PETERBOROUGH CITY COUNCIL

HEALTH AND WELLBEING BOARD

THURSDAY 12 SEPTEMBER 2013, 1.00 PM

Bourges/Viersen Room - Town Hall

Contact – Alexander.daynes@peterborough.gov.uk, 01733 452447

AGENDA

There is an induction hearing loop system available in all meeting rooms. Some of the systems are infra-red operated, if you wish to use this system then please contact on 01733 452447 as soon as possible.

(b) Learning Disabilities **127 - 138**

The Board is asked to name a lead member for learning disabilities, and support the CCG signing up to Mencap's care charter.

INFORMATION AND OTHER ITEMS

9. Board Development

(a) Peer Challenge **139 – 156**

The Board is asked to review the Peer Challenge guidance document and discuss actions required to get ourselves ready for a review in the Spring.

(b) Health and Wellbeing Strategy - Delivery Plan **157 – 174**

The Board is asked to discuss the delivery plan and recommendations.

10. Public Health England's Longer Life Toolkit **175 – 182**

Information only.

11. Joint Commissioning - Child Health Update **183 – 190**

Information only.

12. Child Health Outcomes **191 – 200**

Information only.

13. Health and Wellbeing Board Event **201 – 202**

Information only.

14. Schedule of Future Meetings and Draft Agenda Programme **203 – 204**

To note the dates and agree future agenda items for the Board. To include frequency of reporting from other Boards, where appropriate, including Local Safeguarding Boards, Children's and Adults Commissioning Boards, LCG Commissioning Board. Also to consider how we will monitor progress against the Health and Wellbeing strategy.

Board Members:

Cllr M Cereste (chairman), Cllr W Fitzgerald (vice chairman), Cllr J Holdich, Cllr S Scott, Cllr I Walsh, Gillian Beasley, Louise Ravenscroft (Healthwatch), Dr M Caskey, Dr R Withers, Dr P Van den Bent, Jana Burton; Cathy Mitchell; Sue Mitchell; Andrew Reed; Andy Vowles; Sue Westcott.

Substitutes: Dr Neil Sanders and Dr Harshad Mistry

Further information about this meeting can be obtained from Alex Daynes on telephone (01733) 452447 or by email alexander.daynes@peterborough.gov.uk

PETERBOROUGH CITY COUNCIL

MINUTES OF A MEETING OF THE HEALTH AND WELLBEING BOARD
HELD AT THE TOWN HALL, PETERBOROUGH ON 6 JUNE 2013

Members Present: Councillor Marco Cereste – Leader of the Council (Chairman)
Councillor John Holdich – Cabinet Member for Education, Skills and University
Jana Burton, Executive Director of Adult Social Care, PCC
Sue Mitchell, Director of Public Health, PCC
Sue Westcott, Executive Director of Children's Services, PCC
Dr Richard Withers, Borderline Local Commissioning Group
Dr Mike Caskey, Peterborough City Local Commissioning Group
Dr Harshad Mistry, Peterborough City Local Commissioning Group
Gordon Lacey, Peterborough LINk – Local HealthWatch
Cathy Mitchell, Cambridgeshire & Peterborough Clinical Commissioning Group
Andrew Reed, NHS England East Anglia Local Team
Claire Higgins, Chairman Safer Peterborough Partnership

Also in Attendance: Alex Daynes, Senior Governance Officer, PCC
Kim Sawyer, Head of Legal Services
Wendi Ogle-Welbourn, Assistant Director, PCC
Councillor Irene Walsh, Cabinet Member for Community Cohesion, Safety and Public Health

Item	Discussion and Decision	Action
1. Apologies for Absence	Apologies for absence were received from David Whiles, Councillor Fitzgerald, Councillor Scott, Dr Ken Rigg, Dr Paul van den Bent and Russell Wate.	
2. Declarations of Interest	None were received.	
3. Minutes of the Previous Meeting	The minutes of the meeting held on 25 March 2013 were approved as a true and accurate record.	
4. Register of Interests and Code of Conduct	The Board received a report following guidance from the Local Government Association concerning governance and constitutional issues for Health and Wellbeing Boards. Members were advised of the requirement to complete a register of interest form that would apply when conducting the business of the Board. Members **NOTED** the regulations and requirements concerning Registering Interests and abiding by the City Council's Code of Conduct. Register of Interest forms would be provided for completion.	

5. Board Membership	The Chairman advised the Board of changes to the City Council's Cabinet Member portfolios and the relocation of responsibility for Public Health. It was requested that the Board's terms of reference be amended to allow Councillor Walsh, as Cabinet Member for Community Cohesion, Safety and Public Health, to be a full member of the Board. The Board **AGREED** that the Terms of Reference should be amended to allow the Cabinet Member for Community Cohesion, Safety and Public Health to become a full member. This would be recommended to the full council of Peterborough City Council to approve.	KS
6. NHS England / Local Team	The Board received an oral update on the work of the local area team. Five key issues had emerged: 1. Hospital Trust finances - report from auditors expected by the end of the week; 2. MMR – campaign launched with GPs, data available some time in July; 3. Primary Care Strategy – original deadline of the end of June had been extended, further work with all partners required; 4. Urgent Emergency Care – Accident and Emergency performance not meeting standards; and 5. Liver cancer services – specialised service to be commissioned for the whole region – two bids received (Norwich and Cambridge). Further information provided in response to questions included: • Several area teams may need to coordinate work to ensure a relevant Primary Care Strategy; • The Local Team was aware of issues with ICT provision; • It was expected that there would be constraints around resources, the strategy must address this; • Must address need to move patients out of hospital and into Primary Care; • Local design of Primary Care Strategies was desired. **ACTION:** NHS England to work closely with LCGs and partner agencies to develop Primary care Strategy. The HWB Board to be kept appraised of progress in this area.	
7. Clinical / Local Commissioning Groups	(a) Draft CCG Prospectus The Board received a report from the Clinical Commissioning Group (CCG) on its draft prospectus. Input from the Board was requested in order to develop and finalise the prospectus. Comments and responses to questions included: • Representatives from the Patient Participation Group were included in the Patient Reference Group; • Inclusion of Healthwatch in the prospectus to be discussed further; • The Primary Care Strategy review could be included in the document;	CM

	Further comments from Board members included: • Must ensure NHS England local team and the CCG works together on their various strategies.	
	(b) Older People's Programme The Board received a report updating it on the progress being made by the CCG towards the procurement of Older People's services, to deliver the outcomes developed by the CCG/Local Clinical Commissioning Groups (LCG) in conjunction with the local system Partners. Further comments from Board members included: • Hospital Trust input needed for this work; [Dr Caskey arrives] • Older people's care is a whole community issue – volunteers and public - not just service providers, this should be addressed.	
	(c) Children's Services – Cambridgeshire Community Services Transition / Cambridge and Peterborough Foundation Trust The Board received a report following a workshop on the 20th of May 2013 attended by Health, Local Authority, Area Team and Public Health Commissioners to explore options for the future commissioning of Children's Services within the CCG geographical boundaries. Comments and responses to questions included: • Many options post-April 2014 were being considered; • Joined up commissioning was preferred.	
8. Public Health	(a) Pharmaceutical Needs Assessment The Board received a report to update it on its statutory responsibility to maintain and publish a Pharmaceutical Needs Assessment (PNA). Comments and responses to questions included: • Minimum requirements for pharmacies will be assessed; • The current provision will be reviewed; • Contracts and work conducted at pharmacies would also be reviewed. Further comments from Board members included: • Urgent care should be involved in the review; • Should look to expand ordering on and use of the internet for repeat prescriptions; • Improved ICT options provision should be reviewed too.	
9. Healthy Child Programme 0-5 Years – Regional Project	The members of the Board received an overview of the project. Final report to be presented to the Board in January 2024.	

10. Outcomes from Board Development Sessions	The Board received a report summarising the process and outcomes of recent Board development sessions and sought the Board's views on options for further Board development. The Board requested that more information was provided about the sessions and future priorities in order to better plan its work.	SM
11. Schedule of Future Meetings and Draft Agenda Programme	The Board received and considered the agenda plan for future meetings and was advised that the schedules of meeting for the year ahead should be amended so the meetings would be held on Thursdays from 1-3pm to better enable GP attendance.	AD

1.20 pm
Chairman

Relating to:	**ACTIONS**	**By whom**	**By when**
Board Membership	Submit recommendation to full Council to amend the membership of the Board.	Kim Sawyer	10 July
Draft CCG Prospectus	Consider options to include Healthwatch in the prospectus.	Cathy Mitchell	Ongoing
Outcomes from Board Development Sessions	Provide greater level of information about the sessions and future priorities to enable the Board to better plan its work.	Sue Mitchell	Next Meeting
Schedule of Future Meetings and Draft Agenda Programme	Amend Schedule of meetings to Thursdays 1-3pm.	Alex Daynes	ASAP

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 4(a)
12 SEPTEMBER 2013		PUBLIC REPORT
Contact Officer(s):	Angela Burrows, Chief Operating Officer, Healthwatch	Tel.

ST GEORGES HYDROTHERAPY POOL USER EVALUATION REPORT 2013

RECOMMENDATIONS	
FROM : Healthwatch Peterborough	**Deadline date: N/A**

1. Note the contents of the evaluation report;
2. Consider future provision of the service as a means to improve health and wellbeing of residents.

1. ORIGIN OF REPORT

1.1 This report is submitted to Board following a request from the Healthwatch Peterborough HWB Board Representative.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to:

a) Provide a summary version of a comprehensive report compiled for clinicians for members to review the outcomes and impact of the aquatic therapy service for local residents.
b) Review how aquatic therapies provide measurable outcomes and translate in to a service that reflects the PCC Health and Wellbeing Strategy 2012-15 including:
   - *Deliver the best possible health and well being outcomes, including promoting equality*
   - *Provide the best possible health and social care provision*

c) Provide the Board with detailed information and review of recommendations in light of the resent decisions to review the hydrotherapy services.

2.2 This report is for Board to consider under its Terms of Reference No. 2.2 To actively promote partnership working across health and social care in order to further improve health and wellbeing of residents.

3. MAIN BODY OF REPORT

Overview:

3.1 The report aims to provide a comprehensive data and patient/carer evaluation of aquatic therapies (hydrotherapy) based on research carried out at St George's Community Hydrotherapy Pool where results demonstrated it as a method to improve the lives, health and wellbeing of users and carers.

3.2 St George's hydrotherapy pool is a popular, in-demand and well supported provision that improves the lives, health and wellbeing for users and carers. It is a preventative provision as well as a valuable means of recovery – delivered directly in line with the key aims and objectives of the strategy.

3.3 Hydrotherapy has the rare advantage of being able to deliver benefits to all of Peterborough City Council's public health, education and social care services - contributing to the improvement - *direct use of integrated health and social care solutions.*

3.4 Hydrotherapy shows a greater delivery of innovative, forward thinking and proactive – not reactive – provision.

Pages 37-42 Peterborough City Council Health & Wellbeing Strategy 2012-15

4. CONSULTATION

4.1 As far as Healthwatch Peterborough is aware - this is the only comprehensive report currently available reviewing this service locally.

4.2 Further consultations/reviews would be welcomed.

5. ANTICIPATED OUTCOMES

5.1 That the Board is fully aware of the provision and the service that currently being provided.

5.2 That the Board makes a fully informed choice in regards the future of this provision.

5.3 That further public consultations are undertaken as part of any future changes to this service.

6. REASONS FOR RECOMMENDATIONS

To highlight the improvements this service has been providing for local residents. To maintain such a service to continue to provide a real and evidence based provision for local people.

7. ALTERNATIVE OPTIONS CONSIDERED

N/A.

8. IMPLICATIONS

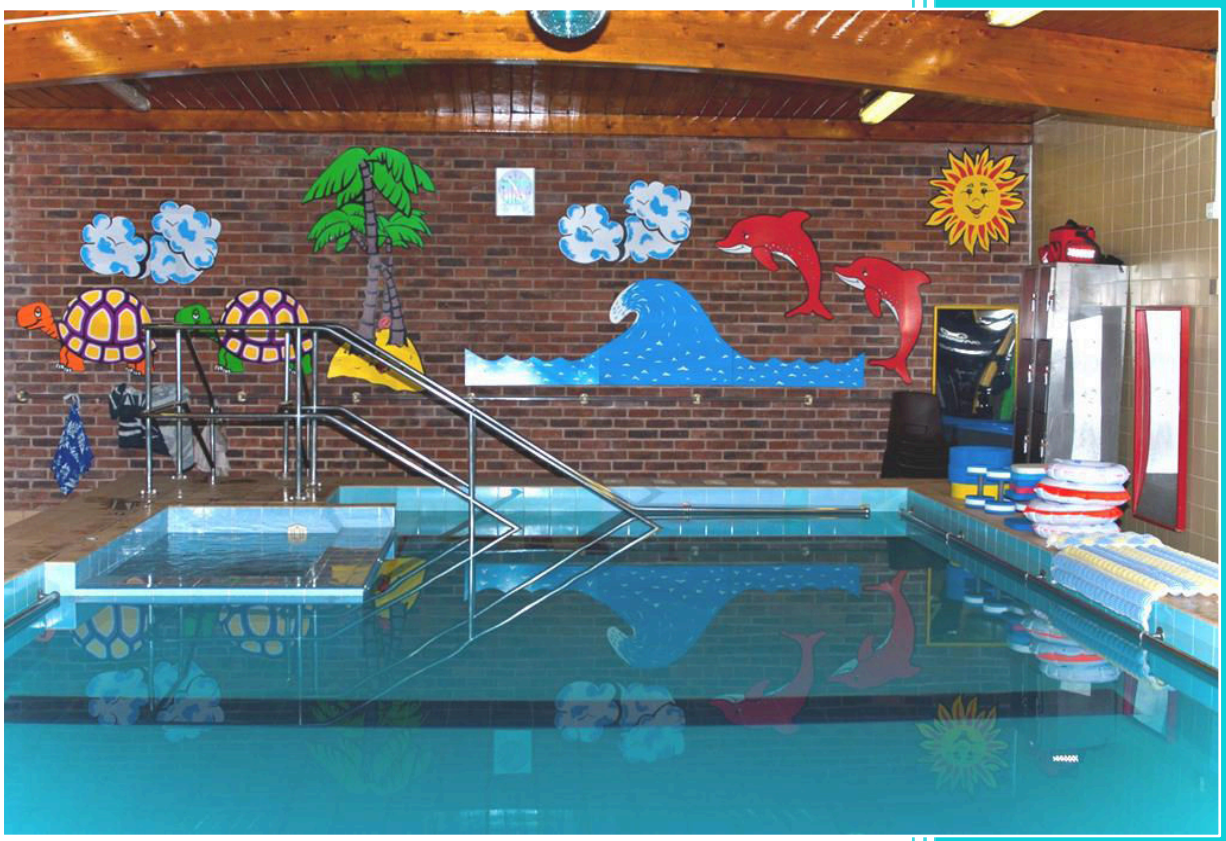
N/A.

9. BACKGROUND DOCUMENTS

Used to prepare this report, in accordance with the Local Government (Access to Information) Act 1985)
N/A.

2013

St George's Hydrotherapy Pool User Evaluation



SAM RING

THE JOHN LEWIS

GOLDEN JUBILEE TRUST

CONTENTS page

Introduction

In 2008 I had an accident; I suffered lower back and hip problems and had to undergo a hip operation the same year. At my GP surgery I came across a leaflet about St George's hydrotherapy pool. Having tried a few sessions of land-based physiotherapy, I was keen to try anything extra to get myself mobile and self sufficient. The effect of using the pool was so great; I became a regular user, and over the months found hydrotherapy to be of immense benefit.

In 2012 I approached my employers –John Lewis – to request their support to start a project to research the hydrotherapy pool during a trial period of commissioning.

The physiotherapist at St George's and I discussed various methods of data collecting, and decided on MYMOP and EQ-5D-L. These are recognised by health professionals who are able to analyse and evaluate the data. MYMOP and EQ-5D-L are tried and tested questionnaires that give a holistic picture of the patient. Numerous studies show their specificity and reliability.

Unfortunately, due to various reasons, commissioning was delayed until September. The delay meant adapting the work plan for collecting data. I decided to use the current users and new users and gathered the feedback from these groups, until the commissioning started.

This paper aims to provide a comprehensive data and patient/carer evaluation of aquatic therapies (hydrotherapy). Based on research carried out at St George's Community Hydrotherapy Pool where results demonstrated it as a method to improve the lives, health and wellbeing of users and carers.

