CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD

Date:Thursday, 21 September 2017

10:00hr

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

Shire Hall
Castle Hill
Cambridge
CB3 0AP

Civic Suite, Pathfinder House, Huntingdon PE29 3TN

AGENDA

Open to Public and Press

1.	**Election of Vice Chairman/ Vice Chairwoman** To elect a Vice Chairman or Vice Chairwoman of the Board from the Clinical Commissioning Group members of the Board for the remainder of the municipal year 2017/18.	
2.	**Apologies for absence and declarations of interest** *Guidance on declaring interests is available at http://tinyurl.com/ccc-conduct-code*	
3.	**Minutes of the Meeting on 6 July and the Extraordinary meeting on 8 September 2017** To follow: minutes of the Extraordinary meeting on 8 September 2017.	**5 - 16**
4.	**Action Log September 2017**	**17 - 22**
5.	**Person's Story** Verbal item.	
6.	**Local Safeguarding Children Board Annual Report 2016-17**	**23 - 90**

14. Date of Next Meeting

The Board will meet next at 10.00am on Thursday 23 November 2017, venue to be confirmed.

The Cambridgeshire Health and Wellbeing Board comprises the following members:

Councillor Peter Topping (Chairman)

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

Julie Farrow (Appointee)

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

Clerk Name: Richenda Greenhill

Clerk Telephone: 01223 699171

Clerk Email: Richenda.Greenhill@cambridgeshire.gov.uk

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Agenda Item No: 3

CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD: MINUTES

Date: 6 July 2017

Time: 10.00am – 12.15pm

Venue: Kreis Viersen Room, Shire Hall, Cambridge

Present: Cambridgeshire County Council (CCC)
Councillors A Bailey, S Bywater, P Hudson, C Richards and S van de Ven
Dr L Robin, Director of Public Health (PH)
C Bruin, Assistant Director: Adults (substituting for the Executive Director, Children Families and Adults)
T Kelly, Strategic Finance Business Partner (substituting for the Chief Finance Officer)

City and District Councils
Councillors M Abbott (Cambridge City), A Dickinson (Huntingdonshire) and M Cornwell (Fenland)

Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)
T Dowling, Chief Officer, J Bawden, Director of Corporate Affairs and Dr S Pai, GP Member

Healthwatch
V Moore, Chair

NHS Providers
D Cohen (substituting for A Thomas) – Cambridgeshire and Peterborough NHS Foundation Trust; M Winn – Cambridgeshire Community Services NHS Trust; and K Reynolds (substituting for S Graves), North West Anglia NHS Foundation Trust

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

District Council non-voting officer advisor
M Hill, South Cambridgeshire District Council

Also in attendance:
B Law, Cambridgeshire Safeguarding Board and Community Safeguarding Network

Apologies:
Councillor L Harford, Chairman – Cambridgeshire County Council (substituted by Councillor P Hudson)
Councillor J Schumann – East Cambridgeshire District Council
Councillor S Ellington, South Cambridgeshire District Council
S Graves, North West Anglia NHS Foundation Trust (substituted by Keith Reynolds)
C Malyon, Chief Finance Officer, Cambridgeshire County Council (substituted by T Kelly)
A Thomas, Cambridgeshire and Peterborough NHS Foundation Trust (substituted by D Cohen)
S Posey, Papworth Hospital NHS Foundation Trust
W Ogle-Welbourn, Executive Director for Children, Families and Adults, CCC (substituted by C Bruin – Assistant Director for Adults)

1. NOTIFICATION OF THE APPOINTMENT OF THE CHAIRMAN

The Clerk reported that Councillor Lynda Harford had been appointed as the Chairman of the Cambridgeshire Health and Wellbeing Board at the meeting of Cambridgeshire County Council on 23 May 2017. The Chairman was unable to attend this meeting and had sent her apologies.

2. ELECTION OF THE VICE CHAIRMAN/ VICE CHAIRWOMAN

The Clerk stated that the Vice Chairman or Vice Chairwoman of the Board was elected at the beginning of each municipal year from the three representatives of the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) appointed to the Board and invited nominations for the appointment. Tracy Dowling, Chief Officer of the CCG, was nominated for the position of Vice Chairwoman by Jessica Bawden, Director of Corporate Affairs at the CCG and seconded by Dr Liz Robin, Director of Public Health.

There being no further nominations it was resolved to:

> appoint Tracy Dowling as Vice Chairwoman of the Cambridgeshire Health and Wellbeing Board for the municipal year 2017/18.

The Vice Chairwoman took the Chair for the remainder of the meeting.

3. APPOINTMENTS

The Vice Chairwoman noted the following appointments to the Board and welcomed all new members:

- Councillor Anna Bailey – Cambridgeshire County Council
- Councillor Simon Bywater - Cambridgeshire County Council
- Councillor Claire Richards - Cambridgeshire County Council
- Councillor Susan van de Ven - Cambridgeshire County Council
- Councillor Angie Dickinson – Huntingdonshire District Council
- Stephen Graves – North West Anglia Foundation Trust

4. APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST

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

The Vice Chairwoman noted that the Clerk was currently updating declarations of interest for non-elected members of the Board and would contact members directly with further information.

5. MINUTES OF THE MEETING ON 30 MARCH 2017 AND THE EXTRAORDINARY MEETING ON 27 APRIL 2017

The minutes of the meeting on 30 March 2017 were agreed as an accurate record and signed by the Vice Chairwoman, subject to the correction of a miss-spelt word on the third bullet point of Minute 268: Review of the Better Care Fund. The corrected minute read '~~*Delated*~~ Delayed transfers of care…'

The minutes of the extraordinary meeting on 27 April 2017 were agreed as an accurate record and signed by the Vice Chairwoman.

6. ACTION LOG

The Action Log was noted. The only item which remained outstanding related to Minute 268: Review of the Better Care Fund (BCF). At the Board's request the previous Chairman had written to the Secretary of State for Health, copied to the Secretary of State for Communities and Local Government, on 3 May 2017 to express strong concern at the delay in issuing guidance for the 2017-19 BCF and the importance of aligning the BCF timeframe with other relevant financial planning considerations. A reply had been received from the Secretary of State's Private Secretary advising that a substantive response could not be provided until after the outcome of the General Election.

The Vice Chairwoman noted that guidance for the 2017-19 BCF had only been issued the previous day, a quarter of the way into its first year of operation. Members of the Board re-iterated their serious concern at this delay and their wish to raise this again with central government.

(**Action: Transformation Manager:** To prepare a further draft letter to central government for the Chairman's signature which sets out the Board's concerns)

7. A PERSON'S STORY

The Vice Chairwoman welcomed Barbara Law to the meeting and invited her to share her story with the Board to provide context to consideration of the following item, the Safeguarding Adults Board Annual Report 2016/17.

Ms Law stated that she was one of three community representatives on the Cambridgeshire Safeguarding Board and a member of the Community Safeguarding Network. She had spent 22 years working in social care in Cambridgeshire before her retirement, had spent 15 years as a trustee of Jimmy's Nightshelter and had acted as an informal carer to family and friends. As members of many other organisations and networks the three Community Network representatives were well placed both to gauge awareness of the public's views and expertise on safeguarding and to share this information with others. They were pleased to be members of Cambridgeshire Adults Safeguarding Board and to be able to assist organisations as they implemented the 'Making Safeguarding Personal' agenda. This included working to ensure that information given to the public was accessible and free from jargon and that those receiving safeguarding support felt that they had control over their own lives.

In response to Ms Law's story the Chairwoman of Cambridgeshire County Council Adults Committee asked that her thanks be recorded on behalf of the County Council for the great work being done by members of the Community Safeguarding Network. She highlighted the difficulty in identifying and gaining access to more isolated members of the community and welcomed all that was done by partner and voluntary organisations to make individuals aware of the full range of safeguarding and other support available to them.

The voluntary sector representative noted with interest the Community Safeguarding Network's involvement in safeguarding training and felt this was something which could usefully be explored further outside of the meeting.

The Vice Chairwoman offered Ms Law her thanks on behalf of the Board for the valuable work being done by members of the Community Safety Network and for their selfless contribution in supporting vulnerable members of the community. Members had been

interested to hear about the newsletter which the Community Safeguarding network produced and she asked the Clerk to obtain a link to this for circulation to all members of the Board.
(**Action: Democratic Services Officer**)

8. SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2016/17

The Board noted that the Independent Chair of the Safeguarding Adults Board had sent apologies that he was unable to attend in person to present the annual report for 2016/17. In his absence, the Assistant Director for Adults at Cambridgeshire County Council presented the report. She stated that the draft annual report published with the meeting papers had since been approved unchanged by the Safeguarding Adults Board (SAB. The headline figures included:

- a reduction in the number of adult safeguarding incidents referred to the Council from 1499 in 2015/16 to 1272 in 2016/17;

- the most common type of referral remained physical abuse (33%), although this had reduced from 42% of total referrals in 2015/16;

- an increase in reported cases of neglect from 24% in 2015/16 to 30% in 2016/17.

The Board had been working on a number of identified priorities during the past year. These included making safeguarding more person-centred, reflecting the guidance in the Care Act 2014. One way in which this was done was to establish a conversation with the person receiving support to find out what outcomes they wanted to achieve and tailoring their support to meet this need in a flexible and personal way. A lot of work had been carried out during the period to embed the principles of making safeguarding personal within the organisation and its staff, but it was acknowledged that this represented a significant change in culture and there was still more work to be done. The development of the new Multi-Agency Safeguarding Hub (MASH) provided a single point of access for all safeguarding referrals which were triaged and referred on to the appropriate teams and agencies for action. This approach was ensuring that cases were prioritised quickly and accurately and was relieving pressure on locality teams. The MASH had good links with both adult health services and voluntary sector organisations and could signpost referrals through these routes where this offered a more appropriate response.

Russell Wate had been confirmed as the new Independent Chair of the Cambridgeshire SAB in September 2016 and his appointment had brought together the chairmanship of the SABs for Cambridgeshire and Peterborough together with the Local Safeguarding Children's Board for both local authority areas. The extension of joint working arrangements across Cambridgeshire and Peterborough had brought together most of the Boards' sub-groups to deliver increasingly collaborative and integrated working practices. Following the introduction of the Care Act 2014 the focus for outcomes of safeguarding enquiries had changed from whether a report was substantiated to recording whether any actions taken in response to the report had led to the risk being reduced or removed. This was considered a more helpful measure by practitioners. The priorities which had been agreed across Cambridgeshire and Peterborough for 2017/18 were domestic abuse, neglect (including self-neglect and hoarding) and adults living with mental illness.

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

- New and more detailed data analysis work was being undertaken by the recently established Business Unit and more detailed information would be available from the second quarter of 2017 onward. This could include a more detailed breakdown of the figures relating to NHS referrals;
- The Safeguarding Adults Board (SAB) worked closely with the Cambridgeshire Fire and Rescue Service and there was strong collaboration in cases of mutual interest;

- In future it would be good to see more space given in the report to the voluntary sector response to safeguarding given the significance of the role of volunteers in supporting vulnerable adults. The Assistant Director for Adults offered to discuss this feedback with the Independent Chair and explore the possibility of future voluntary sector representation on the Board;
  (**Action**: Assistant Director for Adults)

- The CCG GP representative commended the fantastic training offered to GPs by the SAB and noted that locums also attended this training so the actual number of individuals trained would be higher than the figure indicated in the report;

- Information about the Modern Slavery and Discrimination course offered by the SAB would be circulated to all members for information.
  (**Action:** Assistant Director for Adults)

It was resolved to:

a) comment on the content of the covering report and the Cambridgeshire Safeguarding Adults Board Annual Report 2016/17;

b) ask the Independent Chair to present the next Annual Report (for 2017/18) at a Health and Wellbeing Board meeting in 2018.

9. CAMBRIDGESHIRE PHARMACEUTICAL NEEDS ASSESSMENT 2017

The Board received the Cambridgeshire Pharmaceutical Needs Assessment (PNA) 2017 for approval together with a proposed monitoring protocol for keeping the PNA up to date until July 2020 when it was next due to be updated. The Director of Public Health recorded her thanks to Kirsteen Watson and Katie Johnson in the Public Health team for leading the detailed and thorough work, which had formed the basis for the report, to the multi-agency steering group for their expert input, and to all stakeholders and members of the public who had responded to the public consultation exercise.

Every Health and Wellbeing Board in England had a statutory responsibility to publish and keep up to date a statement of the need for pharmaceutical services for the population in its area. This would be used by NHS England to inform future decisions about opening new pharmacies in the area. These decisions were sometimes appealed and challenged in court so it was important that the PNA was kept up to date. The final PNA report and monitoring protocol had been reviewed by LGSS Law Ltd and was compliant with the regulations. The PNA 2017 concluded that there was currently sufficient pharmaceutical service provision across Cambridgeshire. No need for additional pharmaceutical service providers was identified. However, it was highlighted that it was not yet possible to predict whether the overall reduction in pharmacy funding by NHS England might lead to mergers or closures of existing pharmacies within Cambridgeshire and that new housing developments might alter the future pattern of need within the county. The monitoring protocol would, if approved, allow issues such as these to be addressed quickly in advance of the next formal PNA being conducted in 2020.

The following points arose in discussion of the report and in response to members' questions:

- The number of pharmacies which were accessible to wheelchair users had improved since the last PNA;

- Changes to the contractual framework meant that pharmacy mergers were no longer considered to create an automatic gap in provision;

- It was confirmed that the Cambridgeshire PNA took account of the pharmacies which were located just outside of county borders;

- It would be helpful to clarify whether the position in relation to the out of hours service provided by Hertfordshire Urgent Care described on page 49 of the PNA was the same as the service provided by IC24 in Norfolk;
  (**Action:** Director of Corporate Affairs, CCG)

- It would be helpful to look at ways in which the Sustainability and Transformation Plan could link into the services offered by community pharmacies and to facilitate a joined up approach between the acute care sector and pharmacies;
  (**Action**: Head of the STP Delivery Unit)

- The learning which had been obtained through the public consultation process was being applied to the PNA being carried out in Peterborough and would inform the next PNA in Cambridgeshire in 2020;

- Members noted that the PNA related to locality pharmacies rather than clinical pharmacists employed by GP practices, but a member questioned whether any spare capacity amongst clinical pharmacists could be used in support of general practice;

- Members welcomed the acknowledgement within the PNA of the important role played by community pharmacists in delivering preventative services such as smoking cessation and sexual health services;

- Members were pleased to see that access to pharmaceutical services across the county was holding up well and was improving in rural areas;

- With the consent of the meeting it was agreed that the wording to recommendation (b) be slightly amended so that decisions made under delegated authority should be discussed with the Chair and Vice Chair of the Board rather than the Chair or Vice Chair to ensure that both the County Council and the Clinical Commissioning Group were consulted.

Summing up, the Vice Chairwoman thanked officers for a comprehensive report that members could usefully take back to their respective organisations. The self-care agenda provided an important adjunct to primary care and local pharmacies had an important role to play in supporting this.

It was resolved to:

a) note the findings of the Cambridgeshire Pharmaceutical Needs Assessment (PNA_ 2017 and approve the final PNA report submitted by the multi-agency PNA steering group;

b) approve the monitoring protocol for keeping the PNA up to date between now and July 2020, including the delegated authority for approval of supplementary statements to the Director of Public Health, in discussion with the Chair and Vice-Chair of the Board.

10. SUSTAINABILITY AND TRANSFORMATION PLAN UPDATE REPORT

The Board received an update on the Sustainability and Transformation Plan (STP) from the Analytics and Evaluation Director and Head of Communications at the STP Delivery Unit. The STP programme had now transitioned from the development to delivery phase and was looking at both short-term operational and longer term strategic ambitions in its drive to achieve a more accountable care approach. It was proposed to establish both an STP Board and an STP Stakeholder Group within the next few months. Membership of both groups was still under discussion, but it was anticipated that Board members would be drawn from individual stakeholder organisations including both elected members and health representatives with a lay Chair. Significant partnership working and collaboration continued to take place, including joint working with the Cambridgeshire Public Services Board and the Health and Care Executive to maximise benefits across Cambridgeshire and Peterborough.

In the course of discussion, Board members:

- Asked for an update on workforce strategy and recruitment and retention issues. The District Support Officer also reported a question from a district councillor about whether there was a clear workforce plan and monitoring system in place and, if so, where this was reviewed. The Lead on the STP Workforce work stream stated that it was recognised that there were a number of short-term projects which would be looking to draw on the same pool of personnel. Officers were working to bring such schemes together holistically from a joint health and social care perspective so that they would be working together to meet their staffing needs rather than competing to attract the same work force. The Assistant Director for Adults at Cambridgeshire County Council welcomed this commitment from the health sector representatives to working in collaboration rather than competition with social care services.

  The Analytics and Finance Director stated that the first issue addressed in consideration of every proposed project or investment was workforce. Significant work was being undertaken to look creatively at the best use of the workforce available and this represented a key consideration in all decision making.

  The Vice Chairwoman stated that workforce issues was recognised as one of the biggest risk factors to delivering the STP; to ensure that people with the right skills were in the geographical areas where those skills were needed. It was agreed that the STP update reports submitted to the Board's next and subsequent meetings would include specific detail about workforce strategy in relation both to the STP and, where relevant, the Combined Authority. This should include information about workforce planning arrangements including the monitoring systems in place and feedback on why health care professionals were leaving the service, including how this was monitored and feedback from exit interviews. The precise detail would be worked up outside of the meeting through the Health and Wellbeing Support Group, but each STP update report going forward would pick up the workforce issue in addition to any stand-alone reports on workforce issues which might be submitted;
  (**Action**: Interim Executive Programme Director, STP Delivery Unit)

- Noted the variation in the availability of health and social care staff across Cambridgeshire and Peterborough, with areas of both under and over supply;

- Noted that the implications of Brexit on the numbers of health and social care staff both locally and nationally was not yet known;

- Noted that nurse training would become self-funded from September 2017 and that it was not yet known if this would impact on student numbers;

- Noted that leaders within health and social care organisations were exploring the impact of the new apprenticeship levy and how apprenticeships could be used to upskill existing staff within the work environment. Members commented that this might be an issue which they would want to explore in more detail at a future meeting;

- Noted the commitment within the Cambridgeshire and Peterborough devolution deal to enhancing skills within the local area;

- Asked that information on the role of care workers and voluntary sector input should be reflected in future update reports;
  (**Action**: Interim Executive Programme Director, STP Deliver Unit)

- Noted the comment by the GP member of the CCG that GPs represented a scarce asset and the importance of supporting them within their practices and using their skills to best effect. This might include the safe delegation of work to others within the primary care sector where appropriate and an increasingly joined up approach across practices;

- The Healthwatch representative stated that there had been variable public involvement in the STP to date. She urged the STP partners to see the opportunity over the life of the STP to achieve exemplar public involvement at all levels of working. She welcomed the proposal to establish more accountability of the STP and asked for more information about the proposals being formulated as Healthwatch was not aware of them;
  (**Action**: Head of Communications and Engagement, STP Delivery Unit)

- The Vice Chairwoman invited views on membership of the Stakeholder Group and whether it would be preferable to hold frequent meetings for a small representative group or a smaller number of regular events for a wide range of stakeholders (perhaps twice a year). Both the Healthwatch representative and the voluntary sector representative favoured the latter approach which would enable the widest range of stakeholders to participate directly;

- Welcomed confirmation that consideration was being given to including both voluntary sector and GP representation on the STP Board, although the lack of a single representative organisation for GPs was acknowledged as an issue;

- Paragraph 3.4: Noted that use of the word ‘patient’ in the phrase ‘patient and public engagement’ was used within the NHS to refer to stakeholders in the widest sense;

- Noted that a number of STP workstreams were still actively seeking greater public and stakeholder engagement. It was agreed to bring details to the next meeting of those areas where public and stakeholder engagement was already in place and those areas where gaps remained;
  (**Action**: Interim Executive Programme Director, STP System Delivery Unit)

- An elected member expressed concern that they had been told that the participation of elected members on NHS steering groups and bodies should be politically proportionate as this did not recognise the mandate which an elected member had been given by local residents to represent their views. Any party political or other relevant interests would be declared in the usual way and would be entirely transparent within the decision-making process.

It was resolved to:

comment upon and note the update report.

11. LOCAL AUTHORITIES AND HEALTH JOINT WORKING UPDATE

The Board received a report seeking support for the development of a 'Living Well' Partnership Concordat to demonstrate a commitment to whole system partnership working by all organisations involved in the delivery of health and wellbeing for Cambridgeshire's residents. It was proposed that a draft Concordat be developed by partners over the summer and presented to the Board for comment in September 2017. The 'Living Well' Partnership Concordat would provide an alternative to the proposal to sign the Sustainability and Transformation Plan Memorandum of Understanding (STP MOU) and would be a broader document which would embrace a wider range of stakeholders. The STP MOU would remain in place for those key partners who had already chosen to sign up to it with the 'Living Well' Partnership Concordat being designed to complement rather than replace it.

The Board was also invited to note progress on forming joint area delivery partnerships by merging Local Health Partnership and Area Executive Partnership meetings as discussed previously at the Board's development session in March 2017. Further detail including proposed terms of reference would be brought back to the Board at a later date.

The following points were raised in discussion of the report and in response to questions from members:

- A member questioned whether work on the 'Living Well' Partnership Concordat might be included in the work which would be undertaken to refresh the Joint Cambridgeshire Health and Wellbeing Strategy which was to be discussed under Item 11 on the agenda;

- The voluntary sector representative endorsed in principle the inclusive nature of the 'Living Well' Partnership Concordat;

- Members acknowledged that there would be difficulties to be overcome in producing a Concordat which met the governance and other requirements of all of the organisations concerned, but were confident that these could be overcome;

- A member welcomed the proposals to form joint Area Delivery Partnerships as a positive attempt to simplify partnership structures, but emphasised the need to ensure that no groups were disenfranchised by the change.

It was resolved to:

a) support the development of a 'Living Well' Partnership Concordat to demonstrate commitment to 'whole system' partnership working by all partner organisations involved in the delivery of Health and Wellbeing for Cambridgeshire residents and so provide an alternative to signing the Sustainability and Transformation Plan Memorandum of Understanding;

b) Note progress to form joint 'Area Delivery Partnerships' by merging Local Health Partnership and Area Executive Partnerships, as discussed at the Health and Wellbeing Board development session in March 2017.

12. RENEWING THE JOINT CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

The Board received a report the Board from the Director of Public Health seeking approval for the proposed process to renew the Joint Cambridgeshire Health and Wellbeing Strategy and a steer on the approach to be taken and any key priorities. The Board had a statutory duty to prepare a Joint Strategic Needs Assessment (JSNA) of the health and wellbeing of Cambridgeshire residents and to prepare a Joint Health and Wellbeing Strategy to meet these needs. In reviewing this strategy the Board would wish to consider its position within the wider context of the Sustainability and Transformation Plan and devolution to ensure that its work aligned with, but did not duplicate, other strategic work being undertaken across Cambridgeshire and Peterborough. It was proposed to invite the Local Government Association (LGA) to facilitate a development session for the Board on 8 September 2017 to discuss the wider strategic landscape and initial thoughts on priorities. Positive reports had been received from officers at Durham County Council who had recently used the LGA in this role.

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

- Several members expressed concern at the considerable amount of time, effort and resources which were devoted across local government and partner organisations to producing numerous strategies of this kind. Whilst recognising the statutory duty on the Board to produce a Joint Health and Wellbeing Strategy and the positive outcomes which had been achieved under the current strategy they questioned the amount and cost of the work in the proposed renewal process to produce a strategy which would probably be quite similar to the one currently in place.

- A member questioned whether it would be preferable for the Board to concentrate on one or two clearly identified outcomes over an agreed period. The Director of Public Health undertook to explore whether this would meet the duty placed on the Board under statute in advance of the discussion at the development session on 8 September;
  (**Action:** The Director of Public Health)

- A member emphasised the need to ensure that the refreshed Joint Health and Wellbeing Strategy should reflect a focused and pragmatic approach which added value and avoided duplication of work being undertaken elsewhere;

- Members asked that invitations to the wider stakeholder event planned for the afternoon of 21 September 2017 to identify and test priorities for the renewed Joint Health and Wellbeing Strategy should be issued as soon as possible to maximise attendance;
  (**Action:** Head of Public Health Business Programmes)

- Members requested that the development session on 8 September 2017 should include the following:

- A refresher on the purpose of Health and Wellbeing Boards, including what they were required to do by statute and what they could choose to do;
- How the Board monitored progress on the strategies it approved and ensured that these were delivering the outcomes required;

- Reviewing how the Board operated in Cambridgeshire now that it had been in operation for a number of years.

(**Action**: Director of Public Health)

- With the consent of the meeting it was agreed to vary recommendation (b) of the report to approve the extension of the current Health and Wellbeing Strategy (2012-17) ~~to May 31 2018~~ *until a replacement was in place*.

It was resolved to:

a) approve the process and provisional timetable for renewing the Cambridgeshire Joint Health and Wellbeing Strategy as outlined in paragraph 4.1;

b) approve the extension of the current Health and Wellbeing Strategy (2012-17) until a replacement was in place;

c) provide initial comments on the strategic approach and priorities which the Health and Wellbeing Board would wish to see in the new Joint Health and Wellbeing Strategy.

13. FORWARD AGENDA PLAN

The Board noted the Forward Agenda Plan and offered the following comments:

- A request by one member to consider homelessness and related issues in the context of work being undertaken by Cambridge City Council. It was agreed that the Health and Wellbeing Support Group would liaise with officers at the City Council to understand what was required;
(**Action:** Head of Public Health Business Programmes)

- A suggestion that Winter Comfort be invited to provide the Person's Story at the meeting on 23 November 2017;
(**Action:** Voluntary Sector co-opted member)

- Delayed transfers of care remained a high priority within the NHS and were considered regularly by the Board in the context of the Better Care Fund.

14. DATE OF NEXT MEETING

The Board would meet next on 8 September 2017 for a private member development session. The next public meeting of the Board would take place on Thursday 21 September 2017 at 10.00am, venue to be confirmed.

Chairman

HEALTH & WELLBEING BOARD ACTION LOG: AUGUST 2017

MINUTE & ITEM TITLE	ACTION REQUIRED / UPDATE	STATUS
Meeting Date: 30 March 2017		
268. Review of the Better Care Fund (BCF)	To provide a draft letter for the Chairman's signature to the Department for Communities and Local Government setting out the Board's concerns about the delay in issuing guidance on the 2017-19 Better Care Fund and the importance of aligning the BCF timeframe with other relevant financial planning considerations. **UPDATE 03.05.17**: The Chairman wrote to the Right Hon Jeremy Hunt MP, Secretary of State for Health on 3 May 2017, side-copied to the Right Hon Sajid Javid MP, Secretary of State for Communities and Local Government. **UPDATE 06.06.17**: A response received from the Private Secretary to the Parliamentary Under Secretary of State for Health advising that the future of the Better Care Fund will be a matter for the next Government. Should the Board wish to write again following the General Election the Department will be happy to respond in full. The Chairman has asked that the Board consider this when it next receives a report on the BCF (September 2017). **UPDATE 15.07.17**: The Board requested that the Chairman write again to central government setting out members' concern that guidance on the 2017-19 Better Care Fund had only just been issued a quarter of the way into the first year of its operation and highlighting the importance of aligning the BCF timeframe with other relevant financial planning considerations **UPDATE 13.09.17**: Chairman to discuss the draft reply with officers. **Action: G Hinkins**	**On-going**

Meeting Date: 6 July 2017		
7. A Person's Story	To circulate a link to the newsletter produced by the Community Safeguarding Network to all members of the Board. **Action: R Greenhill** **<u>UPDATE 11.07.17, 28.07.17, and 08.08.17</u>:** A link to the CSN newsletter requested from Barbara Law.	**On-going**
8. Safeguarding Adults Board Annual Report 2016/17	To explore the possibility of future voluntary sector representation on the Safeguarding Adults Board with the Board's Independent Chair. **Action: C Bruin** **Updates requested 28.07.17 & 23.08.17**	**On-going**
	To circulate information about the Modern Slavery and Discrimination course offered by the SAB to all members for information **Action: C Bruin** **Updates requested 28.07.17 & 23.08.17**	**On-going**
9. Cambridgeshire Pharmaceutical Needs Assessment 2017	To clarify whether the position in relation to the out of hours service provided by Hertfordshire Urgent Care described on page 49 of the PNA was the same as the service provided by IC24 in Norfolk. **Action: Jessica Bawden** **<u>UPDATE 24.08.17</u>:** Awaiting an update from the CCG project lead.	**On-going**

Meeting Date: 6 July 2017		
	To look at ways in which the Sustainability and Transformation Plan could link into the services offered by community pharmacies and to facilitate a joined up approach between the acute care sector and pharmacies. **Action: Scott Haldane** **UPDATE 28.07.17:** The STP System Delivery Unit confirms that linkages between community pharmacy and relevant Improvement Projects currently being made.	**Completed**
10. Sustainability and Transformation Plan (STP) Update Report	To ensure that each STP update report going forward would pick up the workforce issue in addition to any stand-alone reports on workforce issues which might be submitted to the Board. **Action: Scott Haldane** **UPDATE 28.07.17:** Each future STP report will incorporate a workforce update. In addition, the STP System Delivery Unit would be happy to offer an additional workshop/ development session specifically on workforce issues as required.	**Completed**
10. Sustainability and Transformation Plan (STP) Update Report	To include information on the role of care workers and voluntary sector input in future STP update reports. **Action: Scott Haldane** **UPDATE 28.07.17:** This will be incorporated in update reports from November 2017 onwards, as some work needs to be undertaken to ensure the information is routinely available.	**Completed**
	To provide Healthwatch with more information on the proposals being formulated in relation to the Stakeholder Group. **Action: Scott Haldane**	**Completed**

Meeting Date: 6 July 2017		
	UPDATE 09.08.17: Aidan Fallon contacted Val Moore and Sandie Smith direct to ask how they would like to proceed to ensure that Healthwatch has the opportunity to be briefed on and input views and comments in relation to the proposed revised STP Board and Stakeholder Group arrangements.	
	To bring details to the next meeting of those areas where public and stakeholder engagement was already in place and those areas where gaps remained. **Action: Scott Haldane** **UPDATE 28.07.17:** This will be incorporated into the next STP update report.	**Completed**
12. Renewing the Joint Cambridgeshire Health and Wellbeing Strategy	To explore whether a Joint Health and Wellbeing Strategy which concentrated on one or two clearly identified outcomes over an agreed period would meet the duty placed on the Board under statute in advance of the discussion at the development session on 8 September. **Action: Liz Robin** **Update 21.08.17**: Addressed as part of the preparation for the Board's development session in September.	**Completed**
	To ensure that invitations to the stakeholder event planned for the afternoon of 21 September 2017 should be issued as soon as possible to maximise attendance. **Action: Kate Parker**	**Completed**
	To ensure that the development session on 8 September 2017 included the following: • A refresher on the purpose of Health and Wellbeing Boards, including what they were required to do by statute and what they could choose to do; • How the Board monitored progress on the strategies it approved and ensured that these were delivering the outcomes required;	**Completed**

Meeting Date: 6 July 2017		
	• Reviewing how the Board operated in Cambridgeshire now that it had been in operation for a number of years. **Action: Liz Robin** **<u>Update 21.08.17</u>:** Addressed as part of the preparation for the Board's development session in September.	
Item 13: Forward Agenda Plan	To liaise with officers at Cambridge City Council to explore the work being done in the City on homelessness and related issues and to consider at the Health and Wellbeing Support Group whether and how this might be considered at a future Board meeting. **Action: Kate Parker** **<u>UPDATE 28.07.17</u>:** Officers at Cambridge City invited to provide some information to the Health and Wellbeing Support Group meeting in November 2017 to inform consideration of whether this issue should be added to the Board's forward agenda plan for future discussion.	**Completed**
Item 13: Forward Agenda Plan	To approach Winter Comfort to invite a representative to provide the Person's Story at the meeting on 23 November 2017. **Action: Julie Farrow** **Updates requested 28.07.17 & 23.08.17**	**On-going**

Agenda Item No. 6

CAMBRIDGESHIRE LOCAL SAFEGUARDING CHILDREN BOARD (LSCB) ANNUAL REPORT 2016-17

To:	**Health and Wellbeing Board**
Meeting date:	**21st September 2017**
From:	**Russell Wate, Independent Chair, Local Safeguarding Children Board**
Recommendations:	**The Health and Wellbeing Board is asked to:**

a) acknowledge receipt of the LSCB Annual Report 2016/17.

	Officer contact:		***Member contact:***
Name:	Andy Jarvis	Names:	Councillor Peter Topping
Post:	Service Manager	Post:	Chairman
Email:	Andy.Jarvis@cambridgeshire.gov.uk	Email:	Peter.Topping@cambridgeshire.gov.uk
Tel:	01480 373582	Tel:	01223 706398

1.0 PURPOSE

To present the Local Safeguarding Children Board (LSCB) Annual Report 2016-17 to the Health and Wellbeing Board (HWB).

1.1 The purpose of the LSCB Annual Report is:

- to provide an outline of the main activities of the Cambridgeshire LSCB and achievements during 2016-17 against the objectives of the LSCB Business Plan;
- to comment on the effectiveness of safeguarding activity and of the LSCB in supporting this;
- to provide the public and partner agencies with an overview of LSCB safeguarding activity; and
- to identify gaps and challenges in service development for the year ahead.

1.2 To identify shared priorities between the LSCB and the HWB strategic plans.

2.0 BACKGROUND

2.1 The Cambridgeshire LSCB publishes an Annual Report as required by current statutory guidance, Working Together 2015.

2.2 "The Chair must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area. The annual report should be published in relation to the preceding financial year and should fit with local agencies' planning, commissioning and budget cycles. The report should be submitted to the Chief Executive, Leader of the Council, the local police and crime commissioner and the Chair of the health and well-being board.

2.3 The report should provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action. The report should include lessons from reviews undertaken within the reporting period…"Working Together 2015

2.4 The full Report is attached at Appendix 1.

3.0 SUMMARY

3.1 The Board

The Board has continued to operate effectively with high attendance levels at meetings and a successfully delivered Business Plan.

Over the year the Board has increased the level of structural and strategic coordination with Peterborough LSCB and moved to a position where all sub groups are joint with Peterborough LSCB. This is a key element in a wider review and amalgamation of Safeguarding Board functions. The Local Authority and its partner agencies are in a good position to respond to the anticipated requirements in the new Statutory Guidance,

replacing Working Together 2015, which will be published shortly for consultation.

3.2 **How has the LSCB carried out its Functions?**

a. *Coordinate what is done by partners to safeguard and promote the welfare of children and young people*
   - Launched a Domestic Abuse Strategy
   - Launched a Neglect Strategy
   - Adopted the CSE Protocol
   - Drafted, consulted and approved a new Threshold Document

b. *Ensure the effectiveness of what is done by each partner*
   - Completed the Section 11 Action Plan
   - Monitored Ofsted, HMIP, HMIC and CQC Inspection reports and action plans

c. *Demonstrate inclusion and co-operation*
   - Built on the Inclusion project with the Eastern European communities.

d. *Undertake reviews of cases and practice*
   - Undertaken Multi-Agency Audits on Domestic Abuse, Neglect, referral decision Threshold's and MASH processes
   - Undertaken four Multi-Agency single case reviews where learning was identified and used to promote improvement

e. *Monitor, evaluate and challenge—listen to feedback*
   - Developed a new Dashboard and Dataset of performance information across agencies
   - Consulted children and young people with SEND
   - Heard from the Participation Service
   - Used service user feedback in the development of CSE provision
   - Challenge practice where issues are identified, such as children being held in cells and initial health assessments for looked after children.

f. *Maintain Learning and Improvement framework*
   - Revamped the Learning and Improvement Framework
   - Ensured learning turns into change
   - Mapped the evidence available on Safeguarding in Cambridgeshire to give a coordinated picture of what we know and any gaps

g. *Policy and procedures including thresholds, training, recruitment, supervision, allegations*
   - Launched Threshold Document
   - Undertake a major review of LSCB multi-agency procedures

h. *Communicate and encourage to raise awareness*
   - Provided a well-respected Website
   - Developed use of social media and emails for communication
   - Delivered multi-media campaigns
   - Supported Local Practice Groups
   - Ran training to over 2,000 professionals
   - Undertook a training needs survey

i. Participate in planning of services

- Chair MASH Governance Board and delivered new MASH arrangements
- Participated in the MASH operational group
- Membership of Change Programme Strategic Boards
- Led work strands supporting the Children Service change programme

3.3 **How has the LSCB responded to the Safeguarding issues it identified**?

ISSUE		RESPONSE
There is no evidence that Neglect is present in Cambridgeshire to a disproportionate extent but there is a high level of Neglect in the referrals and CSC caseload.	➡	The LSCB has built on its Neglect Conference in 2016 and launched a Neglect Strategy, supported by an Action Plan and training programme to enable staff to be more effective. An audit of practice will follow in 2017/2018.
There is evidence of higher than national average figures for hospital admissions from self-harm and regional average for misuse of substances	➡	A) There was a major, and successful, initiative to reduce waiting lists for specialist psychiatric services B) Health have embarked on the redesign of provision for young people and commissioned services for those who have emerging needs.
There remains a significant rise in CSC caseloads over the	➡	Working with the LSCB the local authority has launched a major reorganisation to ensure that the right services are available to the right child at the right time.
Domestic Abuse and Parental Mental Health are the most significant factors in CIN and CP cases.	➡	The LSCB has undertaken a major audit of Domestic Abuse cases, launched a Domestic Abuse Strategy, delivered training, and promoted good practice.

3.4 **Priorities 2017-18**

a. Ensure effective safeguarding of children against neglect

- demonstrate the successful implementation of the neglect strategy
- show that staff are equipped to make informed, consistent assessments of families where neglect is an issue using the graded care profile.

b. Child sexual exploitation & missing

- continue the focus on ensuring that children who are vulnerable to exploitation are safeguarded
- ensure the risk and vulnerability of children missing from care, home and education has been effectively managed
- safeguard children from the risk of exploitation by gangs.
- safeguard children from the risk of exploitation by extremism and radicalisation.

c. The voice of the child

- continue developments in obtaining the views of children and young people for decision making and identify the impact of those views.

d. Enhancement of LSCB effectiveness in discharging its responsibilities

- working together is being reviewed in the light of the social care act.
- the LSCB is re-structuring how it works to prepare for this change. It will continue to show it is effective, in line with statutory requirement and meets the needs of Cambridgeshire children.

e. Developing and supporting effective workforce

- to have in place
  - adequate resources and capacity to deliver or commission training.
  - policies, procedures and practice guidelines to inform and support training delivery in line with the learning and implementation framework
- undertake reviews of local training needs, taking into account research, national developments, learning from SCRs and child death reviews (not only those carried out locally), and board priorities.

f. Developing Priorities for 2017-18

- Suicide and serious self-harm in children and young people
- Safeguarding within Faith Groups

4.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

Health and Wellbeing Board Priority to May 2018	LSCB priority, function or activity
Strengthen our multi-agency approach to identifying children who are in poverty, who have physical or learning disabilities or mental health needs, or whose parents are experiencing physical or mental health problems.	Neglect Strategy, supported by the development of tools for use by staff, training, monitoring and audit. Parents with mental health or substance abuse issues remain a significant element in the context for many children subject to safeguarding. As such the work of adult facing services and enabling children services to understand and respond to the impact of parental mental health issues and substance abuse remain an important part of the LSCBs work.
Develop integrated services across education, health, social care and the voluntary sector which focus on the needs of the child in the community, including the growing numbers of children with the most complex needs, and where appropriate ensure an effective transition to adult services.	The LSCB Independent Chair now chairs the MASH Governance Board. The LSCB remains central to the development of the MASH and the effectiveness of the integrated front door into children services. The LSCB continues to have a responsibility for supporting, monitoring and improving multi-agency Early Help provision.

Health and Wellbeing Board Priority to May 2018	LSCB priority, function or activity
	The Board has worked with Health and other providers on the effectiveness of the transition of young people with safeguarding needs into adult services and compliance with the appropriate NICE Guidance.
Support positive and resilient parenting, particularly for families in challenging situations, to develop emotional and social skills for children.	The LSCB continues to have a responsibility for supporting, monitoring and improving multi-agency Early Help provision. There is a shared concern to improve the resilience of children and young people.
Promote sexual health, reduce teenage pregnancy rates and improve outcomes for teenage parents and their children.	The LSCB has a priority area in addressing Child Sexual Exploitation over and above its responsibility to ensure children are safeguarded from sexual abuse. A significant level of effort has been put into ensuring an effective response is in place for children at risk of abuse and exploitation. The level of pregnancy and fatherhood among young people who are looked after by the Local Authority remains a priority area and work is being undertaken to ensure the children have parents who are able to meet their needs effectively.
Work with partners to prevent domestic violence, raise public awareness especially amongst vulnerable groups, and provide appropriate support and services for victims of domestic abuse.	Following a multi-agency audit, the LSCB has a Domestic Abuse Strategy aimed at addressing the main concerns identified and improving existing strengths.
Minimise the negative impacts of alcohol and illegal drugs and associated antisocial behaviour on individual and community health and wellbeing.	Parents with mental health or substance abuse issues remain a significant element in the context for many children subject to safeguarding. As such, the work of adult facing services and enabling children services to understand and respond to the impact of parental mental health issues and substance abuse remain an important part of the LSCBs work.
Commit to partnership working, joint commissioning and combining resources in new ways to maximise cost-effectiveness and health and wellbeing benefits for individuals and communities.	This is a shared priority for all the Statutory Boards in Cambridgeshire and Peterborough.
Identify sustainable, long-term solutions to manage the increase demand on health and social care services.	Responding to the growth of demand for health and social care services at a time when resources are under pressure is an issue under review by the Board.
Encourage increase involvement of service user representatives and local groups in planning	*The voice of the child:* Continue developments in obtaining the views of children and young people

Health and Wellbeing Board Priority to May 2018	LSCB priority, function or activity
services and policies.	for decision making and identify the impact of those views.
Recognise the importance of the Voluntary and community sector and their valuable contribution to implementing the strategy.	*Safeguarding within Faith Groups:* The voluntary sector provide key services. They have a representative on the Board and work is being done to create and maintain an effective support network.

5.0 SOURCE DOCUMENTS

Source Documents	Location
None	

CAMBRIDGESHIRE LOCAL SAFEGUARDING CHILDREN BOARD

Annual Report 2016/17

Foreword by the Independent Chair

It gives me great pleasure to present to you Cambridgeshire's Safeguarding Children Board annual report for the period April 2016 – March 2017.

The report outlines the activity and contribution of the Board and its partners over the last year.

This has been a very active year for all agencies and it has included a major review of Cambridgeshire County Council services that put it in the best possible position to meet the needs of children in the challenging years ahead. The Board has been a key player in ensuring that the changes were made in a context of effective multi-agency working.

Our overarching objectives through Working Together 2015 were to:
1) Co-ordinate what is being done by each person or body represented on the board to safeguard and promote the welfare of children in Cambridgeshire, and
2) Ensure the effectiveness of what is done by each such person or body for those purposes.

We have worked well through our priorities for the year and are continuing with them into the year ahead. They are achieved in conjunction with other boards working in Cambridgeshire and Peterborough and demonstrate clear joint agency working arrangements in Cambridgeshire.

The next year is an exciting one with lots of opportunities for the partnership to continue our work and to move to be a very good, if not outstanding, Safeguarding Board.

We have reviewed how the Board operates and are very well placed to meet the opportunities and challenges that the new Social Care Act brings.

I would like to thank all of the Board members (in particular the Lay Members) and their organisations, especially the frontline staff, for the hard work they have carried out to keep children and young people safe from harm in Cambridgeshire.

Finally I would like to thank Andy Jarvis and all of his team for their unstinting commitment to the work of the Board and keeping children in the County safe.

Dr Russell Wate QPM

Table of Contents

CLICK BELOW TO JUMP TO A SECTION

How has the LSCB Carried out its Functions

How has the LSCB carried out its Functions?

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  Launched a Neglect Strategy
  Adopted the CSE Protocol
  Drafted and consulted on the new Threshold Document

- **Ensure the effectiveness of what is done by each partner**

  Completed the Section 11 Action Plan
  Monitor Ofsted, HMIP, HMIC and CQC Inspection action plans

- **Demonstrate inclusion and co-operation**

  Built on the Inclusion project with the Eastern European communities.

- **Undertake reviews of cases and practice**

  Undertaken Multi-Agency Audits on Domestic Abuse, Neglect, Threshold's and MASH
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  Developed a new Dashboard and Dataset of performance information across agencies
  Consulted children and young people with SEND
  Heard from the Participation Service
  Used service users in the development of CSE provision
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  Revamped the Learning and Improvement Framework
  Ensured learning turns into change
  Mapped the evidence available on Safeguarding in Cambridgeshire to give a coordinated picture of what we know and any gaps

- **Policy and procedures including thresholds, training, recruitment, supervision, allegations**

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  Undertake a major review of LSCB multi-agency procedures

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  Provided a well-respected Website
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- **Participate in planning of services**

  Chair MASH Governance Board and delivered new MASH arrangements
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Glossary of Terms

Glossary of Terms

Acronym	Full Title	Description
CAMH	Child and Adolescent Mental Health	Secondary services covering child mental health
CCC	Cambridgeshire County Council	
CCG	Clinical Commissioning Group	Responsible for organising the provision of health services in the area
CDOP	Child Death Overview Panel	To identify the avoidable causes of child death and reduce or prevent future deaths
CJB	Criminal Justice Board	Strategic Board of agencies involved in the Criminal Justice System
CP	Child Protection	The formal multi-agency process for safeguarding children at immediate risk of serious harm
CPFT	Cambridgeshire and Peterborough Foundation Trust	Local provider of CAMH
CQC	Care Quality Commission	Health Inspectorate and regulatory body
CSC	Children's Social Care	CCC Division working with CP cases
CSE	Child Sexual Exploitation	Child sexual exploitation (CSE) is a type of sexual abuse in which children are sexually exploited for money, power or status
DOLs	Deprivation of Liberty	The legal context that authorises controlling restrictions being placed on children and adults
GCP	Graded Care Profile	An assessment tool for Neglect

Glossary of Terms

Acronym	Full Title	Description
GP	General practitioner	
HWB	Health and Wellbeing Board	Statutory partnership responsible for integrating Health and Social Care provision
LPG	Local Practice Group	Open meetings for all staff involved in working with children to improve practice and communicate learning.
LSCB	Local Safeguarding Children Board	Statutory partnership responsible for monitoring and supporting effective safeguarding of children
MASE	Multi-Agency Sexual Exploitation	A meeting to coordinate the protection of individual children at risk from CSE
NICE	National Institute for Health and Care Excellence	National Health body responsible for setting Standards and Guidance on practice issues.
QEG	Quality and Effectiveness Group	LSCB monitoring and audit committee
SAB	Safeguarding Adults Board	Statutory partnership responsible for the safeguarding of adults with care and support needs
SCR	Serious Case Review	A Statutory case review held when a child dies or is seriously harmed where neglect and/or abuse is a factor.
TDWSG	Training, Development and Workforce Strategy Group	LSCB Training Committee

The Board

The Board

The Cambridgeshire LSCB is the statutory body overseeing multi-agency safeguarding arrangements for children across Cambridgeshire. Compliant with guidance in Working Together to Safeguard Children 2015 and the Local Safeguarding Children Board (LSCB) Regulations 2006, the Cambridgeshire LSCB Board brings together the senior leaders from the core agencies. It has two objectives; to co-ordinate the safeguarding work of agencies and to ensure that this work is effective.

KEY ROLES AND RELATIONSHIPS

Up to September 2016 the Independent Chair of the Cambridgeshire LSCB was Felicity Schofield. From September 2016 this role has been carried out by Dr Russell Wate QPM.

The chair has the professional authority and organisational standing to challenge Board members over the performance of their agency, and works to ensure that national policy and strategy has a local response from partner agencies. The independent chair engages in the national debate and activity around Safeguarding.

As Chair they ensure the Board fulfils its statutory objectives and functions. A culture of transparency, challenge and improvement is key.

Whilst being unable to direct organisations, an LSCB does have the authority to hold agencies to account for their safeguarding. Its influence includes governance as well as direct services that impact on the welfare of children and young people.

In Cambridgeshire, the independent chair of the LSCB also chairs an operational Business Committee and the Child Death Overview Panel. The latter also includes Peterborough. This arrangement brings continuity and consistency whilst driving the delivery of the Business Plan.

The Serious Case Review Sub Committee is chaired by Felicity Schofield.

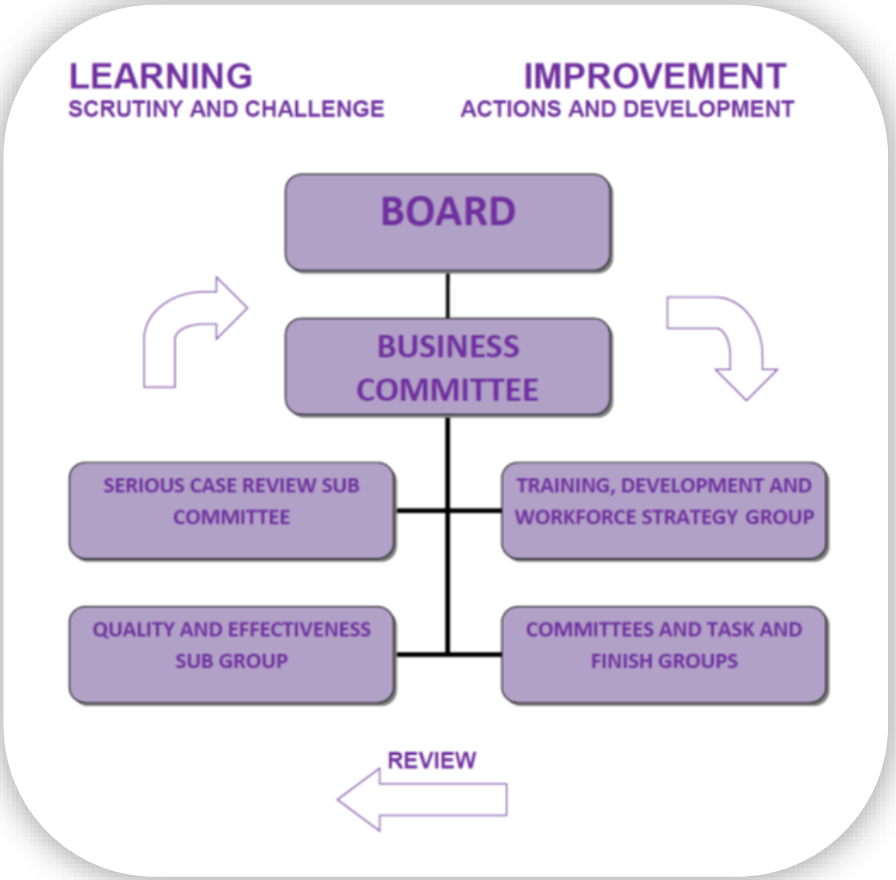
The Board

BOARD MEMBERSHIP

The Board includes representatives from:

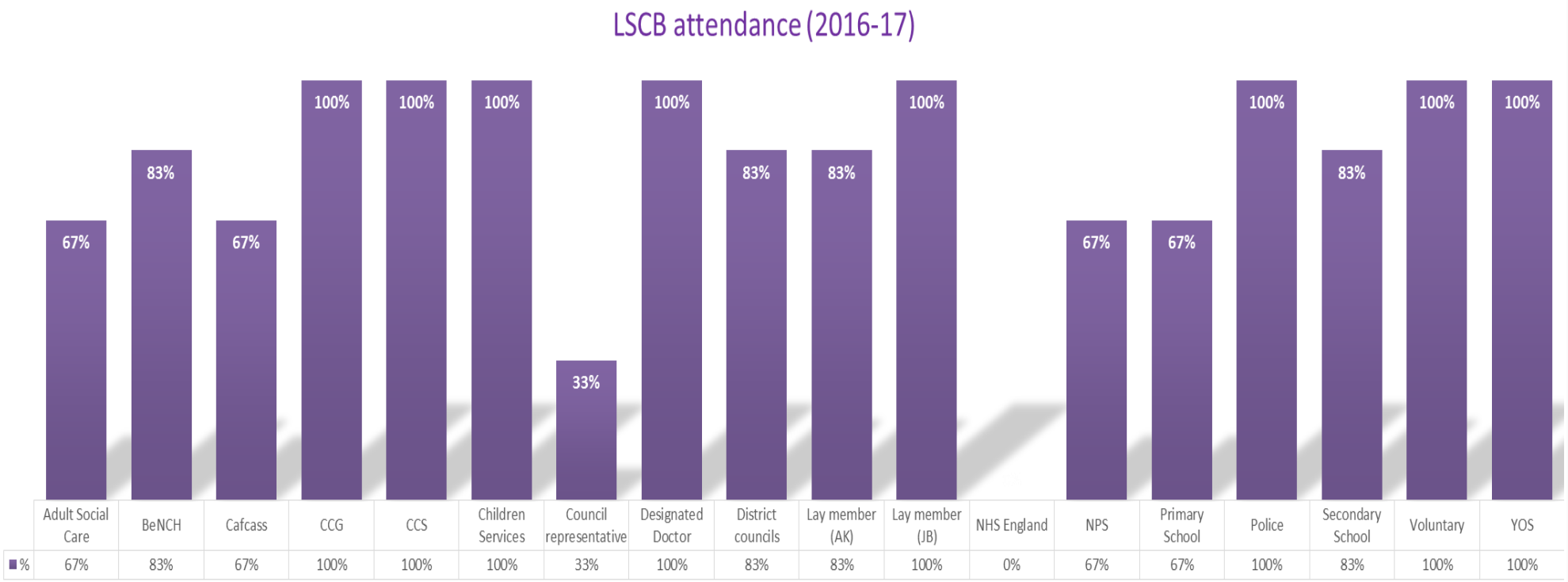
- Adult Social Care
- BeNCH
- Cafcass
- CCC Children Services
- Clinical Commissioning Group
- Council Representative
- Cambridgeshire Community Services
- CCG Children Services Designated Doctor and Nurse
- District councils
- Lay members
- NHS England
- NPS
- Primary School
- Police
- Secondary School
- Voluntary Sector
- YOS

The Board has overall responsibility for the strategic direction of the LSCB. Work is delivered through Sub Committees, Standing Committees and Task and Finish Groups. Each meeting has a clear remit, timescale and purpose linked with the business cycle of the LSCB.



The Board

LSCB ATTENDANCE



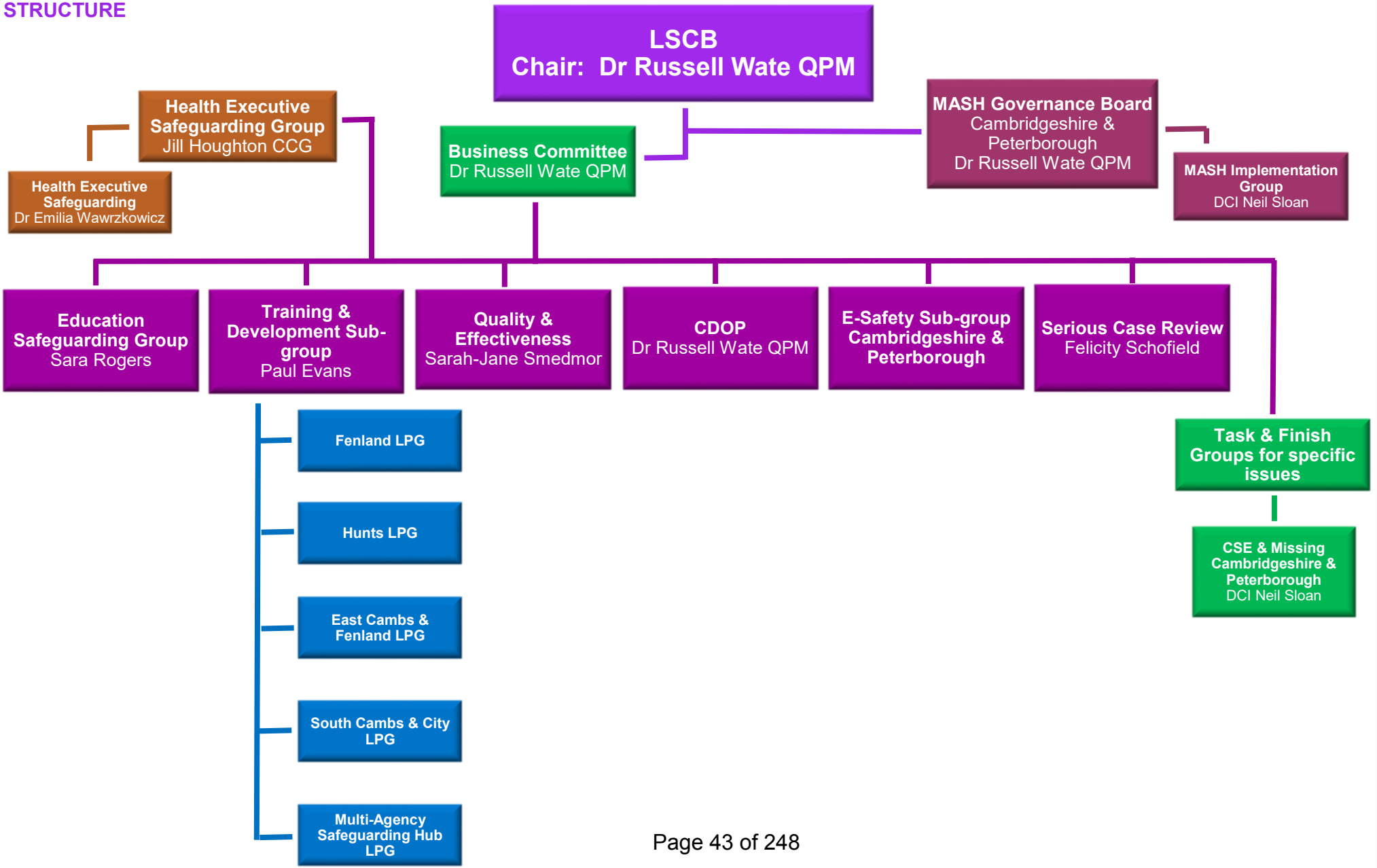
	Adult Social Care	BeNCH	Cafcass	CCG	CCS	Children Services	Council representative	Designated Doctor	District councils	Lay member (AK)	Lay member (JB)	NHS England	NPS	Primary School	Police	Secondary School	Voluntary	YOS
%	67%	83%	67%	100%	100%	100%	33%	100%	83%	83%	100%	0%	67%	67%	100%	83%	100%	100%

LSCB Board Attendance; April 2016 – March 2017 (6 Meetings)

Figures in this diagram include deputies where used. NHS England had formally indicated that they are unable to attend Board meeting. Communication is through the CCG representative.

