CAMBRIDGE LOCAL HEALTH PARTNERSHIP

Date: Thursday, 13 September 2012
Time: 12.00 pm to 1.30 pm
Venue: Council Chamber - Guildhall
Contact: Toni Birkin **Direct Dial:** 01223 457086

AGENDA

1 APOLOGIES

2 PUBLIC QUESTIONS

3 MINUTES AND MATTERS ARISING

To approve the minutes of the meeting held on the 3rd July 2012 *(Pages 1 - 6)*

4 UPDATE ON THE WORK OF THE SHADOW HEALTH AND WELLBEING BOARD *(Pages 7 - 8)*

Liz Robin to introduce this item. Forward Plan attached.

5 AGEING WELL PROGRAMME AND COMMUNITY NAVIGATORS

Mike Hay to introduce this item. Background reports attached. *(Pages 9 - 26)*

6 DEVELOPING A RESPONSE TO THE HWB CONSULTATION DRAFT STRATEGY

Jas Lally to introduce a draft response prepared from discussions at Sub-group meeting on 29th August. Draft response attached. *(Pages 27 - 30)*

7 DEVELOPING A WORK PROGRAMME FOR THE CAMBRIDGE LOCAL HEALTH PARTNERSHIP

Jas Lally to lead a discussion about a work programme for the partnership, including a workshop looking at GP issues and where the local authorities

could contribute to their resolution.

8 AGREEING A FORWARD PLAN FOR THE PARTNERSHIP

Members are asked to agree the issues they wish to discuss at the next meeting of the partnership.

9 DATE OF NEXT MEETING

Members are asked to bring diaries.

Information for the public

Public attendance
You are welcome to attend this meeting as an observer, although it will be necessary to ask you to leave the room during the discussion of matters which are described as confidential.

Public Speaking
You can ask questions on an issue included on either agenda above, or on an issue which is within this committee's powers. Questions can only be asked during the slot on the agenda for this at the beginning of the meeting, not later on when an issue is under discussion by the committee.

Fire Alarm
In the event of the fire alarm sounding please follow the instructions of the Chair.

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CAMBRIDGE LOCAL HEALTH PARTNERSHIP 3 July 2012
12.00 - 1.35 pm

Present:
Mike Hay (Head of Quality and Transformation, Cambridgeshire County Council, Adult Social Care),
Fay Haffenden (Consultant in Public Health),
Rachel Harrison (Manager Camhealth Local Commissioning Group),
Rachel Harmer (GP Cam Health),
Antoinette Jackson (Chief Executive, Cambridge City Council),
Jas Lally (Head of Refuse and Environment, Cambridge City Council),
Geraldine Linehan (GP, NHSC),
Mike Pitt (Executive Councillor, Cambridge City Council),
Jez Reeve (Chief Executive, Cambridge Council for Voluntary Services),
Graham Saint (Strategy Officer, Cambridge City Council)
Wendy Quarry (JSNA Programme Manager, Cambridgeshire County Council),

1 Election of Chair and Vice Chair

Councillor Pitt volunteered to be Chair and this was seconded by Jez Reeve.

The partnership felt that the Vice Chair should come from the health sector. However, none of those present felt able to commit to this role and the present time. This would be reviewed at the next meeting.

Resolved (unanimously) that Councillor Pitt be Chair and Jas Lally be acting Vice Chair of the Cambridge Local Health Partnership.

2 Apologies for Absence

Apologies were received from Inger O'Meara Dr Liz Robin and County Councillor Paul Sales.

3 Noting Terms of Reference

The Partnership noted the Terms of Reference.

4 Public Questions

There were no public questions.

5 Shadow Health and Wellbeing Board Update - Feedback and forward look to next meeting on 11 July and beyond (Liz Robin)

The partnership noted the Shadow Health and Wellbeing Board Forward Agenda Plan. It was agreed that all members would be linked into progress reports on the formation of Local Health Partnership. Jas Lally would arrange this.

Action: Jas Lally

The partnership discussed stakeholder consultations. Jas Lally would contact Tom Dutton to agree a way forward.

Action: Jas Lally

Papers from the Clinical Commissioning Group would be circulated with future agendas. Geraldine Linehan agreed to contact Tom Dutton and request that he produce an update document to this Partnership.

Action: Geraldine Linehan

The Partnership noted that the following items had been deferred: Victim and Offender Joint Health Needs Assessments and Safer Homes Scheme.

6 Draft Health and Wellbeing Strategy for Consultation

The partnership noted that the consultation process on the Draft Cambridgeshire Health and Wellbeing Strategy 2012-17 had begun. The detailed information and broad ranging strategy was praised. Councillor Pitt suggested that the partnership formed a sub group to agree a formal response to the consultation. The following were agreed as sub group members: Jas Lally, Geraldine Linehan, Mike Hay, Rachel Harmer, Inger O'Meara and Jez Reeve (who would consult city voluntary groups and feed back to the sub group).

Jas Lally would arrange the sub group meeting. First thought on the consultation documents to be sent to him by the 27th July 2012. These would be collated and circulated.

Action: Jas Lally

The Partnership expressed the following initial views on the Draft Strategy:

i. Key items were thought to be:
   - Supporting older people to healthy and well;
   - Adding value to existing services by better co-ordination; and
   - 'Doing things differently'.

ii. City priorities were agreed to be:
   - Person centred approaches;
   - Flexibility;
   - Clarity on what resources were available in the community;
   - Gathering and sharing information; and
   - The inclusion of mental health.

Networks were agreed to be key to new ways of working and this was to be highlighted in the consultation responses. The sub group were asked to work on a response to section 4.3 of the consultation to improve the prominence given to partnership working. It was agreed that a city based sub group could add value. The September meeting would finalise the responses drafted by the sub group.

7 Headline local priorities for partners

Geraldine Linehan introduced the Clinical Commissioning – Areas of Focus for 2012-13 report and outlined the progress made on key issues. She clarified that the objective was to find out what people wanted and to agree the best way of delivering that. She stated that delivering what people wanted could deliver better care and need not cost more. For example: improved end of life care could avoid costly hospital admissions and provide more dignity for the dying.

Lessons could be learnt from other areas and it was hoped that a successful scheme, operating elsewhere, of rapid mental health assessment in accident and emergency departments could be implemented locally. Early intervention in this area had reduced repeat admissions and avoided escalating care needs.