Sam Ring
March 2013

Mr Mike Maynard, Grad Dip Phys MCSP MSOM HT[1] describes hydrotherapy:

Roman Spa

St George's community pool

"Aquatic physiotherapy, despite perhaps being the most ancient therapy, is also a contemporary therapy for the modern world. A five year plan published by the Government encompassing the period 2010-2015 emphasises the need for a more preventative, people-centred and productive National Health Service (Department of Health 2009). Modern aquatic physiotherapy involves people who otherwise are likely to be inactive or not regularly involved in exercise (Jackson et al 2004), is suitable for all (Epps 2009), focuses on the individual (HyDAT team (2009) and can be exceptionally cost effective (Maynard 2003). Thus aquatic physiotherapy can be argued to be extremely relevant to the future delivery of an efficient and effective health care service modern aquatic physiotherapy can be defined as:

"A physiotherapy programme utilising the properties of water, designed by a suitably qualified physiotherapist. The programme should be specific for an individual to maximise function, which can be physical, physiological, or psychosocial. Treatments should be carried out by appropriately trained personnel, ideally in a purpose built, and heated Aquatic Physiotherapy pool (Aquatic Therapy Association of Chartered Physiotherapists (ATACP) 2009)"

Thus in contemporary health care provision aquatic physiotherapy should form an integral part of a rehabilitation programme and more broadly be considered as a part of the patient pathway. It may be used as the only form of treatment being offered at that time, or may form part an overall treatment plan, designed to be complementary to other aspects of a person's planned treatment programme.

Working in water at a temperature of around 34 degrees C enables smooth movements in an environment that aids relaxation and pain relief. The buoyancy of the water offers weight relief for painful joints or muscles (e.g. at chest depth only 30% of normal weight is being taken through the legs (Harrison 1983))
Balance and control work can also be carried out in an environment that allows challenging work to be carried out in greater safety than on land, while the properties of water allow very effective mobility strengthening and cardiovascular work to be undertaken especially by those recovering from serious injury, after surgery, or long term illnesses

Mike Maynard is also Editor of the Journal of the Aquatic therapy association of Chartered physiotherapists

[1] http://www.welbeing-cpd.co.uk/Lecturer.aspx?L_ID=20

Golden Jubilee Trust

The Golden Jubilee Trust (GJT) was established as a charity in April 2000 as part of the John Lewis Partnership's Golden Jubilee celebrations. Through the charity, any Partner, regardless of age, seniority or length of service, can apply for a full or part-time volunteering secondment with a UK registered charity for up to six months. The GJT provides innumerable benefits, first and foremost to the charities it supports, by providing them with the resources and skills they need to meet their own objectives in serving the needs of the wider community.

In June 2012 Mrs Sam Ring was successful in her application to the GJT trust in securing a six month part-time secondment. She used two days a week for the six months to create questionnaires, compile case studies, and collate information. Sam is a LINk member and has been a service user of the pool having had hip surgery four years ago.

The primary aim of her secondment was to collect evidence and case studies to support continued commissioning from the PCT, and to produce a document with her findings.

Family Voice Peterborough

Family voice Peterborough (FVP) came about through The Aiming High for Disabled Children Programme which was launched in May 2007. Its stated aim was "to improve service provision across the board for disabled children and their families, enhancing equality and opportunity for them" DCFS. FVP is "pan disability" which means "all disabilities". March 2013 FVP successfully registered as a charity and all the trustees work on an entirely voluntary basis and are themselves parents/carers of children and young people.

They also have an open forum group of parents and carers who are informed and involved in the forum on various different levels. Their charity objects are; to relieve the charitable needs of disabled children and children with complex needs and their families and carers in Peterborough in such ways as the trustees shall think fit, in particular by the provision of advice, information, support and advocacy.

FVP as a local charity were best placed to take on a support role and provide a secondment position to facilitate more in depth research in to the benefits of more comprehensive hydrotherapy provision.

FVP facilitated the secondment of Sam Ring as part of the John Lewis Partnership Golden Jubilee Trust by way of access to families with disabled children, office time and volunteer support.

Sam has used the Family Voice database to carry out an initial phone survey to find out if people on the database had any knowledge of hydrotherapy and the pool.

What is Hydrotherapy?

Hydrotherapy is an aquatic physiotherapy treatment conducted in a heated pool where people undertake exercises to help with rehabilitation, to regain or enhance their well-being and improve their levels of fitness. The therapy has been found to be beneficial in the treatment of the following range of conditions[2];

- Arthritis.
- Pain in the back, neck, and shoulder; sports injuries.
- Balance and co-ordination problems; dementia; Parkinson's disease.
- Post-operative rehabilitation, especially hip and knee replacements.
- Cerebral Palsy, MS and other neurological disorders.
- Autism, Down's syndrome, learning difficulties.
- Stroke rehabilitation

Hydrotherapy has been shown to offer a viable rehabilitation alternative for the treatment of spinal pain and dysfunction.[3]

The Technical Bit

Hydrotherapy (aquatic physiotherapy) is a form of physiotherapy carried out in water, providing a warm, relaxed atmosphere for treating chronic and acute conditions, and an effective therapeutic environment for those in need of rehabilitation. Hydrotherapy is conducted in a pool containing heated water. The water in a pool is typically heated to 32-36°C provides the optimum temperature for muscle relaxation. This helps to decrease pain, increase range of movement and increase muscle activity.

The buoyancy of the water enables movement to be either assisted or resisted and allows for more fluid movements. The properties of water are used to decrease the effects of gravity and provide assistance, support and resistance for exercises. The aim is to gain flexibility of joints, strengthen muscles and enhance core stability to restore or improve function. Users don't need to be able to swim or get their head wet in order to benefit from hydrotherapy.

Water also provides an excellent medium in which to increase patient confidence and motivation prior to embarking on dry land exercise. Hydrotherapy benefits many people with neurological conditions – hospital patients, social services clients, people with long-term neurological disorders, musculoskeletal problems, those recovering from operations, sports injuries, and the elderly population. It is often used with children and adults who have physical and learning disabilities.

For a more detailed explanation of the principles and benefits of Aquatic Environment for rehabilitation, please turn to Annexe 1.

[2] Profundus 2000

[3] Konlian ,1999.Aquatic therapy; making a wave in the treatment of low back injuries. Orthopaedic nursing 18(1);11-8

St George's Hydrotherapy Pool

Since it's re-opening in March 2011, St George's hydrotherapy pool has helped over 1000 people providing pain relief, health improvements, and freedom from isolation. It also offers valuable leisure time for those with learning and physical

disabilities.St George's hydrotherapy pool is situated in Dogsthorpe, Peterborough and is available to the whole community of Peterborough and surrounding areas.

St. George's is a fully accessible hydrotherapy pool with a spa facility.

- Pool measurements 7.35m x 4.25m (24 x 14ft) and is 0.80 (2ft 7") to 1.40m (4ft 7") deep.
- Easy to manage steps with a double handrail
- Hoist with both chair and sling attachments with a full set of slings.
- A wide range of flotation aids
- Exercise equipment and exercise sheets.
- Hoisting facilities in the changing areas, trained staff to assist .
- A hydraulic shower trolley
- Baby changing facilities
- Male and female changing rooms with grab rails and seating.
- The showers are level access- easy push button controls & pull down shower seats.
- Each changing area has a disabled toilet.
- Walking frames are available-crutches should not be used poolside.
- Pull cords for alarms
- Hairdryer at lower level
- Waterproof sheet to protect users wheelchair

The pool is staffed by a small team, a Pool Manager and two life guards. There are three aquatic physiotherapists who volunteer their time on a regular basis

People can access the pool in two ways. They can self-refer or their GP can refer into a clinician-led aquatic physiotherapy session. Anyone can use the pool, along with their family members and carers. The pool currently benefits children and adults, and those rehabilitating from a stroke, long-term conditions or from an injury.

The pool is run by Peterborough City Council working in partnership with the SURF group (service users' rehabilitation forum). It is funded by Peterborough City Council, NHS and local grant giving organizations.

The hydrotherapy pool is supported by local and regional organisations such as: DIAL and LINk/Healthwatch -a local consumer champion for patients, service users and the public.

St George's is a community pool; any users can be involved with the St George's Service Users' Rehabilitation Forum (SURF Group) who have an active role in the pool's operations and decision making process.

Some of the many users

of St George's hydrotherapy pool

Aim of this study: To demonstrate the effectiveness of long term hydrotherapy for health and wellbeing as measured by self reported experience of service users

Why use self reported experience as a measure of outcomes?

Service users' perceptions of services they receive are an essential aspect of assessing whether the personal outcomes that people want from health and care are being delivered and their needs met. The NHS Institute for Innovation and Improvement support the premise that patients care about their experience of care as much as clinical effectiveness and safety. The government has made it clear that patient experience is a crucial part of quality care provision[4]

> *We want an NHS that meets not only our physical needs, but our emotional ones too.*
>
> *Now I Feel Tall, D o H 2007*

Whilst measuring physical improvement outcomes is important, it is just as important to be aware of the emotional and psychological improvement outcomes that any therapy may provide - which is more difficult to measure quantitatively. The reported outcomes with respect to a feeling of overall 'well-being' are just as important and can be measured through qualitative methodology.

Commissioners and providers of health and social care are currently facing the challenges of ensuring that they enable and deliver positive patient and service user experience. Talking to people about how hydrotherapy impacts on their quality of life is a valid and important way of measuring the possible benefits of this therapy to a wide range of people and conditions.

What was the methodology used?

A questionnaire (evaluation form) was created to find out what difference the hydrotherapy pool had made to the lives of users. This survey was carried out on a random selection of users, new and existing, across a six month period.

Case studies/ user quotes were collected.

A phone survey using the Family Voice database was carried out to find out a local charities understanding and knowledge of hydrotherapy and specifically St.George's hydrotherapy pool.

[4] www.institute.nhs.uk/patient_experience/guide/home_page.html

A 'MYMOP' questionnaire was completed by randomly selected self referred new users on their initial visit. On their third visit users completed a MYMOP follow -up questionnaire.

'EQ-5D-L' and 'VAS questionnaire' were completed by randomly selected self referring new users on their initial visit. On their third visit they completed an 'EQ-5D-L' and 'VAS questionnaire' follow- up questionnaire.

From the 28th September 2012, these questionnaires were also used on new GP referred patients on their first session and their follow up session.

Index of the data collected

Self referral user data

Family Voice phone survey	Random selection from FV database	Independent researcher
MYMOP data	1st session	Independent researcher
EQ-5D-L & VAS	1st session	Independent researcher
MYMOP follow-up	3rd session	Independent researcher
EQ-5D-L & VAS	3rd session	Independent researcher
Evaluation Form	3rd session	Independent researcher
Evaluation Form - Existing users	Random selection	Independent researcher
Case studies and quotes	Random selection	Independent researcher

GP referred user data

MYMOP	1ST commissioned session	Clinician/pool manager
MYMOP follow-up	2nd commissioned session	Clinician/pool manager
EQ-5D-L & VAS	1st commissioned session	Clinician/pool manager
EQ-5D-L & VAS follow-up	2nd commissioned session	Clinician/pool manager

The commissioned data collected was sanitised before being given to the author to include into their report

Family Voice Telephone Survey

Over a period from 26/9/12 to 10/10/12 a telephone survey was conducted using the database from Family Voice-Peterborough.

28 Family Voice members were randomly selected. The questions asked were for the purpose of gathering information about St. George's hydrotherapy pool. This was to help give a snap shot of public understanding about the pool within the community.

1. Have you heard of St.George's hydrotherapy pool	**YES**	**NO**
	20	**8**
2. Where did you hear about the hydrotherapy pool?		
Word of Mouth 8 **GP/medical professional 1** **Media Story 1** **Leaflet/poster 2** **Other 8** **Not heard of pool 8**		
3. Would you like to use the pool?	**YES**	**NO**
Comments were invited – see below	**24**	**4**
4. Have you ever used the hydrotherapy pool?	**YES**	**NO**
	3	**25**

User comments about question 3 – Would you like to use the pool?

Yes:

Not used recently, but have booked in for next week

Found it okay but time was limited.

The changing rooms are too small-had to share space

Mum has used the pool, but is too unwell at the moment, but I haven't personally used it

It was long time ago when children were very young-just lost interest

No:

Didn't know when open and access.

I don't have time, I can't swim.

I can't swim, it doesn't appeal to me. I'm as 'fit as a fiddle' I don't see the need to use it.

Not interested.

I don't know what it's about.

I haven't had the time, my children do a lot of swimming at regional pool with school, but I would like more information.

Was not sure of criteria needed.

Didn't know if I could use it.

Didn't know how to.

Lack of information-didn't know where to find it.

I didn't think it was open to the public.

Didn't know anything about it

Knew about it, but hadn't realised the public could use it, thought it was for disabled people only.

Didn't know we could use it .I have a disabled daughter and would need hoist to get her in

I've just booked my 1st appointment

I hadn't heard about it until yesterday, my friend was telling me she had booked her 1st

Appointment, I'm waiting to hear what she has to say.

I didn't know anything about it, but my son has Aspergers and doesn't like noise, would it be too loud for him?

Further information gathered:

25 people have requested news letter/further details mostly by e-mail.

There are a couple of people who have not got access to a computer or e-mail address so requested information to be sent by post.

When asked if they knew about pool 8 people said 'No', but when they were told where it was a few people acknowledged that it was there, but thought it was part of the school and not a separate unit open to the community.

Summary and some thoughts:

A high percentage of people have heard of the pool but have no understanding of the use of the pool and how to access it.

- *This could be addressed by re-designing and simplifying current leaflets and posters.*
- *Ensure that the newsletters are sent out to everyone on the mailing list and regularly updated.*
- *Marketing of the pool to local companies and businesses*
- *Arrange visits to local groups and schools in the community*
- *Ensure physiotherapists and GP surgeries have enough information and understanding of hydrotherapy*
- *This could also be delivered to more specific groups i.e. mother and baby groups, charity groups Age UK, mental health groups.*
- *Strive for media coverage –local radio, television get councillors and celebrity involvement.*

St George's Evaluation users Survey

The evaluation form was designed to collect as much data as possible to measure the benefits if any, that people have had whilst using hydrotherapy. It asked for a time span, and how often they use it .They were also asked to mark on a scale of 0-3 or N/A over 15 headings to rate whether there has been any improvement or not.

They were also asked if they had been in hospital at all over the last 12 months, and why they were using hydrotherapy. They had the opportunity if they chose to share any experiences of the St George's hydro pool and using aquatic therapy. They were also asked if they would recommend St George's Community hydrotherapy pool. Finally they were asked to rate the hydrotherapy pool on a scale of 1 -5. (1-very poor, to 5 - excellent).

This form was kept simple and easy for users to use, which enabled the researchers to capture overall user experience.

To see the evaluation form turn to annexe number 6

Information collated from St George's Evaluation form

47 people took part in the survey- all existing users

Q1) *How regularly do you use the pool*?

- 97% of users visit the hydrotherapy pool once a week, the remaining 3% visited twice a week.(n=41)

Q2) *how long have you used the pool*?

- 11% using the pool in the last 6 months or less (n=5)
- 47% using the pool 6 months – 1 year (n=21)
- 42% using the pool 1 year +(n=19)

Q3) Have you recently received hospital treatment? (In the last 12 months)

- 33% said –yes, they had received hospital treatment recently. (n=15)
- 67% said - No, they hadn't received hospital treatment recently(n=30)
- 8 of the 15 (53%) that said '*yes*' to hospital treatment stated that it was for a surgical procedure(n=8)

Q4) *Would you recommend hydrotherapy at St George's to your family and friends?*

- 96% - Said **yes**, they would recommend St George's (n=43)
- 2% - Said they would '**Maybe**' recommend St George's (n=1)
- 2% didn't write their view n=(1)

Q5) *On a scale of 1-5, how would you rate your experience at St.George's hydrotherapy pool?*

Of the 47 people to take part in the questionnaire

- 47 % of people said they rated the pool "EXCELLENT" (n=22)
- 45 % of people said they rated the pool "GOOD" (n=21)
- 2% of people said they rated the pool "AVERAGE" (n=1)
- 3 people didn't rate (6%)

Summary

The chart below shows in percentages the results. Over the 15 headings it can be seen that there has been significant improvement on all of the headings for long term users.

The results demonstrate that three regular sessions or more (long term use) of hydrotherapy are beneficial for people with various conditions to help with controlling pain, helping people keep mobile, helping their balance and co-ordination. Some users feel this could mean keeping them out of a wheel chair and being able to keep their independence for as long as possible.

It also demonstrates that hydrotherapy provides holistic benefits to the individual, improving their energy levels and general fitness. It would also suggest that quality of life, sleeping pattern, self confidence and relaxation results show mental 'health and wellbeing' are being supported by using hydrotherapy on a regular basis.