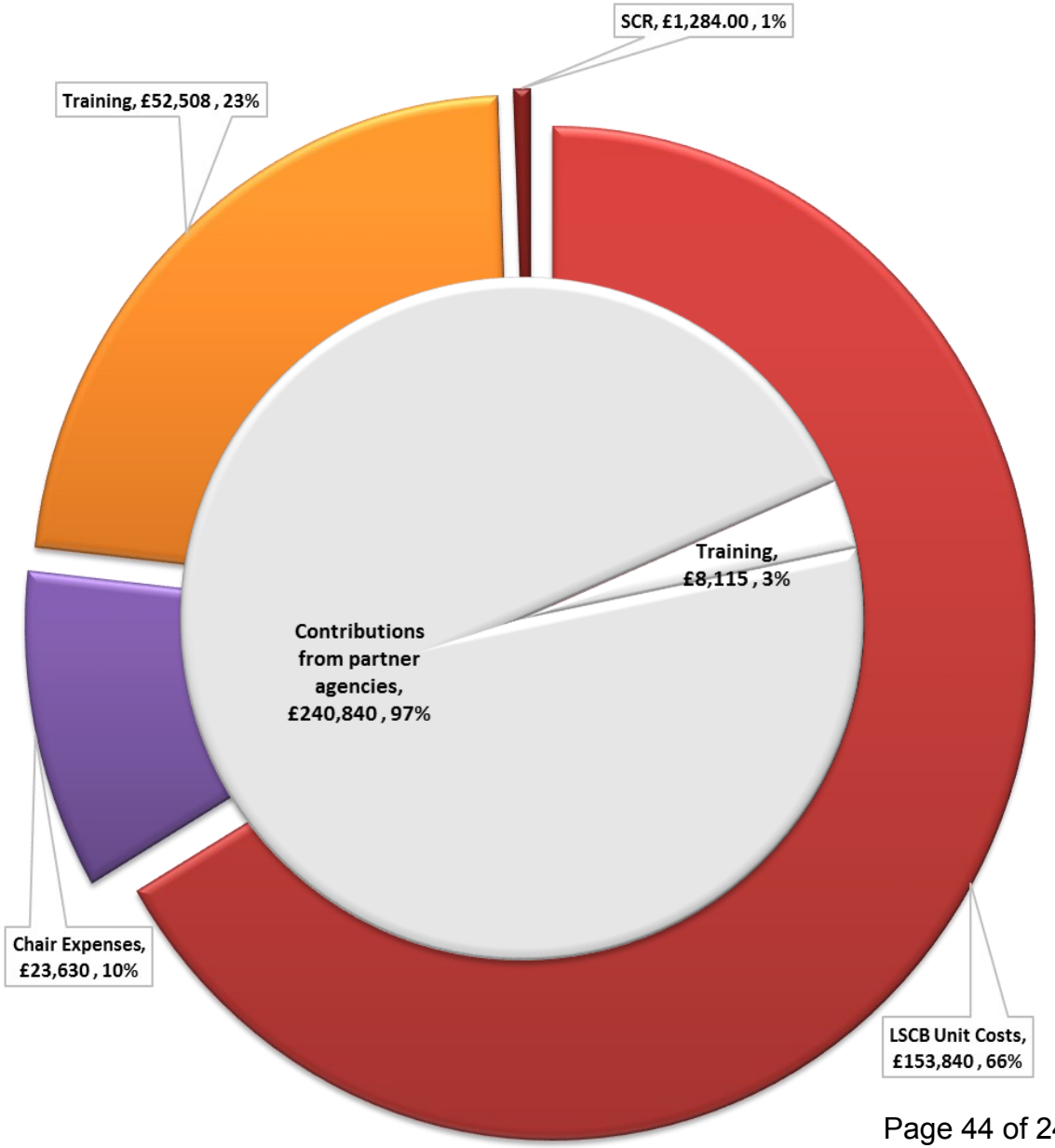
The Board

STRUCTURE



The Board

FINANCIAL ARRANGEMENTS



LSCB INCOME 2016/17	
Contributions from partner agencies	£240,840
Training	£8,115
Total	**£248,955**

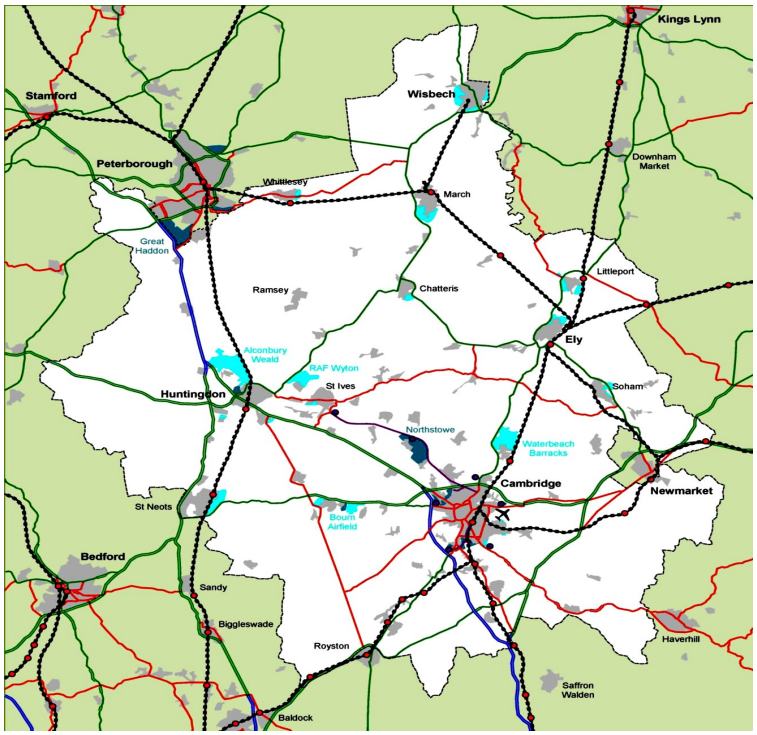
LSCB EXPENDITURE TO END MARCH 2017	
LSCB Unit Costs	£153,840
Chair Expenses	£23,630
Training	£52,508
LSCB – Serious Case Review	£1,284.00
TOTAL	**£231,262**

The LSCB runs a surplus in the SCR Budget allocation in order to manage the significant differences in expenditure that comes from variations in the number of SCRs held. In 2016/17 we had an SCR budget of £29,809.00. In 2017-18 we have an SCR reserve of £27,989.

There was a shortfall in the non SCR budget of £10,296. This was covered by a reserve created from previous underspends allocated to meet the costs of a temporary CSE Coordinator post.

The Board

What our Lay Members say



There are two Lay Members who, together with the Chair, represent the independent element of the LSCB and serve on the main Board. Our role is to provide a different prospective to the professional Board members, to challenge when required and to act as a critical friend. We have had access to training that supports us in undertaking this role.

We have regularly attended Board meetings and have played a full and active part in the work of the Board. We both have a wide experience of local government and the voluntary sector giving us some insight into the difficulties and challenges faced by the statutory services. This is a time of ever tightening budgets and of significant change to the way that services are delivered. It is very important, in the face of these pressures, that the safety of our children remains our top priority. To make sure this is the case is our key role.

During the course of this year we have joined two of the LSCB Sub Groups, the one that monitors the quality and effectiveness of the work done by agencies and the Education Committee that coordinates the Boards work with schools and other providers of education.

The Board represents one of the few, possibly the only place where all the most senior officers with responsibilities for the safeguarding of our children come together around a table. If for that reason alone the LSCB plays a key role in making sure that all partner agencies communicate with each other and share experiences.

We have been impressed by the commitment and determination of all the partner agencies to learn from shared good practice and to take on the lessons learned from past poor practice. To our mind the LSCB has, and continues to have, an important contribution to make towards protecting our children from harm. We are pleased to have the opportunity to play a small role in this important work.

Anne Kent and John Batchelor, Lay Members July 2017

Cambridgeshire Safeguarding Snapshot

Cambridgeshire Safeguarding Snapshot

13% of Cambridgeshire children live in poverty - 16455 children. In some areas up to 38.7% live in poverty.

By 2031 the number of children and young people is forecast to grow 17% compared to 2011.

In the average three month period 3385 children received services from Early Help

Between 49 and 60 children & young people were recorded as missing from care or home each month, in the main being missing for a number of hours or days before returning.

Cambridgeshire had nearly 50% more than the national average 10 to 20 year olds admitted to hospital for self-harm.

In 2016-17 Children Social Care received 4373 referrals, of whom 203 had a disability.

18% of cases referred in were re-referrals

5061 single assessments were completed, 84% of them within timescale

As of March 2017 560 children were on a Child Protection Plan.

675 children & young people were looked after as of March 2017. At that point Cambridgeshire was responsible for 67 Unaccompanied Asylum Seekers

12% of Looked After Children cases had 3 or more placement breakdowns.

Cambridgeshire Safeguarding

Cambridgeshire Safeguarding

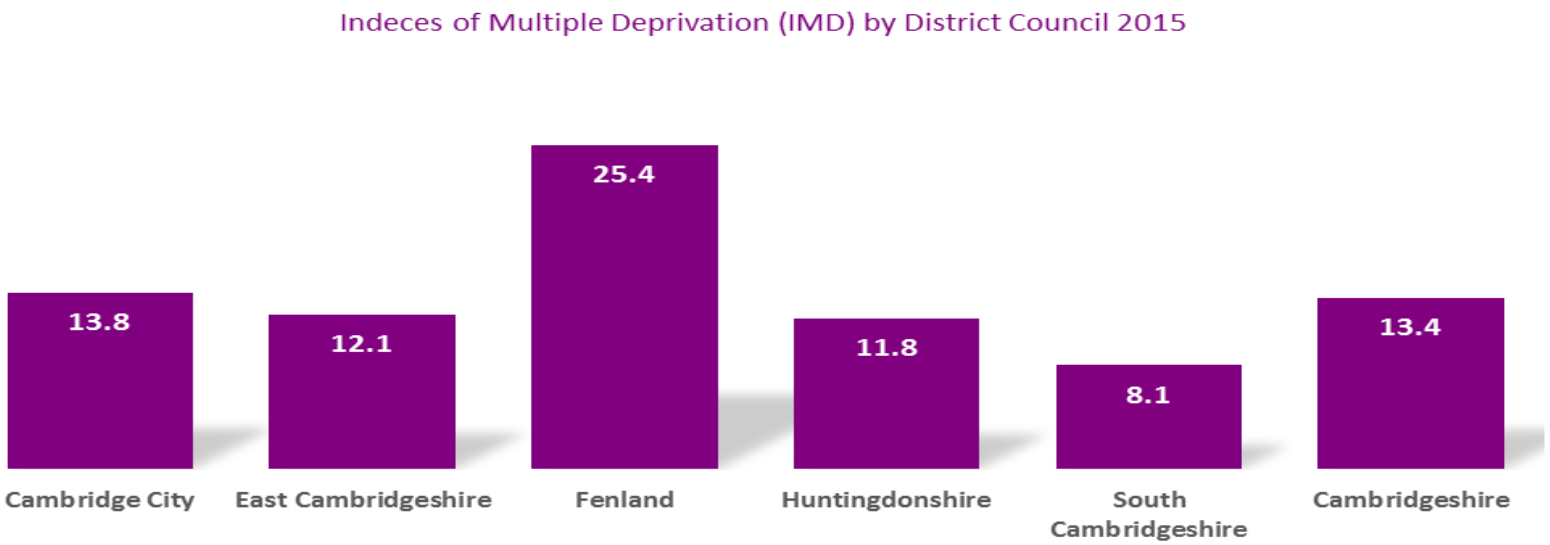
WHAT DOES THE DATA TELL US?

- There is significant deprivation in Fenland, and some wards within Huntingdonshire and Cambridge City
- There is evidence of higher levels of harm being present for children and Young People in Huntingdonshire than the deprivation figures might anticipate.
- There is no evidence that Neglect is present in Cambridgeshire to a disproportionate extent but there is a high level of Neglect in the referrals and CSC caseload
- There is evidence of higher than national average figures for hospital admissions from self-harm and regional average figures for substance misuse.
- There was a significant rise in CSC caseloads over the year
- Domestic Abuse and Parental Mental Health are the most significant factors in CIN and CP cases.

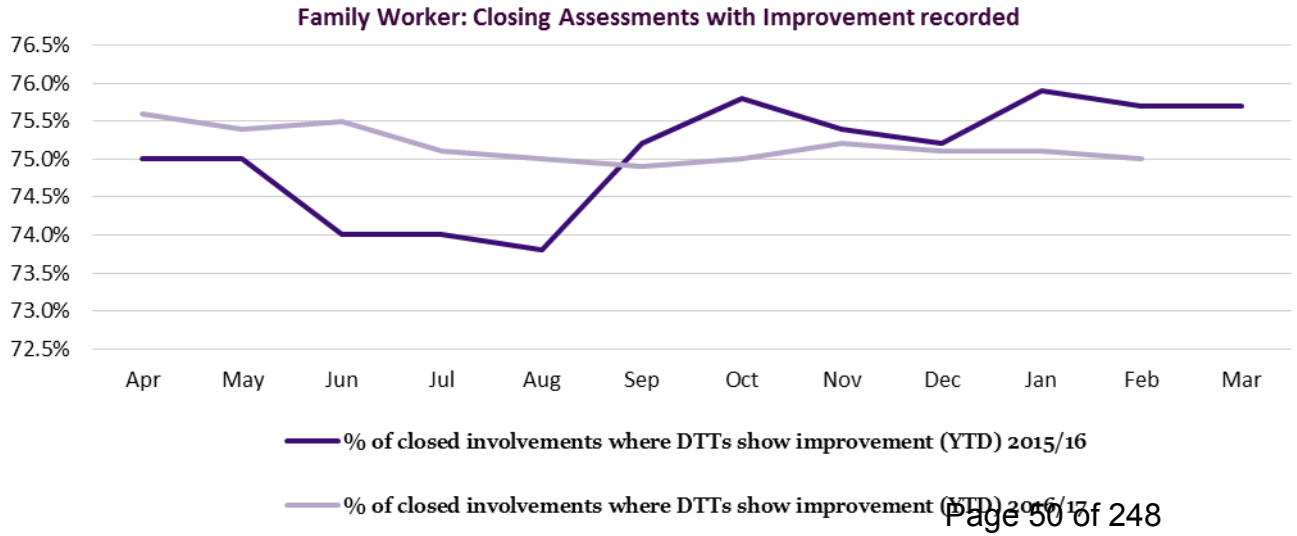
Cambridgeshire Safeguarding

CAMBRIDGESHIRE DEMOGRAPHICS

"Indices of Deprivation" show the overall picture of deprivation faced by children within each District. Fenland stands out as having the most significant issues.



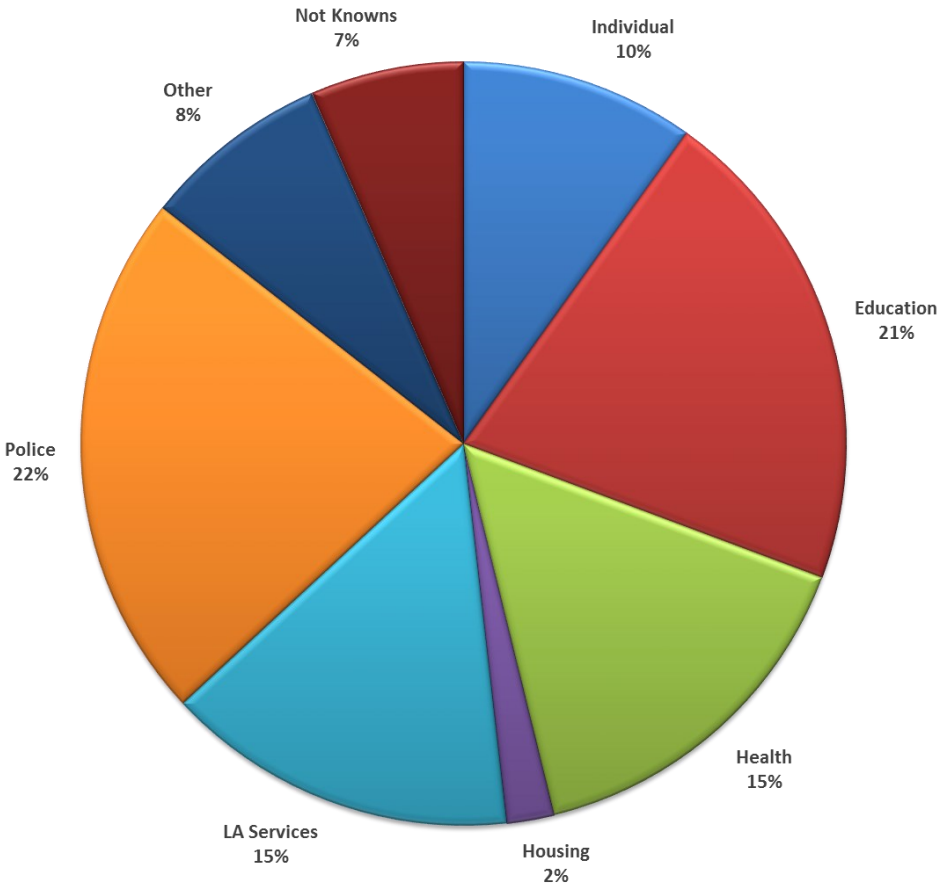
EFFECTIVE EARLY HELP

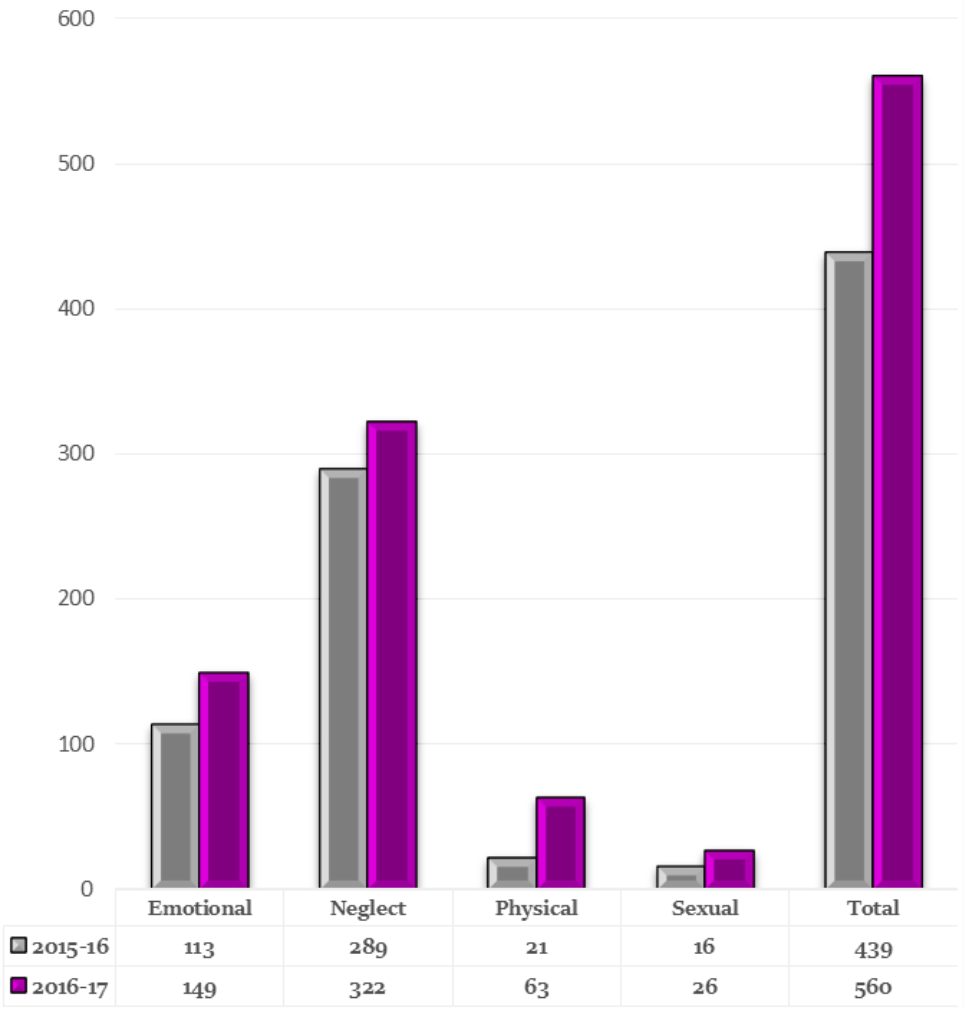


- Closing assessments of Early Help intervention show a consistent level of agreement that there has been improvement.
- On average **4.3%** of Early Help cases became open to Children Social Care each month. **52%** of new Children Social Care cases received Early Help in the preceding year. Early Help that identified and met need effectively would have a low first figure and a high second.

Cambridgeshire Safeguarding

2016-17 REFERRAL SOURCES



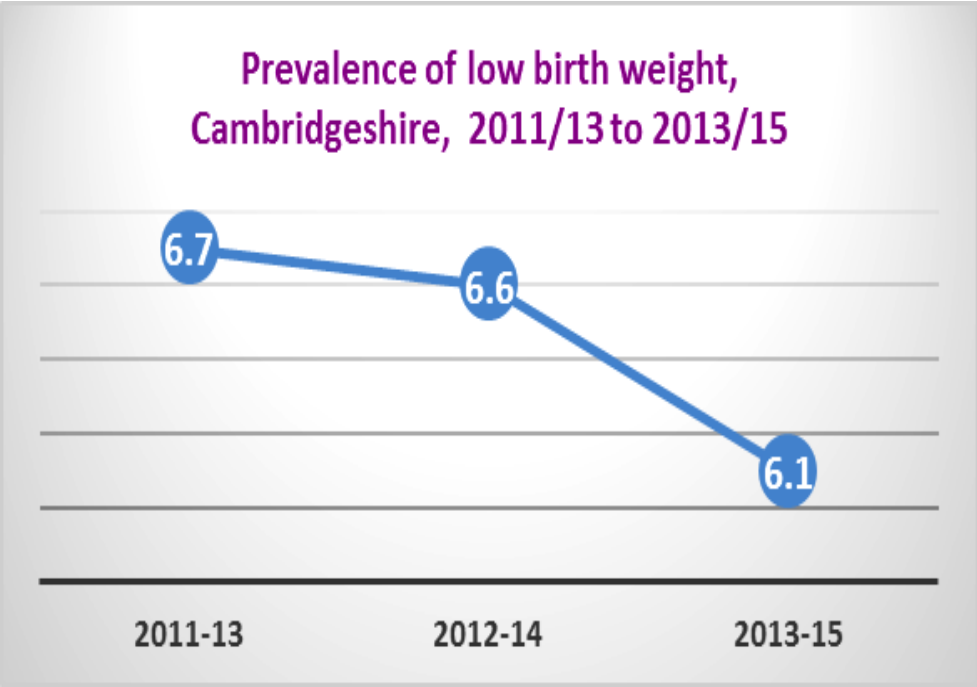


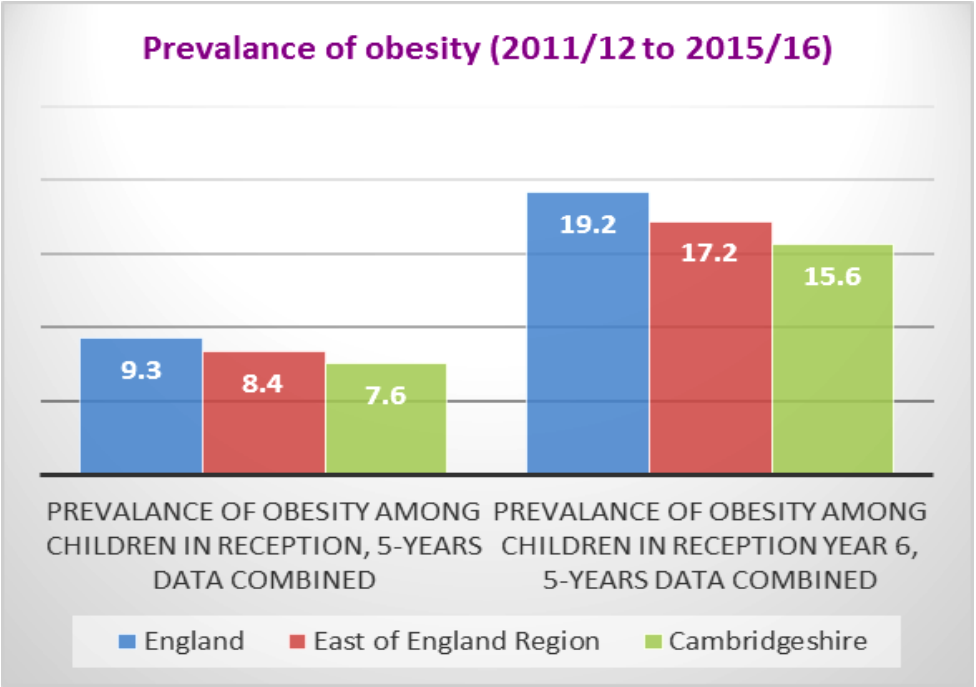
	Emotional	Neglect	Physical	Sexual	Total
2015-16	113	289	21	16	439
2016-17	149	322	63	26	560

- Referrals have increased in number, but there is little change as to the proportion that comes from each source.
- Just under **1 in 5** referrals is a re-referral of a previously opened case.
- CSC caseloads continue to increase. Neglect remains the most significant criteria for a Child Protection Plan.

Cambridgeshire Safeguarding

NEGLECT

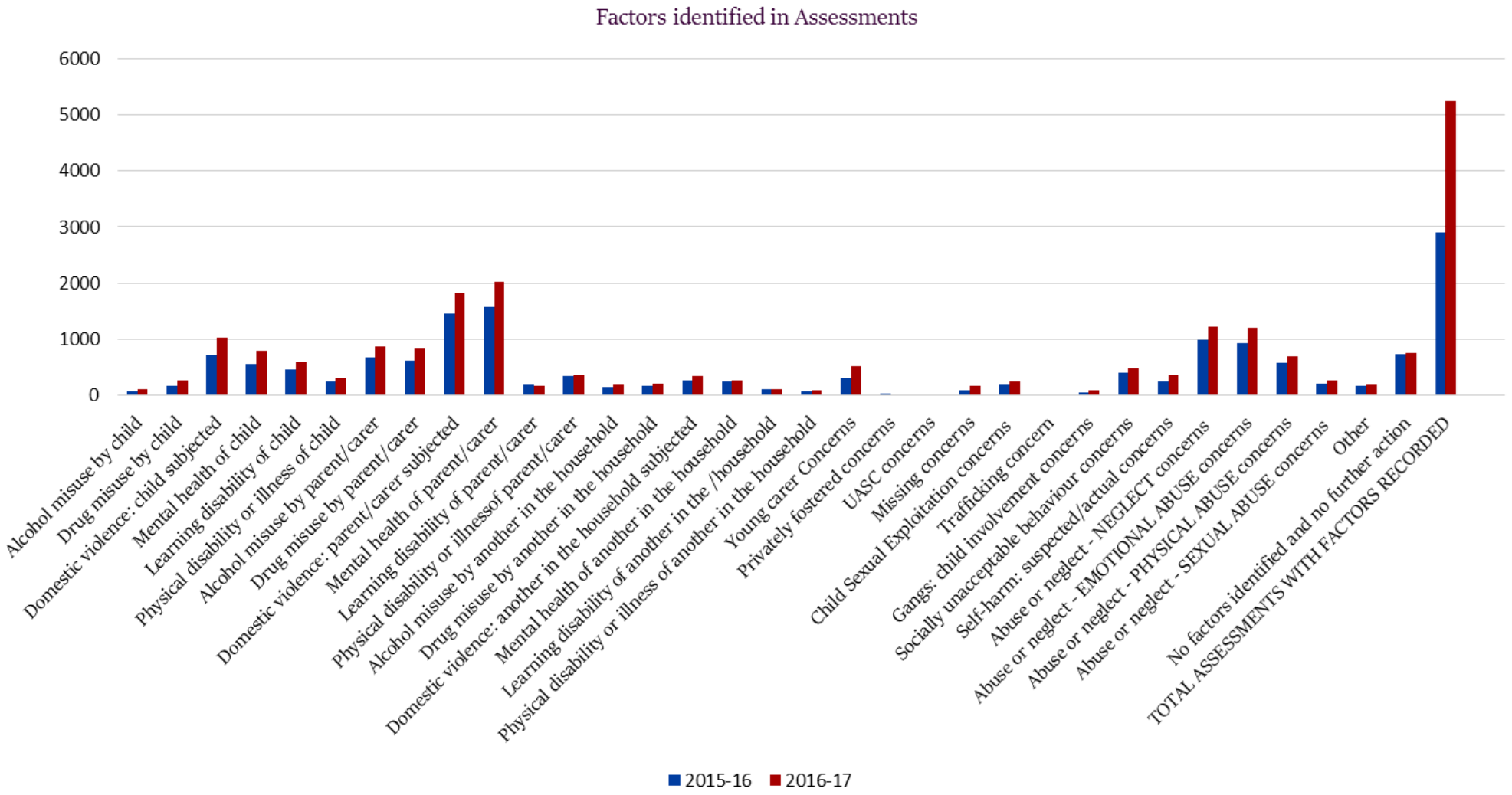




- The prevalence of low birth weight has reduced over the past five years and obesity in primary school aged children is below the national and regional averages.
- Whilst Neglect remains the largest criteria for Social Care intervention, evidence suggests the actual level of neglect present in Cambridgeshire communities is below the national average.
- Cambridgeshire has lower than average rates of under-age pregnancy and sexually transmitted diseases.

Cambridgeshire Safeguarding

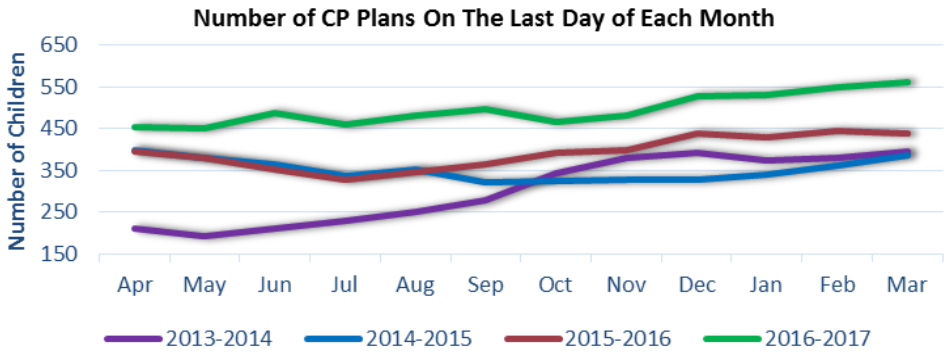
ISSUES PRESENT IN CASES

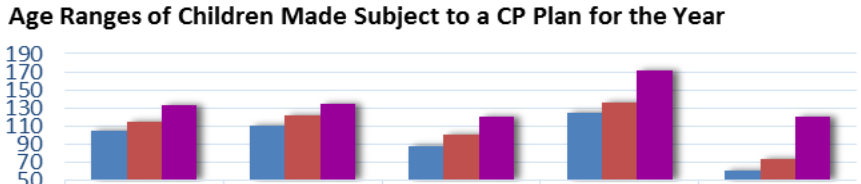


The Factors identified show the nature of issues present in cases when the initial assessment is undertaken. Services should be in place to address these issues effectively if children are to be safeguarded. The most significant presenting issues remain Domestic Abuse and Parental Mental Health.

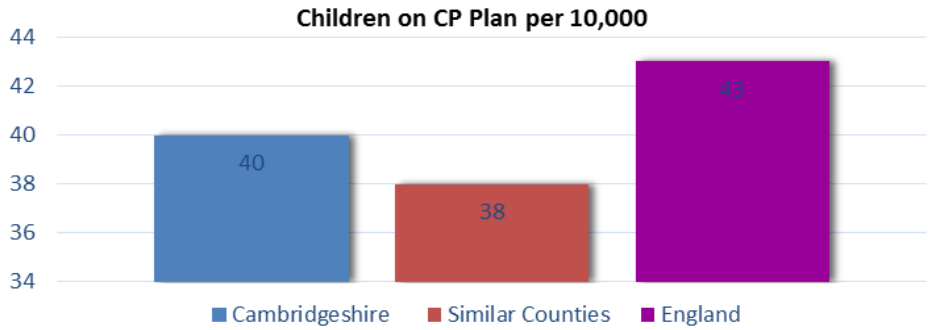
Cambridgeshire Safeguarding

CHILD PROTECTION PLANS

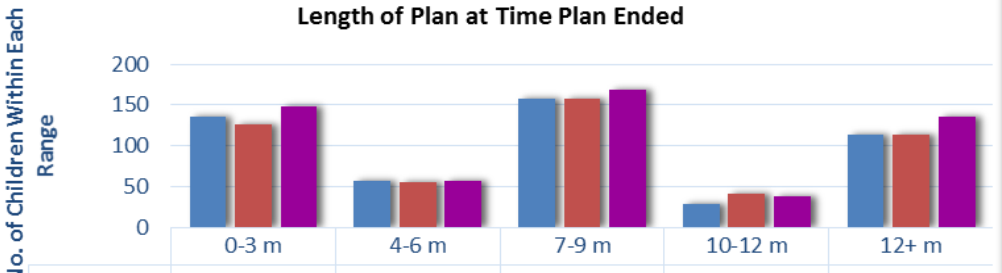




	Unborn & < 1	1-3 Yrs	4-6 Yrs	7-11 Yrs	12-16 Yrs
2014-2015	104	110	87	125	60
2015-2016	114	122	100	136	74
2016-2017	133	134	121	172	121



- The number of children subject to Child protection Plans has risen significantly over the year.
- There has been a noticeable increase in older children on plans.
- When comparisons are made against other areas, the number of children on Plans does not look disproportionate

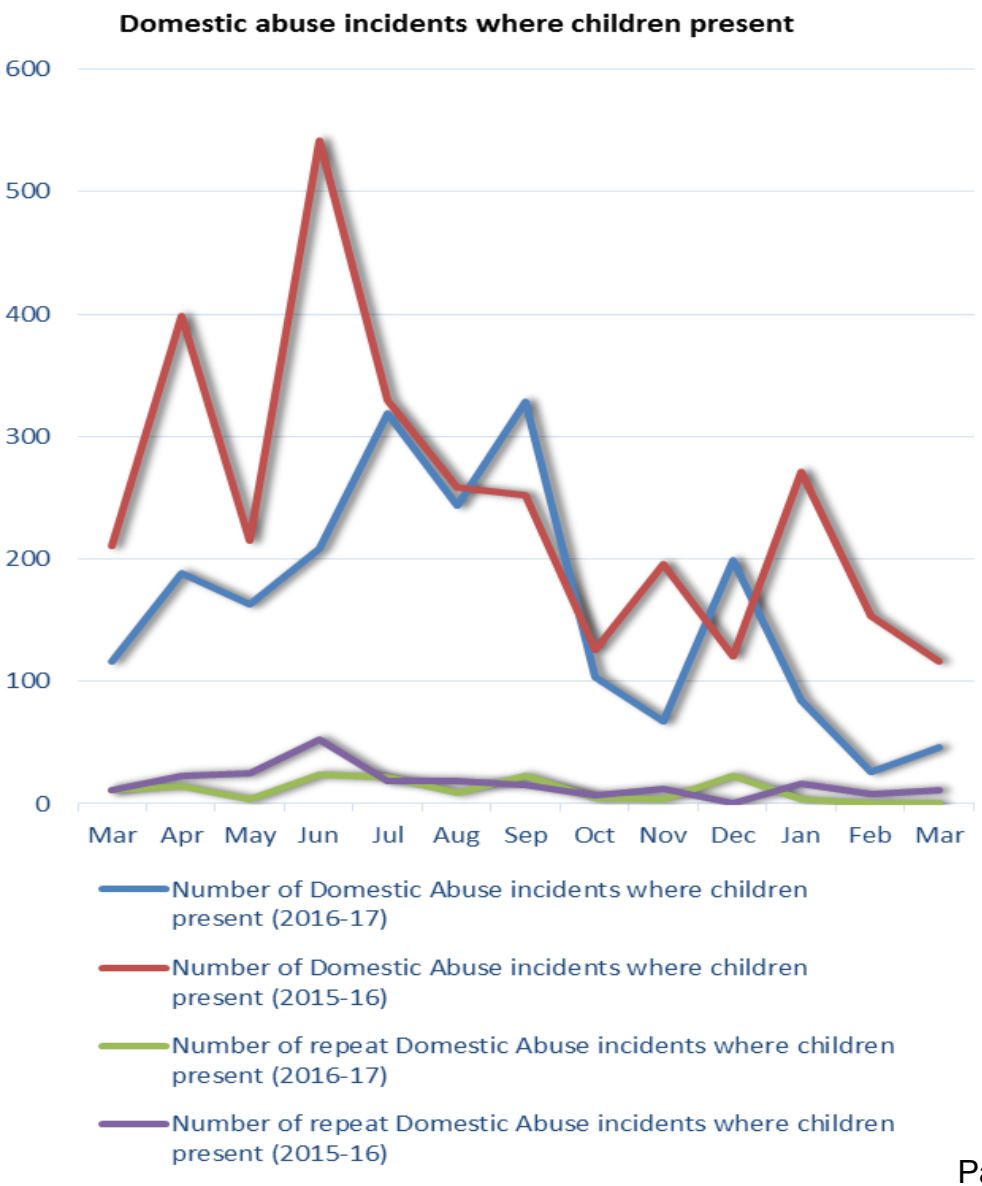


	0-3 m	4-6 m	7-9 m	10-12 m	12+ m
2014-2015	135	57	158	29	114
2015-2016	126	55	158	42	113
2016-2017	149	57	169	39	136

- Plans that end within three months or have been in place over two years will almost invariably involve legal proceedings to decide on the appropriate placement of the child.

Cambridgeshire Safeguarding

DOMESTIC ABUSE



- There is evidence of a gradual decline in the number of Domestic Abuse incidents dealt with by the Police where children were present..

LOOKED AFTER CHILDREN

- The number of looked after children rose over the year from **615** to **675.**

- Whilst there was an increased percentage of cases where there were repeated placement breakdowns, there was significant success in increasing the stability of longer term placements for children under sixteen.

- Over the year the LSCB worked with Children Services and Health staff to improve the number of children coming into care who had a comprehensive health assessment within the first twenty days. These are vulnerable children who are at a point of crisis in their lives. A proper understanding of their physical and psychological needs is critical to providing them with the services they need. This will remain a priority

Cambridgeshire Safeguarding

HOW HAS THE LSCB AND ITS PARTNER AGENCIES RESPONDED TO WHAT DATA SHOWED?

ISSUE	RESPONSE
There is no evidence that Neglect is present in Cambridgeshire to a disproportionate extent but there is a high level of Neglect in the referrals and CSC caseload.	The LSCB has built on its Neglect Conference in 2016 and launched a Neglect Strategy, supported by an Action Plan and training programme to enable staff to be more effective.
There is evidence of higher than national average figures for hospital admissions from self-harm and regional average for misuse of substances.	A) There was a major, and successful, initiative to reduce waiting lists for specialist psychiatric services B) Health have embarked on the redesign of provision for young people and commissioned services for those who have emerging needs.
There remains a significant rise in CSC caseloads over the	Working with the LSCB the local authority has launched a major reorganisation to ensure that the right services are available to the right child at the right time.
Domestic Abuse and Parental Mental Health are the most significant factors in CIN and CP cases.	The LSCB has undertaken a major audit of Domestic Abuse cases, launched a Domestic Abuse Strategy, delivered training, and promoted good practice.

Cambridgeshire

KEY AREAS OF WORK

Looked After Children

The key principles for working with looked after children and young people are:

- Providing early help to reduce calls on specialist services
- Increasing in county foster care provision and reducing out of county residential provision.

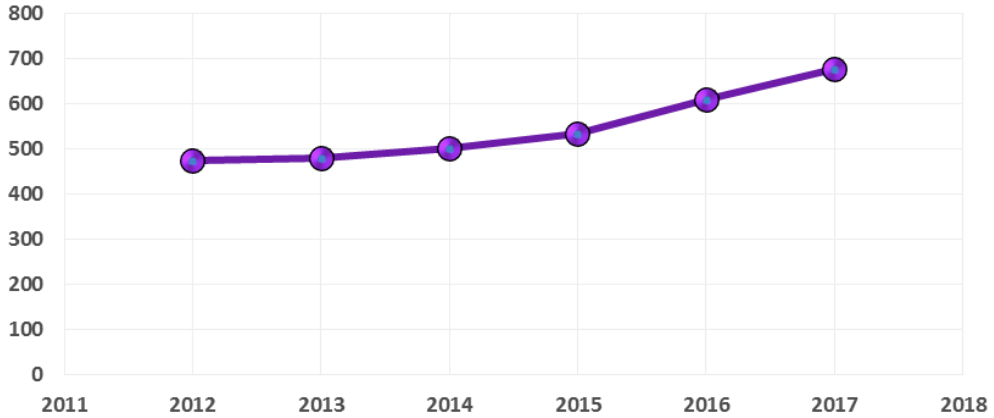
Ensuring reunification as quickly as possible or moving children quickly through to adoption.

All Services should be aware that these children have experienced disruption, trauma and distress prior to being looked after. They need an approach that sets them on a journey towards stability and permanence with a focus on their individual needs and views.

Number of Children who are looked after

There has been a 35% increase in the number of looked after children, in line with national trends.

The number remains below both national and regional average.



There are nearly 700 children who are looked after, with just over 300 moving into being accommodated during the year.

- Adoption: 39 adoption orders were made, 42 children were placed in potential adoptive homes and 62 placement orders were made.
- Fostering: 96 children were referred for a new family placement during April 2016 – March 2017. 41 children were matched to long term foster carers.

For both adoption and fostering the number of sibling groups that are being referred is a key issue. There is a lack of available adopters and long term foster carers who can take three or more children.

Each child or young person will have an Independent Reviewing Officer (IRO), an experienced independent professional whose role is to ensure that the child's care plan fully reflects their needs and to ensure that each child's wishes and feelings are given full consideration.

Cambridgeshire Safeguarding

"They are good because they are there to support you and help and are independent."

"I had my IRO for over 10 years and she really listened to me and understood me and I really miss her now I am over 18".

The 2017 **Voices Matter Young People Champion Award** is chosen by the children and young people themselves.

They have selected the IRO Service for their total dedication to having the young people at the centre of what they do. They ensure that young people feelings and views get heard and they work tirelessly for young people ensuring the best possible outcomes happens.

This service promotes and celebrates the individual achievements for the young people they work with and many times without recognition for the work they do.

"My IRO was really helpful and listened to me and helped me stay with foster carer."

For many young people they are one of the consistent workers in their lives and support them all the way until they become 18.

"My review meeting was excellent, everyone supports me and I feel able to say what I would like help with. My IRO always does excellent meetings"

This award is to say thank you for what they do and that what you do makes a huge difference to the young people you work with. The **Voices Matter Young People Champion Award** goes to the

Independent Reviewing Service.

Cambridgeshire Safeguarding

KEY AREAS OF WORK

Private Fostering

Private Fostering is where children or young people aged under 16 years (18 if they have a disability) are living with someone who is not a close relative for 28 days or more. Local authorities have a statutory duty to assess the suitability of the arrangement and to ensure that the welfare of privately fostered children is safeguarded. We have a comparatively large number of placements in Cambridgeshire.

- Mainstream placements. 27 Children were in placements, an increase on recent years. All have a social worker to ensure effective oversight of their safety and welfare. In recent years our work with these children has been reviewed and the Board is increasingly confident that private foster parents know they need to inform the local authority about the children and that they are then safeguarded and given the opportunities they need.

- Language Schools. 21 of the 33 Language schools in our region are in Cambridgeshire. Nearly all of the young people coming to these schools, often being housed with local families, are from abroad. They frequently come in large, organised groups. Many of the schools work with the Local Authority as it promotes good practice and proper safeguarding for these children. However, there is no requirement for Schools to engage and there remains concern about the safety of children placed through non-cooperating schools. The LSCB has written to the Department of Education raising this issue and proposing a statutory duty on the schools to inform the local authority about their children..

Young Carers

Young carers are young people or children who provide care for another person of any age where that care is not provided for payment. The Local Authority must assess whether a young carer within their area needs support and, if so, what those needs are. There have been growing numbers of young carers identified as more attention has been given to their needs.

In Cambridgeshire the staff from the County Council assess the needs of young carers and develop a support plan. Centre 33 then work to deliver the support plan.

When the young person's circumstances change, service providers are expected to work closely with the local authority worker to review and update the assessment and plan.

Cambridgeshire Safeguarding

KEY AREAS OF WORK

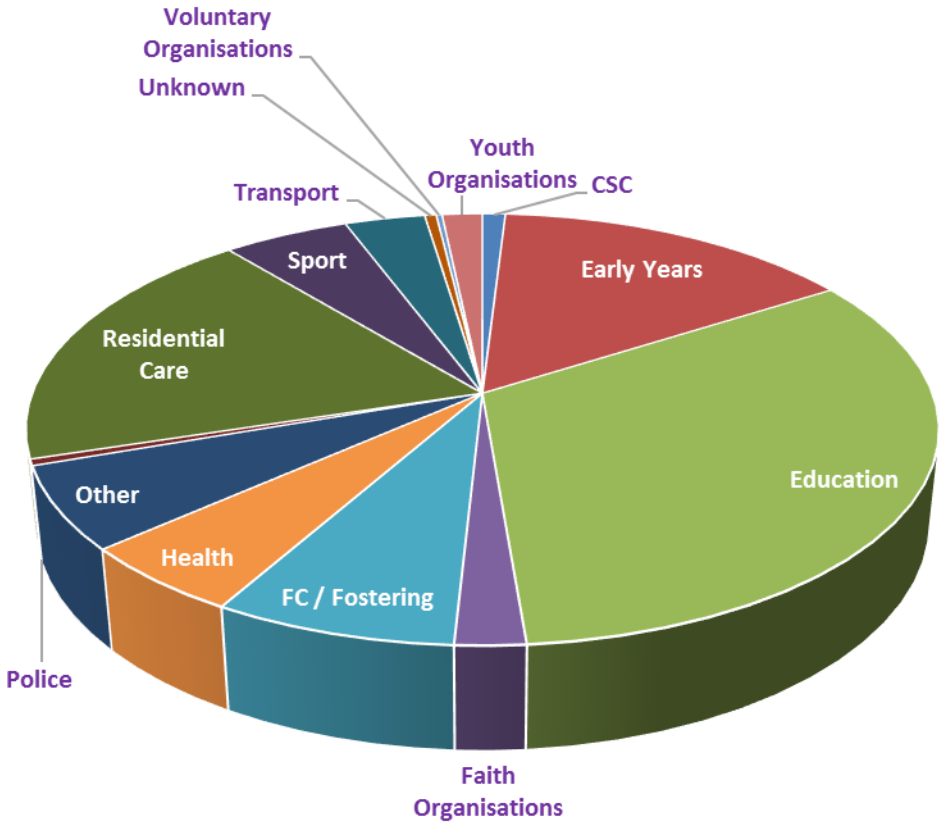
Local Authority Designated Officer (LADO)

The LADO manages allegations against adults who work or volunteer with children in the public, independent or voluntary sectors. The LADO must act where it is alleged that a person who works with children has:

- Behaved in a way that has harmed, or may have harmed, a child
- Possibly committed a criminal offence against, or related to, a child; or
- Behaved towards a child or children in a way that indicates they may pose a risk of harm to children.

There are three pathways for referrals once made:

- 'Logged and Closed'. Cambridgeshire LADO provides and advice to referrer, records and closes the case.
- Internal Investigation. Where there are safeguarding concerns but no immediate evidence to suggest that a criminal offence has occurred. LADO will advise the employer to undertake an internal investigation.
- Multi-Agency Response. Safeguarding concerns have been raised which indicate a possible criminal offence may have occurred. MASH, child protection and criminal investigation processes will be followed.

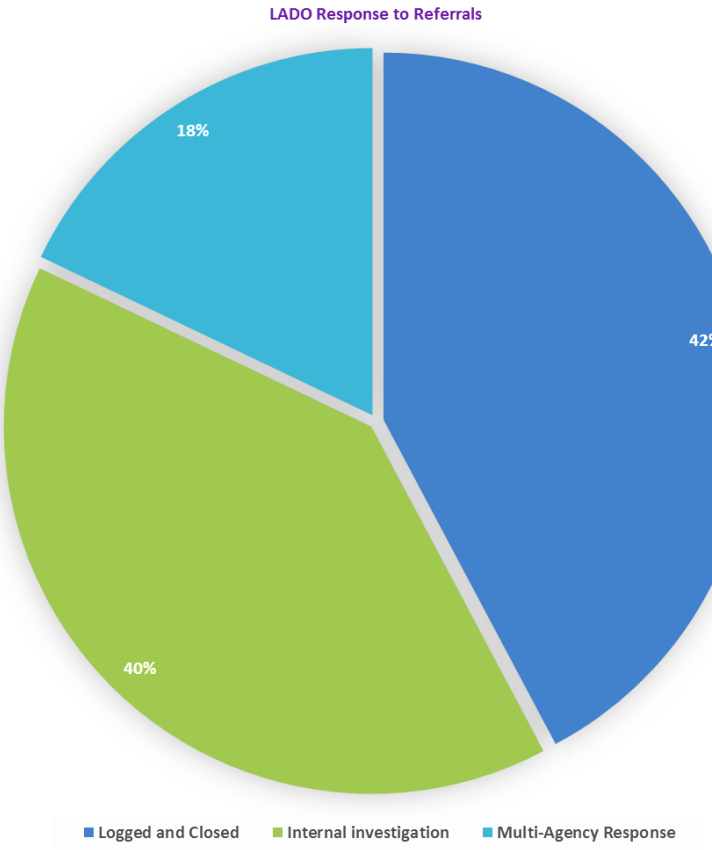


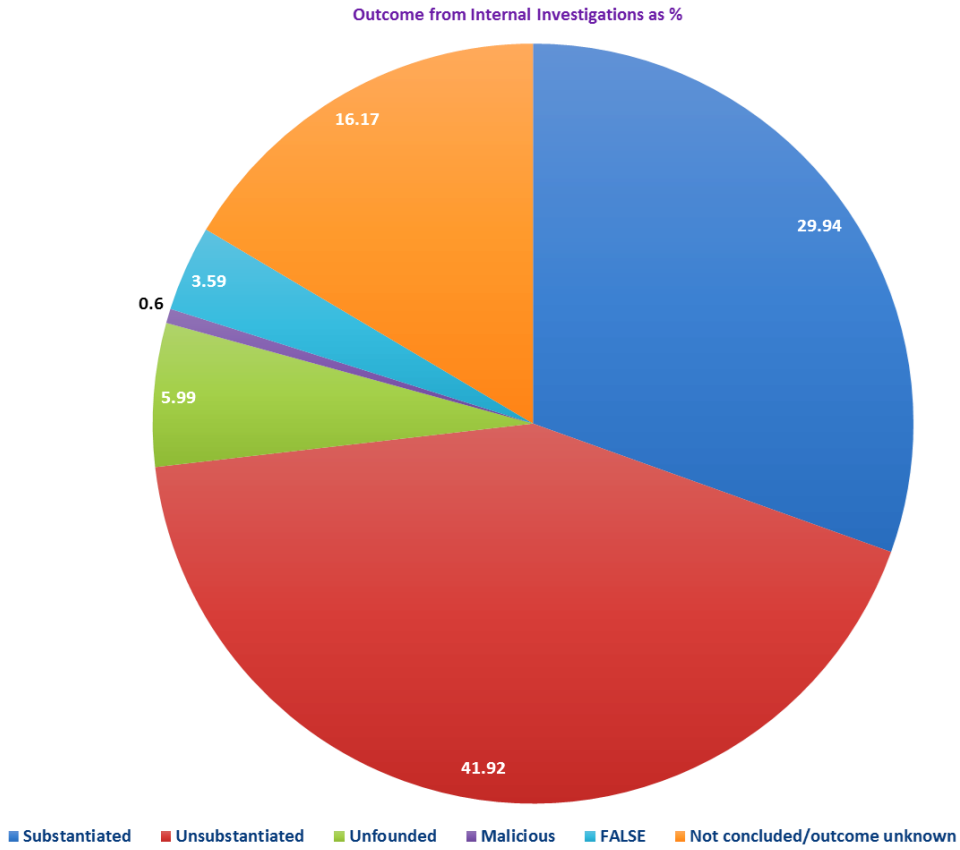
Where do LADO referrals come from?

Cambridgeshire Safeguarding

KEY AREAS OF WORK

Local Authority Designated Officer (LADO)



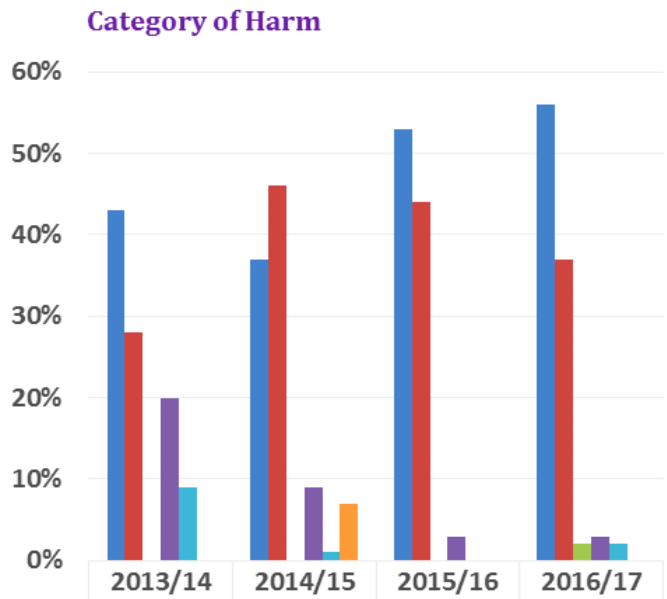


- Over the year there has been a 12% decline in the number of referrals.
- The reduction in referrals has coincided with a reduction in Logged and Closed cases and in increase in internal investigations and multi-agency responses.

Cambridgeshire Safeguarding

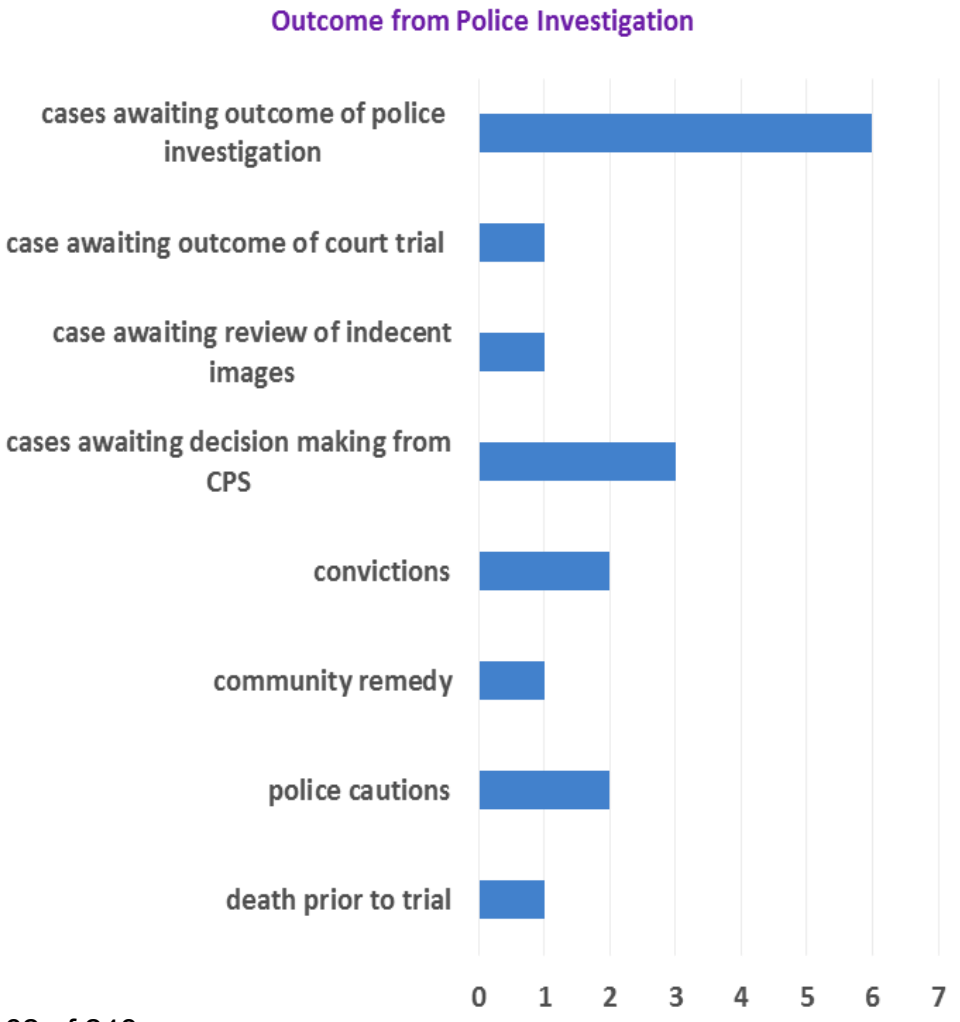
KEY AREAS OF WORK

Local Authority Designated Officer (LADO)



	2013/14	2014/15	2015/16	2016/17
Physical	43%	37%	53%	56%
Sexual	28%	46%	44%	37%
Inappropriate electronic communication	0%	0%	0%	2%
Downloading indecent images of children	20%	9%	3%	3%
Emotional abuse/neglect	9%	1%	0%	2%
Other conduct (suitability issues, such as issues arising outside of the workplace)	0%	7%	0%	0%

- Multi-Agency responses will ensure that identified children are safeguarded.
- Not all allegations required police investigations, but of those that did:



Cambridgeshire Safeguarding

KEY AREAS OF WORK

Children with Disabilities and SEND

Ofsted inspected Cambridgeshire services and found an improving outlook for children and young people with special educational needs and/or disabilities (SEND)

The outcomes for these children and young people are improving, and strong leadership from organisations and agencies is making a difference. In March, Ofsted and the Care Quality Commission (CQC) conducted a joint inspection to judge Cambridgeshire's effectiveness in implementing the disability and special educational needs reforms in the Children and Families Act 2014.

The full findings of that inspection are published by Ofsted, but the main points highlighted by inspectors were that council, health and education leaders understand well the issues around the development of SEND services, improvements they've already made are having an effect and they are clear about what they still need to do.

They found all organisations understood that while they might not have been quick enough to implement changes, there are now credible plans in place to make rapid improvement; and that the actions being taken are making a difference.

Main findings included:

- Leaders collaborate effectively with parents to develop services that meet the needs of children and young people, such as the design of a lifelong pathway for SEND.
- Providers and local area officers make sure that the views of parents and carers, children and young people are included in the plans.
- Safeguarding for this group is given a high priority – particularly for those placed out of county with regular visits and scrutiny of providers.
- Children and young people with SEND progress as well as others at secondary schools and colleges. However, the children receiving SEN support make less progress than all pupils nationally during key stage 2.
- Young people are well supported into adulthood with high proportions in work, further education or in training.
- Specialist health services are providing care within the target 18 weeks.
- Health professionals hold joint clinics to identify those with SEND needs early.
- A high proportion of new education, health and care plans (EHCPs) are completed within the required 20-weeks.
- Specialist services provided by education, health and social care professionals are of high quality and are well regarded.

Cambridgeshire Safeguarding

Main findings included: (cont..)

- Professionals across the local area are organised in geographical teams and make sure that there is close joint working between agencies, including services that are available to all and some targeted at specific groups.
- Professionals share information about individual children and young people, making their work more cohesive and ensuring that needs are met more effectively.

Inspectors found that senior leaders in the local area are working well together to improve services:

- The number of permanent exclusions has reduced by three quarters in a 12-month period.

Strong and effective leadership is evident in joint commissioning arrangements:

- As an example health and social care are jointly commissioning face -to-face and online counselling services as part of their work to improve emotional health and well-being.
- Children and young people were involved in the design of the services provided. Keep Your Head and Kooth.