Jas Lally outlined the linkages between the services provided by Cambridge City Council and the health strategy. Issues such as, housing, air quality, water pollution, community safety and many others, contributed to the wellbeing of local residents.

The Partnership considered ways to improve connectivity and build networks. Using Area Committees, the Tenant Sounding Board and resident surveys to access public opinions on health were considered. Antoinette Jackson recalled a piece of work, some years ago, which had approached a group of residents using a blank page approach and asking what they wanted to discuss. Health had been a key issue. It was suggested that GP's would welcome closer links with housing organisations and that patient care suffered as health staff did not know who to talk to in housing. Jas Lally agreed to produce a contact list of key housing personnel.

Action: Jas Lally

The Partnership agreed that the two key priorities were:

i. Improving communication, including sharing consultations and sharing contact lists.
ii. Personalising the care agenda.

The group felt that web information was available but was currently in multiple locations and was not reaching the target audience. New approaches were discussed such as piggy backing on to other events or using real issues in a case study approach to build a richer picture the current situation. South Cambs had employed communication navigators to good affect.

It was agreed that a snapshot of issued raised in an average day in a GP's surgery would be brought to this partnership to assess how much impact could be made using a network approach. Representatives of City Homes, Social Care Groups and Independent Living Services could also be invited.

Action: Jas Lally

The North Area Committee of the 26th July 2012 would be discussing health issues and feedback from that meeting would be reported to the next meeting.

8 Setting future dates - update on Modern.Gov

The Partnership agreed that finding dates that would suit everyone might not be possible. Provisional dates would be circulated for the remainder of the municipal year and would be agreed at the September meeting.

A library of background papers would be established using the Modern Gov system. Partnership members would be notified when anything new was added. Report to be added to the library to be sent to Jas Lally.

Agenda items would include:

i. Community Navigators
ii. The Aging Well Report (Mike Hay)
iii. Update on the Health and Wellbeing Board Strategy (Liz Robin)
iv. Feedback from the Sub-Group
v. Case Studies

The meeting ended at 1.35 pm

CHAIR

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MEETING DATE	ITEM	REPORT AUTHOR	DEADLINE
11 Oct 2012	**Cambridgeshire Health and Wellbeing Strategy** *Approval of the Health and Wellbeing Strategy for Cambridgeshire*	Liz Robin	Wed 26 Sept 2012
	Areas for Immediate Action *Update on progress against the four areas identified for immediate action.* • *Domestic Abuse (Domestic Violence and Sexual Abuse Strategy – Action Plan)* • *Preventing serious illness and hospital admissions in winter* • *Addressing Health Inequalities (Health Inequalities Action Plan)* • *Road Safety*	Claire Bruin	Wed 26 Sept 2012
	Business Planning 2013	P Harding/T Dutton	Wed 26 Sept 2012
	Joint Commissioning Action Plan	Cathy Mitchell	Wed 26 Sept 2012
	Report on HealthWatch	Mike Hewins	Wed 26 Sept 2012

MEETING DATE	ITEM	REPORT AUTHOR	DEADLINE
	Safer Homes Scheme *To consider a report from the District Forum on the Safer Homes Scheme*	Councillor S Ellington	Wed 26 Sept 2012
	Victim and Offender Joint Health Needs Assessment *To consider the Victim and Offender Joint Health Needs Assessment*	Dorothy Gregson	Wed 26 Sept 2012
	JSNA review and forward workplan	Liz Robin	Wed 26 Sept 2012
16 Jan 2013	**Ageing Well Programme – Report from Local Health Partnerships**	District Forum	Wednesday 2 January 2013
	Health and Wellbeing Strategy Action Plan	Liz Robin	Wednesday 2 January 2013
	Review of the Year	Liz Robin	Wednesday 2 January 2013

Agenda Item No.4

AGEING WELL PROGRAMME

To: Shadow Health and Wellbeing Board

Date : 18 June 2012

From : Claire Bruin, Service Director, Strategy and Commissioning (Adult Social Care)

1.0 Purpose

1.1 To update the Board on a series of engagement events, facilitated by the Local Government Association (LGA) Ageing Well Programme that have taken place within Cambridgeshire. The events explored the challenges faced by an ageing community and considered ways of developing new approaches and sharing best practice around community-based support.

1.2 To seek the Board's support for the proposal that this initial work is considered by the five Local Health Partnerships (LHPs), and agreements reached within the LHPs on how the work could be developed further into more formal plans that are relevant to each locality.

2.0 Background

2.1 The LGA have been working with local authorities to improve their services for older people within the challenging environment of reductions in public sector funding, alongside the unprecedented increase in the numbers of older people. The Ageing Well programme (AWP) was therefore developed to encourage local authorities to take the lead and work in partnership with other local organizations to help develop imaginative approaches to the issues faced in their particular community whilst improving efficiency and maintaining quality services.

2.2 Discussions were initiated by South Cambridgeshire District Council (SCDC) about engaging with the AWP which led to a workshop being held during the summer of 2011 with older people and representatives from the statutory and voluntary sectors to look at the future needs of South Cambridgeshire's older population. Six suggestions for future work emerged from the meeting:

- Using South Cambridgeshire District Council's magazine to publicise services available to older residents.

- Development of the County Council's 'Your Life Your Choice' website to act as one point of contact, and exploration of a one stop phone number for older people to seek advice.

- Transferring the experience and expertise of those villages with well developed community resources for older people to villages where those arrangements are not in place, or are less well developed.

- Developing the community village warden service to offer information about local services and activities available for older people.

- Encouraging local action by simplifying grant application and award processes for local groups.

- Better operational liaison between local authorities, health and the voluntary sector to deliver improved services/ support to older people.

- Encouraging individuals and local groups to take action and helping them to overcome burdensome regulation and other requirements that can stifle local initiatives.

2.3 Following the success of South Cambridgeshire District Council's workshop a meeting was held with representatives from all of Cambridgeshire's District and City Councils to discuss how the AWP might be taken forward, building on the work already started in South Cambridgeshire.

2.4 It was agreed that a proposal be submitted to the LGA to develop a cross-county, strategic approach to the challenges faced by an ageing community with support from the LGA Ageing Well Programme building on and complementing on going work in the different Districts.

2.5 The project's objective was to work with two of the district councils to enhance and develop an active dialogue with older people around health and wellbeing, and to consider ways that local communities can share best practice around community-based support.