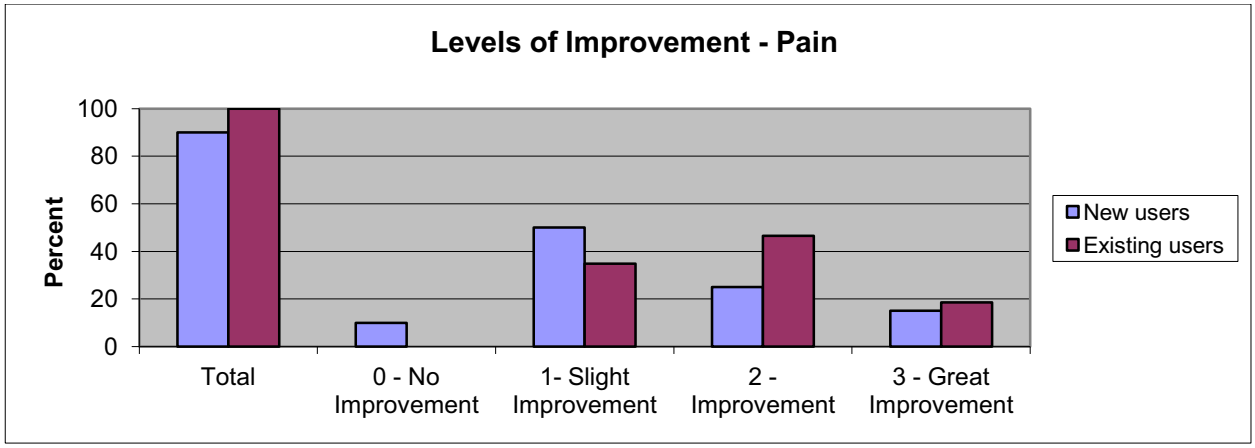
Results

	Total % of overall improvement	**0**-No Improvement %	**1**-Slight Improvement %	**2**– Improvement %	**3**-Great Improvement %
Pain	100.00	0.00	34.88	46.51	18.60
Mobility	97.73	2.27	29.55	47.73	20.45
Range of joint movement	93.18	6.82	25.00	40.91	27.27
Balance and co-ordination	86.49	13.51	29.73	29.73	27.03
Muscle strength	95.00	5.00	30.00	40.00	25.00
Muscle spasms	80.00	20.00	20.00	32.00	28.00
Circulation	88.57	11.43	34.29	25.71	28.57
Energy levels	85.37	14.63	31.71	36.59	17.07
General fitness	90.48	9.52	19.05	59.52	11.90
Self-confidence	92.31	7.69	25.64	30.77	35.90
Relaxation	97.62	2.38	14.29	42.86	40.48
Sleeping pattern	76.92	23.08	33.33	30.77	12.82
Wellbeing/quality of life	95.45	4.55	27.27	43.18	25.00
Medication lowered	44.44	55.56	19.44	2.78	22.22
Reduced visits to GP	57.14	42.86	28.57	2.86	25.71

The following pages have tables and graphs comparing improvement levels between new users, if a relevant symptom, on their third session of hydrotherapy and existing users, who have had six sessions or more.

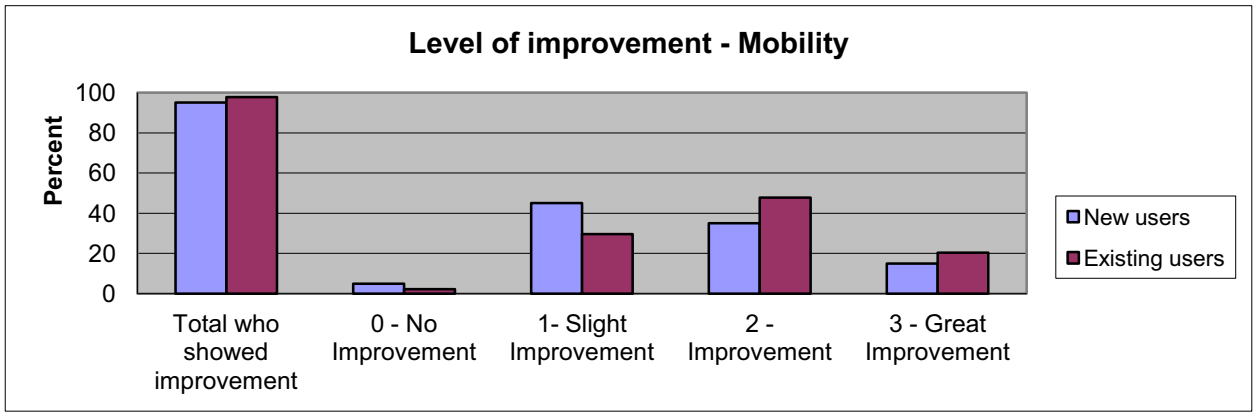
St George's Evaluation-New and existing users

Breakdown of results between new users and existing users



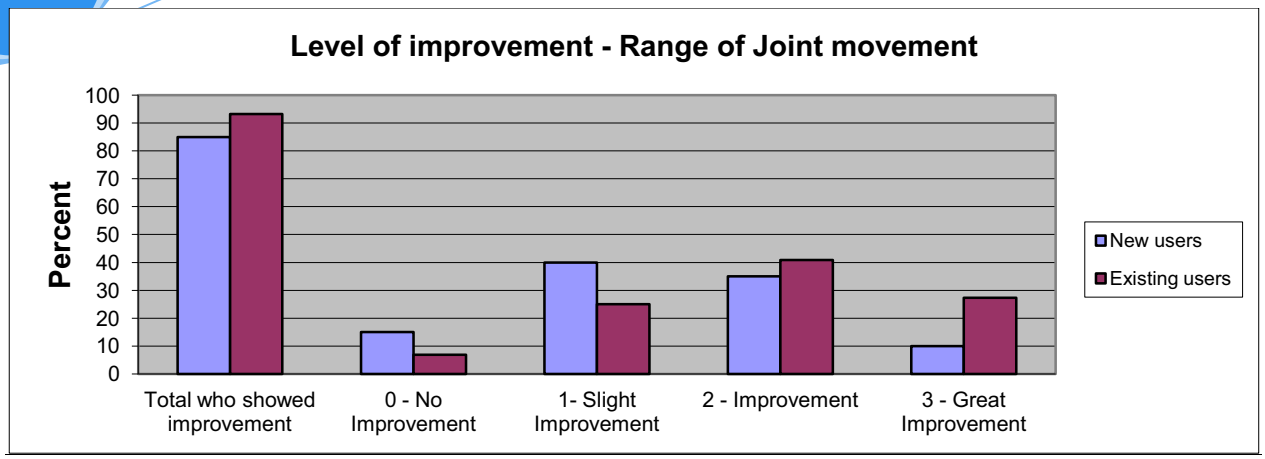
PAIN results shown in %	Total who showed improvement	0 - No Improvement	1- Slight Improvement	2 - Improvement	3 - Great Improvement
New users (third session)	90	10	50	25	15
Existing users (6 sessions or more)	100	0	35	47	19

New users N=20 Existing users N=43



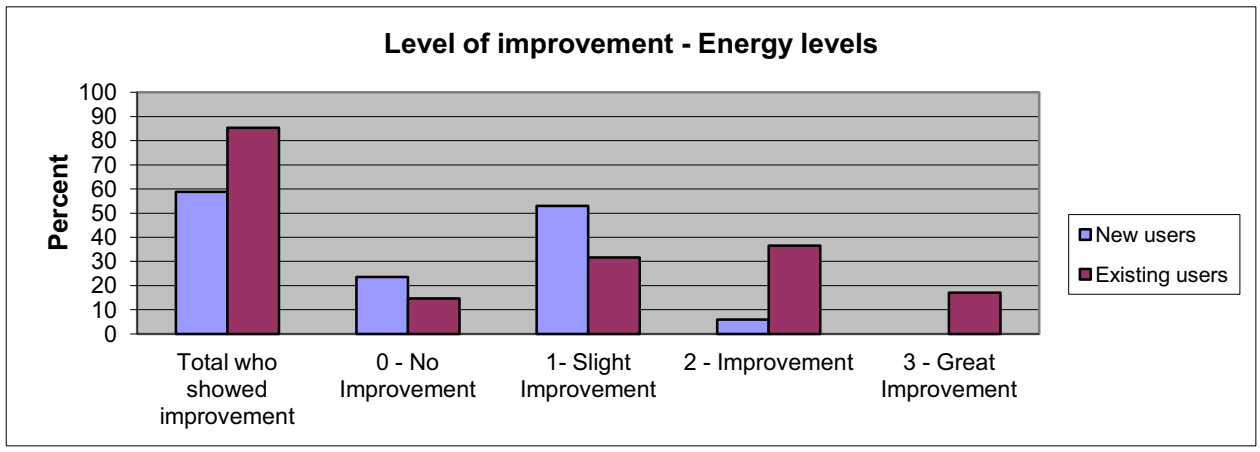
MOBILITY results shown in %	Total who showed improvement	0 - No Improvement	1- Slight Improvement	2 - Improvement	3 - Great Improvement
New users (third session)	95	5	45	35	15
Existing users (6 sessions or more)	98	2	30	48	20

New users N=20 Existing users N=44



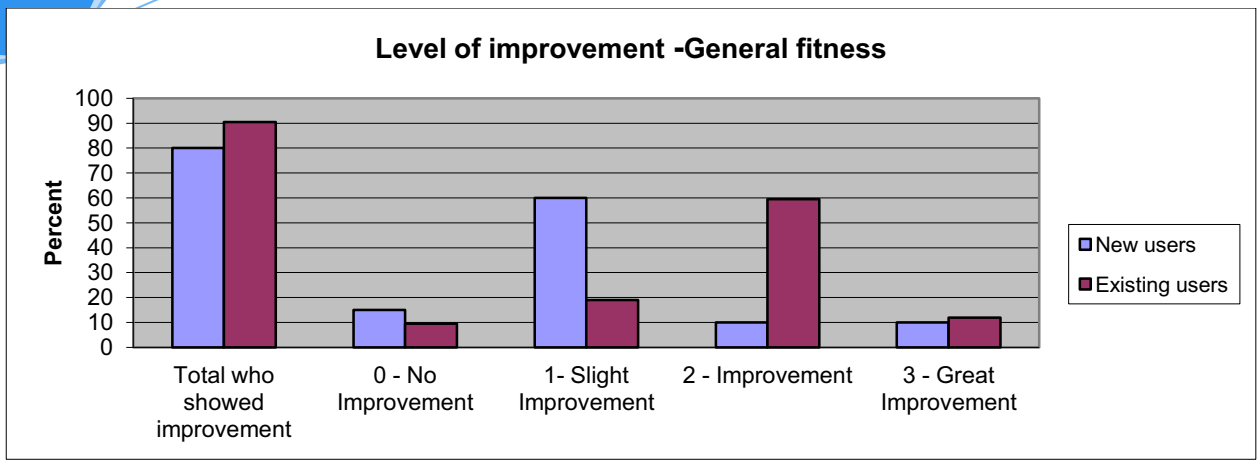
RANGE results shown in %	Total who showed improvement	0 - No Improvement	1- Slight Improvement	2 - Improvement	3 - Great Improvement
New users (third session)	85	15	40	35	10
Existing users (6 sessions or more)	93	7	25	41	27

New users N=20 Existing users N=44



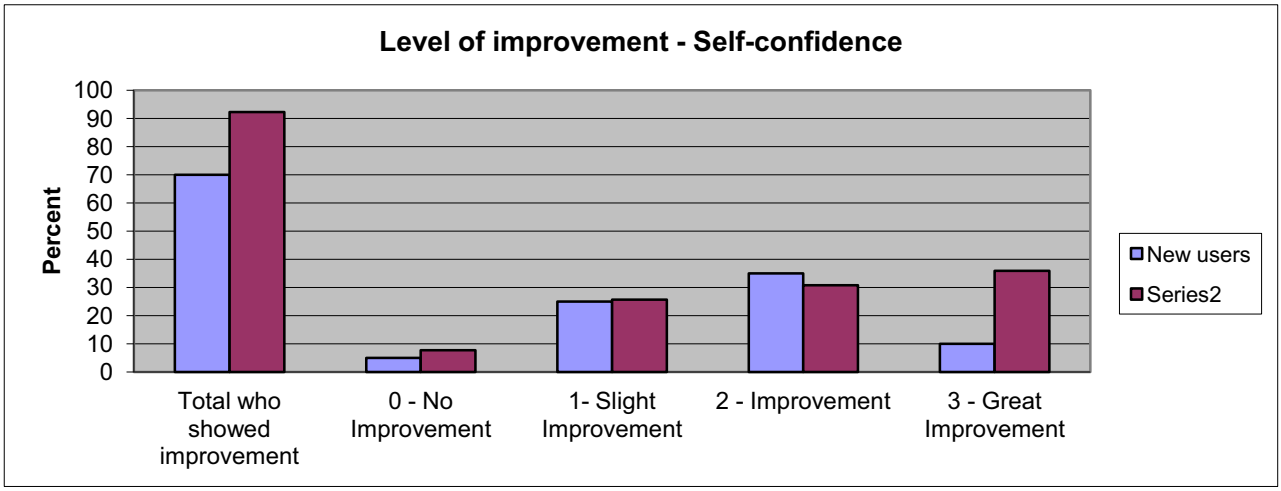
ENERGY results shown in %	Total who shows improvement	0 - No Improvement	1- Slight Improvement	2 - Improvement	3 - Great Improvement
New users (third session)	59	24	53	6	0
Existing users (6 sessions or more)	85	15	32	37	17

New users N=14 Existing users N=41



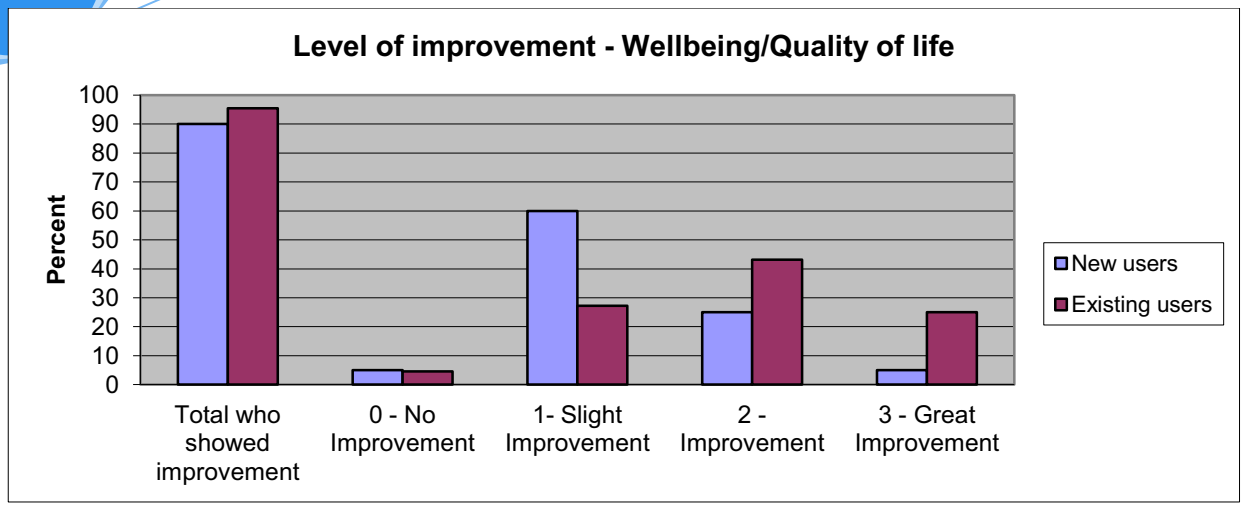
General fitness results shown in %	Total who showed improvement	0 - No Improvement	1- Slight Improvement	2 - Improvement	3 - Great Improvement
New users (third session)	80	15	60	10	10
Existing users (6 sessions or more)	90	10	19	60	12

