
- Reduction in the average length of stay in care homes.

The aim is to reduce costs, where possible by diagnosing and intervening early in order to reduce expenditure on more expensive specialist interventions releasing resources for investment in community based services and support.

4.3 Equality Impact Assessment

Equality impact assessments were completed for the CCG, CCC and PCC[77]. These showed that the impact of the Plan is either positive or neutral on all groups. See Table 5 below:

[77] Available on request from jo.pugh1@nhs.net

Table 5: Summary of Equality Impact Assessment, CCG, CCC and PCC

Positive Impact
Age: Currently there are inequalities in assessment, treatment and support for dementia related to age with greater attention being given to dementia in people aged over 65 years. The Strategic Plan addresses, this, identifying improvement of outcomes for people 65 years and under as a key priority. However, there is also an opportunity to improve outcomes and experience for people aged over 65 years. For people living with dementia aged 65 years or under, there are real and significant gaps in services that address needs effectively. Dementia affects a much wider circle of people than the individual who is diagnosed with dementia. It therefore has an impact on people of all ages. **Disability:** Dementia can affect anyone. Therefore the statement relating to particular age groups above can be applied to this group. **Pregnancy and Maternity:** The onset of dementia is extremely unusual in people aged under 40 years, except where the individual has a learning disability. Therefore, people in this group are unlikely to be diagnosed with dementia and therefore are not likely to be affected directly. However, they may have friends or a family member who is living with dementia and therefore be indirectly affected. They may also be in a caring role. **Race:** Predictions suggest that there will be seven fold increase in dementia amongst people from minority ethnic communities. At present, some cultural groups are under-represented in services and are more likely to be diagnosed at a later stage in the illness due to a lack of awareness, stigma and availability of appropriate services. The needs of this group are addressed in the Dementia Strategic Plan. **Religion or Belief:** Dementia can affect anyone. Therefore the statement relating to particular age groups above can be applied to this group. Where the difference relates to a difference in race, action will be taken under the actions related to race above. **Rural:** One of the objectives within the Strategic Plan is to ensure equality of/consistent access to, treatment and support across Cambridgeshire and Peterborough. To achieve this, issues related to rurality will be addressed. **Deprivation:** One of the objectives within the Strategic Plan is to ensure equality of/consistent access, treatment and support across Cambridgeshire and Peterborough. To achieve this, issues related to deprivation will be addressed.
Negative Impact
None
Neutral Impact
Gender Reassignment: The Strategic Plan does not directly address the needs of this group. However, dementia can affect anyone. Therefore the statement relating to particular age groups above can be applied to this group. **Marriage and Civil Partnership:** The Strategic Plan does not directly address the needs of this group. However, dementia can affect anyone. Therefore the statement relating to particular age groups above can be applied to this group **Sex:** The Strategic Plan does not directly address the needs of this group. However, dementia can affect anyone. Therefore the statement relating to particular age groups above can be applied to this group. **Sexual orientation:** The Strategic Plan does not directly address the needs of this group. However, dementia can affect anyone. Therefore the statement relating to particular age groups above can be applied to this group.

4.4 Risk Assessment

There are a number of risks to delivery of the Strategic Plan. The key risks and actions to mitigate these are summarised in Table 6 below.

Table 6: The Dementia Strategic Plan: Risks and Mitigating Actions

	Risk	Impact	Mitigating Actions	Current Status
1	**Insufficient capacity within OPMH commissioning and provider organisations to deliver a complex programme of work with the detailed level of analysis necessary to achieve the outcomes required**	1. Inability to deliver the required improvement to outcomes and experience for people living with dementia and their carers. 2. Lack of a proper understanding of where there are opportunities for improved effectiveness and efficiency and/or a need for investment. 3. Inability to develop the business case: Autumn 2018.	1.Prioritisation of actions following the gap analysis 2. Secured programme support: CCG and CCC/PCC 3. Seeking SDU support for analysis of activity and performance across the health and social care system.	
2	**The need for system wide participation in delivery of the strategy.**	1. Inability to deliver the required improvement to outcomes and experience for people living with dementia and their carers. 2. Lack of a proper understanding of where there are opportunities for improved effectiveness and efficiency and/or a need for investment. 3. Inability to develop the business case: Autumn 2018.	1. Identification of the risk and securing commitment to address the issue as part of the process of sign off of the Strategic Plan. 2. Liaison with key managers within each organization. 3. Advance planning of workshops etc.	
3	**Lack of resources to support external facilitation for the development of the care pathway**	1. Inability to deliver the required improvement to outcomes and experience for people living with dementia and their carers. 2. Lack of a proper understanding of where there are opportunities for improved effectiveness and efficiency and/or a need for investment. 3. Inability to develop the business case: Autumn 2018.	1. Seeking resources to support delivery of the PCSP programme from NHS source and CCC/PCC transformation funds.	

5 Next Steps

5.1 Next Steps

A high level plan for delivery of the actions/milestones required from 2017/18 – 2018/19 is included at Figure 2 above. This aims to confirm support for the Strategic Plan from all relevant commissioning and provider organisations across the health and social care system, to deliver the action plans for each of the Pillars and Cross Cutting themes of the Well Pathway for Dementia and early onset dementia. From all of these, a business case for dementia is produced for consideration by the STP. CCC and PCC during the Autumn of 2018 with implementation from 2019/20.

Following this process, the action plans for each Pillar and Cross Cutting Theme of the Well Pathway will be reviewed according to the outcome of the business case and progress with implementation of each action plan with revised action plans being agreed for implementation during 2019/20 and 2020/21.

Implementation of the Strategic Plan will be overseen by the OPMH Delivery Board. Regular progress reports will be made within the lead organisations and to the relevant Boards across Cambridgeshire and Peterborough.

Appendix 1: The Cambridgeshire and Peterborough Well Pathway for Dementia: Gap Analysis

1. Preventing Well

Gap Analysis

In considering prevention of dementia, it is important to consider health throughout the life course. Risk factors for dementia have been identified from preconception to early, mid and later life. This section presents the epidemiology of these risk factors in Cambridgeshire and Peterborough.

Figure 11 below is taken from the PHE Dementia Profile and shows how Cambridgeshire and Peterborough compare against England and East of England region for a number of these risk factors. Yellow indicates that there is no significant difference between the local area and the England average, dark blue indicates that the local area is lower than the England average and light blue indicates it is higher than the England average.

Figure 11: Summary dashboard for key dementia prevention indicators, East of England

Indicator	Period	England	East of England region	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
Smoking Prevalence in adults - current smokers (APS)	2016	15.5	14.4	15.1	15.2	10.3	14.0	13.5	16.3	13.5	17.6	17.2	14.7	20.8
Percentage of physically active and inactive adults - inactive adults	2015	28.7	27.6	27.2	25.3	22.7	28.0	25.9	30.9	29.0	34.3	29.5	28.3	29.6
Excess Weight in Adults	2013 - 15	64.8	65.6	66.0	63.2	67.1	66.3	62.8	64.6	67.0	70.8	67.0	66.1	70.3
Admission episodes for alcohol-related conditions (Narrow) - 40-64 yrs	2015/16	904	820	729	874	732	799	665	1131	1003	1037	778	788	788
People receiving an NHS Health Check per year	2016/17	8.5	9.7*	6.6	9.6	9.2	10.7	7.5	9.0	8.9	10.4	9.5	12.7	11.3
Hypertension: Recorded prevalence (all ages)	2015/16	13.8	14.1	13.7	12.7	14.0	15.0	12.8	12.0	15.8	11.8	15.2	15.2	14.0
Stroke: Recorded prevalence (all ages)	2015/16	1.7	1.7	1.5	1.5	1.5	1.7	1.6	1.2	2.2	1.3	1.7	2.0	1.5
Diabetes: Recorded prevalence (aged 17+)	2015/16	6.5	6.2	7.0	5.5	6.0	6.4	5.5	7.6	6.7	6.5	6.5	6.3	6.4
CHD: Recorded prevalence (all ages)	2015/16	3.2	3.1	3.0	2.9	3.0	3.2	2.7	2.5	3.8	2.6	3.3	3.7	2.6
Depression: Recorded prevalence (aged 18+)	2015/16	8.3	8.0	9.3	7.7	8.6	7.7	7.9	6.5	7.9	7.4	8.5	8.9	8.5

Source: PHE Dementia Profile

In summary this shows that:

- Smoking prevalence in adults is below the national average in Cambridgeshire 15.2% but just above in Peterborough at 17.6%.
- In Cambridgeshire, 25.3% of adults are physically inactive which is lower than the national average. This is classified as doing less than 30 “equivalent” minutes of at least moderate intensity physical activity per week in bouts of 10 minutes or more in the previous 28 days. It is important to note that this definition falls below accepted national recommendations.

- In Peterborough, 34.3% of adults are physically inactive which is higher than the national average.
- In Cambridgeshire 63.2% of adults are overweight or obese – this is less than the national average. In Peterborough, 70.8% of adults are overweight or obese which is greater than the national average.
- In Cambridgeshire 9.6% and in Peterborough 10.4% of the eligible population had received their NHS health check.

2. Diagnosing Well

The 'Prime Minister's 2020 Challenge on Dementia' included a commitment to increase the number of people living with dementia who have a formal diagnosis. The rationale being that a timely diagnosis enables people living with dementia, their carers and healthcare staff to plan accordingly and work together to improve health and care outcomes. This commitment was further supported by the NHS 2014-15 mandate which set a target of increasing the Estimated Dementia Diagnosis Rate by two-thirds by March 2015 and to sustain this throughout 2015/16.

The diagnosis rate is defined as the rate of persons aged 65 and over with a recorded diagnosis of dementia per person estimated to have dementia given the characteristics of the population and the age and sex specific prevalence rates of the Cognitive Function and Ageing Study II, expressed as a percentage with 95% confidence intervals.

Diagnosis rates for each local authority in the East of England are presented in figure 8 below. Yellow indicates that the area is in line with the national average, green indicates that the area has a statistically significantly higher than national average diagnosis rate, and red indicates that it is statistically significantly lower.

Figure 12 below shows that Peterborough performs well when compared with the rest of the county with a current diagnosis rate of 78.4%, whilst Cambridgeshire is slightly below average with a diagnosis rate of 62.7%.

Figure 12: Estimated dementia diagnosis rate (aged 65+), East of England and England, by local authority area, 2017 (Source: PHE Dementia Profile)

Estimated dementia diagnosis rate (aged 65+) 2017 Proportion - %

Area	Count	Value	95% Lower CI	95% Upper CI
England	432,152	67.9	61.2	73.7
East of England region	48,448	63.2	56.9	68.5
Peterborough	1,305	78.4	69.5	86.2
Southend-on-Sea	1,708	72.1	64.3	79.2
Luton	1,153	66.2	58.6	72.9
Hertfordshire	8,866	64.7	58.2	70.2
Suffolk	7,134	63.3	56.9	68.8
Thurrock	926	63.1	55.4	69.7
Norfolk	8,414	62.8	56.5	68.2
Cambridgeshire	4,670	62.7	56.2	68.2
Bedford	1,150	62.1	55.0	68.4
Essex	11,463	60.5	54.4	65.7
Central Bedfordshire	1,659	58.8	52.1	64.4

Current waiting times for Memory Services are well within the current national target of 18 weeks averaging between 8 and 12 weeks. The very small number of people who wait longer than 18 weeks are for very specific reasons that are not related to the service. On average the service sees 2,000 people a year out of which some 18 people had waited longer than 18 weeks.

Stakeholders identified the following strengths:

- Access to and speed of diagnosis

The following gaps/opportunities for improvement were identified:

- Variation in diagnosis rates between GP practices.

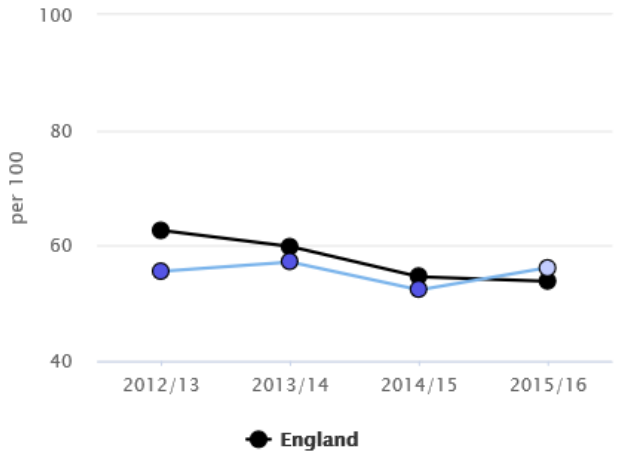
- Advance care planning so that crises and avoidable admission to hospital can be prevented, particularly in the event of a carer being unable to care temporarily
- Case finding in care homes (being addressed through STP investment in a case finding tool)

3. Supporting Well

The 'NHS England Well Pathway for Dementia' states that people with dementia and their carers should have access to safe and high quality health and social care.

Figures 13 and 14 below show data on the number of people with dementia using inpatient hospital services as a percentage of recorded diagnosis of dementia. This ratio gives a useful indication of the use of inpatient general hospital services for people diagnosed with dementia. Both Cambridgeshire and Peterborough currently have a higher than average proportion of people diagnosed with dementia using inpatient hospital services. This requires further investigation to understand the possible causes and implications of this figure.