2.6 The feedback would then provide a mechanism for the needs and priorities of older people to be taken into account in the work of the Local Health Partnerships and the Shadow Health and Well Being Board (SH&WBB).

2.7 The LGA agreed to support the project by providing free facilitation to take the project forward. The following aims were jointly agreed for the project:

- To develop a shared understanding and vision of how to take forward the Ageing Well agenda across Cambridgeshire
- To harvest and share best practice around community capacity building and how to grow and develop it in areas where there is less
- To identify the assets, skills and gifts of older people in the area and how these resources can be put to use to support one another in communities
- To enable the voices of older people to be heard and through this, for older people to have a part in priority setting for the SH&WBB – more than simply feeding views into the board but actually coming to the conclusions together

- To model a process that could enable the SH&WBB to deal with other cross-cutting themes in the future

2.8 Workshops were held in Fenland and East Cambridgeshire involving officers, councillors, voluntary and community organisations and older people themselves in 'conversations' about health, wellbeing and local support networks. A final county wide meeting was then held on 16th March 2012 with 6 representatives from each of the District / City Council's made up of at least 50% older people with the remaining representatives being officers, Members or representatives of the voluntary sector.

2.9 The county meeting was opened by Cllr Sue Ellington from South Cambridgeshire District Council, who is vice chairman of the Shadow Health and Well Being Board and representative of the District and City Councils and was closed by Cllr Martin Curtis, from Cambridgeshire County Council, who is the portfolio holder for Adult Social Care. The write up from this event is attached.

2.10 The attendees spent the morning working on the key points that had arisen at the district meetings. A summary of these are grouped under the following headings:

Connecting with others

Issues: Need to address rural Community needs – reach isolated areas. Need to train professionals to recognise trigger points and know when to intervene.

Being Active

Issues: Need for population to improve health by starting younger. Programmes should be relevant and engaging. Accessibility and cost may be barriers.

Support and Feeling Safe

Issues: Fear of crime leads to isolation - police bobby scheme seen as positive support network. Need for community navigator who could signpost people to appropriate services.

Learning

Issues: Recognition that learning assists in keeping people's minds active and improves memory and wellbeing. Accessibility and cost of courses may be a barrier and consideration is needed of how to engage those with less positive experiences of education.

Various issues

Issues: A range of different issues were raised including not assuming people want to go out, planning for later years, barriers to accessing services, having confidence to use the choices out there, accessibility to services, and isolation versus independence.

2.11 These themes and issues were refined to focus on the following areas:

- Support and feeling safe
- Connecting people together
- Learning in and planning for retirement
- Better information
- Choice and independence including transport

2.12 Participants were asked to develop a range of ideas on how to take these themes forward looking at traditional, different and radical solutions. These solutions were then voted upon to identify five ideas for some more detailed planning. These were:

- Ensuring every older person has a trusted person/advocate – Look at linking older people to a single person / advocate

- Wiggle Buses - Develop wiggle bus services in Cambridgeshire. These are demand led with the route being determined by the people requiring transport each day.

- Variety of tailored approaches/local activities – determined by local people and leading to people feeling safer and supported.

- Smarter well-being campaigns – Develop work already being carried out in the county to include well being campaigns. Promoting positive images of older people as assets rather than burdens.

- Community navigators - Develop the "community navigator"/"village agent" concept that is already operational in some parts of the county to link people into services and help them to feel supported and safe.

3.0 Future action

3.1 South Cambridgeshire District Council has an Ageing Well Group, linked to the Local Health Partnership that is taking forward the ideas generated at the workshop in summer 2011 and informed by the work with the LGA. A further "engagement event" will take place in September with older people and other stakeholders to review progress.

3.2 Huntingdonshire Health and Wellbeing Partnership (HHWP) has received a report on the Ageing Well events to promote this work in Huntingdonshire.

Further discussion is needed within the HHWP on how the work could be developed further into more formal plans that are relevant to the locality.

3.3 Reports will also be presented to the Local Health Partnerships in Fenland, East Cambridgeshire and Cambridge City to inform discussions on how to take forward the issues raised through this work in a way that is relevant and appropriate to each area.

4.0 Recommendations

4.1 It is recommended that the Shadow Health and Wellbeing Board:

(i) note the feedback from the Countywide event held on 16 March 2012, following events with Fenland District Council and East Cambridgeshire District Council all of which were supported by the LGA Ageing Well programme, and the earlier work in South Cambridgeshire District Council.

(ii) support the proposal that this initial work is considered by the five Local Health Partnerships (LHPs), and agreements reached within the LHPs on how the work could be developed further into more formal plans that are relevant to each locality, recognising that this work is already underway in South Cambridgeshire District Council.

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Agenda Item No: 8

ADULT SOCIAL CARE – STRENGTHENING PREVENTION

To:	**Cabinet**
Date:	**12 June 2012**
From:	**Service Director: Adult Social Care**
Electoral division(s):	**All**
Forward Plan ref:	**N/A** *Key decision:* **No**
Purpose:	**This report proposes the strengthening of the strategic framework for prevention in Cambridgeshire, delivering the objectives of the Adult Social Care Prevention and Early Intervention Strategic Plan, the Ageing Well Programme and the Council's Integrated Plan 2012-13.** **The report is based on the introduction of an initial three year Community Navigator project to contribute to the bridging of the gap between local communities, statutory and voluntary organisations, enabling older people to find services that meet their needs.** **This approach is an ambitious 'community facing' programme which is led by the needs, desires, and aspirations of Cambridgeshire's older people, supporting the countywide prevention framework aimed at delaying people's need for costly health and social care services and at the same time improving people's quality of life and reducing social isolation.**
Recommendation:	**Cabinet is being asked to endorse the principles of the Cambridgeshire Adult Social Care prevention framework through the development of a Community Navigator function across the county.**

	Officer contact:		***Member contact***
Name	Mike Hay & Sunny Singh	Name:	Councillor Martin Curtis
Post:	Head of Quality &Transformation Strategic Development Manager	Portfolio	Cabinet Member for Adult Social Care
Email:	Mike.Hay@cambridgeshire.gov.uk Sundeep.Singh@cambridgeshire.gov.uk	Email:	Marin.Curtis@cambridgeshire.gov.uk
Tel:	01223 715342	Tel:	01223 699173

1. BACKGROUND

1.1 The Council's Integrated Plan 2012-13 commits to invest in prevention, stating, 'we will focus on services that help people early on, increasing their independence and choice and helping them to help themselves.'