New users N=19



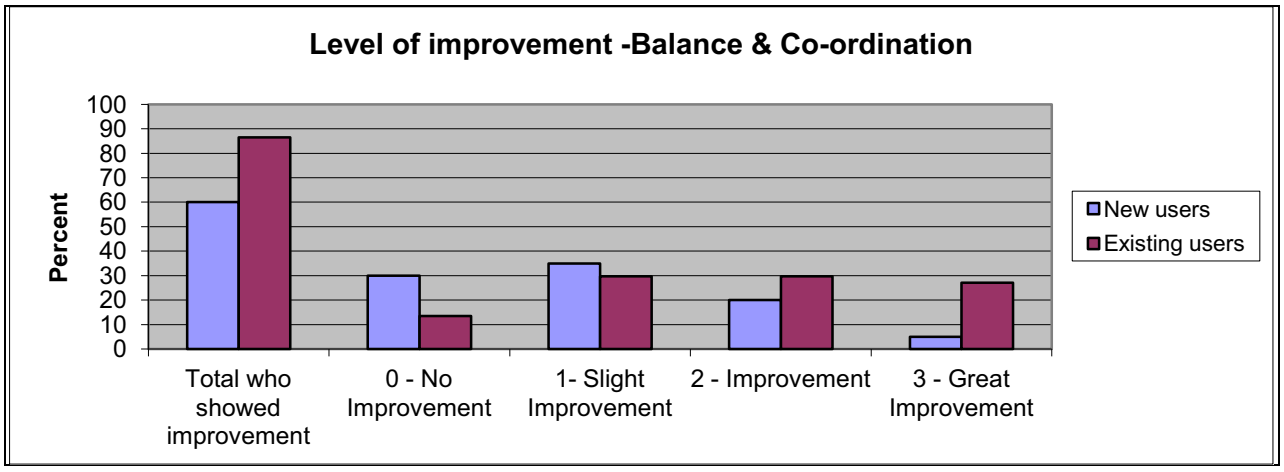
SELF CONFIDENCE results shown in %	Total who showed improvement	0 - No Improvement	1- Slight Improvement	2 - Improvement	3 - Great Improvement
New users (third session)	70	5	25	35	10
Existing users (6 sessions or more)	92	8	26	31	36

New users N=15 Existing users N=39



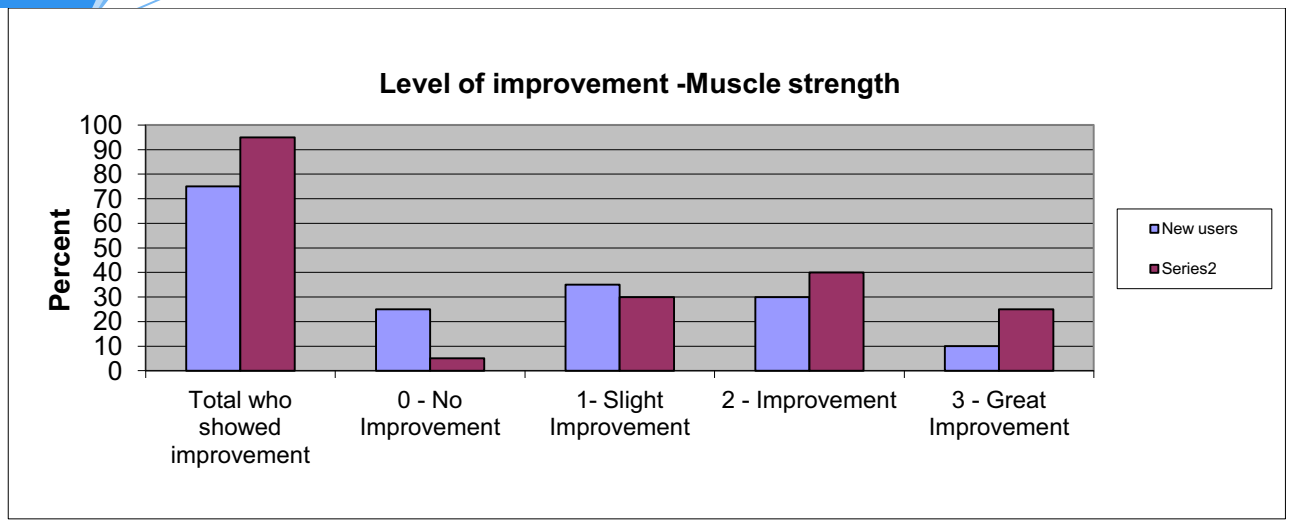
WELLBEING results shown in %	Total who showed improvement	0 - No Improvement	1- Slight Improvement	2 - Improvement	3 - Great Improvement
New users (third session)	90	5	60	25	5
Existing users (6 sessions or more)	95	5	27	43	25

New users N=19 Existing users N=44



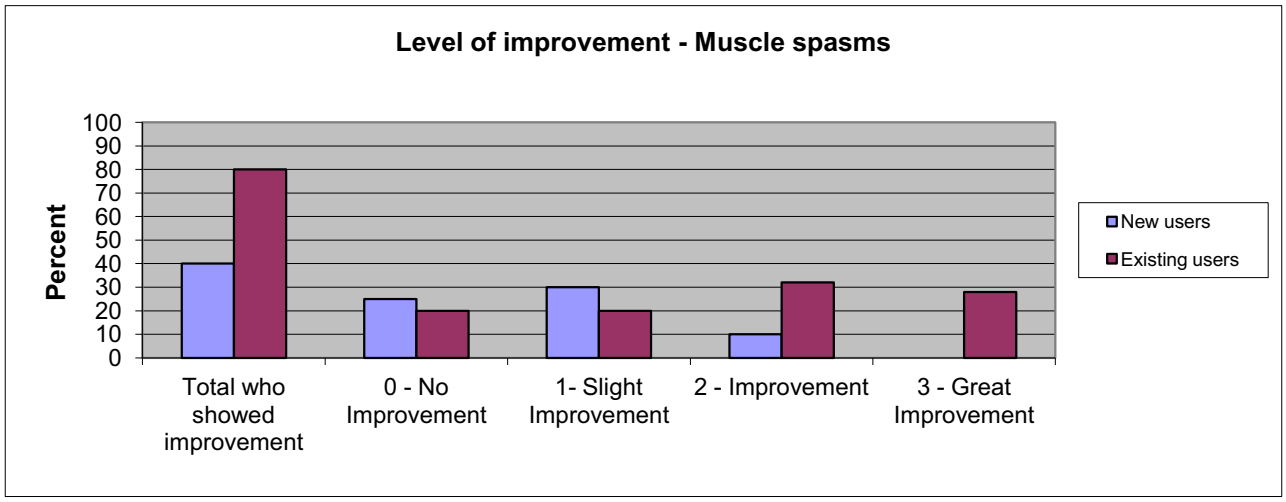
Balance and Co-ordination results shown in %	Total who showed improvement	0 - No Improvement	1- Slight Improvement	2 - Improvement	3 - Great Improvement
New users (third session)	60	30	35	20	5
Existing users (6 sessions or more)	86	14	30	30	27

New users N=18 Existing users N=40



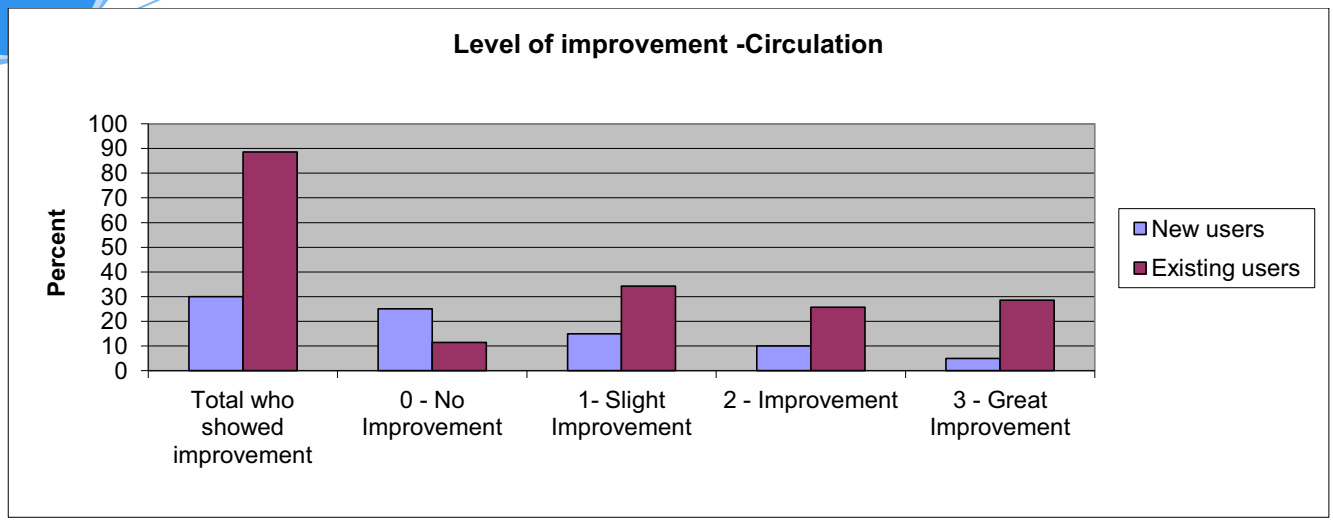
Muscle strength in %	Total who showed improvement	0 - No Improvement	1- Slight Improvement	2 - Improvement	3 - Great Improvement
New users (third session)	75	25	35	30	10
Existing users (6 sessions or more)	95	5	30	40	25

New users N=20
Existing users N=37



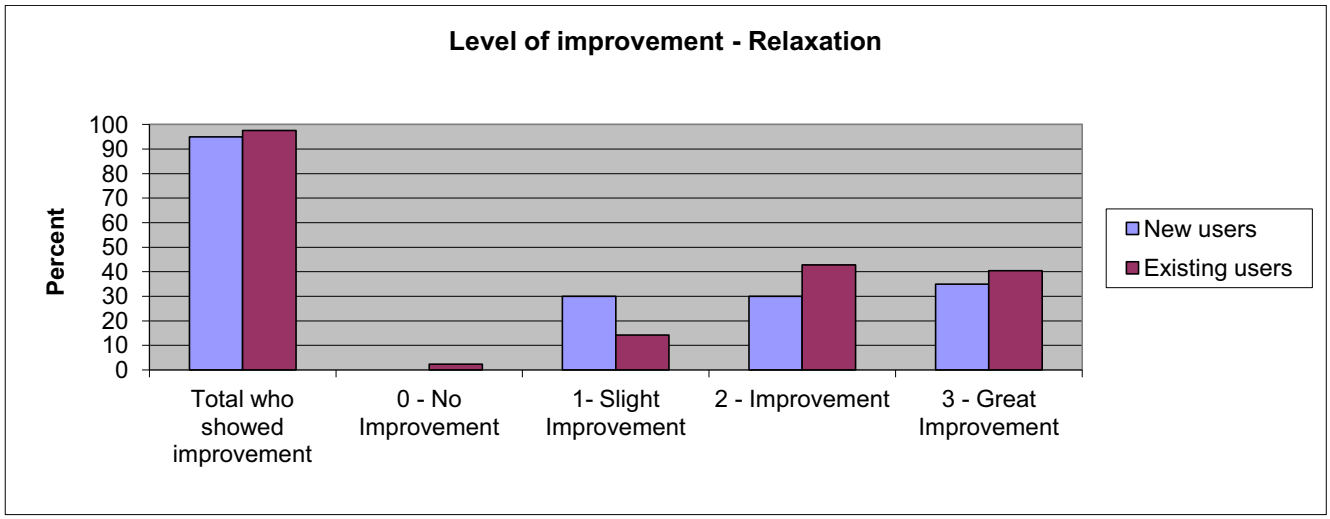
Muscle spasms results shown in %	Total who showed improvement	0 - No Improvement	1- Slight Improvement	2 - Improvement	3 - Great Improvement
New users (third session)	40	25	30	10	0
Existing users (6 sessions or more)	80	20	20	32	28

New users N=13
Existing users N=25



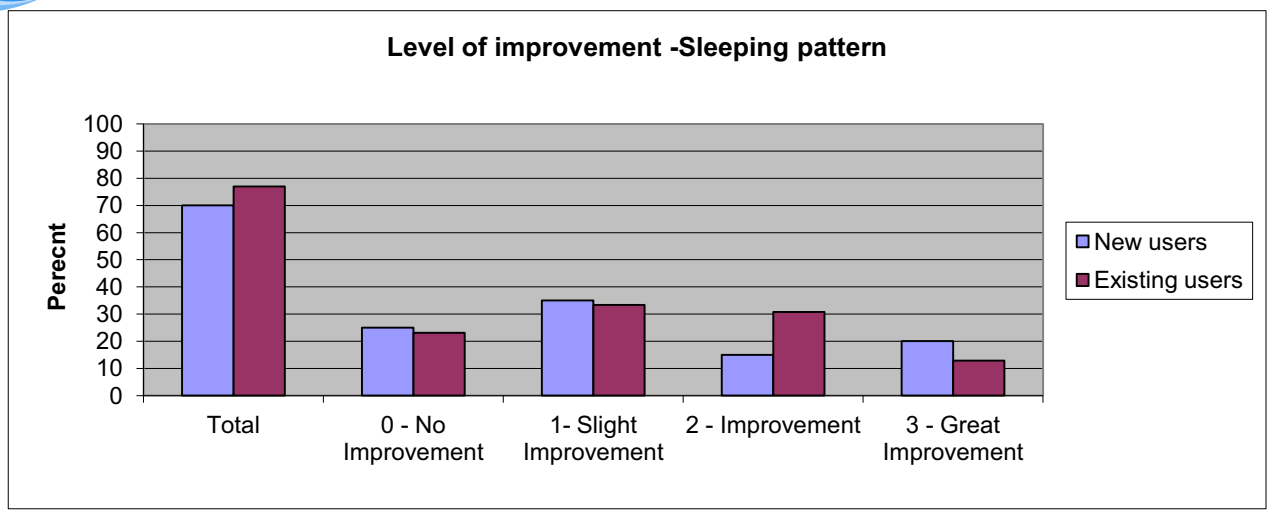
Circulation results shown in %	Total who showed improvement	0 - No Improvement	1- Slight Improvement	2 - Improvement	3 - Great Improvement
New users (third session)	30	25	15	10	5
Existing users (6 sessions or more)	89	11	34	26	29

New users N=11
Existing users N=35



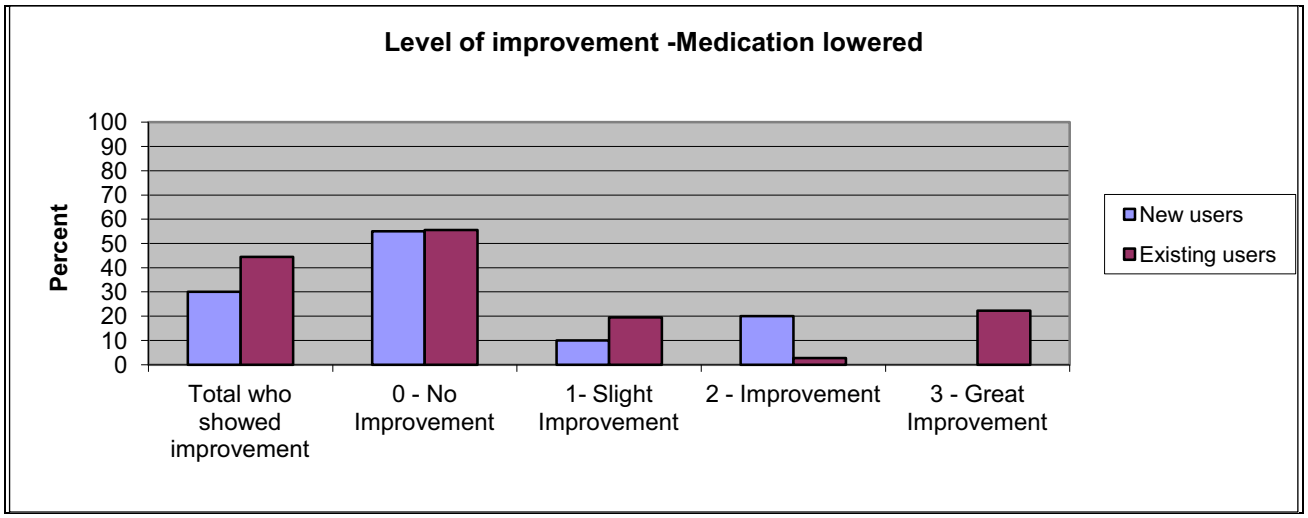
Relaxation results shown in %	Total who showed improvement	0 - No Improvement	1- Slight Improvement	2 - Improvement	3 - Great Improvement
New users (third session)	95	0	30	30	35
Existing users (6 sessions or more)	98	2	14	43	40

New users N=19
Existing users N=42



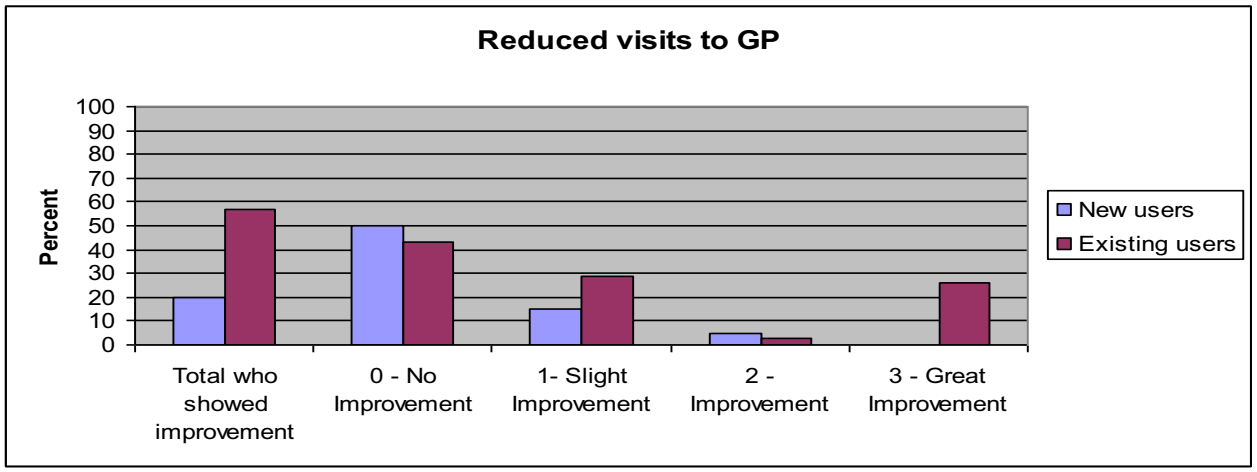
Sleep pattern results shown in %	Total who showed improvement	0 - No Improvement	1- Slight Improvement	2 - Improvement	3 - Great Improvement
New users (third session)	70	25	35	15	20
Existing users (6 sessions or more)	77	23	33	31	13

New users N=19
Existing users N=39



MEDICATION LOWERED results shown in %	Total who shows improvement	0 - No Improvement	1- Slight Improvement	2 - Improvement	3 - Great Improvement
New users (third session)	30	55	10	20	0
Existing users (6 sessions or more)	44	56	19	3	22

New users N=17 Existing Users N=36



REDUCED GP VISITS results shown in %	Total who showed improvement	0 - No Improvement	1- Slight Improvement	2 - Improvement	3 - Great Improvement
New users (third session)	20	50	15	5	0
Existing users (6 sessions or more)	57	43	29	3	26

New users N=14 Existing users N=35

Summary conclusion

The data collected using the evaluation form has shown great support for using hydrotherapy (aquatic therapy) for a complex variety of conditions. All the users were self-referring, paying clients who have sourced hydrotherapy through their own means including internet research, word of mouth, advertising or recommended by someone.