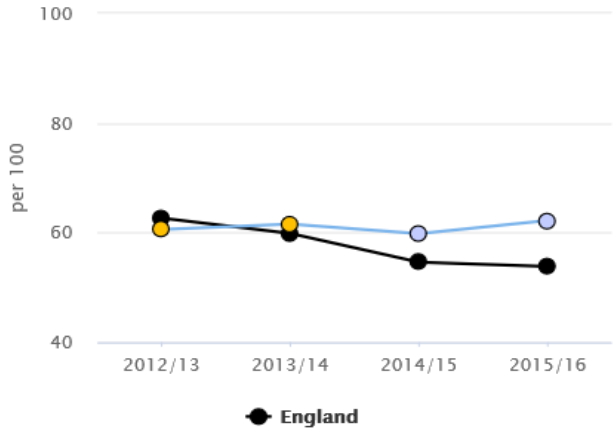
Figure 13: Ratio of inpatient service user to recorded dementia diagnoses, Cambridgeshire, 2012/13 – 2015/16



Period		Count	Value	Lower CI	Upper CI	East of England	England
2012/13	●	1,936	55.5	53.9	57.2	63.4	62.6
2013/14	●	2,150	57.2	55.6	58.7	61.4	59.8
2014/15	●	2,374	52.3	50.9	53.8	56.9	54.6
2015/16	○	2,581	56.2	54.8	57.6	55.4	53.8

Source: NHS Digital

Figure 14: Ratio of inpatient service user to recorded dementia diagnoses, Peterborough, 2012/13 – 2015/16



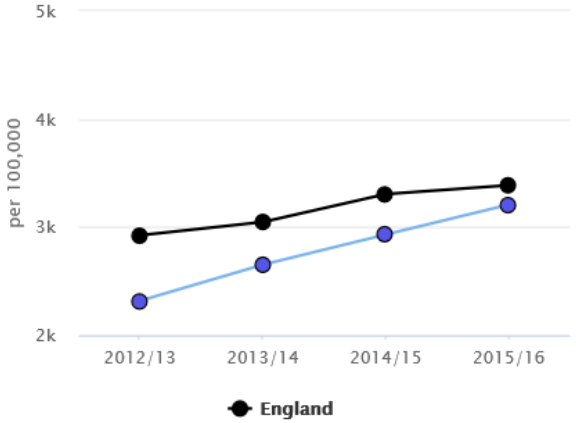
Period		Count	Value	Lower CI	Upper CI	East of England	England
2012/13		539	60.6	57.3	63.7	63.4	62.6
2013/14		605	61.5	58.5	64.5	61.4	59.8
2014/15		711	59.8	57.0	62.5	56.9	54.6
2015/16		780	62.2	59.5	64.8	55.4	53.8

Source: NHS Digital

Source: PHE Dementia Profile

Figures 15 and 16 show data on the rate of emergency admissions for people with dementia aged 65 years and over. It is important to note that these admissions may not be *due* to person's dementia and will include a range of different reasons for admission. They show that there is an upward trend in this indicator in both Cambridgeshire and Peterborough. The rate in Cambridgeshire is lower than the national average, whilst the Peterborough rate is significantly higher than the national average. This requires further investigation to understand the possible causes and implications of this figure.

Figure 15: Directly age standardised rate of emergency inpatient hospital admissions for people with dementia (aged 65+) per 100,000, Cambridge, 2012/13 – 2015/16

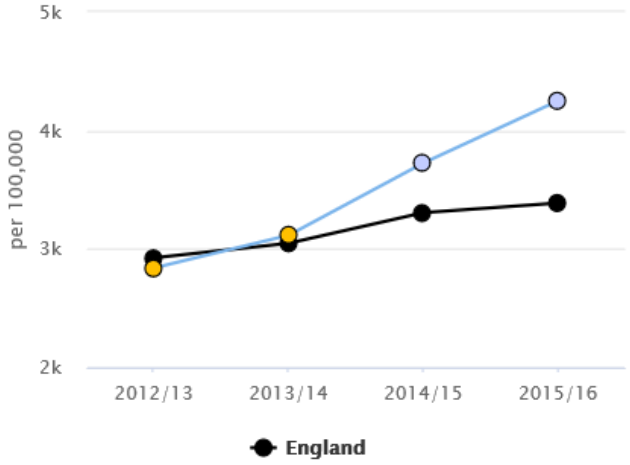


Period		Count	Value	Lower CI	Upper CI	East of England	England
2012/13		2,540	2,318	2,228	2,410	2,643	2,924
2013/14		2,975	2,652	2,558	2,750	2,795	3,047
2014/15		3,407	2,931	2,833	3,032	3,103	3,306
2015/16		3,771	3,208	3,106	3,313	3,108	3,387

Source: NHS Digital

(Source: PHE Dementia Profile

Figure 16: Directly age standardised rate of emergency inpatient hospital admissions for people with dementia (aged 65+) per 100,000, Peterborough, 2012/13 – 2015/16



Period		Count	Value	Lower CI	Upper CI	East of England	England
2012/13		758	2,839	2,638	3,050	2,643	2,924
2013/14		850	3,115	2,907	3,333	2,795	3,047
2014/15		1,050	3,725	3,501	3,959	3,103	3,306
2015/16		1,213	4,251	4,013	4,499	3,108	3,387

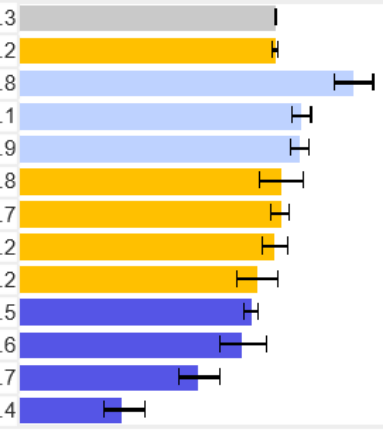
Source: NHS Digital

Source: PHE Dementia Profile

Figure 17 below shows how Cambridgeshire and Peterborough compare to the rest of the region and England in terms of the proportion of emergency inpatient admissions for people (aged 65+) with dementia which are short stays, i.e. 1 night or less. This indicator is important as changes in the surrounding environment can increase the levels of anxiety and stress for an individual. People with dementia can be more susceptible to these changes, which can cause additional distress. Admissions to hospital, particularly ones of short duration should be avoided if at all possible for this population. It shows that Cambridgeshire and Peterborough have similar rates of short stay admissions as the national and regional average of 28%. This rate has remained broadly stable over the last four years.

Figure 17: Percentage of emergency inpatient admissions for people (aged 65+) with dementia that are short stays, East of England and England, by local authority area, 2015/16

Area	Count	Value	95% Lower CI	95% Upper CI
England	101,050	28.3	28.2	28.5
East of England region	11,328	28.2	27.8	28.7
Southend-on-Sea	667	36.8	34.6	39.1
Suffolk	1,964	31.1	29.9	32.2
Hertfordshire	2,117	30.9	29.8	32.0
Peterborough	353	28.8	26.3	31.4
Norfolk	1,663	28.7	27.6	29.9
Cambridgeshire	1,151	28.2	26.8	29.6
Central Bedfordshire	331	26.2	23.9	28.7
Essex	2,531	25.5	24.7	26.4
Luton	248	24.6	22.0	27.3
Bedford	224	19.7	17.5	22.1
Thurrock	79	11.4	9.2	14.0



Source: Health and Social Care Information Centre (HSCIC)

Source: PHE Dementia Profile

The mortality rate for people with dementia in Cambridgeshire and Peterborough is slightly lower than the England average at 845 per 100,000 people.

The average number of admissions from care homes within the Cambridgeshire and Peterborough region per month for the months April 16 to March 17 was 323. For each admission to the hospital there is an average cost of £1,337.29 and for every emergency department attendance there is an average cost of £97.39 excluding the cost of calling an ambulance which is £247. In 2016/2017 49% of all non-elective admissions from care homes in

Cambridgeshire and Peterborough had a code of dementia recorded as part of their admission, taking into account the admission costs of £1,337.29 the total cost to the NHS was 2.5 million pounds. RightCare data indicates that Cambridgeshire and Peterborough CCG spending on dementia non-elective admissions is higher than the average of the 10 most demographically similar CCGs. The data from RightCare indicates that Cambridgeshire and Peterborough CCG are better performing on average for short stay admissions for residents with dementia, however the dementia sufferers are more likely to die in a place that is not their usual residence indicating that End of Life Care for dementia sufferers can be improved to ensure that residents die within their preferred place of care with advanced care planning in care homes.

Care Homes

Currently Cambridgeshire and Peterborough region has 141 Residential and Nursing Care Homes and a further 15 Residential and Nursing Care Homes that can utilise the Cambridgeshire and Peterborough secondary care services due to their geographical location. There is variation in the standards within the care homes across the county, there are currently no CQC rated outstanding care homes. There are 54 care homes with 845 beds within the Cambridgeshire and Peterborough region registered with the CQC specialising in learning disabilities. National studies indicate that it is likely that people with a learning disability aged under 65 years who develop dementia are likely to be moved inappropriately into care homes for older people. National studies show that, on average, 70% of people living in care homes are suffering with Dementia. The Care Homes within Cambridgeshire and Peterborough provide over 6000 beds for people unable to live independently. It is likely that 4200 residents within Cambridgeshire and Peterborough care homes are living with dementia.

The CQC report, Cracks in the Pathway (2014) stated that it is likely that someone living with dementia will experience poor care at some point while living in a care home or being treated in hospital, the reasons behind this are:

- Assessment of care needs
- Providers working together
- Involvement in care
- Planning and delivery of care
- Staffing

- Monitoring of the quality of care

The identification of dementia, depression and delirium is paramount to ensure a timely response to resident's needs. Currently there is no formal process in place for care homes to utilise a dementia case-finding tool for care workers to use with individuals living in care homes, with a view to identifying people with dementia, thereby increasing the rate of diagnosis There is little evidence within the region to show that care home staff routinely follow evidenced based practice such as the NICE dementia quality standards when care planning with and for their residents. Key stakeholders want to develop a partnership with care homes to support care homes to deliverr best practice to ensure that care is person centred and of of a high quality and that care home staff are able to recognise and promote mental and emotional wellbeing. All care homes should be able to demonstrate the achievement of the Dementia Care standards.

The Care Home population are often disregarded when considering the needs of the local population and Care Home Managers feel that they are considered as very separate to the NHS and Social Care System and let down by this system when trying to access help for their residents. This fhas also been evidenced nationally by the Alzheimer's Society who states that "….the NHS is failing to provide adequate, timely access to vital services including continence advice, physiotherapy and dentistry….we have also found that some GP practices are wrongly charging care homes, and the people who pay care home fees, for NHS services that should be free. These practices contravene the NHS Constitution, which states that everyone, regardless of who they are or where they live, should have access to the NHS services they need and these should be free at the point of use."

Research has found that the prevalence of comorbid conditions in people with dementia is high. Studies have estimated that 61% of people with Alzheimer's disease have three or more comorbid diagnoses. As the severity of the dementia increases, so does the rate of comorbid conditions. (Dementia and comorbidities: Ensuring parity of care, 2016). People with dementia living in a care home are more likely to go into hospital with avoidable conditions (such as urinary infections, dehydration and pressure sores) than similar people without dementia. (Prime Minister's challenge on dementia 2020, 2015). Research has found that the prevalence of comorbid conditions in people with dementia is high. Studies have estimated that 61% of people with Alzheimer's disease have three or more comorbid diagnoses. As the severity of the dementia increases, so does the rate of comorbid conditions. (Dementia and comorbidities: Ensuring parity of care, 2016). The CQC and the British Geriatrics Society have shown that many the health needs of people with dementia living in care homes are not regularly assessed and met. One consequence is avoidable admissions to hospital. Nationally, poor access to NHS services has led to people with dementia being bedbound, incontinent and sedated.

The average number of admissions from care homes within the Cambridgeshire and Peterborough region per month for the months April 16 to March 17 was 323. For each admission to the hospital there is an average cost of £1,337.29 and for every emergency department attendance there is an average cost of £97.39 excluding the cost of calling an ambulance which is £247. In 2016/2017 49% of all non-elective admissions from care homes in Cambridgeshire and Peterborough had a code of dementia recorded as part of their admission, taking into account the admission costs of £1,337.29 the total cost to the NHS was 2.5 million pounds. RightCare data indicates that Cambridgeshire and Peterborough CCG spending on dementia non-elective admissions is higher than the average of the 10 most demographically similar CCGs. The data from RightCare indicates that Cambridgeshire and Peterborough CCG are better performing on average for short stay admissions for residents with dementia, however the dementia sufferers are more likely to die in a place that is not their usual residence indicating that End of Life Care for dementia sufferers can be improved to ensure that residents die within their preferred place of care with advanced care planning in care homes.

Advance care plans have also been found to reduce the number of inappropriate hospital admissions in patients with dementia. People with dementia and their carers need to be involved in planning end of life care which recognises the principles outlined in the Department of Health End of Life Care Strategy. There is a disjointed service within the region for end of life care. There are currently no agreed multi-agency protocols in place regarding end of life pathways and care home residents. The result of poor proactive management results in residents being admitted to hospital via A&E. One of the hospices within the region offers a Gold Standard Framework (GSF) for Care Homes training programme at a charge, however there has been little engagement. Regionally the Care Homes need to be included within the End of Life Care Strategy and include the requirement to consider dementia.