1.2 The importance of this focus is made all the more pertinent by a number of demographic drivers, not least an increasingly older population, together with cultural shifts such as the growing demand for choice and higher expectations. These changes require a move away from reactive expensive services, accessed at a point of crisis, to a more enabling provision that is preventative in nature and seeks to promote healthy lifestyles and general wellbeing.

1.3 The requirement to engage people in preserving and improving their own health and wellbeing is outlined by a number of key local strategies including[1]:

- Adult Social Care Prevention and Early Intervention Strategic Plan (2009)
- JSNA Phase 5 Prevention of ill health in adults of working age (2011)
- JSNA Phase 4 Older people including dementia (2010)
- Physical disability and sensory services commissioning strategy (2011-14)
- 'Making Change Happen' – commissioning strategy for support for adults with a learning disability (2011-14)
- Framework for older people's joint commissioning strategy (2011-13)
- Mental health commissioning strategy
- Assistive technology commissioning strategy (2011-14)
- Carers commissioning strategy (2012 -16)
- Supporting people commissioning strategy (2011-15)

2. WHAT IS PREVENTION IN ADULT SOCIAL CARE?

2.1 Preventative services are often thought about in three levels:

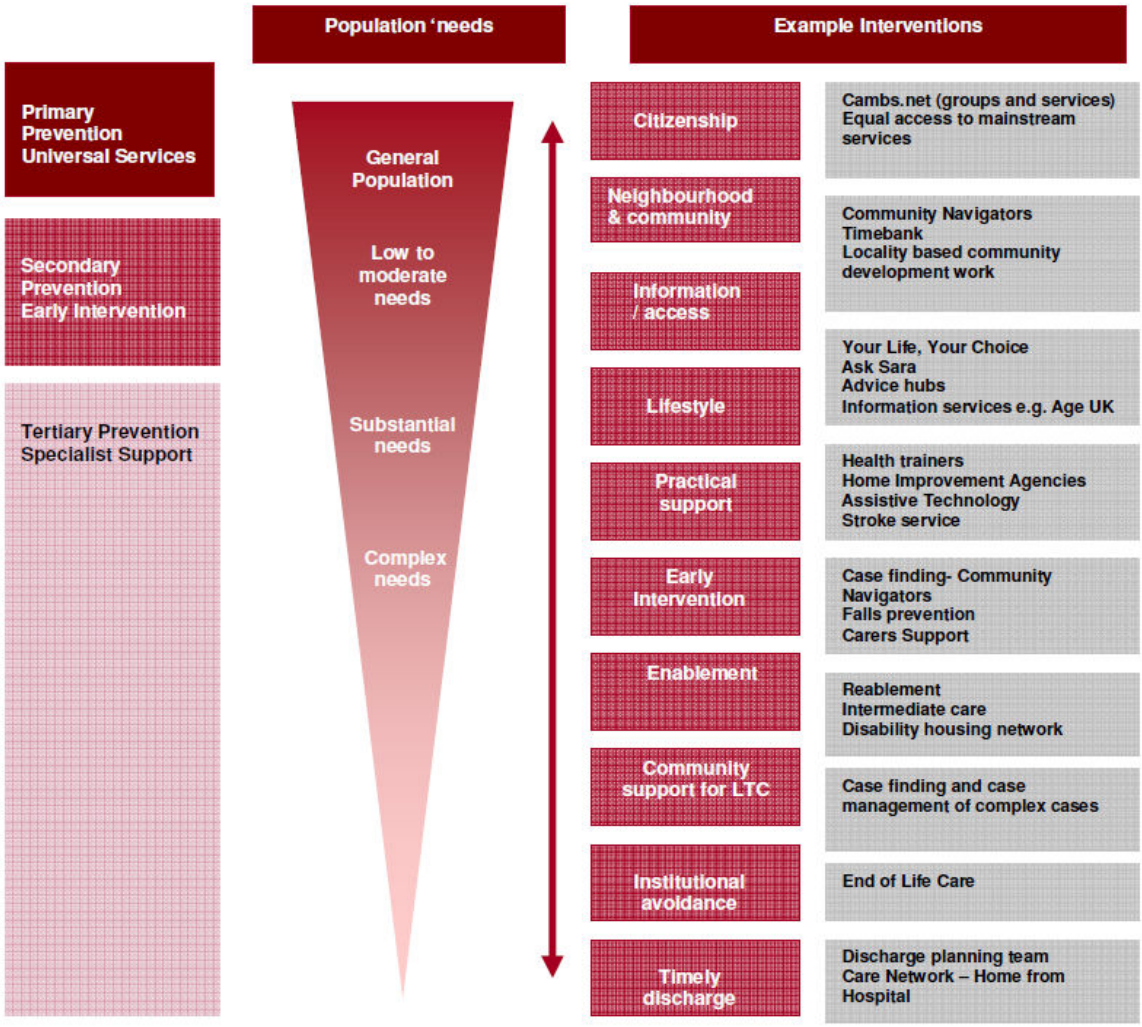
- **Primary prevention** – universal services that are aimed at people who have no or particular social care needs or symptoms of illness (but including those who are at risk of needing social care support)
- **Secondary prevention** (early intervention) – services that aim to halt or slow down deterioration for people who have some social care need or illness
- **Tertiary prevention** (specialist support) – services that are aimed at minimising disability or deterioration from established health conditions or complex social care needs

2.2 Social care and support services have traditionally focussed on specialist support, often at the expense of preventative and community based interventions[2]. The continuum of needs and interventions model below demonstrates how the traditional model of care can be inverted and provides examples of what those low level interventions might look like in Cambridgeshire.