The majority of existing users have been using the pool regularly once a week, between 6 months and a year. This would support the theory that regular long term hydrotherapy sessions are found to be beneficial to most users.

A third of those have received hospital treatment in the last 12 months, half of those stated that they had a surgical procedure in relation to the condition that they use the pool for. Many of the existing users have shown great improvement right across the heading. The results from new users have also been very encouraging, and show a similar trend. 100% of existing users showed improvement with their levels of pain. The results show many of the existing users have shown great improvement right across the headings.

The results from new users have also been very encouraging, and show 90% of new users also reporting that their levels of pain had improved over a short time of using the pool.

90% of existing users and 80% of new users are both showing significant improvement in their general fitness. Both groups have reported very encouraging

scores of improvement with mobility and a steady improvement with range of joint movement.

Energy levels shows 85% of existing users are gaining a steady feeling of having more energy, were 59% of new users have shown slight improvement.

With an amazing score of 95%, existing users say that their wellbeing and quality of life has improved since using hydrotherapy. 90% of the new users also reported that their quality of life and general wellbeing had improved.

An impressive 44% of existing users and 30% of new users said they have been able to reduce their medications since using hydrotherapy for their conditions.

The results shows 50% of longer term users and 20% of new users have reported reducing their visits to their GP. It gives good evidence that hydrotherapy covers many important aspects, including helping to reduce GP visits, emergency hospital admissions and medication. Whilst also demonstrating the increase in personal health and wellbeing and less pain.

Hydrotherapy enables local people to access a facility that is not a luxury, but an essential part of the patient pathway to recovery and/or rehabilitation. It is also a vital provision that stabilises or improves a number of longer term conditions.

Family and Friends Test

'Would you recommend St George's Hydrotherapy pool to friends and family?'

A resolute **96%** of users stated they would.

List of conditions from evaluation forms:

Knee surgery & replacements; recovering from stent operation; stroke; Rheumatoid arthritis; Ankle surgery; Pain in thigh; General wellbeing/fitness; Kyphoscoliosis; Diabetic; Spinal muscular atrophy; Spasmodic back pain; Various –Arthritis; back pain and slipped disc; Cerebral palsy; Insomnia; Muscle weakness /spasms Arm surgery; Cervical spondilosys; Spinal muscular atrophy; Ehlers-Danlos Syndrome; Breast cancer-radiotherapy recovery; Developmental dyspepsia; Osteoporosis; Selective dorsal rhizotomy Osteoarthritis; Hip replacement; Walking/standing - weight issues breast cancer; Fibromyalgia; ME; Anxiety; Foot surgery; Joint problems; Nerve compression; weight bearing on leg; Ankylosing Spondilitis; Neck problems;

EQ-5D-L

The Eq-5d-l is a tried and tested questionnaire that gives a holistic picture of the patient. It is well recognized throughout the health services. It is useful for researchers and clinicians, health care providers and policy makers who need to evaluate health care.
EuroQOL (EQ-5D)[5]. The EQ 5D has five domains (physical, self care, ability to perform usual activities, pain/discomfort, and anxiety/depression) and five levels of severity on each domain. Scoring generates a single health state profile and subsequently a single utility score.
Patients also rate their own health on a visual analogue scale, ranging from 0 (worst imaginable health state) to 100 (best imaginable health state).

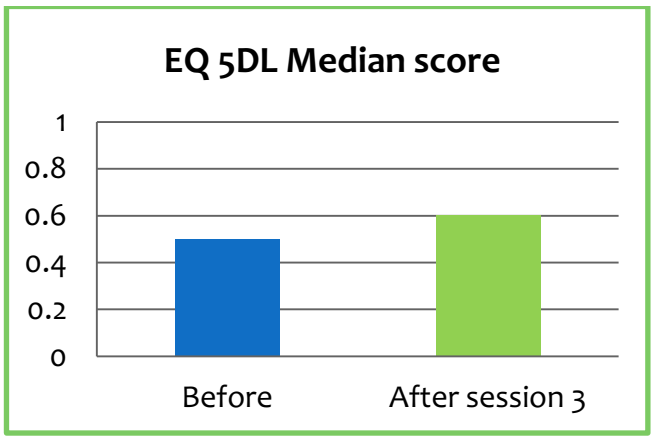
EQ-5D-5L Results for self referring hydrotherapy users

	Before treatment	**After treatment (Session 3)**
	N=33	**N=18**
Mean (Standard deviation)	**0.488 (0.242)**	**0.561 (0.171)**
Median	**0.498**	**0.602**

(Scale: 1 = full health and 0 = death) **(Better health depicted by higher scores in Eq-5d-l)**

The results from the self referring users who took part in the EQ-5D-L questionnaire have shown: Between their first session and their third session there had been a small change of improvement in their index values. The EQ 5D score improved by mean .073, median .10

Graph showing EQ-5DL figures for self referring user



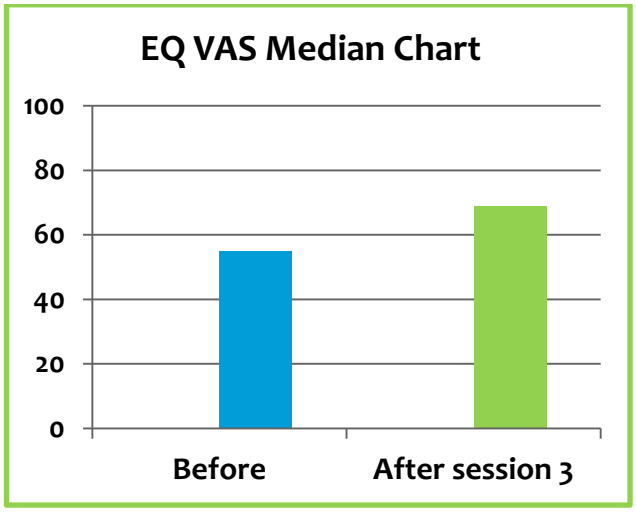
[5] The EuroQol group.EuroQol –a new facility for the measurement of health related quality of life, *Health Policy 1990:16:199-208.*

EQ-5D VAS score results for self referring hydrotherapy users

	Before treatment	After treatment (session 3)
	N = 33	N = 18
Mean (standard deviation)	57(18.68)	60 (21.34)
Median	55	69

The EuroQol Vas scores showed improvement of mean +3, Standard deviation 2.66, and median of +14

Graph showing EQ VAS figures for self referring user



Measure Yourself Medical Outcome Profile (MYMOP)

MYMOP is a tried and tested questionnaire that gives a holistic picture of the patient. Numerous studies show their specificity and reliability**.** With their consent, each user was asked to complete Measure Yourself Medical Outcome Profile (MYMOP) form immediately prior to treatment and post treatment.

MYMOP is an individualised questionnaire where the patient is asked to nominate the problem that they are coming to use the hydrotherapy pool for help with (symptom 1 & 2) and one way in which it affects their daily living. The patient scores severity on a seven point scale and also scores their general well being. An overall MYMOP profile score and individual dimension scores are calculated. The Mymop questionnaires were administered according to their standard instructions.

MYMOP designed by Dr Charlotte Paterson[6] Mymop has been used by clinicians, GPs and the NHS .

Self referring users -session 1 & 3

The MYMOP was used to determine the effectiveness of the treatment of hydrotherapy (aquatic therapy). Initial sessions 1, 3 and 6 were going to be the target sessions to collect data. For various reasons; users being poorly, unable to attend, being in hospital, not wanting to continue. The figures for session 6 were too small so we have concentrated on session 1 and 3 only.

The MYMOP has an initial assessment and a follow-up assessment. The follow up assessment was 2 sessions after the initial assessment. Below is a table of the findings, detailing the changes. The MYMOP scales range from 0-6. Higher values represent the worst outcome and lower scores represent the best outcome.

MYMOP Results

The questionnaire data was transferred from paper data collection forms to an excel spreadsheet where it could be analysed.

Self referring new users (Questionnaire responders n=31)

	Number	Percent
Female	**24**	**77 %**
Male	**7**	**23 %**
Gender not reported	**0**	**0 %**
Duration of health problem		
4 -12 weeks	**2**	**7 %**
3-12 months	**6**	**19 %**
1-5 years	**8**	**26 %**
Over 5 years	**15**	**48 %**

With an average age of 52 years old

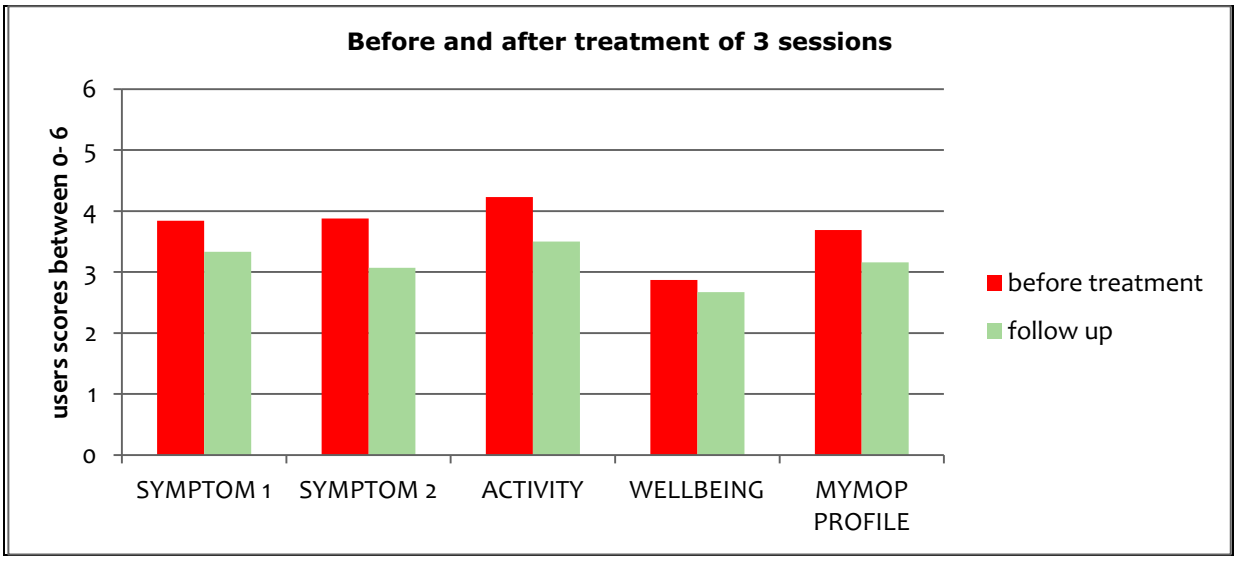
MYMOP Results for new self referring users

MYMOP scores	Before treatment N=31	At follow-up (3 sessions) N=18	Change in score	
	Mean (SD)	Mean (SD)	Mean (SD)	95% confidence interval
Symptom 1 n.31	3.84 (1.18)	3.33 (1.41)	0.51 (1.09)	0.13 0.89
Symptom 2 n = 26	3.88 (1.21)	3.07 (1.10)	0.82(0.79)	0.52 1.12
Activity n = 31	4.23 (1.12)	3.50 (1.29)	0.73 (1.04)	0.35 1.10
Wellbeing n = 30	2.87 (1.55)	2.67 (1.14)	0.20 (1.55)	0.65 075
MYMOP profile n = 31	3.69 (0.84)	3.16(0.99)	0.53 (0.65)	0.30 0.76

Scale: 0="as good as it can be" to 6 ="as bad as it could be." rated by the user.

Although the number of participants was small the majority showed improvement. This study indicates that overall there were positive effects over the three sessions of hydrotherapy.

MYMOP chart - new self referring users



MYMOP scored 0-6, with lower scores = better health

Improvement was found for Symptom 1, Symptom 2, Activity, and Wellbeing. These findings indicate that the treatment was a positive success

The MYMOP profile score represents the overall experience for the patient. As shown, this score was *lower* after treatment, indicating success with the treatment.

This shows that even after a short trial period of three sessions improvement overall can be seen. This would support the St George's evaluation report that long term use of hydrotherapy produces successful results.

The MYMOP also asks patients about the importance of reducing medication and about the doses of medication that they are on, 39% of patients indicated that cutting down medication was very important to them and 19% were successful in reduction or cessation. This indicates some success with the treatment.

(A change in score is clinically significant when it represents a change that is of importance to the individual patient concerned. Using a seven point score such as MYMOP, the clinically minimal important difference for the change score is between 0.5-1.0. This means that any change below 0.5 does not represent a change of any importance to the patient, and any change above 1 probably does. In-between 0.5 and 1.0 we are uncertain. [7] [8])

[7] Guyatt GH, Juniper EF, Walter S, Griffith L, Goldstein RS. Interpreting treatment effects in randomised trials. British Medical Journal 1998;316:690-693.]

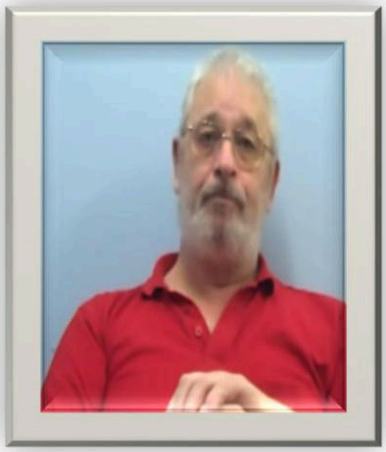
1. [8] *MYMOP* - Faqs *sites.pcmd.ac.uk/**mymop**/index.php?c=faqs*

CASE STUDIES

JACKIE MANDLEY- lives in Chatteris, and has been a regular visitor and user of the hydrotherapy pool since April 2012. She uses the pool once a week. Jackie has arthritis in her right hip and is also waiting for a hip replacement. Jackie found out about hydrotherapy and the pool through visiting her masseuse for her monthly massage. She discussed using the hydrotherapy pool with her consultant who also agreed, and recommended it after her surgery too.

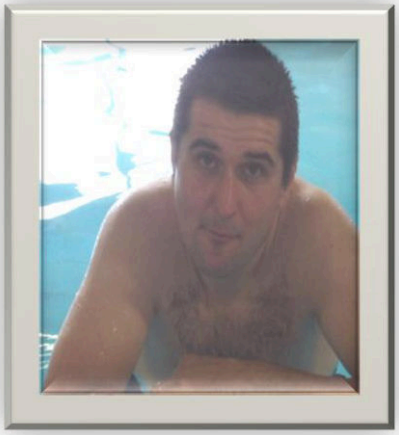
Jackie finds it very difficult to walk upright, and struggles with land based exercise. Using the hydrotherapy pool she finds exercising in water so much easier as the water supports her body, enabling her to stand up straight. Jackie believes that it is using the hydrotherapy pool that keeps her mobile, helping to strengthen her muscles.