Previous research has found that poor pathways between care homes and hospitals are resulting in people with dementia receiving poor care. In 2014, the CQC found variable or poor care regarding arrangements for sharing information when people moved between services in 83% of hospitals (Care Quality Commission, 2014). When arriving at the emergency department, elderly frail people and people with dementia suffer from higher delays in diagnosis, unsuspected diagnoses such as Delirium, depression, drug and alcohol use, elder abuse, polypharmacy. They receive under treatment for certain conditions and management and overtreatment with higher rates of Foley catheters and overuse of sedation and restraints as examples and have poorer outcomes as a result of being in hospital. (Bannerjay & Conroy, 2017, CQC, 2014).

Many people with dementia who live in care homes have high levels of mental health needs as a result of the cognitive, psychological and behavioural symptoms of dementia and other mental health conditions such as depression. Nationally, 45% of care home managers surveyed by the Alzheimer's society said that the NHS isn't providing residents with dementia with adequate and timely access to mental health services, in a report commissioned

by Cambridgeshire and Peterborough CCG 22% of care home managers expressed difficulty in accessing mental health reviews and assessments. When accessing Mental Health services in a crisis there has been a lack of clarity for care home managers in Cambridgeshire and Peterborough, when ringing 111 and utilising the option 2 service. One care home manager recalled a distressing event when contacting 111 and choosing option 2 for mental health crisis and was informed that this service was for under 65 years of age only. The incident resulted in a compromise of staff and patient safety involving the police. Cambridgeshire and Peterborough CCG has one of the lowest rates of referrals into access into psychological therapies for residents over the age of 65 and the rate of contact with secondary MH services by people aged 65+ per 100,000 with no inpatient stay is one of the lowest nationally.

The issue of recruitment and retaining staff is a major concern; we do not see a significant change in the current issues of attracting staff changing in the coming years. Furthermore support is required for Care Homes in addressing the current challenges by excessive use of Agency Nurses. There is a requirement for improved quality of care for people with dementia in care homes through:

- The development of explicit leadership for dementia care within care homes
- Defining the care pathway within
- Commissioning of specialist in-reach services from community mental health teams
- Through inspection regimes
- Support from the county wide system through the Care Home Support Team to ensure care homes are allowed to follow continuous improvement processes using evidenced based guidance

Stakeholders identified the following strengths:

- Management of dementia in acute hospital (Right Care).
- Early work undertaken in relation to meeting the needs of people from minority groups with dementia.
- Percentage of patients whose care was reviewed at least annually by GPs (Right Care).
- Working to meet the needs of people with dementia from hard-to-reach groups.

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and gaps:

- Sufficient capacity in services to enable access.

- Advance care planning so that crises, avoidable admission to hospital is minimised, particularly in the event of a carer being unable to care temporarily and plans are made for end of life.
- The availability of transport to access services.
- The availability of care at home, particularly in more rural areas.
- Pressure on the cost of nursing home care in Cambridgeshire as an affluent area.
- Access to nursing home care for those with the most complex needs, particularly on discharge from hospital.
- Dementia care in residential care and nursing homes; care that is at least of the minimum standard with a percentage of care homes achieving the 'outstanding' rating and equity of access to NHS assessment, treatment and support
- Support and treatment to remain at home for people living in residential care and nursing homes
- Assessment, treatment and support for people with early onset dementia.
- Detailed understanding of activity relating to dementia in acute hospitals e.g. where dementia is not the main reason (primary diagnosis) for admission.
- Need for stronger commissioning/leadership for dementia care within both CCG and the Local Authorities.
- Dedicated psychological treatment within the Memory Assessment Service
- Access to psychology in inpatient MH wards.

In December 2016, a review was conducted of care homes with the top ten A&E attendance rates (using ambulance data) plus a further 8 care homes added to the study. The most common reason for calling an ambulance from care homes was for falls (47%). The study identified particularly poor relationships between care homes and acute providers including poor handover from A&E to care homes, lack of involvement of care home in discharge planning, lack of information sharing with care home staff, and failure to return medications and/or DNAR paperwork. It also identified inappropriate use of 999, a disjointed approach to end of life care planning in care homes, and a common disregard for care planning by ambulance staff where it is in place. The review concludes that the issues identified in the report, including those highlighted above, results in residents being admitted to hospital via A&E, although hospital admission may be unnecessary and against the wishes of the resident or the agreement of the family. The Care home support team, working alongside Admiral UK, will promote End of Life care in Dementia in care homes, with the aim of improving some of the areas identified in this study.

4. Living Well

The 'Prime Minister's 2020 Challenge on Dementia' states that carers of people with dementia should be made aware of and offered the opportunity for respite, education, training, emotional and psychological support so that they feel able to cope with their caring responsibilities and to have a life alongside caring.

Figure 18 shows how the **carer-reported quality of life score for people caring for someone with dementia** varies across the East of England region. This measure gives an overarching view of the quality of life of carers based on outcomes identified through research by the Personal Social Services Research Unit. This is a current measure related to quality of life for carers looking after people with dementia and supports a number of the most important outcomes identified by carers themselves to which adult social care contributes. It shows that the average score in Cambridgeshire is slightly higher than the England average (7.7) at 7.9 and the Peterborough average score is significantly lower than the England at 6.7.

Figure 18: Carer-reported quality of life score for people caring for someone with dementia, East of England and England, by local authority area, 2014/15 (Source: PHE Dementia Profile)

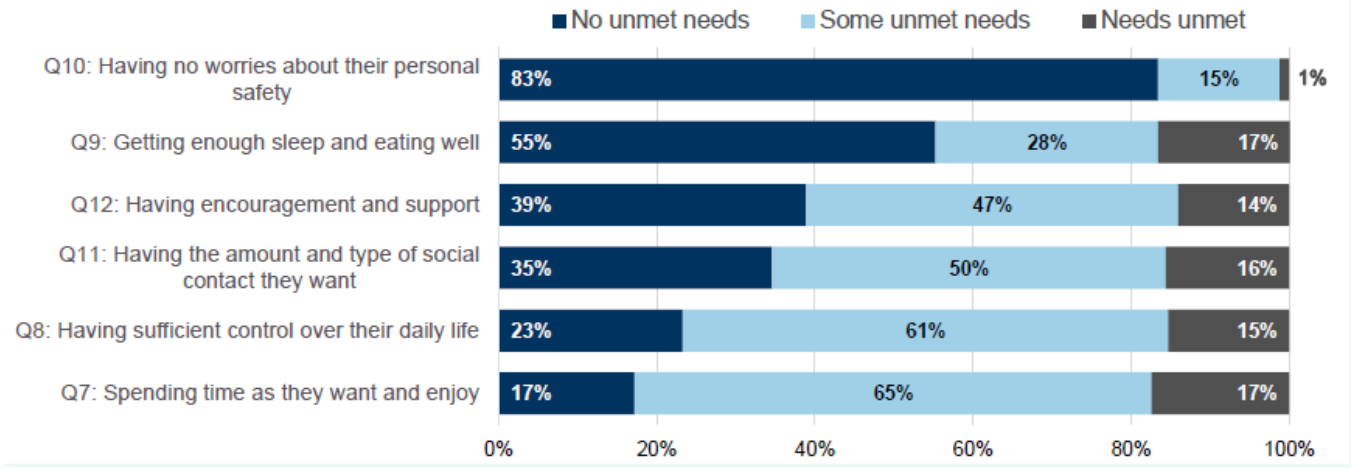
Carer-reported quality of life score for people caring for someone with dementia 2014/15 Score

Area	Count	Value	95% Lower CI	95% Upper CI
England	-	7.7	7.6	7.8
East of England region	-	7.9	7.7	8.1
Luton	-	8.3	7.7	8.9
Hertfordshire	-	8.2	7.8	8.6
Central Bedfordshire	-	8.1	7.7	8.5
Southend-on-Sea	-	8.1	7.5	8.7
Essex	-	7.9	7.4	8.4
Cambridgeshire	-	7.9	7.6	8.2
Bedford	-	7.4	6.9	7.9
Thurrock	-	7.4	6.7	8.1
Suffolk	-	7.3	7.0	7.6
Norfolk	-	7.3	6.9	7.7
Peterborough	-	6.7	6.2	7.2

Source: NHS Digital, ASCOF

A national survey of adult carers in 2014/15 (see figure 10) showed that the most commonly felt unmet need was being able to spend time as they want and enjoy, having sufficient control over their daily life and having the amount and type of social contact they want. The majority of carers (83%) felt that they had no unmet needs in terms of worrying about their personal safety.

Figure 19: Carers' agreement with survey statements in the Personal Social Services Survey of Adult Carers in England, 2014-15



Source: www.hscic.gov.uk/pubs/psscarersurvey1415)

Figure 20 below shows how Cambridgeshire and Peterborough compare to England and local authorities in the East of England in terms of the proportion of adult carers who feel that they have as much social contact as they would like. It shows that Cambridgeshire is approximately in line with the national average of 38.6%, whilst Peterborough is significantly lower at 29.7%. Loneliness and social isolation can have a significant impact on individual's health and wellbeing; evidence shows a link between loneliness and social isolation and increased risk of diseases such as cardiovascular disease and dementia.

Figure 20: Proportion of adult carers who have as much social contact as they would like, East of England and England, by local authority area, 2014/15

Social Isolation: % of adult carers who have as much social contact as they would like 2014/15 Proportion - %

Area	Count	Value	95% Lower CI	95% Upper CI
England	-	38.5	38.0	39.0
East of England region	-	42.2	40.1	44.3
Hertfordshire	-	46.8	42.2	51.4
Southend-on-Sea	-	45.8	40.9	50.7
Thurrock	-	45.1	38.6	51.6
Essex	-	44.3	40.0	48.6
Central Bedfordshire	-	41.0	36.6	45.4
Luton	-	39.0	34.3	43.7
Cambridgeshire	-	38.6	35.3	41.9
Bedford	-	38.6	35.0	42.2
Norfolk	-	32.2	28.1	36.3
Peterborough	-	29.7	25.5	33.9
Suffolk	-	25.6	23.2	28.0

Source: Personal Social Services Survey of Adult Carers in England (HSCIC)

Source: PHE Dementia Profile

Stakeholders identified the following strengths:

- Dementia friendly communities
- The Dementia Resource Centre in Peterborough which provides a focus for dementia support

and gaps:

- Geographical consistency and capacity in relation to the Dementia Resource Centres (commissioned in Peterborough but not in Cambridgeshire and insufficient capacity and potential for development in Peterborough)
- Geographical consistency in relation to Dementia Friendly Communities

- Geographical consistency in relation to Dementia Friendly Environments
- Carer assessment and support
- Information, advice, guidance and support for carers so that they can continue caring when they wish to do so.

5. Dying Well

The 'NHS England Well Pathway for Dementia' states that people living with dementia should be able to die with dignity in the place of their choosing. Figure 21 is a spine chart comparing the Cambridgeshire and Peterborough STP area against the England average for a number of end of life care indicators. This shows that:

Figure 21: Spine chart showing performance of Cambridgeshire and Peterborough STP area against the England average for a range of 'Dying Well' dementia indicators, 2015

Indicator	Period	Cambridgeshire and Peterborough		England			
		Count	Value	Value	Lowest	Range	Highest
Directly Age Standardised Rate of Mortality: People with dementia (aged 65+)	2015	1,300	845	873	733		1,019
Deaths in Usual Place of Residence: People with dementia (aged 65+)	2015	953	74.3%	68.6%	52.9%		82.8%
Place of death - care home: People with dementia (aged 65+)	2015	818	62.9%	59.2%	39.4%		69.2%
Place of death - hospital: People with dementia (aged 65+)	2015	322	24.8%	30.4%	14.9%		43.9%
Place of death - home: People with dementia (aged 65+)	2015	140	10.8%	8.9%	6.5%		14.1%

Source: PHE Dementia Profile

Cambridgeshire and Peterborough generally performs well in terms of the place of death for people with dementia. It has higher than average proportion of people dying in their usual place of residence, at home and in care homes, and a lower than average proportion of people dying in hospital.

6. Early Onset Dementia

Early onset dementia is defined as dementia occurring before the age of 65 years. The conditions that are the underlying causes of the dementia syndrome are different in early onset dementia compared to late onset. Though Alzheimers disease is the most common there is a greater contribution from frontotemporal dementias and Huntington's disease. It is an ongoing debate as to whether cases of early onset Alzheimer's disease differ from late onset disease and if they are best served by a separate service or being cared for in general dementia teams. The relative rarity of early onset dementia means that the teams are often small and therefore not robust if there is unexpected sickness or staff turnover for any other reason. Currently in Cambridgeshire early onset patients are cared for in all age dementia services. We have excellent diagnostic clinics for Parkinson's disease (and related Parkinsonian conditions such as progressive supranuclear palsy, corticobasal degeneration and multi-system atrophy), Huntington's disease and frontotemporal dementia. These clinics provide excellent diagnosis, access to research and neurological assessment. We have worked hard to build links between these diagnostic clinics and community services ot make sure after care is coherent and excellent. We will further strengthen these relationships and work with colleagues in the University, neurology and the acute hospital to make sure the community offer for these patients is robust.