[1] For hard copies of the above strategies please email sundeep.singh@cambridgeshire.gov.uk

[2] 'All Our Tomorrows: Inverting the triangle of care', ADASS & LGA, October 2003 www.adass.org.uk/old/publications/other/alltomtext.pdf

Fig 1: Continuum of needs and interventions - Cambridgeshire



3. WHAT DO WE KNOW?

3.1 Demographic projections show that Cambridgeshire has an ageing population; data from the Older People's JSNA demonstrates:

- By 2021 the 15-64 age group will reduce by 31%, with increases in over 65s by 59% and over 75s by 54%, with the largest increase, in South Cambs; 81% [3]
- There will be corresponding increases, of over 50%, in people with dementia[4]
- There will be increasing demands for services at home and extracare[5]
- The importance of health promotion and physical activity for older people
- A focus on falls prevention and improved nutrition

[3] Cambridgeshire County Council Research Group Mid-2006 district level population forecasts by age and gender
[4] Dementia UK
[5] Extracare housing is used to describe developments that comprise self-contained homes with design features and support services available to enable self- care and independent living

3.2 These demographic changes mean that there is the potential for a significant increase in the numbers of people accessing social care and health services in the years to come. This is largely due to increases in the aging population but we are also anticipating an increase in demand for services to support people with disabilities and mental health issues. This increase in demand is clearly taking place within a period of considerable financial pressure. Therefore, there is a need to invest in lower level prevention aimed at maintaining people's health and social connections to reduce and/or delay the likelihood for more expensive statutory services.

3.3 Further analysis of the Cambridgeshire population was undertaken in the *Adult Social Care Prevention - Summary Report of Current Activity in Cambridgeshire (*Appendix 1). This report highlights that target groups can be analysed in the following way:

- **Adults 50 – 64** – There are estimated to be 114,000 adults aged 50-64 living in Cambridgeshire (source: LGSS RP mid-2010 estimates). The concentration of people falling into this group is higher in rural parts of Cambridgeshire than elsewhere in general.

- **Adults over 65** – There are estimated to be 99,000 adults aged 65+ living in Cambridgeshire (source: LGSS RP mid-2010 estimates). The concentration of people falling into this group amongst the general population is higher in and around Wisbech, March, St Ives and the villages immediately surrounding Cambridge City. This group is forecast to increase to approximately 140,000 by 2021 (source: LGSS RP mid-2010 forecasts).

3.4 Appendix 1 highlights best practice examples such as the Department of Health's - Partnership for Older People Projects (POPPS) models. The evidence base indicates that approaches aimed at promoting health, well-being and independence can prevent or delay the need for higher intensity or institutional care.[6]

3.5 The report (Appendix 1) analysed this best practice, and using Dorset POPPS as a case study, suggests that primary level prevention works best with an active, community-led approach, building on a base of community grassroots activity, and enabling communities to identify their own needs and provide support with addressing them. The report also highlights the mix and coverage of community activity in Cambridgeshire through analysis of www.cambridgeshire.net which provides a directory of local services, activities and groups.

3.6 The report details that there are just under 4000 services listed on Cambridgeshire.net. These services span a range of categories from arts and culture to health and wellbeing groups. A report undertaken for the Older People's Reference Group 'Cambridgeshire Community Study: Unsung Heroes in a Changing Climate (Feb, 2010)[7] highlighted the range of services

[6] National Evaluation of Partnerships for Older People Projects: final report (DH, 2010) www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111240

[7] Cambridgeshire Older People's Reference Group report. Older people's access to and experience of different services in Cambridgeshire (D.Runnicles, Feb 2010). Email sundeep.singh@cambridgeshire.gov.uk for a copy

on offer to older people in Cambridgeshire and highlighted the importance of signposting people to these services and supporting people to access them. Examples of these services include:

***Cambridge Cancer Help Centre** (Life Line)*
which provides drop in facilities and support for people living with cancer and their carers. The centre was founded in 1986 with the object of giving help and encouragement for people with cancer and their families.

Thursday Tea Dance Club meets weekly at the Queen Mary Centre, Wisbech. There are 50 people attending for dancing only.

The **NHS Retirement Fellowship** has 45 people attending monthly at Kirkgate Church in Walsoken. Activities include speakers and outings. This group is listed on the Fenland Club Directory.

The **British Korean War Veterans Association, Ely and District Branch** is about the welfare of ex-servicemen. We were told that 90 people attend monthly meetings at a hotel in Ely.

3.7 We now know (from this summary report and previous mapping of services commissioned from the voluntary sector), that there is much activity in Cambridgeshire which already meets a prevention approach, but that a coherent countywide infrastructure is missing and that, at a local level, there is low awareness of these activities and services.

3.8 National research (the Wanless Report) has also identified three main trigger points for the need for adult social care (around bereavement, personal health issues and housing), which requires further exploration in Cambridgeshire.

3.9 It is in fact hard to overstate the effects of social isolation (on individuals and service systems), or the importance of responding effectively. Health risks associated with social isolation have been compared in magnitude to the well-known risks of smoking cigarettes and obesity (House 2001[8]). Numerous aspects of isolation have been linked to mortality, increased morbidity, diminished immune function, depression, and although later life is not always characterised by social isolation, the health risks of social isolation loom especially large for older adults[9].

4. WHAT LOCAL OLDER PEOPLE SAY

4.1 A key purpose of this proposal is also to respond to the views expressed locally by Cambridgeshire residents and stakeholders, through a number of consultation events including; Ageing Well, Somersham Community Planning and the Melbourn Locality Commissioning workshops. These consultations reinforce the findings of previous local and national consultations through highlighting that older people want to be able to remain in their own home and

[8]. Social Isolation Kills, But How and Why? (House, James S. 2001) www.psychosomaticmedicine.org/content/63/2/273.x
[9] SCIE Research briefing 39: Preventing loneliness and social isolation: interventions and outcomes (2011) www.scie.org.uk/publications/briefings/briefing39/

to live healthy active lives for as long as possible. A number of main themes have been identified as being important to older people including:

- Access to a range of social and community activities in order to help tackle social isolation and loneliness
- Access to high quality information to enable access to services
- Ensuring there are the means to develop ways of providing "that bit of help" at the right time, such as a listening ear, help with gardening etc
- To help people plan for a fulfilled older age
- To reach out into communities to engage with hard to reach and isolated older people

4.2 The significance of community based preventative work is further supported by a piece of local research recently published by the University of Cambridge, who were commissioned on behalf of the Cambridgeshire Older People's Reference Group to explore older people's access to, and experience of, different services in Cambridgeshire[10].

4.3 One of the key research questions asked was – "What services do older people use in Cambridge?" The report highlighted that health services were vital and were used by everyone. Most people used the bus and were reliant on their free bus pass. The library was an important service for those in the 50-64 yrs old age groups. It was very apparent from the research that services that provide social interaction and social activities are very highly valued, particularly amongst the 'older' old age groups (65+yrs). Several participants involved in the research described the social activity they took part in as a "lifeline". People also described wanting to get out and meet people and to avoid being lonely.