Jackie said" I can move in the water without the pain and can walk upright in the pool. It makes such a difference to me; it is also mentally refreshing too. When you struggle with pain and aches on a daily basis it wears you down, if I'm having a low day, once I get in the pool and start moving around I start to feel uplifted. There's always a great group of people there. I come with my friend, and it's like a social gathering- the lifeguards are so friendly and kind too. I would definitely recommend the hydrotherapy pool to friends and family."



Peter Hook from Parnwell has started to use the hydrotherapy pool after undergoing a hip replacement. Peter had found that his recovery from his hip operation was very slow. He had been off work since June and had surgery in September 2012.

Peter said "I had been on very strong pain killers and didn't seem to be getting any better. I was at the end of my tether, and decided I needed to investigate whether I could do something different. I used the internet and found out about St George's and hydrotherapy. When I had my first session I enjoyed the warmth of the water, and it enabled me to move through the water without the pain. It means I can exercise without the strain and it has made a marked improvement on my health and well- being. Mentally I'm in a much better place and start back to work part-time next week .I will carry on using hydrotherapy, it's a great way to keep fit and trim. I do recommend hydrotherapy to everyone."



Darren Towell was knocked down by a car last September whilst walking on the pavement over the town bridge in Stamford. He broke both legs and severely damaged both cartilages and ligaments in his knees.

After 3 months of bed rest while the breaks healed and the swelling to both knees subsided, he lost most of the muscle tone in his legs and gained quite a bit of weight.
He started land based physio but could not weight-bear unless he used a walking frame, Eventually he was able to weight-bear long enough to build up enough muscle tone to walk very short distances and tackle a few stairs using crutches.
He was then advised to try the hydrotherapy pool which he says;"has been an absolute godsend, it has enabled me to have a lot more movement in my legs and has also built up my muscles again. The hydrotherapy pool has also been a very good meeting place to talk to people who have similar conditions. The staffs are very friendly and there is always a good atmosphere. I would recommend this to anyone who has had an operation, got poor circulation or who has got limited movement with aches and pains. It has definitely speeded up my recovery. Before I started using the pool my consultant and physiotherapist thought I was going backwards with my rehabilitation.

Karen Oldale-conditions: Spinal muscular atrophy, Ehlers-Danlos Syndrome, Developmental dysplasia of the hips (6 left hip operations) Osteoarthritis, Osteoporosis, Kyphoscoliosis, Mild heart failure.

Hydrotherapy is the only treatment I have received that has genuinely worked and helped improve my conditions. I use it to manage my pain; I do not take any medication for this at all. Hydrotherapy allows me to manage my conditions and I very rarely visit my GP. I use hydrotherapy as an alternative to hospital procedures, such as facet joint injections.

For the past ten years, hydrotherapy has enabled me to postpone major and complex hip surgery at Guys. By continuing hydrotherapy I hope I can prevent it altogether. There are enormous financial and personal benefits to this.

It has genuinely slowed the degenerative progress of my conditions and allows me to retain a greater degree of independence for longer. Without regular hydrotherapy, I have increased pain and signs of irreversible muscle weakness within a couple of weeks. Pain, lowered medication intake, energy levels and wellbeing/quality of life are the four most important aspects for me, and in all these I have gained great improvement through hydrotherapy. If hydrotherapy was not available to me, I'm certain none of the above would continue."

User's stories and quotes

Female user - 62 years old. She has been using the pool for about six months and visits on a weekly basis. She suffers with Arthritis and has found using the hydro pool very beneficial. Mrs.M. said
" the pool is brilliant, and has changed my life as I have a lot of pain and have mobility issues. I make sure I come regularly to the pool as it helps to keep my joints moving. If I miss a session I can really feel the difference. It's something that I enjoy doing and I look forward to coming each week. I'm proof it works".

User in her 5o's- she has used the pool over the last year and a half on a weekly basis with her friend. She has been using the hydrotherapy pool to help with muscular pain, and to help with her Arthritis.
They both agree that it helps relieve some of the stresses of life too. Using the pool has helped them to socialise, meeting up with other users, and getting them out into the community. They both recommend using the hydrotherapy pool to friends and family.

A user aged 51 years old Recovering from spinal surgery- Mrs S. uses the pool weekly said, "I've been coming to the hydrotherapy pool for just over a year. I originally came to ease the pain as I had a lot of spasms in my back and I was waiting for spinal surgery. Now I've had the surgery, so I'm now building my core muscles again. I find it great for relieving the pain, and great to be able to exercise without weight bearing. I find the physiotherapist very helpful- I recommend it to everyone. I haven't met anyone yet who hasn't got something beneficial from using the pool."

User with back and leg trauma- 47 years old

"I suffered a fall and lost the use of my leg, I also had to have a hip operation. I struggled with land based physiotherapy. Progress was slow, and I wondered if I would ever recover. After using the hydrotherapy I found I could reduce my painkillers and other medication too. This made me feel much better- mentally- I had been in a very low place. I was shown gentle exercises to try, and to be able to move in the warm water enabled me to do so much more than I could with land based physio. I wish I had been told about it earlier, I wish my GP had known more about hydrotherapy. I now walk unaided, and have returned to work. I would definitely recommend it to friends and family"

Mrs T talking about her son: 'My son comes to hydrotherapy once a week. He is autistic and water has a very calming influence on him. It really calms him when he is finding situations difficult. It is the only thing that calms him down. He has a trapped nerve in his skull which is causing him a lot of pain. He has found this very difficult to cope with, so hydro has been a godsend and he really looks forward to it each week. It makes him calm for the rest of the day even if he is in discomfort with pain, it helps him deal with it better'

LINk Pathfinder *Healthwatch Peterborough*

In 2010 Peterborough LINk were contacted by Karen Oldale who raised the awareness of a lack of hydrotherapy facilities locally. The new Peterborough City Hospital did not re-locate the provision after a drop in referral rates at Peterborough District Hospital. LINk worked in partnership with adult social care, health services, hospitals, local community groups, councillors and other interested parties to research and attempt to find a solution to the loss of this service. LINk organised and facilitated partnership meetings across the city to listen and collate information about the service from local people.

Research showed that there were 35,000 people with long-term conditions in the city, so re-establishing this provision for local people was vital.

A local under-used local authority pool was identified as a possible alternative. Peterborough City Council funded refurbishment and management costs to evaluate the demand for the pool during the trial open week. Between 23rd and 30th March 2011 users came from across the city to see, use and evaluate the pool. In the first four weeks over 200 had used the pool from across all parts of the city.

LINk formulated a survey to obtain constructive feedback about the pool and the effect of hydrotherapy as a health provision. The demand was overwhelming, and the benefits to those who used the pool were demonstrated in the comments and reactions from users and carers.

St George's Open Day 2011

The age of users range from the very young to senior citizens over 80 years of age. Users have come from central, outlying, rural parts of Peterborough covered by 24 wards.

Under government reforms to the NHS, clinical commissioning was becoming the new way of commissioning NHS services, in January 2012 LINk lobbied over 100 local GPs to commission hydrotherapy-with support from numerous local and national statutory and voluntary organisations - who have supported and championed the need for the pool.

Peterborough LINk delighted Hydrotherapy Pool to be commissioned:

"This is fantastic news and a massive step in securing the future of hydrotherapy locally. Many people behind the scenes have worked very hard to make this facility available. There is clear evidence that it is both cost effective and hugely beneficial to those who use it - and the carers to those who use it. This decision will increase patient choice and demonstrates how valuable local people and organisations working together can be."

David Whiles
Chair – Peterborough LINk

What does commissioning mean?

At the end of September 2012, NHS Peterborough sent information packs explaining that a commissioned NHS aquatic physiotherapy service was now available at St George's Community Hydrotherapy Pool to every GP practice in the Peterborough and the surrounding Borderline area.

This means GPs working in these practices can refer suitable patients for two sessions of hydrotherapy at St George's with an aquatic physiotherapist.

Patients in Lincolnshire are also able to receive the same service at St George's because NHS Lincolnshire has agreed to be an associate to this commissioning agreement.

The commissioning of this provision will increase patient choice and the available services a GP can offer for a range of conditions.

The commissioning of this service addresses the Equalities Act 2010 by providing a service for the health and wellbeing of disadvantaged groups by making the provision available to all and tackling local health inequality.

The first patient cutting the ribbon at the opening ceremony for commissioning at St George's:

It is decided by the GP if a patient is suitable for aquatic therapy. Each patient can have two NHS aquatic therapy sessions.

The aquatic therapist will assess the patient and plan an individual treatment programme for them. They receive exercises appropriate for their condition to practise in the water.

Their second aquatic therapy session will be very similar to the first, followed by an assessment. After the two sessions the aquatic therapist will send a report on their progress to the GP.

They would be able to continue with their aquatic therapy programme either in a supervised class or on their own at St George's by using the self-referral pathway. Commissioning addresses health inequalities and makes the provision available to anyone who needs it.

EQ-5D-5L Results for GP Commissioned Patients

GP commissioned patients attending their first appointment were asked if they would fill in the same EQ-5D-L questionnaire that self referring users also completed.

The following charts and grids show the results of this questionnaire.

	Before treatment	After treatment (Session 2)
	N=34	N=31
Mean (Standard deviation)	0.521 (0.293)	0.523 (0.336)
Median	0.5375	0.567

Scale1=full health and 0=death (better health depicted by higher scores in Eq5dl)

Spread sheet of Eq-5d-l GP commissioned users shown in appendix 11 and 12

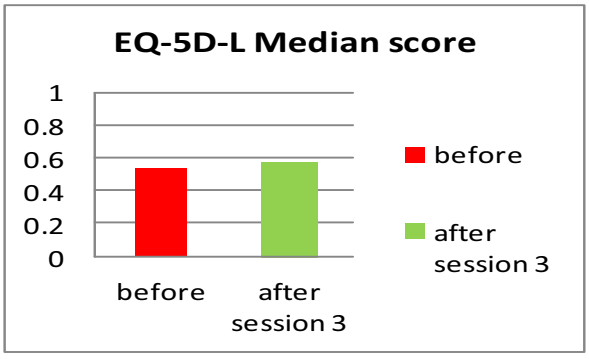
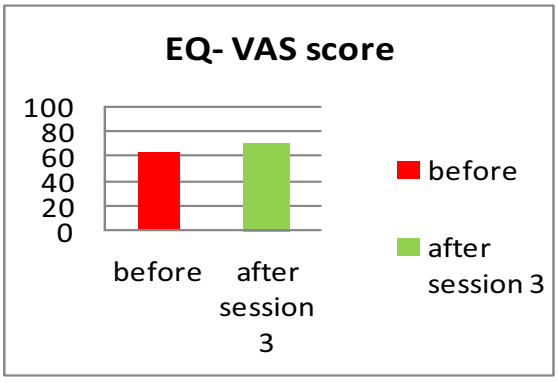


Table showing EQ-5D VAS score

	Before treatment	After treatment (session 3)
	N = 33	N = 18
Mean (standard deviation)	57 (30)	62 (25)
Median	62.5	70.



EQ -5d-l and EQ VAS results have not shown any great change in results.

The EQ Vas scores showed result mean of +5, standard deviation -5, median +7.5.

Because EQ VAS asks the user how they are on that particular day may not reflect specifically to their condition but to how they are generally feeling overall.

The results from the GP commissioned users who took part in the EQ-5D-L questionnaire have shown: Between their first session and their follow up session there has been a small change of improvement in their index values.

The EQ 5D score improved by .002

MYMOP Results for GP commissioned patients

The same MYMOP questionnaire that self referring users filled in were then completed by GP commissioned patients. Data spreadsheet annexe 9 and 10.

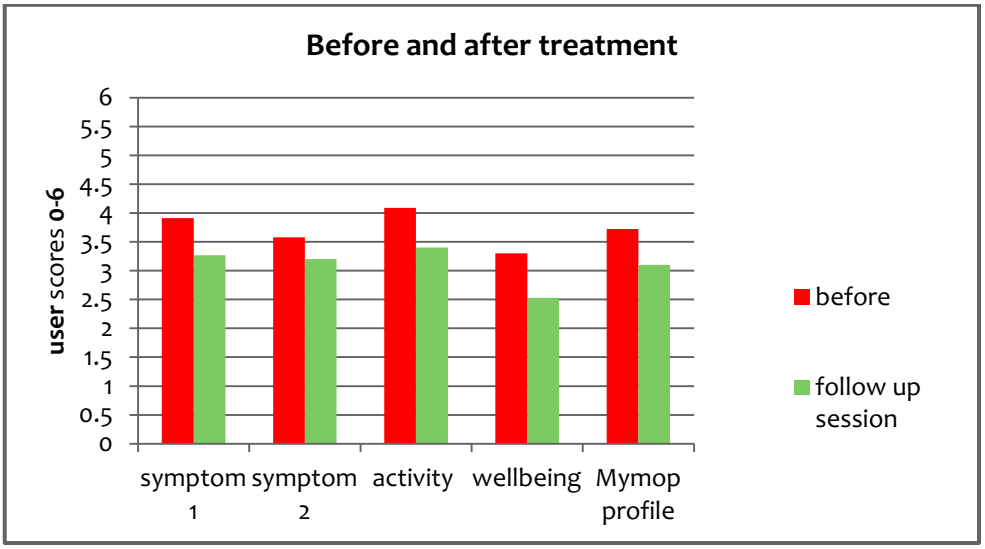
The following charts and grids show the results of this questionnaire. (N=33)

	Number	Percent
Female	**26**	**79 %**
Male	**7**	**21 %**
Gender not reported	**0**	**0 %**
Duration of health problem		
4 -12 weeks	**2**	**6 %**
3-12 months	**16**	**48 %**
1-5 years	**9**	**28 %**
Over 5 years	**6**	**18 %**

MYMOP scores	Before treatment N=33	At follow-up N=30	Change in score	
	Mean (SD)	Mean (SD)	Mean (SD)	95% confidence interval
Symptom 1	3.91 (1.23)	3.27 (1.23)	0.60(1.30)	0.16 1.04
Symptom 2	3.58 (1.70)	3.20 (1.69)	0.30 (0.88)	0.00 0.60
Activity	4.09(1.44)	3.40 (1.43)	0.67 (1.42)	0.19 1.15
Well being	3.30 (1.70)	2.53(1.76)	0.80 (1.77)	0.20 1.40
MYMOP Profile	3.72 (1.23)	3.10 (1.25)	0.59 (0.90)	0.28 0.90

Scale: 0 = "as good as it can be" to 6 = "as bad as it could be average age 52 years old

MYMOP chart showing before and after treatment of 2 sessions for commissioned users



MYMOP scored 0-6, with lower scores = better health

As with the self referring users it can be clearly seen from the data collected from the patients that they feel that they have improved over their two symptoms, and their chosen activity and well being.

The MYMOP profile score represents the overall experience for the patient. As shown, this score was lower after treatment, indicating success with the treatment.

The 80% who said they had improved following their two hydrotherapy sessions did so by an average of 0.90.

The 13% who said they felt worse did so by 0.95

7% of the sample said they were unchanged

After the project ended, the hydropool decided to continue collecting routine outcome data for GP commissioned patients by using MYMOP-and EQ-5D-L.

Peterborough City Council Health and Wellbeing Strategy 2012-2015

The Health and Wellbeing Strategy 2012-2015 to be delivered by health commissioner in the Local and Clinical Commissioning Groups and Peterborough City Council want to ***translate their aspirations and needs into services that:***

- ***Deliver the best possible health and well being outcomes, including promoting equality***
- ***Provide the best possible health and social care provision and***
- ***Achieve this with the best use of available resources***

Hydrotherapy can provide a service to meet these targets and this report and the feedback from users and their carers demonstrates the impact to reflect that.

St George's hydrotherapy pool is a popular, in-demand and well supported provision that improves the lives, health and wellbeing for users and carers. It is a preventative provision as will a valuable means of recovery – delivered directly in line with the key aims and objectives of the strategy.

Hydrotherapy has the rare advantage of being able to deliver benefits to all of Peterborough City Council's public health, education and social care services - contributing to the improvement- *direct use of integrated health and social care solutions.*

Hydrotherapy shows a greater delivery of innovative, forward thinking and proactive – not reactive – provision.

Will have a positive preventative effect through promoting timely intervention

By recognising conditions and illnesses and well being targets – and focusing on preventative and rehabilitation services – hydrotherapy demonstrates an effective way to deploy services- *a single provision meeting a range of needs- proving the best possible health and social care provision*.

The strategy protects and gives due regard to the health and wellbeing needs of disadvantaged groups specified with the Equalities Act 2010 – and the database demographics and city council ward access shows it to be a service that is accessed by all protected groups in the city.