7. Researching Well

We are lucky in Cambridgeshire to be close to a world class university which has expert dementia clinicians and academics. We already have very strong local research and participation in international research in Alzheimer's, Parkinson's, Lewy body disease, Huntington's disease, mild cognitive impairment and frontotemporal dementia. We also have high levels of engagement with the Clinical Research Network who in 2017 exceeded their target for recruitment in to dementia studies. Our aim is to give every person diagnosed with dementia the chance to take part in high quality research. We recognise that not every patient will want to do this, and will work with CPFT to make sure robust measures are in place in the electronic patient

record which safeguards patient autonomy and choice. Any contacts for research will be within NHS guidance and frameworks. We also recognise that not every patient may wish to take part in research which involves experimental therapy. We will therefore offer a wide range of potential research projects so no person is excluded. We will continue to work with the Windsor clinical research unit at Fulbourn hospital. They currently offer 14 different studies and recruit approximately 300 patients per year. Our aim is to double this number. Studies offered include commercial and non-commercial drug trials, trials of assistive technology and cognitive stimulation, service evaluation, quality of life studies and bio-banking. With regards to the latter we aim to make Cambridgeshire a world leader in incorporating research opportunity in to 'business as usual'. We will work with CPFT and CUH to make sure that patients who have a scan have the opportunity for their scan to become part of an anonymised research library which will be available for future academic research. We will work with 'Join Dementia Research' (JDR) to give patients a continued offer of research participation and also work closely with research coming out of the University of Cambridge. Our services will make full use of JDR to make sure that patients only need to make a single expression of interest to open up the opportunity of all the research relevant to them.

Stakeholders identified the following strengths:

- A strong research base and access to the latest drugs through trials conducted there.

8. Integrating Well

Stakeholders identified the following strengths:

- Cohesion and partnership working across agencies – statutory and non-statutory.
- A bottom up approach to improvement.

and the following gaps:

- A clearly defined multi-agency dementia pathway, including:
    - Meeting physical and mental health needs in a seamless way ensuring that both health and social care and physical and mental health needs are considered in an holistic way.

- Fiona – this bit is what CPFT are all about. I could write another 120 pages but, in brief. CPFT are national leaders in bringing together physical and mental healthcare. We will continue to work with them to make sure that patients diagnosed with dementia have their needs assessed and dealt with holistically without requiring the individual to navigate care. The unification of community care under one organisation gives a great opportunity to develop this approach and we will work with CPFT to make sure that dementia patients are assessed holistically and can seamlessly access all community services they may require, including district nursing, occupational therapy, physiotherapy, SALT, podiatry, specialist nursing, emergency nursing, continence, tissue viability and if necessary physical inpatient rehabilitation as well as a full range of inpatient and outpatient dementia specific care.
- Knowledge and understanding of the wider care pathway of staff in community and specialist teams.

9. Commissioning Well

Gaps identified:

- Need for stronger commissioning/leadership for dementia care within both CCG and the Local Authorities.

10. Training Well

A gap in training in multi-agency working to ensure that care is seamless and use of all the resources available within the community and assessment, treatment and support is timely was identified.

11. Monitoring Well

The performance of specialist dementia services in Cambridgeshire is currently monitored by CCG and Council Commissioners as required through the national mental health integrated dashboard as follows:

- Memory Service clinic waiting times (CCG).

- Neighbourhood Teams (CCG).
- Inpatient ward performance (CCG).
- Carers of people with mental health problems receiving services advice or information (Councils).
- No. Care packages (Councils).
- Take up of self-directed support/direct payments.
- Use of nursing and care home services (CCG and Councils).
- Use of home care (Councils).

Gaps were identified in the following areas:

- Detailed understanding of activity relating to dementia in acute hospitals e.g. where dementia is not the main reason (primary diagnosis) for admission.
- Detailed monitoring of activity, finance and outcomes relating specifically to dementia within and across mental and physical health and social care services.

Agenda Item No: 8

DEEP DIVE: NEIGHBOURHOOD CARES PILOT

To:	**Adults Committee**
Meeting Date:	**24 May 2018**
From:	**Executive Director: People and Communities**
Electoral division(s):	***All***
Forward Plan ref:	**N/A** *Key decision:* **No**
Purpose:	**To note this 'deep dive' report provides an update on progress on the Neighbourhood Cares Pilot to date as well as future plans for the pilot.**
Recommendation:	**To consider the report and provide comments on progress, proposed developments and issues raised by the pilot so far.** **To endorse the recommendations for the next phase of the pilot as set out in Section 8 of the report.**

Officer contact:		***Member contacts:***	
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1.0 BACKGROUND

1.1 What is the Neighbourhood Cares Pilot?

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

1.1.2 Buurtzorg Model

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

We are also collaborating with the East of England Local Government Association as part of a regional programme, supported by Public World, to promote awareness and learning about the Buurtzorg approach and how it might be applied in the UK in adult social care. http://www.publicworld.co.uk/project/buurtzorg/

1.1.3 The key outcomes set out in the business case are:

- Shift as much resource as possible to the front line.
- Free up staff to have more direct contact with people enabling them to do the right thing, at the right time in the right place and improve job satisfaction because they can see the difference they can make.
- Improve the quality and continuity of care and support to people.
- Increase capacity where we currently have capacity gaps, particularly in home care.
- Reduce the cost of care.
- Set ourselves up for the future, learning from the pilot sites to form the basis for the wider transformation of the whole system.

1.1.4 The NCP has two pilot sites with a population of 10,000, one in an urban setting and the other in a more rural setting. The decision on the sites was taken following analysis of the demographic information and in consultation with key stakeholders such as the NHS, voluntary sector and the Older People's Partnership Board. Performance of and outcomes from the pilot sites will be evaluated and compared with two similar sites, Eaton Socon and Littleport.

1.1.5 While the Soham NCP covers the town itself the St Ives NCP is attached to the Spinney GP practice. Consequently this NCP covers a larger geographical area as patients live in surrounding villages including Fenstanton, Hartford, Houghton and Wyton.

There are four other GP practices in the St Ives area. This has meant that the St Ives team has not actively promoted itself in community settings because residents not registered at the Spinney Practice cannot participate in the pilot. This has not prevented other residents receiving advice but has highlighted the issue of pilot sites covering part of a larger town.

1.1.6 A new job role, 'Neighbourhood Cares Worker' (NCW), has been created for this project. Each self-managed team is made up of the equivalent of four full time workers recruited at Senior Social Worker (MB2) level. The recruitment process has successfully brought together staff from a range of professional backgrounds. The teams are committed to working flexibly and creatively and are equipped to take on new challenges and responsibilities.

1.1.7 Following the completion of a comprehensive training and induction programme the NCP teams went live from October 2017. The topics covered in their induction that were additional to the induction of other social workers were:

- Networking and understanding the local community by listening and spending time with those that live, work and volunteer in the community.
- Developing the ground rules of being a self-managed team, agreeing day to day operational practice of the team and the role and responsibilities of each NCW.
- Building relationships with key partners and stakeholders to raise awareness about NCP.
- Training to provide personal care and support with daily living.

1.1.8 A Neighbourhood Cares Manager was appointed to support the NCP teams to operate in a different way. This role involves being:

- A coach /manager to ensure day to day performance requirements are met.
- A 'heat shield' for the NCWs that allows them to test new ways of working, and maximise their autonomy.
- A consistent link to corporate colleagues, partners and members to ensure that the NCP is fully testing the principles set out in the business case.
- Identifying and working with external evaluators and other sources of external support and challenge such as 'Public World'.

1.1.9 York Consulting has been appointed to complete an external evaluation and will provide an interim report in September 2018 and a final report in March 2019.

2.0 IMPACT AND LEARNING FROM THE NEIGHBOURHOOD CARES PILOT TO DATE

2.1 Work with local people

2.1.1 NCP has worked with 180 people in St Ives and 260 people in Soham. 47% of the people in Soham are already known to other adult social care teams compared with 12% in St Ives. This reflects the significantly higher number of people in St Ives who may have eligible needs but are funding their own care.

Cases are now being transferred from the Older Peoples and Physical Disabilities Teams. This is being done prior to a person's annual review of their care and support plan to test if NCP can achieve better outcomes using different care and support options including community solutions. To date 56 people in St Ives and 90 people in Soham have been transferred.

2.1.2 One of the differences between NCP workers and other adult social workers is that they are trained to provide personal care and support with daily living. This is provided in urgent and unplanned situations. This enables short term support to be provided quickly by someone already known to the client. This approach can also help to bridge a gap until longer term care is sourced. 12 people in St Ives and 10 in Soham have been supported in this way.

For example:

- Family carers needed to go away for a few days and their father refused to have respite care in a care home. The NCWs visited him three times to support him with his personal care and help him prepare meals.
- The neighbour of a woman who was seen wandering at night contacted the team for advice. The NCW visited the woman and thought that she may be suffering from a urinary tract infection. The worker stayed with the woman while arranging for a urine test to be done, collected the antibiotics and made her a meal to ensure that the medication was taken appropriately. The NCW checked that she was recovering over the following days.
- After a woman had broken her arm she was visited by a NCW for three days. This involved helping her work out alternative ways to do everyday tasks while her arm was in plaster and arrange for her to have equipment to help her.

The key role of the NCWs is co-ordinate the care and support needed to ensure that long term needs are met safely, and the ability to provide some short term care provides a rapid response and an opportunity understand, prevent or meet longer term needs, if required.

2.2 A new approach to recruitment, selection and team building

2.2.1 The importance of appointing the right people to the role of NCWs cannot be underestimated. We have used an assessment centre approach to select staff for the NCP. This has helped increase confidence that the people we are appointing have the skills we need. Whilst it is more intensive and costly it has also helped to promote the pilot and the Council.

2.2.2 For the teams to be ready to operate on the 'go live' date, it required a considerably longer induction period than is offered to other social workers. To be effective the NCWs needed time to network with key partners, understand and be known to community organisations, and begin to understand the needs and gaps in local capacity. This confidence building and community appraisal phase will be a prerequisite when creating new teams.

2.2.3 It has also been important to enable the people appointed to have time to work through what it means to be part of a self-managed team and make the best use of each worker's knowledge and strengths.

2.2.4 The two NCP teams meet every four weeks to share learning and compare challenges and talk about how best to meet them.

These challenges have included:

- Testing a new way of working while operating with existing systems and the adult social care legal framework.
- Ensuring that all the information needed to support the evaluation is being collected when one of the aims of the NCP is to reduce paperwork.
- Managing expectations of NCP while its future is uncertain.
- Recognising that the presence of NCP may be threatening to others.
- Balancing responding to requests for information with the need to deliver and implement.
- Providing evidence on reducing the cost of care.

2.3 Promotion and marketing of the NCP

2.3.1 Encouraging people to access good quality information and advice is a key part of NCP's offer which enables people to act for themselves to prevent or delay the need for support. It has been important to develop a distinct branding from NCP that is welcoming and also recognises that some people may be wary of talking to "Social Services".

2.3.2 The NCWs have designed and developed their own marketing materials and leaflets and shared them with all local groups. These will be developed to reflect local feedback to include the information and advice people want.

2.4 Accommodation

2.4.1 Having the Soham library as the team's base has been beneficial in terms of foot fall and access to a range of meeting spaces. The NCP has been able to use the library building during and outside of normal opening times. A common response from people attending events run by the NCP at the library is "I have not been in the building since I was at school. I will now come in again it's got such a welcoming atmosphere". However, the unreliable IT has been a real challenge and has affected the team's ability to function effectively.

2.4.2 The St Ives NCP is based in the Broad Leas Centre in St Ives. In the early days there was plenty of space for the NCWs. Following changes in Children's Services less space is now available and the Centre is not particularly accessible for people with disabilities who need space to have a private conversation.

2.5 Working with Primary Care and community health services

2.5.1 The Staploe Surgery in Soham has been very welcoming to the NCP but has not been able to provide space within the surgery for the NCWs to work. Once the NCP went

live the practice quickly saw the benefits of the work done by the team and invited the NCWs to their monthly multi-disciplinary meeting. The number of referrals from the practice is significantly lower than in the St Ives NCP. In Soham 6 of the 184 referrals have come from the GPs. Some people who have made contact themselves, have said that the surgery recommended that they did so.

2.5.2 The Spinney Practice has been able to offer the NCWs a meeting space in the practice once a week and have arranged for workers to have access to their IT systems. Having a regular presence in the practice has helped build relationships with all staff and is reflected in the relatively high number of referrals (42 out of 116) from GPs. The practice has actively promoted NCP to all patients over 80 years of age and hosted a social event which 60 patients and 11 local organisations attended. One of the outcomes from the event was that NCWs have supported the development of new community groups e.g. a lunch club.

2.5.3 A number of the Case Studies in Appendix 2 demonstrate the benefits of gaining the trust of health colleagues and working collaboratively with them.

2.6 Developing social capital

2.6.1 The people of Soham have shown a high level of interest in developing community groups. The NCWs in Soham are responding to this by re-energising and re-establishing community groups and encouraging them to work together to prevent duplication. For example the NCP is working with a number of groups in Soham is ensuring a range of opportunities are available to ensure that "No one is ever alone in Soham".