LADO

37 (9%) of referrals to LADO were in relation to an adult who worked or volunteered with children with a disability. Of these

- 8 Logged and Closed
- 23 went to Internal Investigation
- 5 led to Multi-Agency involvement
- 1 involved a police investigation

Cambridgeshire Safeguarding

Youth Offending

During the year there was a Full Joint Inspection on Youth Offending Work in Cambridgeshire. The key findings were:

Reducing Reoffending	★★★☆
Protecting the public	★★★☆
Protecting children & young people	★★★☆
Making sure the sentence is served	★★★★
Governance & partnerships	★★★☆

Reducing reoffending

- Staff and managers were committed to the delivery of high quality work to make a positive difference to those affected by offending.
- Managers and staff should be commended for maintaining their services over a difficult period
- Some attention was needed to return aspects of practice to the levels they expected.
- Good attention was given to the quality of engagement with children and young people.
- A broader range of approved interventions was needed.
- Work in the courts was strong and custodial sentences were used only in the most serious cases.
- There was a strong Intensive Surveillance and Supervision scheme in place.

Protecting the public

- Assessment of the risk of harm to others was generally good.
- Planning, and making effective use of assessment tools to support it, required improvement.
- Multi-Agency Public Protection Arrangements were not understood well and partnership work was not effective
- There were good examples of restorative justice
- More attention needed to be given to the needs of victims
- Oversight by managers was not always effective
- Police intelligence sharing needed to be more comprehensive
- Children and young people were able to describe work undertaken with them to reduce their risk of harm

Protecting children & young people

- Work carried out to safeguard or reduce vulnerability of children & young people was often good
- Joint work and information sharing with children's services was not always effective
- Planning and management oversight required some improvement
- The sexually harmful behaviour service was well integrated with the YOS, and Multisystem Therapy was used as well

Cambridgeshire Safeguarding

Making sure the sentence is served

- This was an area of significant strength
- Staff were good at understanding and then seeking to address those factors in the lives of children and young people that were likely to affect their engagement with the YOS
- Where children and young people did not comply with the sentence appropriate action was taken to encourage future compliance or, when necessary, to return the order to court
- Good attention was given to health and well-being factors.

Governance and partnerships

- Outcomes against national criminal justice system indicators were consistently among the best in England and Wales
- There were important gaps in attendance at the Management Board
- The partnership had not been effective in improving education, training and employment outcomes for those known to the YOS post-16
- The YOS was highly valued by partners and well led by a respected YOS manager
- Cambridgeshire County Council had shown a high degree of commitment to the work of the YOS and to maintaining a unique identity for youth offending work
- Difficulties with IT systems had a substantial impact on the work of the YOS
- An action plan is in place to address the areas for improvement and the LSCB will receive an update on progress.

Progress on Cambridgeshire Priorities

Progress on Cambridgeshire Priorities

This year has seen a major review and re-organisation of how Children Services are delivered in Cambridgeshire. The LSCB has been a key point for consultation and communication between the local authority and its statutory partners.

The LSCB has been closely involved in the development of cross agency working. The two most significant areas of activity have been

- a new Threshold Document to replace the MOSI and
- the development of the Multi-Agency Safeguarding Hub (MASH).

The MASH has joined up with the new Early Help Hub to make the two halves of an Integrated Point of Entry for all local authority services for children. This Integrated Point of Entry is designed to make it easier for the right children to get the right service at the right time.

These developments were built on the learning from effective practice in Cambridgeshire and across the country.

The LSCB will receive performance information and audit findings from the Integrated Front Door in order to establish its effectiveness.

INTEGRATED POINT OF ENTRY

The MASH and Early Help Hub (EHH) together make up the Integrated Front Door. The Integrated Front Door is the single point of contact for all safeguarding and wellbeing concerns regarding children and young people in Cambridgeshire. It does this by:

- Acting as a “front door” to manage all safeguarding referrals including Child Protection investigations where required
- Acting as a “front door” to Early Help advice and support

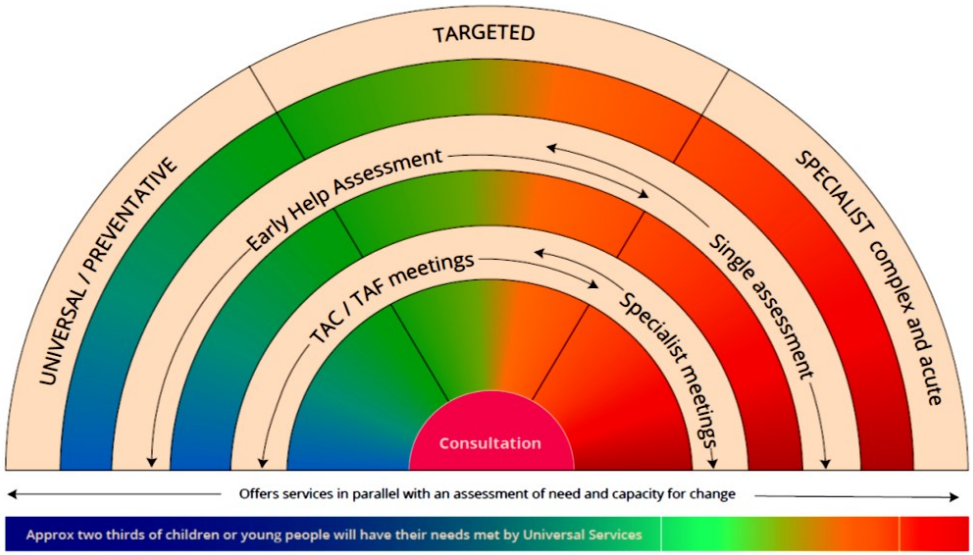
The MASH and Early Help Hub are designed to meet the two key principles of effective safeguarding as defined by Working Together 2015.

- Safeguarding is everyone’s responsibility: for services to be effective each professional and organisation should play their full part; and
- A child-centred approach: for services to be effective they should be based on a clear understanding of the needs and views of children.

Both MASH and EHH operate within a Think Family approach and the Thrive framework. They identify and develop the capacity of the whole family to meet the needs of its children, adjusting services to the changing needs of the family over time.

Progress on Cambridgeshire Priorities

THRESHOLD DOCUMENT



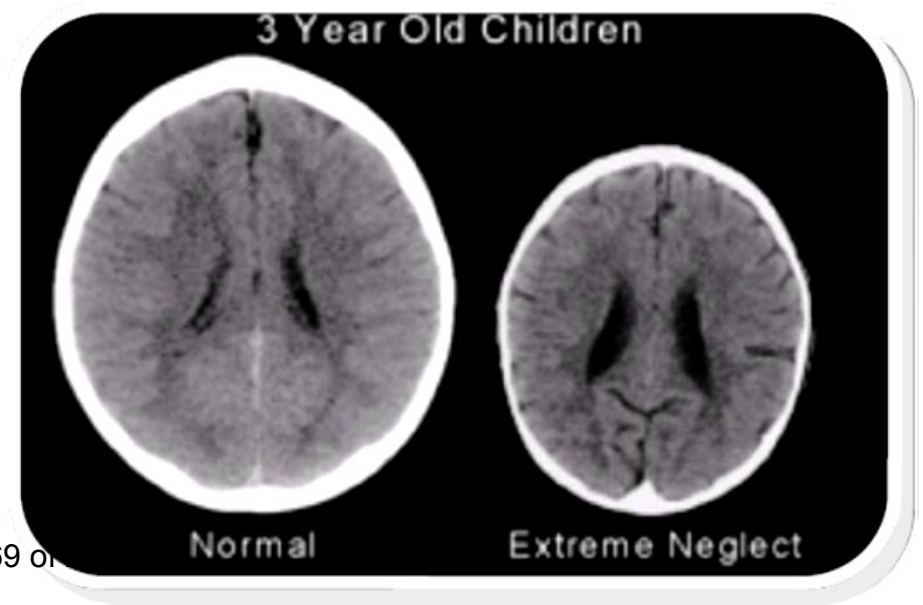
Each LSCB is required to have a Threshold. Ours sets out how Cambridgeshire services approaches keeping children and young people safe and protected from harm. At its centre is the continuum of need, a model that emphasises that the assessment of a child's needs, and meeting those needs, is never a static process. Situations change and as a result so does the level of need and risk.

The guidance, which covers the threshold of need and intervention, is a vital tool that underpins the local vision to provide targeted support services at an early stage through to specialist and statutory interventions when it is needed. It offers a clear framework and a common understanding of thresholds of need for practitioners within all agencies. This promotes a shared awareness of the different interventions required to effectively support children, young people and their families or carer. The Document provides information, advice and guidance that enables any practitioner working with children to know when additional services may be required, including when there is a risk of harm, and how to access those services.

The Document and Integrated Point of Entry were supported by an LSCB publicity campaign and a training programme delivered to a thousand professionals across the county.

NEGLECT

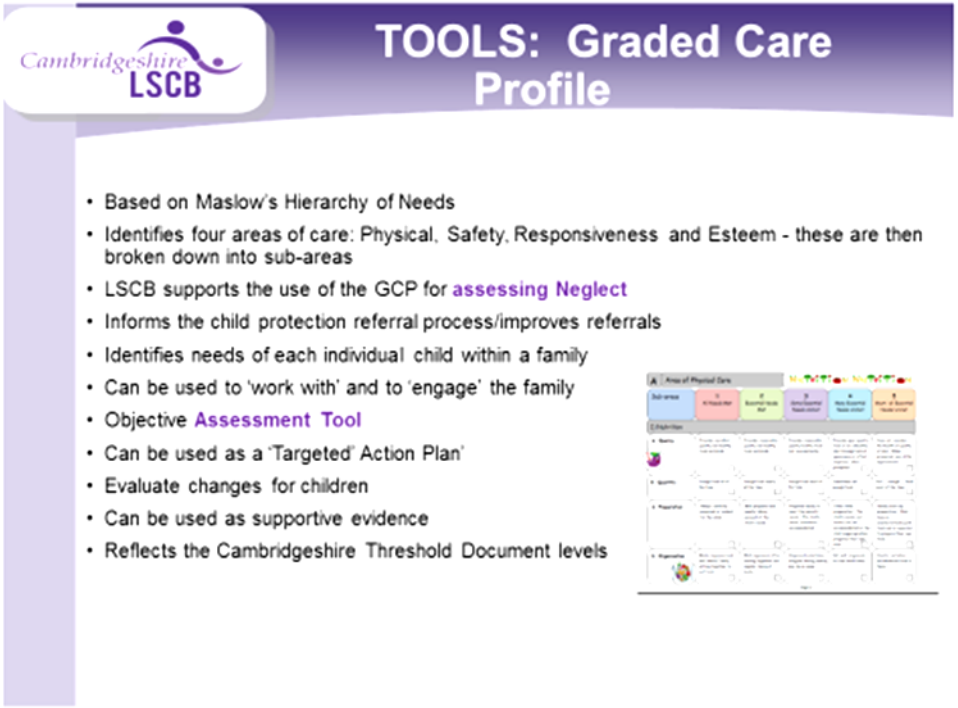
Neglect remains the single most significant reason for a child to be on a Child Protection Plan.



Progress on Cambridgeshire Priorities

Following our Conference in February 2016 it has been an area of priority of Cambridgeshire. We have:

1. Developed better data on the prevalence of neglect in Cambridgeshire
2. Adopted and launched a Strategy that sets out how agencies in Cambridgeshire recognise and respond to "neglect"
3. Outlined what this means for professionals and agencies exercising their duties and responsibilities to protect children and young people
4. Defined how agencies should work together to reduce the chances of children and young people being neglected
5. Reviewed and relaunched the Cambridgeshire Graded Care profile (GCP)
6. Supported the GCP with publicity and a training programme
7. Planed a series of Neglect Workshops to promote good practice and awareness of the available resources



http://www5.cambridgeshire.gov.uk/lscb/info/12/child_neglect

Progress on Cambridgeshire Priorities

MULTI-AGENCY SAFEGUARDING HUB (MASH)

Evidence of the performance and effectiveness of Cambridgeshire services

- Through the Cambridgeshire Children's Change programme there is increased partnership representation within the MASH responding to safeguarding concerns across the county.
- There is a stronger governance structure for the MASH and associated partner agencies. There is a Governance board, chaired by the LSCB chair, and attended by suitably senior representatives of MASH agencies covering the three MASH thematic areas of child protection, domestic abuse and vulnerable adults.
- The MASH operations meeting sits monthly with appropriate managers from MASH partners.
- The Early Help Hub is now up and running and situated next door to the MASH.
- The developments of the MASH through the Cambridgeshire Children's Change programme have increased safeguarding partners within the MASH and created the Missing Exploited Trafficked (MET) hub within the MASH.
- A MASH dataset has now been created and will be subject to monthly scrutiny through the MASH operational meeting.
- There are weekly multi agency audits of 10 cases that have moved through the MASH.

Strengths and weaknesses

- At the start of this year the governance arrangements around the MASH were weaker than previously experienced. This is now addressed with an embedded Governance Board and the previously mentioned Operational meeting.
- Developments within the MASH have targeted children related services over this year. There is still a focus on developing multi agency services for adults in the coming year.

Actions undertaken by LSCB and partners

- There is a single threshold document for child protection / concern matters.
- There is a defined CSE protocol.
- There is a single CSE risk management tool used within the MASH.

Progress on Cambridgeshire Priorities

Impact of the actions taken

- The MASH has enhanced partnership representation in a collocated environment to deliver multi agency safeguarding responses.
- The MASH is aligned to the early Help Hub.
- Agencies all working to and understanding the defined thresholds.

Future Plans

To develop the MASH estate and infrastructure to deliver a bespoke MASH environment across child and adult safeguarding concerns alongside related domestic abuse issues.

CHILD SEXUAL EXPLOITATION

We have two key objectives:

- Develop a model of staged intervention or "Offer" for the victims and potential victims of CSE
- Ensure the risk and vulnerability of children Missing from Care, Home and Education has been effectively managed

Work has continued to realign how we structure services to meet the needs of the children and young people at risk. The ability of professionals to identify and respond to CSE has been enhanced by the creation of a Joint Risk Management tool specifically for CSE which now clearly highlights the level of risk and the correct level of intervention necessary to reduce it.

There is a coordinated multi-agency response to CSE:

LSCB Joint CSE and Missing Strategic Group

This is the forum to manage our services through the joint CSE action plan. Issues arising with partners can be dealt with at this meeting and it is the forum where we would apply lessons from national themes and trends.

MASE Meeting

This meeting ensures we respond to the identified themes and trends in Cambridgeshire. We have access to significant data surrounding CSE and Missing for analysis and respond to areas of concern as they emerge.

Operation Makesafe

This is a police led monthly meeting concentrating specifically on an identified "cohort" of individuals most at risk. The intelligence provided focuses specifically on potential victims, locations and offenders.

Actions arising from the meeting are managed by the CSE and Missing Coordinator who will ensure that the right agencies are engaged.

Progress on Cambridgeshire Priorities

Actions undertaken by LSCB and partners

- There has been targeted CSE education programmes have been delivered to schools across Cambridgeshire.
- They engaged with hotels and identified that wider engagement across this industry was required. This has been progressed via a wider regional CSE forum and national Police safeguarding leads.
- There was partnership engagement with a range of hotels across the county to deliver education in relation to spotting indicators of CSE and seeking such establishments to be more proactive in raising concerns to appropriate safeguarding agencies.

Future Developments

- We are developing measures to show impact of our work that will go alongside the existing data on numbers of young people at risk and Missing incidents.
- Respond to the recognition that exploitation can be broader than just sexual and may include gang association or gang related exploitation.

HEALTH

The 'Health Family' have continued to seek to champion the needs of vulnerable children within the health sector and to work effectively with partners during 2016/17.

Together we have

- Maintained high levels of compliance within health providers for safeguarding children training
- Engaged with multi agency audit programme
- Embedded recommendations from CQC Inspections county wide.
- Ensured due process is followed in the event of a child death, and provided a Consultant led rapid response process
- Monitored timeliness and quality of LAC Health Assessments.
- Ensured an effective high quality service for children who are victims of child sexual abuse.
- Embedding a case conference report template into primary care to strengthen their contribution to case conferences.
- Strengthened engagement within the Multi Agency Safeguarding Hub
- Strengthened the use of a "think family" approach in emergency department settings.
- Developed a pathway for unaccompanied asylum seekers to manage blood born viruses.
- Developed and utilised a personal health care record for care leavers.
- Reviewed processes around transitioning of children to adult services in accordance with NICE guidance.
- Annual Safeguarding GP conference focussing on referrals to social care, fire safety, and unaccompanied asylum seekers.

Progress on Cambridgeshire Priorities

This has improved outcomes for children and young people by

- Improvements in Primary Care contribution with Case Conferences.
- Raising awareness of adults presenting in Emergency Departments where there may be hidden children who need support.
- Improved engagement around LAC health processes
- Supporting care leavers to be aware of their health needs.
- Enabled partners to know where to access information and support for young people with emotional wellbeing concerns.

In the year to come we will seek to

- Fully embed the Child Protection Information System across the county.
- Engagement with No Wrong Door project for looked after children to improve their life chances.
- Further embed neglect tool kits across health.
- Implement resources and awareness of the work of the Lucy Faithful Foundation across the health family
- Quality audit Child Protection Medical and Sexual Abuse services

SCHOOLS & COLLEGES

The LSCB has a designated group looking at the Education sector that includes representation from all education sectors, LA, Locality, LADO, school nurse and this year one of the LSCB lay Members joined the group.

Its main impact has been to ensure messages get to the right groups and that consistent advice and guidance is provided to schools and settings across all sectors. It has also ensured that LSCB priorities are highlighted with schools and settings, often through the conferences that are run throughout the year

- All changes across Children's Services have been highlighted and the Threshold document considered
- Reports have been submitted to the group on safeguarding Reviews and Safer Recruitment Audits carried out in schools.
- Changes and updates in Government guidance has been scrutinised including Keeping Children Safe in Education.
- There has been a response to particular issues: Sexting, Exploitation, Neglect and Children Missing

Progress on Cambridgeshire Priorities

VULNERABLE GROUPS & CURRENT ISSUES

Unaccompanied Asylum Seekers

At any time around sixty unaccompanied asylum seekers are in the care of Cambridgeshire County Council. The overwhelming majority are from Iran, Iraq and Eritrea. Over 80% are male, sixteen or seventeen and placed in another local authority area. They have needs assessments and plans in place to support them but these processes were identified as needing to be enhanced. Specialist provision is being established within the Children Services 14 to 25 Team to support this and their effective integration.

Looked after children

The outcomes for Looked After Children remain unsatisfactory. The Council's Corporate Parenting Strategy is supported by workstreams to improve this and the LSCB has received reports on the progress made, providing support and challenge as required.

The number of children getting the medical assessment they need within a month of being accommodated was low and attention has been focussed on this issue at the Board. Action has been taken to improve performance and there is evidence it has been successful.

Children detained in cells overnight.

There was considerable attention paid during the year to the impact on young people of their being held overnight in police cells.

The most significant action to reduce the number of children detained in police cells overnight has come from increased access to responsible adults able to support the child or young person in interview. The Office of the Police and Crime Commissioner provided temporary funding to improve access and this provided ample evidence that this facility was needed. The LSCB has supported agencies in finding a long term solution to meeting this need.

Safeguarding and Sport

The LSCB undertook a review of current safeguarding within organised football and was able to confirm the good level of Safeguarding practice now within the Football Associations.

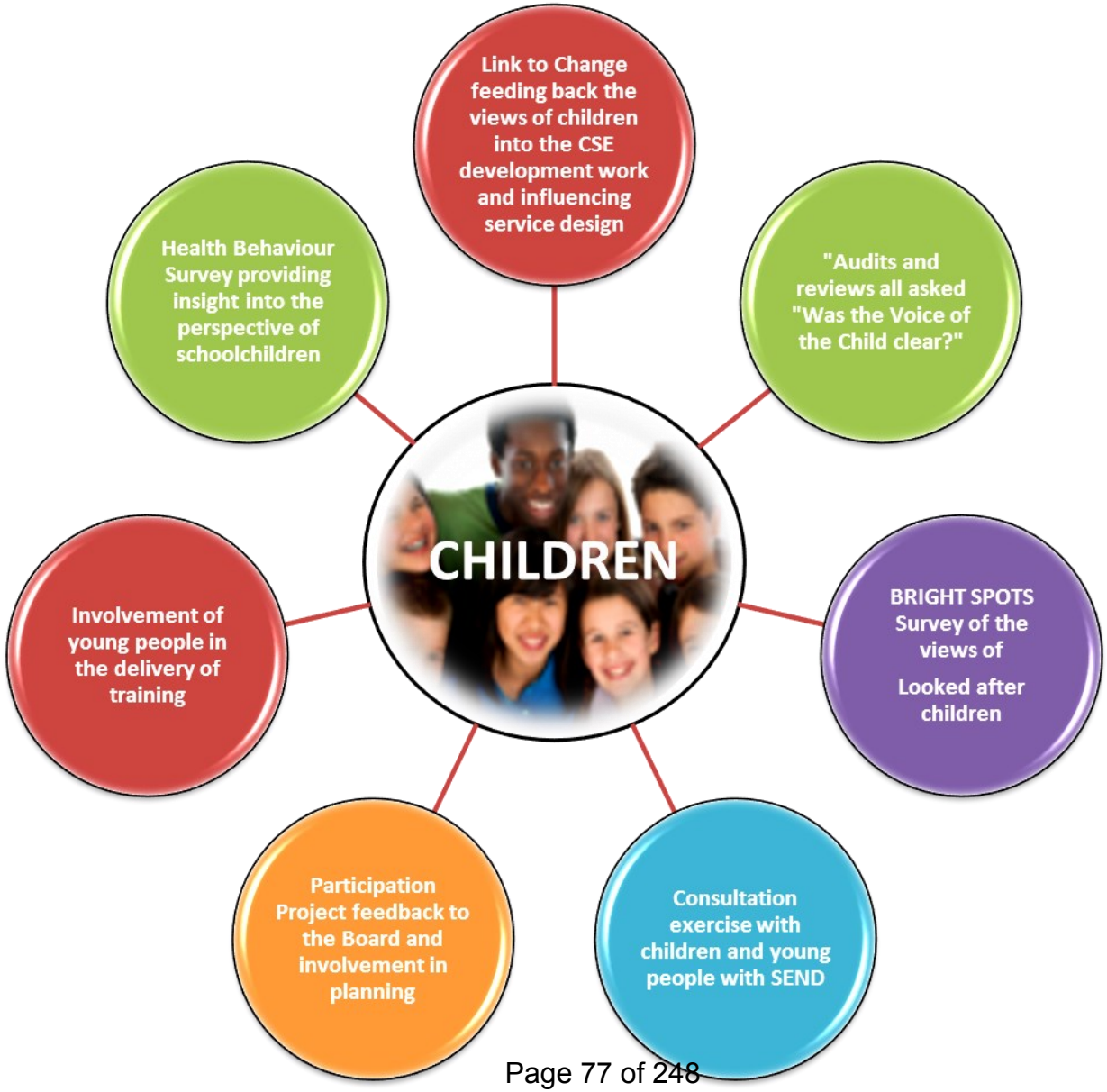
JOINED UP WORKING

- Work with the other statutory partnerships to develop an integrated plan on how key shared objectives will be met to reduce duplication, confusion and delay.
- Work with the Adult Safeguarding Board and Peterborough Safeguarding Boards to increase efficiency and simplify the safeguarding message for staff across the partnership.

Learning and Improvement

Learning & Improvement

VOICE OF THE CHILD



Learning & Improvement

THE VOICE OF FAMILIES

Partner agencies all have a responsibility to get the views of families and service users, through consultation, survey and Customer Care Teams. The LSCB is kept informed of the key messages that come through.

Over the last year:

- Updated and clearer information has been made available by the LSCB and agencies to service users, including those becoming involved with the Child Protection process or Court proceedings.
- The LSCB and the Children Services emphasised the need for timely reports and minutes to be prepared and shared with young people and their families. Everyone needs to be ready and prepared if they are to engage productively in discussion and decision making.
- Children Services staff have been reminded of the need to keep service users informed of progress in actions, and if there is no progress the helpfulness of making certain families know and understand how things stand and that they have not been forgotten.
- Even greater care is being exercised with information being used and shared in meetings where there is more than one family member involved, including when it is recorded on Flip Charts. Agencies have continually remind their staff about the importance of confidentiality and the safe communication of personal information.
- Professionals have been reminded that families need to know who professionals are, how they can be contacted and what their role is.
- We have been reminded that good customer service, be it answering the phone, proper use of Out of Office or displayed ID, is important when working with young people and families.
- It has been confirmed that professionals need to be particularly careful to provide information and a supportive service to people at points of greatest importance and sensitivity to them. This includes when services begin to be involved, if there is a start to any legal process, or when there are changes in contact arrangements.
- The LSCB has embarked on producing a web based film giving important information to children and families about how services work and what they can expect to happen when they become involved.

Learning & Improvement

REVIEW OF PRACTICE (SCR)

For the second year running there have been no SCRs in Cambridgeshire. We have, however, undertaken a number of Multi-Agency Reviews on cases which did not meet the criteria for a SCR but about which there were some concerns about multi-agency working.

Examples include:

- a boy with specialist mental health needs for whom an appropriate placement could not be identified
- two families linked by the same father where the children had been physically abused by him for a considerable period of time before the abuse was discovered
- a young woman who was in care and who was vulnerable to further abuse once she had returned to live in her local community.
- a case where historic information about sexual abuse was not appropriately shared with partners, potentially putting children at risk

In each of these cases, practitioners and managers from the relevant agencies met together and discussed their involvement with the case and identified where lessons might be learned for the future. Action plans were developed for each of the cases.

The learning points were then shared with other practitioners within the partner agencies and included in relevant LSCB training and development events. Where necessary, practice guidance and procedures were reviewed and amended. A 'lessons from practice' leaflet also summarises the learning from these Multi-Agency Reviews.

Throughout the year, work has continued with an independent school where two teachers were convicted of sex offences. The aim has been to ensure that appropriate changes had been made to the school's safeguarding practice. This work will continue into 17/18. The school have made significant changes since the offenders were identified.

From January 2017, Peterborough and Cambridgeshire combined their respective SCR sub-committees in recognition that the majority of members covered both local areas.

Felicity Schofield
Independent SCR Chair

Learning & Improvement

AUDITING

Section 11 Audit

Every two years agencies audit how well they comply with their legal requirements to safeguard and report the audit findings to the LSCB. This was the second year of the cycle. We required confirmation that issues had been addressed as planned. This is how we know if agencies have the leadership, policies and training in place required to safeguard children effectively.

In Cambridgeshire the key agencies were able to show they met these requirements and were set up to safeguard children.

There was a separate Section 11 Audit of GP surgeries carried out this year by the CCG. This highlighted Safeguarding with this key group of professionals and enabled the CCG to work with GPs in enabling them to safeguard children.

THRESHOLDS

Are children getting the right services at the right time? Prior to the changes in Children Services there was an audit of how the MASH responded to referrals that didn't go into Children Social Care.

It found:

1. Thresholding decisions were appropriate.
2. Subsequent work had been undertaken within Early Help to address the needs of the children referred.
3. Referring agency records had some information missing.
4. Feedback to referrers by MASH, and therefore to families, wasn't always understood and used effectively.
5. There was only limited evidence that families understood the referral process and the reasons that CSC had decided it was not in the child's interest they become involved.
6. Some agencies are required to provide information to CSC and/or to request information from Children Services when risk is not so high that a referral was required. This causes difficulties in communication between referrers and CSC.

As a result

1. The new MASH arrangements have clearer referral pathways for professionals and feedback to referrers is a priority.
2. Early Help and Children Social Care are working ever more closely together to ensure a child's needs are met by the right service at the right time.
3. The MASH navigator role will simplify appropriate information sharing between children services and other agencies.
4. MASH and the Early Help Hub have a multi-agency audit process to ensure the right decisions are being made to meet children's needs consistently and on time.

Learning & Improvement

DOMESTIC ABUSE

Agencies participated in an audit using the Ofsted inspection processes with a focus on Domestic Abuse cases

It found:

1. There was evidence of good work being done between agencies.
2. It could be difficult to get a clear picture of the child or young person's perspective on their home life and needs
3. Professionals continued to feel that resources were not readily available to respond to Domestic Abuse
4. Professionals found it difficult to manage the complex tension involved in responding to the needs of the adults present, particularly the victim, whilst focussing on safeguarding the children.

The key actions coming from it were:

1. The LSCB has adopted a Domestic Abuse strategy and resource pack which includes assessment models and interventions that practitioners can use when working with cases of Domestic Abuse
2. The LSCB ensures that the following are addressed in all multi-agency training. a) That the perspective of the child and significant adults must be present in all cases. b) Communication between agencies should include accurate information about the assessed needs of parents and carers.
3. Agencies will ensure that they have robust ways to identify relevant cases and quality assure the work being done
4. The Cambridgeshire QEG should continue to monitor and improve the Child Protection Conference invitation process and attendance by agencies.
5. A review of the communication process following the identification by the police of a domestic abuse incident with a child present, including passing this information to early years provision, schools and Early Help Teams.

CSE

Shortly before the start of the year we undertook a multi-agency audit of CSE cases. The learning was used during 2016-17.

It found:

1. There was a need for more effective risk assessment of cases
2. There was an under developed range of resources available to meet the needs of young people at risk of CSE
3. Return Interviews were not being used to establish the views of the child and ensure their voice was heard by agencies.

All of these concerns have been addressed by the actions outlined in the CSE section of this report.

The Child Death Overview Panel

The Child Death Overview Panel

THE PROCESS

The primary function of the Cambridgeshire and Peterborough Child Death Overview Panel (CDOP) is to review all child deaths in the area. It does this through two interrelated multi-agency processes; a paper based review of all deaths of children under the age of 18 years by the CDOP and a rapid response service, led jointly by health and police personnel, which looks in greater detail at the deaths of all children who die unexpectedly.

This is a statutory process, the requirements of which are set out in chapter 5 of 'Working Together to Safeguard Children 2015'. The CDOP is chaired by the Independent Chair of the LSCB. The CDOP annual report can be found on the LSCB website.

There are two versions of the annual report, one for professionals and one for general publication. This second version summarises some information in order to prevent individual children from being identified.

The information in this summary relates only to Cambridgeshire children.

NUMBER OF CHILD DEATHS REPORTED AND REVIEWED

During the period of this report, 35 children's deaths were reported in Cambridgeshire, which is 6 deaths more than the previous year. Of those children who died, 66% were less than a year old, the majority of whom never left hospital.

MODIFIABLE FACTORS

It is the purpose of the Child Death Overview Panel to identify any 'modifiable' factors for each death, that is, any factor which, with hindsight, might have prevented that death and might prevent future deaths.

There were two deaths in Cambridgeshire where a modifiable factor was identified. Both of these deaths were babies that died following complications during delivery.

Training & Development

Training & Development

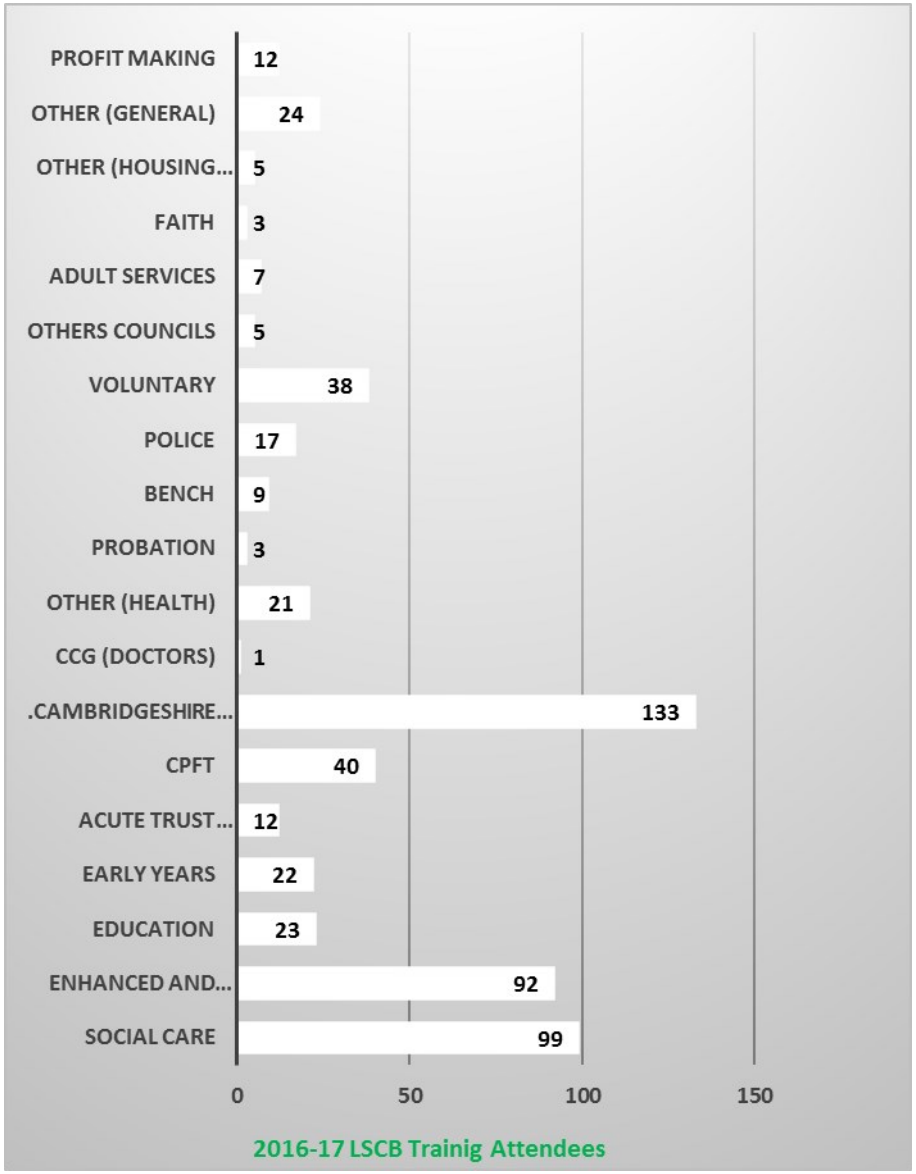
LSCB TRAINING PERFORMANCE & IMPACT

Just over 2000 professionals attended LSCB training events, free at point of delivery to LSCB contributing agencies.

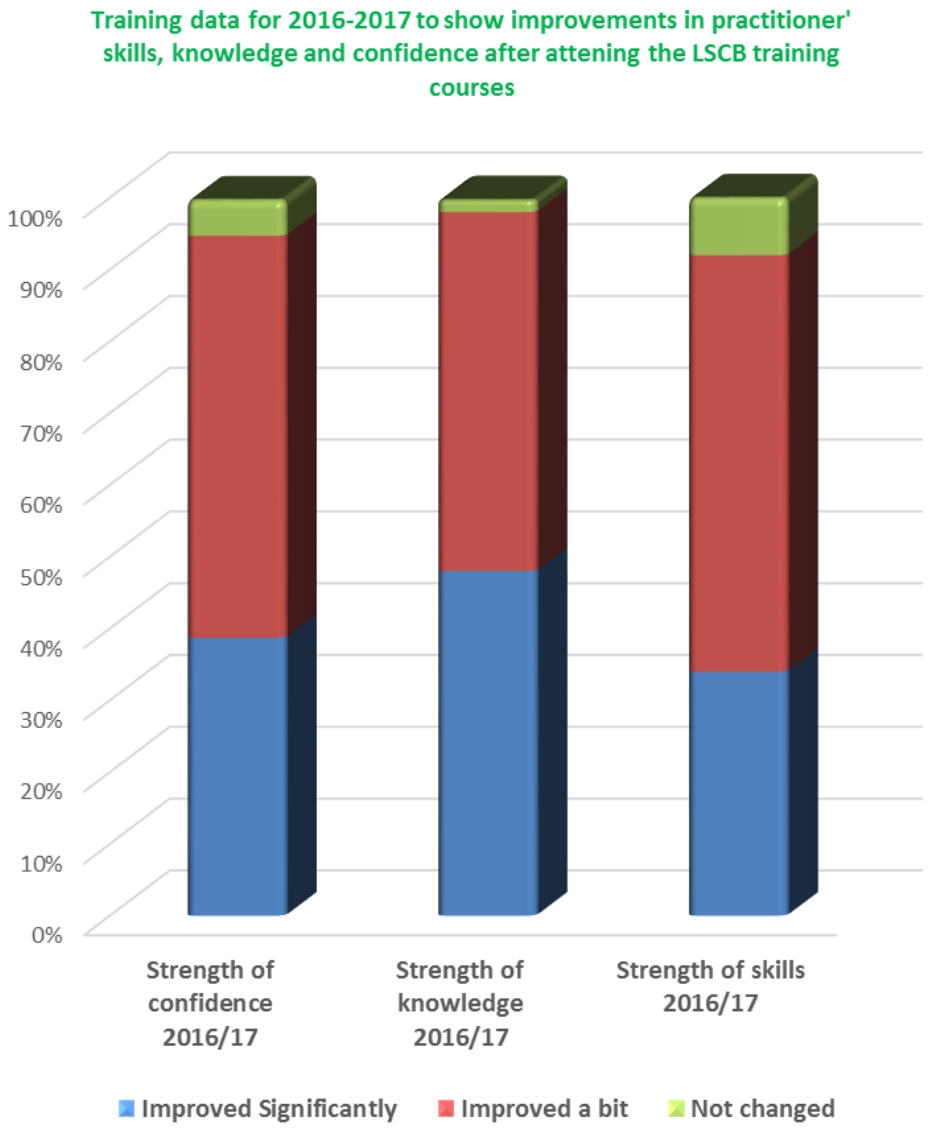
- 578 practitioners attended 42 safeguarding training courses. 17 Local Practice Groups took place with approximately 217 practitioners attending. Overall, 1,289 practitioners attended 48 LPG Specialist workshops, facilitated to cascade important messages and safeguarding priorities to front line practitioners from a wide range of agencies.

- 161 people attended the joint LSCB Annual Conference day. 92% of attendees rated the day as 'excellent to good'.

- As in previous years the LSCB training continues to offer a high standard of training; according to attendees over 90% rated the LSCB training as excellent to good, achieving the aims and outcomes. Overall the feedback on all aspects of the conference were resoundingly positive and practitioners valued the time to reflect on practice and to 'network', finding out about other agencies, their roles and responsibilities for safeguarding children. Local Practice Groups continue to be a safeguarding 'mainstay' for practitioners offering focussed safeguarding workshops and networking opportunities. Practitioners report that '*trainers are brilliant, I feel more confident, will feedback to my team and has increased knowledge and skills'.*



Training & Development



- Practitioner and manager reviews on the impact of the LSCB training indicate that practitioners feel that they are *'100% better informed'* and that the training*' is relevant to practice'*
- More importantly practitioner's state that their confidence, skills and knowledge has improved for working to safeguard children and young people.
- Only 3 single agency training courses have been validated by Cambridgeshire LSCB and 1 by Peterborough LSCB (3 health 1 from CCC workforce development) over the year;
- The LSCB continues to provide and support safeguarding training for those professionals who are deemed as 'hard to reach'

Training & Development

STRENGTHS & WEAKNESSES

Strengths	Weaknesses
• A comprehensive LSCB training programme • Training is well evaluated and reviewed - is shown to impact upon improving practice to safeguard children and young people • Voice of the child within the training / child centred • Well received annual conference • Excellent partnership working • Validation panel to validate single agency training • Proactive quorate workforce development group soon to be joint • Leaflets / information designed to support training on the LSCB website • Booking bug and survey monkey utilised for getting people on courses and evaluation / impact tools	• Depleted training pool with few people available to facilitate courses- courses cancelled • Few planning leads for the LPGs/ LPG's closing • Partners not taking responsibility for LSCB training – to co-ordinate / update / contribute / enable trainers to facilitate • Partners putting pressure on LSCB training with practitioners to be trained as limited single agency courses available • Single agency training not being validated • Website will be changed over shortly may not have all previous programmes available
Opportunities	**Threats**
• Peterborough and Cambridgeshire LSCB Business Units joining- joined up working shared training opportunities • LSCB Business Unit restructure – new roles and responsibilities could enhance training • Assessment Tools becoming mandatory across the council leading to potential single agency training champions to take specialist training forward • New LSCB website / joint with Adults safeguarding and Peterborough • Workforce development group bi annual joint meetings for joined up approach • New CCC structure to support LPGs	• LPGs at risk if there are no planning leads to take forward • Restructure and cost savings within agencies- reducing availability of support and staff involved within LSCB training • Training calendar reduced as no training pool to facilitate the training- courses deleted or cancelled • Lack of validation may impact on child protection and safeguarding – how do we know the training is happening and it's valid / robust and effective? • LSCB Training Manager role is changing – may impact on full time support for training in terms of planning, oversight, development and delivery

Training & Development

Action Undertaken by LSCB and Partners

There is little match between agency use of training and commitment of resources to the training pool, and an increase in support for the pool from some agencies is needed if we are to maintain training with reliable levels of delivery.

To support a local multi-agency approach the LSCB partners need to renew their commitment to allowing staff to continue to facilitate in both the LSCB training pool and the LSCB specialist training pool or both pools will close and the LSCB training will be at risk. Trainers should be willing to commit their time to the training and to plan accordingly.

Business Committee and Workforce development members need to agree on what training is a priority. Both LSCBs are in discussion regarding what courses can be cross the county and what issues are coming out of research, section 11 returns, serious case reviews as local training needs.

Heads of service from social care and Early Help are meeting with the LSCB with a view to bolstering the planning group's membership, reviewing the terms of reference for the LPGs and mapping the LPGs onto the new district model.

In terms of validating courses agencies need to understand that this is a statutory requirement and to ensure that their safeguarding training is either validated or accredited to ensure the training is fit for purpose for a competent and skilled workforce in terms of child protection.

Impact of Actions Taken

The impact of the actions suggested above should ensure the continuation of LSCB training programme and local practice groups for the foreseeable future. This will inform practitioners and improve practice for safeguarding and protecting our children and young people. Additionally by monitoring and reviewing single agency safeguarding training we can be assured that practitioners within agencies are equipped and confident to undertake safeguarding work with children and families.

Future Plans

Cambridgeshire LSCB training is a grounded and respected safeguarding resource for front line practitioners and managers. Moving forward, we need partner support and trainers for the programme. There will be a joint training programme with Peterborough and we will explore the possibility of a different focus on our training, holding shorter days and workshops to enable staff to attend.

Priorities for Next Year & Beyond

Priorities for Next Year & Beyond

ENSURE EFFECTIVE SAFEGUARDING OF CHILDREN AGAINST NEGLECT

- Demonstrate the successful implementation of the Neglect Strategy.
- Show that staff are equipped to make informed, consistent assessments of families where neglect is an issue using the Graded Care Profile.

CHILD SEXUAL EXPLOITATION & MISSING

- Continue the focus on ensuring that children who are vulnerable to exploitation are safeguarded
- Ensure the risk and vulnerability of children Missing from Care, Home and Education has been effectively managed
- Safeguard children from the risk of exploitation by Gangs.
- Safeguard children from the risk of exploitation by extremism and radicalisation.

THE VOICE OF THE CHILD

- Continued development in obtaining the views of children and young people for decision making and identify the impact of those views.

ENHANCEMENT OF LSCB EFFECTIVENESS IN DISCHARGING ITS RESPONSIBILITIES

- Working Together is being reviewed in the light of the Social Care Act.
- The LSCB is re-structuring how it works to prepare for the changes. It will need to continue to show it is effective, is in line with statutory requirement and meets the needs of Cambridgeshire children.

DEVELOPING AND SUPPORTING EFFECTIVE WORKFORCE

- To have in place adequate resources and capacity to deliver or commission training.
- That policies, procedures and practice guidelines inform and support training delivery in line with the Learning and Implementation Framework
- Undertake reviews of local training needs, taking into account research, national developments, learning from SCRs and child death reviews (not only those carried out locally), and Board priorities.

Agenda Item No: 7

LOCAL TRANSFORMATION PLAN REFRESH FOR CHILDREN AND YOUNG PEOPLE'S EMOTIONAL AND MENTAL HEALTH AND WELLBEING 2017/18

To: **Health and Wellbeing Board**

Meeting Date: **21 September 2017**

From: **Kathryn Goose, Project Manager, Cambridgeshire and Peterborough Clinical Commissioning Group**

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

a) **Note the planned refresh of the Local Transformation Plan**
b) **Provide delegated authority to the Director of Public Health in consultation with the Chairman of the Board to sign off for the plan prior to the publication deadline 31 October 2017**

	Officer contact:		***Member contact:***
Name:	Kathryn Goose	Names:	Councillor Peter Topping
Post:	Project Manager, CCG	Post:	Chairman
Email:	kathryn.goose@nhs.net	Email:	Peter.Topping@cambridgeshire.gov.uk
Tel:		Tel:	01223 706398

PURPOSE

1.1 The purpose of this paper is to inform the Cambridgeshire Health and Wellbeing Board of the planned refresh of the Local Transformation Plan (LTP) for children and young people's emotional, mental health and wellbeing. The LTP is required to be signed-off by Health and Wellbeing Boards; therefore this paper is to advise the Cambridgeshire Health and Wellbeing Board of the planned refresh and asked for delegated sign-off in time for the required publication date of 31 October 2017.

2 BACKGROUND

2.1 In August 2015 NHS England launched a guidance document for local areas regarding the development of LTP for Children and Young people's mental health and wellbeing. The LTP is a plan which is locally developed and sets out the vision, areas for service transformation and investments to be made for children and young people's emotional and mental health services based on local needs. The LTP includes information of local need, challenges, areas in need of improvement and how developments will increase the number of young people accessing services and improve their outcomes and overall emotional and mental wellbeing. The LTP looks at services across a spectrum of services from universal through to the point a young person may require an inpatient facility. The plan also details the investment to be made and key performance indicators from when the plan commenced in 2015/16 to 2020/21

2.2 The first LTP for Cambridgeshire and Peterborough was developed with a range of stakeholders and published in October 2015 and detailed the first year's initiatives. A second refreshed plan was published in October 2016 and provided a more detailed plan for the five years of transformation up until 2020/21. Both of these plans have been developed with a range of stakeholders and signed-off by the Health and Wellbeing Boards of both Cambridgeshire and Peterborough.

3. MAIN ISSUES

3.1 The LTP is currently undergoing a third refresh and will be known as the LTP 17/18, as the timeframe it covers is 1 November 2017 to 31 October 2018. There are a range of areas the plan covers including: improved access to information through the 'Keep-your-head' website, ongoing development of parenting support programmes for children with behavioural issues, pathway developments in specialist mental health services including autism spectrum disorder/ attention deficit hyperactivity disorder, eating disorders and crisis services, a focus on developing the workforce to ensure we have skilled sustainable workforce to deliver a range of evidence based services. The LTP details the needs of the population and engagement with children and young people, families and carers and how their views have helped shape the areas of developments and investments.

3.2 The LTP is currently being refreshed to ensure the information is accurate and developments are based on population needs including Joint Strategic Needs Assessment (JSNA) and public health information, feedback, learning from existing developments and that it aligns with local commissioning intentions and national drivers for change. This process has commenced and will take some time to have a final draft for comment, which will require a range of stakeholders to sign-off the plan including Health and Wellbeing Boards of

both Cambridgeshire and Peterborough, the Director of Children's Services, Local Safeguarding Boards, NHS specialist commissioning and parent/carers groups.

3.3 The LTP is not currently refreshed to the point of being able to be signed-off as work is required with a range of stakeholders to update the LTP and ensure it is fit for purpose and meets the needs of the local population. Therefore this paper is to inform the Health and Wellbeing Board of the LTP refresh and ask that there is a process for delegated sign-off of the LTP by the Health and Wellbeing Board during October to enable the LTP to be published by the required deadline of 31 October 2017.

3.4 The Health and Wellbeing Board will be provided with the opportunity to review the final draft plan for comment prior to the submission and publication date of 31st October.

4 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

4.1 The LTP is relevant to priorities (1, 3, 4, 6) of the Health and Wellbeing Strategy:

- Priority1: Ensure a positive start to life for children, young people and their families.
- Priority 2: Support older people to be independent, safe and well.
- Priority 3: Encourage healthy lifestyles and behaviours in all actions and activities while respecting people's personal choices.
- Priority 4: Create a safe environment and help to build strong communities, wellbeing and mental health.
- Priority 5: Create a sustainable environment in which communities can flourish.
- Priority 6: Work together effectively.

5 SOURCES

Source Documents	Location
Local Transformation Plans for Children and Young People's Mental Health and Wellbeing – Guidance and support for local areas	***https://www.england.nhs.uk/wp-content/uploads/2015/07/local-transformation-plans-cyp-mh-guidance.pdf***
Cambridgeshire and Peterborough Local Transformation Plan for children and young people's emotional, mental health and wellbeing 16/17	***http://www.cambridgeshireandpeterboroughccg.nhs.uk/about-us/who-we-are-and-what-we-do/our-work-and-priorities/emotional-health-and-wellbeing-project/***

Agenda Item No: 8

CAMBRIDGESHIRE ANNUAL PUBLIC HEALTH REPORT 2017

To: **Health and Wellbeing Board**

Meeting Date: **21st September 2017**

From: **Dr Liz Robin, Director of Public Health**

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

a) **discuss and comment on the information outlined in the Annual Public Health Report;**

b) **to consider any recommendations the Health and Wellbeing Board may want to make, to address issues outlined in the Report.**

	Officer contact:		***Member contact:***
Name:	Dr Liz Robin	Names:	Councillor Peter Topping
Post:	Director of Public Health	Post:	Chairman
Email:	Liz.robin@cambridgeshire.gov.uk	Email:	Peter.Topping@cambridgeshire.gov.uk
Tel:	01223 703261	Tel:	01223 706398

1. PURPOSE

1.1 The purpose of this paper is to present the Annual Public Health Report 2017 to the Health and Wellbeing Board.

2 BACKGROUND

2.1 The Health and Social Care Act (2012) includes a requirement for Directors of Public Health to prepare an independent Annual Public Health Report (APHR) on the health of local people.

2.2 Last year's Annual Public Health Report focussed on health and wellbeing issues at a very local level – providing health 'maps' of the county broken down into individual electoral wards. It also provided case studies of what is being done at the moment in communities in Cambridgeshire to support healthy lifestyles and wellbeing.

3. MAIN ISSUES

3.1 This year's Annual Public Health Report 2017 has a new focus – concentrating on the wider social and environmental factors affecting our health and wellbeing, and how these influence the differences in health outcomes we see across the county. The report also looks at key lifestyle behaviours which impact on longer term health and wellbeing, and at trends in life expectancy and preventable deaths in the county.

2.2 The overall picture is of a county with generally positive health outcomes and improvement in many long term trends. However there are specific issues of concern including significant health inequalities across the county, and between neighbourhoods at a more local level.

2.3 The summary and recommendations of the Report include the following:

- Where possible and statistically valid, we should be mapping more health and wellbeing indicators at the local neighbourhood level to help 'fine tune' the provision, targeting and monitoring of campaigns and services.
- That the disparity in educational outcomes between children receiving free school meals across the county and their peers should be a public health priority, given the impact of educational attainment on future health and wellbeing
- That the work taking place across the NHS and local authorities to improve early intervention and support for young people with mental health problems should lead to an improvement in current trends, and that the impact of this work needs careful monitoring.
- That a consistent and sustainable focus on the North Fenland and Wisbech area from a range of organisations is needed to address the determinants of health such as educational attainment and economic development, as well as a focus from health and care providers on delivering accessible prevention, treatment and support services to meet current needs.

4 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

4.1 As a high level summary of key factors affecting health and wellbeing in Cambridgeshire and current trends in outcomes, the Annual Public Health

Report 2017 is relevant to all six priorities of the Health and Wellbeing Strategy:

- Priority1: Ensure a positive start to life for children, young people and their families.
- Priority 2: Support older people to be independent, safe and well.
- Priority 3: Encourage healthy lifestyles and behaviours in all actions and activities while respecting people's personal choices.
- Priority 4: Create a safe environment and help to build strong communities, wellbeing and mental health.
- Priority 5: Create a sustainable environment in which communities can flourish.
- Priority 6: Work together effectively.

5 SOURCES

Source Documents	Location
Annual Public Health Report (2015/16)	http://cambridgeshireinsight.org.uk/health/aphr
Public Health Outcomes Framework	http://www.phoutcomes.info/
Fair society heatlhy lives: The Marmot Review Institute of Health Equity	http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

Cambridgeshire County Council

Cambridgeshire

Annual Public Health Report 2017

Contents

INTRODUCTION

The purpose of this Annual Public Health Report 2017 is to provide a clear picture of the main health issues and trends in Cambridgeshire. Sitting behind the report is a wealth of web-based statistics and information, which can be accessed through the website for Public Health England's Outcomes Framework www.phoutcomes.info/ and Local Health www.localhealth.org.uk/

My Annual Public Health Report for 2016 focussed on health at a very local electoral ward level – providing information through pictograms and maps rather than traditional text and tables. It was designed to start a conversation with all three tiers of local government and the voluntary and community sector, understanding how we can work with communities to improve health and building on activities and assets which already exist at local level. The 2016 Report is available on http://cambridgeshireinsight.org.uk/health/aphr

This year's report has a different focus – concentrating on the wider social and environmental factors affecting our health and wellbeing, and how these influence the differences in health outcomes we see across the county. A brief report such as this can only skate across the surface of these complex issues, but can reflect some of the main findings and trends. The report also looks at key lifestyle behaviours which impact on longer term health and wellbeing, and at trends in life expectancy and preventable deaths in the county.

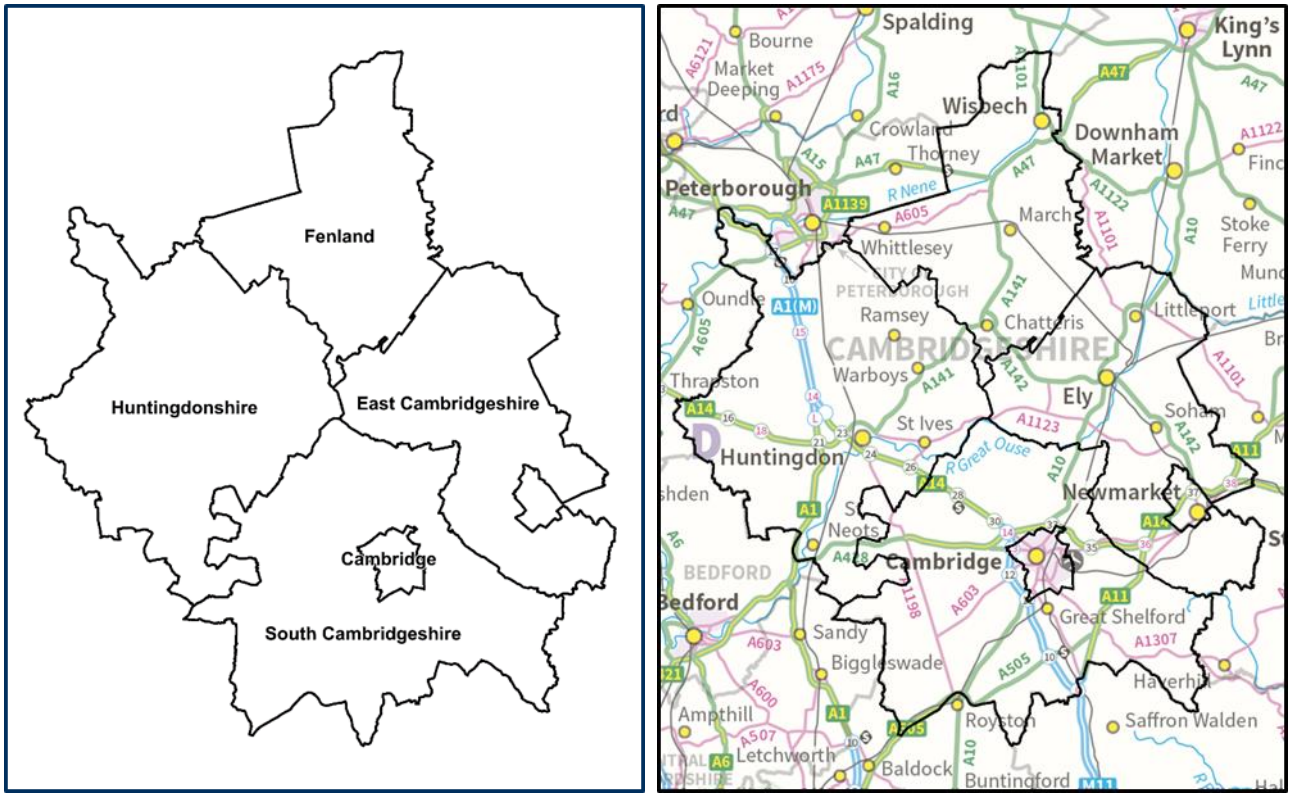
While issues of population growth and increasing demand on health and care services are critical issues for Cambridgeshire, these are covered in some depth in the Joint Strategic Needs Assessment Core Dataset available on http://cambridgeshireinsight.org.uk/jsna so are not duplicated in this report.

I'd like to thank the local Public Health Intelligence Team for their work in extracting and interpreting the key health information for Cambridgeshire and its districts, and for carrying out more detailed local analyses.

MAPPING HEALTH IN CAMBRIDGESHIRE

Because much of the information in this report is based on the five District/City Councils in Cambridgeshire, it's important to understand the geography of the county. The map below shows the boundaries of the District/City Councils within Cambridgeshire and the main towns and villages which sit within each district. .

Map 1: Local authority districts and major market towns, Cambridgeshire



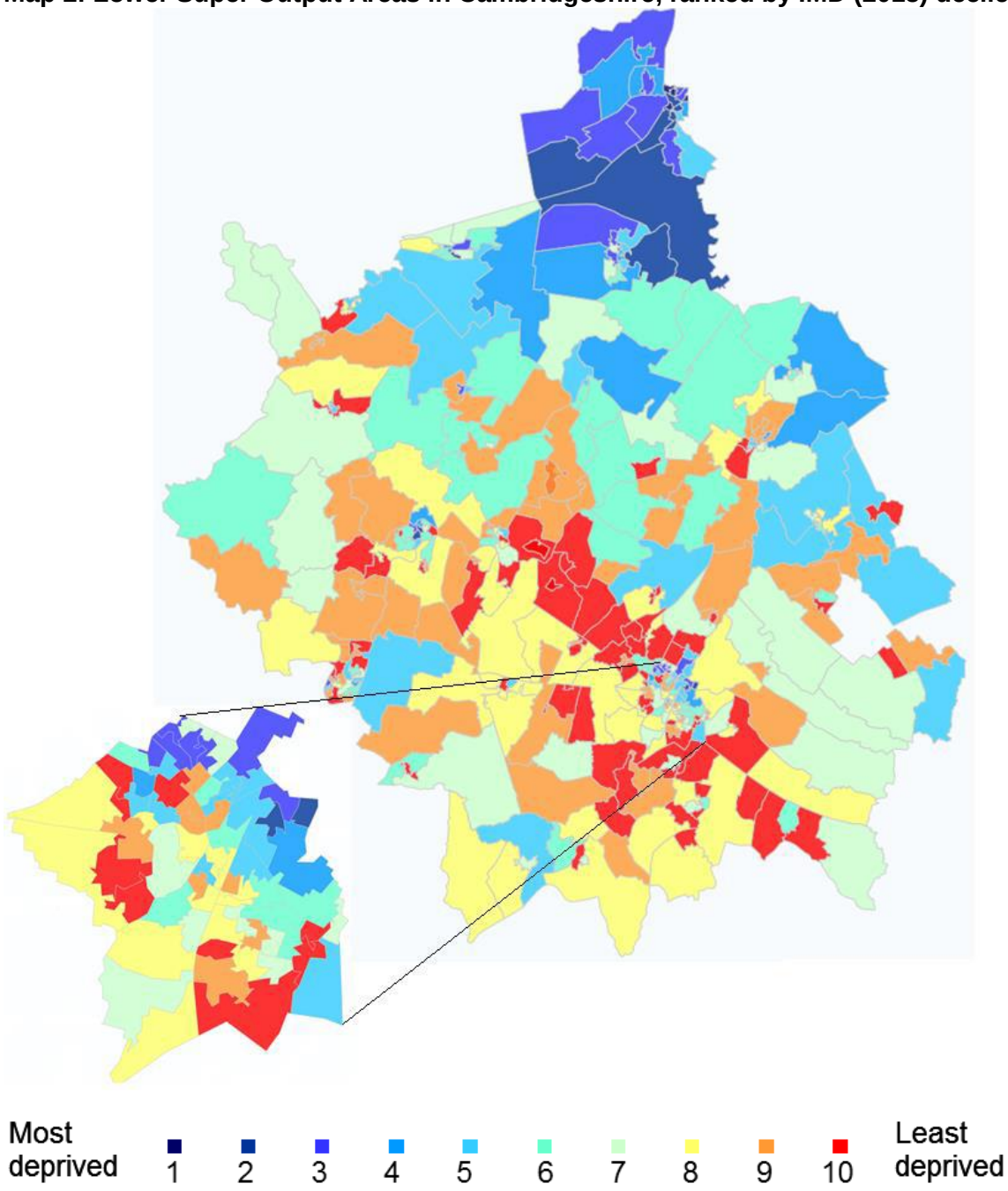
SECTION 1: THE DETERMINANTS OF HEALTH AND HEALTH OUTCOMES

1.1 The Index of Multiple Deprivation (2015)

An accepted way to look at the multiple factors which influence outcomes across communities and combine these into a single measure, is the 'Index of Multiple Deprivation' (IMD) which was last updated in 2015. The IMD (2015) calculates scores for neighbourhoods of about 1,500 people (called lower super output areas or 'LSOAs) for a range of factors, and then ranks all LSOAs in the country for their level of socio-economic deprivation.