Key facts

***Peterborough has more than the average number of children aged 11 are obese*.**

The hydro pool can offer privacy to those who may avoid activity in water due to the personal perception of their image – for those with a range of eating disorders (aqua-aerobics groups).

Over 1,400 children and young people ages 0 -17 are in receipt of Disability Living Allowance

Schools with aquatic provision can service limited numbers - many miss out on the provision (and it is not available for holiday periods – in excess of 13 weeks a year). Hydrotherapy is an effective way to treat children with neurological and orthopaedic conditions. It is enjoyed by children because it is fun and gives them a freedom of movement only experienced in a hydrotherapy pool.

Peterborough has a higher than average number of pupils who are determined as having Special Educational Need (SEN)

Family Voice Peterborough (FVP) working collaboratively with LINks were invited to be involved in discussions with various other agencies about hydrotherapy provision. FVP are aware many benefits exist for those with SEN ranging from physical freedom to emotional wellbeing. Hydrotherapy has shown that children with autism benefit from being in the warm water, helping them relax enabling them to concentrate better after their session. This also enables them to exercise freely and calmly in the water helping to treat other physical conditions they may have.

St George's hydrotherapy pool can support SEN schools and the council with providing special group sessions with stimulating music, lighting and fun. To encourage and develop movement, communication and social skills.

A grandmother who helps to care for her grandson with hyper mobility syndrome and suspected autism/ Aspergers said; " general fitness, confidence, relaxation and well being/quality of life has greatly improved since attending hydrotherapy. He has also learnt to swim underwater."

Children with Cerebral palsy may find hydrotherapy beneficial as the water supports their body weight, enabling them to enjoy a level of movement and independence which they cannot achieve elsewhere. The resistance of the water can help to strengthen the muscles, and can also reduce muscle spasms.

Peterborough has a growth in the population aged 85+.This frail group need well organised and responsive health and social care services

Hydrotherapy at St Georges can provide vital exercise sessions for our older population. Supporting groups like AGE UK, using gentle exercises in a friendly environment that makes them feel safe and comfortable in sessions of same age users.

A couple in their late 70's have been visiting the pool for the last 18 months. Mr K says: "hydrotherapy has done him the world of good. He no longer has to wear a support belt and does not need to take pain killers anymore. Before visiting the pool Mr K tried sessions with a chiropractor but that did not help. Within two weeks of coming to the pool his condition improved". The spa has also helped Mr K. he says" It is the best massage you can get, so gentle on your muscles". Before he started to use the pool he could not lift his arms above his head, he can do this easily now.

The water provides fabulous physical support - making users feel safer on their feet, especially if they are unsteady and prone to falls – which in old age is one of the highest reasons for emergency admissions to hospitals i.e. broken hips and bones.

Hydrotherapy is proven to speed recovery in those who have been unfortunate to have suffered a fall and demand from local care homes for the service has increased over the last two years.

As well as the physical benefits it can also offer a social network, as people get older they often find that they are by themselves for the majority of their time.

It may be the one time in the week that the actually get to interact/talk to other people. Being part of a group encourages people to keep active physically and mentally.

If they have someone who cares for them, St Georges could play a part in 'signposting' people to the right help, and create a 'hub' for people who need support from others who may also be carers. Being a carer can be very isolating, exhausting and distressing.

Mr. W. who is in his early 80s has Myelitis[9] disease which causes injury to the spinal cord with varying degrees of weakness, sensory alterations, and autonomic dysfunction: "I've been visiting the pool now for about four months, it is helping my mobility, in water I can move around supported by the warm water, it has been such a great help. It is also helping me get more confident with doing many things; it makes me mentally feel better too".

Peterborough City Council currently commits substantially more of its gross budget on services for adults with a learning disability than comparator authorities

Feedback has shown greater mobility / less support/ care needed for adults with learning disabilities who use hydrotherapy. Feedback from carers note that there is a freedom once in the water that allows people to be able to express themselves easier and have better mobility in the water.

They say that if someone has been restless, frustrated, not being able to express themselves verbally, angry or general 'out of sorts' before their session, once they have gone into the warm water, being able to just relax, or be stimulated by the sensory lights and music has a very positive calming effect .This has lead to better response to socialising, learning and behaviour.

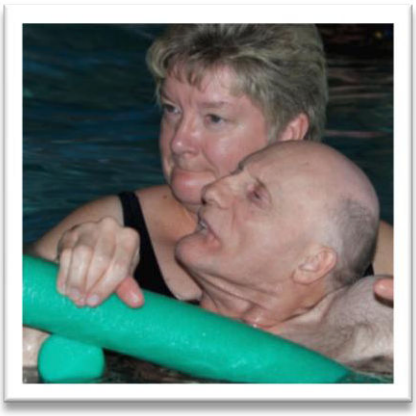
1 [9] Transverse *Myelitis* Society, UK
www.myelitis.org.uk/

Peterborough has a higher than average number of obese and those low in terms of physical activity (a quarter of adults are estimated to be obese)

The hydro pool is open to people in the community who would like to have privacy because of having personal body image issues, either being overweight or being under weight /anorexic.

Anonymous user said "I was advised by my consultant to come to the hydrotherapy pool to help to control my weight which in turn will help with my condition. I can come to 'quiet, small sessions' as I find being in public difficult"

Offering availability to target groups, male /female only, ethnic groups the hydrotherapy pool offers provision not available anywhere else locally.



The provision can be used by the education sector in collaboration with other activities to tackle those at risk or with obesity e.g. having regular aqua aerobics for 11- 15 yrs in small groups etc

Dementia – it is estimated that 20% of the over 80's will be affected. As this age group increase- so will be demands and effects of this most serious illness have on carers and local services

Hydrotherapy sessions can support people with dementia and their carers by providing sessions by having fun, creating social interaction and stimulation and expression of enjoyment.

In 2002 Alzheimer's Society awarded a hydrotherapy project an Excellence in Dementia Care Nursing Award[10].

Senior Policy Officer Martina Kane from the Alzheimer's Society said *There are well understood benefits of physical activity to people with dementia, such as being engaged, increased social contact, exercise, and releasing energy. There is some anecdotal evidence about the benefits of swimming and water for people with dementia especially around difficult behaviour (aggression and agitation). This is probably due the combination of exercise, activity, calming environment etc rather than to one factor in particularly.*

Penny Smith, author of the Waterworks Project Report in Cornwall[11] worked in a specialist dementia unit in a nursing home. She, along with the support of others, used a local hydrotherapy pool to support a number of residents. She reported; ***" it creates positive changes in mood, communication skills and agitation for the residents. It shows much enjoyment is gained from these sessions"***

[10] ; http://www.careinfo.org/a-passport-back-to-youth-strength-and-independence/
[11] Penny Smith waterworks project-

St George's can offer a facility that can accommodate sessions to offer support to those with dementia and their carers in the local community.

Peterborough have a higher than average hip fractures

Hydrotherapy can be used wisely to help those after surgical intervention if commodities allows.

Falls Assist UK: "***exercise designed to improve strength and balance and co-ordination (& safety changes at home) can lead to a reduction in falls***"[12]. Hydrotherapy could provide almost risk-free exercise for this group.

Physiotherapy supported hydrotherapy for hip fractures and other musculoskeletal injuries

- Shorten recovery time
- Faster return to work
- Less pain medication
- GP attendance
- Complication/corrective surgery

Hydrotherapy user attends Guys and St Thomas' Hospitals for various conditions including congenital dislocation in her hip with secondary osteoarthritis problems. ***"I consider (hydrotherapy) to be essential for her care…I cannot stress too highly the importance of her need to continue to receive hydrotherapy on a regular ongoing basis…"*** Professor R Grahame CBE MD FRCP FACP Emeritus Professor of clinical Rheumatology supporting her use of hydrotherapy to control her conditions and pain to the PCT and her GP.

Stroke

Stokes affects more than 300 people in Peterborough annually. Hydrotherapy can benefit stroke survivors by improving their functional movement and well-being. Charles Ryan, Improvement Development Manager for Long Term Conditions said: "***These services will make a real difference to people with stroke, their families and carers. Stroke can have a devastating and lasting impact on people's lives and individuals often live with the effects for the rest of their lives.***

That's why it's important that patients, families and carers have access to and receive good quality rehabilitation services delivered by skilled professionals, as this will enhance long-term recovery and reduce long-term disability. We want to give patients access to quality services delivered in the local community, and to ensure these services are co-ordinated between different service providers for the benefit of patients.[13]"

[12] Only Peterborough magazine –March 2012.

[13] Peterborough NHS- Improvements on the way for community stroke services in Peterborough

Working together…

Brian Tyler Disability Forum Manager and founder of DIAL Sport has been an active supporter of the hydrotherapy pool since the re-launch. Brian has ensured the provision is widely know about by his service user groups through publicity and will signpost organisations and individuals to the pool.

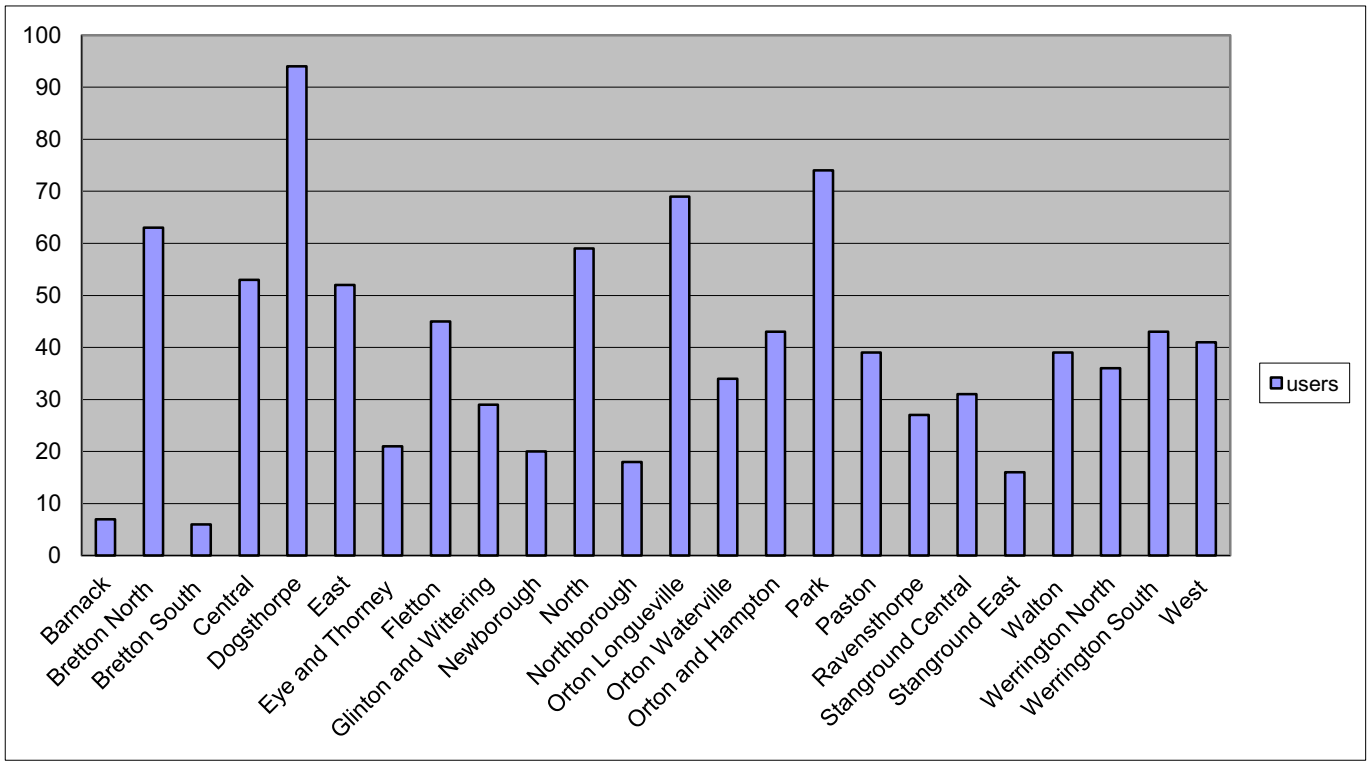
Local councillors from many of the wards across Peterborough have helped promote the hydrotherapy pool within their wards and also very kindly donated from their Community Leadership Funds (CLF). These funds enable elected members to support projects that will have a positive impact on communities within their wards.

The hydrotherapy pool has been well supported by a great deal of statutory and voluntary organisations and many other local businesses and groups.

Volunteers administer and design the website, produce the newsletter, assist in fundraising and provide front of house services. They also have volunteer physiotherapists providing clinical guidance to users.

The 'Friends of St George's hydrotherapy pool' fundraise to provide users with additional equipment.

Hydrotherapy users by ward (latest figures March 2013)



This demonstrates that the facility has been accessed by residents in all wards of Peterborough City. At the time of publishing this report - March 2013 - there were 1400 users on the database. Including:

- 8 care homes
- 2 day centres
- 6 schools and/or nurseries

Final summary

Between July and December 2012 Sam Ring carried out, with a range of research methods, a comprehensive case for the use of St George's Community Hydrotherapy Pool as a provider of aquatic physiotherapy to improve the lives, health and wellbeing of patients, users and carers and demonstrate it by supported evidence of patient experience reports and feedback.

The research was carried out at the hydrotherapy pool in Dogsthorpe, Peterborough. Users were engaged with throughout the project and updated on progress and outcome/s. Evidence and commentary was gathered by users attending their regular sessions whether through self-referring or GP referred.

Data was collected using MYMOP, EQ-5D-L questionnaires, the St. George's evaluation form and oral testimony and feedback. Further soft intelligence was gathered from the provided anonymous comments box.

Sam had the opportunity to spend valuable time and resources talking to users and carers to help her to compile case studies, obtain quotes and valuable constructive user experiences.

The study provides sound evidence that measurable improvement in the quality of everyday living may be obtained by users with various conditions by using hydrotherapy. Evidence shows that it can be of benefit for users who have chronic and progressive conditions showing it as an effective way of controlling pain and increasing mobility.

The majority of the existing users have shown great improvement right across the 15 target areas evaluated. The results from new users have also been very encouraging, showing a similar trend.

The report provides positive evidence that hydrotherapy provides a cost effective provision to both the NHS and social care services - covering many important aspects, including reducing GP visits, reduction in emergency hospital admissions and medication reduction and in preventing conditions worsening.

Continued commissioning and referrals for this service would show that the emerging surrounding Clinical Commissioning Groups (and the Local Commissioning Groups); Peterborough City Council; the primary and secondary sector recognise the tangible and evident health and social care benefits that hydrotherapy provide to the residents of Peterborough and surrounding areas.

* People in the community should to have access to a facility that is proving to be an essential part of the patient pathway to recovery and wellbeing.

* The delivery of hydrotherapy as a health and wellbeing provision is directly in line with the key aims and objectives of the health and wellbeing strategy 2012-2015.

* The provision of this service will help in improving quality of life for many people. Aquatic therapy can help to stabilise or improve many life-long conditions.

Enhancing opportunities for independent living for people with life- long disabilities and complex needs[14].

After completion of the research, having spent six months at St George's, Sam Ring has been so impressed with the impact the service has brought to such a range of vulnerable people, the ethos of the pool and the belief in the need for such a service, she has become a trustee of 'The friends of St George's hydrotherapy pool'.

[14] Health and wellbeing Strategy 2012-2015.NHSPeterborough

Appendix

1. The principles and benefits of Aquatic Environment for rehabilitation
2. Example VAS questionnaire example MYMOP questionnaire
3. Example MYMOP questionnaire
4. Example St George's evaluation form
5. EQ-5D-L self referring data spreadsheet session 1
6. EQ-5D-L self referring data spreadsheet session 3
7. MYMOP publications
8. MYMOP self referring data spreadsheet session 1
9. MYMOP self referring data spreadsheet session 3
10. GP commissioned MYMOP data spreadsheet session1
11. GP commissioned MYMOP data spreadsheet follow up
12. GP commissioned EQ-5D-data spreadsheet session 1
13. GP commissioned EQ-5D-L data spreadsheet session 3
14. Example EQ-5D-L questionnaire
15. Latest data results from MYMOP and Eq-5D-5L

Annexe 1

The principles and benefits of Aquatic Environment for rehabilitation supplied by Pat Baker- physiotherapist

Principles and Benefits of Aquatic Environment for Rehabilitation

Usually when you are up to your neck in something you're in trouble, but research shows that being up to your neck in water may be just what you need. Dr. Bruce E. Becker, who has published, taught, and researched extensively on aquatics, wrote an article titled "Considering the Biologic Aspects of Water" which was published in April 1995 in Advance for Directors in Rehabilitation. His article included the latest information and research on the physiological changes that occur when the body is immersed in water. The following points are summarized from Dr. Becker's article to provide you the benefit of his observations.