2.6.2 The NCP also hosted a Volunteers Fair from which 15 people have become involved in:

- Libraries at Home
- IT Buddy
- Age UK Visiting Scheme
- Pos+Ability
- Ely Social Car Scheme
- Neighbourhood Cares Volunteers
- Soham's first Repair Café will happen on 20 May at Soham Library
- A local resident is exploring setting up a ' Men in Sheds@ project
- New 'Friendly Dogs' session being set up at the library. This will be delivered by volunteers from a local Dog Training School
- Finding volunteers to help produce a Soham newsletter
- Supporting residents to develop a Community Map of local activities

2.6.3 In St Ives the following activities have been supported by NCP to create new solutions to emerging needs:

- Men linked into existing volunteering opportunities including the St Ives Timebank, Men's Sheds in Bury (Ramshed) and Mind, Body and Soil

- Collaborative approach to setting up a Men's group with Care Network Cambridgeshire at the Norris Museum
- Partnership working with local community car scheme and Time bank offering transport to community events
- An intergenerational project with Thorndown Primary School. This included letter writing exchange between children and adults in St Ives. We intend to build on this to include a regular meeting between adults and children on a monthly basis
- Development of monthly 'Coffee and Cake' at Bests coffee shop. This was popular between Christmas and New Year and has continued on a monthly basis
- St Ives has a new lunch club. Twenty people now meet at the Haywain pub which has started an OAP menu
- New craft group held at the library once each month

2.6.4 Both teams have been working to attract volunteers to work as part of the NCP. For example one volunteer is being used to visit and befriend a woman with Multiple Sclerosis whose husband provides all her care and is reluctant to give himself breaks. The volunteer has been able to establish a positive relationship with both the husband and wife and both are benefitting from her support. Another is providing an ambassadorial role for the Soham NCP linking with other community groups and promoting the role of NCP in Soham. Other volunteers have done leaflet dropping and regularly attend drop ins and community meetings to make cups of tea and welcome people and record who attends.

3.0 FEEDBACK FROM EXTERNAL EVALUATOR, YORK CONSULTING

3.1 The Evaluation Process

3.1.1 Much of their initial work has focused on gaining an understanding of the implementation processes, the model of delivery, early successes, and challenges and issues faced by the project. Researchers have consulted with managers, visited the teams, spoken to key partners and had initial consultations with clients. The next stage will be to undertake 20 in-depth, client case studies (10 in each team). These case studies will provide evidence of the benefits to clients/family members and services supporting them. The evaluators will also use the case studies to provide a detailed cost-benefit assessment of the pilot.

3.1.2 The main implementation challenges arise from an approach which is innovative, flexible and responsive but must fit within existing structures. York Consulting advised that lack of control of the care budgets for the people supported by the teams has impacted on the teams' ability to provide a truly flexible response. This is now being addressed. See Section 8.

They also stated that in the early stages a lack of understanding of the teams' role and what they can do, was evident amongst other services. This is not surprising given the nature of the pilot and that it is a new approach to delivery of care and support. Concerns were also expressed that the teams are duplicating work already undertaken by other services. In response, the teams have worked hard to raise awareness of their offer and how it fits with and can add value to existing provision and this will be an iterative process as the project develops.

Cover over weekends and outside normal working hours has been raised as an issue. To address this NCWs are making contingency plans with people that will help them access appropriate support from family, friends, NCWs, re-ablement and primary care services.

Early successes have focused on the experience and calibre of the teams and their ability to provide an immediate, local response without a formal assessment. What has made the difference is their strengths-based, client-centred, localised approach and ability to deliver on what clients say they need. "*I was invisible, now I'm visible*" (Client).

York Consulting has commented that the approach being taken by the team enables them to treat clients as individuals, work on reducing their dependency and help them to manage their own conditions, which in turn is reducing demands on other services such as GPs and 111. The teams are helping clients manage the services involved with them, as well as identifying and accessing other individuals, groups and/or services that can help meet their needs more effectively. They are also helping to step down support because it is no longer required. There is evidence to show that the teams are helping to de-escalate potential crises, such as mental health crises and emergency hospital admissions. They are also supporting clients who currently do not meet thresholds for services but whose needs are likely to escalate with age and increased frailty. They are helping clients develop protective mechanisms /support that they can draw on to build their resilience.

4.0 FEEDBACK FROM PUBLIC WORLD AND SHARED LEARNING WITH OTHERS IN THE UK USING BUURTZORG PRINCIPLES

4.1 To ensure we are using the Buurtzorg principles in delivering the project outcomes we asked Public World to carry out a 'health assessment' on our approach.

Public World concluded: "We have met many enthusiastic and energised individuals in this pilot, which clearly has inspired many people. As a result, it was a great pleasure to carry out this brief 'health assessment'".

Public World recommend that in order to support the aim of having self-managed teams we should

- Give the NCWs the opportunity to meet with Buurtzorg Nurses to set a bench mark on what is achievable.
- NCWs to receive training on Buurtzorg's Solution Driven Method of Interaction. This would support the teams in decision making, conflict resolution and enhance their ability to operate as self-managed teams.
- Develop a framework that defines the boundaries for the teams to work in and organisational requirements to deal with budgets and appraisals.
- Provide Coach Training and ongoing support.
- Provide Heatshield training and ongoing support to simplify, protect and support the teams and review what care solutions are possible/needed.
- Develop a framework with the teams that addresses the need for performance data.

We plan to continue to work closely with Public World in order to strengthen the pilot and its outcomes.

4.2 We are also in regular dialogue with other local authorities using the Buurtzorg Principles. These include Suffolk, Newham and Tower Hamlets and have planned learning opportunities and workshops with them.

5.0 CASE STUDIES

5.1 Appendix 2 provides a number of case studies to illustrate the work of the pilot as were outlined in the business case for NCP:

- Understanding their communities. Identifying people at all levels of need who might require help, as well as the people within communities with the capacity to help others.
- Building community capacity. Working to encourage the development of social or micro enterprises as new care provision or to support other community-led activities to establish.
- Complementing the Adult Early Help (AEH) team where face to face contact is needed to advise on ways people and their carers can organise help for themselves and resolve issues without the need for a formal assessment or care plan.
- Visit people that go into hospital or other settings and help them plan a return to living as independently as possible.
- Assessing needs. This might be a statutory assessment but a lot of the 'assessment' work is part of the regular home visits and is built into "hands on" care.
- Identifying where housing adaptations, community equipment or assistive technology should be used and making sure it is put in place.
- Identifying and investigating (or escalating) safeguarding concerns.
- Identifying where people need ongoing care and working with them to make and organise a plan.
- Providing "hands on" care where appropriate, including ongoing care.
- Liaising with local health teams and other key partners to ensure wider needs are met.
- Reviewing people's needs, not as a formal process, but constantly, responding flexibly to needs day to day by working as a team.

6.0 FEEDBACK FROM PEOPLE WHO HAVE RECEIVED SUPPORT FROM THE NCP

6.1 "What you're doing for me is really useful. It's made me think about widening my networks and getting involved with things."

6.2 A quote from a couple who are keen to move their mother to this area to live with them for extra support: "Thank you so much for taking your time with us and explaining everything" (in relation to disabled facilities grants and local support and voluntary agencies). "We didn't know where to go before".

6.3 From a woman who lives alone: "I'm telling people how good you have been, you have given me confidence. It's a very nice life line, to be able to call someone if needed".

6.4 Mr Q in St Ives asked to speak to me directly to say that the NCW was very good and had gone the extra mile in supporting him and his wife. He also felt that the service was a brilliant service and much needed by the local community.

6.5 It's more about sharing, than caring. People like to be cared about, but not to have care done to them. When you change that mind-set to sharing time with someone, it changes the whole perspective and experience for both parties. A problem shared is a problem halved and a cost saved.

6.6 One person when asked if she would like a photo taken with a caption of what the NCWs meant to her said she would love to say how important they have been to her, except that she was welling up with tears when she related how much NCW had changed her life and didn't want to be red-eyed in a photo!

6.7 "I just wanted to drop you a line to thank you for coming out to meet my father yesterday. It was so lovely to meet you and having someone as experienced and communicative as yourself to chat to, is so reassuring for him. I and my sister were so delighted that you spent so much time with him, listening to his opinions. He was very, very impressed to meet you. Thanks for arranging to see him independently. His partner can be tricky and has some mental health issues which mean that she struggles with caring for him at times and struggles to communicate well with myself and my sisters so having someone as professional and experienced as yourself to be an outside eye at times is invaluable."

7.0 QUOTES FROM FOUR OF THE NEIGHBOURHOOD CARES WORKERS

7.1 "Being able to do what is right for the person, building relationships so that the person gets to know you and the Neighbourhood Cares Team, and the NCW knows the person they are supporting. Being able to support the person flexibly and with the approach that is best for the person and what they want not just with a set process. Being able to support someone ongoing for as long as required and not just for one or two visits, then no support until the next review or assessment. Building up a network of support and knowledge of the local community so that people can access and get the most out of the community they are living in".

7.2 "By being allowed the freedom to do what is right for the person makes such a huge impact of all involved".

7.3 "I really enjoy the fact that - most of the time – we can flex the service to suit the needs of the people we work with, rather than forcing them into a system. I like the fact that we get to know the community in depth, so that we have a real understanding of what is on offer for people locally, and how we can develop that. I like the fact that we can have an ongoing relationship with the people we work with, so we can see them develop their strengths, their confidence and their resilience, and of course, the point I keep coming back to, this job allows me to be the social worker I always wanted to be."

7.4 "Working in one community makes so much sense. We know the people, we know the place. By supporting people early on - before they hit crisis – we can prevent them needing our services later, and we do that in the best possible way by connecting them to the wealth of local assets. Assets you only know about when you really get to know

a community. A centralised team can't possibly know about the tiny local bereavement group or the family who want to offer their help with respite, we do."

8.0 NEXT STEPS IN THE DEVELOPMENT OF THE NEIGHBOURHOOD CARES PILOT

8.1 We want to be more ambitious in the next phase of the pilot and will test the application of the Buurtzorg model by implementing the following actions.

Until now NCP has been operating broadly within the same framework as other adult social care teams. Now that the teams are established we want to fully test the Buurtzorg principles. To do this it is proposed that each team becomes financially accountable for a devolved budget that is made up from the personal budgets from all the people in the pilot. In addition each team will have a capitated sum from their share of preventative services such as assistive technology and re-ablement.

In making their decisions the NCWs will aim to achieve one or more of the following outcomes:

- Improve outcomes for service users.
- Manage costs by achieving the same or better outcomes in a more cost effective way.
- Manage demand by care and support.

8.2 We will continue to work with York Consulting to develop the evaluation process to provide evidence of improved outcomes. A baseline devolved budget is being created for each site using financial data for October 2017 i.e. at the point NCP went live. The trend in overall spend and by type of service will be monitored to provide evidence of the financial outcomes. The NCP financial position will be reported in the July Finance and Performance Reports that are presented to committee in September.

8.3 We will allocate some of the funding identified for recruitment of additional re-ablement staff to the teams and allow them to decide how they wish to recruit staff to work as part of their team.

8.4 Develop new ways to meet unplanned and ongoing personal care needs. This will include promoting a more personalised approach through direct payments and micro enterprises or having alternative operating models with partner providers. Any alternative arrangements that are made would be coordinated by the NCWs as the main point of contact.

8.5 Increase the number of personal care assistants working in both communities to deliver personalised care as part on the NCP.

8.6 Change our relationship with local domiciliary care providers to achieve more flexibility and a focus on prevention and outcomes.

8.7 Recruit and support more volunteers who will work as part of the NCP and with existing or new community groups.

8.8 Working closely with discharge planning colleagues to ensure people exit hospital with the help they need as soon as they are fit to do so ensuring they do not stay in hospital longer than is necessary.

8.9 Ensure that the implementation of the new adult social care information system (Mosaic) enables the NCP approach.

8.10 Continue to facilitate the growth of social enterprises, community groups and local businesses to reduce dependency on traditional statutory services.

9.0 ALIGNMENT WITH CORPORATE PRIORITIES

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

9.2 Developing the local economy for the benefit of all

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

9.3 Helping people live healthy and independent lives

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

9.4 Supporting and protecting vulnerable people

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

10.0 SIGNIFICANT IMPLICATIONS

10.1 Resource Implications

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

10.2 Procurement/Contractual/Council Contract Procedure Rules Implications

10.2.1 *There are no significant implications within this category*

10.3 Statutory, Legal and Risk Implications

10.3.1 *There are no significant implications within this category*

10.4 Equality and Diversity Implications

There are no significant implications within this category

10.5 Engagement and Communications Implications

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

10.6 Localism and Local Member Involvement

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

10.7 Public Health Implications

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

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

Source Documents	Location
Key Trend graphs	Laura Jane Winter and Patrick Killenny 2nd Floor Octagon Shire Hall Cambridge

Appendix 1

In this Appendix, information is provided to give a statistical overview of the NCP to date. Data provided includes both the two pilot communities of Soham and St Ives and the two comparison communities of Littleport and St Neots (Eaton Socon).