The map of Cambridgeshire below shows neighbourhoods (LSOAs) in the county with their IMD (2015) ranks. Neighbourhoods among the most deprived 10% in the county are coloured dark blue, and those among the least deprived are coloured red. Cambridge City is expanded for clarity.

Map 2: Lower Super Output Areas in Cambridgeshire, ranked by IMD (2015) decile



It is clear that there is a north-south gradient in Cambridgeshire, with neighbourhoods with higher levels of deprivation concentrated in the north of Fenland district, while the most socio-economically advantaged neighbourhoods cluster in the southern part of the county. But there is also significant variation between neighbourhoods in each district.

IMD (2015) DNA charts

An alternative way of presenting information shown on the map above is called a ‘DNA chart’ because the bars on the chart look like pieces of DNA. Instead of putting each neighbourhood (LSOA) onto the geographical map of an area, the LSOAs from that area are lined up in rank order, and colour coded by the

national decile (10% banding) in which they fall. The national DNA chart would have ten colour coded bands of equal size (10% each). The DNA chart below for the districts of Cambridgeshire shows most districts have more neighbourhoods in the least socio-economically deprived deciles than the national average, although all have some neighbourhoods in more deprived deciles. The notable exception is Fenland district, which has no neighbourhoods in the most socio-economically advantaged 20%, and a higher proportion in the most deprived deciles.

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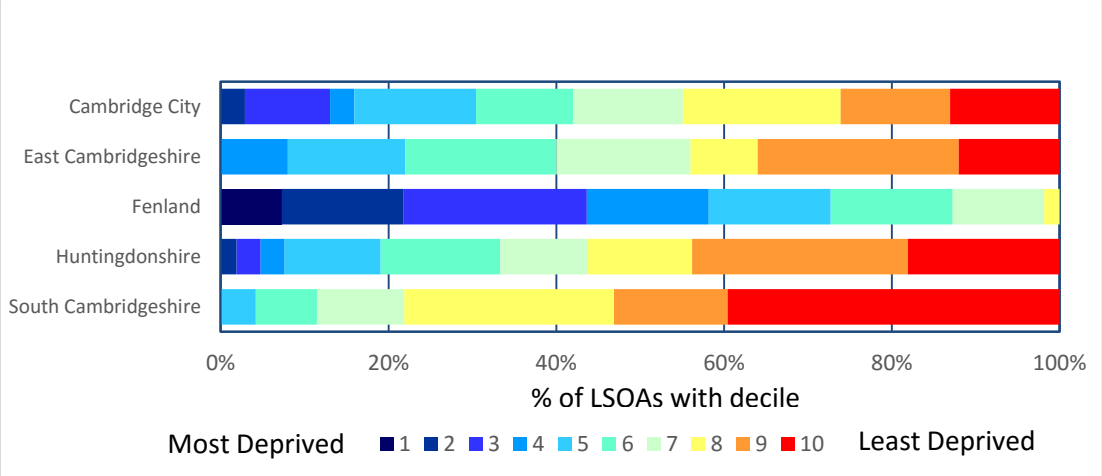
Figure 1: Cambridgeshire & Districts LSOAs, Index of Multiple Deprivation Deciles 2015



Source: Index of Multiple Deprivation, Department for Communities & Local Government, https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

1.2 What is the impact of socio-economic deprivation on health?

This section of the report breaks down the key components of the IMD (2015) in order to look in more detail at the impact of socio-economic deprivation on health. The IMD (2015) score for each neighbourhood (LSOA) is created from a range of data summarised into seven 'domains as follows. The percentage next to each domain, shows its contribution to the overall IMD (2015) score.

IMD (2015) Domains

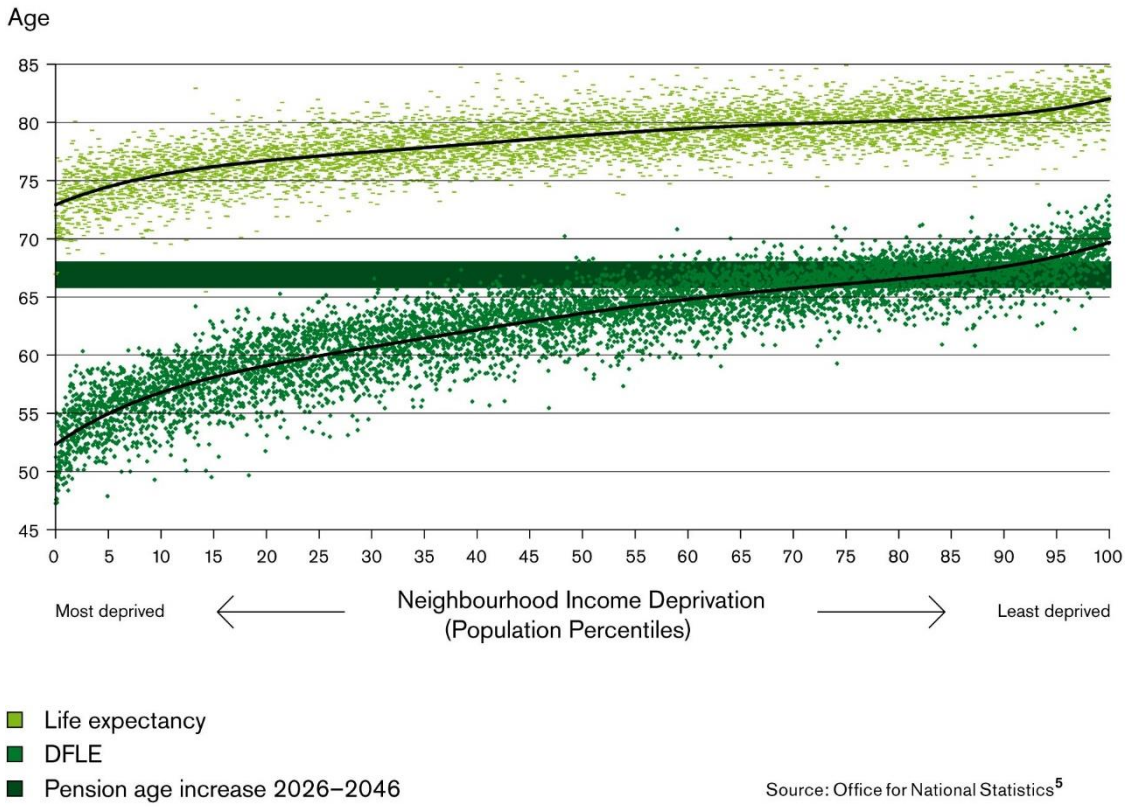
- Income (22.5%)
- Employment (22.5%)
- Education, Skills and Training (13.5%)
- Health deprivation and Disability (13.5%)
- Crime (9.3%)
- Barriers to Housing and Services (9.3%)
- Living Environment (9.3%)

More detail of the data included in each of these IMD (2015) domains is provided in Appendix A.

1.3 Income and health

We know that income levels are strongly linked with overall health and wellbeing. National research by the Institute of Health Equity showed that while there was a difference of around 10 years in overall life expectancy between neighbourhoods with the lowest and the highest incomes, the difference in 'disability free life expectancy' was closer to 20 years. This indicates that people who live in neighbourhoods with low average levels of income are likely to experience significant illness and disability at an earlier stage in their lives.

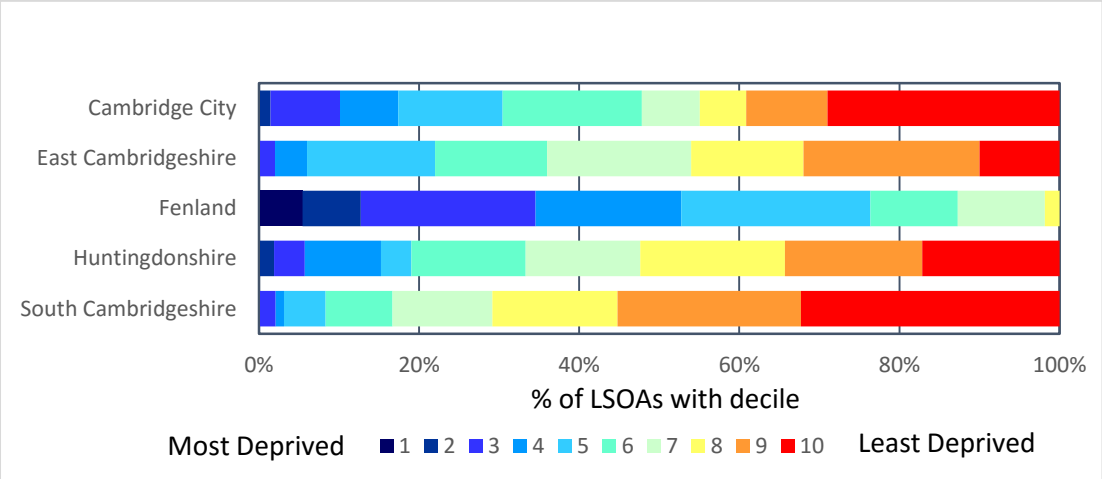
Figure 2: Life expectancy and disability-free life expectancy (DFLE) at birth, persons by neighbourhood income level, England 1999-2003



1.4 Income levels in Cambridgeshire districts

The following DNA chart shows the 'Income' domain scores for IMD (2015) for each Cambridgeshire district. Most districts have more neighbourhoods with low income deprivation. It's clear that Fenland has a higher proportion of income deprived neighbourhoods than other districts. The research from the Institute of Health Equity would predict that Fenland would have shorter average life expectancy and 'disability free life expectancy' than the rest of the county.

Figure 3: Cambridgeshire & Districts LSOAs, Index of Multiple Deprivation Deciles 2015 (Income)



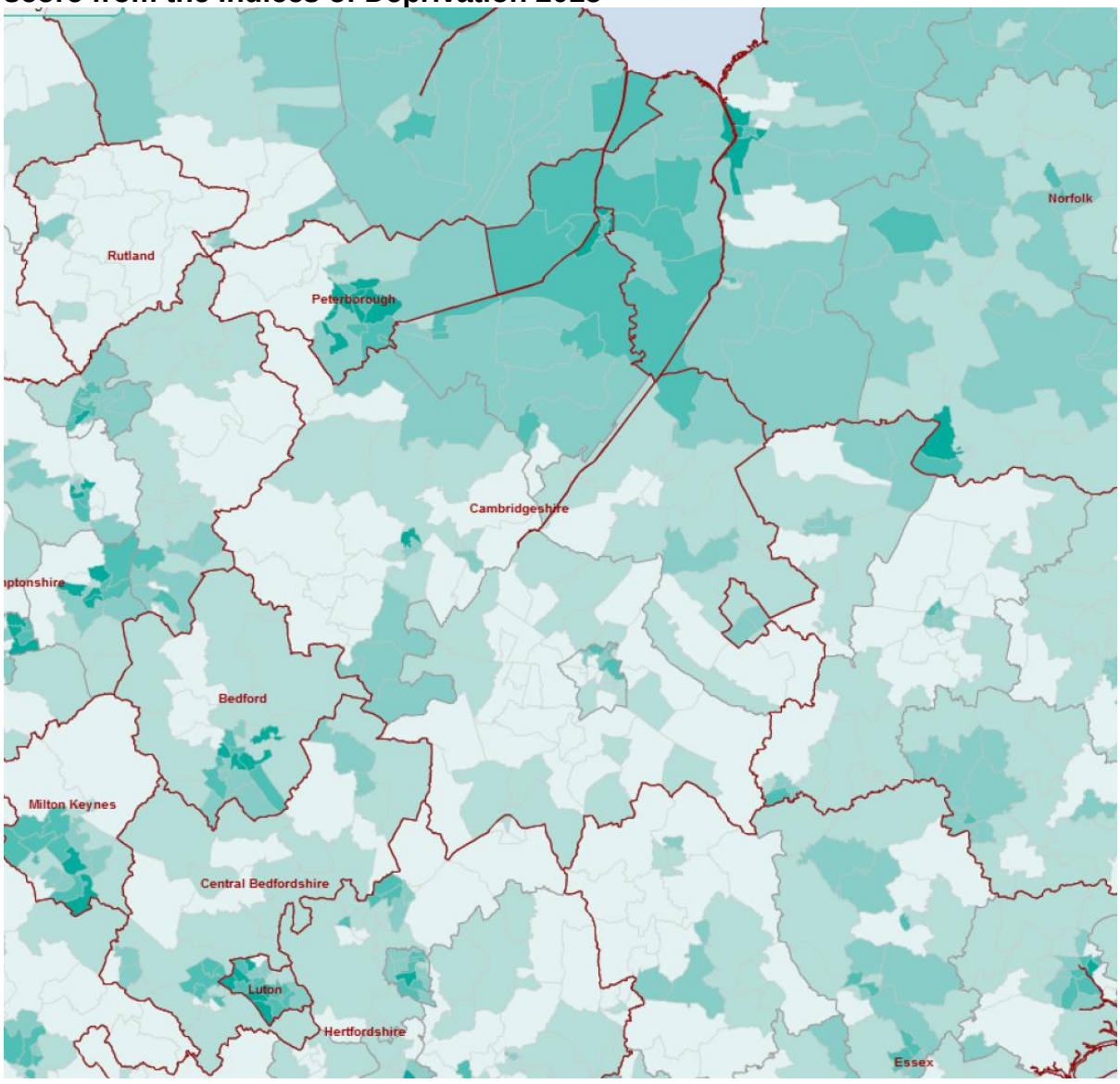
Source: Index of Multiple Deprivation, Department for Communities & Local Government, https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

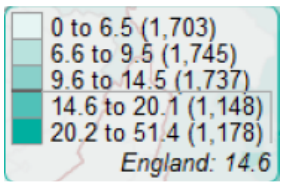
1.5 Factors affecting income deprivation

Income deprivation is related to the proportion of low paid work in the local economy, which in turn depends on the types of employment available. This varies across the county, with a higher dependence on farming and associated industries such as food processing and packing in the northern rural areas. The map below shows the IMD (2015) income deprivation domain for Cambridgeshire and surrounding areas. It's clear that the higher levels of income deprivation in North Fenland form part of a wider picture, extending into West Norfolk and Lincolnshire. Conversely the low levels of income deprivation in South Cambridgeshire district are part of a wider picture extending into Suffolk, Essex and Hertfordshire.

It is also important to note that for people on low incomes living in the south of the county including Cambridge City, high housing costs can significantly limit the income they have available to meet other needs. More sophisticated economic analyses would also include measures of income deprivation after allowing for housing costs.

Map 3: Cambridgeshire and surrounding areas - % living in income deprived households reliant on means tested benefit, income domain score from the Indices of Deprivation 2015

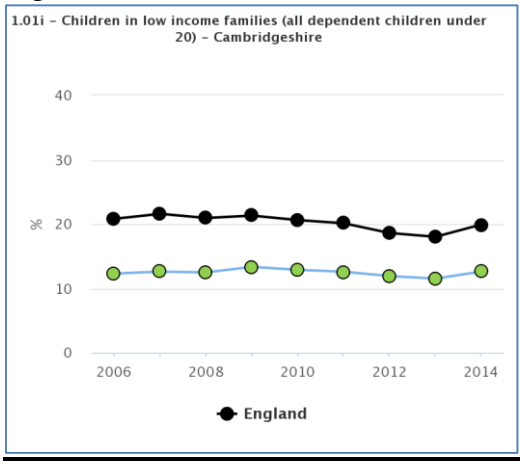


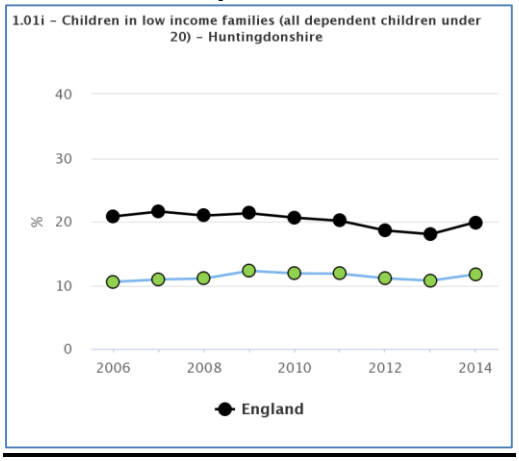


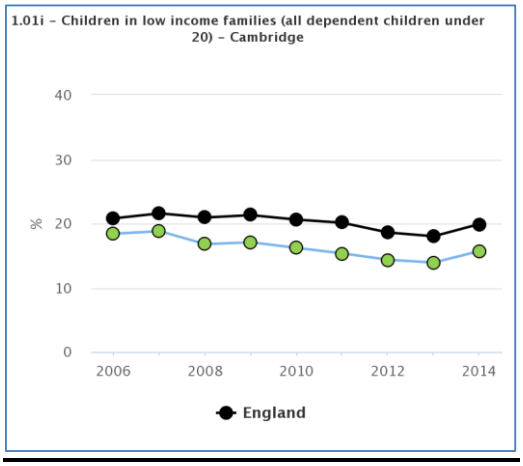
1.6 Children in low income families

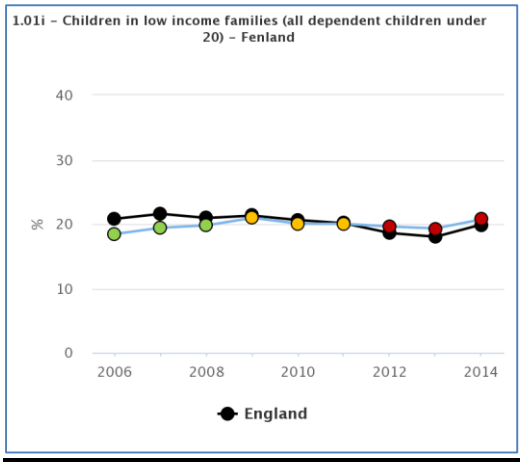
While the IMD (2015) is a useful overall measure of deprivation across the county it describes one point in time and it is also useful to look at long term trends. One measure that is routinely presented as part of the national Public Health Outcomes Framework is the proportion of children under 20 living in low income families. The following charts show the trend in this measure for Cambridgeshire as a whole and for each of its district/city councils, against the average for England.

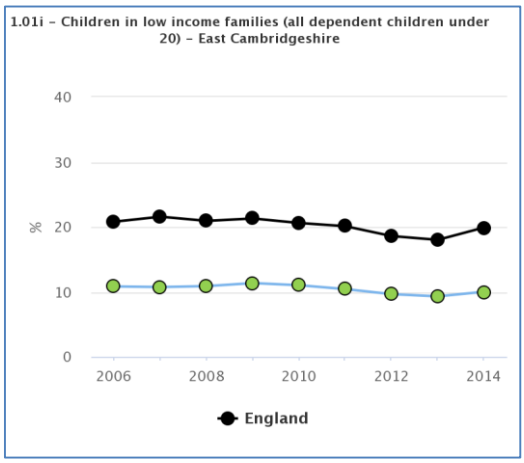
Figure 4: Children in low income families (children under 20)

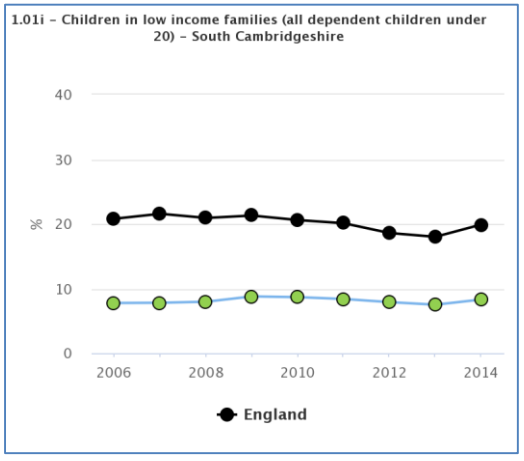












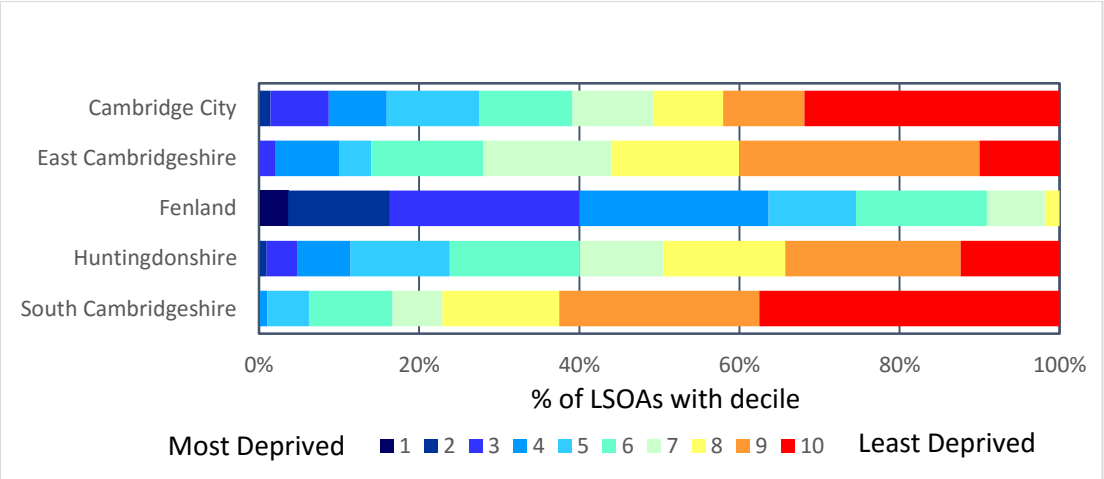
Source: Public Health Outcomes Framework

For Cambridgeshire and most of its districts, the percentage of children in low income families has remained well below the national average. While the proportion of children in low income families was similar in Cambridge City and in Fenland in 2006, the two areas have since diverged – with Cambridge City now having significantly fewer children in income deprived families than the national average, while in Fenland the percentage has increased and is now significantly above average. However the impact of high housing costs in Cambridge City on lower income families should also be considered.

1.7 Employment and health

The IMD (2015) DNA chart for employment for Cambridgeshire districts, which is based on the proportion of residents receiving out of work benefits, is very similar to that for income. As for other measures, there is a high proportion of neighbourhoods (LSOAs) in the least deprived 20% nationally in most Cambridgeshire districts, but Fenland has no neighbourhoods in the least deprived 20% and a higher proportion in the more deprived deciles.

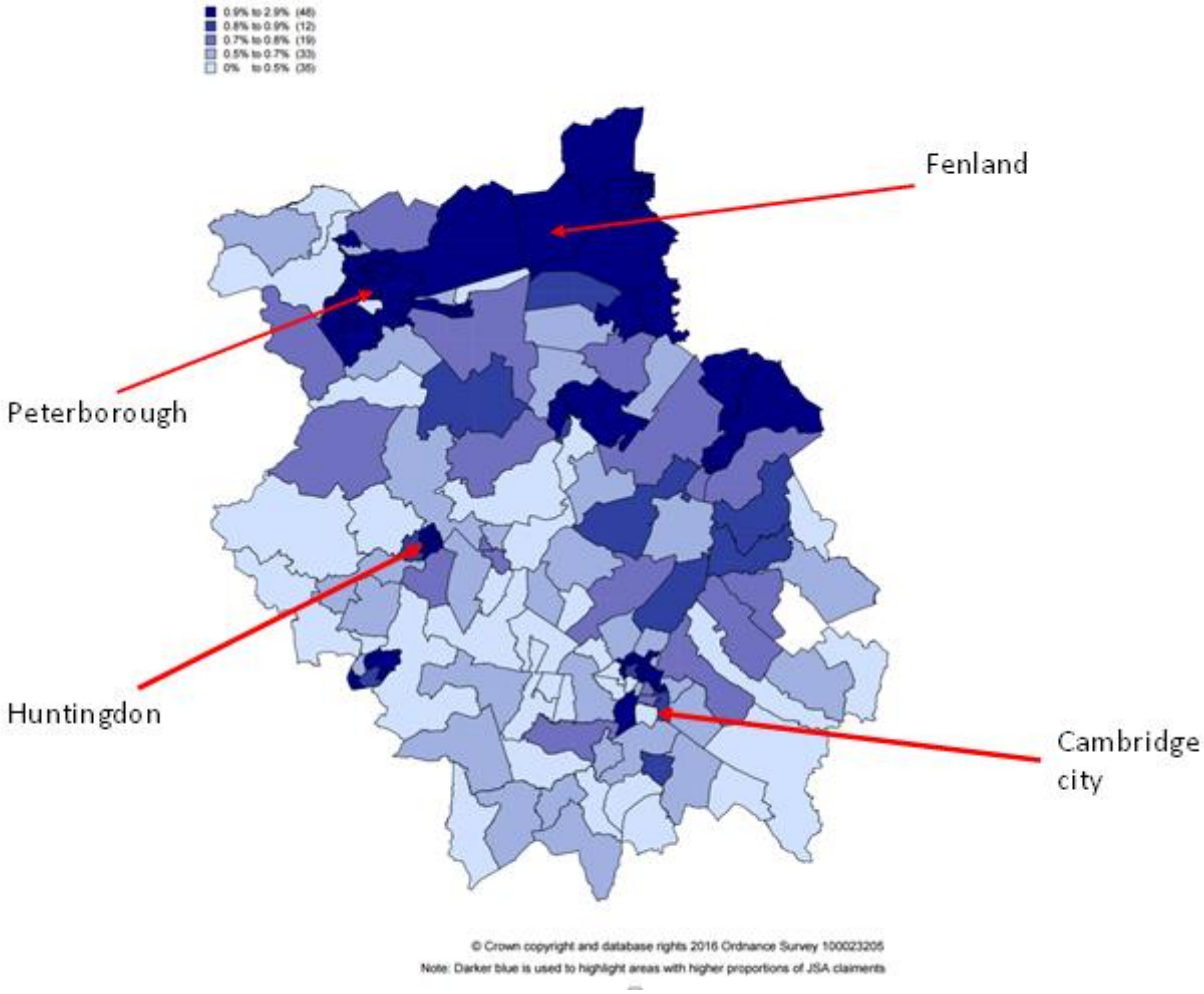
Figure 5: Cambridgeshire & Districts LSOAs, Index of Multiple Deprivation Deciles 2015 (Employment)



Source: Index of Multiple Deprivation, Department for Communities & Local Government, https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

The most common out of work benefit claimed is Employment Support Allowance (ESA) which provides financial support to people with illness and disability who are unable to work or are receiving personalised support to help them return to work. There is a complex relationship between work and health – where unemployment and low income are known to be risk factors for poorer health outcomes, but poor health can in turn lead to reduced productivity, unemployment or reduced income. The map below shows the rates of ESA claimants for neighbourhoods in Cambridgeshire and Peterborough, with closely mirrors the picture for wider IMD (2015) deprivation levels.

Map 4: Rate of Employment Support Allowance (ESA) claimants in Cambridgeshire, May 2016

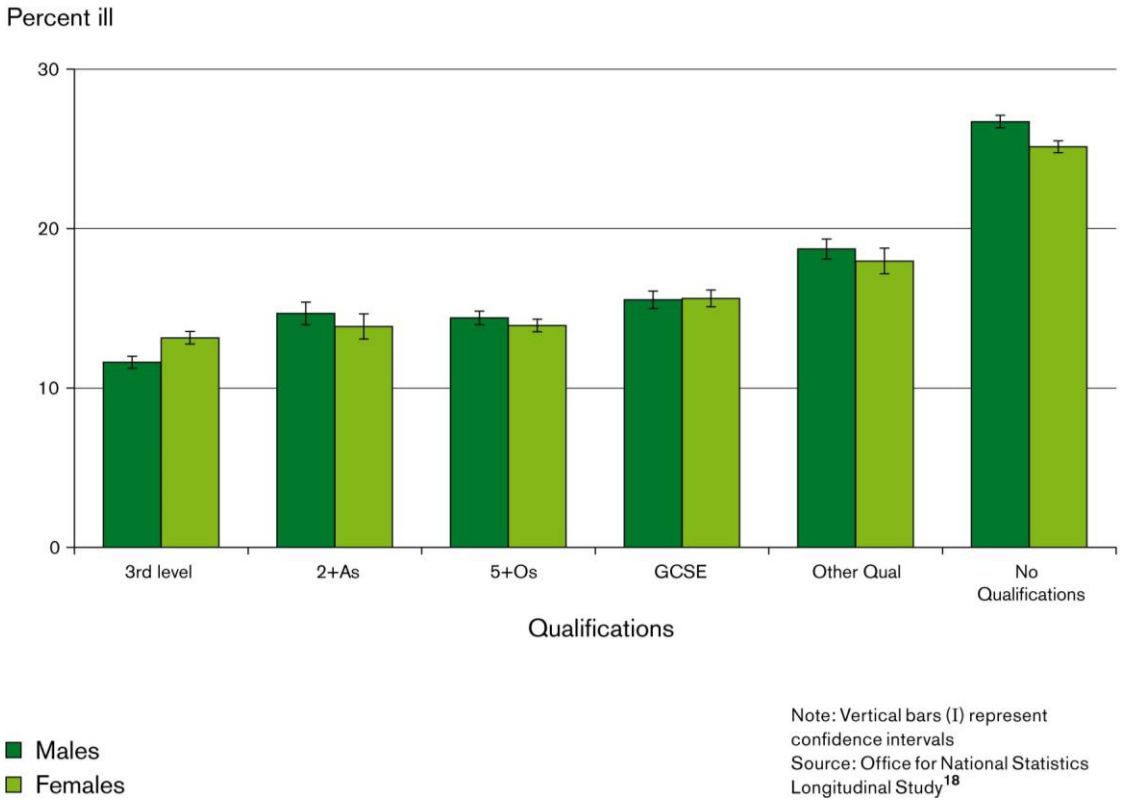


Source: DWP Data and Analytics

1.8 Education and health

We know that levels of education are closely related to health. Much of this relationship is likely to be the result of better employment prospects and incomes for people with higher qualifications. But there is also evidence that education is linked to better 'health literacy' and adoption of healthier lifestyles. The graph below shows that nationally, for adults up to the age of 75, people with no educational qualifications are more than twice as likely to have an illness which limits their daily life than people with degree level or similar qualifications.

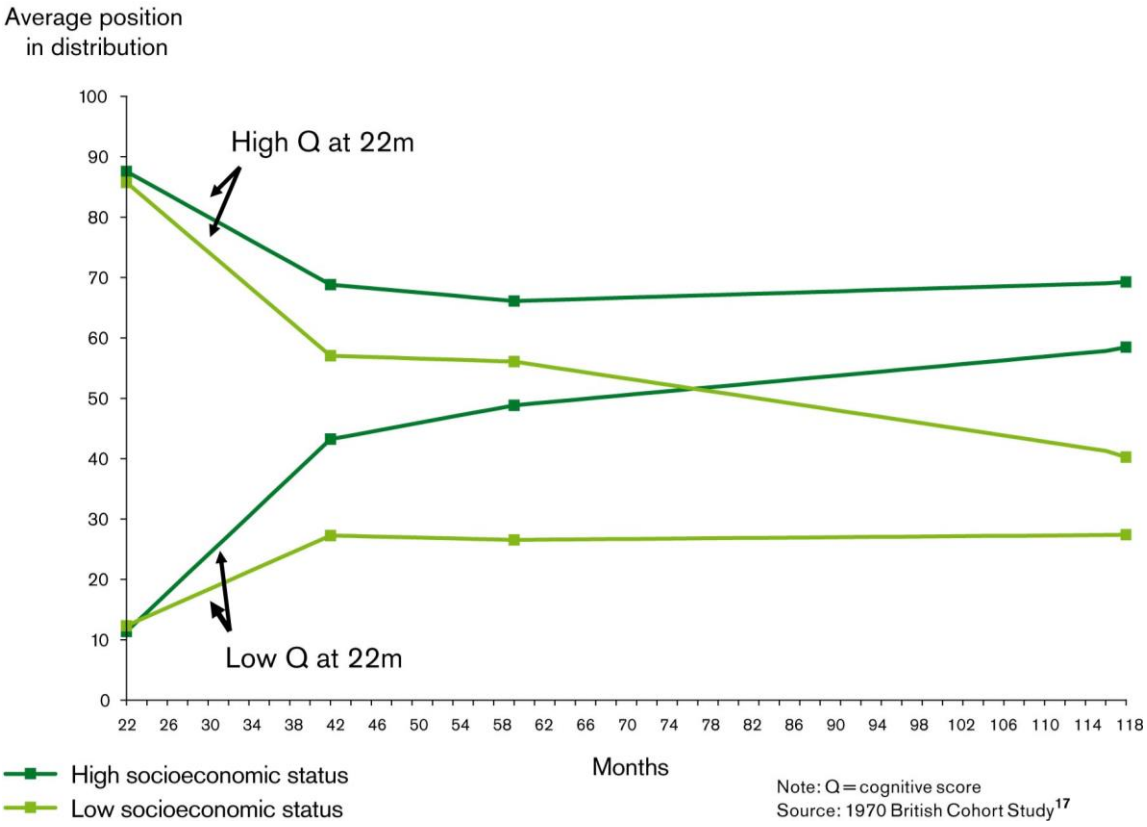
Figure 6: Standardised limiting illness rates in 2001 at ages 16-71, by education level recorded in 2001



Note: Vertical bars (I) represent confidence intervals
Source: Office for National Statistics Longitudinal Study[18]

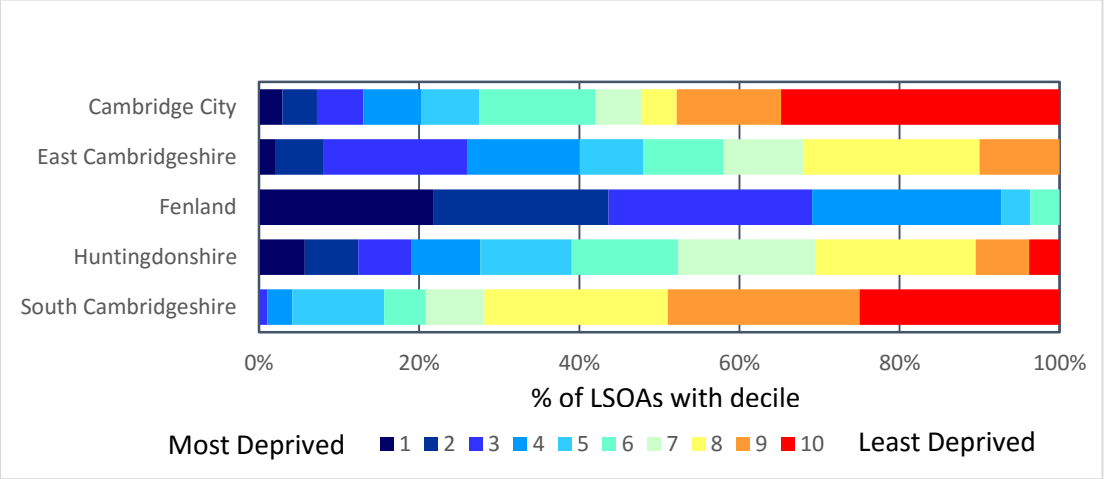
We also know that as children grow, their cognitive ability - which will enable them to do well at school, is strongly influenced by their social background. The following graph, based on a study of children born in 1970, shows that children from disadvantaged social backgrounds who had some of the highest (best) cognitive scores (Q) at age two, had moved to below average cognitive scores by age ten. Children from the most advantaged backgrounds with poor cognitive (Q) scores at age two, had moved to better than average scores by age 10.

Figure 7: Inequality in early cognitive development of children in the 1970 British Cohort Study, at ages 22 months to 10 years



The Cambridgeshire DNA chart for the IMD (2015) Education Skills and Training, shows that some Cambridgeshire districts score less well for this domain than for income and employment. While Cambridge City and South Cambridgeshire have relatively high numbers of neighbourhoods in the least deprived 20% for this domain, the proportion in both Huntingdonshire and East Cambridgeshire in the top deciles is lower than the national average. Fenland has no neighbourhoods (LSOAs) in the top 40% nationally, and nearly half of its LSOAs are in the lowest 20%. There are also significant inequalities within districts. Huntingdonshire, Cambridge City and East Cambridgeshire all have neighbourhoods (LSOAs) in the lowest 10% nationally. Educational attainment, including its future impact on health and wellbeing is therefore a particular concern for Cambridgeshire.

Figure 8: Cambridgeshire & Districts LSOAs, Index of Multiple Deprivation Deciles 2015 (Education, Skills and Training)



Source: Index of Multiple Deprivation, Department for Communities & Local Government, https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

1.9 School readiness

The first step to good educational attainment is for children to be ready to start school, so that they are prepared for learning and can enjoy lessons. The 'school readiness' of pupils is assessed in primary schools at the end of Reception year and involves a range of assessment areas: personal, social and emotional development; physical development; and communication and language; as well as the specific areas of mathematics and literacy. Figures for the 2015/16 school year showed that for Cambridgeshire as a whole, the percentage of children who were 'school ready' at age five was 69.7% - similar to the England average of 69.3%. However, a more detailed breakdown figures from the 2014/15 school year showed that only 49.3% of Cambridgeshire children from more disadvantaged backgrounds who were eligible for free school meals were 'school ready', lower than the England average of 54.4% for this group.

CASE STUDY – MAKING A DIFFERENCE

Waterlees (Wisbech) Community Literacy Project

This project ran from 2012 to 2014. The total funding was £77,000, provided by Cambridgeshire County Council. The project aimed to develop a community approach to literacy development. The focus was the youngest children and their families, and any people with low literacy within the community, supported by initiatives that drew on local skills and capacity.

In 2013 in Wisbech only 31% of Reception children achieved a good level of development at the end of Reception year, using the national 'school readiness' measure. Two years later in 2015 this had risen to 57%, showing an increase of 26%. This was almost double the national rate of improvement.

Because of the good results seen the County Council has agreed to fund a further community literacy project in Wisbech and a small number of other areas around the county, and planning is underway for this.

1.10 GCSE attainment

In 2015/16, 61.2% Cambridgeshire children achieved five or more GCSEs at grade A-C including English and Maths. This was better than the national average of 57.8% and Cambridgeshire ranked sixth out of a comparator group of 16 County Councils with similar social and economic characteristics.

However in in the more detailed national analysis of GCSE results from 2014/15, only 23.4% of Cambridgeshire children eligible for free school meals achieved five or more GCSEs grade A-C. The national average for children eligible for free school meals was considerably higher than this at 33.3%. Cambridgeshire children eligible for free school meals had the worst results in our comparator group of similar local authorities.

Figure 9: Children who attained five A*-C GCSE's and who are eligible for free school meals, Cambridgeshire compared to similar local authorities (2014/15)

Area	Value	Lower CI	Upper CI
England	33.3	33.0	33.6
Hertfordshire	35.3	32.3	38.4
Essex	32.3	29.8	34.8
Buckinghamshire	32.2	27.6	37.2
West Sussex	31.9	28.5	35.6
Warwickshire	31.3	27.3	35.7
Oxfordshire	31.2	27.2	35.5
Staffordshire	30.3	27.2	33.5
North Yorkshire	30.0	25.8	34.5
Gloucestershire	29.2	25.4	33.4
Leicestershire	29.0	25.4	32.9
Worcestershire	28.3	24.7	32.3
Suffolk	27.7	24.7	30.9
Somerset	27.4	23.6	31.6
Northamptonshire	27.2	24.4	30.3
Hampshire	26.3	23.7	28.9
Cambridgeshire	23.4	20.0	27.2

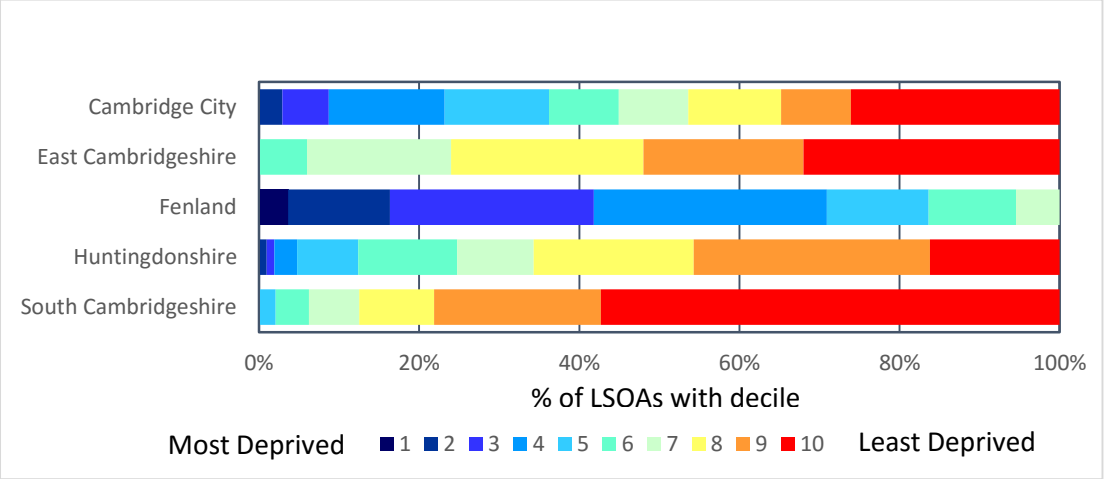
Source: Department for Education

This is a county-wide issue which isn't confined to one geographical area, and demonstrates the risk that economic disadvantage associated with reduced health and wellbeing can continue across generations.

1.11 Health deprivation and disability

The health domain of IMD (2015) combines information on life years lost through premature death, illness and disability ratios, acute illness leading to emergency hospital admission, and mental health. The majority of areas in Cambridgeshire show very good scores on this domain, with nearly 80% of South Cambridgeshire neighbourhoods in the least deprived 20% nationally, and all neighbourhoods in East Cambridgeshire in the least deprived 50%. This does make the difference between Fenland and the rest of the county more striking, as over 80% of Fenland neighbourhoods are in the most deprived 50% nationally. Cambridge City and Huntingdonshire also have internal inequalities, with a small number of neighbourhoods in the lowest 20% nationally. As expected, the DNA chart shows that health deprivation and disability is closely linked with and shows a similar picture to, other aspects of the IMD (2015) in Cambridgeshire.

Figure 10: Cambridgeshire & Districts LSOAs, Index of Multiple Deprivation Deciles 2015 (Health)



Source: Index of Multiple Deprivation, Department for Communities & Local Government, https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

1.12 Other IMD Domains

The three remaining IMD (2015) domains which together account for 28% of the overall IMD score are 'crime', 'barriers to housing and services', and 'living environment'. Of these 'barriers to housing and services' is an area which generally scores poorly across Cambridgeshire.

Figure 11: Public Health England's framework for understanding the relationship between health and housing

Source: Public Health England

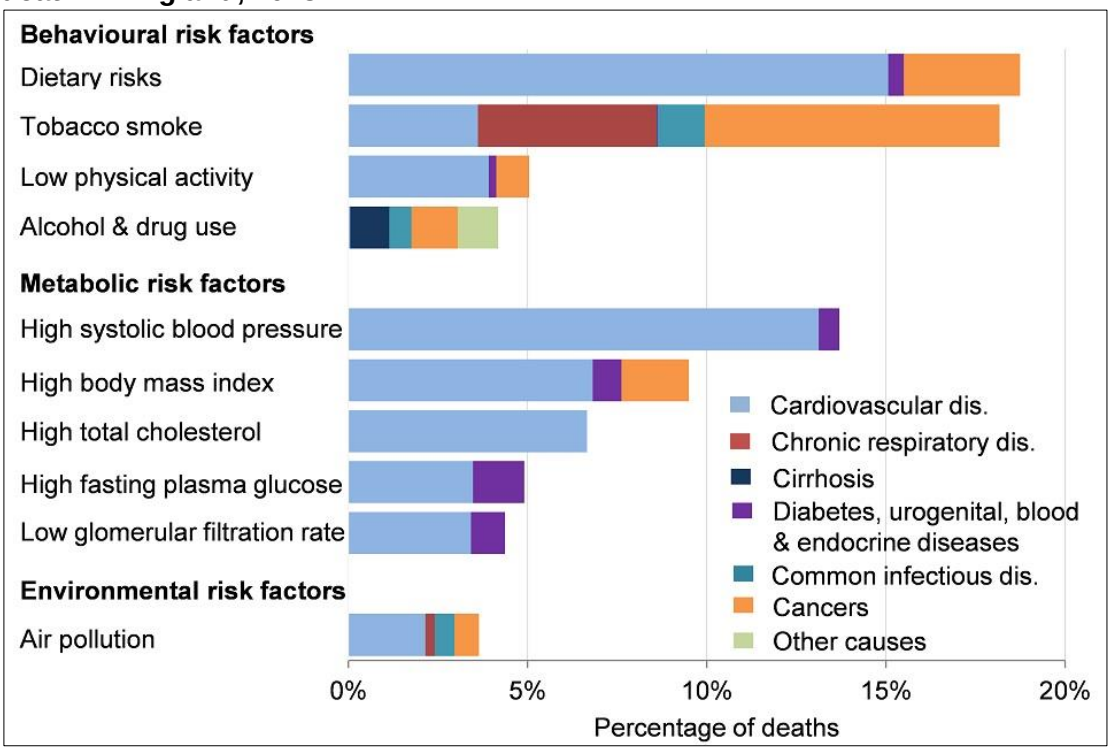
It is a composite of the distance of neighbourhoods from services such as primary schools and GP surgeries, which is often higher in rural areas; together with factors indicating reduced access to housing such as overcrowding, homelessness and housing affordability.

Housing affordability is a particular issue across much of Cambridgeshire, and can increase the risk of homelessness. There are a number of issues for areas with high private sector market rents such as Cambridge City, which can accentuate disadvantage for people on low incomes and significantly reduce the money they have available to spend on needs other than housing.

SECTION 2: KEY LIFESTYLE AND HEALTH BEHAVIOURS - HOW DOES CAMBRIDGESHIRE COMPARE WITH OTHER AREAS?

It is increasingly recognised that a set of key lifestyle and health behaviours influence people's risk of developing long term health conditions earlier in life and of dying prematurely. The chart below indicates that almost one in five deaths in England can be attributed to dietary factors and almost one in five to smoking. Lack of physical activity and alcohol/drug use are also important risk factors.

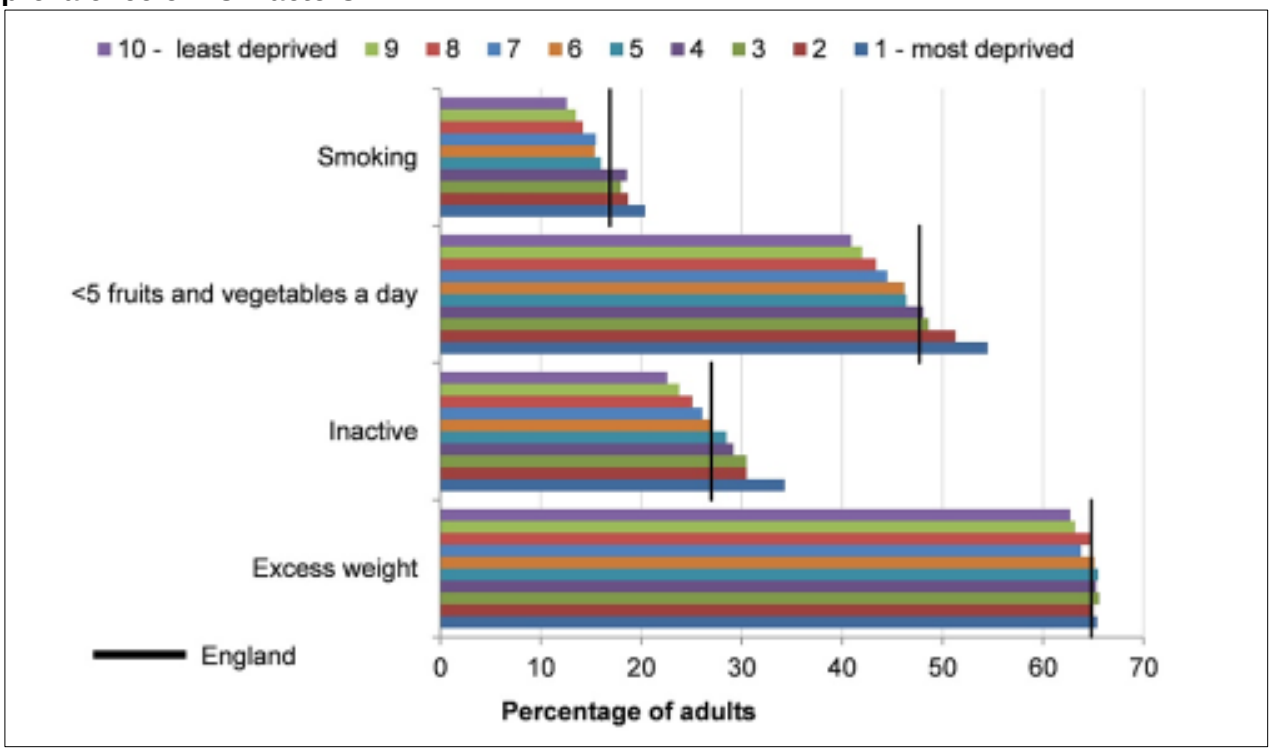
Figure 12: Attribution of deaths to risk factors and broken down by broad causes of death in England, 2013



Source: Public Health England 'Health Profile for England' 2017

It is also known that people's social and environmental circumstances are linked with their lifestyle behaviours and this has recently been mapped at local authority level by Public Health England.

Figure 13: The prevalence of risk factors varies across upper tier local authorities grouped into deprivation deciles, whereby the least deprived areas had the lowest prevalence of risk factors



Source: Public Health England 'Health Profile for England' 2017

2.1 Smoking and tobacco in Cambridgeshire

The table below shows that the percentage of adults who smoked in Cambridgeshire in 2016 was similar to the national average in most District/City Council areas and for Cambridgeshire as a whole. In Fenland the smoking prevalence was significantly worse than the national average, at 21.6% compared with 15.5% nationally.

Figure 14: Percentage of adults who smoked, Cambridgeshire & Districts 2012-2016

Area	Smoking Prevalence (%)				
	2012	2013	2014	2015	2016
Cambridge City	13.4	9.2	16.5	17.7	15.1
East Cambridgeshire	19.6	18.9	16.2	14.4	15.3
Fenland	31.3	24.3	21.7	26.4	21.6
Huntingdonshire	18.8	12.7	15.2	13.9	14.0
South Cambridgeshire	15.5	11.5	11.6	12.8	12.8
Cambridgeshire	18.9	14.4	15.7	16.4	15.2
England	19.3	18.4	17.8	16.9	15.5

Source: Public Health Outcomes Framework

Key

	Statistically significantly lower (better) than England
	Statistically similar to England
	Statistically significantly higher (worse) than England

By comparing Fenland with local authorities which are socially and economically similar, we can see whether the rate of smoking is at the expected level, given the local socio-economic circumstances, or whether it still seems high. Fenland has the second highest smoking prevalence in its 'nearest neighbour' group of local authorities, which indicates there is potentially more local work to be done to encourage a reduction in smoking.

Figure 15: Smoking prevalence in adults – current smokers (APS) 2016

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	-	15.5	15.3	15.7
Boston	–	10	-	24.9	16.9	32.9
Fenland	–	-	-	21.6	15.6	27.5
Mansfield	–	12	-	20.9	15.1	26.7
East Staffordshire	–	14	-	20.2	14.6	25.7
South Holland	–	1	-	19.0	13.4	24.7
West Lancashire	–	13	-	16.5	11.0	21.9
Newark and Sherwood	–	7	-	16.3	11.2	21.5
South Kesteven	–	15	-	16.0	11.5	20.4
Wyre Forest	–	4	-	15.6	10.3	21.0
King's Lynn and West Norf...	–	9	-	15.5	11.2	19.8
Bassetlaw	–	3	-	14.9	9.8	19.9
Carlisle	–	8	-	14.2	10.1	18.2
Kettering	–	11	-	13.2	7.9	18.4
Breckland	–	2	-	11.9	7.7	16.2
Amber Valley	–	5	-	10.7	6.3	15.1
Erewash	–	6	-	10.7	5.6	15.7

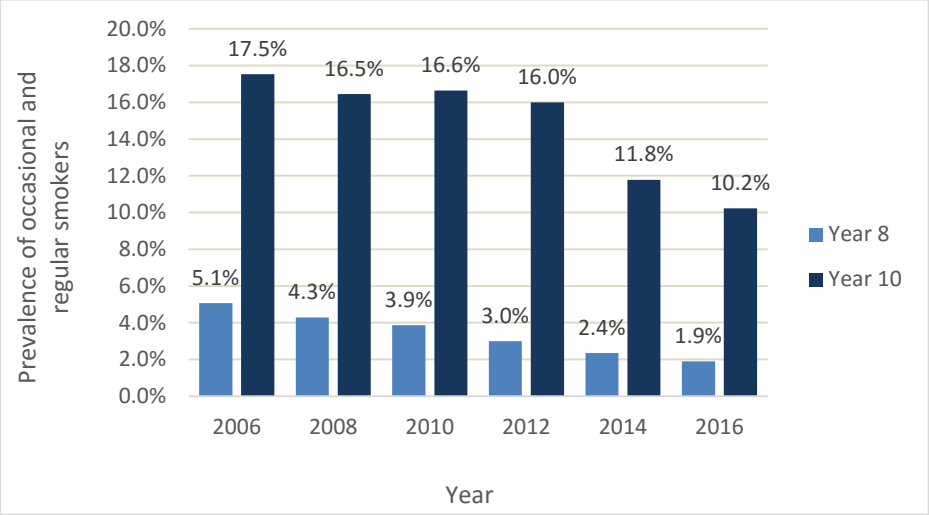
Source: Annual Population Survey (APS)

Source: Public Health Outcomes Framework (August 2017)

2.2 Smoking: children and young people

Two thirds of smokers start before they reach the age of 18, so when looking to the future it's important to understand current smoking behaviour among teenagers. In Cambridgeshire we are lucky to have data collected over several years from the Health Related Behaviour Survey carried out for school years 8 and 10 in nearly all Cambridgeshire secondary schools. These data show that since 2006, there has been a signifcant reduction in the percentage of children who say that they either occasionally or regularly smoke, both among children in year 8 (12-13 year olds) and year 10 (14-15 year olds).

Figure 16: Health Related Behaviour Survey – smoking – occasional and regular smokers (%), Cambridgeshire, 2006-2016



Source: Health Related Behaviour Survey

CASE STUDY – MAKING A DIFFERENCE

Kick Ash – A young person led smoke free programme in Cambridgeshire schools

Cambridgeshire's young person led smoke free programme, Kick Ash, has been running in selected schools since 2009/10, working with support from a range of staff including public health, Personal, Social, Health, Education (PSHE), trading standards and communications experts. Year 10 peer mentors lead and deliver the programme, focusing on smoking-related decision-making and promoting a smoke free lifestyle to Years 5, 6 and 8.

Initial analysis suggests that the percentage of Year 10 students currently smoking in Kick Ash schools has fallen significantly since the programme began, and the percentage never having smoked has increased. Whilst we know that young people's smoking has fallen across the county, our findings suggest that the rate of decline in Kick Ash schools has been faster than in other schools.

The results are particularly encouraging as schools included in the Kick Ash programme have been those in areas where a higher proportion of both young people and adults are smokers. The programme reports many additional benefits, including increased confidence and communication skills from the mentors and improved transitioning from primary to secondary school.

2.3 Unhealthy weight and obesity

There has been national concern for some time about the long term rising trend in both childhood and adult obesity, the implications that this has for individual health and wellbeing, and the potential for increased demands on the health service due to obesity related illness such as diabetes, joint problems and heart disease.

In Cambridgeshire a lower proportion of adults have an unhealthy weight than the national average. When this is reviewed at a district level it's clear that while Cambridge City, with its young population, has a very low proportion of people with unhealthy weight, East Cambridgeshire, Huntingdonshire and in particular Fenland all have proportions of people with unhealthy weight which are significantly above the national average. Fenland also has a high rate of people with recorded diabetes (associated with overweight and obesity) at 7.8% of adults, compared with 6.4% nationally.