4.4 The most common issue raised in this report was social isolation which was also highlighted in the Ageing Well Consultation. Here the voluntary sector organisations provided highly valued social activities that helped to keep the older people who participated in the research 'happy and positive'.

"I always look forward to Wednesday and Monday, it gets me out of the house. I have been coming here for over 15 years. It is an absolute lifeline. Without it I would be lost. It is a lifeline. It is incredibly lonely on your own. I don't look forward to weekends. They are so lonely".

5. WHAT DO WE NEED TO DO?

5.1 From the evidence outlined above and a number of community conversations with older people, there is a need to:

- Coordinate existing activity (organisational and individual) at a local level

- Raise awareness of, and connect people to, existing activities and services

[10] Service use amongst older people in the Cambridge area A report for the Cambridge Older Peoples' Reference Group (Cambridge University, Jan 2012) Email sundeep.singh@cambridgeshire.gov.uk for a copy

- Ensure high quality information is available in key locations (eg with GP's and Parish Councils) within communities, alongside trusted individuals who can help interpret it

- Reach out to isolated and lonely people at a local level, to reduce the (health) impact of loneliness, and to avoid the adult social care pathway starting with an expensive crisis, as far as is possible

- Use local intelligence to identify, and propose solutions to, gaps (or poor quality) of provision

- Identify duplication of effort or resource, enabling more rational deployment

- Focus attention on those at risk of requiring adult social care, through a better understanding of trigger events (eg bereavement; even loss of loved pets) their precursors, and effective responses

- Create a District and Countywide infrastructure to enable coherence in the "whole system"; to gather further information about trigger events, and to be able to disseminate training, learning and to deploy any relevant future agreed resource

- Work with strategic partners to identify common objectives (eg the Public Health Outcome Framework, which outlines four domains; (1) improving the wider determinants of health; (2) health improvement; (3) health protection and (4) preventing premature mortality[11].

- Encourage vibrant local activity through the leadership of the voluntary sector, supported by statutory partners

- Help develop (then deliver) a "universal offer" to every older resident in Cambridgeshire about access to services which will support independence, health and wellbeing

- Through collaborative working and enhanced localised activity, increase communities' own capacity to support their own members and increase overall community resilience

5.2 In order to achieve this, the new and job-neutral idea of "Community Navigators" is being proposed, to focus and coordinate current activity. There are many people in Cambridgeshire who are currently engaged in the above activities, especially at the local level. They may be paid or unpaid; supported through an organisation, or simply active members of their local community, struggling to advise or support their neighbours to navigate their way through a complex arena of service provision.

[11] Improving Outcomes and Supporting Transparency; A Public Health Outcomes Framework for Health 2013-16 (www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132559.pdf)

5.3 It is proposed to develop a voluntary sector led infrastructure that will better coordinate and develop such activity.

5.4 This structure will help facilitate the required linkages across the "whole prevention system" in Cambridgeshire and link with other initiatives in local government (housing and transport), health and the voluntary sector itself. For example, for many people their first stop for information is to their GP, who are themselves looking closely at prevention and early intervention as in the project being run by the Borderline Group.

5.5 To encourage local creativity, a small "Innovation Fund" is proposed (see below)

5.6 To this end, we are negotiating a position with Care Network, a voluntary organisation which is heavily involved in prevention activity, and which already has a base in each District. This will enable the project to begin with the infrastructure outlined below:

- **Countywide Community Navigator Coordinator**- (1 paid post) would steer and coordinate the Navigators, develop and support a cross sector steering group, make strategic links to partners and develop a robust funding portfolio to ensure sustainability. This role would also oversee the collection of data, linking into JSNAs and the further research into the triggers that bring people into statutory services, return on investment modeling and the facilitation of external evaluation.

- **District Navigator Facilitators** - (1 paid post per district) would coordinate and facilitate partnerships with local, voluntary and statutory sector partners, identify gaps in services and stimulate innovation through a bespoke Innovation Fund. The Facilitators would also develop a training package for the Community Navigators.

- **Community Navigators** - are an essential part of the programme. The Community Navigators are friendly and approachable first points of contact who are out and about in Cambridgeshire's communities. These Navigators could be staff or volunteers used by a range of voluntary organisations that are already active in communities. Through the Community Navigator approach these people would be offered some focused training in aspects of statutory, voluntary and community services and activities; enabling them to find and support people with unmet needs within their community.

  The Community Navigators will provide advice and/or support to help older people live active, independent lives The Community Navigators will know what is available to support older people in their communities. This might range from access to home adaptations, such as grab rails on the front step to stop someone having a fall in their own home, to benefit advice to ensure people are financially secure, or support to access a local friendship club to stop someone feeling isolated.

  In similar schemes around the country a number of case studies have emerged which show the impact of the Navigator function:

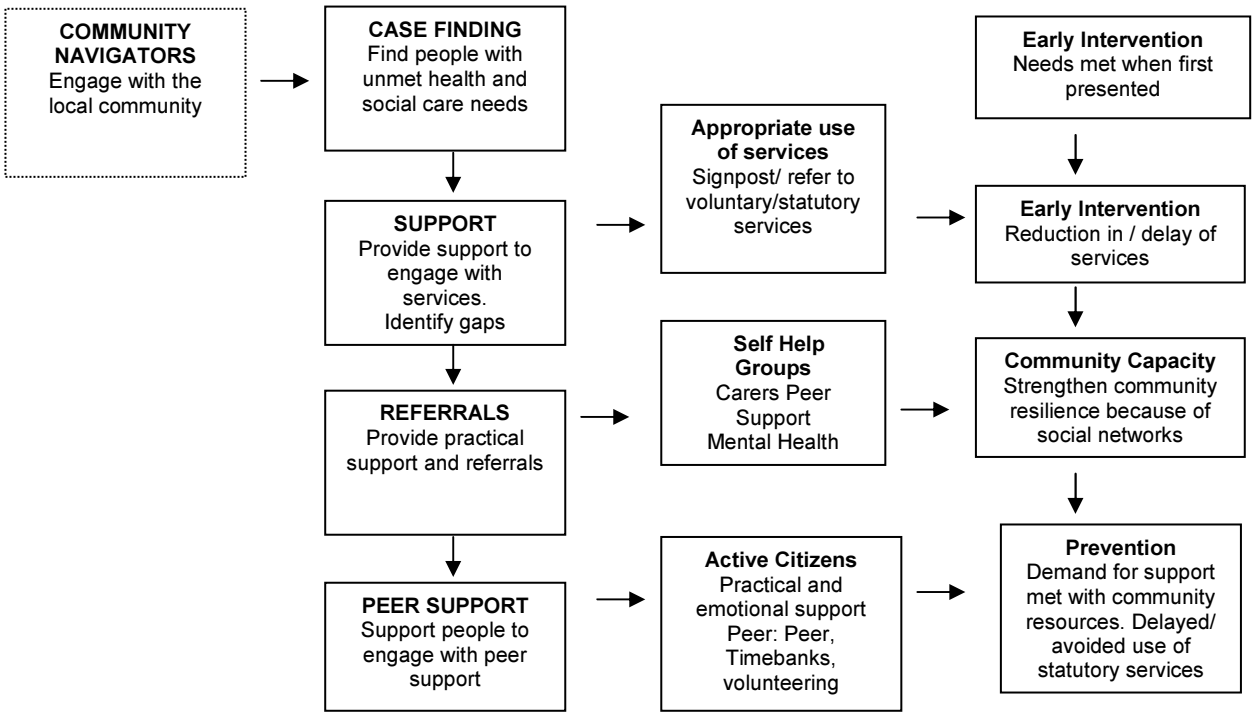
I recently visited a lady who in the last 2 years has lost her husband and then suffered a stroke – leaving her without use of her left side. She also has cataracts on both eyes and is awaiting the operation. She doesn't go out at all and her family all live some distance away. I visited her because she wanted a cleaner and someone to do her shopping – I immediately referred her to Age UK. As we got chatting about what she used to like to do she mentioned that she misses reading. I asked her if she knew about the Home Library Service – her reply was she couldn't read because she couldn't see well with her cataracts but "she really missed reading a good romance" I then went on to tell her about Spoken Word Books available on either CD or tape – her face lit up! I straight away referred her to the home library service that will ensure that she can listen to a good book even if she can't actually read it! It's a small thing but I really felt it was going to make a difference to her![12]

- **Innovation Fund** - funding would be used to kick start, inject life or enhance existing community based services or activities. The grant pot would be available to the community/ voluntary organisations to support innovation or respond to an identified need which will improve the quality of life of older people in Cambridgeshire.

6. OUTCOME

6.1 The overall broad aim of the Community Navigator approach is to help people move from vulnerability to social isolation and regain a sense of contribution and social capital. The flow of service users entering this project is captured in the diagram below:

Figure 2: Proposed pathway - Community Navigator Function



[12] Essex Village Agents Case Studies (2010)
www.villageagents.co.uk/Docs/Case%20Studies%202%20August%202010.pdf

6.2 To support the development of a coherent prevention framework in Cambridgeshire, a number of other pieces of work are also underway which will complement the Community Navigator approach. These include:

- A review of adult social care records over the past 10 years to more closely identify the events and triggers that lead individuals to need adult social care services
- Developing better understanding of the types of prevention, early intervention and support that can best ameliorate these events and triggers
- Better understanding of the relationship between prevention, early intervention and support and the more 'mainstream' adult social care services
- The development of an "avoided costs" model to measure the return on investment impact of prevention and early intervention services. This tool will support the Community Navigator approach and will form part of the evaluation of the project
- An examination of the extent to which, in a general shift to a prevention approach, the Council can sustainably move beyond its current approach to eligibility (ie of only offering adult social care packages to meet critical and substantial needs)

7. EVALUATION OF THE NAVIGATION APPROACH

7.1 To support greater understanding of the impact of the Community Navigator project, the University of Cambridge; Cambridge Centre of Housing and Planning Research (CCHPR) could undertake independent evaluation. The research team have a reputation as a leading academic research institution and are currently undertaking an evaluation of the FirstStop information and advice service for older people that is funded by the Department of Communities and Local Government (DCLG)[13]. The evaluation has been assessing the value for money of the initiative and analysing what savings to the public purse investment in the project is generating.

7.2 The evaluation programme would run a number of processes to evaluate the Community Navigator project including:

Meetings and feedback - There would be an inception meeting to discuss the project, evaluation aims and methods, with interim meetings with the Steering Group as necessary.

Literature, policy and existing evidence review - A literature and policy review of existing and ongoing work in this field will provide a context to the evaluation and will feed into any cost benefit analysis if this is identified as part of the evaluation.

Data collection system - The evaluation team will work with the Community Navigators and the Countywide Coordinator to develop a simple monitoring system and standard system for data collection at the beginning of the project. This will capture the inputs, outputs and outcomes of the casework.

[13] http://www.communities.gov.uk/newsstories/housing/1896913

Interviews - Over the three year project, at appropriate intervals, interviews would be conducted with the Countywide Coordinator, District Facilitators and the Community Navigators to analyse progress, successes and challenges.

Survey - A short survey would be conducted of users of the service to collect information on their experience, identify success/challenges, outcomes, alternative outcomes if the service had not been used etc. The survey would be ongoing throughout the three year project and the mechanism for distributing the survey would be built into the scheme from the beginning.

Analysis - The analysis of the data would explore how the project is meeting its objectives. It is possible that some simple value for money analysis could be carried out.

Evaluation reporting - Interim reports would be produced throughout the evaluation depending on the timetable agreed with a final report at the end of the evaluation period.

8. EXIT STRATEGY

8.1 At the core of this project is the aim of supporting a mixture of paid staff and volunteers. It is a goal that the approach associated with this project will be embedded in organisations across the county. Supported by independent evaluation, a review of the impact of the project will also be done. This will help shape the business case for continuing to commission this approach through the appropriate channels.

9. ALIGNMENT WITH PRIORITIES AND WAYS OF WORKING

9.1 **Developing the local economy for the benefit of all**
Although it is difficult to draw an exact parallel with mainstream economic development, the benefits in terms of an ageing population staying fitter and more active for longer can be seen, even as more active consumers of all types of services for longer. A reduced reliance on statutory services also implies a greater use of (possibly commercial) alternatives.

9.2 **Helping people live healthy and independent lives**
The report above sets out the implications for this priority in paragraph 2-7.

9.3 **Supporting and protecting vulnerable people**
The report above sets out the implications for this priority in paragraph 2-7.

9.4 **Ways of Working**
The new Integrated Plan identifies three characteristics of our new approach to tackling our priorities:

- Developing our leadership role
- Working at the local level
- Investing in growth

Paragraphs 1, 3, 4-8 of this report sets out the implications for leadership, working locally, investing in growth.