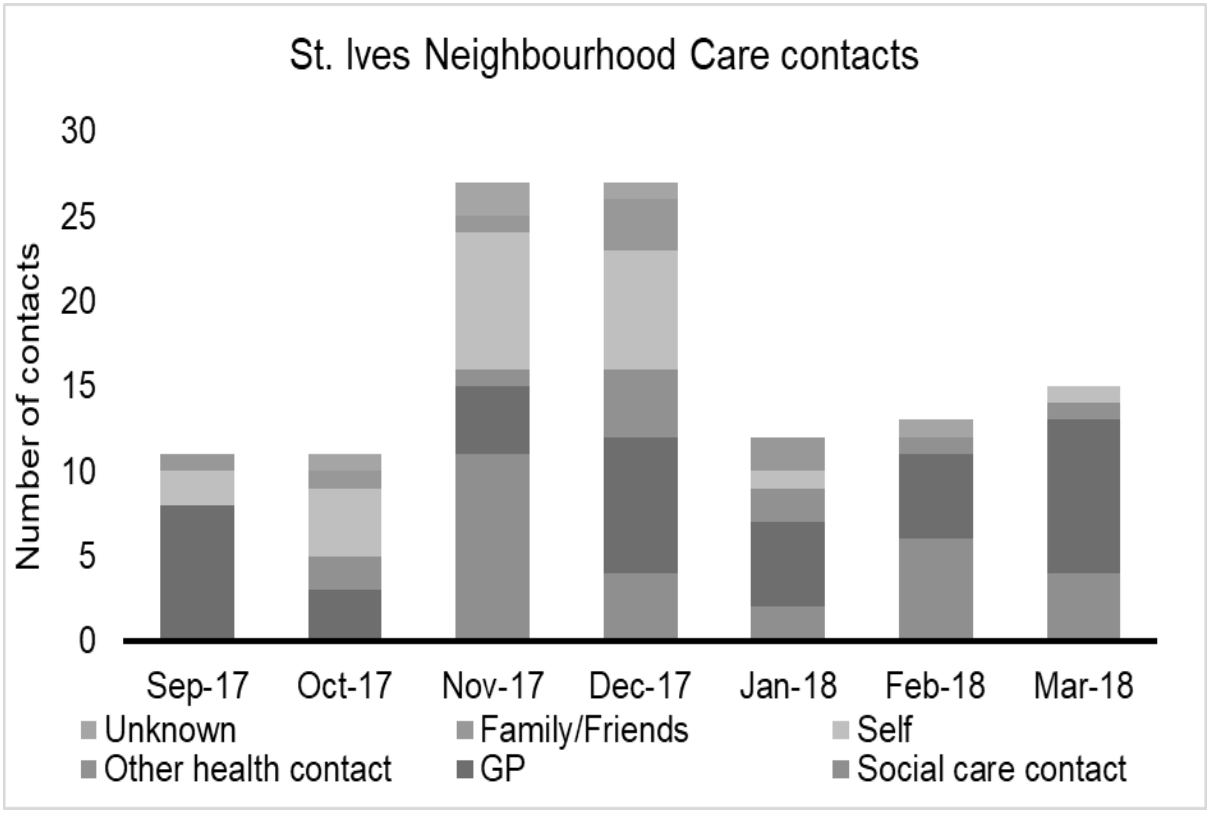
Number of service users receiving home care and rates of home care per 1000 population for Neighbourhood Care Pilot areas and their comparator areas

- This is based on data from the October 2017 statutory return.
- All service areas are included.

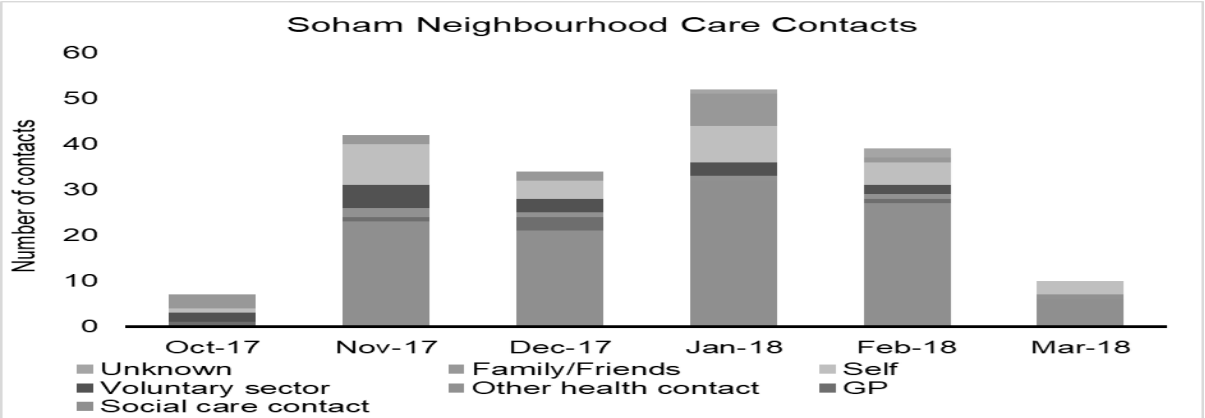
NCP patch	Age band	Population	Number of homecare provisions	Rate per 1000 population
Littleport	18-64	5480	22	4.0
	65+	1680	42	25.0
	All adults	**7160**	**64**	**8.9**
Soham	18-64	8020	22	2.7
	65+	2020	43	21.3
	All adults	**10040**	**65**	**6.5**
St Ives	18-64	10310	17	1.6
	65+	3300	65	19.7
	All adults	**13610**	**82**	**6.0**
St Neots	18-64	20130	30	1.5
	65+	6040	132	21.9
	All adults	**26170**	**162**	**6.2**

Monthly referrals/contacts to the Neighbourhood Care Teams

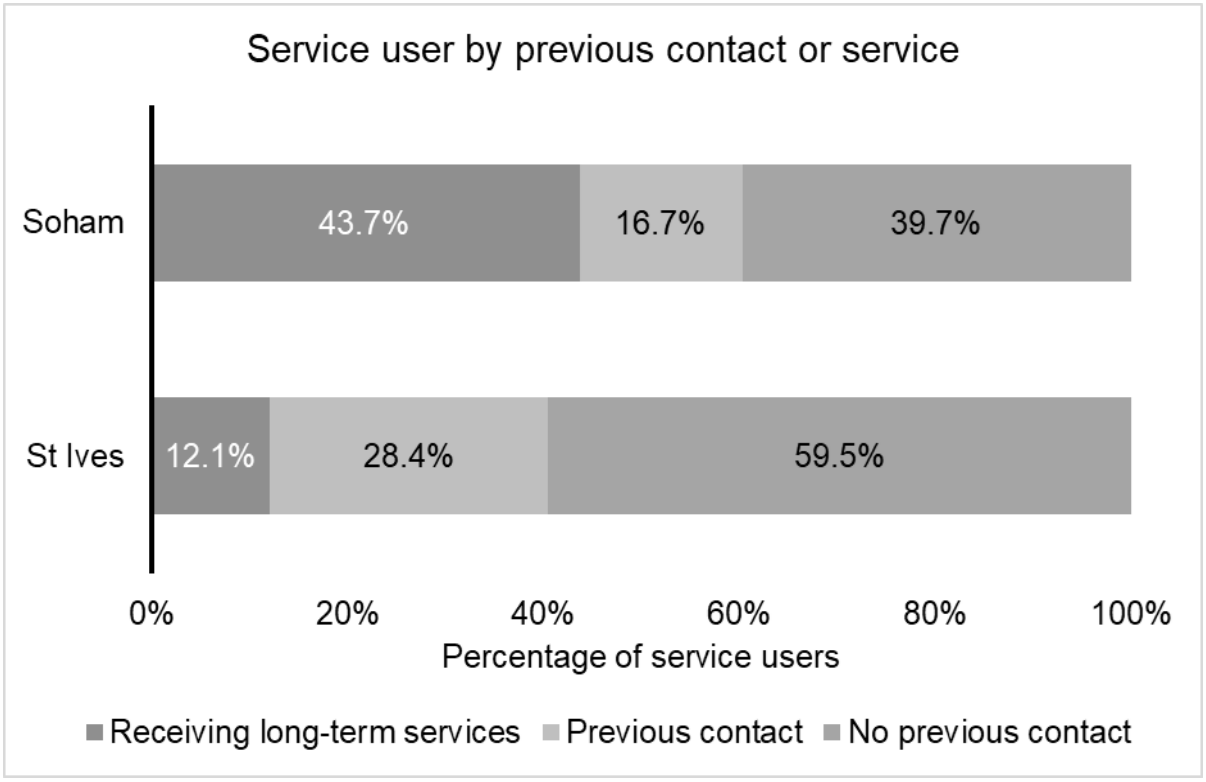
(Although both teams went officially live during October 2017, St Ives did start taking on work at the end of September 2017).



Month	Social care contact	GP	Other health contact	Self	Family/ Friends	Unknown	Total
Sep-17		8		2	1		11
Oct-17		3	2	4	1	1	11
Nov-17	11	4	1	8	1	2	27
Dec-17	4	8	4	7	3	1	27
Jan-18	2	5	2	1	2		12
Feb-18	6	5	1			1	13
Mar-18	4	9	1	1			15
Total	**27**	**42**	**11**	**23**	**8**	**5**	**116**



Month	Social care contact	GP	Other health contact	Voluntary sector	Self	Family/Friends	Unknown	Total
Oct-17		1		2	1	3		7
Nov-17	23	1	2	5	9	2		42
Dec-17	21	3	1	3	4	2		34
Jan-18	32		1	3	8	7	1	52
Feb-18	27	1	1	2	5	1	2	39
Mar-18	6		1		3			10
Total	**109**	**6**	**6**	**15**	**30**	**15**	**3**	**184**



	St Ives	Soham
Receiving long-term services	14	76
Previous contact	33	29
No previous contact	69	69
Total	**116**	**174**

Appendix 2

Case Studies

Case study 1 - Mr A and partner Ms M

Mr A is a gentleman over 65, referred by GP due to immobility and low mood. I went to visit but he was very ill and was admitted to hospital that day. I supported his partner, she was struggling with medication as Mr A usually took care of this for her. She had been without medication for 3 days as Mr A had been ill in bed for that time. I arranged with GP surgery and pharmacy to switch her meds to a Dossett box which was done that day. Mr A was in hospital for a week; I kept in regular touch with his partner and I also spoke to the hospital. Following discharge, I visited to see if there was any support needed. On second visit post discharge I was able to identify with Mr A that he would like to be more socially active, as he spends most of his time in the home reading and watching TV. He also expressed an interest in volunteering opportunities. I have found a book group for him to join and also put him in touch with the Volunteer Bureau and with the Time Bank. I am visiting this week to support him to complete an application for Attendance Allowance. I have also spoken to his partner about her needs as a carer, and whether she would also benefit from additional support.

Key Outcome: Working with GP and Pharmacy ensured partner can self-medicate even if partner not well, also preventing need for formal care. Visit post hospital discharge helped ensure appropriate support to enhance recovery.

Mr A and Ms M both receiving all benefits eligible for so have additional income. Hands on support has prevented any need for commissioning of formal support and regular contact has enhanced mental wellbeing by reducing social isolation and promoting self-worth.

Case Study 2 – Mrs B

Mrs B is in her 80s. Following a stay in hospital was discharged to a nursing home. Nephew contacted the team as aunt keen to return to her own home and he did not know how to support her to do this. Mrs B has daily care needs and is financially able to pay for the care she needs, but requires support in setting this up to ensure it is the most appropriate care and is also linked into all support available to Mrs B and her family and friends who wish to support her living in her own home.

NCW worked alongside CPFT colleagues in assessing what support Mrs B needed to live at home. This included ensuring the right equipment was in place, as well as assisting Mrs B and her nephew in finding who could provide the care to assist with all Mrs B's personal care needs. Using personal care assistants was discussed but initially Mrs B wanted to use a care agency she had previously used. Following Mrs B's return home, NCW visited regularly and as Mrs B's confidence grew, was able to support her in reducing the amount of daily help she needed. This was done by the NCW keeping in regular contact by visits and phone calls to ensure that Mrs B is not only getting the practical support she needs, but is also in contact with friends and opportunities in the community to prevent her feeling isolated.

Key Outcome: Mrs B does have ongoing care needs but the NCW's intervention has meant that this care is being provided in her own home rather than residential care. That the most

appropriate equipment and technology to support her independence is in place. As someone liable to fund her own care, she is paying for the most appropriate care that meets her needs so that her own finances will last longer. Ms B does not feel isolated and family and friends also feel able to access the advice and support they need so they feel able to support Mrs B.

Under current model, people who self-fund their own care are at risk of spending more than they need to. NCP is establishing relationships with providers who work in the communities to ensure that if ongoing services need to be commissioned either privately or via the Council, the support provided is the best value for money. The key to this and the best interests of the person receiving the care is to listen and ensure everyone involved is clear of their roles and responsibilities and agree how they will communicate with each other.

Case Study 3 – Mr and Mrs S

Both are in their 80s. Mr S has been diagnosed with prostate cancer and is having investigations to see if it has spread; he is also blind and hard of hearing. Both Mr and Mrs S have heart conditions and Mrs S has leg ulcers which are dressed regularly by the District Nurse. NCW is supporting both Mr and Mrs S to receive all the care and support they need that enables them to continue living at home. This has included staying with Mr S so Mrs S could attend hospital appointments; preparing Mr S's meal and assisting him to the toilet; supporting Mr and Mrs S's family in coordinating a rota of support and assisting with daily living tasks as well as others to provide support.

Key Outcome: Over a period of 4 weeks as Mr S's health declined, his family's wish was for him to die at home. NCW provided care and support as and when it was needed. This enabled Mr S to die at home supported by his family and nurses and without the need to involve commissioned services. In the final few days, NCW was not required to provide any support as the family and nursing team were with him. Since Mr S's death, the NCW has kept in touch with Mrs S who currently has family living with her and feels at this time does not need ongoing support from NCW. However both she and her family are aware they can make contact if needed in the future.