Figure 17: Percentage of adults with excess weight, Cambridgeshire & Districts, 2012/14 – 2013/15

Area	Excess weight in adults, %	
	2012/14	2013/15
Cambridge City	48.3	46.7
East Cambridgeshire	68.0	68.1
Fenland	73.1	72.9
Huntingdonshire	67.3	67.6
South Cambridgeshire	63.6	63.6
Cambridgeshire	63.6	63.2
England	64.6	64.8

Source: Public Health Outcomes Framework

Key

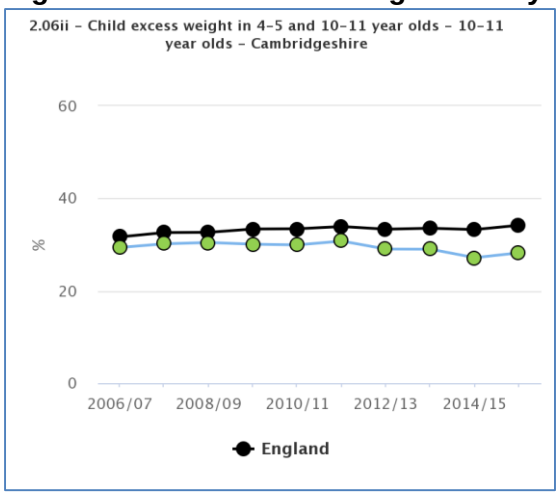
	Statistically significantly lower (better) than England
	Statistically similar to England
	Statistically significantly higher (worse) than England

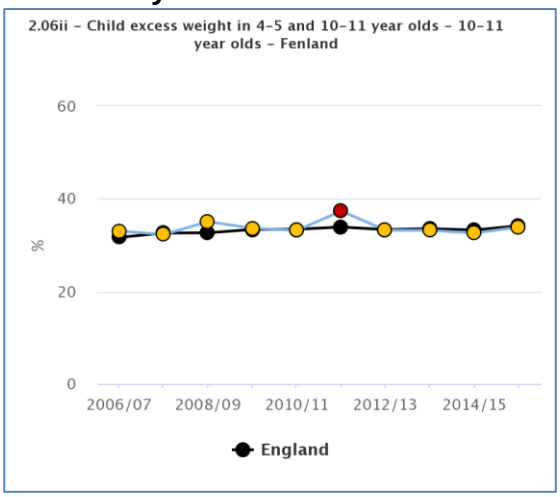
2.4 Unhealthy weight and obesity: children and young people

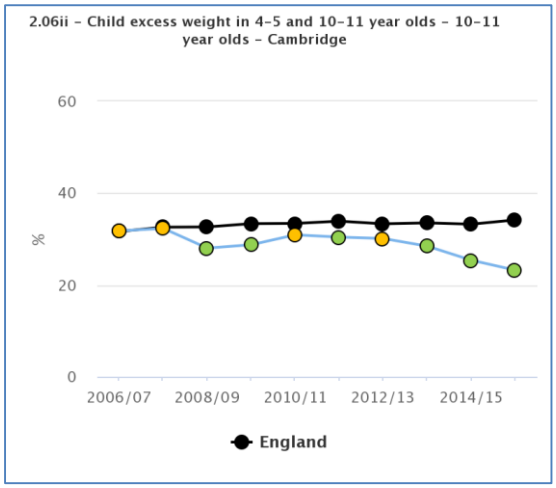
The weight of children in reception (age 4-5) and year 6 (age 10-11) is now measured at school as part of the National Childhood Measurement Programme (NCMP).

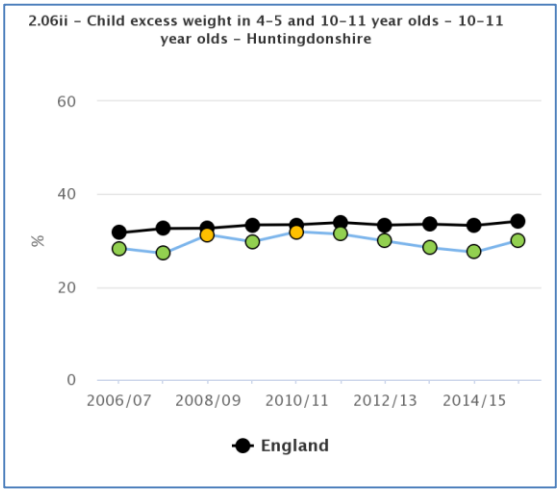
The following trend graphs from 2006/07 through to 2015/16 show that the percentage of children in year 6 in Cambridgeshire with an unhealthy weight has fallen slightly from 29.4% to 28.2% between 2006/07 and 2015/16, compared with a national increase from 31.7% to 34.2%. In Fenland rates have stayed similar to the national average.

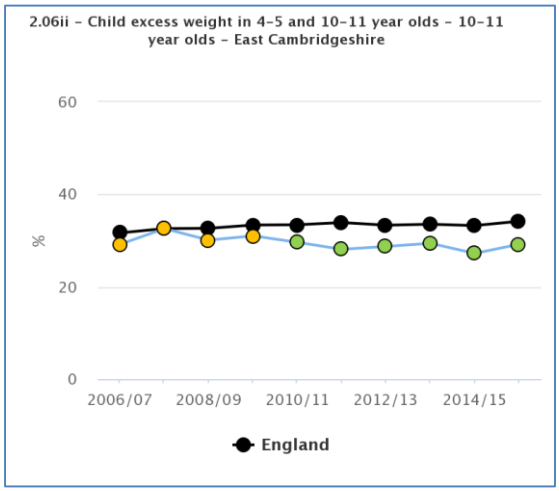
Figure 18: Child excess weight in 4-5 year olds and 10-11 year olds

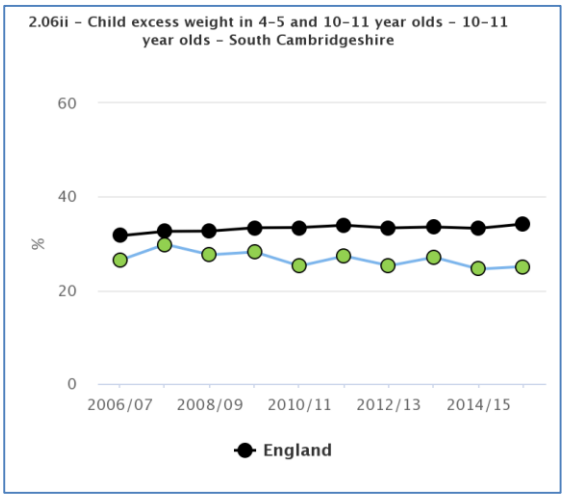












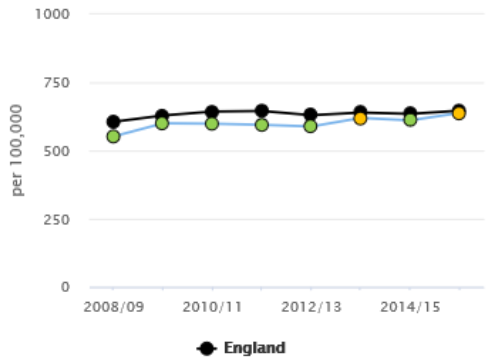
Source: Public Health Outcomes Framework August 2017

2.5 Alcohol and drug use

While alcohol and drug misuse have a smaller impact on overall population mortality than smoking and diet, they cause a higher proportion of deaths under the age of 50, and are associated with significant costs to wider society, including the criminal justice system.

Hospital admissions for alcohol related conditions have been increasing slightly in Cambridgeshire as a whole and are now similar to the national average. Both Cambridge City and Fenland have alcohol related hospital admission rates which are significantly above the national average and which have risen in recent years. Rates in the other districts of Cambridgeshire remain below the national average.

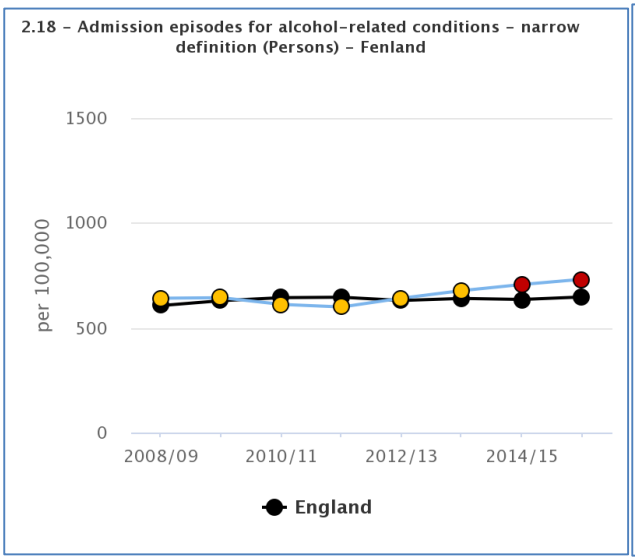
Figure 19: Cambridgeshire - admission episodes for alcohol-related conditions - narrow definition (persons), 2008/09 to 2015/16

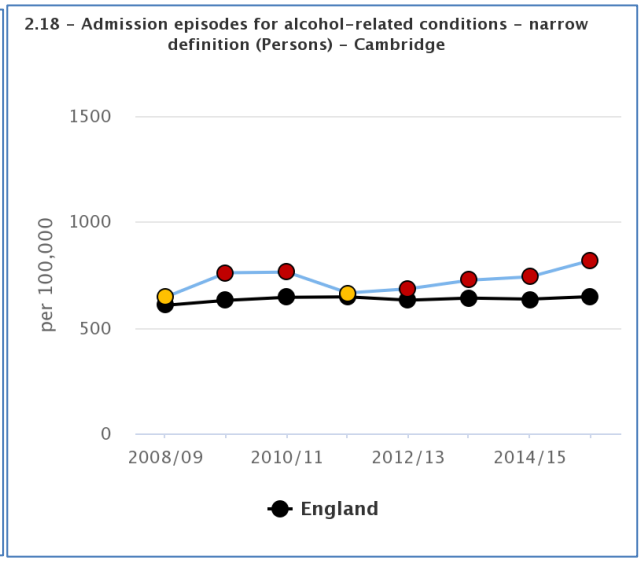


Recent trend: –

Period		Count	Value	Lower CI	Upper CI	East of England	England
2008/09		3,168	552	533	572	490	606
2009/10		3,464	600	580	621	531	629
2010/11		3,503	599	579	619	542	643
2011/12		3,536	595	575	615	559	645
2012/13		3,526	589	569	608	552	630
2013/14		3,782	620	600	640	582	640
2014/15		3,772	611	591	631	580	635
2015/16		3,981	638	618	658	588	647

Source: Calculated by Public Health England: Risk Factors Intelligence team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.



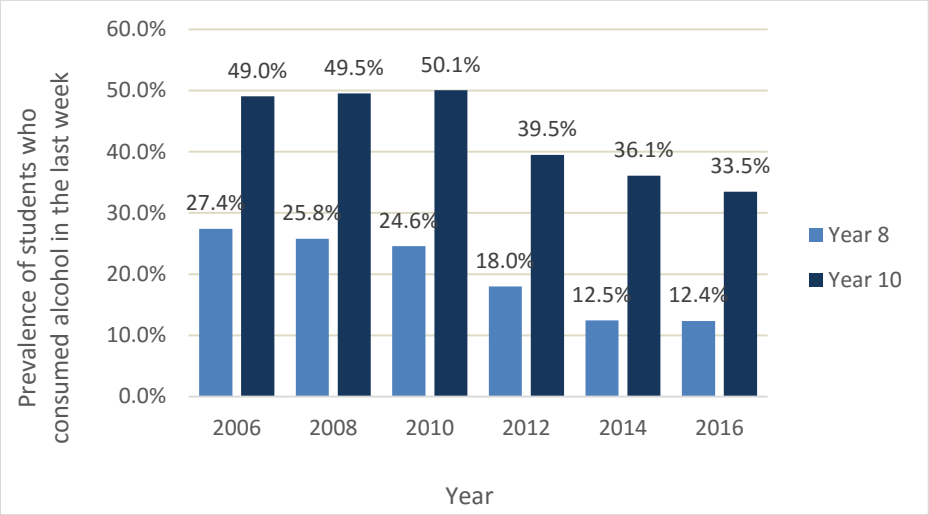


Source: Public Health Outcomes Framework August 2017

2.6 Alcohol use: children and young people

The Health Related Behaviour Survey carried out every two years in Cambridgeshire for school children in year 8 and year 10, shows that the proportion of children who have had an alcoholic drink in the week before the survey has fallen significantly since 2006.

Figure 20: Health Related Behaviour Survey – alcoholic drink consumed in the past seven days (%), Cambridgeshire



Source: Health Related Behaviour Survey

SECTION 3: MENTAL HEALTH TRENDS IN CAMBRIDGESHIRE

3.1 Suicide

Suicide is always a very sad and distressing event, and is the commonest cause of death nationally for men under 50 and women under 35. The suicide rate in Cambridgeshire is similar to the national average. While in the past, suicide rates in both Cambridge City and Fenland have sometimes been significantly above the national average, more recently suicide rates in Cambridgeshire and all its districts have been similar to the national picture.

Figure 21: Suicide rate, persons, directly age-standardised rate per 100,000, Cambridgeshire & Districts, 2001/03 – 2013/15

Area	Suicide rate, directly age-standardised rate per 100,000, persons												
	2001-03	2002-04	2003-05	2004-06	2005-07	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13	2012-14	2013-15
Cambridge City	15.3	15.7	13.0	14.6	14.2	15.6	12.8	12.1	11.3	11.9	9.6	9.4	7.6
East Cambridgeshire	*	*	*	*	*	*	*	*	*	*	*	*	*
Fenland	11.1	*	*	*	11.4	14.4	15.7	14.6	10.2	9.9	*	12.0	12.7
Huntingdonshire	*	*	6.6	8.8	9.5	8.4	7.7	6.9	8.0	7.2	9.0	8.9	9.2
South Cambridgeshire	10.2	13.0	10.5	7.8	*	6.9	8.7	8.0	7.2	*	8.3	7.9	9.7
Cambridgeshire	9.6	9.8	8.7	8.8	9.4	10.1	10.2	9.1	8.3	7.8	8.7	9.0	9.1
England	10.3	10.2	10.1	9.8	9.4	9.2	9.3	9.4	9.5	9.5	9.8	10.0	10.1

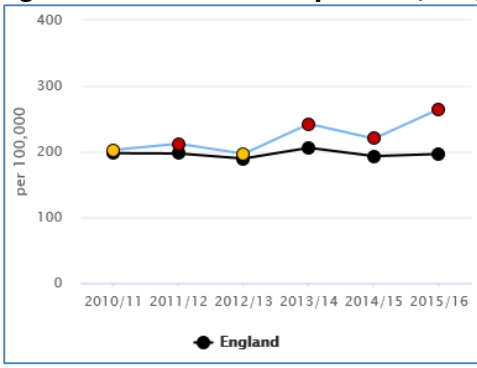
Source: Public Health Outcomes Framework

Key

	Statistically significantly lower (better) than England
	Statistically similar to England
	Statistically significantly higher (worse) than England

Unlike the suicide rate, emergency hospital admissions for self-harm have been increasing recently, and are now higher than the national average in all Cambridgeshire districts apart from South Cambridgeshire. Some caution is needed in interpreting rising admissions for self-harm as these may be partly dependent on better recording and coding by hospitals. But the rise is of concern and needs further careful investigation.

Figure 22: Emergency hospital admissions for intentional self-harm, persons, directly age-standardised rate per 100,000, Cambridgeshire, 2010/11 – 2015/16



Recent trend: –

Period		Count	Value	Lower CI	Upper CI	East of England	England
2010/11		1,311	202.8	191.9	214.1	150.7	197.6
2011/12		1,386	212.1	201.0	223.6	154.1	197.2
2012/13		1,296	196.8	186.2	207.8	153.5	189.6
2013/14		1,598	242.3	230.5	254.5	183.5	205.9
2014/15		1,454	220.0	208.8	231.6	173.0	193.2
2015/16		1,777	264.9	252.6	277.5	179.5	196.5

Source: Hospital Episode Statistics (HES), NHS Digital, for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2016, Re-used with the permission of NHS Digital. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to Public Health England Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England. Analysis uses the single year of age grouped into quinary age bands, by sex.

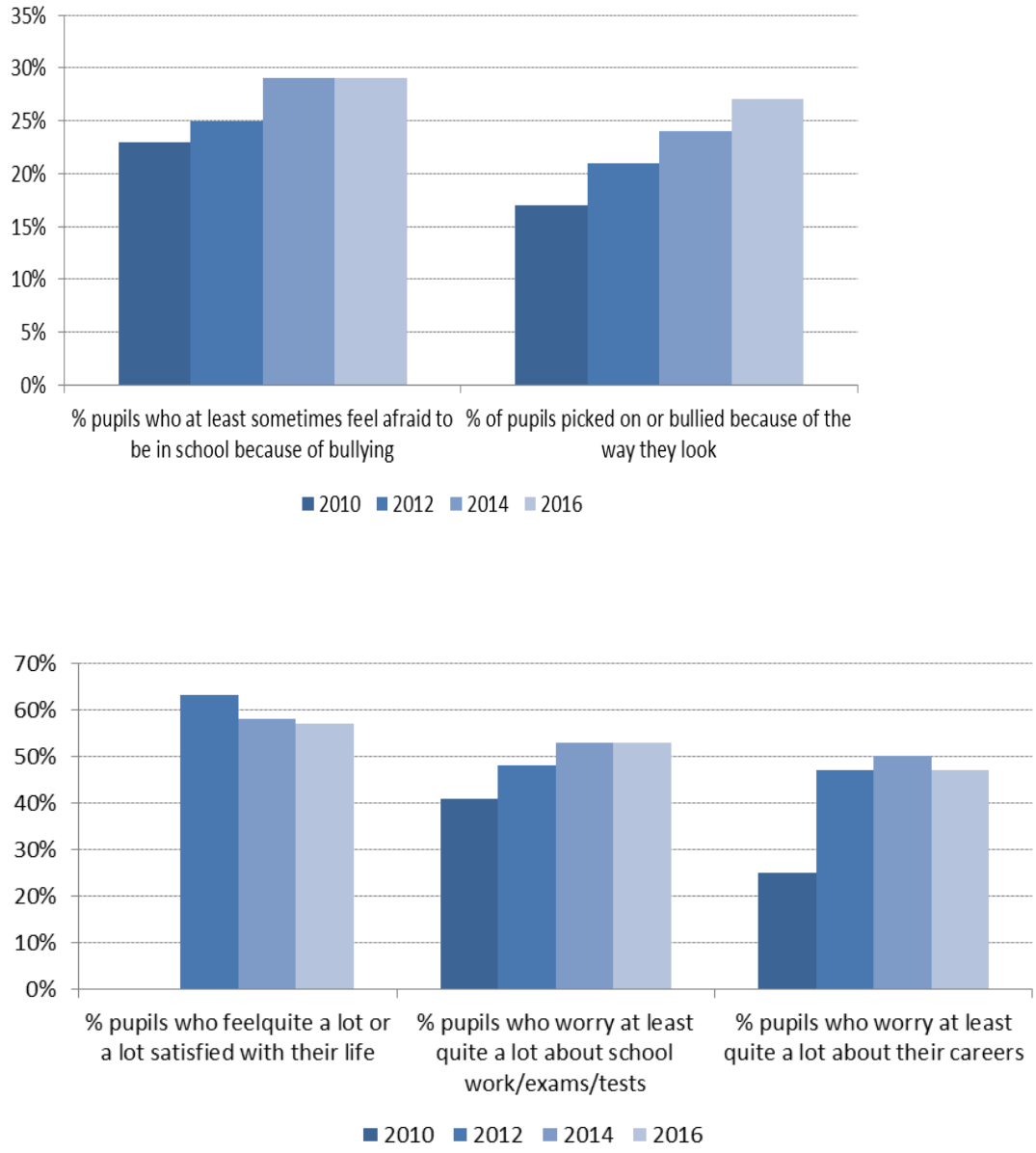
Source: Public Health England 'Fingertips' website

3.2 Children and young people's mental health

There has been concern nationally about children's and young people's mental health and access to appropriate mental health services, with a national commitment to invest more in these services.

In Cambridgeshire, the Health Related Behaviour Survey of children in years 8 and 10 of secondary schools indicates some adverse trends in emotional wellbeing since 2010, although these appear to have levelled out. Since 2010 the proportion of children who describe themselves as sometimes afraid to go to school because of bullying has increased, and the proportion of children worried about exams and their future careers is also higher.

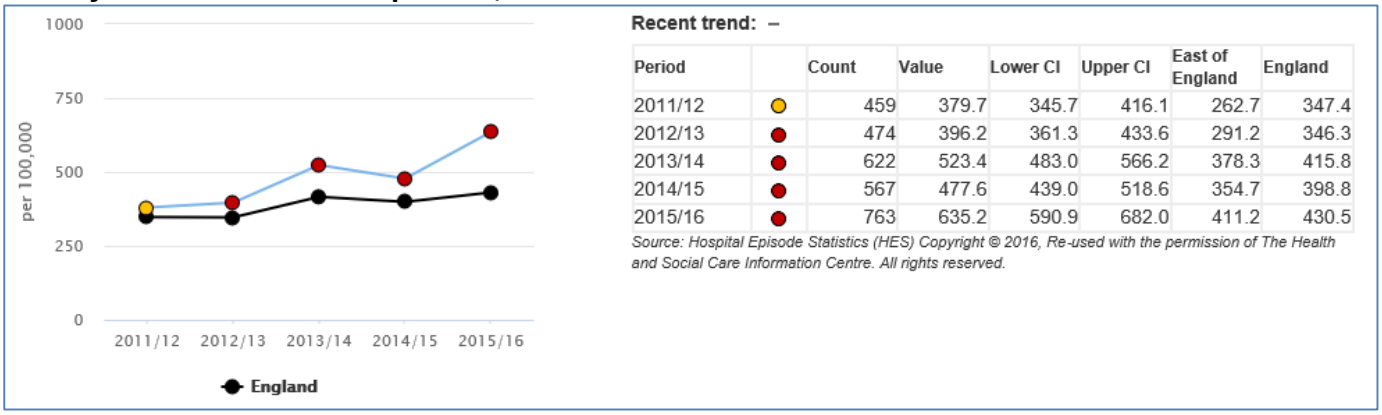
Figure 23: Cambridgeshire Schools Health Related Behaviour Survey findings 2010-2016



Source: Health Related Behaviour Survey

Rates of hospital admissions for self-harm amongst young people aged 10-24 have a rising trend in Cambridgeshire between 2011/12 and 2015/16, and are well above the national average. Some caution is required as trends may be the result of improved recording and coding by hospitals, but the issue is of significant concern and requires further investigation.

Figure 24: Hospital admissions as a result of self-harm (10-24 years) Cambridgeshire. directly standardised rate – per 100,000



Recent trend: –

Period		Count	Value	Lower CI	Upper CI	East of England	England
2011/12		459	379.7	345.7	416.1	262.7	347.4
2012/13		474	396.2	361.3	433.6	291.2	346.3
2013/14		622	523.4	483.0	566.2	378.3	415.8
2014/15		567	477.6	439.0	518.6	354.7	398.8
2015/16		763	635.2	590.9	682.0	411.2	430.5

Source: Public Health England Child and maternal health profiles

CASE STUDY – MAKING A DIFFERENCE

Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) Mental Health Crisis First Response Service (FRS) and Sanctuaries

What was the problem?

Before this service was launched in September 2016 there was no capacity to see people in need of mental healthcare out of hours except via A&E, and no self-referral route, meaning many sought help direct from A&E. Service users told us that it was very difficult and stressful trying to get help when in a mental health crisis and they found the emergency department a stressful environment.

What was the solution?

- A new community-based crisis mental health service – 'first response' – provides timely access to safe, effective, high quality care for people in mental health crisis.
- The first response service provides assertive and responsive support and triage for anyone experiencing mental health crisis, including face-to-face assessment if needed.
- Open 24/7 for people of all ages throughout Cambridgeshire and Peterborough.
- Welcomes self-referrals via dialing 111 and asking for option2 as well as urgent referrals from carers, GPs, ambulance crews, police (anyone!) and the emergency department.

What were the results?

- The service has demonstrated an immediate decline in the use of hospital emergency departments for mental health needs with a 21% reduction in attendance despite the local context of many years of rapidly increasing figures.
- A 26% reduction in the number of people with mental health needs being admitted to acute hospitals from the emergency department.

SECTION 4: LIFE EXPECTANCY AND PREVENTABLE DEATHS

Life expectancy is an important summary measure for the overall health outcomes in an area. It is generally quoted as an average over three years to make the statistic more reliable. Life expectancy in Cambridgeshire as a whole has been consistently above the national average since 2001-03 and has improved by over three years for both men and women between 2001-03 and 2013-15. However life expectancy in the county has 'plateaued' more recently, with no improvement for men since 2010-12 and only a small improvement for women.

There are inequalities in average life expectancy across the county, reflecting differences in the wider determinants of health and lifestyle 'risk' behaviours described in earlier sections. Average life expectancy for men in Fenland in 2013/15 was 78.6 years (significantly worse than the national average), while all other districts in Cambridgeshire have above average male life expectancy, the highest being South Cambridgeshire at 82.1 years. For women life expectancy in Fenland is similar to the national average at 82.6 years, and again above average in all other districts, the highest being South Cambridgeshire at 85.2 years.

Figure 25: Cambridgeshire and districts average life expectancy by gender, 2013 to 2015

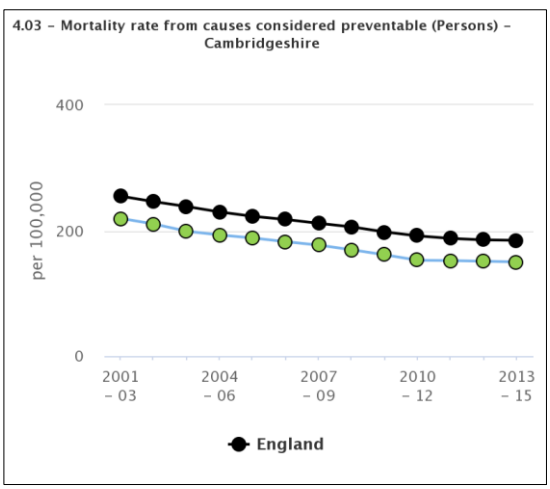
Indicator	Data period	Cambs Value	England value	Cambridgeshire Districts				
				Cambridge	E Cambs	Fenland	Hunts	S Cambs
Life expectancy at birth (Males), years	2013-15	80.9	79.5	80.3	81.6	78.6	81.0	82.1
Life expectancy at birth (Females), years	2013-15	84.4	83.1	84.1	84.8	82.6	84.7	85.2

Source: Public Health Outcomes Framework

	Statistically significantly higher (better) than England
	Statistically similar to England
	Statistically significantly lower (worse) than England

4.1 Trends in preventable deaths

Public Health England calculates a summary measure of deaths considered preventable through public health interventions in their broadest sense, and Cambridgeshire as a whole has shown a positive trend on this measure since 2001- 03. However there has been a worrying upward movement in the most recent data on preventable mortality in Fenland, associated with an upturn in preventable deaths under the age of 75 from cardiovascular disease (heart disease and stroke).



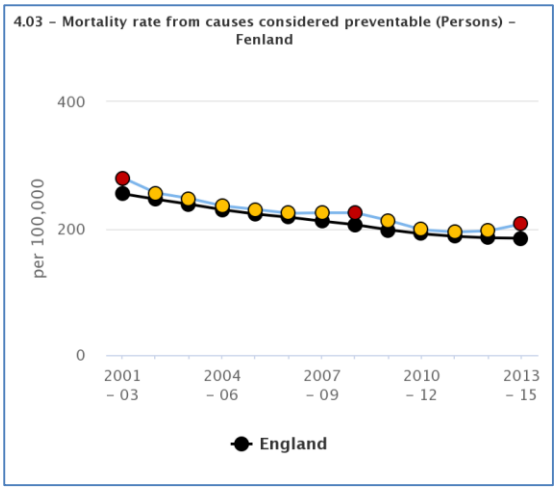
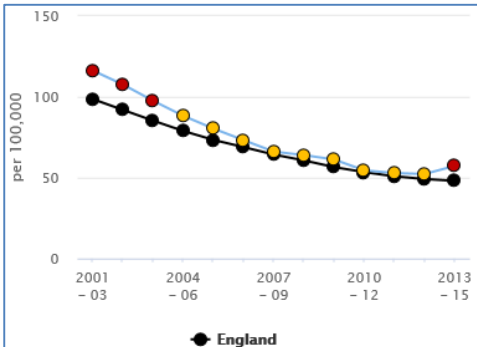


Figure 26: Under 75 mortality rate from cardiovascular diseases considered preventable (persons), directly age-standardised rate per 100,000, Fenland, 2001-03/2013-15



Recent trend: –

Period		Count	Value	Lower CI	Upper CI	East of England	England
2001 - 03	●	264	116.3	102.6	131.2	84.2	98.6
2002 - 04	●	250	107.6	94.7	121.9	78.5	91.9
2003 - 05	●	231	97.6	85.4	111.0	73.3	85.3
2004 - 06	●	214	88.3	76.8	100.9	68.5	78.9
2005 - 07	●	198	80.4	69.6	92.4	63.3	73.4
2006 - 08	●	183	73.2	63.0	84.7	59.3	68.9
2007 - 09	●	169	66.1	56.5	76.9	55.2	64.3
2008 - 10	●	166	64.0	54.6	74.5	53.5	60.7
2009 - 11	●	160	61.3	52.1	71.5	50.3	56.6
2010 - 12	●	144	54.5	46.0	64.2	48.1	53.5
2011 - 13	●	143	52.9	44.6	62.4	45.2	50.9
2012 - 14	●	144	52.3	44.0	61.6	43.5	49.2
2013 - 15	●	162	57.3	48.8	66.9	42.0	48.1

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

Source: Public Health Outcomes Framework

SUMMARY AND RECOMMENDATIONS

This Annual Public Health Report 2017 has attempted to give a brief overview of some of the factors and circumstances which affect the health and wellbeing of Cambridgeshire residents. It is clear that there are significant differences in health and the factors affecting health, both across the County as a whole and between neighbourhoods within individual districts. One recommendation for the future is that where possible and statistically valid, we should be mapping more health and wellbeing indicators at the local neighbourhood level to help 'fine tune' the provision, targeting and monitoring of campaigns and services.

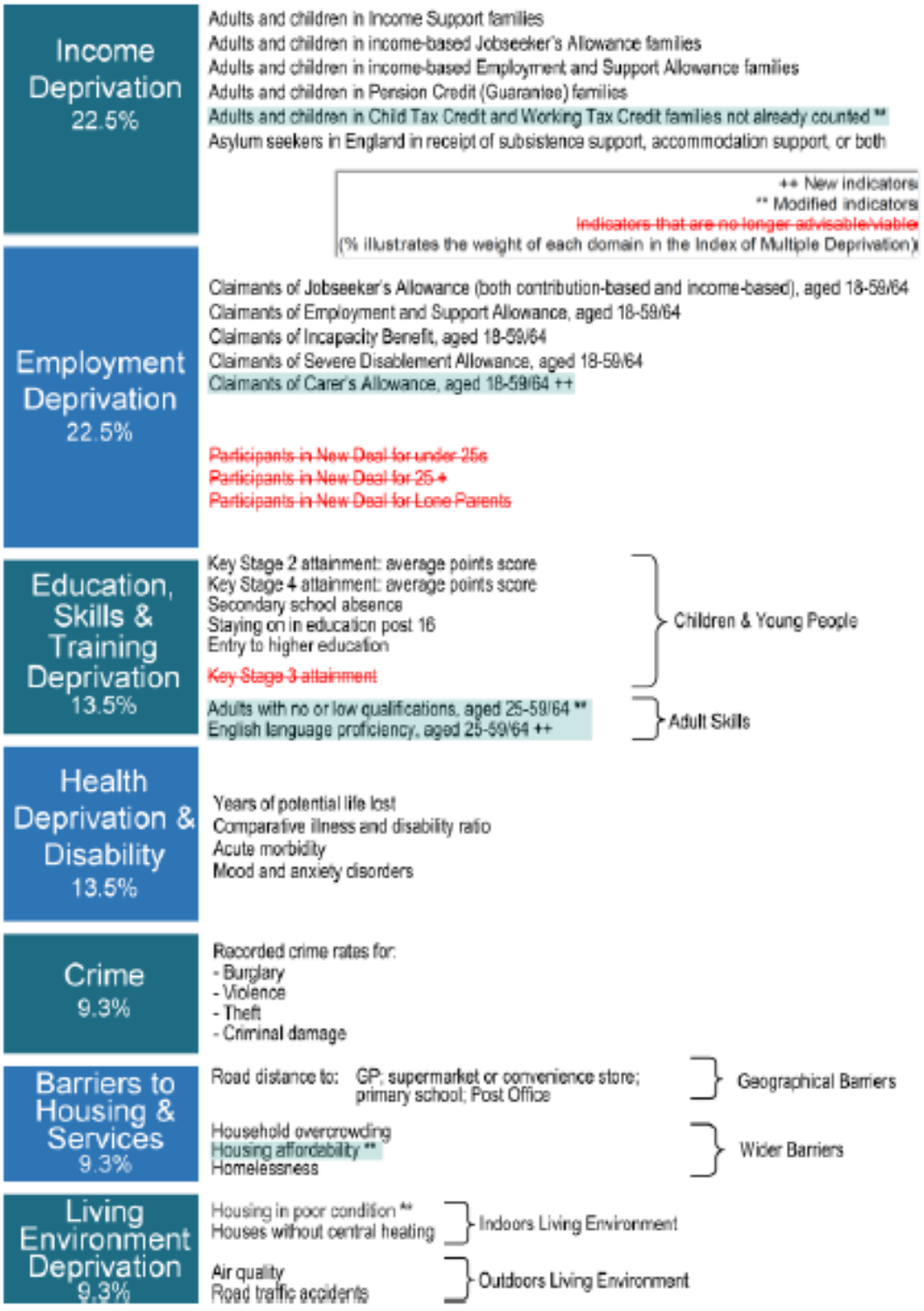
It is often difficult to obtain data which is defined by circumstances other than geography, but this is possible for data on educational outcomes. The disparity in educational outcomes between children receiving free school meals and their peers of the same age is a county-wide issue, and is consistent from the measurement of school readiness in reception year right through to GCSE attainment at age 16. Addressing this should be a key public health priority due to the impact of educational attainment on future health and wellbeing.

Another county-wide issue is young people's emotional wellbeing – with some adverse trends seen since 2010 in the school based Health Related Behaviour Survey, and more recently a rising trend in hospital admissions for self-harm. Joint work is already taking place across the NHS and local authorities to improve early intervention and support for young people with mental health problems, so we would hope to see these trends improving, and the impact of this work needs careful monitoring.

Finally, there are a wealth of statistics throughout this report which demonstrate the health and wellbeing challenges for Fenland residents – in particular for the North Fenland and Wisbech area. The causes are complex, with no easy answers – but a consistent and sustainable focus on the area from a range of organisations will be needed to address the determinants of health such as educational attainment and economic development, as well as a focus from health and care providers on delivering accessible prevention, treatment and support services to meet current needs.

APPENDIX A

Domains and indicators for the updated Index of Multiple Deprivation IMD (2015) showing changes from the IMD (2010). ***DCLG 2014***



Agenda Item No: 9

JOINT HEALTH AND WELLBEING BOARD DEVELOPMENT SESSION PROPOSAL

To:	**Health and Wellbeing Board**
Meeting Date:	**21 September 2017**
From:	**Kate Parker, Head of Public Health Business Programmes**
Purpose:	**To provide the Health and Wellbeing Board with details of a proposed joint development session for Cambridgeshire and Peterborough Health and Wellbeing Boards, to be held in January 2018.**
Recommendations:	**The Health and Wellbeing Board are asked to:**

1. **To approve a joint development session with Peterborough and Cambridgeshire Health and Wellbeing Boards to be held in January 2018.**
2. **Comment on the proposal and potential content and focus for the joint session.**

	Officer contact:	***Member contact:***
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1.0 PURPOSE

1.1 The purpose of this paper is to seek approval for a joint development session with Peterborough and Cambridgeshire Health & Wellbeing Boards, to be held in January 2018.

1.2 The paper will provide a brief overview of a proposal for a Joint Development Session with Peterborough and Cambridgeshire Health and Wellbeing Boards.

1.3 This report is submitted at the request of the Director of Public Health and the Executive Director for People & Communities and will be presented to both Boards at their respective meetings in September.

1.4 This report is for the Health and Wellbeing Board to consider under its Terms of Reference (Part 3B Cambridgeshire County Council's Constitution)

Its [The Board's] remit is to work to promote the health and wellbeing of Cambridgeshire's communities and its focus is on securing the best possible health outcomes for all residents.

The report will be considered under Peterborough's Health and Wellbeing Board's Terms of Reference (Number: 2.8.2.2)

To actively promote partnership working across health and social care in order to further improve health and wellbeing of residents.

2.0 BACKGROUND AND KEY ISSUES

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

2.2 The session will be aimed at seeking greater alignment of interest and approach across the two Health and Wellbeing Boards and how they can work together collaboratively on shared priorities. It is important to note that this is about identifying key shared priorities and is not about a merger of Health and Wellbeing Boards.

2.3 It is proposed that the session will be facilitated by the Local Government Association (LGA). This is a joined up process and the January event will build on the discussions at the Cambridgeshire Board Development session and Stakeholder event in September 2017. For Peterborough's Health and Wellbeing Board this is a continuation of work undertaken by the LGA in 2014 building on their Board's peer review.

The LGA believe that to make a real difference for the people they serve, health and wellbeing boards need to be agents of change. From recent research, the

LGA believes the following are drivers and barriers to being an effective health and wellbeing board:

Drivers of and barriers to effective health and wellbeing boards
Committed leaders, both political and managerial
Collaborative plumbing, often reflecting a history of partnership working
Clarity of purpose, being clear about the primary task of the board
A geography that works, or has been made to work
The response to austerity, which can drive either collaboration or a retreat to silos
A focus on place, with local priorities that drive collaboration
A director of public health, who gets it
High quality support, and a flexible approach to the council committee thing
Churn in the system, within local government and health
Getting the basics right, to enable effective systems leadership

2.4 As part of the LGA's development session package, their representative will assist the Boards to create a questionnaire which will be sent to members in advance of the development session. The questionnaire will ask members about the vision and role of their board, system leadership, partnership working and communication and engagement.

The responses to the questionnaire will then be collated and form the basis of the development session. Members will look at strengths, weaknesses and challenges and then work together to produce an action plan to take forward the agreed issues and challenges.

If the Board agrees to the proposal, a scoping meeting will be held with the LGA to agree the focus areas for the joint development session, and a further report will be brought to a future HWB meeting for approval.

3.0 CONSULTATION

3.1 This proposal was considered by the Peterborough HWB meeting on 11th September 2017, who were in agreement subject to consultation with the Cambridgeshire HWB to proceed.

4.0 ANTICIPATED OUTCOMES OR IMPACT

4.1 The anticipated outcome is for members to agree to the proposal for a joint LGA led development session in January 2018, with Peterborough and Cambridgeshire Health and Wellbeing Boards.

5.0 REASON FOR THE RECOMMENDATION

5.1 A joint development session will look at ways in which both boards can be strengthened to better enable local people to have improved health and reduced health inequalities by working together to tackle shared priorities.

5.2 For the Cambridgeshire Health & Wellbeing Board a joint development session is very timely as the board undertakes its development phase of the new health and wellbeing strategy and provides an opportunity to consult with Peterborough board members to discuss how their current strategy was developed.

Agenda Item No: 10

DATA SHARING

To:	**Health and Wellbeing Board**
Meeting Date:	**21 September 2017**
From:	**Charlotte Black, Director of Adult Social Care, Cambridgeshire County Council**
Recommendations:	**The Board is asked to:** • Note the report and comment on future approaches to Data Sharing.

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1.0 BACKGROUND

1.1 At its meeting in March 2017, the Health and Wellbeing Board considered a paper on Dual Diagnosis of Substance Issues and Mental Health conditions. Highlighted in the report was the fact that difficulties in accessing data held in different services had made the work more complicated. Following discussion at the meeting, the Health and Wellbeing Board requested that an overview of data sharing issues be brought to a future meeting.

1.2 Effective data sharing between services is essential for delivering seamless services that consider how to meet people's needs effectively. Issues surrounding the sharing of people's personal information and data are becoming more complicated as services become more complex. The inter-connected nature of health and care services means that people's information is held by a range of different organisations. This has increased significantly in recent years, particularly for three reasons:

- Greater use of digital technology means that more information is being stored in a format that is easily shared;
- More effort is being made to integrate services for people who access services from across health, social care, and the rest of the public sector – and this requires sharing information; and
- Due to some high profile incidents of data loss or inappropriate sharing of information, people want to influence how their data is used by public services and want to know more about their rights.

1.3 Information sharing is a commonly cited barrier in providing more integrated care for people across local organisations; and has been identified as a key challenge across planning of services in Neighbourhood Teams; in making referrals between organisations; and in sharing information about who is known to different services. Professionals are often unsure what information they can and cannot share; and significant changes to legislation will be brought in from May 2018 when a new 'General Data Protection Regulation' comes into force.

2.0 BENEFITS OF INFORMATION SHARING

2.1 Carried out responsibly and with appropriate safeguards in place, information sharing can have significant benefits for patients and citizens. These include:

- Ensuring that the right people are offering the right help to the right people.
- With an emphasis on prevention and well-being paramount in the Care Act (2014), it is vital that services come together to share information in the correct manner, spotting where people can be supported at a 'low level' by a wide range of services before needs escalate.
- Integrated care is seen as increasingly important and this cannot be delivered without effective information sharing.

- Professionals can work together more efficiently
- Giving information only once and sharing appropriately can lead to more efficient use of resources.
- To ensure proper safeguarding.
- Sometimes, failing to share information can have devastating impacts. Concerns about the safety or wellbeing of an individual not shared with others or collectively considered with others who have contact with them has led to several high profile enquiries into deaths through neglect or abuse.
- Time and time again, people who use services talk of having to 'tell their story' multiple times to many different agencies. Often the assumption from the individual is that agencies will 'talk to one another' and share data, when in fact they do not. Information sharing is key to delivering better, more efficient services that can be coordinated around individual needs[1].

3.0 LOCAL AMBITIONS AND PROGRESS

3.1 In 2015, a Cambridgeshire and Peterborough Data Sharing project was established via the Better Care Fund to promote better sharing of information across the health and care system. The project identified a number of common scenarios where effective information sharing could offer patient or strategic benefits that have progressed to various different extents:

3.2 Early help referrals for people who are beginning to become more vulnerable

We want staff across the system to be able to act as 'eyes and ears' – trained to spot indications that someone is becoming more vulnerable, and to refer them to appropriate support. This includes not just clinical or social care staff, but any public or voluntary sector worker who comes into contact with the public. This might include support for staff to enable them to go beyond their core role to provide some low level interventions, where appropriate. Indicators would lead to a planned response to offer support, advice and information. Data to be shared may include the contact information necessary to allow a referral, and a brief description of the nature of the concern identified.

Current status: Some information sharing is in place between individual services – notable examples include the County Council's Adult Early Help service sharing information with voluntary sector organisations where appropriate; and a partnership arrangement between the Cambridgeshire Fire and Rescue Service and local authorities to share information about households that have vulnerable residents. However each instance requires the creation of individual data sharing agreements between organisations, which has limited the speed of development.

[1] http://www.skillsforcare.org.uk/Documents/Topics/Digital-working/Information-sharing-for-social-care-employers.pdf

3.3 Case finding to identify people that are receiving services from a number of organisations and may benefit from a more co-ordinated approach;

We want to use data from across organisations to identify patients who may benefit from the multi-disciplinary team (MDT) case management process. This data might include medical triggers such as low mood/depression, continence/ frequent Urinary Tract Infections (UTIs), injuries caused by falls, or frequent missed medical appointments. This data will highlight people whose needs are changing over time, to indicate that they might benefit from further support in order to remain independent; and could include identification of patients by care professionals based on their contact with the patient, with a referral into the case finding process. This could be achieved, either through sharing of data from a range of organisations which is then analysed by a single system, in which case data shared would include individual details such as medical conditions and history; or by each organisation analysing their own data and only sharing information on the individuals identified as most at risk. In this case, sharing could potentially be achieved using only a personal identifier (such as an NHS number) and a proxy risk 'score' generated based on an agreed weighted algorithm.

Current status: A 'proof of concept' was developed in 2016 which enabled sharing of data between community health; GP surgeries; acute providers; and local authority social care. This showed that people's identity could be encrypted or 'pseudonymised' and compared across different database to identify individuals at risk. This was followed by a lengthy process of developing information sharing agreements between Cambridgeshire and Peterborough Foundation Trust (CPFT) and all 106 GP practices in Cambridgeshire to allow this work to become mainstream. This was completed in early 2017. However, difficulty in finding capacity has meant that lists of 'at risk' patients are not yet routinely provided to Neighbourhood Teams to inform prioritisation of cases. This process is currently carried out manually, but work is ongoing on a technical solution that would automate the process and make more routine sharing possible.

3.4 Case management, with a lead professional identified for each person and an agreed plan spanning all the services that they receive;

MDT (multi-disciplinary team) proactive case management describes an agreed approach to case management, with a lead professional identified for each person and an agreed plan spanning a range of services in health, social care and wider statutory and voluntary sector organisations. Plans will be personalised and based on the person's needs and choices. Teams will include social care staff who will be aligned to, or 'vertically integrated' with Neighbourhood Teams to ensure the appropriate person is identified as the

lead professional. The benefits of MDT working will be built upon with an assumption that this is a way of working that won't always rely on a set meeting; more a team around the person mode where the relevant professionals come together. To work effectively, professionals across the MDT will need to work in an integrated way, and are likely to therefore have access to a wide range of medical and care information about individuals identified for case management.

Current status: Case management is now well embedded in Neighbourhood Teams. Information is shared between professionals following a request for, and agreement to, consent from each individual patient.

3.5 Secondary use of data to support service planning, research and strategy

Any use of health and care data other than directly providing care to an individual is classed as 'secondary use'. This includes (but is not limited to) healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development. Use of data in this way is essential in planning and developing services and improving care for the population. However, precautions need to be taken to ensure that data is used appropriately.

Current status: This is agreed between organisations on a case by case basis. Often this can be done based on data that removes any personal information; where personally identifiable information is required the creation of data sharing agreements is a considerable part of the process.

3.6 Shared care records that bring together information held about individuals into a single system

A stated aim of the Data Sharing Project is for practitioners and professionals to have appropriate access to all relevant data held about a person when making decisions about their care needs.

Currently, data are recorded in a variety of different electronic systems within and across services in health, social care and other organisations. Typically it is not possible for a professional in one part of the system to see information that is held in another - so the GP might not know what the mental health team has written about a patient and vice versa; and hospital staff cannot easily view information held by social care that might be pertinent to the patient's care. Where professionals have permission to view more than one record, this generally requires them to log into more than one system – and this often results in that access being underused.

Current status: As an interim solution, in some areas, selected staff are being offered access to multiple organisations' systems in order to see

information held across organisation boundaries; but it is noted that this approach is sub-optimal and introduces additional risks. A key priority for the future will be to establish a shared record, or single view, so that professionals can access data in other systems in order to make the best possible decisions and recommendations about people's health and care services. This system would require a mechanism that would either:

- Access other systems and pull data across for individual patients at the point of access;
- Pull all data held in various systems into a central system that would offer a single view of the patient's record; or
- Offer a single shared record separate from each organisation's core system that would allow information to be inputted by all services.

3.7 The concept of a 'patient held' record system is being actively explored across the local health and care system. This would allow patients' records from different sources to be stored online with each patient controlling which organisations and professionals they would wish to access their data, granting or withdrawing their consent at any time. This addresses concerns over ensuring consent has been given, enabling greater sharing of information between services. Such systems also offer patients the opportunity to add their own information between appointments with professionals; this could be particularly valuable for managing long term conditions.

4.0 A COMMON APPROACH TO INFORMATION GOVERNANCE

4.1 Despite significant progress highlighted in many areas of ambition for data sharing in Cambridgeshire, embedding data sharing across the health and care system remains challenging. One of the key reasons for this is the perceived complexity of regulations surrounding information governance. What is permissible is influenced by different legislation, including the Data Protection Act 1998, the Health and Social Care Act 2010, and the Care Act 2014, as well as a common law duty to protect confidentiality. A 'General Data Protection Regulation' (GDPR) will come into force from May 2018, and will provide a single framework for information governance. This may ultimately make information sharing easier, but in the short term is likely to lead to further confusion.

4.2 There is a certain degree of subjectivity in how this legislation is interpreted, meaning that different organisations often approach information sharing in different ways. With fifteen organisations currently represented on the Health and Wellbeing Board and a further 106 GP practices, each with different appetites for risk, agreeing a common approach to information sharing is a significant task.

4.3 Recognising the difficulties, the Better Care Fund (BCF) Data Sharing Project brought together information governance professionals to try and agree common approaches to information sharing across the county. The report from that work is attached as Appendix 1 to this report.

4.4 The work demonstrated that across local organisations there was a **broad consensus on lawfulness and willingness to share with care providers and other public services.** Our organisations recognise the benefits of sharing information; and agree that with reasonable policies in place and adequate communication, the sharing that we want to carry out is legal. Organisations were committed to working together to ensure that appropriate sharing can take place.

4.5 Secondly, the group recognised that there is **no one size fits all approach to sharing data**. The precautions that need to be put in place will vary depending on what is being shared; who is involved; and how much data is being shared. Our approach needs to be proportionate – and importantly we should restrict what we share, **only sharing personal confidential data if it is necessary.**

4.6 The group suggested three specific recommendations for data sharing across Cambridgeshire and Peterborough. Collectively our organisations should:

1. Ensure that all organisations are signed up to the Cambridgeshire Information Sharing Framework – and have agreed a common set of clear, transparent principles on consent, information governance and the use of personal information – a common 'data processing notice'

2. These principles then need to be widely communicated to staff through ongoing training and awareness raising, and included in inductions for all staff who might have access to patient and service user data. They should be made widely available – displayed prominently on each organisation's website; displayed in offices, surgeries and care locations; and shared with new patients and service users.

3. These principles need to form the basis of a marketing campaign, making clear to patients and service users:
    a. The benefits of information sharing;
    b. How we will work together to share people's information; and
    c. How we will work together to keep people's information safe.

4.7 Whilst there is a willingness amongst partners to resolve these issues and share information, the time needed to address issues of information governance should not be under-estimated. Existing Information Governance professionals in separate organisations have been unable to commit to moving this work forward; the BCF project highlighted the fact that there is insufficient capacity in the system for developmental Information Governance work. This is likely to become a more significant issue as organisations adapt to meet the requirements of the new GDPR.

4.8 It is anticipated that to address this, a strong commitment from leaders in the health and care system to promoting and improving data sharing is required; and that specific Information Governance capacity is needed to work across the system, promoting better sharing and a common understanding of the issues. Partners continue to make the case for this through the Better Care Fund and Sustainability and Transformation Plan (STP) Digital Delivery Group.

5.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

5.1 This work is relevant to priority 6 of the Health and Wellbeing Strategy: Work together effectively.

6.0 SOURCES

Source Documents	Location
Information Sharing for Social Care Employers	http://www.skillsforcare.org.uk/Documents/Topics/Digital-working/Information-sharing-for-social-care-employers.pdf

Consent and Information Governance in Cambridgeshire and Peterborough

Workshop findings

December 2016

Geoff Hinkins

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Background

On 14 July, a workshop was held for Information Governance professionals, operational staff and other relevant professionals from across the health and wellbeing system in Cambridgeshire. The aim of the day was to reach a common understanding across health, social care, housing and voluntary sector organisations in Cambridgeshire and Peterborough about:

- Levels of consent required when sharing information about people who receive, or may benefit from, health and care services; and
- How to establish the legal framework for sharing to take place, ensuring that any barriers to sharing are highlighted and overcome.

Information sharing is a commonly cited barrier in providing more integrated care for people across local organisations; and has been identified as a key challenge across planning of services in Neighbourhood Teams; in making referrals between organisations; and in sharing information about who is known to different services. A particular issue across Cambridgeshire and Peterborough is the issue of the level of consent required when sharing information about individuals. Interpretations of the law and aspects of Information Governance differ across the county on whether 'explicit' consent is required in any circumstances; or whether there are circumstances in which 'implicit' consent is sufficient for information to be shared. Likewise the common law duty of confidentiality and data protection legislation and other legislation can make it confusing and complicated to share data and information. The particular circumstances in which a clear agreement on levels of consent required would be helpful include (but are not limited to):

- Early help referrals for people who are beginning to become more vulnerable;
- Case finding to identify people that are receiving services from a number of organisations and may benefit from a more co-ordinated approach;
- Case management, with a lead professional identified for each person and an agreed plan spanning all the services that they receive;
- Secondary use of data to support service planning, research and strategy
- Shared care records that bring together information held about individuals into a single system

The workshop explored many of the issues above in an effort to reach an agreed position; this report represents the summary findings of the workshop.

The Caldicott Principles

The Caldicott Principles were first described in the first Caldicott Report into the use of patient information in the NHS. They remain central to our approach to the use of people's personal information:

1. **Justify the purpose(s)**
   Every single proposed use or transfer of patient identifiable information within or from an organisation should be clearly defined and scrutinised, with continuing uses regularly reviewed, by an appropriate guardian.
2. **Don't use patient identifiable information unless it is necessary**
   Patient identifiable information items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s).
3. **Use the minimum necessary patient-identifiable information**
   Where use of patient identifiable information is considered to be essential, the inclusion of each individual item of information should be considered and justified so that the minimum amount of identifiable information is transferred or accessible as is necessary for a given function to be carried out.
4. **Access to patient identifiable information should be on a strict need-to-know basis**
   Only those individuals who need access to patient identifiable information should have access to it, and they should only have access to the information items that they need to see. This may mean introducing access controls or splitting information flows where one information flow is used for several purposes.
5. **Everyone with access to patient identifiable information should be aware of their** responsibilities
   Action should be taken to ensure that those handling patient identifiable information - both clinical and non-clinical staff - are made fully aware of their responsibilities and obligations to respect patient confidentiality.
6. **Understand and comply with the law**
   Every use of patient identifiable information must be lawful. Someone in each organisation handling patient information should be responsible for ensuring that the organisation complies with legal requirements.
7. **The duty to share information can be as important as the duty to protect patient** confidentiality
   Professionals should in the patient's interest share information within this framework. Official policies should support them doing so.

Data Protection Principles

From Schedule 1 to the Data Protection Act

1. Personal data shall be processed fairly and lawfully and, in particular, shall not be processed unless –
   (a) at least one of the conditions in Schedule 2 is met, and
   (b) in the case of sensitive personal data, at least one of the conditions in Schedule 3 is also met.

2. Personal data shall be obtained only for one or more specified and lawful purposes, and shall not be further processed in any manner incompatible with that purpose or those purposes.

3. Personal data shall be adequate, relevant and not excessive in relation to the purpose or purposes for which they are processed.

4. Personal data shall be accurate and, where necessary, kept up to date.

5. Personal data processed for any purpose or purposes shall not be kept for longer than is necessary for that purpose or those purposes.

6. Personal data shall be processed in accordance with the rights of data subjects under this Act.

7. Appropriate technical and organisational measures shall be taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data.

8. Personal data shall not be transferred to a country or territory outside the European Economic Area unless that country or territory ensures an adequate level of protection for the rights and freedoms of data subjects in relation to the processing of personal data.

The Common Law Duty of Confidentiality:

If information is given in circumstances where it is expected that a duty of confidence applies, that information cannot normally be disclosed without the information provider's consent.

In practice, this means that all patient information, whether held on paper, computer, visually or audio recorded, or held in the memory of the professional, must not normally be disclosed without the consent of the patient. It is irrelevant how old the patient is or what the state of their mental health is; the duty still applies.

Three circumstances making disclosure of confidential information lawful are:

- where the individual to whom the information relates has consented;
- where disclosure is in the public interest; and
- where there is a legal duty to do so, for example a court order.

Key messages

Overall, the group agreed twelve key messages for Data Sharing – these are contained in an appendix to this report.

Most importantly there was a **broad consensus on lawfulness and willingness to share with care providers and other public services.** Our organisations recognise the benefits of sharing information; and agree that with reasonable policies in place and adequate communication, the sharing that we want to carry out is legal. We will commit to working together to ensure that appropriate sharing can take place.

Secondly, the group recognised that there is **no one size fits all approach to sharing data**. The precautions that need to be put in place will vary depending on what is being shared; who is involved; and how much data is being shared. Our approach needs to be proportionate – and importantly we should restrict what we share, **only sharing personal confidential data if it is necessary.**

As well as the specific recommendations for individual projects described in the rest of this document, there are three key pieces of work that should be taken forward by the Data Sharing Board:

1. Ensure that all organisations are signed up to the Cambridgeshire Information Sharing Framework – and have agreed a common set of clear, transparent principles on consent, information governance and the use of personal information – a common 'data processing notice'

2. These principles then need to be widely communicated to staff through ongoing training and awareness raising, and included in inductions for all staff who might have access to patient and service user data. They should be made widely available – displayed prominently on each organisation's website; displayed in offices, surgeries and care locations; and shared with new patients and service users.

3. These principles need to form the basis of a marketing campaign, making clear to patients and service users:
    a. The benefits of information sharing;
    b. How we will work together to share people's information; and
    c. How we will work together to keep people's information safe.

The remainder of this report highlights the scenarios explored during the workshop, and makes recommendations for an appropriate approach to information governance and consent in each.

Data Sharing Scenarios

Early help referral

Summary:

We want staff across the system to be able to act as 'eyes and ears' – trained to spot indications that someone is becoming more vulnerable, and to refer them to appropriate support. This includes not just clinical or social care staff, but any public or voluntary sector worker who comes into contact with the public. This might include support for staff to enable them to go beyond their core role to provide some low level interventions, where appropriate. Indicators would lead to a planned response to offer support, advice and information. Data to be shared may include the contact information necessary to allow a referral, and a brief description of the nature of the concern identified.

Suggested approach:

- The officer should tell the citizen that they think they might benefit from another service; and should either:
    - Provide information so that the citizen can refer themselves; or
    - Ask for their permission to forward their details on to another organisation. In this situation, verbal consent is acceptable – the citizen should not be required to fill in a form to record their consent. The officer should record the discussion; but this does not need to be logged centrally.
- The officer should then use an existing / agreed referral process with the individual's details.
- This applies equally to sharing information within the statutory sector and with partners in the voluntary sector.
- The officer should only share the information that is necessary for the referral to take place. Where the referral is not a formal medical referral, they should not share the individual's complete record, or details of any condition or circumstance that are not relevant to the request.
- Sharing and use of the persons details should be restricted to the purpose the consent was obtained and as outlined in the organisation's Fair Processing Notice. Where possible this should be provided to the citizen.

Multi-disciplinary team working: case finding and case management

Summary:

We want to use data from across organisations to identify patients who may benefit from the MDT case management process. This data might include medical triggers such as low mood/depression, continence/ frequent Urinary Tract Infections (UTIs), injuries caused by falls, or frequent missed medical appointments. This data will highlight people whose needs are changing over time, to indicate that they might benefit from further support in order to remain independent; and could include identification of patients by care professionals based on their contact with the patient, with a referral into the case finding process. This could be achieved, either through sharing of data from a range of organisations which is then analysed by a single system, in which case data shared would include individual details such as medical conditions and history; or by each organisation analysing their own data and only sharing information on the individuals identified as most at risk. In this case, sharing could potentially be achieved using only a personal identifier (such as an NHS number) and a proxy risk 'score' generated based on an agreed weighted algorithm.

Suggested approach:

- Explicit consent is **not required** from individuals for a single organisation to identify people at risk, as long as the data does not leave that organisation.
- However, in order to share that information with other organisations, steps must be taken to protect the person's personal confidential data.
- In order to share the information, explicit consent **will not be required** as long as the following guidelines are adhered to:
    - The data shared does not identify the person or persons that the data is attributable to. This can be done through 'pseudonymisation' (encryption) of the individual's NHS Number. This ensures that it is difficult to identify an individual if the data were to be intercepted.
    - The minimum necessary data to identify people who may benefit from case management should be shared. Data that might allow people to be identified should not be shared.
    - People's identities should only be revealed once the data has been compared between organisations – and must only be revealed for those individuals who will be offered a service.
- Once people's identities are revealed, the **next step** should be to contact them and ask for them to provide their **explicit consent** for case management. If they refuse consent, information gathered for the exercise should be disposed of safely; and their withdrawal of consent should be noted.
- When the exercise is repeated, individuals who have previously withdrawn consent should not be contacted for an agreed period.
- To formalise the approach described here, a **data processing agreement** should be drawn up between all partners contributing data (the **data controllers**). This must name the organisation receiving data as a **data processor** and provide clear guidelines for use of the data.
- Alongside this – patients should be made aware that this data processing is happening, through publicity shared in surgeries, care centres and when they come into contact with staff.