10. SIGNIFICANT IMPLICATIONS

10.1 **Resource and Performance Implications**

There is a strong likelihood that successful prevention (delaying or reducing the need for statutory services) will have a positive impact on resources, although this has to be seen in the context of the overall demographic changes and increasing demand. Creating a Community Navigators infrastructure will also enable the whole system to work more efficiently, and lead to more certainty that intensive and expensive interventions are brought into play at the right time and not prematurely.

There is a continuing need to analyse benefits and to which organisation they are falling because there is no straightforward correlation between the spending organisation (e.g. the Council) and the beneficiary of efficiencies (eg the NHS). A better understanding of this will enable a more rational "whole system" approach to investment.

10.2 **Statutory, Risk and Legal Implications**

There are no significant implications for any of the prompt questions within this category

10.3 **Equality and Diversity Implications**

The following implications have been set out in the attached Community Impact Assessment (Appendix 2)

10.4 **Engagement and Consultation**

The report above sets out details of significant implications in paragraph 2, 3, 4 and 5.

Source Documents	**Location**
Listed in the footnotes above	3rd floor, C wing Castle Court Shire Hall Cambridge

Version: 2
Draft Cambridgeshire Health and Wellbeing Strategy 2012-17
Response to the consultation by the Cambridge Local Health Partnership

1. Introduction

1.1 The Cambridge Local Health Partnership ("the partnership") welcomes the opportunity to give its views about the draft Health and Wellbeing Strategy ("the strategy") and ways it feels it can contribute to the improvement in the health and wellbeing of people residing in the City. As a new partnership, set within the health and wellbeing network in Cambridgeshire, we are still looking to define how best we can make a difference locally, using our joint resources to bring about benefits, by working more collaboratively.

1.2 A cornerstone of our approach is to try to focus on a few actions that we know we can deliver, and to deliver them in a relatively short period of time so that we can build some momentum as a new partnership. We hope that the new strategy that emerges from the consultation will not end up being overly bureaucratic with its management and has room to support, new, local actions. Until an action plan is provided to show how the strategy will be delivered the partnership feels that it cannot give a detailed response at this stage.

"Coordinated working between partners across service silos is where we think the biggest gains can be made."

1.3 The partnership fully supports the approach set out in the draft strategy, its principles and the five broad priority areas. It is felt that the priority areas reflect a great deal of the existing activity provided in current strategies and it is hoped that their inclusion in a single document will allow some commonality to emerge across the priority areas to try to diminish the tendency for "silo" working. Coordinated working between partners across service "silos" is where we think the biggest gains can be made.

2. Priority areas within the draft strategy

2.1 We feel that there are a number of themes that run across each priority area in the strategy, which perhaps haven't been given sufficient attention. One of these is the abuse of alcohol in Cambridge and its consequences, which despite a lot of good local work, has been a difficult "nut to crack". The partnership feels that more partnership effort in reducing alcohol consumption in the City is required, looking at the matter in the round and taking into account the lifestyle choices of young people, including the large student population in the City. This should be defined more prominently and clearly in the final strategy and be included as an area of focus under the proposed priority on encouraging healthy lifestyles (Q4c) Some of the local interventions to reduce alcohol abuse have been innovative, however, and can show a way

forward, such as tailoring services to fit with the needs and choices of individual clients.

"…more partnership effort in reducing alcohol consumption in the City is required…"

2.2 The partnership believes that each partner has a great deal of knowledge about the communities and groups that they engage with and that un-locking this knowledge and giving it an airing amongst partners, who may not have the same insights or awareness of different groups, will be useful. There is no substitute for good community development work on the ground for helping to build the capacity of communities and empowering individuals to make a contribution and it is thought by the partnership that this aspect should be given more weight in the final strategy.

"There is no substitute for good community development work on the ground…"

2.3 The principle of strengthening user participation in service delivery following the "nothing about us, without us" approach is something we think can be built on. Each contact that public services have with local people, whether users of services or community activists who are a part of delivery, provides the chance to convey positive messages about lifestyle advice and it was thought that the "Making Every Contact Count" approach could be usefully transferred into other settings.

2.4 The partnership believes that investment in the infrastructure and capacity of local communities to provide support for older people, who often become isolated, lonely and endure depression, as their networks and family fall away with growing age, should be identified as a priority area with the strategy. The findings of research looking at the triggers that lead to isolation for older people and their journey into adult social care will give a valuable insight into how we can intervene in a more meaningful way in the future. The isolation and loneliness of older people is equally an issue within the built up area of Cambridge as it is more rural areas where people may have a more geographical isolation from others.

"The isolation and loneliness of older people is equally an issue within the built up area of Cambridge…"

2.5 The partnership is keen to meet with established local groups representing older people, as part of its work, to look at ways we can start to improve the social capital that is available locally. One issue that the partnership has identified, which seems crucial to the provision of ongoing support and care for adults, is the difficulty in recruiting and retaining care workers in the City. The partnership thinks that this is fundamental to the provision of care packages and should be shown as a matter to be focused on in the strategy.

"…the difficulty in recruiting and retaining care workers in the City."

2.6 The growth of Cambridge and planning for the health and wellbeing of new communities is an issue that the partnership feels should be given more prominence in the strategy. The planning of services, particularly primary care and location of GP practices, should be based on plans that look across developments, so that facilities are affordable and avoid duplication. Planning for health goes beyond the built environment and it will be important to ensure that there is appropriate community development capacity in place to help build social capital and cohesion, and support the wellbeing of new communities. (Ref JSNA New Communities and Building Communities that are Healthy and Well)

"The growth of Cambridge and the establishment of new communities is an issue that the partnership feels should be given more prominence…"

2.7 Whilst we acknowledge that Cambridge is overall a wealthy place with relatively high levels of good health in its population, it should be remembered that there is poverty concentrated within some local communities, which its associated levels of higher ill-health. Income deprivation affecting children is an example of this – in 8 wards in Cambridge more than 40% of children live in households in receipt of benefits. This exacerbates inequalities in health outcomes and the partnership supports the principle of improving the health of the worst off fastest. A reduction in health inequalities would be a key marker of achievement (Q5).

This draft response will be considered at the Cambridge Local Health Partnership's meeting on 13 September. It was based on the discussions that took place in a Sub-group meeting on 29 August 2011.

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