Case Study 4 – Mr F

Having completed a review for Mr F, the NCWs will now provide the lunch time call for him on Monday to Friday as he does not need assistance every day. The arrangement is that the NCWs phone to check if a visit is required and if it is, they will deliver the care, which is assistance with pulling up trousers and redressing. This clearly demonstrates the benefits of a locally based team which can allocate a task to be performed by any member of the team only if it is needed.

Key Outcome: Following the review, Mr F's care package was reduced by the five lunch time calls which meant a saving of £41 each week on the amount of weekly commissioned care needed to meet Mr F's ongoing care needs.

Case Study 5 – Jim

Jim is 72. He lived all his life with his mother until she died 4 years ago. The GP has referred Jim to NCP as Jim is becoming more socially isolated and also has developed some cognitive loss. The GP referral also says that Jim is becoming muddled about his medication and his paperwork and has missed several important appointments recently.

Jim is due to have an operation in hospital in the next couple of weeks. This is a rescheduling as he was due to have this operation last month but failed to turn up. He had previously had contact

with the AEH team who had arranged for him to have a bath step put in place. Jim was quite happy to have a visit from a NCW but wasn't sure what help if any he needed.

Over a number of weeks, NCW built up a relationship with Jim. It was clear that he had memory issues but that he was also coping independently and had done for a number of years. However, he was also struggling with paperwork, with keeping appointments and with some social activities. NCW did try to find a volunteer who could support him with his paperwork but so far have drawn a blank. However, I pop in when passing to catch up with him and see if he has had any important letters which need dealing with. I was able to support him through a medical procedure earlier this year. Jim was unable to understand the instructions regarding his medication prior to the op. I accompanied him to the local pharmacy, arranged with the pharmacist to adjust the medication in his Dossett box and wrote out the instructions for the medication he had to take instead in an easy-to-follow format. The medical preparation (Moviprep) which he had to take at 7 pm the evening before and at 7am on the day was provided by the hospital. I spent some time going through the instructions with Jim, and phoned him the day before the operation to remind him to not eat after lunchtime and to take his Moviprep that evening. However, Jim managed to mislay the Moviprep the night before the operation and so the operation was unable to go ahead. I therefore rebooked the operation, liaised with the pharmacy again and a member of the team stayed with Jim on the afternoon/evening before to ensure that the Moviprep was taken correctly at the right time. Another team member returned at 7am to ensure that Jim took the morning dose and that he had everything he need for his hospital stay. The operation went ahead successfully.

Jim has gained confidence in the team and has attended some social events we have arranged including a lunch club and coffee afternoons. We were recently informed by the receptionist at The Spinney that Jim used to take up a lot of their time as he was always turning up at the surgery asking the receptionists to help him with his paperwork, but that since we have been working with him he has not needed their help.
Key Outcome: This case study demonstrates the value of providing "Hands on Care' that is flexible and able to do the right thing at the right time. Without the active involvement of NCWs, Jim would not have had received the hospital treatment he needed or may have had to be admitted over night to ensure that he received the correct pre-operative care in order to have the operation he required. People such as Jim who have no family support, could potentially cost both health and social services time and money in cancelled appointments or use of staff time inappropriately. They are also at risk of not being able to live independently if they do not have access to support that can assess the risks they face on a daily basis and put in place support that will prevent an escalation of their needs.

Case Study 6 – Amanda

Amanda is in her 50s and lives at home in a housing association bungalow with her beloved two cats. She has had previous involvement with under 65 mental health services including long term, crisis and inpatient services and has been diagnosed with personality disorder, anxiety and depression and psychosis. Amanda also has physical health problems including fibromyalgia, ongoing back problems and COPD.

Amanda was referred to Neighbourhood Cares by her GP who feels that she is struggling as a carer for her mum and needs "social care support" due to her current levels of anxiety and social isolation. She is very distrusting of people she identifies as 'professionals' and feels that she has been let down over and over again by statutory/support services.

Amanda has very few social relationships and describes not having anything to live for outside of looking after her mum, who lives in sheltered housing a short drive away. Caring for her mum is a very important aspect of her life. She tells you she would love to have "something else to live for" or she will "likely go when mum goes".

Amanda loves art and has explained how beneficial having a creative outlet has been in the past, but she has no motivation to do this on her own and feels her current level of anxiety prevents her from accessing anything on her own. She is also concerned about going out because she has no motivation to wash or brush her hair (doing so also causes her shoulder and neck pain). She has thick curly hair and describes how in the past this has become so matted during times of deep depression she has had to have the majority of her hair cut off.

There are several things she says need sorting in her home as there is a hole in the roof and no access to the back garden she can use due to her mobility. Amanda used to love to garden and be outside but does not feel able to contact the housing association as they "don't listen to her" when she calls.

The NCWs have spent time getting to know Amanda and gaining her trust. They have supported her in liaising with her housing provider and getting the repairs required completed. Amanda is considering the best way to maintain her garden and NCWs have provided her with all the contacts and information regarding local garden services and community groups.

Visits with Amanda have been combined with providing her with "hands on care' that has included washing her hair. Also spending time with Amanda and her mother separately and together to maintain their relationship and appreciating each other's strengths.

Key Outcome: This case demonstrates the benefits of accessing needs while delivering hands on care and supporting two people who also play a key role in supporting each other, but require some coaching/family therapy to appreciate each other's strengths and focus on those rather than difficulties or problems. The support of a skilled professional that is locally based that is promoting positive messages is having a positive effect on both Amanda and her mother.

Case Study 7 – Nicki

A case study that demonstrates the benefits of a team that has no labels of whom it supports other than the person is over 18 years old and a patient of the GP surgery and that people can refer themselves.

Nicki is a woman in her early 40s and contacted The Neighbourhood Cares Team in early December after seeing a poster in her GP surgery. In her first telephone call, she said she "didn't know where to start" with trying to work things out. She said her children had been removed from her care which has also meant the breakdown of other family relationships. Nicki is at risk of eviction and is trying to end years of substance misuse, her benefits are changing, and she is really angry with statutory services.

A member of the team arranged to visit that day and learnt that Nicki had been off substances for nearly 3 months. It really saddened her that the difficulties within her family meant that this wasn't recognised or celebrated by anyone. Nicki also said she loved writing, especially stories for children. She had a job working a few hours a week doing cleaning and that and the children no longer living with her meant her benefits needed changing but she didn't have easy access to the internet or the benefits office which was in another town.

Nicki had an appointment with a mental health team but didn't know whether that was something she wanted to engage in. Nicki described how not having her children with her had taken the structure and joy out of her days – she loved cooking for them, for example, and now she had no one to cook for. Nicki talked about a relationship she had developed with a friend's mother, who she was able to spend time with to alleviate the older woman's loneliness. The most pressing issue was a court date regarding eviction because of rent being unpaid. Nicki had missed a previous court date because of anxiety and the practicalities of getting into Cambridge, and was feeling unable to go along to this one, but knew that not attending meant that she would lose her home.

The NCW has attended court with Nikki and ensured that she has maintained her tenancy and has an agreed payment plan in place. Nicki is in contact with her children and is being a good friend to an older person in the community. Nicki knows how to contact the NCWs if she has issues she needs to discuss or check. The most common way she does this is by text.
Key Outcome: For Nicki, knowing she has someone she can discuss things with before they become a major issue helps her deal with the ongoing issues she faces. It is helping her to value herself and therefore reduce the risk of her addiction. It is also a benefit for her family and friends who see the positive effect it has on Nikki being able to maintain her home and her own well-being.

Case Study 8 – Lenny

The GP surgery contacted the Neighbourhood Cares Team to ask if we could support 68 year old Lenny to an appointment at Addenbrookes due to a serious medical concern. They were concerned that Lenny often didn't attend appointments and that he would not be able to get to Cambridge, find his way around the hospital, or understand medical information. One of the Neighbourhood Cares Team telephoned him and arranged to go with him to the appointment.

On the journey, Lenny said that has lived alone since his parents died over 30 years ago. He used to work for a supermarket and in some firms around his home town, but has some bad memories of being bullied in these settings. He said he went to what he describes as a "special" boarding school, while his brother went to grammar school. He talks about the towns he likes visiting and shares his knowledge of reptiles. He talks about having been burgled and assaulted on several occasions in the recent past.

At the hospital, Lenny is told that it is likely that he has cancer, which will mean that he is going to need surgery in the near future. He is given several appointments for biopsies and scans. It is unclear whether Lenny understands all the information he has been given. The NCWs arrange a rota to ensure some from the team is available to accompany Lenny to his various hospital appointments.

In doing so, the NCWs are able to establish Lenny does have the capacity to understand the treatment he requires and the risks associated with it. The NCWs, also with Lenny's permission, liaised with the hospital regarding the pre and post operative care Lenny would require and ensured that Lenny was given the time to discuss with them the implications of all that it involved. The NCWs supported Lenny to get together all he needed for his admission to hospital for surgery and took him to the hospital.

During his hospital admission, the NCWs visited and liaised with the hospital to ensure that he was discharged as soon as he was medically fit. On discharge, the NCWs provided the hands on support he needed encouraging him to follow his post operative care and on one occasion taking him to the GP as they were concerned he was developing a chest infection which was in fact the

case. Without them having actively encouraged Lenny to see his GP, this could have resulted into a readmission to hospital. Again, with Lenny's consent, the NCWs made contact with his brother so he was aware of Lenny's health issues. They normally communicate infrequently via Christmas cards and this appears unlikely to change.

Lenny is now about to start a programme of radiotherapy and the NCWs are supporting Lenny to ensure that he attends each session. If, as is likely, the radiotherapy has a detrimental effect on his health, the NCWs will ensure he receives the support he needs.

Key Outcome: To date, Lenny has not had any commissioned care and has undergone surgery that he may never have received had the NCWs not been there to gain his trust and provide both the emotional and practical support he required. At all times, NCWs have respected how Lenny chooses to live and made sure he had the opportunity to discuss with them what the implications of his treatment and what help he requires to continue living in his own home. The fact that health professionals in both the hospital and community have an open pathway of communication with the NCWs means they feel able to provide Lenny with ongoing appropriate support and advice regarding his postoperative care and treatment.

Case Study 9 – Ralph

Ralph's daughter got in touch having seen our details, wanting to know if we could support her father. We arranged that she would check with her dad if he was happy for us to visit and then arranged a visit to him when his daughter would be present. Ralph's initial feeling was that we couldn't help him with anything as he was managing fine. However, during our first conversation, he said he was struggling with a couple of things, including putting his bins out for collection. As he walks with two sticks, he found it almost impossible to move the bin bags to the end of his driveway and was scared of falling in the process. I arranged an assisted bin collection for him via HCDC. I also suggested to him that a referral to an OT and to the Fire Service might be appropriate as he was finding it difficult to mobilise in his home, and he felt that he was at risk of falls as he tried to carry plates of food and hot drinks form the kitchen to his dining table. Neither he nor his daughter were aware that the Fire Service offered "Safe and Well" checks but took up the offer of a referral. The Fire Service subsequently visited and made some suggestions, fitted additional smoke detectors and also arranged for the smoke detectors to be linked to Ralph's lifeline. We also identified with Ralph that he was finding his social life had shrunk and he wanted more social interaction. I gave Ralph information about the voluntary car scheme in St Ives and also about various activities and social groups. Ralph and a friend subsequently attended a lunch group. I am currently supporting Ralph to complete an Attendance Allowance form.

Key Outcomes: It is not uncommon for people to not know what support is available to them or how to access it. The value of having a single person who can inform you about the range of support that is available and help you access it, that reduces the risk of falls, prevents social isolation and increasing a person's income so they themselves can pay for additional support is evidenced by this case, plus the fact that Ralph and his daughter both have a point of contact if they require further advice or support.

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

To:	**Adults Committee**
Meeting Date:	**24 May 2018**
From:	**Chief Executive**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable** *Key decision:* **No**
Purpose:	**To consider appointments to outside bodies, internal advisory groups and panels, and partnership liaison and advisory groups.**
Recommendation:	**It is recommended that the Adults Committee:**

(i) review and agree the appointments to the partnership liaison and advisory groups detailed in Appendix A

(ii) delegate, on a permanent basis between meetings, the appointment of representatives to any outstanding outside bodies, groups, panels and partnership liaison and advisory groups within the remit of the Adults Committee to the Executive Director: People and Communities, in consultation with the Chairman/ woman of the Adults Committee.

	Officer contact:
Name:	Ruth Yule
Post:	Democratic Services Manager
Email:	michelle.rowe@cambridgeshire.gov.uk
Tel:	01223 699180

1. BACKGROUND

1.1 The County Council's Constitution states that the General Purposes Committee (GPC) has

- Authority to nominate representatives to Outside Bodies other than the Cambridgeshire and Peterborough Fire Authority, the County Councils' Network Council and the Local Government Association.

- Authority to determine the Council's involvement in and representation on County Advisory Groups. The Committee may add to, delete or vary any of these advisory groups, or change their composition or terms of reference.

1.2 The GPC has previously agreed to refer appointments to Internal Advisory Groups and Panels, and Partnership Liaison and Advisory Groups to the relevant Policy and Service Committee.

2. APPOINTMENTS

2.1 The appointments to be made by the Adults Committee are set out in Appendix A, attached. The previous representative(s) is indicated. It is proposed that the Committee agree the appointments to these bodies.