MDT proactive case management

Summary:

MDT (multi-disciplinary team) proactive case management describes an agreed approach to case management, with a lead professional identified for each person and an agreed plan spanning a range of services in health, social care and wider statutory and voluntary sector organisations. Plans will be personalised and based on the person's needs and choices. Teams will include social care staff who will be aligned to, or 'vertically integrated' with Neighbourhood Teams to ensure the appropriate person is identified as the lead professional. The benefits of MDT working will be built upon with an assumption that this is a way of working that won't always rely on a set meeting; more a team around the person mode where the relevant professionals come together. To work effectively, professionals across the MDT will need to work in an integrated way, and are likely to therefore have access to a wide range of medical and care information about individuals identified for case management.

Suggested approach:

- Put simply, **explicit consent should be sought and granted** before an individual is discussed in detail by an MDT / Neighbourhood Team.
- A request should be made by the Neighbourhood Team or MDT Coordinator. The request should make clear the benefits of case management to the individual and the positive effect that it is expected to have on their care; and should make clear what information will and will not be shared (and in particular be clear that no information from financial assessments will be shared between organisations).
- If the individual does not have capacity to consent, the request should be directed to the person that has permission to make decisions on the individual's behalf. The request should be restricted to case management and not invite a blanket refusal to share data under any circumstances.
- If consent is refused, this decision must be respected; and the decision should be recorded.

Secondary use of data

Summary:

Any use of health and care data other than directly providing care to an individual is classed as 'secondary use'. This includes (but is not limited to) healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development. Use of data in this way is essential in planning and developing services and improving care for the population. However, precautions need to be taken to ensure that data is used appropriately.

Suggested approach:

- Personal confidential data that allows an individual to be identified **should not be shared** for secondary use.
- Data can be freely shared if it is **anonymised:** that is that all patient identifiable data has been removed.
- When individual patients need to be tracked across services provided by different organisations, it is possible to share **pseudonymised** data.
- If pseudonymised data is to be used, then a data processing agreement should be drafted and agreed between all parties to the sharing.
- At all times, the general principle of sharing the minimum data necessary should be adhered to. The data sharing agreement should define the data necessary for the exercise, and sharing should be limited to that data.

Shared care records

Summary:

A stated aim of the Data Sharing Project is for practitioners and professionals to have appropriate access to all relevant data held about a person when making decisions about their care needs.

Currently, data are recorded in a variety of different electronic systems within and across services in health, social care and other organisations. Typically it is not possible for a professional in one part of the system to see information that is held in another - so the GP might not know what the mental health team has written about a patient and vice versa; and hospital staff cannot easily view information held by social care that might be pertinent to the patient's care. Where professionals have permission to view more than one record, this generally requires them to log into more than one system – and this often results in that access being underused.

As an interim solution, in some areas, selected staff are being offered access to multiple organisations' systems in order to see information held across organisation boundaries; but it is noted that this approach is sub-optimal and introduces additional risks. A key priority for the future will be to establish a shared record, or single view, so that professionals can access data in other systems in order to make the best possible decisions and recommendations about people's health and care services. This system would require a mechanism that would either:

- Access other systems and pull data across for individual patients at the point of access;
- Pull all data held in various systems into a central system that would offer a single view of the patient's record; or
- Offer a single shared record separate from each organisation's core system that would allow information to be inputted by all services.

Suggested approach:

- Significantly more work is needed on information governance surrounding a move towards a single system containing shared records.
- The goal is to move towards a system where **implied** consent allowed the sharing of information into a central system; and **explicit** consent was used for the accessing of each individual record.
- However, this would need to be accompanied by a significant publicity campaign to ensure that that residents might reasonably expect their data to be used in this way.
- 'Patient held' solutions should be explored as an alternative – these systems allow patients to control which professionals can access their data and rely on explicit consent and patient opt-in.
- In the interim – sharing access to systems presents a useful way of sharing information. Each organisation remains responsible for their own systems, and should reach their own decisions about appropriate levels of access. However, it is recommended that:
    - Where systems are shared, this should be governed by a Memorandum of Understanding between organisations.
    - Where possible, access should be limited so that individuals that do not need to see a full record can only access the information that they need.
    - Access requests are documented; and individual access is reviewed regularly to establish whether it is still needed; and
    - Where possible, use is audited.

APPENDIX: 12 Key messages:

The following statements were agreed by participants in the workshop on the day:

1. **There is a broad consensus on lawfulness and willingness to share with care providers and other public services**

The vast majority of organisations recognise the benefits of sharing information; and agree that with reasonable policies in place and adequate communication, the sharing that we want to carry out is legal. We will commit to working together to ensure that appropriate sharing can take place

2. **The level of consent required is balanced by data volume and sensitivity**

Consent can be explicit or implicit; and our approach needs to be proportionate, based on what is being shared. We do not always need to seek explicit consent if the level of data being shared is low and not very sensitive – and if the individual might reasonably expect that we would share that information.

3. **We need a governance framework that includes all parties**

The Cambridgeshire Information Sharing Framework has signatures from the majority of public sector organisations in Cambridgeshire, but not all. We need to work to ensure that all organisations are signed up to a set of principles about how information will be used across the system.

4. **Training is needed across our organisations**

There are currently different understandings of what is possible and what is appropriate across all levels of our organisation. Training is needed to ensure that consistent messages are shared throughout our organisations

5. **We need to engage patients and service users in our discussions**

It was agreed that we would consider how best to involve patient and service user representatives in our work, to ensure our plans are informed by what citizens would reasonably expect

6. **Frontline change must be supported by timely, proportionate and accurate data**

It was agreed that access to data was necessary to support change across our services – in order to understand the effect that changes were having on our services and on demand

7. **Nothing happens without communications and branding**

We agreed that our organisations need to agree a consistent set of messages about information sharing and widely communicate these – with a clear and recognisable brand and focusing on the benefits of information sharing

8. **As well as seeking consent, we need to understand what to do when it is refused**

If we are to rely more on implicit consent, the system needs a definite way of managing the process when individuals withdraw their consent for sharing. This needs to make clear for those individuals how their services will be less coordinated as a result

9. **Organisational risks are low in terms of the Information Commissioner's Office; but high in terms of reputational damage**

The biggest risk to our organisations (assuming we have clear policies and follow them) is in reputational damage if we get this wrong.

10. **Don't use personal confidential data if you don't have to**

It was recognised that sharing anonymised or pseudonymised records is preferable to sharing personal information wherever possible.

11. **Data's role is strategic**

Data is needed to support strategic planning. Individual's information is information – data is anonymised

12. **We should explore opportunities to put people in control of their data**

People should be able to see the data held about them – and if they want to, decide who can access what.

To:	**Health and Wellbeing Board**
Meeting Date:	**21 September 2017**
From:	**Sustainability & Transformation Plan (STP) Update Report**
	Presented By:
	Gemma McGeachie, System Strategy, Planning and Development Director Cambridgeshire & Peterborough System Delivery Unit
	Aidan Fallon, Head of Communication & Engagement Cambridgeshire & Peterborough System Delivery Unit
	On behalf of:
	Scott Haldane, Interim Executive Programme Director, Cambridgeshire & Peterborough System Delivery Unit
Recommendations:	**The Health and Wellbeing Board is asked to comment upon and note this update report**

	Officer contact:
Name:	Aidan Fallon
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1. PURPOSE

1.1 The purpose of this report is to update the Health & Wellbeing Board on a range of issues relating to the STP, as requested at the previous Board meeting, namely:

- Workforce;
- STP leadership and proposed changes to governance arrangements; and
- Communication & stakeholder engagement.

A further area of Board interest – the role of care workers and the voluntary sector – will be addressed in subsequent reports.

2. MAIN ISSUES

2.1 Workforce

2.1.1 A system wide Workforce Task and Finish Group, made up of Deputy Directors/ Associate Directors of Workforce from all partner organisations within our STP, was established in May 2017 as a sub-committee of the Local Workforce Advisory Board (LWAB). The group meets formally on a monthly basis, although members come together between meetings to take forward specific pieces of work. The group's Terms of Reference set out the scope of work as follows:

- To review and analyse workforce plans across the STP and Better Care Fund to identify hot spots and identify actions to address gaps with operational and multi-professional clinical input as required.
- To develop, agree and implement ways of working as a system, which impact positively on the sustainability of the workforce across Cambridgeshire and Peterborough, supporting the delivery of the STP workstreams.
- To coordinate appropriate workforce input and challenge to business cases as required in a timely way to enable sign off of the workforce elements of STP business cases.
- To oversee workforce actions in relation to STP Delivery Group business cases, and to undertake planning for implementation of system workforce changes as a result of the respective service changes.
- To discuss, identify and agree solutions to system workforce issues to enable the delivery of identified STP workstreams
- To escalate any workforce items that required wider agreement either the through the appropriate delivery group or the appropriate place within each organisations governance structure.
- To escalate risks or issues within partner organisations that may have an impact on the identified STP workstreams
- To identify and co-ordinate workforce resources required from each organisation to implement actions and to identify where additional resources are required.
- To provide workforce input to other STP delivery groups as and when required.
- To provide strategic oversight of workforce activities impacting across STP workstreams and taking action as required including management of interdependencies.

2.1.2 The group is currently completing a comprehensive qualitative and quantitative analysis of the workforce challenges the system is facing. This will inform a joined up cross system workforce delivery plan which will set out how we will address our immediate recruitment needs in order to support STP implementation. It will also inform our workforce strategy which will describe longer term solutions and address

supply and retention as well as utilising our existing resource effectively by reducing agency usage, sickness absence and turnover.

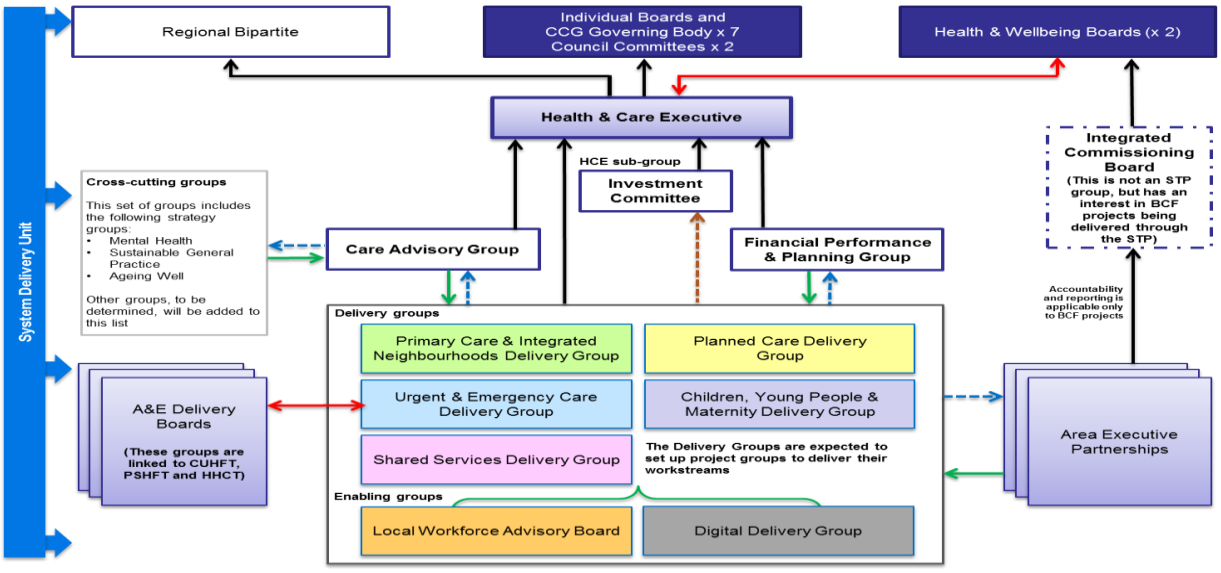
2.1.3 The table below summarises the workforce requirements included in the STP business cases approved for investment and implementation in 2017/18. Board members will be provided with an up-to-date picture of progress in recruiting and deploying this additional workforce across the STP Improvement Projects, at the meeting on 21st September.

WTEs	TOTAL across all projects	Stroke ESD	JET	D2A	Respiratory	Falls	Heart Failure	Dementia	Suicide Prevention	Case Mgt	Diabetes
Consultant	**2.1**	0			2						4 PAs per month
8b	**1.4**	0.4						1			
8a	**7**	1		3		1	1				1
7	**68.5**	5	25	10	6**	3	4.16	1	0.4	5	9
6	**49.2**	9	5.7	16		3	2.5	4.3	0.2	8.5	
5	**13**	6								6	1
4	**38**	4		9		4				9	12
3	**137.2**	8	43	79			2			1	4.2
2	**33**	2		31							
Other*	**7.8**		0.8	7							
TOTAL	**357.2**	**35.4**	**74.5**	**155**	**8**	**11**	**9.66**	**6.3**	**0.6**	**29.5**	**27.2**

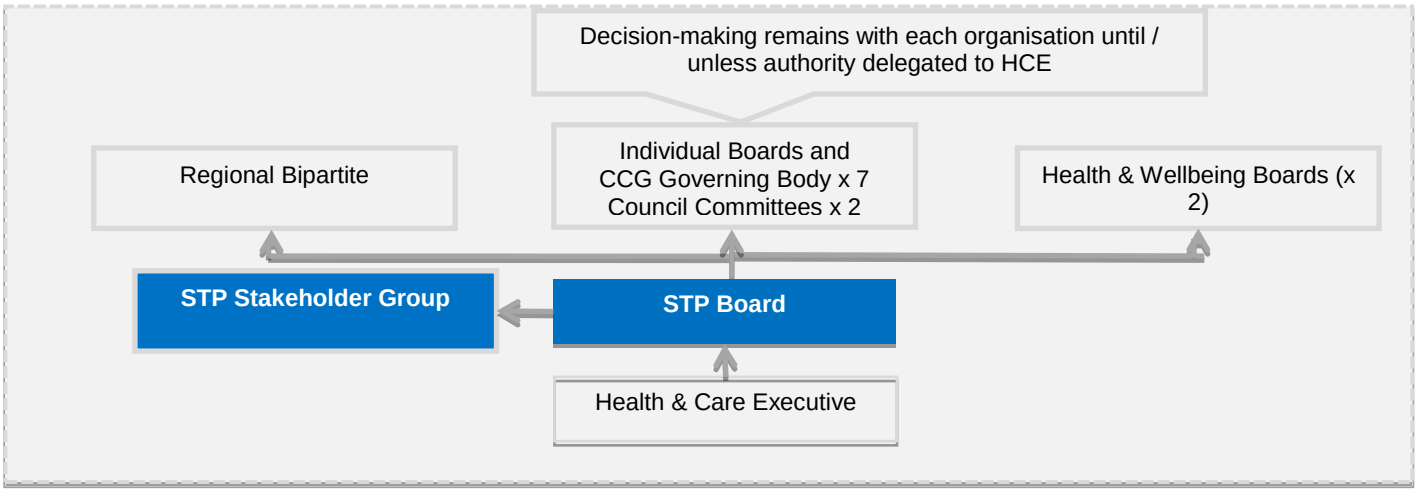
2.2 STP Leadership and Proposed Changes to Governance Arrangements

2.2.1 Establishing an STP Board

2.2.1.1 Below is a diagrammatic representation of the current STP governance arrangements and it can be noted that the Health and Care Executive (HCE) reports directly to individual NHS partner Boards and the Governing Body of the Clinical Commissioning Group (CCG).



2.2.1.2 In order to strengthen STP accountability, ownership and engagement with partner organisations and wider key stakeholders, NHS partner Chairs and the HCE have proposed the establishment of an STP Board (see diagram below) which will, in addition to Chief Executives, have Non-Executive Director (NED) membership from across the system as well as Local Authority elected representation.



2.2.1.3 The proposed membership of the STP Board is as follows:

- Chair: Independent Chair
- Cambridgeshire & Peterborough CCG: Clinical Chair and Accountable Officer
- Cambridgeshire & Peterborough NHS Foundation Trust: Chair and Chief Executive
- North West Anglia NHS Foundation Trust: Chair and Chief Executive
- Cambridge University Hospitals NHS Foundation Trust: Chair and Chief Executive
- Cambridgeshire Community Services NHS Trust: Chair and Chief Executive
- Papworth Foundation Trust: Chair and Chief Executive
- East of England Ambulance Service NHS Trust: Chair and Chief Executive
- Local Authority Representation
- Executive Programme Director
- Care Advisory Group Chair
- Financial Performance & Planning Group Chair
- System Delivery Unit Secretariat

2.2.1.4 Broadly, it is anticipated that the STP Board will be responsible for setting medium and long term STP strategy as follows:

	STP Board
Strategic decision making	• Responsible for **medium and long term STP strategy**, including ensuring the system has in place a process for working towards **Accountable Care**
Operational delivery	• **Holds to account HCE** for delivery of the STP, ensuring accountability and reporting arrangements are in place
Governance	• Ensures adherence to collective **governance** arrangements
Risk management	• Reviews/ addresses **strategic programme risks**

Engagement	• Ensures there is a process in place to understand how the system manages the expectations of **service users and the general public and members of the STP Stakeholder Group**
Accountability	• Receives brief update from the HCE regarding STP delivery. Chair attends Bipartite meetings.

2.2.1.5 Practical arrangements currently being taken forward to establish the STP Board include:

- A first meeting of the Board will take place on 14th September in order to consider key documentation, including the Terms of Reference (ToR) and revised STP Governance Framework. It is anticipated that further changes to the current governance arrangements may be necessary, including clarification of the respective responsibilities of the STP Board and the HCE;
- it is anticipated that ratification of the STP Board and supporting documentation, by individual partner Boards/CCG Governing Body, will happen in October 2017;
- meetings will then take place on a bimonthly basis.
- a process is underway to appoint an Independent Chair. The post holder is expected to be in post by the November meeting; and
- Local Authority colleagues are currently considering appropriate elected representation to sit on the STP Board.

2.2.1.6 The ToRs, revised STP Governance Framework and other governance documentation can be made available to the Health & Wellbeing Board, once finalised.

2.2.2 Establishing an STP Stakeholder Group

The STP Board, once operational, will consider the establishment of an STP Stakeholder Group. The purpose, function, membership and relationship of this Group to other engagement mechanisms will need to be defined and partner views will be sought regarding all these aspects.

2.2.3 Proposed reconfiguration of Area Executive Partnerships and Local Health Partnerships

The Cambridgeshire Public Services Board and HCE has proposed that, in Cambridgeshire, Area Executive Partnerships will merge with Local Health Partnerships to form three Area Delivery 'Living Well' Partnerships (ADP) to ensure local delivery and re-design of health & living well services in local communities. Arrangements in Peterborough to continue as currently configured.

This proposal is being led by District Council colleagues and is currently being considered across the system.

2.2.4 STP Executive Leadership

Tracy Dowling, who has recently taken up the role of Chief Executive of Cambridgeshire & Peterborough NHS Foundation Trust, will continue in the role of STP Accountable Officer for the medium term.

Catherine Pollard has been appointed as Executive Programme Director and will replace Scott Haldane who will resume his full-time responsibilities as Finance Director at CPFT.

2.3 Communication & Stakeholder Engagement

2.3.1 The HWB has requested an update regarding those areas where patient and public involvement is in place and those areas where gaps remain.

2.3.2 Representation on Delivery and Improvement Groups

2.3.2.1 There are currently 22 patient, voluntary sector, carer and public representatives on STP Delivery Groups and their constituent Improvement Projects. As the focus for delivery in 2017/18 is Urgent & Emergency Care (UEC), Primary Care & Integrated Neighbourhoods (PCIN) and Planned Care, so has the focus been on ensuring that these Delivery Groups have appropriate representation. The PCIN Long Term Condition Improvement Projects are well served, as is the Planned Care Cancer Improvement Project and UEC Stroke Pathway. Furthermore, the Children, Young People & Maternity (CYPM) Local Maternity System Group has good representation.

2.3.2.2 The most significant gaps are in the Planned Care ENT, Cardiology, Ophthalmology, Diagnostic and Pain Management Improvement Projects, as well as the PCIN Falls Prevention, Dementia, Case Management and Stroke - Atrial Fibrillation Improvement projects. These are now the focus for recruiting representation.

2.3.3 Communication & Engagement Planning

2.3.3.1 Our Communication & Engagement Plan, published in December 2016 (attached as Annex 1) has provided the framework for focussed activity as the STP moved from design to implementation. The Plan's work programme has been overseen by the STP Communications Cell – a representative group of the senior communication colleagues from partner NHS organisations, Social Services Local Authorities, Cambridge University Health Partners and NHS England.

2.3.3.2 The Plan is currently being refreshed to capture the focus for Communication & engagement over the next six to nine months, for example, ensuring a greater focus on communicating STP delivery and achievements.

2.3.4 Guide to Effective Communication n& Involvement in STP Implementation

2.3.4.1 In July 2017, we published a *Guide to Effective Communication n& Involvement in STP Implementation* (Attached at Annex 2) - a set of useful resources, best practice and example documentation to support effective communication & involvement in Fit for the Future Improvement projects. The publication was accompanied by training sessions for relevant colleagues.

3. ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

3.1 The STP is relevant to priorities 1, 2, 3, 4 and 6 of the Health and Wellbeing Strategy:

- Priority1: Ensure a positive start to life for children, young people and their families.
- Priority 2: Support older people to be independent, safe and well.
- Priority 3: Encourage healthy lifestyles and behaviours in all actions and activities while respecting people's personal choices.
- Priority 4: Create a safe environment and help to build strong communities, wellbeing and mental health.
- Priority 5: Create a sustainable environment in which communities can flourish.
- Priority 6: Work together effectively.

Annex 1: *Fit for the Future* Communications & Engagement Plan

Annex 2: Guide to Effective Communication n& Involvement in STP Implementation

STP Communications & Engagement Plan

1. Introduction

This plan proposes approaches for the programme-wide engagement and communications:

- communicate key messages
- promote the work and future plans
- advertise opportunity to get involved with the groups' development work
    - engage with, and get input from staff
    - engage with, and get input from service users
    - engage with, and get input from stakeholders
- support programmes to educate service users and empower staff

This plan links to the overarching Communications and Engagement Strategy, and delivery groups' plans.

2. Background

From our draft Sustainability and Transformation Plan, produced in June 2016, we know that we need to develop improved communication and stronger working relationships across our organisations.

We also need a shared culture that means we can learn and make improvements together. We are committed to delivering the healthcare you need - working together as one system with one budget.

We have much to be proud of and are well placed to make the changes we need. Cambridgeshire and Peterborough has a committed and expert health and care workforce. We provide some excellent services to which people travel from other parts of the country. We host groundbreaking research and deliver excellent medical education and training. We have a resourceful voluntary sector, strong organisations, active local communities, and we work alongside research and technology industries which are world leaders in improving healthcare.

Through discussion with our staff, patients, carers, and partners we have identified four priorities for change and developed a 10-point plan to deliver these priorities.

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

3. What it means for staff

Networks of care: Our approach is to move knowledge and not patients wherever possible and appropriate. Our acute clinicians are beginning to agree how to work as operational networks of care, sharing protocols for referrals, using best practice to determine treatment, building workforce resilience through an enhanced career development offer, sharing out-of-hours rotas, and offering flexibility to match staffing requirements with available physical capacity.

Our new, networked approach to care will mean that our staff and GPs will be asked to think of themselves as part of the Cambridgeshire and Peterborough system, not just the organisation that employs them. Although this is a new way of working, we believe that it will benefit staff by presenting new career development opportunities, reducing frustrations arising from poor inter-organisational communications, and that it will make our services more resilient particularly out-of-hours. The relationship between Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and provider organisations will need to evolve from one that is transactional to one that is outcome focused, strategic, transformative, and equitable.

For all specialties, including those where physical consolidation does not make sense such as ophthalmology and obstetrics, the service will increasingly be run as one across the acute sites making the most of the expertise we have in some providers.

Skills flexibility: Many of the emerging new models of care, including our aspiration to operate in care networks, require both the current and future workforce to work more flexibly across locations. We will seek to develop the flexibility of our workforce and to normalise working patterns that, at times, may see individuals working in different organisations at different times in line with the demand for our services and our capacity to deliver them.

Similarly our HR model will need to become more flexible, and where possible we will do things in common for example via staff passports, to enable staff to move between organisations more easily.

Promote direction of travel and service changes: We will communicate the proposed changes, progress and what it means for system-wide services and teams. We will celebrate successes and acknowledge what we have learnt.

4. What it means for patients and service users

Our engagement and communications with the public aims are:

Publicising our plan: We will articulate our vision for health and care by telling a compelling story which describes the benefits of our proposals, for patients and local people. This will help us to achieve the transformational changes required.

Co-designing care models: We will work with our health and care users, including those who require the most intensive support, to ensure that the care we design is person-centred and promotes independence. We will need to engage fully with the public about service redesign that will change how and where they access services. We aim to develop a patient choice hub to ensure the care we offer is person-centred and promotes independence.

Promote direction of travel and successes of service changes: We will communicate the proposed changes, progress and successes. What it means for them and their families and communities.

Supporting behavioural change among patients and residents: We will work with the public to promote healthy behaviours and individual responsibility for health and wellbeing, stressing to our population the importance of leading healthy lives. We see ourselves as partners with the public; we have a joint role in keeping healthy and we want to be sure that our local population is equipped with the tools they need to keep fit and well for as long as possible. We will provide education around appropriate and effective ways of using services including self-care, urgent care and A&E. We will re-educate people that A&E is only for serious or life threatening injury or illness.

5. Communications principles

The proposed approach is based upon these principles:

- Shared leadership of the communications and engagement programme, between the STP System Delivery Unit (SDU) and in-house communication leads of each partner (Comms Cell).
- Establishing and maintaining a central resource of consistent and coherent public-facing information through a STP website (standalone) and digital/social media channels, with links to and from partner organisations to ensure wider reach
    - The key projects and activity matches those in the CCG and trusts e.g. GP member communications by CCG, Vanguard in CPFT, merger Communications in HHCT and PSHFT, so a joined-up approach will be taken for communications on these projects.
- Predominant use of 'borrowed' channels for delivery (i.e. cascade by and through partner organisations), as this represents both the most cost effective approach and the ability to use credible, recognised channels.
- Widely distributed regular briefings, with staff communication tailored and cascaded locally, and differentiated between organisations and teams (where appropriate).
- Support to leaders throughout the system to represent and champion the STP and emerging plans, including how to use core materials and messaging.
- Close management of key stakeholders to ensure that they are heard and 'no surprises', led via named relationship managers, and coordinated and supported by the programme team (SDU).
- A single engagement programme to enable co-design and support pre-consultation
    - The key stakeholders will mirror those in the CCG, Trusts and local authorities, so a joined-up approach will be taken for engagement and pre-consultation.

6. Our communications aim to:

- Continue to raise awareness
- Build confidence in STP
- Build understanding
- Provide reassurance
- Build pride in the plan

- Build relationships
- Build public support
- Build a reputation of trustworthiness and integrity

7. Our approach

- Build on what is in place and planned:
    - social media campaigns, website & STP narrative
- Develop the Fit for the Future brand:
    - throughout materials
    - so seen as whole system brand
- Developed with partners:
    - idea development
    - content development
    - cascade / supporting (retweets etc)

8. Key Messages

Key messages will be developed from the Case for Change and draft Sustainability and Transformation Plan, and ongoing engagement.

These will be used across the communications and engagement materials, and included in any FAQs.

The messages will target appropriate stakeholders.

9. Audience

A stakeholder list in the Communications and Engagement Strategy identifies the key audiences for the communications and engagement. See Appendix A.

For this plan the audiences are grouped as:

- **Programme and group members** – executives, management, clinical and care leads, and partner staff and patient representatives working across projects and delivery groups
- **Staff** – across all organisations not directly working on the STP projects or groups
- **GPs** – across all practices and federations
- **Key stakeholders** – including MPs, scrutiny groups, Health and Wellbeing Boards, Healthwatch, unions, patient reference groups/patient participation groups
- **External** – public, service users and patients, media and social media followers

10. Channels

Sustainability and Transformation Plan and 'borrowed' channels for delivery (i.e. cascade by and through partner organisations), as this represents both the most cost effective approach and the ability to use credible, recognised channels.

Sustainability and Transformation Plan channels:

- Monthly on-line newsletter
- Website - www.fitforfuture.org.uk
- Social media campaigns - Twitter: @fitforfuturenhs, Facebook: fitforfuturenhs & Instagram: fitforfuturenhs
- Slides for staff briefings (established channels: staff internal communications, GP communications channels (LMC committee)
- Video – STP-produced videos, Vlogs
- Blogs
- Articles produced for staff communications/cascade (Intranets, emails, newsletters)
- Face to face – stalls, events, workshop presentations
- STP-produced documents, leaflets, posters & FAQs
- Word of month – staff as champions
- Media

11. Evaluation

Feedback will be sought from all communications and engagement activities. In addition, the communications and engagement will be evaluated, including:

- Number of comments received/questions raised
- Attendance figures for events (both internal and external)
- Fit for Future website usage
- Social media – reach and conversations
- Media evaluation
- Feedback from patient and carer groups, including Healthwatch and voluntary organisations.

12. Communications and engagement programme

Communications planning

Proactively managing and generating content

- Nominated leads - matched to their CEO Accountable Officer
- Specialist leads, where appropriate e.g. Elective improvement projects lead by CCG, with Cardiology supported by Papworth Comms Lead
- Includes communications and patient & public involvement
- Attend key meetings
- Advise on stakeholder management and risk management
- Identify key messages with Comms Cell and CEO
- Use Fit for the Future branding and templates (to be developed)
- All consultations continued to be led and managed by CCG

A theme a quarter: 1st quarter: Partnership working – 'Delivering Together'

- Communications promotes and supports theme
- To demonstrate the added benefit of the system-wide, Fit for the Future having impact

Topics

- Improvement project communications leads provide proactive, ongoing communications and engagement management
- Leads to produce delivery groups' timelines
- Comms Cell to converts timelines into a master communications planning document, shared and agreed at meetings/calls

Theme for 1st quarter- Delivering Together (to be demonstrated in key messages: "What STP activity added value as a system")

Programme and group members	Staff	GPs	Key stakeholders	External
HCE and CAG Updates, staff newsletters	Slides for briefings, newsletters articles, emails, STP Newsletter, intranets, social media	5 headline slides for briefings, GP News, LMC briefings, STP Newsletter, social media	Reports, briefings, presentations, emails, STP Newsletter, website, social media	Meetings, emails, STP Newsletter, website, social media

13. Public involvement in our STP

Principles

1. Shift from concept to delivery
2. Patient and carer involvement to improve services and in delivering change
3. Public engagement to develop priorities, strategies and plans
4. Community engagement to identify needs and aspirations

Approach

- Build on reps previously involved in CWGs, workshops, PIAs and who have contacted us since the summer summary publication and last month's launch
- Healthwatch to advise how it can support Delivery Groups
- Accountable Officer, Comms Leads and Healthwatch Cambs to:
    - review group's PPI opportunities – identify reps or groups that can be targeted
    - review appropriate stages for PPI – depending on development of group and schemes
    - explore involvement of voluntary sector and local government
    - build members - staff and PPI reps - to be voices for the improvements and change - in their organisations, peer groups, families and communities
    - commitment to recent NHSE guidance on 'Engaging local people in STPs' and CCG's commitment to 'Transforming public participation'

PPI proposed activities

Shift from concept to delivery

1. Bolstered patient and carer involvement in delivery and work groups
2. Promote Fit for the Future website as central point of contact with up to date information on activity and progress
3. Advertise the opportunities – ongoing and events

Patient and carer involvement to improve services and in delivering change

As above, plus,

1. Develop a network for practical support to individuals involved in programme
2. Develop opportunities for groups to develop their involvement skills e.g. quality events, conference or guides
3. Involvement in consultations about specific areas of significant change

Public engagement to develop priorities, strategies and plans

1. Develop public involvement assemblies, building on 2015 and 2016 events
2. Look at independent facilitated public participation panels to generate values on prioritisation - to give a public perspective on questions asked by the executive

Community engagement to identify needs and aspirations

1. Target hard to reach groups – content and timings to be defined
2. Consultations about specific areas of significant change
3. Promote behavioural change and a wider conversation on prevention and resources

Key external stakeholders

For Cambridgeshire and Peterborough STP

NHS/Partners

- Department of Health
- NHS England and its local offices
- Cambridgeshire and Peterborough CCG Member Practices
- Local Medical Committee (LMC)
- Local Pharmaceutical Committee
- Independent and salaried contractors: GPs, dentists and pharmacists
- Optometrists
- NHS provider Trusts
- Bordering CCGs
- Private and voluntary sector providers
- Health and Wellbeing Boards: Cambridgeshire, Peterborough, Northamptonshire, Hertfordshire, Rutland & Lincolnshire
- Health Overview and Scrutiny Committees: Cambridgeshire, Peterborough, Northamptonshire, Hertfordshire, Huntingdonshire, Rutland & Lincolnshire
- Education: University - health sciences, research, innovation and training
- Media
- Other Public Services i.e. police, fire etc
- Social Partnership Forum

Patients and the public

- People who use local health services and their carers
- Patient Participation Groups (PPGs)
- Patient Forums
- BME or community groups who traditionally experience difficulties accessing NHS services
- Our residents in Cambridgeshire and Peterborough, Oundle, Wansford and Royston
- Interest groups
- Voluntary, community and third sector organisations
- Charitable organisations
- Healthwatch organisations: Cambridgeshire, Peterborough, Northamptonshire, Hertfordshire, Rutland & Lincolnshire
- Governors of local Foundation Trusts
- Lay representatives on local Boards

Local Government

- Politicians: MPs for Cambridge, North East Cambs, South East Cambridgeshire, South Cambs, North West Cambs, Huntingdon, Peterborough, Corby & East Northants, North East Herts, Grantham and Stamford, Rutland and Melton, South Holland and The Deepings, Leicester East, Leicester South and Leicester West & Bedford
- Cambridge County Council and Peterborough City Council - leaders, councillors, chief executives and officers
- District Councils - leaders, councillors, chief executives and officers
- Unitary Councils - leaders, councillors, chief executives and officers
- Town and Parish Councils - leaders, councillors, and officers

Appendix B – Three-month planner

Three-month planner – communications and engagement		
January 2017	**February**	**March**
• Quarterly comms themes & key messages - Jan focus • tbc, publication of mental Health Strategy • Local Digital Roadmap published • 4 Jan, any pre-local election consultations need to start • Patients, carers, public & staff involved in delivery groups • Delivery groups & schemes comms & engagement plans	• Quarterly comms themes & key messages - Feb focus	• Quarterly comms themes & key messages - Mar focus • Weds 29, Latest Purdah starts for local elections 4 May
Tues 3, Hunts Overview and Scrutiny Panel	Thurs 2, CCG Patient Reference Group	Thurs 2, Herts Health and Wellbeing Board
Thurs 5, C&PCCG Patient Reference Group	Tues 7, C&PCCG Governing Body Meeting	Thurs 2, CCG Patient Reference Group
Tues 10, Peterborough Scrutiny Commission for Health Issues	Weds 8, CUHFT Board of Directors' Meeting	Tues 7, Huntingdon Overview and Scrutiny Panel
Tues 10, C&PCCG Governing Body Meeting	Weds 8, CCS Board Meeting	Weds 8, CUHFT Board of Directors' Meeting
Tues 10, Hunts Patient Congress	Tues 14, Greater Peterborough Patient Forum	Weds 8, CCS Board Meeting
Tues 10, Greater Peterborough Patient Forum	Thurs 16, Cambridgeshire Health Committee	Tues 14, Hunts Patient Congress
Weds 11, CUHFT Board of Directors' Meeting	Tues 21, Healthwatch Peterborough Community Meeting	Tues 14, Greater Peterborough Patient Forum
Weds 11, CCS Board Meeting	Weds 22, CUHFT - Council of Governors Meeting	Tues 14, Peterborough Scrutiny Commission for Health Issues
Thurs 12, Cambridgeshire Health Committee	Tues 28, PSHFT Public Board Meeting	Weds 15, Cam Health Patient Forum
Weds 18, Healthwatch Peterborough Community Meeting		Weds 15, Healthwatch Cambridgeshire Board of Directors
Weds 18, Cam Health Patient Forum		Thurs 16, Cambridgeshire Health Committee
Weds 18, Healthwatch Cambridgeshire Board of Directors		Fri 17, Northants Scrutiny Committee
Thurs 19, Northants Health and Wellbeing Board		Tues 21, CCG Governing Body Meeting
Thurs 19, East Northants Health and Wellbeing Board		Thurs 23, Peterborough Health and Wellbeing Board
Thurs 19, Cambridgeshire Health and Wellbeing Board		Thurs 23, Northants Health and Wellbeing Board

Thurs 19, Herts Health Scrutiny Committee		Thurs 23, CATCH Patient Forum
Tues 24, Fenland Health and Wellbeing Board		Thurs 30, Cambs Health and Wellbeing Board
Tues 24, South Cambs Local Health Partnership		Thurs 30, HHCT Board Meeting
Weds 25, Huntingdon Health and Wellbeing Group		Thurs 30, Papworth Board meeting
Weds 25, MP Westminster briefing		
Thurs 26, CATCH Patient Forum		
Thurs 26, HHCT Board Meeting		
Thurs 26, Papworth Board Meeting		
Tues 31, Rutland Health and Wellbeing Board		
Tues 31, Huntingdon Overview and Scrutiny Panel		
Tues 31, PSHFT Council of Governors		

Staff communications

CUH	CEO - Weekly cycle 8.27am Tues for 30mins Weekly nurses forum Regular consultants' forum Chair/CEO/senior manager drop-in bi-monthly Team Brief Cascade	CPFT	Monthly cycle (Department heads meeting Tuesdays every 4-5 weeks) Wider leadership every 3 months Exec Team Roadshow every 6 months	CCS	Leadership forums (c100 leaders) Clinical scrutiny (clinical leads) - every other month Paeds consultant & nursing leads meeting
		HHCT	Monthly Open Forums - CEO drop-in briefings	PSHFT	Weekly (Monday) email newsletter Monthly Team Brief – Post board meeting

Cambridgeshire and Peterborough Sustainability and Transformation Partnership (STP)

Guide to Effective Communication & Involvement in STP Implementation

Final Version 19.07.17

Content

1. What is this Guide?

A set of useful resources, best practice and example documentation to support effective communication & involvement in *Fit for the Future* Improvement projects.

.

2. Who is this Guide for?

This guide is for anyone who is involved in implementing an Improvement Project within the Cambridgeshire & Peterborough *Fit for the Future* (STP) Programme. Colleagues who will find this guide of use are:

- Project Leads
- Clinical Leads
- Senior Responsible Officers (SRO)
- Accountable Officers (AO)
- Patient/Public representatives
- Human Resource Leads.

The Guide will also help communication and engagement specialists from across the STP partner organisations as it pulls together, in one place, the templates, tools and guidance used in the day-to-day operational delivery of effective communications and engagement.

3. What do we mean by involvement?

Involvement is about enabling people to voice their views, needs and wishes, and to contribute to plans, proposals and decisions about services, as well as how changes are delivered. Our use of the term 'patients and the public' includes everyone who uses services or may do so in the future, including carers and families.

The term 'involvement' is used interchangeably with 'engagement', 'participation', 'consultation' and 'patient or public voice' and there are many different ways to involve patients and the public, as illustrated below and as set out in the Supporting Resources at the end of this section.

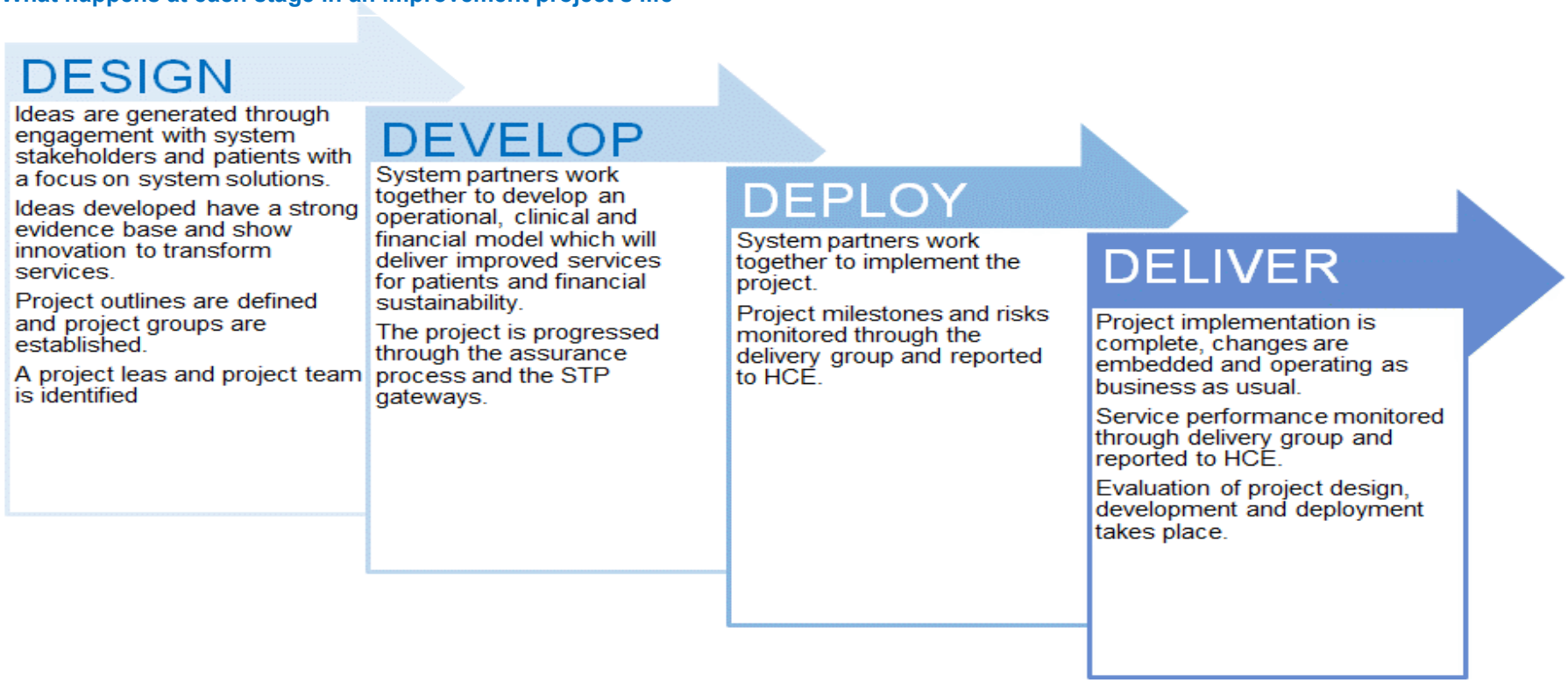
Different approaches will be appropriate, depending on the nature of the activity and the needs of different groups of people.

4. From Planning to Implementation

As the STP moves from planning into implementation and delivery, it became apparent that we needed a clear and consistent structure to frame the various processes across the STP to reduce confusion and ensure appropriate accountability across the 'lifecycle' of the STP improvement projects.

We have identified 4 stages in an improvement project's life - Design, Develop, Deploy and Deliver – and the diagrams below describe in more detail what happens at each stage.

What happens at each stage in an improvement project's life

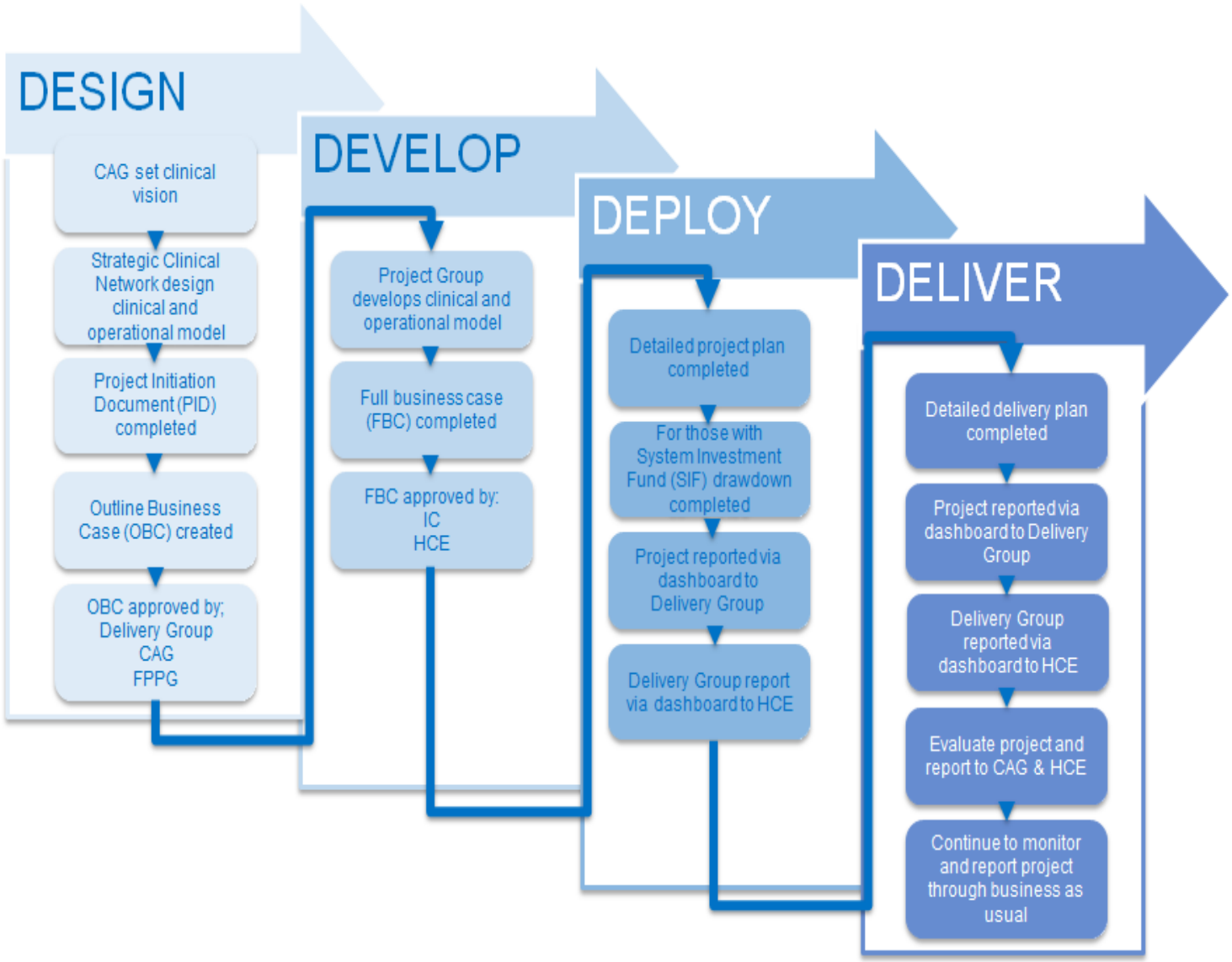


The System Delivery Unit (SDU) has developed a suite of guidance documents and tools to support understanding of what is required at each stage in terms of:

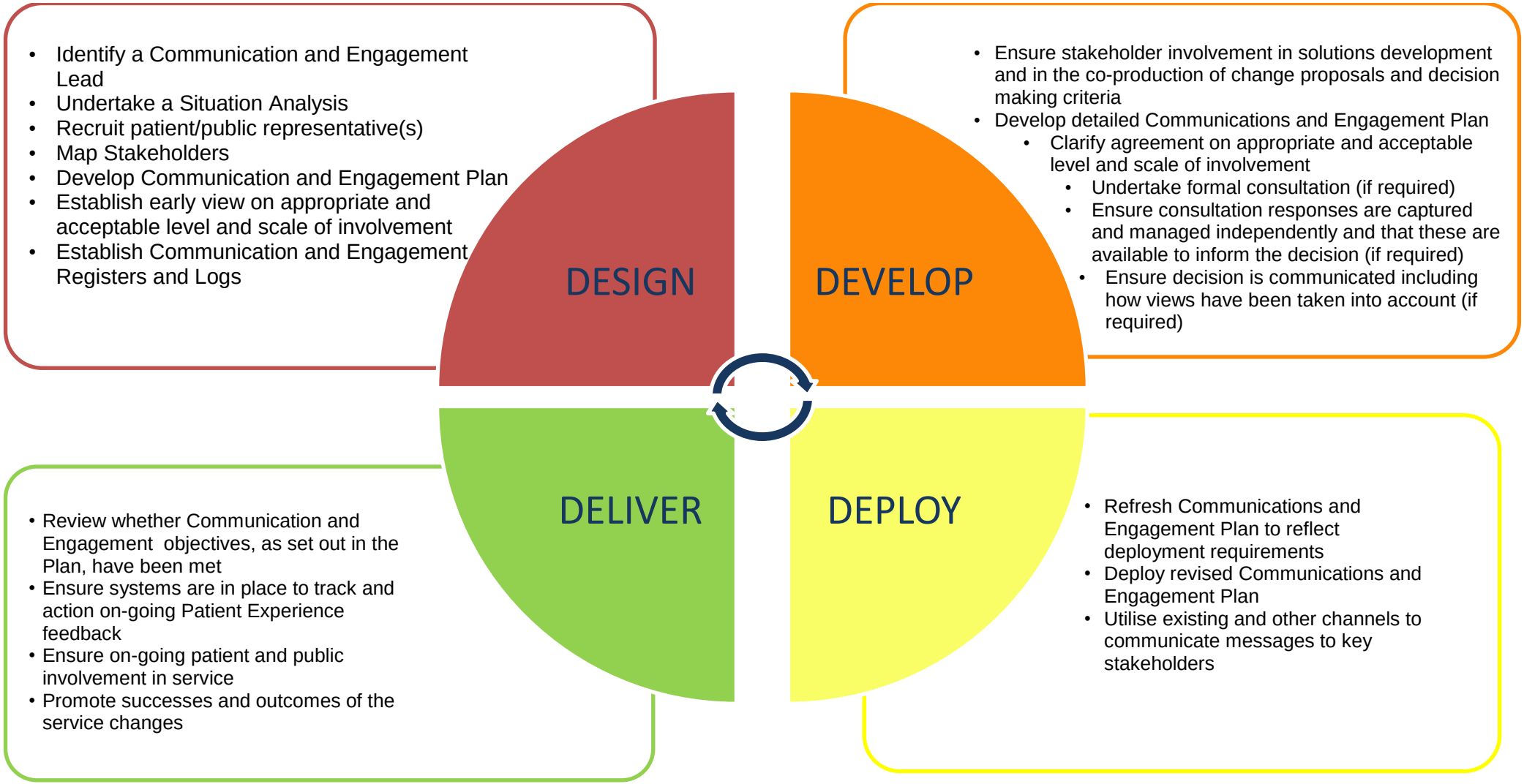
1. The respective roles and responsibilities;
2. The reporting requirements;
3. The governance requirements;
4. ***The communication and involvement requirements.***

This Guide addresses the latter requirement and provides practical advice, guidance and tools to effectively communicate with and involve stakeholders in STP Improvement projects

How a project moves through each stage



The diagram below sets out the communication and involvement inputs to be considered at each of the 4 stages and Section 7 of this Guide provides more detail on the key inputs.



Communication and Involvement inputs at each Improvement Project stage

5. Why is involving people, communities and stakeholders important?

Involving people, communities and stakeholders in STP Improvement Projects is the right thing to do to ensure that planning, decision making and delivery is robust and meets the needs of people and communities. Our aim must be to work in co-production with the knowledge, skills and experience of people in their communities.

Involving people, communities and stakeholders meaningfully is essential to effective service improvement and system transformation, from collectively identifying problems and designing solutions to influencing delivery and review. Effective communication and involvement throughout the process will help to build ownership and support for proposals to transform health and care and will also help identify potential areas of concern.

In addition, NHS partners with responsibility for the STP have a number of legal duties including to involve the public in the exercise of their statutory functions. Not doing so effectively runs the risk of legal challenge and lengthy delay. A well thought through and documented engagement approach, that involves local stakeholders on an ongoing basis and identifies those experiencing the greatest health inequalities, will lead to:

- the development and delivery of better quality solutions;
- Project solutions that draw on a range of insight and expertise, including from patients and the public; and
- reduced risk of legal challenge.

Healthwatch Cambridgeshire & Peterborough have produced a useful summary guide to standards and methodology for involvement and consultation in Fit for the Future implementation and the Guide can be found in the Supporting Resources at the end of this section.

6. Legal duty to involve Patients and the Public

The key relevant statutory duty that will need to be adhered to in STP delivery is set out in:

- Section 14Z2 of the Health and Social Care Act 2012 for CCGs and NHS England; and
- Section 242 of the NHS Act 2006 for other NHS bodies.

Section 14Z2 of the Health and Social Care Act 2012

This places a requirement on CCGs to ensure public involvement and consultation in commissioning processes and decisions including involvement of the public, patients and carers in:

- planning of commissioning arrangements, which might include consideration of allocation of resources, needs assessment and service specification; and
- proposed changes to services which may impact on patients.

Section 242 of the NHS Act 2006

This places a duty of care on those providing health services to make arrangements to involve users of services.

The relevant clauses in the Acts are as follows:

… must make arrangements to secure that individuals to whom the services are being or may be provided are ***involved (whether by being consulted or provided with information or in other ways)*** –

a) in the ***planning*** of the commissioning arrangements by the group;

b) in the ***development and consideration or proposals*** by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and

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

It is important to note here that the ***legal duty is to involve*** and that involvement can be undertaken effectively in a variety of ways, as set out in the Supporting Resources at the end of this section.

There is not a legal duty to consult, although formal consultation may be necessary, as agreed with the relevant Overview & Scrutiny Committee(s). More guidance is set out in the Supporting Resources at the end of this section.

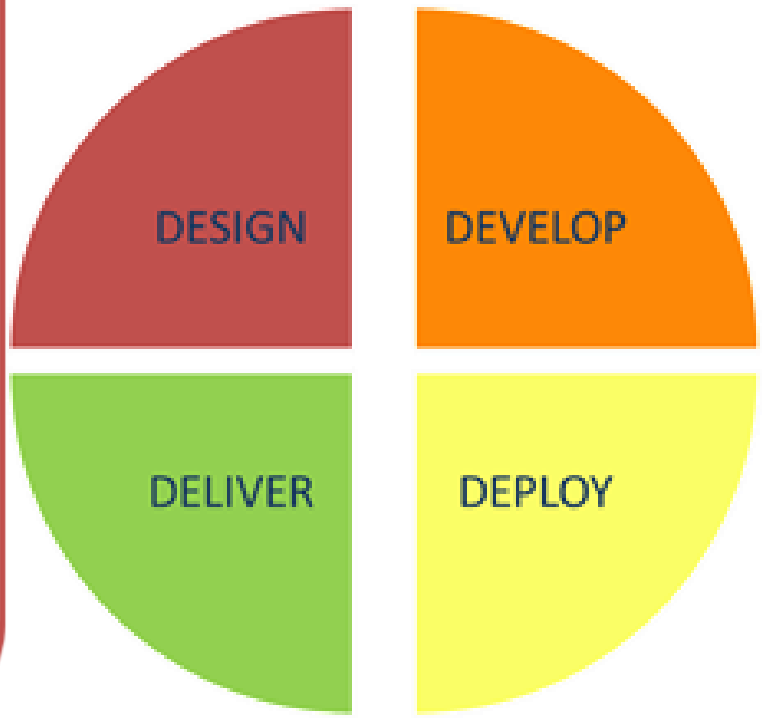
Supporting Resources:

- Resource 1 - Healthwatch Cambridgeshire & Peterborough Guide
- Resource 2 - The Participation Toolkit
- Resource 3 - Legal Duties for NHS Bodies for Involvement

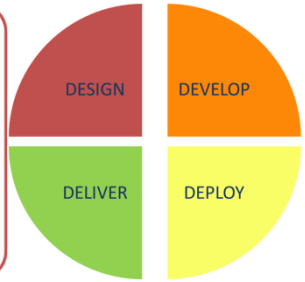
7. Communication & Engagement Guidance and Resources

This section provides more detailed guidance on those key inputs needed to successfully communicate with and involve stakeholders in your Improvement Project, as well as supporting resources, tools and templates.

- Identifying a Communication and Engagement Lead
- Undertaking a Situation Analysis
- Recruiting patient/public representative(s)
- Stakeholder Mapping
- Communication and Engagement Plan
- Communication and Engagement – Key Supporting Documentation
- When and how to communicate and involve



7.1: Identifying a Communication and Engagement Lead



KEY POINTS

1. The Delivery Group Communication and Engagement Lead:

- is matched to their CEO / Accountable Officer (AO) (See table below);
- has a key relationship with their AO/Senior Responsible Officer (SRO);
- will have a communications and engagement oversight of the whole Delivery Group, working with the AO/SRO;
- is a member of the Delivery Group and should attend Delivery Group meetings; and
- is responsible for ensuring that each 'live' Improvement Project/Scheme within the Delivery Group has a Communication and Engagement Lead.

2. Each 'live' Improvement Project/Scheme within a Delivery Group will also be allocated a Communication and Engagement Lead – to be matched by their skills and knowledge. This may be a different lead to the Delivery Group Communication and Engagement Lead and may be from a different system partner organisation.

3. The Delivery Group Communication and Engagement Lead is responsible for the overall communications and engagement for the Delivery Group – so will need to work with any other supporting Communication and Engagement Leads allocated to their Improvement Project/Schemes.

4. Each 'live' Improvement/Project Scheme should have a Communication & Engagement Plan to be written by the Improvement Project/Scheme Communication and Engagement Lead.

5. Improvement Project/Scheme Communication and Engagement Leads will collate project timelines – of key stages/dates – for the Delivery Group Communication and Engagement Lead and to be reviewed and managed by the Communications Cell.

Delivery Group Communication & Engagement Leads

Lead	Urgent & Emergency Care (UEC)	Primary Care & Neighbourhood Teams (PCIN)	Planned Care	Children, Young People & Maternity	Shared Services
AO	Roland Sinker	Aidan Thomas	Tracy Dowling	Matthew Winn	Stephen Graves
Communication & Engagement	Dail Maudsley-Noble	Andrea Grosbois	Sue Last	Karen Mason	Aidan Fallon

Enabling Group Communication & Engagement Leads

Lead	Digital	Local Workforce Advisory Board (LWAB)
AO	Stephen Posey	Matthew Winn
Communication & Engagement	Kate Waters	Karen Mason

OTHER ROLES & RESPONSIBILITIES

1. It is the responsibility of the Delivery Group SRO to ensure that resources are identified for communication, involvement, marketing and other associated activities. The Implementation Project Business Case should identify resources needed for HCE approval.
2. Events will be managed within the Implementation Project teams – with advice and support from their communication & Engagement Lead
3. Media will be managed by the Communication Cell (review media protocol)
4. The Fit for the Future website web master is the STP Communications Manager working in the System Delivery Unit (SDU).

5. The STP Head of Communication & Engagement will be responsible for the Communication Cell, supported by the STP Communications Manager

6. Fit for the Future templates will be provided, where appropriate

7. Activity and messages will be branded *Fit for the Future*

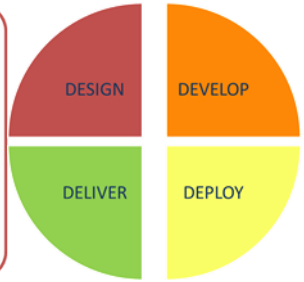
8. Messages will be approved by Delivery Groups, CAG or HCE

9. Existing channels will continue to be used for external and internal communications

Supporting Resources:

- Resource 4 - Delivery Group and Improvement Project Communication & Engagement Leads

7.2: Undertaking a Situation Analysis



KEY POINTS

1. A situation analysis involves checking out what has already happened and/or what is already in place in respect of Communication and involvement. The beginning of an Implementation Project doesn't necessarily mark the beginning of the involvement of stakeholders.

2. Consider the following:

- **Has a 'Case for Change' already been made?** The Cambridgeshire and Peterborough STP published an **Evidence for Change** document in March 2016 See Supporting Resources at the end of this section) and which had extensive stakeholder involvement. Although this document is STP system-wide, it may contain elements of the case for change for your specific Improvement Project.

- **What individuals and Groups are already involved?** Disease or condition specific groups, patient groups, staff members, clinicians, and other stakeholders may already be actively engaged with the work and can be recruited as champions. Stakeholder Mapping will help you identify those who may already be involved.

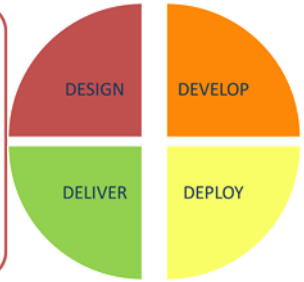
- **What involvement activities have already taken place?** What, if any, stakeholder meetings, focus group work, surveys, patient stories, etc. have already happened? The documented outcomes of such activities can inform the change process and means you don't need to cover the same ground again. Also, stakeholders won't appreciate being asked for their views on the same issues multiple times.

- **What communication channels already exist**? Don't create new channels of communication unless these are necessary. Communication colleagues will have regular channels for both external and internal communication that you can use. Many voluntary sector and community groups have their own communication mechanisms that can be used to inform and engage with stakeholders. Remember that Healthwatch will also be happy to let you use their communication channels and networks.

Supporting Resources:

- Resource 5 - Cambridgeshire & Peterborough STP Evidence for Change

7.3: Recruiting patient/public representative(s)



KEY POINTS

1. All Delivery Groups and 'live' Improvement Project/Schemes within a Delivery Group should have, wherever possible, at least one patient/public representative.

2. It is the responsibility of the Delivery Group Communication and Engagement Lead, working with the STP Head of Communications and Engagement to ensure patient/public representation within the Delivery Group programme of work. Other key partners in ensuring this are the Improvement Project/Scheme Project Lead and Communication and Engagement Lead.

3. We have developed a Process for Recruiting Patient/Public Representative(s) including advice on groups and organisations that can support you and/or provide representatives and this can be found in the Supporting Resources at the end of this section.

4. All patient/public representatives should:
    a. have a role description (see supporting resources);
    b. be provided with an induction to the Group and be given a Support Pack;
    c. have a named link person for support;
    d. be reimbursed for any costs they may incur as part of their involvement.

5. The central role of the patient/public representative is to provide their own views and opinions to inform the work of the Group and is not to ensure wider engagement with patients and the public.

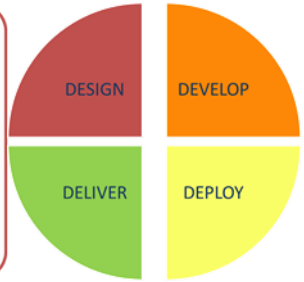
6. Although an essential contributor, the patient/public representative cannot provide all requirements for patient and public involvement in a project. Stakeholder Mapping will identify all those individuals, groups and organisations with an interest and who's involvement needs to be sought at different stages.

7. The Delivery Group and/or Improvement Project/Scheme Communication and Engagement Lead will support identifying and involving wider stakeholders.

Supporting Resources:

- Resource 6 - Process for Recruiting Patient/Public Representative(s) [Not currently available]
- Resource 7 - Patient/Public Representative Role Description
- Resource 8 - Patient/Public Representative Support Pack [Not currently available]
- Resource 9 - Reimbursement of Expenses Policy
- Resource 10 - FftF Patient & Public Reimbursement of Expenses Claim Form

7.4: Stakeholder Mapping



KEY POINTS

1. Stakeholders are those individuals or groups who depend on the NHS to fulfil their own goals and on whom, in turn, the NHS depends. Stakeholders can be patients, the public, local communities, councillors, NHS England, clinicians, staff, unions, etc.

2. It is important to understand stakeholder expectations and the extent to which they are likely to seek influence over the changes that you are seeking to make.

3. Stakeholder expectations will differ and stakeholders are rarely of equal importance. It is normal for conflict to exist between stakeholders regarding the importance or desirability of many aspects of service changes and this is a critical aspect of service change to understand and plan for – compromise between stakeholders may need to be facilitated.

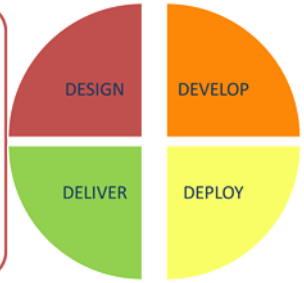
4. We have provided a useful guide to stakeholder mapping (see Supporting Resources at the end of this section).

5. We have also provided a list of stakeholders with whom we engaged in developing the Cambridgeshire and Peterborough STP (see Supporting Resources at the end of this section). Although it is highly likely that some of these stakeholders are relevant to individual Implementation projects/schemes within the STP umbrella, a stakeholder mapping exercise should be undertaken for each project to ensure that, for example, specific patient groups, staff groups or voluntary organisations with an interest in your service change are not overlooked.

Supporting Resources:

- Resource 11 - Guide to Stakeholder Mapping
- Resource 12 - STP Stakeholders

7.5: Communication and Engagement Plan



KEY POINTS

1. Each 'live' Improvement/Project Scheme should have a Communication & Engagement Plan to be written by the Improvement Project/Scheme Communication and Engagement Lead.

2. It is the responsibility of the Delivery Group Communication and Engagement Lead to ensure that a plan exists and is being implemented.

3. Why develop a Communication & Engagement Plan?

- A plan makes it possible to target communication and engagement accurately. It gives a structure to determine who needs to be reached and how;

- A plan makes communication and engagement efforts more efficient, effective, and lasting; and

- A plan makes everything easier. Time spend planning at the beginning, will save a great deal of time later on, because it will be clear what exactly should be happening at any point in the Improvement Project lifecycle.

4. The Plan should consider/include the following:

[**NOTE:** Detailed Guidance is included in the Template Communication & Engagement Plan in the Supporting Resources at the end of this section]

- **Clarify the purpose of the communication and engagement**

- **Include a situation analysis**. A situation analysis involves checking out what has already happened and/or what is already in place in respect of Communication and involvement for the Improvement Project (see Section 7.2 of this Guide).

- **Define the communication and engagement objectives.** These will be specific communication/engagement objectives (distinct from but supporting delivery of the overall Improvement Project's objectives) and these could relate to, for example:
  - Ensuring stakeholder co-production in project design, development, deployment and delivery;
  - Ensuring statutory duties to involve are met throughout the Improvement Project lifecycle; and
  - Achieving a change in patient behaviour.

  Objectives should be S.M.A.R.T

- **Identify the audience(s). Who** are the stakeholders affected by or having an interest in the Improvement Project? (See Section 7.4 of this Guide).

- **Plan and design messages. What** is the key messaging for the Improvement Project? These should be developed by the project team and should address, for example, what the Improvement Project is seeking to achieve, why it is happening and how it will benefit patients and other stakeholders.

- **Approach. How** is communication and engagement going to happen and what activities will be deployed? This is the range of tools and methodologies to be used and can include, for example, one-way communication approaches such as press releases, leaflets, displays and letters, to co-production approaches such as Solution Circles, Focus Groups and Citizens' Juries. The key point is that the approach should be appropriate and proportionate to the needs of the project and stakeholders (See Section 8.1 of this Guide).

- **Timescales. When** are the communication and engagement activities going to happen?

- **Channels. Where** is the communication and engagement going to happen? Wherever possible, existing channels should be used, for example, staff newsletters, Healthwatch newsletters, Fit for the Future Website, GP Gateway, patient and service user groups, etc.

- **Resources.** Will a bespoke website be needed? What about video's, marketing materials, workshops, venue hire and social media costs? The Plan must set out all the anticipated costs of communication & engagement activities associated with the Implementation Project. Some costs will be met from existing budgets and resources, e.g. specialist communication staff input, but other costs may be additional and should be identified for inclusion in the Improvement Project Business Case for approval with all other Project costs by the HCE.

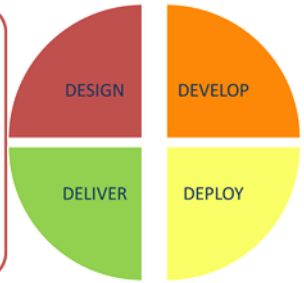
- **Create a tactical action plan.** This is the detailed week by week activities and is usually included as an appendix to the Communication & Engagement Plan. It should evidence when actions have been completed as a log of Implementation Project Communication and Engagement activities.

- **Evaluation.** How successfully have we delivered the communication and engagement objectives? This can be assessed by pre-determined measures such as attendance at events, social media reach and conversations, media evaluation, etc. Also, the reflections of key partners such as patient representatives and Healthwatch should be sought.

Supporting Resources:

- Resource 13 - Template Communication & Engagement Plan

7.6: Communication and Engagement – Key Supporting Documentation



KEY POINTS

1 **Record of Stakeholder Engagement.** This records all engagement activity and provides evidence that the Improvement Project has properly and effectively engaged with all key stakeholders. An on-going review will also highlight any areas where engagement has been missed or needs strengthening. A Template Record of Stakeholder Engagement can be found in the Supporting Resources at the end of this section.

2 **Communication & Engagement Risk & Issue Log.** Risks to the effective delivery of communication and engagement objectives should be recorded and managed via the Risk & Issue Log. This could include, for example, challenges in engaging effectively with particular key stakeholders such as GPs or could include risks to public confidence in a service. A Template Communication & Engagement Risk & Issue Log can be found in the Supporting Resources at the end of this section.

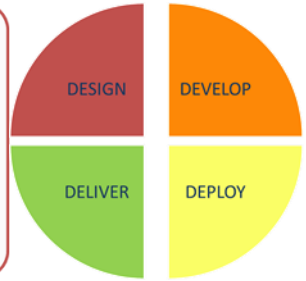
3 **STP Project Communication and Engagement Tracker.** As part of implementing the STP programme management approach, an Improvement Project Tracker template was developed to record project actions, risks, membership, performance and so on. The Template also incorporates a Communication and Engagement tab to track key tasks and milestones at each of the 4 stages of the Improvement Project lifecycle. This should be completed by the Improvement Project Communication and Engagement Lead once the Communication and Engagement Plan has been developed and should be updated in collaboration with the Improvement Project Lead as part of the routine reporting arrangements. The STP Project Communication and Engagement Tracker can be found in the Supporting Resources at the end of this section.

4 **Attendance Log.** It is essential that an evidential record is kept of who attended involvement events and activities and a Template Attendance Log can be found in the Supporting Resources at the end of this section.

Supporting Resources:

- Resource 14 - Template Record of Stakeholder Engagement
- Resource 15 – Template Communication & Engagement Risk Log
- Resource 16 - STP Project Communication and Engagement Tracker
- Resource 17 - Template Attendance Log

7.7: When and How to communicate and involve



KEY POINTS

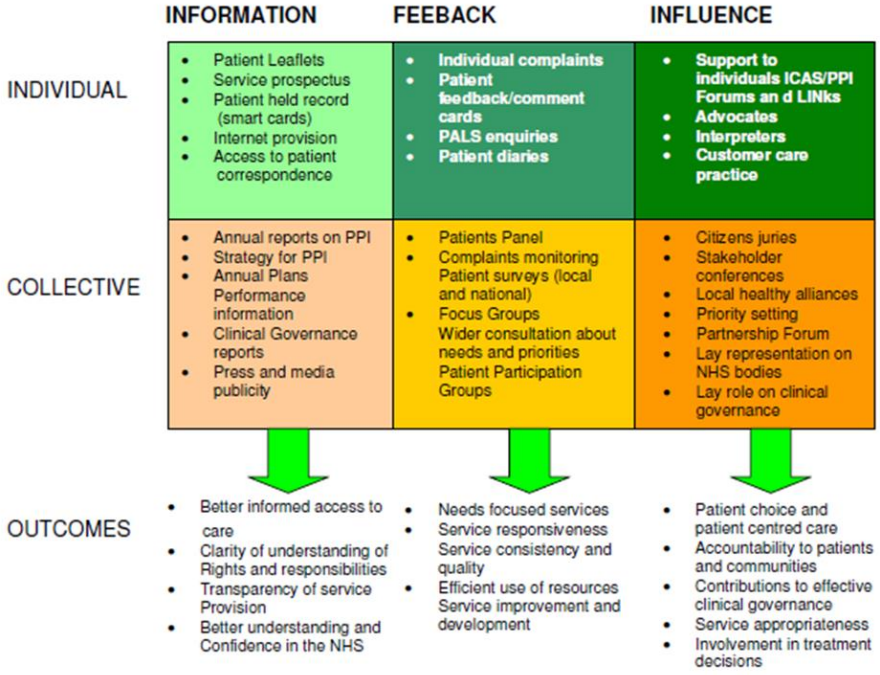
1. Communication and involvement should happen at each of the 4 stages in an Improvement Project's lifecycle. **It is not appropriate to develop solutions, proposals or decision making criteria in isolation of key stakeholders** who may be affected by or have an interest in the service change you are planning

2. In the worst case scenario, failure to effectively communicate and involve can lead to legal challenge. There are numerous cases of successful legal challenge to decisions made by NHS organisations, as well as the wider public sector, because due process was not followed by, for example, presenting change options as if there is no choice but those being proposed.

3. Therefore, a solid Communication and Engagement Plan is essential to identify and address the needs of all key stakeholders, from the outset.

4. How stakeholders are communicated with and involved can be flexible, depending on the circumstances, but it must be appropriate. For example, one Improvement Project may require little more than ensuring patients and service users receive service information, whereas another Improvement Project may require in-depth engagement and formal consultation.

5. The graphic below demonstrates this continuum of involvement from one-way communication, on the one hand, to co-production on the other hand.



5 The trick is to deploy the most effective methodologies to engage with the range of stakeholders you have identified. Rarely, if ever, will a single approach suffice because the needs of your various stakeholders will be different. For example, a weekday workshop may be fine to collect the views of retired people, however, it is unlikely to work if you also need to get the views of working parents. A public meeting is unlikely to excite the interest of teenagers, however, an effective social media campaign may have a better chance.

6 Avoid the mistake of focussing your engagement only on those stakeholders that are 'easy to reach' and/or readily available or willing to participate. The risk here is that you may collect the same narrow range of views. The reality is that some stakeholders will present a greater challenge to engage with because of, for example, cultural or language barriers, disabilities or attitudes to public services. This means that you will need to deploy more creative and bespoke approaches to engage effectively. It's likely to require time and energy, however, the effect is that your Improvement Project will be influenced by the widest range of stakeholder views.

7 The Scottish Health Council has developed an excellent web based and downloadable toolkit that describes an extensive range of innovative involvement methodologies and this can be found in the Supporting Resources at the end of this section.

Supporting Resources:

- Resource 2 - The Participation Toolkit

Agenda Item No: 12

JOINT STRATEGIC NEEDS ASSESSMENT CORE DATASET 2017

To: **Health and Wellbeing Board**

Meeting Date: **21st September 2017**

From: **Dr Liz Robin, Director of Public Health**

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

a) **discuss and comment on the information outlined in the Joint Strategic Needs Assessment (JSNA) Core Dataset 2017**
b) **note that information on themed Joint Strategic Needs Assessment work in Cambridgeshire can be found in the JSNA Summary of Themed Reports 2017**
c) **Consider the key health and wellbeing needs identified in the JSNA information presented, and how these should feed into revising the Joint Health and Wellbeing Strategy**

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1. PURPOSE

1.1 The purpose of this paper is to present the Joint Strategic Needs Assessment (JSNA) Core Dataset (2017) to the Health and Wellbeing Board.

2 BACKGROUND

2.1 The Health and Wellbeing Board has a statutory duty to joint assess the health and wellbeing needs of the population which it covers and to prepare a joint health and wellbeing strategy to meet these needs. In Cambridgeshire a regular programme of themed Joint Strategic Needs Assessments (JSNAs) is carried out with new themes for each year agreed by the Health and Wellbeing Board. These are outlined in the JSNA Summary of Themed Reports (2017) included at Appendix 1.

2.2 This year a detailed JSNA Core Dataset has also been prepared to provide an overview of health and wellbeing data and statistics in Cambridgeshire, including benchmarking and trends, in preparation for the revision of the Joint Health and Wellbeing Strategy, of which the current version runs from 2012-2017.

3. MAIN ISSUES

3.1 The JSNA Core Dataset Executive Summary (Appendix 2) identifies key points from the document as a whole, which are given in the following paragraphs. The full JSNA Core Dataset 2017 is available on the Cambridgeshire Insight website (link at the end of this report under Source Documents)

3.2 Population Health outcomes

- **Life expectancy** in **Cambridgeshire** in men and women is generally **above national averages** and premature and overall **death rates** are **low**. However, **Fenland** has relatively **lower life expectancy and higher death rates**, at levels around and sometimes below England's and there are also **important gaps** in life expectancy and mortality in **deprived areas of Cambridgeshire** compared with more affluent ones. This pattern is generally maintained for the principal causes of death.
- Levels of **disability** and **general ill-health** are generally **low in Cambridgeshire**, but are **higher in Fenland**
- The general practice (GP) recorded **prevalence** of some specific long-term conditions like **diabetes** and **cancer** appear to be **higher** in **Cambridgeshire** than nationally, but this is influenced by GP clinical recording quality, varying age structures and deprivation, the as well as the amount of disease in the population. **Fenland** tends to have the **highest prevalence** rates for many diseases.
- The picture for **mental health** is again influenced by GP recording and access to services, with the **highest** recorded prevalence of more **severe mental illness** in **Cambridge** and the prevalence of **depression higher** in **Fenland** and **Huntingdonshire**.
- **Self-harm** appears to be a particular **issue across Cambridgeshire**, with sustained high rates of emergency hospital admissions and increasing trends at levels above the national average in all districts other than South Cambridgeshire and **notably high levels in Cambridge City**. However this

may reflect recording issues, hospital A&E practices, and repeated admissions of individuals, as well as overall population prevalence.

- **Suicide** rates in Cambridgeshire do not differ significantly from England levels. **Male** rates are higher than female rates. **Fenland's male suicide rate** is significantly higher than the Cambridgeshire average. A continuing focus on **suicide prevention** is warranted.
- As the **population ages** a continuing **focus on dementia** will be necessary, along with surveillance of dementia and Alzheimer's disease as a potentially emerging and increasingly important cause of death.

3.3 Health and social care usage

- In terms of **NHS healthcare services**, the **numbers** of **total** and **emergency** inpatient **hospital admissions increased** over time in all districts from 2011/12 to 2015/16, and numbers of **elective admissions increased** over this period in **Cambridge**, **Fenland** and **Huntingdonshire**. In general, **rates** of all types of **hospital admission** are **highest** in **Fenland** and **Huntingdonshire**. Numbers and rates of **accident and emergency** attendances have **increased** in **all districts.**

- The **Adult Social Care Outcomes Framework** indicates that the only indicator that is statistically significantly **worse** than England is the proportion of people who use services who say that those services have made them **feel safe and secure**. Other indicators, where local values differ from national averages, but the differences are not formally statistically significant, may warrant some attention.

3.4 Demography and population growth

- **Cambridgeshire** and **all districts** have experienced recent overall **population increases** and, while these differ between areas in terms of levels and demographic structure (age), all areas are expected to **continue to experience growth** in the short, medium and longer term to 2036 whether based on **Cambridgeshire County Research Group (CCC RG)** forecasts or **Office for National Statistics (ONS)** population projections
- Although starting at a similar level in 2016, there are differences between **Cambridgeshire County Research Group (CCC RG)** population forecasts, which are house building policy–led, and **Office for National Statistics (ONS)** population projections which are based only on current population trends. **CCC RG** forecasts predict 151,000 more people by 2036 (a proportional rise of **23%**) and **Office of National Statistics (ONS)** projections predict 101,000 more (a proportional rise of **15%**).
- The proportional changes to 2036 across **districts are in the same rank** order whether CCC RG or ONS, but the levels of change are **larger** in the **CCC RG forecasts**.
- The **differences** between CCC RG forecasts and ONS projections are much **more marked** in the **child and working age** population groups than in the **older age** groups.
- To **2026**, **CCC RG** house-building policy led forecasts indicate a proportional change for Cambridgeshire's population of **16%** and **ONS** forecasts predict **9%.** The proportional changes across **districts** are **larger** in the **CCC RG forecasts** and **both** CCC RG and ONS predict the **highest levels** of growth to 2026 in **East Cambridgeshire** and **South Cambridgeshire**, but with the East Cambridgeshire the higher in the CCC RG forecasts.

- The **drivers of population change** differ by district, with migration, natural change (births and deaths) and housing development playing respectively greater and lesser parts.
- Overall Cambridgeshire is **not ethnically diverse** and most districts follow this pattern.
- Cambridgeshire is a generally **rural area** with low levels of population density, especially outside of the relatively more urban areas.

3.5 Wider determinants of health

- Cambridgeshire overall has **low levels of socio-economic disadvantage** and relative to the England is a **prosperous place with low levels of deprivation**.
- **Deprivation is higher and most widespread in Fenland** and some smaller areas of East Cambridgeshire, Huntingdon and north-east Cambridge.
- **Child development** and **educational performance** warrants further attention across Cambridgeshire, particularly in Fenland and other relatively deprived smaller areas.
- In general, **levels of employment** are **better** than found nationally in **most areas of Cambridgeshire**, but are **similar to England's average in Fenland**. There are **greater levels** of income based **disadvantage** in small areas **within Fenland**.
- More **urban areas**, such as **Cambridge**, have the highest levels of fast food outlets and household overcrowding, but **Fenland** also has a **higher density of fast food outlets** than the national average.
- **Fenland** has a high level of **unpaid carers**.

3.6 Lifestyle behaviours which affect health

- Generally, levels of **overweight children are lower in Cambridgeshire**, but **Fenland has a similar level** to that found nationally. Children's **activity levels tend to decrease** as they get older.
- Almost **two-thirds of Cambridgeshire adults are overweight**, with higher levels than found nationally in **East Cambridgeshire, Fenland and Huntingdonshire**. A **quarter** are **physically inactive**, with the **lowest** activity levels in **Fenland**.
- **Adult smoking** is statistically significantly **worse** than the national average in **Fenland** and levels of smoking do not differ in Cambridgeshire as a whole compared with England. 15% of all Cambridgeshire adults are smokers and there appears to have been a **decline in children smoking**. Cambridgeshire's stop smoking service met its most recent targets.
- **Alcohol misuse** warrants some attention **across Cambridgeshire**, in both younger people and adult populations. Rates of **hospital admissions** for **alcohol-related conditions** are statistically significantly **higher** than the England average in **Cambridge** and **Fenland** and appear to be **increasing**.

- The picture regarding **sexual health** in Cambridgeshire is mixed, and sometimes unclear with **infection testing** rates **lower** than in England, which could be attributable to low levels of disease or poor detection. **HIV testing** at later stages of infection is **relatively high** in Cambridgeshire and is **increasing**. **Conceptions** in **young women** are generally **low in Cambridgeshire**, but are **higher** than found nationally in **Fenland**.

- **Falls** are an issue requiring **continuing attention** in **Cambridgeshire**. Emergency **hospital admissions** for falls are **higher in Cambridgeshire's very elderly population** and are **higher** than the national average in people aged **65 years plus in Cambridge City and Fenland**.

3.7 **Screening and immunisation**

- **Cancer screening rates** in **Cambridgeshire**, and especially in **Cambridge City and Fenland**, are relatively **low**.
- Some **childhood vaccinations** have relatively **low**, and **declining**, coverage rates in **Cambridgeshire**.
- **Cambridgeshire's flu vaccination rates** for older people and at risk individuals are sustained at levels **below national targets**.

4 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

4.1 The information in the JSNA Core Dataset 2017 and in the Summary of Themed JSNAs 2017, is relevant to all six priorities of the Health and Wellbeing Strategy:

- Priority1: Ensure a positive start to life for children, young people and their families.
- Priority 2: Support older people to be independent, safe and well.
- Priority 3: Encourage healthy lifestyles and behaviours in all actions and activities while respecting people's personal choices.
- Priority 4: Create a safe environment and help to build strong communities, wellbeing and mental health.
- Priority 5: Create a sustainable environment in which communities can flourish.
- Priority 6: Work together effectively.

5 SOURCES

Source Documents	Location
Cambridgeshire Joint Strategic Needs Assessment: Summary of Themed JSNA Reports 2017	http://cambridgeshireinsight.org.uk/jsna
Cambridgeshire Joint Strategic Needs Assessment Core Dataset 2017	http://cambridgeshireinsight.org.uk/jsna
Public Health Outcomes Framework	

Cambridgeshire County Council

Joint Strategic Needs Assessment

Summary of Themed JSNA Reports 2017

cambridgeshire.gov.uk

Table of Contents	Page

Introduction

The purpose of **Cambridgeshire's Joint Strategic Needs Assessment** is to identify local needs and views to support local strategy development and service planning. In order to understand whether we are achieving good health and care outcomes locally, it is useful to benchmark outcomes in Cambridgeshire against those in other areas and look at trends over time.

This **Joint Strategic Needs Assessment (JSNA) Summary of Themed Reports 2017** provides a brief overview and update on the entire breadth of themed JSNA work in Cambridgeshire to date. It is designed to identify and flag key pieces of information about the health and wellbeing needs of people who live in Cambridgeshire and local inequalities in health for specific population groups, through the 'deep dive' themed needs assessments, which are summarised here.

This report should be read in conjunction with the **Joint Strategic Needs Assessment Core Dataset 2017**, which provides a general overview of health data and statistics for Cambridgeshire's residents. Both documents inform the county-wide Health and Wellbeing Strategy.

This JSNA Summary of Themed Reports does not have the depth of information needed to support planning of services, however, the detailed reports are available at:

http://cambridgeshireinsight.org.uk/jsna

As part of the **2016/17 JSNA programme of work**, the following JSNA reports have been developed:

- **Drugs and Alcohol (published in 2016)**
  http://cambridgeshireinsight.org.uk/JSNA/Drugs-and-Alcohol-2015

- **Migrant and Refugee (published in 2016)**
  http://cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/migrant-and-refugee-2016

Summary of Health and Wellbeing Needs

The needs identified in the JSNA are addressed by the Health and Wellbeing Board through the priorities in their **Joint Health and Wellbeing Strategy**. The table below highlight the key priorities for Cambridgeshire for **2012-2017**.

Cambridgeshire

1. **Ensure a positive start to life for children, young people and their families**
2. **Support older people to be independent, safe and well**
3. **Encourage healthy lifestyles and behaviours in all actions and activities while respecting people's personal choices**
4. **Create a safe environment and help to build strong communities, wellbeing and mental health**
5. **Create a sustainable environment in which communities can flourish**
6. **Work together effectively**

Further details of these priorities are available in the executive summary of the Cambridgeshire HWB Strategy and the full HWB Strategy 2012-17, available at:

www.cambridgeshire.gov.uk/info/20004/health_and_keeping_well/548/cambridgeshire_health_and_wellbeing_board

The following strategies have been adopted as annexes to the Health and Wellbeing Strategy:

- **Learning Disability Partnership Commissioning Strategy**

www2.cambridgeshire.gov.uk/CommitteeMinutes/Committees/AgendaItem.aspx?agendaItemID=9416

- **Children and Young People's Emotional Wellbeing and Mental Health Strategy**

www.cambridgeshire.gov.uk/downloads/file/2664/emotional_well_being_and_mental_health_strategy_children_and_young_people

- **Older People's Strategy**

www.cambridgeshire.gov.uk/download/downloads/id/3669/cambridgeshire_older_people_strategy

- **Joint Adult Carers Interim Strategy**

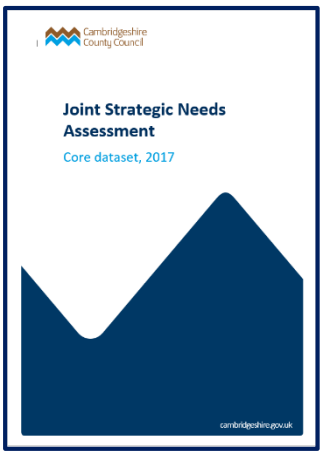
www.cambridgeshire.gov.uk/info/20166/working_together/577/strategies_and_plans

- **Crisis Care Concordat Declaration and Action Plan**

www.crisiscareconcordat.org.uk/wp-content/uploads/2014/11/Cambridgeshire-and-Peterborough-Local-Mental-Health-Crisis-Care-Declaration-November-2014-signed.pdf

JSNA core dataset 2017

The **Cambridgeshire JSNA core dataset 2017** contains local benchmarked information for a range of health and wellbeing determinants and outcomes, as well as local demographic data. The report is structured around these key topic areas:



- Geography and demography.
- Relative deprivation and the wider determinants of health.
- Lifestyles, risk factors and health and wellbeing.
- Screening, vaccination and immunisation.
- Levels of illness and health and social care services.
- Life expectancy and mortality.

The high-level executive summary for the report shows:

- Overall, **Cambridgeshire is a healthy place** to live and one that **compares generally well** with national health and wellbeing determinants and outcomes.
- However, there are **areas within Cambridgeshire** with **more widespread health and wellbeing issues** where health determinants and outcomes are often more adverse than in Cambridgeshire and often **similar to, or worse than, national averages**. In **Fenland** it is a priority to broadly improve health determinants and outcomes and to reduce health inequalities.
- There are also some **very small areas**, often with relatively high levels of disadvantage and deprivation, which have correspondingly **adverse** health and wellbeing determinants and outcomes. In some areas of **Cambridge City** in particular further attention may be needed to **reduce health inequalities** and to **reverse emerging adverse trends** in some health determinants and outcomes.

Please **note** that any summary is by necessity high-level, relatively crude, and cannot include the detailed differences and nuances of health and wellbeing across a large area like Cambridgeshire. For more information see the full JSNA core dataset 2017 at http://cambridgeshireinsight.org.uk/jsna.

Cambridgeshire Insight and other sources of health and wellbeing data

As well as the Cambridgeshire JSNA Core Dataset 2017, the Health and Wellbeing pages of **Cambridgeshire Insight** host a number of other health related resources:

- http://cambridgeshireinsight.org.uk/health

The most wide-ranging of these is the **Public Health Outcomes Framework (PHOF)** at http://cambridgeshireinsight.org.uk/health/phof.

Other areas of **Cambridgeshire Insight** provide further information on the wider determinants of health and background population based information covering:

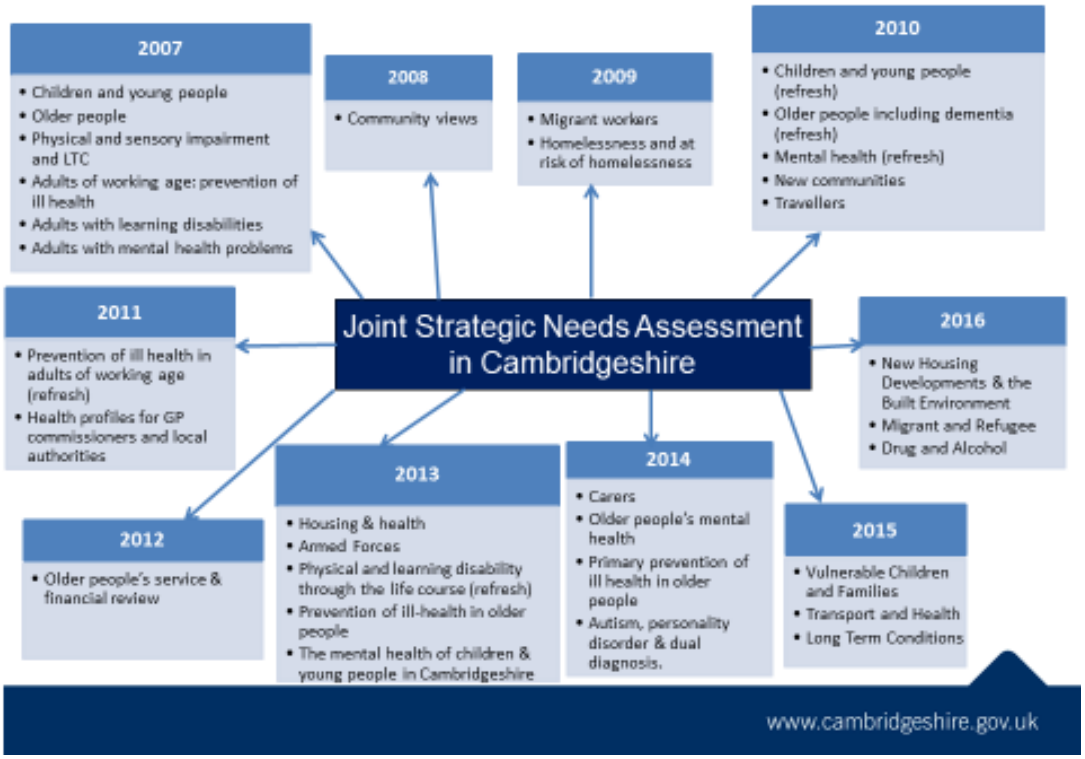
- Community safety
- Deprivation
- Economy
- Education
- Housing and planning.
- Population and demographics
- Voluntary and community sector (VCS)

Public Health England also provide a range of information profiles for various health and wellbeing topics and these can all be accessed from:

https://fingertips.phe.org.uk/

Cambridgeshire Joint Strategic Needs Assessment (JSNA) Programme

To date the following JSNA's have been completed in Cambridgeshire.



The following sections provide a brief summary of the key information presented in each JSNA topic, along with stakeholder views and a link to the full JSNA. It is strongly advised that the full report is read to gain an understanding of the breadth and depth of each JSNA.

Please note that the sources and references for data and evidence have not been included within these summary sections, as they can be found in the original document. It is also important to note that any figures presented are as at the time the JSNA was completed and therefore more up to date data may be available. The data sources are available in the full JSNA document and up to date wider determinants and health data are available on Cambridgeshire Insight (www.cambridgeshireinsight.org.uk).

Stakeholder and Community views

An important part of producing a JSNA is to seek the views of stakeholders and the local community to help inform the JSNA. In Cambridgeshire, the JSNA teams have held a range of workshops with stakeholders from defining the scope of the JSNAs to agreeing the key findings and the next steps. These events, together with closer partnership working, have helped to ensure the gathering of differing and varying perspectives. With community views, the priority has been to ensure that they are fairly represented and include capturing information with different groups and in different ways right through the process.

Migrant and Refugee (2016)

For the purposes of this JSNA, the term 'migrant' is used to describe a person who has moved to the UK who at the time of entry to the UK is not a British national. Migrants are not a homogeneous group, coming from all over the world and with different socio-economic backgrounds.

In terms of data, Migrants can be defined by: place of birth (i.e. foreign-born), nationality (i.e. foreign citizens), and length of stay in the UK. The JSNA also uses information based on language spoken at home to define migrants locally.

The local population of Cambridgeshire, like that of all areas of England, has experienced migration of people coming from non-UK countries to live, study, work or seek asylum for many years. Some migrants are now long-established in Cambridgeshire communities while others are recent arrivals, often seeking work, or in the case of Cambridge City, seeking education.

This JSNA focuses on migrants from the A8 countries. The **A8 countries are: Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia.**

Key findings

Demography

- Non-UK born residents in the East of England are primarily adults of working age, 43% aged 20-39 and 71% aged 20-59 years of age.
- Existing migrant populations are highest in Cambridge City. Fenland has a relatively low rate of non-UK born population overall. The East of England continues to experience relatively high levels of migration in comparison to other areas of the UK. The percentage increase in migration has been high in Fenland and Peterborough.
- Cambridge City has a higher rate of long-term migration (defined as migrants settling for a period of 12 months or longer) than England and the East of England as well as Peterborough and other districts of Cambridge.

Children and Education

- Although academic attainment at key stage 2 and at GCSE level has improved between 2013 and 2015 in Cambridgeshire for pupils who primarily speak a Central or Eastern European language at home, attainment remains below that of pupils who primarily speak English.
- The percentage of pupils within Cambridgeshire that primarily speak an EU A8 language is 3.8% and among districts, it is highest in Fenland at 8.6%.
- Communication with parents can be problematic due to poor English skills and poor overall literacy skills. Translators are required in schools to communicate effectively with parents.

Employment

- The highest rate of employment in non-UK born residents is in Fenland (73.5%), followed by East Cambridgeshire (72.0%). This is much higher than the England rate (56.7%) and higher than the East of England rate (61.2%), indicating that migrants in Fenland and East Cambridgeshire are settling in these locations for employment purposes
- A8 migrants in Fenland often work in low-skilled, seasonal jobs that are low-paid and may be subject to zero-hours contract and often are working below their skill level.

Housing

- 82% of migrants who answered the survey question in Cambridgeshire and Peterborough live in rented accommodation, with **39%** living in shared rented housing. This compares with 32% of the general population in Cambridgeshire living in rented housing and only 2% living in shared rented accommodation.
- There is a prominence of Houses in Multiple Occupation (HMO) making up the private rented sector in Wisbech. Analysis of HMOs and migrant housing needs through 'Operation Endeavour' and 'Operation Pheasant' in Wisbech have uncovered a broad range of issues: overcrowding, unhygienic and unsafe living conditions and illegal evictions.

Health

- Over the 10 years 2003/04 - 2013/14, new migrant GP registrations have risen by 37.6% in England. In Cambridgeshire, the increase over this time period has been 55.6% and the rise has been most substantial in percentage terms in Fenland (a 113.5% increase in migrant registrations.
- Evidence suggests rates of smoking and excessive alcohol consumption is higher among Eastern European communities. Dental care in A8 migrants is thought to be poor.
- Fenland and Cambridge City are among the areas with the highest unadjusted rate of tuberculosis (TB) within the Anglia & Essex area. TB in the UK is higher among migrants from countries with high incidence of TB and these include Lithuania and Latvia.
- Sexual health is an area of concern in the migrant population.
- Suicide rates are higher in all of the EU A8 countries compared to England and there is evidence that the suicide rate of Eastern European migrants living in Cambridgeshire is also higher than would be expected.
- The percentage of births to non-UK born mothers was 53% of all births in the Cambridge City area in 2014.

Migrants and Criminal activity

- 'Operation Pheasant' in Fenland uncovered a broad range of issues: Exploitation of individuals was uncovered in terms of no tenancy rights, illegal evictions, child protection issues, control, trafficking, and threats of violence.
- The wider community is concerned about some of the consequences of migrant exploitation and behaviours particularly when work 'dries up', including street drinking, homelessness and anti-social behaviour.

www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/migrant-and-refugee-2016

Drugs and Alcohol (2015/16)

The impact of substance misuse is addressed throughout the lifecourse allowing consideration of key transition periods for prevention and treatment.

There are many factors associated with an increased risk of the misuse of drugs and alcohol among young people and adults. These factors often lead to risk taking behaviours and poor health outcomes such as mental health problems and offending. The aim of preventative interventions is to tackle risk factors and build resilience to developing drug and alcohol problems.

The cost of alcohol and drug misuse

There are far ranging effects upon the physical and mental health of those who misuse drugs and alcohol which impact upon their families and communities and across wider aspects of their lives.

There are socio-economic costs to society and services which includes health services, social care, the criminal justice system, employers and housing services.

Parental drug use is a risk factor in 29% of all serious case reviews; heroin and crack addiction causes crime and disrupts community safety; a typical heroin user spends around £1400 per month on drugs. The public value drug treatment because it makes communities safer and reduces crime.

Alcohol misuse harms families and communities

- Almost **half** of violent assaults
- Domestic violence and marital breakdown
- **27%** of serious case reviews mention alcohol misuse
- Physical, psychological, and behavioural **problems for children** of parents with alcohol problems
- 13% of **road casualties**

The JSNA provides information about the evidence of effectiveness and also the cost benefits of interventions. The headline figures are as follows and sourced from Public Health England (Alcohol and drugs prevention, treatment and recovery: Why invest? 2014)

- Every £1 spent on interventions on young people's drug and alcohol services brings benefits of £5-£8.
- For every 100 alcohol dependent people treated at a cost of £40,000, £60,000 is saved on 18 Accident & Emergency visits and 22 hospital admissions.
- Every 5,000 patients screened in primary care may prevent 67 Accident and Emergency visits and 61 hospital admissions - costs of £25,000 saves £90,000.
- One alcohol liaison nurse can prevent 97 Accident & Emergency visits and 57 hospital admissions so costs of £60,000 saves £90,000.
- For every £1 spent on drug treatment £2.50 is saved through averting costs to society.
- Drug treatment prevents an estimated 4.9 million crimes every year.
- Treatment saves an estimated £960 million of costs to the public, businesses, criminal justice and the NHS.

www.cambridgeshireinsight.org.uk/JSNA/Drugs-and-Alcohol-2015

Children and Young People

Overall, alcohol and drug misuse among young people in Cambridgeshire is not dissimilar to national figures but there is still a proportion of children and young people who are starting and continuing to misuse drugs

The Cambridgeshire Health Related Behaviour Survey found that alcohol use amongst young people has fallen since 2008. In 2014 the percentage of Year 10 pupils reporting drinking alcohol in the seven days prior to the survey fell from 50% in 2008 to 36% in 2014. The same survey found that nearly 17% of Year 10 pupils reported taking drugs. The percentage reporting ever taking drugs was statistically significantly higher than the county average in Cambridge at 22% and statistically significantly lower than the county average in Huntingdonshire at 14.4%.

Amongst young people, admissions to hospital for alcohol and drug misuse are statistically significantly lower than the national figures. However, in line with national figures, the number and rate of admissions have doubled over the last five years. The number of young people in treatment fell in 2014/15 to 200 from 245 in 2013/14 and over 90% of the planned exits from treatment did not re-present within six months. The majority of children and young people have one or more vulnerabilities, the most common being mental health and self-harming.

A **key concern** is the needs of children and young people in **vulnerable groups** who are at a **higher risk** of misusing substances for example **looked after children** and children who live with **parents or carers who misuse**. This includes those who have not started and those who are using but are not yet dependent on substances.

Adults

There were 211 deaths in Cambridgeshire due to alcohol related causes in 2014. Alcohol specific mortality rates are generally higher in the more disadvantaged areas and average life expectancy is reduced from alcohol related conditions in Fenland. The rate of alcohol related liver disease has increased amongst women in 2012/14 to a level similar to the national figure.

Overall, in line with national figures, hospital admissions for conditions totally attributable to alcohol (specific) and related conditions have increased and they fall within the top 25% of local authorities. In 2013/14 1,890 people in Cambridgeshire were admitted to hospital for conditions totally attributable (specific) to alcohol. In the same year there were around 6,650 people who were admitted to hospital for alcohol related conditions. Hospital admission rates are generally higher in Fenland and Cambridge.

In terms of illicit drugs there were 143 hospital admissions with a primary diagnosis of illicit drug poisoning, with rates lower in men and similar in women to national figures. 732 admissions were with a primary or secondary diagnosis of drug-related mental health and behavioral disorders. In Cambridgeshire the annual rate of drug related deaths has been stable for over the past 10 years but they are statistically significantly higher in the more deprived wards.

Older People

Key risk factors for substance misuse in older people are **loneliness** and **life changes** including **bereavement;** more time and opportunity to drink; **loss of friends** and social status**; being a carer** and **chronic pain**

There is increasing awareness that substance misuse, especially alcohol, is more prevalent in the older population (over 65 years) than previously thought. Many who misuse alcohol may have started earlier in life but some commence in response to traumatic life events such as loss of a partner. Professionals often find it difficult to ask 'embarrassing' questions of older people but there are **warning signs**.

New Housing Developments and the Built Environment (2016)

- Cambridgeshire was the fastest growing county authority between 2001 and 2011 and is expected to continue to grow. It is estimated that there are 627,000 people living in Cambridgeshire.
- Forecasts suggest that the population of Cambridgeshire is set to increase by 25% over the next 20 years, with the majority of the increase seen in Cambridge City and South Cambridgeshire. This is associated with a forecast increase in the number of new dwellings up to 2036 of 73,000.
- The age profile breakdown for GP Practice populations serving new developments show the that majority have an age structure similar to the CCG area, except for Cambourne which shows a spike in the 0-14, and 25-44 age groups.
- The average household size in new developments ranges from 2.6 to 2.8.

There is strong evidence that the following aspects of the environment affect health and wellbeing:

- Generic evidence supporting the impact of the built environment on health.
- Green space.
- Developing sustainable communities.
- Community design (to prevent injuries, crime, and to accommodate people with disabilities).
- Connectivity and land use mix.
- Communities that support healthy ageing.
- House design and space.
- Access to unhealthy/"Fast Food".
- Health inequality and the built environment.

The Built Environment – this term includes open space, networks and connectivity between areas as well as the physical structures and includes the places where people work, live, play and socialise. The built environment includes several material determinants of health, including housing, neighbourhood conditions and transport routes, all of which shape the social, economic and environmental conditions on which good health and wellbeing is dependent.

The planning system involves making decisions about the future of cities, towns and the countryside. This is vital to balance the desire to develop the areas where we live and work with ensuring the surrounding environment isn't negatively affected.

Key findings

- There is a lack of consistency across the Local Authority Local Plans with regard to the inclusion of policies to improve health. The main policies to include in future local plans need to focus on green infrastructure, active travel, suicide prevention and Health Impact Assessment requirements.
- There is a lack of consistency and understanding on the funding of Primary Care facilities and securing Community Infrastructure Levy/Section 106 funding.
- Importance of accessible green space and parks, which need to be designed to maximise potential use. There is a need for an open space specific design code to complement the policies on open space within Local Plans, design code should cover provision of paths, cycleways and unstructured routes through and to the green space, provision of toilets and other facilities.
- The importance of providing infrastructure to enable people to make more active travel choices.
- Securing what can be perceived as "nice to have" infrastructure as part of the overall design of new development to support healthy ageing, eg street furniture, public toilets.
- The need to consider suicide prevention and public mental health as part of the design of high rise private and public buildings to limit their access and opportunities for suicide.
- The NHS Local Estates Plan should be reflected in the District/City Councils local plans and Infrastructure Delivery Plans.

Social Cohesion/Community Development - There is a marked difference between those occupying private rented market homes and other tenures in the amount of time those occupiers intend to stay in those properties, with the majority intending to stay less than three years. Occupiers in new developments show a difference in occupations compared to the working population as a whole. More residents are employed in the managers and senior officials, associate professional and technical occupation sectors. Less residents are employed in the skilled trade, sales and customer service, process, plant and machine, and elementary occupation sectors.

Key findings

- The need for community development in the early stages of new developments is strong, however, more research is needed locally into the measures of and approaches taken to improve social cohesion and community resilience in new developments, and the funding opportunities available to secure this.
- Community development work needs to continue to focus on building resilient empowered communities rather than dependent communities. This should be carried out with other key agencies. Responsibility lies with all stakeholders and that all statutory agencies can benefit from active participation in building resilient empowered communities.

Assets and Services - Of the larger new communities in Cambridgeshire, feedback from some frontline practitioners, including housing, children's social care and family workers, report that they are seeing higher needs in the initial years in new communities. Data has been used from some of the new communities in Cambridgeshire and has been analysed to see whether these reports of higher needs in new communities are translating into increased utilisation of health and social care services.

Key findings

- A joint strategy is needed to develop a way to engage and attract the leisure market into new communities early in the development.
- Further research to understand the length of time that referral to Social Services cases are open, and what was the primary reason for referral.
- During the pre-application stage of the planning process, services and the community should be engaged and a working group of people centred support established so that there is a clear co-ordinated effort and communication channels between services and the planning of the new community.
- Additional support to be provided to schools to enable them to deal with the additional challenges that new community schools can expect to face.
- Provide incentives to attract full day care/early years providers to developments.
- Further research into categories of crime committed and to look into other new communities and compare them to the rest of the county.

NHS Commissioning - the landscape is complex with commissioners at different levels (from local to regional to national) commissioning different services which make up the NHS.

Main findings:

- The current engagement between Planning Authorities, CCG and NHS England need to be strengthened, with NHS England and the CCG needing robust cases when seeking Section 106/CIL contributions with a defined need and costed solution.
- Health partners should come together at the earliest opportunity to discuss needs at strategic sites.

www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/new-housing-developments-and-built-environment

Long Term Conditions across the Lifecourse (2015)

Long Term Conditions (LTCs) include any ongoing, long term or recurring condition requiring constant care that can have a significant impact on people's lives, limiting quality of life.

The JSNA focussed on adults and older people with LTCs who may be considered 'at-risk' of poor health outcomes (such as admission to hospital or increased need for care).

Nearly a third of people in Cambridgeshire (31.7%) reported having at least one LTC in the GP survey, and the 2011 census found that 90,420 people (15.1% of household residents) reported a long term activity-limiting illness.

Long Term Conditions Across the Lifecourse - LTCs develop over a long period of time and similarly, many important adult risk factors for LTCs (poverty, smoking, diet, physical activity) also have their own natural histories. Thus by adopting a lifecourse approach to LTCs a range of potential interventions, which includes the wider determinants of health, that could reduce the risk of development of a condition or improve health outcomes is a useful and holistic population health approach.

This JSNA complements the work and findings of the Primary Prevention JSNA

LTCs in the Population: characteristics of those at high risk.

This JSNA is scoped to focus on care management for high risk people with adult-onset LTCs representing 10-15% of the population with LTCs. In discussion with local stakeholders, the key characteristics that described people with LTCs were determined as: multiple long term physical and mental health conditions; important level of limitations, such as in activities of daily living (ADL); living with a significant level of pain and experiencing depression and/or anxiety.

The Department of Health estimates that those with multiple LTCs are due to rise from 1.9 million in 2008 to 2.9 million in 2018.

LTCs in Cambridgeshire

A longstanding illness is defined as any physical or mental health condition of illness lasting or expected to last 12 months or more. If a longstanding illness reduces participants' ability to carry out day-to-day activities, either a little or a lot, it is considered a limiting longstanding illness.

For the adult population aged 18-64 years, individual level data was analysed from the Health Survey for England (HSE 2012) and those results were applied to the local Cambridgeshire population. In terms of health conditions the survey is all inclusive – participants report any longstanding illnesses and specify up to six conditions.

Results

- For the adult population - 9.8% of people reported two or more longstanding illnesses which equates to over 39,000 people in Cambridgeshire.
- People aged 18 to 64 years estimated to have two or more LTCs and who report limitation is around 14,700 people. When mental ill health is considered as well around 11,000 people report two or more LTCs, with limitation and with mental ill health.

For the older population aged 65 and above, local data from the MRC Cognitive Function and Ageing Study (CFAS II) was used.

For the purpose of this JSNA, the following conditions were selected as LTCs: angina, intermittent claudication, hypertension cancer, diabetes, Parkinson's Disease, stroke, myocardial infarction and chronic obstructive pulmonary disease (COPD), asthma, arthritis and thyroid problems.

- 45% of people aged 65 and over with two or more LTCs experience limitation. Applied to the Cambridgeshire population, this suggests around 29,800 people aged 65 and over with two or more LTCs and limitation, an additional 2,800 people with mental ill health and an additional 5,400 with multiple LTC, limitation and mental ill health (dementia, anxiety and depression). In total, it is estimated that **66,200** people aged 65 and over in Cambridgeshire have two or more LTCs.

- Over 51% of those with multiple (three or more) LTCs experience limitation. Applied to the Cambridgeshire population, this suggests around 17,700 people aged 65 and over with multiple LTC with limitation, an additional 1,300 people with mental ill health and an additional 3,700 with multiple LTC, limitation and mental ill health (primarily dementia, anxiety and depression). In total, it is estimated that **34,700** people aged 65 and over in Cambridgeshire have three or more LTCs.

Living with LTCs: Local Views

The views of Cambridgeshire people living with LTCs and their carers.

They detailed challenges and difficulties that they faced, the impact of the physical, emotional and mental health symptoms, including pain and fatigue. Many are providing care for family and friends with even more complex needs, and experience the complexity of balancing caring responsibilities with their own health issues. Some of the stakeholders' concerns included managing household tasks, getting out and about, financial and practical issues, and a lack of knowledge of what is available in the community for support or social opportunities.

The theme that emerged for the health and care system is that there is a level of fragmentation, a lack of communication between different services and providers of care and a very broad web of care that people with LTCs interact with; this can mean that coordination is difficult and care is not optimal.

Care Management: The House of Care

NHS England recognises that care needs to be designed and implemented around the individual, the King's Fund 'House of Care' model has been adopted as a framework to describe the components of personalised care. This is a co-ordinated service delivery model which is designed to deliver proactive, holistic, preventive and patient-centred care for people with long term conditions.

Improving Care Management: Targeting and Intervening

This chapter gives an overview of the current evidence exploring interventions to prevent hospital admissions and admissions to care settings. The current health care system attempts to discharge elderly patients quicker from acute care facilities. There is strong evidence that an individualised discharge plan for hospital inpatients is more effective than routine discharge care that is not tailored to the individual.

National Expert Panels have recommended the following key approaches to reducing and preventing unplanned hospital admissions: direct delivery of rapid access care in the community; Access to rapid response nursing and social care at home; Intermediate care and acute nursing home beds; Mental health crisis teams; Rapid access specialist clinics; Increased nursing home capacity for acute illness.

Improving Care Management: Supporting Self-Management

It is estimated that during each year for a person with LTCs, only a few hours are spent in the presence of health care professionals. The vast majority is 'self-care' or 'self-management' of conditions.

www.cambridgeshireinsight.org.uk/JSNA/LTCs-across-the-lifecourse-2015

Transport and Health (2015)

The Transport and Health JSNA covered air pollution, active travel and access to transport.

Air pollution

There are several hotspots of traffic air-related pollution in Cambridgeshire, especially in busy urban areas and around arterial and trunk roads, such as the A14. Some new developments in the county are sited near to poor air quality areas.

In 2010 it was estimated that there were **257** deaths attributable to air pollution in Cambridgeshire and that over **5%** of population mortality is attributed to air pollution

Air pollution impacts on respiratory and cardiovascular hospital admissions and incidence of respiratory disease. There are higher levels of nitrogen dioxide in the winter months and peaks of larger particulate matter in the spring, which may lead to seasonal health impact. Stakeholders identified **priorities** as **lower emission passenger transport fleet, modal shift from cars to walking and cycling** and **exploring the potential for reducing person specific exposure**. Increasing physical activity reduces all-cause mortality and reduces ischemic heart disease, stroke and dementia. **Those that are most inactive benefit the most, with even small increases in walking and cycling helping health.**

Active travel

There are over **18,000 car trips** to work that are **less than 2km** (1.2 miles) in Cambridgeshire, with over a third of these in Huntingdonshire

Half of **work trips** are **walked or cycled** in **Cambridge City** compared with only **one in seven** in the **rest of the county**. The proportion of people who use active transport for work decreases with distance and most notably in those that walk, although cycling rates do not decline until the trip is longer than 5km. Nearly 60% of primary school children walk to school, but only 35.3% of secondary school children do. Cycling is much less popular with only 6.7% of primary school and 15.5% of secondary school children cycling to school. **Priorities** identified were: **improving safety** and **perception of safety, infrastructure, culture** and **further assessment of data and intelligence**. It was also emphasised that an initial focus modal shift on densely populated towns and cities may be a preferred starting point.

Access to transport

People vulnerable to transport barriers include:

- Those who may be **socially excluded** (or in lower socioeconomic groups)
- Those living in **rural areas**
- Those **without cars** or stopping driving
- Those **lacking** the **knowledge** or **skills** and **confidence** to use available modes of transport

Transport barriers are not experienced equally through the population. There is evidence to suggest that transport barriers are a contributory cause of missed and cancelled health appointments, delays in care, and non-compliance with prescribed medication. These forms of disrupted and impaired care are associated with adverse health outcomes. In Cambridgeshire, there are geographical wards where there are high numbers of vulnerable people with limiting conditions, many in households without access to a car, living a long distance from health services and these may impact access to services. Stakeholders identified **priorities** of **system led perspective on health and transport planning, additional provision such as bus provision or novel alternatives**, **alternative models of health support**, such as telemedicine and **further analysis of travel to GP practices** and **other health services.**

www.cambridgeshireinsight.org.uk/JSNA/Transport-and-Health-2014/15

Vulnerable Children and Families (2015)

Children can experience many adverse 'risk factors' relating to health, family or environment. These risk factors rarely occur in isolation and can combine to lead to relatively poor outcomes later in life. Establishing which children face different combinations of these risk factors would allow for a whole range of services to be better targeted and coordinated to improve positive outcomes later in life.

The JSNA looked at both geographical patterns of vulnerability factors and explored joining datasets together to identify which groups of children and young people were most vulnerable in Cambridgeshire, and to examine which services they were in touch with.

Vulnerability factors **Maternal qualifications**, **language spoken** at **home**, **mother's** self-rated **health**, **depression** and **socio-economic** situation are **common risk factors** across **educational**, **behavioural** and **health outcomes** for **children**. The **home learning** environment, where mothers provide more stimulation and teaching, was found to be a **protective factor**. Data were analysed at low geographical areas for proxies of these indicators and concluded that there are **areas outside of those most deprived** that would benefit from **additional prevention** work. The table below presents the data at district level. **Fenland** appears challenged for all indicators reported.

Indicator		Cambridge City	East Cambridge shire	Fenland	Huntingdon shire	South Cambridge shire
Poor performance (all pupils)	EYFS	High	Low	High	Low	Low
	KS2	High		High	Low	Low
	KS3	High		High		Low
Breastfeeding 6-8 weeks		High	Unknown	Low	Low	Unknown
Teenage conceptions			Low	High		
Mothers aged under 22 years		Low		High		
Hospital admissions due to unintentional and deliberate injuries	0-4 years			High	High	Low
	0-14 years				High	Low
A&E attendances (0-14 years)		High (under 5's only)	High	High	Low	Low
Female population with low qualifications		Low	High	High	High	Low
Household overcrowding		High	Low	High	Low	Low

Statistically significantly higher/worse than Cambridgeshire Statistically significantly lower/better than Cambridgeshire

Please note : admissions for Huntingdonshire may be over-represented due to local data recording issues

Person specific analysis The main aim of the JSNA was to identify groups of children and young people who had risk factors which made them potentially vulnerable to poor educational outcomes and to examine which services they were in contact with. The original scope of the study was wider than this, with the intention of bringing together data from stakeholders at an individual level to better understand how risk factors combine over several services, but this proved not possible at the time and was limited to County Council services and data only.

Key findings

- **Poor attainment** is more **concentrated** in the **most deprived** parts of the county. Almost one in three (29%) children with poor attainment levels live in the 20% most deprived parts of the county (and approximately two in three (71%) outside these areas).
- A **large proportion** of children with **poor levels of attainment** accessing **free school meals are in touch with council services**, particularly at Key Stage 2.
- Children with **special educational needs** account for a **large proportion** of children with **poor attainment** who access **free school meals**, particularly in Key Stage 2, where the Council is also in contact with a high percentage of these children.
- There are **parts of the county** where there are **lower levels of good attainment**, and these are not necessarily in the most deprived parts of the county.

www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/vulnerable-children-and-families-2015

Carers (2014)

A carer is a person of any age - adult or child - who provides unpaid support to a partner, child, relative or friend who could not manage to live independently or whose health or wellbeing would deteriorate without this help. Those receiving this care may need help due to frailty, disability or a serious health condition, mental ill-health or substance misuse.

Young carers are significantly more likely to grow up in **poverty**. They have significantly **lower attendance** and **attainment** at school and may be **victims of bullying**. Young carers may be at **higher risk** of **poorer health** and **risk-taking behaviour** as they move into **adulthood**.