2.2 On 13 July 2017, the Committee agreed to delegate, on a permanent basis between meetings, the appointment of representatives to any outstanding outside bodies, groups, panels and partnership liaison and advisory groups, within the remit of the Adults Committee, to the Executive Director (CFA) in consultation with Adults Spokes. Following changes in the Council's structure and Constitution, that delegation should now be to the Executive Director: People and Communities in consultation with the Chairman/woman of the Adults Committee.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

There are no significant implications for this priority.

3.2 Helping people live healthy and independent lives

There are no significant implications for this priority.

3.3 Supporting and protecting vulnerable people

There are no significant implications for this priority.

4. SIGNIFICANT IMPLICATIONS

4.1 There are no significant implications within these categories:

- Resource Implications
- Procurement/Contractual/Council Contract Procedure Rules Implications
- Statutory, Legal and Risk Implications
- Equality and Diversity Implications
- Engagement and Communications Implications
- Localism and Local Member Involvement
- Public Health Implications

Implications	Officer Clearance
Have the resource implications been cleared by Finance?	Not applicable
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by Finance?	Not applicable
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	Not applicable
Have the equality and diversity implications been cleared by your Service Contact?	Not applicable
Have any engagement and communication implications been cleared by Communications?	Not applicable
Have any localism and Local Member involvement issues been cleared by your Service Contact?	Not applicable
Have any Public Health implications been cleared by Public Health	Not applicable

Source Documents	Location
Adults Committee Agenda and Minutes – 13 July 2017	https://cmis.cambridgeshire.gov.uk/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/604/Committee/3/Default.aspx
General Purposes Committee Agenda and Minutes -	https://cmis.cambridgeshire.gov.uk/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/188/Committee/2/Default.aspx

Appendix A

CAMBRIDGESHIRE COUNTY COUNCIL
APPOINTMENTS TO OUTSIDE BODIES, INTERNAL ADVISORY GROUPS AND PANELS AND PARTNERSHIP LIAISON AND ADVISORY GROUPS: ADULTS COMMITTEE

NAME OF BODY	MEETINGS PER ANNUM	REPS APPOINTED	REPRESENTATIVE(S)	CONTACT DETAILS
Carers Partnership Board The role of the Board is to develop, co-ordinate and monitor services and support delivered to carers across Cambridgeshire.	6	1	Councillor Kevin Cuffley (Con)	Carol Williams Strategic Development Manager Adults and Safeguarding 01223 706130 Partnership.Boards@cambridgeshire.gov.uk
Learning Disabilities Partnership Board Members of the Board include people with learning disabilities and people on the autistic spectrum (Speak Out Leaders), carers, representatives from voluntary organisations, service providers and the Learning Disability Partnership (County Council and health services). The role of the Board includes: • Providing an opportunity for people to be involved in the decisions made about services that affect them and their carers. • Raising issues/concerns heard by the Speak Out Leaders from people with learning disabilities or on the autistic spectrum across the county.	4	1	Councillor Adela Costello (Con)	Tracy Gurney Head of Service Learning Disability Partnership 01223 714692 tracy.gurney@cambridgeshire.gov.uk

NAME OF BODY	MEETINGS PER ANNUM	REPS APPOINTED	REPRESENTATIVE(S)	CONTACT DETAILS
Mental Health Governance Board Provide the strategic governance overview of the delegated Service as set out in the Section 75 Agreement.	6	1	Councillor D Wells (C)	Charlotte Wolstenholme Business Support Assistant Older People's Mental Health Team 01223 715940 charlotte.wolstenholme@cambridgeshire.gov.uk
Older People's Partnership Board The OPPB brings together Older People, their representatives, the public and third sector, to work together to ensure the highest quality and best value services for older people across Cambridgeshire.	4	1	Councillor Anna Bailey (Con)	Carol Williams Strategic Development Manager, Adults and Safeguarding 01223 706130 Partnership.Boards@cambridgeshire.gov.uk
Physical Disability and Sensory Impairment Partnership Board Members of the Board include people with lived experience of physical disability and/or sensory impairments, representatives from voluntary organisations and representatives from statutory services such as health and social care. The role of the Board is to enable the voice of those with a physical disability and/or sensory impairments to be heard and to work together to ensure the highest quality and best value services for people locally	4	1	Councillor Mark Howell (Con)	Carol Williams Strategic Development Manager, Adults and Safeguarding 01223 706130 Partnership.Boards@cambridgeshire.gov.uk

Agenda Item No: 10

ADULTS COMMITTEE TRAINING PLAN

To:	**ADULTS**
Meeting Date:	**24 May 2018**
From:	**Charlotte Black, Service Director: Adults**
Electoral division(s):	***All***
Forward Plan ref:	*Key decision:* **No**
Purpose:	**To summarise the training outlined during 2017/18 and to introduce the draft training plan for the Adults Committee for 2018/19.**
Recommendation:	**The Committee are asked to comment and make suggestions for the Committee's training plan for 2018/19**

	Officer contact:		***Member contacts:***
Name:	**Charlotte Black**	Names:	Cllr Bailey/Cllr Howell
Post:	Service Director: Adults and Safeguarding	Post:	Chair/Vice-Chair
Email:	charlotte.black@cambridgeshire.gov.uk	Email:	annabailey@hotmail.co.uk / mark.howell@cambridgeshire.gov.uk
Tel:	01223 699692	Tel:	01223 706398

1. BACKGROUND

1.1 It is stipulated in the Cambridgeshire County Council constitution that all Committees will have a training plan developed and in place for existing and new members for that Committee.

2. MAIN ISSUES

2.1 Since May 2017, the Adults Committee has conducted several training and visits to introduce Members to Adults and Safeguarding. This included utilising reserve committee meeting dates as workshops for Members to attend to further fulfil their knowledge base. The training plan has grown throughout the year and Workshops have been developed to meet Member needs. There have been a small number of training events which has not been undertaken and these have been transferred onto the 2018/19 training plan. Appendix 1 outlines the training which has been undertaken to end March 2018.

2.2 In general most visits and training have been well attended from Members of the Adults Committee. Initial feedback has suggested that the workshops have been well received and the induction visits have been valuable and the Adults Committee were informed of key areas and developments. In addition feedback from staff included that they really value the member engagement and was seen as an important part of their development also.

2.3 The draft Committee training plans for 2018/19 can be found in Appendix 2 and the Adults Committee are asked to comment and make further suggestions for training plan. It is suggested that the workshops should be continued as part of the training plan for Committee in 2018/19, where possible utilising the reserve committee dates.

2.4 The Committee will review the plan at forthcoming Committee meetings.

3. ALIGNMENT WITH CORPORATE PRIORITIES

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

There are no significant implications for this priority.

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

There are no significant implications for this priority.

3.3 **Supporting and protecting vulnerable people**

There are no significant implications for this priority.

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

There are no significant implications within this category.

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

There are no significant implications for this priority.

4.3 Statutory, Legal and Risk Implications

There are no significant implications for this priority.

4.4 Equality and Diversity Implications

There are no significant implications for this priority.

4.5 Engagement and Communications Implications

There are no significant implications for this priority.

4.6 Localism and Local Member Involvement

Please see section 2.1 and 2.2

4.7 Public Health Implications

There are no significant implications for this priority.

Source Documents	Location
None	

Appendix 1

Adults Committee Training Plan 2017/18

Below is an outline of completed training committee sessions and visits.

Date	Timings	Topic	*Presenter*	Location	Audience
30 June	1-4:30pm	Local Government Finance	*Chris Malyon*	KV Room	Completed
7th July	2-4pm	Safeguarding *(Children's & Adults)*	*Theresa Leavy / Sarah-Jane Smedmor / Claire Bruin*	KV Room	Completed
September (12 & 20 Sept)	9.00-17.00	Induction to Adults Services - A service -users journey from Short Term & Access services such as Adult Early Help, Reablement and Assistive Technology through to Long Term Older People's services, including an overview of Discharge Planning – a day visiting various teams.	*Head of Service lead (Jackie / Vicky)*	Various	Completed
21 November	TBC	Local Government Finance	*Chris Malyon*	KV Room	Completed
11th January	11:30am	An overview of the Adults Social Care review process, current performance and overview of the finance	*Claire Bruin*	KV Room	Completed All Adults Members
8th March	11am	An overview of Learning Disability Partnership, Physical Disability services and Adults Social Care	*Claire Bruin /' Tracy Gurney*	Room 128	Completed All Adults Members invited

Training to be arranged:

- Visit to the Multi-agency Safeguarding Hub (MASH) / Visit to Respite care and day services
- Commissioning Services – what services are commissioned and how our services are commissioned across P&C
- An overview of Carers Strategy *(this was presented at Committee)*
- Adults Social Care and Support Plans

Appendix 2

Draft Adults Committee Training Plan 2018/19

Below is an outline of dates and topics for potential training committee sessions and visits. The preference would be to organise training and visits prior to Committee meetings and utilising existing Reserve Committee dates:

Date	Timings	Topic	*Presenter*	Location	Audience
12 April	2:30-4:30pm	Adults Positive Challenge	Geoff Hinkins	KV Room	Completed
TBC		Safeguarding: - Overview of safeguarding - Visit to the Multi-agency Safeguarding Hub (MASH) - Visit to Respite care and day services	Helen Duncan		
Ongoing		Induction to Adults Services - A service-users journey from Short Term & Access services such as Adult Early Help, Reablement and Assistive Technology through to Long Term Older People's services, including an overview of Discharge Planning – a day visiting various teams.	Jackie Galwey	Various	All Members
TBC		Commissioning Services – what services are commissioned and how our services are commissioned across P&C	Oliver Hayward	TBC	All Members
TBC		An overview of the Adults Social Care: - Support plans - Process - Performance	Jackie Galwey	TBC	All Adults Members
TBC		An overview of Adults social care finance	Stephen Howarth / Charlotte Black	TBC	
TBC		An overview of the Council's work in relation to Carers	Jackie Galwey		

Reserve Committee dates for 2018/19:

- 12 April 2018
- 7 June 2018
- 16 August 2018
- 14 February 2019

ADULTS POLICY AND SERVICE COMMITTEE AGENDA PLAN	Published on 1st May 2018 Updated 14th May	Cambridgeshire County Council	

Notes

Committee dates shown in bold are confirmed.
Committee dates shown in brackets and italics are reserve dates.

The definition of a key decision is set out in the Council's Constitution in Part 2, Article 12.
* indicates items expected to be recommended for determination by full Council.
+ indicates items expected to be confidential, which would exclude the press and public.

Draft reports are due with the Democratic Services Officer by 10.00 a.m. eight clear working days before the meeting.
The agenda dispatch date is five clear working days before the meeting.

The following are standing agenda items which are considered at every Committee meeting:

- **Minutes of previous meeting and Action Log;**
- **Finance and Performance Report;**
- **Agenda Plan, and Appointments to Outside Bodies.**

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for reports	Agenda despatch date
07/06/18 Provisional Meeting				24/05/18	29/05/18
19/07/18	Proceed to procurement the care and support services at Hauxton extra care scheme	L O'Brien	2018/045	06/07/18	10/07/18
	Learning Disability Partnership Section 75 and pooled budget arrangements	C Bruin	Not applicable		
	Annual Complaints Report	C Bruin	Not applicable		
	Home Improvement Agency (HIA) Update	A Chapman	Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for reports	Agenda despatch date
	Deep dive: Social Care labour market	W Patten	Not applicable		
16/08/18 Provisional Meeting				03/08/18	07/08/18
06/09/18	Business Planning	W Ogle-Welbourn	Not applicable	23/08/18	28/08/18
	Care Homes Development – maximising existing contracts and tender opportunity to expand existing care home provision	S Torrance	2018/034		
	Proceed to procurement the care and support services at Whittlesey extra care scheme (currently known as Bassenhally)	L O'Brien	2018/044		
	People and Communities – Risk Register	D Revens	Not applicable		
	Joint working with health – key priorities	W Patten	Not applicable		
	Annual report from the Adults Safeguarding Board	H Duncan	Not applicable		
	Deep dive: Continuing Health Care		Not applicable		
	Deep dive: Learning Disability employment opportunities	M Darbar	Not applicable		
18/10/18	Business Planning	W Ogle-Welbourn	Not applicable	05/10/18	09/10/18
	Deep dive: Adult Safeguarding	H Duncan	Not applicable		
	Neighbourhood Cares Update	L Tranham	Not applicable		
	Adult Early Help / Prevention / Early Intervention	J Galwey	Not applicable		
15/11/18	Business Planning	W Ogle-Welbourn	Not applicable	02/11/18	06/11/18

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for reports	Agenda despatch date
	Annual Survey of Adults Social Care Users	C Black			
13/12/18	Business Planning	W Ogle-Welbourn	Not applicable	30/11/18	04/12/18
10/01/19	Adults Self-Assessment	C Black	Not applicable	21/12/18	31/12/18
	Delayed Transfers of Care – progress report	C Black / W Patten	Not applicable		
14/02/19 Provisional meeting				*01/02/19*	*05/02/19*
21/03/19	CPFT Annual report	F Davies	Not applicable	08/03/19	12/03/19
18/04/19 Provisional meeting				*05/04/19*	*09/04/19*
16/05/19	Full Evaluation of Neighbourhood Cares (May 2019)	L Tranham / C Black	Not applicable	02/05/19	07/05/19

To be programmed:

- Care Quality Commission Findings report
- Review of the number of people waiting for a change to their current domiciliary care service, or for a new package of domiciliary care (monitoring item identified at meeting on 8 March 2018)
- Review progress of the action plan arising from the Adult Social Care Service User and Carers 2017 Survey