In Cambridgeshire young carers reported that they want time to have **fun** and **socialise**, to get **breaks** from caring, to get **more help** for the person they care for, to be **less isolated**, to have **more money** in their families, to have **help at school**, to get help to get the best from **learning** and **work towards** an **independent future**. As well as, to be meaningfully **involved** in the planning for their cared for person, to be given **information** and **knowledge** about the practicalities of caring, to have **emotional support** with worry, anxiety and low self-esteem and to get help **planning** for and dealing with **family crises**.

In the 2011 census **60,176** people in **Cambridgeshire** self-identified themselves as **carers,** with a **fifth** providing **50 or more hours** of unpaid care per week

Around **60%** of carers are **aged over 50 years**. The highest proportion of unpaid carers are in **Fenland (11.1%).** There were **4,208** young people aged **under 25 years** providing care, with almost **one** in **ten** providing **over 50 hours**

Dementia carers need and value **information** and **support** at a number of **critical points** along their caring journey. It is key that the carer knows where to go to for **advice**, knows what **support** is **available**, that the **professionals** they are in contact with are **knowledgeable** regarding dementia, that they **engage** with both the carer and the person with dementia and they understand the **carers needs** and issues, not just those of the person with dementia.

End of life carers share many of the positive and negative aspects of any other form of caring, but there are **additional challenges**, including **rapidly changing** care **needs**, the need to understand **complex** and often uncertain **medical information** around prognosis and symptom control, and the prospect and reality of **death** and **bereavement**. The impact on health and wellbeing of caring for someone who is dying includes the physical and psychological impacts of any caring role but with the additional strain of bereavement.

Parent carers need **breaks** from their caring responsibilities, access to **continuous emotional support** including out of hours, weekends and during school holidays and support from diagnosis through to **adulthood**. This includes support from professionals and other parents and support for their wellbeing and a safe place to show their feelings.

Carers may **not prioritise** their **own health** and may miss routine health appointments like influenza vaccinations or check-ups with doctors or dentist. Carers may **give up work** as a result of their caring responsibilities. This is significant given the importance of 'meaningful activity' (such as employment) to maintaining an individual's positive **mental health**. Such activity also reduces **social isolation**. **Cambridgeshire carers asset mapping** has identified the importance of **local community networks** and services in supporting the health and wellbeing of carers. Carers in **new communities** may therefore be at risk of having fewer opportunities for support. Carers from **BME groups** are likely to be under-identified in Cambridgeshire. Services for carers are not necessarily culturally sensitive in relation to the **Gypsy and Traveller** community. This community is at particular risk of missing out on Carers Allowance because of the impact of travelling and may be forced to move away from established community networks to be able to access equipment and adaptions.

www.cambridgeshireinsight.org.uk/jsna/carers

Primary Prevention of Ill Health in Older People (2014)

Modification of risk factors in later life is still beneficial for health: chronic degenerative disease and ill health are not inevitable outcomes of ageing

It is never too late to make changes

There is significant variety in the way individuals experience and respond to their senior years, and a range of cultural differences, preferences and perspectives on what healthy ageing means for each person which could inform effective preventative work locally.

Encouraging healthy behaviours in 55-75 year olds may be most effective as they may be more ready, interested and intend to change than individuals in older age groups.

Active ageing needs to ensure the **mobility** of older people so that they are able to participate in society and the community around them, maintain social networks, access services, and benefit from leisure, social and volunteering opportunities. **Access** to **local shops** and **food sources** are important in maintaining a **healthy diet**. **Loneliness** has detrimental impacts on **physical** and **mental health**, and **increases** the likelihood of multiple **unhealthy behaviours**. Access to **transport** influences healthy behaviours.

Physical Activity is the fourth leading risk factor for death worldwide. Volume of activity is more important that engaging in specific types of activity. Community assets in Cambridgeshire exist but may not be available to all and sustained funding is not assured.

Dietary improvements made in older age significantly **reduces** the risk of chronic diseases. Nationally, older adults consume **low levels** of **fruit and vegetables**, **fibre**, **oily fish**, and **high levels of salt** relative to recommendations. Daily **vitamin D** supplementation is recommended by the Department of Health for all adults aged 65 years and over. Locally there are **lifestyle support services** accessed by older adults, and **practical advice** and **support** through social care and voluntary sector organisations. There may be **opportunities** to look at **enhancing messaging** about a healthy balanced diet for older adults through local services, stakeholders, health and social care professionals, and to consider the **healthiness** of the food offered in **residential** and **social settings**.

Malnutrition in about **two thirds** of cases are **not recognised**; the impacts are increased burden of disease and treatment costs. **Social networks** have a **preventive role**, as interest groups and shopping clubs support motivation and the means for good nutrition. **Regular screening** for malnutrition in care settings is recommended by NICE. Awareness of malnutrition needs to be improved by both healthcare workers and the wider public. The majority of individuals at **risk** of malnutrition **live** in the **community**. **Preventative resources** include home help schemes, community navigators, lunch clubs, day care centres, shopping services and the support offered by voluntary organisations. **Service coverage** is **not even** across the **county** e.g. there are fewer lunch clubs in rural areas, where social isolation may be a greater problem.

An estimated **10,000** to **14,000** older residents in Cambridgeshire are **malnourished**, with many more are at risk

Smoking cessation in people aged 60+ years **significantly improves health** and **reduces mortality**. **Increasing access** to **stop smoking services** should be **encouraged** for older smokers.

An estimated **17,700** people aged over 60 years **smoke** in Cambridgeshire, with prevalence being higher in Fenland

There are opportunities for local health and social care professionals to **make every contact count** in modifying these risk factors in older people. A **positive view** of **healthy ageing** and an **increased awareness** of the **available services** will enable **tailored support for older adults,** with potential advantages in overcoming social isolation and in strengthening local communities.

www.cambridgeshireinsight.org.uk/primary-prevention-ill-health-older-people2014

Older People's Mental Health (2014)

Over a **third** of **older people** in the UK are likely to experience **mental health problems**. **Depression** and **anxiety** are the most common conditions, followed by **dementia**. The JSNA focussed primarily on depression and dementia.

Dementia is a group of related symptoms associated with an **ongoing decline of the brain** and its abilities, including problems with memory loss, thinking speed, mental agility, language, understanding and judgement

Depression is a **mood disorder** that causes a persistent feeling of sadness and loss of interest

There appears to be widespread under-diagnosis of depression in primary care in Cambridgeshire, as reflected nationally. Rates of diagnosis also vary between practices. Depression is a distressing, but highly treatable condition, so improvement in rates of diagnosis is important.

Dementia is also under-diagnosed in primary care, with unexplained variation in rates of diagnosis and prescribing. **Early diagnosis** means that patients and carers can receive appropriate information and support, so ensuring the condition is recognised promptly is beneficial. **Improving diagnosis** in primary care is a priority, as part of an integrated approach and partnership working, to improve awareness of mental health needs in the community. Training programmes to raise awareness of dementia are in place across primary care, community and acute settings. Local support services are also provided by the Alzheimer's Society and Mind.

By **2026** the number of people aged **over 90 years** is forecast to more than **double**, with the number of people in their **80s** rising by **more than 50% ***

Over this time it is expected that the number of older people with **depression** will **increase by 12%*** (1,500 people) and the number with **dementia** will **increase by 64%* (**4,700 people)

Increases of this size over a short period will put **severe strain** on **existing services**

* between 2012 and 2026

NICE recommend **reviewing** and **treating vascular** and other **risk factors** for **dementia** in **middle-aged** and **older** people. These include **smoking**, **excessive alcohol use**, **obesity**, **diabetes**, **hypertension** and raised **cholesterol**.

There is substantial **variation** in the **rate of referrals** to the older people's mental health service, with **lower** rates seen in **South Cambridgeshire**, and **higher** rates in **Cambridge City, Fenland** and **East Cambridgeshire**. The reasons for this variation are unclear, and may relate to data quality problems so would merit further investigation.

The main concerns of local service users and carers were:

- Service delivery
- Organisational challenges
- Co-ordination of services
- Safeguarding of vulnerable people
- Access to services
- Transition between services
- Continuity of relationships
- Culture and equity
- Physical health and mental health
- Carer's needs

Service improvement ideas from service users and carers included more **help** with **practical things**, such as **maintaining relationships**, **applying for benefits**, and a **focus** on the **positives** rather than the diagnosis. **Community support** and **signposting** for where to go for **help**, **ideas or friendship** were also considered important. **Information** and **training** for **families** and **carers** as well as those with mental health disorders, and seeing the **same health professional consistently** were also suggested.

www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/older-peoples-mental-health-2014

Adult Mental Health : Autism, Personality Disorder and Dual Diagnosis (2014)

Autism Spectrum Conditions are a group of complex brain development disorders that affect the way people communicate, relate to others and make sense of the world around them.

Personality disorders are conditions in which an individual differs significantly from an average person, in terms of how they think, perceive, feel or relate to others.

People with **dual diagnosis** have a mental health problem and also misuse drugs or alcohol.

An **increase** in prevalence of **common mental health disorders**, as well as those conditions specific to this JSNA, is predicted **across all Cambridgeshire districts**, with growth in numbers concentrated **especially in Cambridge City,** due to **population growth**.

In Cambridgeshire, many people with depression have not been diagnosed and recorded by their primary care teams, which reflects a national trend. This suggests that there is unmet mental health need within the population. In addition, depression occurs in people with Autism Spectrum Conditions, personality disorder and dual diagnosis, so this under-diagnosis of depression is relevant to their needs.

Adults with **severe mental illness** have a substantially **reduced life expectancy** due to both mental and physical ill health, with a significant proportion of excess deaths being associated with physical conditions. A proportion of those within the specific conditions considered in this JSNA are likely to have severe mental illness. In addition, there is often **inequality of access** to **health services** for **physical illness** for people who use mental health services.

By **2026 *** it is predicted that there will be:

- **2,000** people with **borderline personality disorder**
- **1,600** with **anti-social personality disorder**
- **5,100** with **autism spectrum conditions**

* from 2012

For adults with autism, a high-quality diagnostic service is available from Cambridgeshire and Peterborough Foundation Trust. However, services to support adults with **autism** and their **carer's** in the **community** are sometimes **fragmented** and **difficult** to **access**. There are strong indications of problems in services for people with **dual diagnosis**. There are examples from both service providers and service users which suggest that sometimes neither the substance misuse service nor mental health services are willing to take on patients with more severe dual diagnoses.

Adults with mental disorders, including personality disorder, dual diagnosis and autism, sometimes experience mental health crisis and need help quickly to stop them harming themselves or others. The Crisis Care Concordat is aimed at making sure that people experiencing a mental health crisis receive an appropriate emergency mental health service.

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- Organisational challenges
- Co-ordination of services
- Safeguarding of vulnerable people
- Access to services
- Transition between services
- Continuity of relationships
- Culture and equity
- Physical health and mental health
- Carer's needs

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www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/autism-personality-disorders-and-dual

Armed Forces (2013)

The Armed Forces JSNA focuses on **military personnel, veterans, reservists** and their **dependents.**

Service in the Armed Forces is generally associated with good physical and mental health, due to good diet, exercise and access to medical services. However, there is a variety of health and lifestyle issues that ex-service personnel face on leaving the Armed Forces, with Early Service Leavers being the most vulnerable.

There are **four** Armed Forces bases in Cambridgeshire

- **Bassingbourn** RAF/Army
- **Waterbeach** Army
- **Brampton/Wyton** RAF
- **Alconbury** USAF

As at **1 January 2013** there were **1,240 Armed Forces personnel** located in **Cambridgeshire** (70% Army, 28% Royal Air Service and 2% Naval Service)

Two thirds of personnel live in **South Cambridgeshire**, with a further **31%** living in **Huntingdonshire** and **2%** in **Cambridge City**

Health The majority of **veterans** are older people who face the **same health issues** as the general population. However, veterans may have a **higher prevalence** of **musculoskeletal** conditions, **cardiovascular disease**, **respiratory** problems, **sight** problems and **mental health** problems. **Stigma** and **reluctance** to access services are the **main barriers** to **care**.

Mental health The **prevalence** of **mental disorders** in **younger veterans** is **three times higher** than the **UK population** of the same age. **Exposure** to **violent** or **traumatic experiences**, **instability** in **domestic life**, **difficulties** in making the **transition** from **service** to **civilian** life and the consequences of the **excessive drinking culture increase mental health risks** for **veterans**.

Oral health **Dental emergencies** are up to **five times higher** in a **dentally ill-prepared Force**, compared to a well-prepared force. Dental morbidity is one of the most significant causes of Disease and Non Battle Injury (DNBI) and subsequent lost time from operation is considerable.

Lifestyles **Alcohol misuse** in the serving population is **substantially higher** than the **general population**, at **over double the rate**.

Wider determinants of health The Armed Forces, especially the Army, **recruit** from more **deprived communities**. **Unemployment** rates in people of working age are similar to the national average, but double the national average for people aged 18-49 years. There is an increased risk of **violence** by veterans due to experiences of combat and trauma, mental health problems and alcohol misuse. It is estimated that 3.5% of the **prison** population are veterans, with a higher prevalence of sexual offences compared to the general prison population. Access to **housing** is an issue for personnel leaving the service. All districts in Cambridgeshire include Armed Forces personnel in their eligibility criteria for social housing. It is estimated that between 6% and 12% of **rough sleepers** are ex-armed forces personnel.

Dependents and families Service children who face regular moves from home and school can suffer high levels of **anxiety** and **stress**. **Access to services**, such as NHS dentistry, immunisations and planned hospital care, is a particular issue for families that frequently move, as is their opportunities for **employment**, **education** and **training**.

Cambridgeshire has an **Armed Forces Covenant Board** that aims to improve the outcomes and life choices of military personnel, reservists, their families and veterans living in Cambridgeshire and Peterborough. The Covenant Board also aims to enhance the relationship between the civilian and military communities.

www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/armed-forces-2013

Housing and Health (2013)

Housing needs in the Cambridgeshire are regularly assessed and updated through the Strategic Housing Market Assessment (SHMA). The JSNA examined the link between the health and wellbeing of Cambridgeshire residents and the housing priorities from the SHMA.

Affordability of housing is a key issue for Cambridgeshire. Affordability ratios vary across the county, but even in Fenland, which is a relatively affordable area, the average house price was 4.7 times above the average income. **Affordable housing** and the **limited availability of affordable tenure homes** are significant issues across the county, and is under pressure as people find it hard to access the private housing market, particularly those on lower incomes.

Another significant issue for Cambridgeshire is the provision of **appropriate housing** for the **growing older population**, for example through 'floating support services', sheltered housing or extra-care housing, which are likely to reduce the need for residential care.

Across the county more than **70,000 new homes** are planned to be built between **2011** and **2031**

Since 2003, a total of almost **6,000 new affordable tenure homes** have been built across Cambridgeshire (27% of the total number of homes built)

Housing-related support (previously known as the 'Supporting People Programme') **supports** some of the most **vulnerable** and **socially excluded** members of society. The primary purpose is to develop and sustain an individual's capacity to live independently in their accommodation. Housing related support is vital to many, helping them recover from a life trauma, maintain their existing housing, or continue to live at home.

Low income households and **vulnerable groups** are the most **likely** to occupy **poor standard homes**, often related to issues of **overcrowding**, **fuel poverty**, **disrepair**, **damp** and **mould**. **Homelessness** remains a major issue across the county.

As fuel prices rise more rapidly than income and benefit levels, **heating** will become increasingly difficult to afford for some groups. The risk to vulnerable and older residents is likely to increase, and measures to improve energy efficiency will be needed even more than at present to maintain health and independence at home.

In **March 2013**, nearly **20,000 people** were **registered with Home- Link** i.e. in housing need and applying for social housing, across Cambridgeshire. Of these, more than 1,000 had an 'urgent' or 'high' health and safety or medical need

More than **800 households** approached the local authority as **homeless** in **2011/12**, of which nearly **600 were accepted** as 'statutory homeless'- **250** of these were living in **temporary accommodation** at the end of March 2012

Estimates made in 2010 showed more than **46,000** of Cambridgeshire **households**, or 14.5%, were in fuel **poverty** (ie more than 10% of household income is spent on heating) compared with 11.5% in 2008. Levels of **fuel poverty** were **highest** in **Fenland** and **lowest** in **Huntingdonshire**

A local new development survey found that:

- **Younger population** than the general population; 78% aged under 45 years; 9% aged 60+ years
- The main reasons for moving were: **larger/smaller home, employment** and to be near **family and friends**
- Negative issues experienced were **lack of shops**, **parking, public transport, anti-social behaviour** and **too much traffic**

www.cambridgeshireinsight.org.uk/housing-jsna-2013

Prevention of Ill Health in Older people (2013)

Early interventions can enable older people to remain well and live independently at home, or in a community setting, and prevent or reduce unnecessary hospital admissions

Preventing hospital admissions and developing integrated care model

Early interventions to prevent ill health and deterioration are desirable for both older people and their families or carers, and to reduce the use of expensive acute hospital care. Nationally, integrating care for older people is proposed as an approach to meet the funding challenges of financial austerity, rising acute healthcare costs and an ageing population with an increasing demand on acute services.

Case management by multi-disciplinary teams for 'frail' elderly people

A frail person is someone with a number of physical or mental disabilities or a cumulative loss of function, which makes a person more vulnerable to an acute health or social crisis. Intervening early requires identification of those who are most at risk. Risk stratification tools use data from primary and secondary health care to predict a patient's risk of future emergency admission. Primary prevention is also important in reducing the risk of respiratory and circulatory diseases, the top two causes of hospital admissions in Cambridgeshire for older people. There is also strong evidence base for secondary and tertiary prevention to reduce the impact of a stroke or heart attack.

Nearly **17,000** people aged **over 65 years** (16.8%) are likely to be '**frail**'

Falls prevention

Falls are a major cause of disability and the leading cause of mortality due to injury in older people over 75 years old. Cambridge City has significantly high admission rates for falls and hip fractures. There are a range of falls prevention and falls services available across Cambridgeshire.

There were **2,650** emergency admissions in **2011/12** for **injury due to falls** in the **over 65s**, accounting for **7.7%** of **all emergency admissions**

Mental Health

Over a third of older people in the UK are likely to experience mental health problems. The prevalence of depression in older people is almost three times more common than dementia (and increases with age), particularly in those living alone with poor material circumstances. Although 20% to 40% of older people in the community show symptoms of depression, only 4% to 8% will consult their GP about this problem.

Reducing social isolation and loneliness

Loneliness and isolation amongst older people is a key issue which impacts on their health and wellbeing

Approximately **29,000** people over 65 years old **live alone** in Cambridgeshire

Social care and support in the community

There are a number of local interventions and examples of good practice which help prevent or delay the need for health and social care. Re-ablement services are widely available and proven to be effective in helping older people regain their independence. GPs are a key point of contact with 'at risk' older people and provide an opportunity to signpost to preventative and community support services.

Housing

Supporting older people to remain in their own homes meets their aspirations and generates significant financial savings. Fuel poverty is a growing problem, with the percentage of households in fuel poverty increasing from 11.5% to 14.5% between 2008 and 2010.

Supporting carers

Carers provide a crucial role in supporting older people to be independent and live in the community. Better recognition of a caring role would help older people identify themselves as a carer at an earlier stage. Many carers are older people themselves and have specific health and wellbeing needs, as well as needs relating to their caring role.

Nationally **65%** of **older carers** have **long-term health problems** or a **disability** and **69%** report being a carer has an **adverse effect** on their **mental health**

www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/prevention-ill-health-older-people-2013

The Mental Health of Children and Young People (2013)

There are a large number of **risk factors** that increase the vulnerability of children and adolescents experiencing mental health problems. These include **deprivation**, **poor educational** and **employment opportunities**, **enduring poor physical health**, **peer** and **family relationships**, **witnessing domestic violence**, and having a **parent who misuses substances** or **suffers from mental ill-health**. Children who have been **physically and sexually abused** are at particular risk. **Asylum seeker** and **refugee** children can have higher levels of mental health problems, including post-traumatic stress, anxiety and depression. The way that children are **parented**, their **diet** and **exercise**, their **school** and **education**, **experimentation** with **drink**, **drugs** and other **substances**, along with many other factors, will all affect a child's mental wellbeing or mental ill-health.

Many children experience more than one risk factor, and four or five adverse childhood experiences (child abuse, parental depression, domestic abuse, substance abuse or offending) which increases the risk of developing mental health problems throughout life. Around half of lifetime mental illness starts before the age of 14 years. Potentially, half of these problems are preventable.

If children and young people are at risk of developing poor mental health, they need to **develop resilience**; **self-awareness**; **social skills**; **empathy to form relationships**; **enjoyment of one's own company; deal with life's normal setbacks constructively.**

it is estimated that **one** in **ten** children and young people aged **five to sixteen** years have a **clinically significant mental health** problem, with a **higher** prevalence of mental disorder in **boys** than girls. It is estimated that mental health disorders more prevalent in parts of Fenland and Cambridge City.

Since 2010/11, the number of children and young people admitted to hospital for self-harm has increased.

A local consultation asked children and young people to describe what makes them feel well, what helps them recover if they are unwell and how mental health workers and services should behave.

It is estimated that there are following number of children and young people have mental health problems:

- **5,000** children **under** the age of **five**
- **8,000** between the ages of **5-16**
- **1,275 16-17** year-olds

Of the children aged **5-16 years**:

- **3,100** have an **emotional disorder**
- **4,800** have a **conduct disorder**
- **1,200** have a **hyperkinetic disorder**
- **1,100** have a **less common disorder** including **740** with **Autism**

Conduct disorder is the **most common** diagnosis, with the **majority** found in **boys**. **Emotional disorder** (depression and anxiety) is the next most common condition, the **majority** of which is found in **girls**

Parental mental health has a critical impact on children's mental health. It is estimated that there are the following number of children and young people in Cambridgeshire:

- **22,700** living with at **least one parent** with **mental illness**
- **5,400 living with a problem drinker** with **concurrent mental health problems**
- **3,300 living with a drug user** with **concurrent mental health problem**

What makes young people well?
(from local consultation)

- **Accessible support** in general is important, rather than waiting to be 'ill'
- **Support** from **family** and **friends** is important, as is their **awareness** of mental health
- **Support needs** to be from **friendly**, **approachable** and **empathic people**.
- Being **protected** from harm/bullying, parents
- Learning **to deal with stress**

www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/mental-health-children-and-young-people

Physical disabilities and Learning Disabilities through the life course (2013)

People with **disability** are more likely to **live in poverty** and be **unemployed**. People with **learning disabilities** are more likely than their non-disabled peers to be exposed to **poverty, poor housing conditions, unemployment**, **social exclusion, violence, abuse** and **discrimination**. Those who are already disadvantaged are at a greater risk of becoming disabled later in life. Children and adults with disabilities are **vulnerable to abuse**.

As the Cambridgeshire population grows and ages, the number of people with disabilities is also expected to rise. The proportion of people with a learning disability aged over 55 years is expected to increase and parents caring for them are likely to have died or become frail. **Social care** requirements for people with learning disability in England are expected to **increase** by **14%**, up to **2030.**

The number of **children** with **disabilities** is predicted to **increase**. Children with **special educational needs** are **three times more likely** to be recipients of **free-school meals**. Parents of children with disabilities in Cambridgeshire report a need for better emotional and relationship support for parents right from the start, and for access to skilled, knowledgeable and sensitive health workers.

People with disabilities are subject to the **same risk of chronic diseases** as the population as a whole, but may be less able to **access healthy choices**. People with disabilities may be less able to **access leisure services**, and people with learning disability and their carers may have poor knowledge of **healthy eating**. People with learning disabilities are less likely to take up **screening** and other **health promotion** activities.

People with learning disabilities are more likely to experience **ill health** and to die younger. In part, this is related to a number of environmental factors, including, poverty, discrimination and unemployment. Preventable causes of death are relatively common, such as pneumonia, which can result from swallowing difficulties and seizures.

Supporting those with the most complex needs requires joint working across sensory, learning disabilities, older peoples and complex care teams. The key to improving the health and wellbeing of people with learning disabilities is the ability for services to share information.

www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/physical-and-learning-disability-through-life

Summary of older JSNAs completed

The following section outlines the priority needs in the older JSNA's completed.

Prevention of Ill Health in Adults of Working Age (2011)

There is substantial evidence that prevention works, it can provide cost benefits and importantly can make significant improvements to the health of the population, decrease health inequalities and effectively address health and social problems.

Up to date local data on lifestyle indicators are available through the Public Health Outcomes Framework : www.cambridgeshireinsight.org.uk/health/phof

- Surveys indicate that participation in physical activity decreases with age.
- Nationally, the prevalence of obesity among adults has increased sharply in recent decades. Key factors for prevention of obesity are a healthy diet and physical activity.
- Tobacco use remains the leading cause of preventable morbidity and mortality worldwide. Smoking prevalence is higher in more deprived populations and amongst routine and manual group of workers.
- Excessive alcohol use, either in the form of heavy drinking or binge drinking, can lead to increased risk of health problems such as liver disease or unintentional injuries.
- Liver disease is one of the top causes of death in England and people are dying from it at younger ages. Most liver disease is preventable and much is influenced by the prevalence of hepatitis B and hepatitis C infections, which are both amenable to public health interventions. Persons who inject drugs are at higher risk of contracting hepatitis B and C infections.
- The vulnerable and socio-economically disadvantaged groups are more likely to be at risk of poor dental and oral health. Adults who smoke, take drugs, binge drink or who are obese are more likely to suffer from gum disease and mouth cancer.

Screening programmes that are mostly accessed through general practices are well established and generally meet the targets to ensure that the population as whole is protected. However there is some inequity of service provision across the county and there is insufficient information about screening in vulnerable and hard to reach groups.

Prevention priorities identified :

- Lifestyle issues
- Workplace health
- Domestic violence
- Socio-economic factors especially housing
- Long term conditions

www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/prevention-ill-health-older-people-2013

Children and Young People (2010)

The priority needs that were identified for Cambridgeshire were:

- Ensuring that all children get a good start in life as an increasing body of evidence shows that the first few years will impact lifelong.
- Supporting good mental health and emotional wellbeing which are fundamental to achieving good health.
- Preventing/reducing the negative impact of alcohol and substance misuse, obesity and overweight, childhood accidents, child poverty, domestic violence and disabilities and the consequent inequalities in outcomes for children, young people and their families.

www.cambridgeshireinsight.org.uk/currentreports/children-and-young-people

Mental Health in Adults of Working Age (2010)

The priority needs that were identified for Cambridgeshire were:

- Ensuring a positive start to life: childhood and early adulthood are key periods in the development of personal resilience and educational and social skills that will provide the foundations for good mental health across the whole life course. Key interventions to promote a positive start in early life are:
    - Promoting parental mental and physical health.
    - Supporting good parenting skills.
    - Developing social and emotional skills.
    - Preventing violence and abuse.
    - Intervening early with mental disorders.
    - Enhancing play.
- Interventions that particularly help to maintain mental health for older people include reducing poverty, keeping active, keeping warm, lifelong learning, social connections and community engagement, such as volunteering.
- Interventions to increase individual, family and community resilience against mental health problems include those which reduce inequalities, prevent violence, reduce homelessness, improve housing conditions and debt management, and promote employment.

www.cambridgeshireinsight.org.uk/currentreports/mental-health-adults-working-age

New Communities (2010)

The priority needs that were identified for Cambridgeshire were:

- Provision of 'lifetime homes which can be adapted to the needs of residents as they become older.
- Incorporating a range for formal and informal green space into new developments.
- Identification of community development roles, (which could be funded from a variety of sources) during building of large new housing developments – to provide early social infrastructure and support the integration of new residents including young families into the community.

www.cambridgeshireinsight.org.uk/cambridgeshire-jsna/new-communities

Travellers (2010)

The priority needs for Gypsies and Travellers in Cambridgeshire were:

- Continue to implement and evaluate the existing county wide Gypsy and Traveller strategy to improve outcomes and life chances for Gypsy and Traveller communities and promote and enable community cohesion in Cambridgeshire.
- Improving data collection and ethnic monitoring to support better planning and commissioning of services.
- Ensuring good access to health services and support especially for early intervention/prevention, health promotion, mental health and wellbeing and for those with complex health needs. Providing public health and other service information and communications in an accessible format to the Gypsy and Traveller population with appropriate content.
- Improving site management and provision, promoting good practice in education, sharing good practice across different organisations and promoting continuing community engagement between the settled and Traveller communities to reduce mistrust, fear and discrimination.

www.cambridgeshireinsight.org.uk/currentreports/travellers

People who are homeless or at risk of homelessness (2010)

The priority needs for homeless people in Cambridgeshire were:

- Addressing the needs of chronically excluded adults, single homeless and rough sleepers in Cambridgeshire focusing on the complex interrelationships between health, housing and social care to improve outcomes. The MEAM project is showing good initial outcomes.
- Developing methods to encourage service user and frontline staff engagement in planning, service redesign and commissioning processes. Service users' experience and perceived needs should be embedded in the planning of their own care and of wider services.
- Developing integrated information systems, data collection tools and ways of unifying individual client records so they can be used and accessed across services to allow more holistic and person-centred care.
- Developing services enabling prevention of homelessness and early intervention for the newly homeless to improve individual lives and to reduce overall homelessness. Support is particularly required at transition points such as leaving care, prison release and hospital discharge.

www.cambridgeshireinsight.org.uk/currentreports/homelessness-and-at-risk-of-homelessness

Migrant workers (2009)

The wellbeing and integration of migrant workers is affected by their financial situation, access to adequate and affordable accommodation and access to English language courses. The numbers of international migrants are increasingly spread throughout the county, with notable migration from Western Europe and Asia. Access to good quality and affordable accommodation is critical in providing stable circumstances for migrants to be economically active and to promoting community cohesion.

A number of projects have been undertaken to meet needs in recent years. Continuing work of partners in Fenland includes promoting community cohesion, provision of support for English as a second language, multiagency action to address issues relating to Houses in Multiple Occupation and provision of community services.

www.cambridgeshireinsight.org.uk/currentreports/migrant-workers

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EXECUTIVE SUMMARY BY JSNA CORE DATASET 2017 REPORT CHAPTER

GEOGRAPHY AND DEMOGRAPHY

Population estimates and forecasts

- The **population** of Cambridgeshire in 2015 was estimated locally as just under 650,000 having increased by around 4% since 2011.
- Cambridge has seen the largest absolute and proportional **population growth**.
- Population growth to 2020, based on natural change and migration, suggests that population increases will be concentrated in children and in adults aged 55 and older.
- Overall Cambridgeshire's **population profile** by sex and age is similar to England's but a lower proportion of people are from minority ethnic groups.
- Cambridgeshire is a relatively rural area, with lower **population density** than in England and the East of England but notably higher density in Cambridge.
- Population density in Cambridgeshire has increased since 2007 with a slightly higher proportional increase than in the East of England and England.

Population forecasts

- Please ensure that the **IMPORTANT NOTE REGARDING USE OF POPULATION FORECASTS AND PROJECTIONS on page 24** is read and understood before using the data in this part of the Executive Summary.
- This **section of the Executive Summary is largely based** on locally produced forecasts from **CCC's Research Group**, which include the **impact of local planning policy**, as well as natural change and migration. It should be noted that **national public sector funding allocations** tend to be based on adjusted **Office of National Statistics (ONS) population projections** and these are generally **lower** than the CCC Research Group forecasts, as the sensitive local data on future housing development are not included. The **divergence** between the ONS projections and the Research Group forecasts tends to **increase over time**. The **differences** between CCC RG forecasts and ONS projections are **more marked** in the **child and working age** population groups than in the **older age** groups. The **detailed differences** can be found in the **relevant sections of the report**.
- CCC Research Group predict that Cambridgeshire's **population** is **forecast** to grow by 23% between 2016 and 2036, increasing by 151,000 people to just over 800,000. ONS predicts that Cambridgeshire's population will grow by 15%, or 101,000 over this period.
- South Cambridgeshire is forecast to have the largest absolute and proportional increase in population, but growth is forecast across the county.
- In the shorter term, to 2021, Cambridge is forecast to have the highest absolute and proportional population increases, followed by South Cambridgeshire.
- Between 2021 and 2026 the rate of growth is expected to fall in Cambridge and Fenland but continues in the other districts, notably in East Cambridgeshire.
- Cambridgeshire and its districts are forecast to experience absolute and proportional increases in **all age groups** in the next 5 to 10 years.
- The proportional increase in **under 16s** over the next 5 years is forecast to be highest in Cambridge; and in **16-64s,** in Cambridge and South Cambridgeshire. Increases are notably higher in people **aged 65+** across all districts.

Factors influencing population change

- Major **new housing developments** are proposed across Cambridgeshire: Northstowe, and the proposed Wisbech Garden Town, have the highest numbers of planned dwellings followed by Waterbeach New Town, Alconbury and March.
- The greatest **density** of proposed new housing sites and numbers of dwellings is expected to be in South Cambridgeshire. Cambridge has had the greatest number of completed developments since 2001.

- **Birth rates** have stabilised in recent years after generally increasing trends to 2012; rates are highest in Fenland but notably lower in Cambridge.
- In Fenland **migration** had the largest proportional impact in Cambridgeshire in 2016/17 and was the dominant component of annual population change over that period. In Fenland, the vast majority of migrants are from EU countries (96%) but in Cambridge 65% originate from non-EU countries.

RELATIVE DEPRIVATION AND WIDER DETERMINANTS OF HEALTH

Relative deprivation

- Cambridgeshire as a whole has **low levels of deprivation** with small proportions of people living in the most deprived 20% of areas nationally.
- Fenland is the only district with a level of overall **deprivation above the national rate** and has a larger proportion of its population living in the most deprived 20% of areas nationally, similar to the national average.
- The greatest levels of relative deprivation are in the north of the county, clustered in Fenland, but with some areas in East Cambridgeshire, Huntingdon and north-east Cambridge.
- The percentage of children aged **under 16 living in poverty** is statistically significantly worse than England average in Fenland. Although relatively stable in recent years, it has worsened in relation to the national average as the national position has improved.
- The highest levels of **income deprived older people aged 60+ years** within Cambridgeshire are in Fenland with a rate that is around the national average.

Child development and education

- Cambridgeshire's percentage of children with **free school meal status achieving a good level of development** at the end of reception has been statistically significantly worse than the England rate since 2012/13.
- Fenland's **GSCE attainment rate** is statistically significantly worse than the England and Cambridgeshire averages.
- The rate of **pupil absence** in Cambridge is significantly worse than the Cambridgeshire and national averages.

Employment

- Fenland has many more **deprived areas in terms of employment and income** compared to the other districts of Cambridgeshire.
- **Employment rates** in Cambridgeshire and its districts are statistically better or similar to the national average but rates are lowest in Fenland.
- Rates of **employment support allowance** (ESA) claimants for mental and behavioural disorders are increasing in all districts; the rates is highest in Fenland but statistically significantly similar to the England average.
- Fenland and Cambridgeshire as a whole have significantly higher rates of **sickness absence** than found nationally.

Other wider determinants

- There is a higher **density of fast food outlets** compared to the Cambridgeshire average in Cambridge and Fenland.
- Cambridge has statistically higher levels of **household overcrowding** than found on average in England.
- Fenland has a statistically higher level of **unpaid carers** than England and Cambridgeshire collectively.

LIFESTYLES AND RISK FACTORS

Excess weight and physical activity

- Rates of **excess weight in children** are statistically similar to the England average in Fenland but statistically significantly better elsewhere and for the county as a whole.
- The rate of **excess weight in adults** is statistically significantly worse than the national average in East Cambridgeshire, Fenland and Huntingdonshire. 63% of Cambridgeshire adults are overweight.
- 8% of Year 10 Cambridgeshire **children** were **inactive** in the week before they were surveyed in 2016 and the percentages have notable increased since 2006.
- The percentages of **adults physically active and inactive** are statistically significantly worse than the national averages in Fenland. 25% of all Cambridgeshire adults are inactive.

Smoking

- 10% of Year 10 Cambridgeshire **children** are **smokers** though rates have decreased since 2006.
- The percentage of **adults smoking** is statistically significantly worse than the national average in Fenland. 15% of all Cambridgeshire adults are smokers.
- Cambridgeshire's **stop smoking service** (CAMQUIT) met its target for the number of people successfully quitting smoking at 4 weeks in 2016/17. In 2016/17, quit rates per 100,000 smokers increased in Cambridgeshire compared with 2015/16.
- Levels of smoking quitters have tended to fall and have stabilised at a lower rate following the wider use of e-cigarettes.

Alcohol and drug use

- The percentage of **15 year olds** in Cambridgeshire that have **ever had an alcoholic drink** is statistically significantly higher than the England average, but the rate has notably decreased.
- The percentage of Cambridgeshire **adults who abstain from drinking alcohol** is statistically significantly lower than the England average.
- The rates of **hospital admission episodes** for alcohol-related conditions are statistically significantly higher than the England average in Cambridge and Fenland and appear to be increasing. There are pockets of higher than national average rates across the county.
- 16% of Year 10 **children** in Cambridgeshire report having ever **taken drugs**.
- Around 28 **adults** die each year due to **drug misuse** in the county; rates of deaths are higher in Cambridge and Fenland.

NHS Health Checks

- Although the percentage of the eligible population invited for an NHS Health Check in Cambridgeshire is higher than the England average, the uptake of those offers is statistically significantly lower than average.

Sexual health

- The **chlamydia detection rate** is lower than the national target in Cambridgeshire and each of its districts. It is notably low and falling in Cambridge.
- The percentage of **HIV diagnoses** at a late stage of infection in Cambridgeshire is currently worse than the national target and national average and appears to increasing.
- **STI testing** rates are statistically significantly lower than the national average in Cambridgeshire. Although rates have increased, positivity rates have declined, which may indicate poor targeting or a general decrease in prevalence of infection in the population.

Under 18 births

- Although rates have declined, **birth rates to mothers aged under 18** are statistically significantly higher in Fenland compared with the national average.

Falls

- Rates of **emergency hospital admissions due to falls** in people aged 65 and over are statistically significantly higher than the national average in Cambridge and Fenland. Rates in people aged 80+ are higher than the national average in Cambridgeshire.

SCREENING, VACCINATION AND IMMUNISATION

Adult screening

- The rate of **breast cancer screening** has been statistically significantly lower than the England average in Cambridge since 2010. Coverage for the county as a whole is decreasing.
- The rate of **cervical cancer screening** in Cambridgeshire is statistically significantly lower than the England average and has declined. Coverage is notably low in Cambridge.
- The rate of **bowel cancer screening** is statistically significantly lower than the England average in Cambridge and Fenland.

Children

- Vaccination coverage rates for **Hib/MenC booster at 5 years** of age and **2 doses of MMR by 5 years** of age are below national targets in Cambridgeshire and are declining.
- Coverage rates are also declining in Cambridgeshire for **Dtap/IPV/Hib**, **Hib/MenC booster at 2 years**, and **PCV booster**.

Influenza

- Cambridgeshire's **flu vaccination** rates for **older people** and **at risk individuals** have been statistically significantly below national targets since 2010/11.

LEVELS OF ILLNESS AND HEALTH AND SOCIAL CARE SERVICES

Cardiovascular, respiratory and long-term conditions

- The recorded prevalences of **coronary heart disease** and **stroke** have been statistically significantly higher than the national averages in Fenland since 2008/09.
- The recorded prevalences of **high blood pressure** have been statistically significantly higher than the national average in Fenland and Huntingdonshire since 2008/09.
- The recorded prevalence of **asthma** has been consistently statistically significantly higher than the England average in East Cambridgeshire, Fenland, Huntingdonshire, and South Cambridgeshire since 2008/09. Rates appear to be increasing in South Cambridgeshire.
- The recorded prevalence of **chronic obstructive pulmonary disease** has been consistently statistically significantly higher than the England average in Fenland since 2008/09.
- The recorded prevalence of **cancer** is statistically significantly higher than the national average for the county as a whole and in all districts except for Cambridge.
- The recorded prevalence of **diabetes** in people aged 17 years and over has been statistically significantly higher than the England average in Fenland since 2008/09.

Mental health

- The prevalence of recorded **schizophrenia, bipolar disorder and other psychoses** has been consistently statistically significantly higher than the national average in Cambridge since 2008/09.
- Rates of recorded **depression** are statistically significantly higher than the national average in Fenland and Huntingdonshire.
- Levels of recorded **dementia** across the county are increasing but are significantly lower or similar to the national average. The estimated diagnosis rate, however, is below the national target in East Cambridgeshire, Fenland and Huntingdonshire.
- The proportion of people with a recorded **learning disability** is statistically significantly higher than the England average in Fenland.
- Rates of emergency admission to hospital for **self-harm** have been statistically significantly higher than the national average in Cambridgeshire since 2013/14 and appear to be increasing. Rates are worse than England in all districts except for South Cambridgeshire and notably high in Cambridge.

- **Suicide** rates in Cambridgeshire do not differ significantly from England levels. Male rates are higher than female rates. Fenland's male suicide rate is significantly higher than the Cambridgeshire average and is sustained at a level above both the England Cambridgeshire averages.

Inpatient hospital admissions

- Numbers of **inpatient hospital admission episodes** have increased among residents of all districts.
- The rates of inpatient admission episodes are statistically significantly higher than the Cambridgeshire average in Fenland and Huntingdonshire and appear to be increasing. There are also signs of increasing rates in 75s and over in Cambridge.
- Numbers of **elective** inpatient hospital admission episodes have increased in Cambridge, Fenland and Huntingdonshire residents.
- The rates of elective admissions in under 75s are statistically significantly higher than the Cambridgeshire average in Fenland and Huntingdonshire. In 75s and over, rates are statistically significantly higher than the county average in Fenland and Huntingdonshire; rates have notably increased in Fenland but decreased in South Cambridgeshire.
- Numbers of **emergency** inpatient hospital admission episodes have increased among residents of all districts.
- The rates of emergency admissions in under 75s are statistically significantly higher than the Cambridgeshire average in Fenland and Huntingdonshire. In 75s and over, rates are statistically significantly higher than the county average in Fenland. Rates have increased across the county but more notably in 75s and over and in Fenland.

Accident and emergency attendances

- Numbers and rates of attendances have increased among residents of all districts, at both 24-hour consultant-led A&E and minor injuries units.

Social care services

- The proportion of people who use services who say that those services have made them feel **safe and secure** is statistically significantly worse in Cambridgeshire than the England average.
- Although not statistically assessed, Cambridgeshire fairs worse than the England average for:
    - People who use services who receive **direct payments**
    - Adults with a **learning disability** in paid **employment**
    - Adults in contact with secondary **mental health** services in paid **employment**
    - Adults with a **learning disability** who live **in their own home** or with their family
    - Adults in contact with secondary **mental health** services **living independently**, with or without support
    - **Older people** (aged 65 and over) who were still at home 91 days after discharge from hospital into **reablement/rehabilitation** services;

LIFE EXPECTANCY AND MORTALITY

Life expectancy

- **Life expectancy at birth** is statistically significantly lower than the England average in men in Fenland.
- The **gap in life expectancy** between the least and most deprived is noticeably high in Cambridge in both men and women.

All-cause mortality

- The rates of **all-age and under 75 all-cause mortality** have been statistically significantly higher than the Cambridgeshire average in Fenland since 2006-08.
- Rates declined in Fenland and Cambridgeshire as a whole up to 2010-12 but have since stabilised or increased again, particularly in under 75s in Fenland.

- The rate of all-age all-cause mortality is statistically significantly higher than the county average in the **most deprived 40% of wards**, and in under 75s, in the **most deprived 20%**.
- Rates have declined in the most deprived 20% of wards, but have remained worse than the county average and increased again in 2014-16.
- The **main causes of death** in Cambridgeshire residents are cancer (29%), cardiovascular disease (27%), respiratory disease (12%) and dementia and Alzheimer's (12%).

Overall health status and levels of disability

- At the 2011 Census, the age-standardised percentage of household residents reporting **good or very good health** was statistically significantly lower than the England average in Fenland.
- The age-standardised percentage reporting a **long-term activity-limiting illness** was statistically significantly higher than the England average in Fenland.

Cardiovascular mortality

- Rates of **all-age and under-75 mortality from cardiovascular disease** have been higher than the Cambridgeshire average in Fenland since 2006-08 but continue to fall.
- In Cambridge, rates have increased since 2011-13 becoming statistically significantly higher than the county average.
- The rate of all-age and under-75 mortality in the **most deprived 20%** of wards has been statistically significantly higher than the county average since 2006-08 but continues to fall.
- Rates have notably increased in recent years in the **middle quintile** of wards by deprivation becoming statistically significantly higher than the county average in 2014-16.

Cancer mortality

- Rates of **all-age mortality from cancer** have been higher than the Cambridgeshire average in Fenland since 2008-10 and have increased in contrast to a decline seen for the county as a whole.
- Rates of **under-75** mortality from cancer have been higher than the county average in Fenland since 2009-11; they appear stable but in contrast to a decline seen for the county as a whole.
- Rates have generally been statistically significantly higher than the Cambridgeshire average in the **most deprived 20%** of wards since 2006-08 but have fallen in recent years.

Respiratory disease mortality

- Rates of **all-age and under-75 mortality from respiratory disease** have been higher than the Cambridgeshire average in Fenland since 2006-08. All-age rates were falling but have increased since 2010-12 in contrast to continued decline for the county as a whole.
- Rates of all-age mortality in Huntingdonshire were in decline up to 2009-11 but have increased to level statistically significantly worse than the county average.
- Rates have been statistically significantly higher than the Cambridgeshire average in the **most deprived 20%** of wards in the county since 2006-08. Rates have generally declined but the rate in the under 75s increased in 2014-16.

Dementia and Alzheimer's mortality

- The rate of **all-age mortality from dementia and Alzheimer's** has been statistically significantly higher than the Cambridgeshire average in Cambridge since 2011-13 and has been increasing, as it has across the county (some of this is thought to be related to increased awareness, diagnosis and recording).
- The rates of all-age and under 75 mortality due to dementia and Alzheimer's are statistically significantly higher than the Cambridgeshire average in the **most deprived 20%** of wards in the county.
- All-age rates are also statistically significantly higher than the county average in the **middle 20%** of wards in Cambridgeshire by deprivation.

1.1 Health Profile summary for Cambridgeshire and districts

Public Health England's Health Profiles give a snapshot of the overall health of each local authority in England. The profiles present a small set of some of the most important health indicators that show how each area compares to the national average in order to highlight potential problem areas. In this section, we present a summary of these key indicators to provide a rapid overview for Cambridgeshire and its districts. Many of these indicators are described in more detail in the main report.

Table 1. Public Health England (PHE): annual health profile summary for Cambridgeshire and the districts - selected indicators, 2017

Category	Indicator*	Period	England value	Cambs value	Cambs recent trend	Cambridgeshire Districts				
						Cambridge	E Cambs	Fenland	Hunts	S Cambs
Our Communities	Index of Multiple Deprivation Score 2015 (score)	2015	21.8	13.4	-	13.8	12.1	25.4	11.8	8.1
	Children in low income families (%)	2014	20.1	12.9	↓5	15.9	10.1	21.3	11.9	8.5
	Statutory homelessness (per 1,000 households)	2015/16	0.9	0.5	-	2.3	Supressed	Supressed	0.1	0.2
	GCSEs Achieved (%)	2015/16	57.8	61.2	-	63.3	58.7	52.2	59.2	70.2
	Violent crime (violence offences per 1,000 popn)	2015/16	17.2	10.9	↑5	16.2	7.3	14.6	9.9	7.1
	Long term unemployment (per 1,000 working age popn)	2015/16	3.7	1.1	↓5	1.6	0.9	1.4	0.6	0.9
Children's & young peoples health	Breastfeeding initiation (%)	2014/15	74.3	DQ	-	DQ	DQ	68.8	80.9	DQ
	Obese children (year 6) (prevalence - %)	2014/15	19.8	14.9	→10	11.3	15.3	20.0	15.8	12.6
	Hospital stays for alcohol-specific conditions (under 18s) per 100,00	2013/14-15/16	37.4	38.5	-	42.5	27.9	37.6	54.2	25.4
	Under 18 conceptions per 1,000 females 15-17	2015	20.8	16.5	↓6	15.9	12.7	26	14.5	15.2
Adult's health & lifestyle	Smoking prevalence in adults (%)	2016	15.5	15.2	-	15.1	15.3	21.6	14.0	12.8
	Physically active adults (%)	2015	57.0	58.6	-	69.8	53.8	47.9	57.9	59.5
	Excess weight in adults (%)	2013-15	64.8	63.2	-	46.7	68.1	72.9	67.6	63.6
Disease & poor health	Cancer diagnosed at an early stage (%)	2015	52.4	56.8	-	55.8	56.2	55.9	58.4	56.6
	Emergency hospital stays for self-harm (per 100,000 population)	2015/16	196.5	264.9	-	351.5	253.0	310.7	226.8	197.8
	Hospital stays for alcohol-related harm (per 100,000 population)	2015/16	647	638	-	818	589	731	590	558
	Recorded diabetes (%)	2014/15	6.4	5.5	↑5	3.3	6.5	7.8	6.1	4.8
	Incidence of TB (per 100,000)	2013/15	12.0	6.0	-	9.8	2.7	7.8	5.0	4.6
	New sexually transmitted infections (per 100,000 popn 15-64)	2016	795	511	↓5	761	342	475	495	400
	Hip fractures in people aged 65 and over (per 100,000 population)	2015/16	589	583	-	660	497	667	562	542
	Estimated dementia diagnosis rate (aged 65+) (%)	2017	67.9	62.7	-	67.4	58.0	60.1	69.6	54.8
Life expectancy, causes of death & selected inequalities indicators	Life expectancy at birth (males), years	2013-15	79.5	80.9	-	80.3	81.6	78.6	81.0	82.1
	Life expectancy at birth (females), years	2013-15	83.1	84.4	-	84.1	84.8	82.6	84.7	85.2
	Infant mortality - deaths under 1 year per 1,000 live births	2013-15	3.9	3..1	-	4.0	1.0	4.3	2.5	3.4
	Suicide rate (per 100,000)	2013-15	10.1	9.1	-	7.6	Supressed	12.7	9.2	9.7
	Smoking related deaths (per 100,00 aged 35 +)	2013-15	283.5	227.8	-	-	-	-	-	-
	Under 75 cardiovascular disease mortality rate (per 100,000 popn)	2013-15	74.6	63.5	-	75.8	59.8	83.5	60.5	50.2
	Under 75 cancer mortality rate (per 100,000 popn)	2013-15	138.8	120.3	-	119.9	115.6	145.4	114.5	113.3
	Excess winter deaths (index)	8/2012 - 7/2015	19.6	16.7	-	24.6	14.5	19.7	12.5	14.4
	Premature (under 75) mortality from all causes (male) - per 100,000	2013-15	408	339	-	361	306	444	328	299
	Premature (under 75) mortality from all causes (female) - per 100,000	2013-15	266	225	-	237	227	286	218	187
	Dependency ratio (%)	2015	60.7	59.6	-	39.4	67.5	69.0	63.1	65.5

* Full indicator descriptions and definitions are available at https://fingertips.phe.org.uk/profile/health-profiles

Statistically significantly better than the England average
Statistically similar to the England average
Statistically significantly worse than the England average

Lower than the England value
Higher than the England value

Suppressed: removed due to small numbers
DQ: data quality issue
'-': not available

↑n Getting worse (number of years on which trend based)
→n No significant change (number of years on which trend based)
↓n Getting better (number of years on which trend based)

Public Health England Health Profiles at https://fingertips.phe.org.uk/profile/health-profiles

Source: Public Health England Health Profiles for 2017

Key points:

- Overall **Cambridgeshire** is a healthy place to live, with many health and wellbeing determinants and outcomes more favourable when compared with England averages.
- For **Cambridgeshire** as a whole particular areas of concern, based on the local health profile, potentially include: violent crime where the rate of offences is increasing; mental health and self-harm; alcohol abuse; adult physical activity; suicide and excess winter deaths.
- The district area of Cambridgeshire with most adverse issues remains **Fenland**, where many indicators are more challenging than the county averages and sometimes when compared nationally. Areas of particular concern in Fenland are: general inequalities in health determinants and some outcomes across the life-course; child poverty; educational attainment; breastfeeding uptake; smoking; physical activity and excess weight in adults; mental health and self-harm; alcohol abuse; recorded diabetes; male life expectancy at birth. Many other important indicators are also closer to national, rather than local county, averages and so remain areas of concern (see those measures assessed as 'statistically similar' to England averages in the Figure above).
- **Cambridge** has many health and wellbeing indicators that are better than national averages. However, there is an increasing trend of some indicators moving towards national, rather than overall local, averages and this is of some concern. Issues to consider further are alcohol abuse; smoking; mental health and self-harm; TB incidence; sexual health; falls and hip fractures in older people; dementia diagnosis rate; suicide; excess winter deaths.
- For the remaining districts of **East Cambridgeshire**, **Huntingdonshire** and **South Cambridgeshire**, most indicators are relatively favourable when assessed against national comparators and, broadly, it is these districts that drive the Cambridgeshire position as a healthy place compared with England collectively. Particular areas of concern in **East Cambridgeshire** are: adult excess weight; mental health and self-harm; dementia diagnosis rate. In **Huntingdonshire**: alcohol abuse; adult excess weight. In **South Cambridgeshire**: dementia diagnosis rate. In these relatively healthy areas it is important to also have regard for those indicators that are similar to national averages or are also of concern more broadly in Cambridgeshire: in **East Cambridgeshire** educational attainment; smoking; adult physical activity; recorded diabetes; in **Huntingdonshire** educational attainment; smoking; adult physical activity; falls and hip fractures in older people; suicide; excess winter deaths; in **South Cambridgeshire** alcohol abuse; smoking; adult physical activity and excess weight; mental health and self-harm; falls and hip fractures in older people; suicide; excess winter deaths.
- It should be noted that some measures may still be important, even if they are not shown to be locally or nationally adverse – for example if significant numbers of people are involved, they are good overall measures of population health status or trends are adverse.
- Similarly, some issues that are masked at county and district level may be important at a **smaller area level** and smaller area analysis may highlight particular pockets of deprivation where there are relatively worse health determinants and outcomes. Small area data can be found on **Cambridgeshire Insight at http://cambridgeshireinsight.org.uk/** and within **Local Health at http://www.localhealth.org.uk/**. We will also shortly begin work on a small area JSNA Core Dataset.

The list below **summarises areas of potential priority**:

- Fenland - broadly improving health determinants and outcomes in this district and reducing health inequalities.
- Cambridge, reducing health inequalities in this district and improving emerging adverse trends in some health determinants and outcomes.
- Educational attainment in East Cambridgeshire, Fenland and Huntingdonshire.
- Alcohol abuse.

- Mental health including self-harm and suicide.
- Smoking.
- Physical activity and weight management across the life-course, including diabetes in East Cambridgeshire and Fenland.
- Falls and hip fractures in older people.
- Dementia.
- Excess winter deaths.

Notes:

- The following two indicator are in the local health profiles on Public Health England's website but not are not included in the summary above for the reasons below.
- **Infant mortality.** This indicator is assessed as the same as the national average In Cambridgeshire as a whole and in all districts other than East Cambridgeshire. It is important to note that the numbers of deaths are relatively few and this means that the test used to assess statistical importance yields wide levels of uncertainty and hence similarity to the average. No district has a rate that is higher than the county average either. The rate is highest in Fenland, but does not differ statistically when compared with the national and local averages.
- **Killed and seriously injured on roads.** This indicator benchmarks poorly locally compared with the national measure. However, it is a poor indicator that uses area based road casualty data as its numerator and resident based population data as its denominator. This gives a clear mismatch between the component parts of the indicator and does not deal with area based traffic flow patterns. Local measures should be taken from the County Council's own road safety team at **https://www.cambridgeshire.gov.uk/residents/travel-roads-and-parking/roads-and-pathways/road-safety/.**

CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD
FORWARD AGENDA PLAN

MEETING DATE	ITEM	REPORT AUTHOR	
21 September 2017 10.00am, Civic Suite, Pathfinder House, Huntingdon	**Health and Wellbeing Board**		
	Election of Vice Chairman/ Vice Chairwoman	Oral	**Reports to Richenda Greenhill by Friday 8 September 2017**
	Apologies and Declarations of Interest	Oral	
	Minutes of the Meeting on 6 July 2017 and the Extraordinary meeting on 8 September 2017	Richenda Greenhill	
	Action Log Update	Richenda Greenhill	
	Person's Story – Children's Emotional Health and Wellbeing	tbc	
	Local Safeguarding Children's Board Annual Report 2016-17	Russell Wate, Andy Jarvis	
	Child and Adolescent Mental Health Services Transformation Plan	Kathryn Goose, CCG	
	Annual Public Health Report	Liz Robin	
	Data Sharing	Charlotte Black/ Geoff Hinkins	
	Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation Programme: Update	Scott Haldane	
	Joint Strategic Needs Assessment (JSNA) Core Dataset	Liz Robin	

MEETING DATE	ITEM	REPORT AUTHOR	
	Health & Wellbeing Board – Joint Development session with Peterborough Health & Wellbeing Board	Kate Parker	
	Forward Agenda Plan	Richenda Greenhill	
	Date of Next Meeting		
23 November 2017 10.00am (venue tbc)	**Health and Wellbeing Board**		
	Apologies and Declarations of Interest	Oral	**Reports to Richenda Greenhill by Friday 10 November 2017**
	Minutes of the Meeting on 21 September 2017	Richenda Greenhill	
	Action Log Update	Richenda Greenhill	
	Person's Story	Winter Comfort tbc	
	Health and Wellbeing Strategy 2018-22: Draft for Consultation	Liz Robin	
	Better Care Fund: Six month Health Data Update	Gill Kelly, CCG	
	Draft 'Living Well' Partnership Concordat	Mike Hill	
	Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation Programme: Update	Scott Haldane	
	Forward Agenda Plan	Richenda Greenhill	
	Date of Next Meeting		
1 February 2018 10.00am (venue tbc)	**Health and Wellbeing Board**		
	Apologies and Declarations of Interest	Oral	**Reports to Richenda Greenhill by Friday 19 January 2017**
	Minutes of the Meeting on 23 November 2017	Richenda Greenhill	
	Action Log Update	Richenda Greenhill	

MEETING DATE	ITEM	REPORT AUTHOR	
	Person's Story		
	Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation Programme: Update	Scott Haldane	
	Forward Agenda Plan	Richenda Greenhill	
	Date of Next Meeting		
22 March 2018 10.00am (venue tbc)	**Health and Wellbeing Board**		
	Apologies and Declarations of Interest	Oral	**Reports to Richenda Greenhill by Friday 9 March 2018**
	Minutes of the Meeting on 1 February 2018	Richenda Greenhill	
	Action Log Update	Richenda Greenhill	
	Person's Story		
	Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation Programme: Update	Scott Haldane	
	Forward Agenda Plan	Richenda Greenhill	
	Date of Next Meeting		
31 May 2018 10.00am (venue tbc)	**Health and Wellbeing Board**		
	Apologies and Declarations of Interest	Oral	**Reports to Richenda Greenhill by Friday 18 May 2018**
	Election of a Vice Chairman/ Chairwoman	Oral	
	Minutes of the Meeting on 22 March 2018	Richenda Greenhill	
	Action Log Update	Richenda Greenhill	
	Person's Story		
	Safeguarding Adults Board Annual Report 2017/18	Russell Wate	

MEETING DATE	ITEM	REPORT AUTHOR	
	Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation Programme: Update	Scott Haldane	
	Forward Agenda Plan	Richenda Greenhill	
	Date of Next Meeting		

Updated: 13 September 2017