Although water is the oldest rehabilitation modality, few understand the magnitude, variety, and rapidity of its healing effects. Yet much research over the centuries validates these effects, and recent research adds further understanding: The aquatic environment produces physiologic changes that help remove metabolic waste, improve cardiac function, lower blood pressure, and assist the body in tissue healing.
In regard to the circulatory system, Dr. Becker stated that: "Immediately after a person is immersed, water begins to exert pressure on the body…Central venous pressure rises with immersion to the chest and increases until the body is completely immersed… Cardiac volume increases by nearly one-third with immersion to the neck…Since the ultimate purpose of the heart is to pump blood, its measure of performance is the amount of blood pumped per unit of time." This is called cardiac output and "submersion in water to the neck depth increases cardiac output, 32% at rest." "Therefore the claim that water exercise is not aerobically efficient is faulty. In fact, it may be the ideal cardiovascular conditioning medium."

"Like the circulatory system, the pulmonary system is profoundly affected by immersing the body to the thorax. Part of the effect is due to blood shifting into the chest cavity, and part is due to compression of the chest wall. The combined effect alters pulmonary function, increases the work of breathing, and changes respiratory dynamics. In fact, expiratory reserve volumes decrease by 75 percent at neck immersion, with vital capacity decreasing only slightly …The combined effects of these changes increase the total work of breathing by 60 percent. Thus for an athlete used to land-based exercise, water-based exercise is a significant workload challenge to the respiratory apparatus. If water training time is sufficient, this challenge can improve the respiratory system's efficiency."

"Water immersion positively affects the musculo-skeletal system as well, particularly with vasoconstriction. On land, for instance, sympathetic vasoconstriction tightens the resistance vessels of the skeletal muscle to resist blood pooling. But in water, immersion pressure removes the biologic need for vasoconstriction, thus increasing muscle blood flow. In fact, resting muscle blood flow increases by 225 percent during neck immersion"
"Aquatic immersion creates many effects upon renal blood flow and the renal regulatory systems. For instance, the flow of blood to the kidneys increases immediately upon immersion, which produces an increase in urine production, as well as sodium and potassium excretion. Sodium excretion also increases as a function of depth due to the shifting of circulating central blood volume."

Immersion up to the neck during deep water running is often utilized for its conditioning effect." Although some controversy exists about the optimal training program for athletes who need joint off-loading during a recovery period, it is known that aquatic exercise can indeed increase conditioning in that population. In fact, water running equals land running in its effect upon maintaining VO2 max. When training intensities and frequencies are matched."

"Similarly, when aquatic exercise is compared with land-based equivalent exercise in its effect upon maximum gains in VO2 in unfit individuals, aquatic exercise achieves equivalent results."

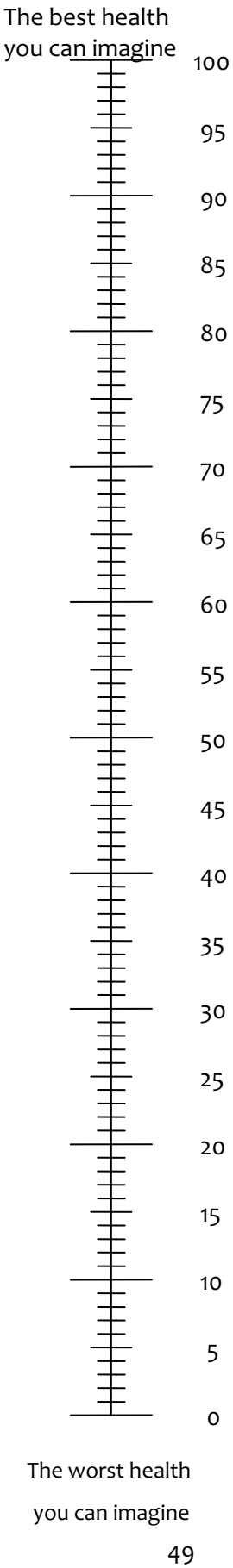
"Water-based exercise programs may be used to sustain or increase aerobic conditioning in athletes who need joint offloading… Studies, have shown excellent cross-over benefits."

ANNEXE 2

Copy of EQ VAS form

- We would like to know how good or bad your health is TODAY.
- This scale is numbered from 0 to 100.
- 100 means the best health you can imagine.
  0 means the worst health you can imagine.
- Mark an X on the scale to indicate how your health is TODAY.
- Now, please write the number you marked on the scale in the box below.

YOUR HEALTH TODAY = ☐



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ANNEXE 3

COPY OF MYMOP FORM

*** MYMOP2 ***

Full name ..... Date of birth .....

Address and postcode .....

.....

Today' s date ..... Practitioner seen .....

Choose one or two symptoms (physical or mental) which bother you the most. Write them on the lines.
Now consider how bad each symptom is, over the last week, and score it by circling your chosen number.

SYMPTOM 1:	0	1	2	3	4	5	6
.....	As good as it could be						As bad as it could be
SYMPTOM 2:	0	1	2	3	4	5	6
.....	As good as it could be						As bad as it could be

Now choose one activity (physical, social or mental) that is important to you, and that your problem makes difficult or prevents you doing. Score how bad it has been in the last week.

ACTIVITY:	0	1	2	3	4	5	6
.....	As good as it could be						As bad as it could be

Lastly how would you rate your general feeling of wellbeing during the last week?

0	1	2	3	4	5	6
As good as it could be						As bad as it could be

How long have you had Symptom 1, either all the time or on and off? Please circle:

0 - 4 weeks 4 - 12 weeks 3 months - 1 year 1 - 5 years over 5 years

Are you taking any medication FOR THIS PROBLEM ? Please circle: YES/NO

IF YES:

1. Please write in name of medication, and how much a day/week

.....

2. Is cutting down this medication: Please circle:

Not important a bit important very important not applicable

IF NO:

Is avoiding medication for this problem:

Not important a bit important very important not applicable

MYMOP, Measure Yourself Medical Outcome Profile

St George's Hydrotherapy Evaluation Form

Name:_____

Address:

Email Address:_____

Phone No:_____ Mobile:_____

Today's date:____/____/____

How long have you used the pool?_____

How regularly do you use the pool? *(Please tick below)*

Three times a week ☐ Twice a week ☐ Once a week ☐ Only occasionally ☐ Until recovered ☐

	0	1	2	3	N/A – Don't know
Pain					
Mobility					
Range of joint movement					
Muscle strength					
Muscle spasms					
Balance and co-ordination					
Circulation					
Energy levels					
General fitness					
Self-confidence					
Relaxation					
Sleeping pattern					
Wellbeing/quality of life					
Has it allowed you to lower your medication intake?					
Has it allowed you to reduce your visits to the GP?					

We would be very grateful if you could help us by completing the following table

0 = No improvement 1 = Slight improvement 2 = Improvement 3 = Great improvement

Please mark on a scale of 0-3 how much hydrotherapy has improved your:

If you would like to tell us anything more about your experience of using hydrotherapy, please **use the box below.**

Thank you so much for making the effort and taking the time to complete this. We do appreciate it. We will use this data to evaluate the effectiveness of hydrotherapy as a medical treatment.

And finally…

Would you recommend St George's Community Hydrotherapy Pool? (Please tick box)

Yes ☐ No ☐ Maybe ☐ Don't know ☐

On a scale of 1-5, how would you rate your experience at St George's Community Hydrotherapy Pool? (Please circle)

Very Poor	Poor	Average	Good	Excellent
1	**2**	**3**	**4**	**5**

Please return your completed form to Sam Ring or Kasia Chiva at:

St George's Community Hydrotherapy Pool

367 Dogsthorpe Road

Peterborough

PE1 3RE

Alternatively, you can attach and send it by email for the attention of Sam or Kasia at:

stgeorgeshydrotherapypool@peterborough.gov.uk

Annexe5

EQ-5D-L. self referring data spreadsheet

session 1

Mobility	Self care	Usual activities	Pain / Discomfort	Anxiety / Depression	State	EQ VAS
1=No problems 2= Slight 3= Moderate 4= Severe 5= Unable to 9= Missing value	1=No problems 2= Slight 3= Moderate 4= Severe 5= Unable to 9= Missing value	1=No problems 2= Slight 3= Moderate 4= Severe 5= Unable to 9= Missing value	1=No pain 2= Slight 3= Moderate 4= Severe 5= Extreme 9= Missing value	1=Not anxious 2= Slighty 3= Moderately 4= Severely 5= Extremely 9= Missing value		
3	2	4	3	1	32431	75
2	1	2	4	2	21242	35
5	3	5	4	3	53543	20
3	1	3	4	2	31342	70
3	3	4	4	1	33441	50
2	1	2	4	1	21241	45
2	3	3	4	4	23344	72
3	2	3	3	2	32332	47
2	3	3	4	4	23344	72
3	1	5	4	1	31541	70
1	1	2	3	1	11231	70
3	3	4	4	1	33441	40
1	2	2	2	1	12221	72
1	1	1	3	2	11132	50
2	1	1	3	1	21131	100
3	1	1	3	1	31131	85
3	1	2	1	1	31211	40
4	2	3	3	1	42331	60
2	1	2	3	1	21231	62
2	1	4	2	1	21421	77.5
4	1	5	4	1	41541	35
2	1	3	3	1	21331	45
3	1	1	3	1	31131	50
3	1	3	3	2	31332	60
2	3	5	3	1	23531	40
1	1	2	2	2	11222	80
2	1	1	1	2	21112	70
4	3	4	4	2	43442	50
3	2	2	3	1	32231	55
1	2	3	4	3	12343	70
4	3	3	4	1	43341	35
4	1	4	4	1	41441	20
4	3	4	4	3	43443	50
						56.74242

Annexe 6

EQ-5D-L self referring session 3 data spreadsheet

Mobility	Self care	Usual activities	Pain / Discomfort	Anxiety / Depression	State	EQ VAS	Change + or -
1=No problems 2= Slight 3= Moderate 4= Severe 5= Unable to 9= Missing value	1=No problems 2= Slight 3= Moderate 4= Severe 5= Unable to 9= Missing value	1=No problems 2= Slight 3= Moderate 4= Severe 5= Unable to 9= Missing value	1=No pain 2= Slight 3= Moderate 4= Severe 5= Extreme 9= Missing value	1=Not anxious 2= Slighty 3= Moderately 4= Severely 5= Extremely 9= Missing value			
3	2	2	2	1	32221	85	10
							-35
							-20
3	1	2	2	1	31221	70	0
							-50
							-45
2	2	3	4	3	22343	70	-2
2	2	3	3	2	22332	3	-44
							-72
4	1	3	5	1	41351	75	5
3	3	3	3	1	33331	70	0
3	2	4	4	1	32441	45	5
1	2	2	2	1	12221	78	6
							-50
							-100
3	1	2	3	1	31231	60	-25
3	1	3	2	1	31321	55	15
4	2	4	3	1	42431	75	15
2	1	2	2	1	21221	68	6
2	2	3	3	1	22331	85	7.5
3	1	5	3	1	31531	40	5
3	1	2	2	3	31223	48	3
							-50
							-60
2	3	3	3	2	23332	35	-5
1	1	2	3	2	11232	80	0
							-70
							-50
3	3	3	3	1	3331	43	-12
							-70
							-35
							-20
							-50
						60.27778	-787.5

Annexe 7

MYMOP Publications

Short list of publications describing evaluations of, or use of, MYMOP.

1. Chapman R, Norton R, Paterson C. A descriptive outcome study of 291 acupuncture patients. The European Journal of Oriental Medicine 2001;48-53.
2. Hill S, Eckett MJH, Paterson C, Harkness EF. A pilot study to evaluate the effects of floatation spa treatment on patients with osteoarthritis. Complementary Therapies in Medicine 1999;7:235-8.
3. Paterson C. Measuring outcome in primary care: a patient-generated measure, MYMOP, compared to the SF-36 health survey. British Medical Journal 1996;312:1016-20.

Available online

4. Paterson C. Complementary practitioners as part of the primary health care team: consulting patterns, patient characteristics and patient outcomes. Family Practice 1997;14:347-54.
5. Paterson C,.Britten N. In pursuit of patient-centred outcomes: a qualitative evaluation of MYMOP, Measure Yourself Medical Outcome Profile. J Health Serv Res Policy 2000;5:27-36.
6. Paterson C, Langan CE, Mckaig GA, Anderson PM, Maclaine GDH, Rose LH. Assessing patient outcomes in acute exacerbations of chronic bronchitis: the measure yourself medical outcome profile (MYMOP), medical outcomes study 6-item general health survey (MOS-6) and EuroQol (EQ-5D). Quality of Life Research 2000;9:521-7.
7. Paterson, C. The context, experience and outcome of acupuncture treatment: users' perspectives and outcome questionnaire performance. 2002. University of London. PhD thesis
8. Peace G,.Mannasse A. The Cavendish Centre for integrated cancer care: assessment of patients' needs and responses. Complementary Therapies in Medicine 2002;10:33-41.
9. Ritchie, J, Wilkinson, J, Gantley, M., Feder, G., Carter, Y., and Formby, J. A model of integrated primary care: anthroposophical medicine. 2001. London, Department of General Practice and Primary Care, St Bartholomew's and the Royal London School of Medicine and Dentistry, Queen Mary, University of London.
10. Paterson C, Britten N. Acupuncture for people with chronic illness: combining qualitative and quantitative outcome assessment. Journal of Alternative and Complementary Medicine 2003; 9:671-681
11. Paterson C. Seeking the patient's perspective: a qualitative assessment of EuroQol, COOP-WONCA Charts and MYMOP2. Quality of Life Research 2004;13: 871-881
12. Paterson C.(2006) Measuring changes in self-concept: a qualitative evaluation of outcome questionnaires in people having acupuncture for their chronic health problems.

[1] Guyatt GH, Juniper EF, Walter S, Griffith L, Goldstein RS. Interpreting treatment effects in randomised trials. British Medical Journal 1998;316:690-693.]

[1] *MYMOP* - Faqs *sites.pcmd.ac.uk/**mymop**/index.php?c=faqs*

MYMOP Self referring Session 1

Annexe 8

			SESSION 1					
Research ID	Age	Sex	Duration of problem	Symptom1 at Time 1	Symptom 2 at Time 1	Activity at Time 1	Welbeing at Time 1	MYMOP profile at time 1
1 MR	73	M	3M-1YR	3	3	5	0	2.75
2 SL	41	F	5 YRS	4	4	4	5	4.25
3 HW	50	F	1-5 YRS	6	6	6	5	5.75
4 JH	72	F	1-5YRS	3		3	3	3.00
6 MM	73	F	5 YRS	5	5	3	2	3.75
7 WC	50	F	5 YRS	4	3	3	4	3.50
8 SB	27	M	5 YRS	4		6	4	4.67
9 KC	28	F	3M-1YR	4	4	4	3	3.75
10 SP	62	F	1-5 YRS	5	6	4	1	4.00
11 LC	65	F	5 YRS	3	3	5	3	3.50
12 SC	54	F	5 YRS	4	5	5	5	4.75
13 JR	52	M	4-12WKS	3	3	2	0	2.00
14 SJ	54	F	5 YRS	5	4	5	4	4.50
15 OS	68	F	5 YRS	2		3	1	2.00
16 MB	58	F	1-5 YRS	3	3	3	3	3.00
								#DIV/0!
17 PP		F	1-5 YRS	5	3	5	2	3.75
18 MH	58	F	5 YRS	4	3	5	1	5.29
19 JH	35	M	3M-1Y	2	5	4	3	3.50
20 PH	60	M	3M-1Y	4	3	4	2	3.25
21 GG	60	F	3M-1Y	5	3	5	3	4.00
22 KW	26	F	5 YRS	3	5	5	4	4.25
23 MC	83	F	5 YRS	4		3	1	2.67
24 MB	40	F	5 YRS	3	3	3	3	3.00
25 AW	54	F	5 YRS	4	2	3	3	3.00
26 SR	38	F	3M-1Y	4		4	5	4.33
27 RW	29	F	1-5 YRS	5	2	5	1	3.25
28 JM	59	F	5 YRS	0	6	5		3.67
29 ST	61	F	5 YRS	4	5	3	3	3.75
30 CS	41	M	1-5 YRS	4	5	6	5	5.00
31 JB	60	F	4-12WKS	5	4	4	2	3.75
32 DT	40	M	1-5 YRS	5	3	6	5	4.75
Number of clients				31	26	31	30	29.50
Averages				3.8387097	3.8846154	4.225806	2.866667	3.70

MYMOP Self referring -Session 3

Annexe 9

FOLLOW UP SESSION 3										
Symptom1 at Time 2	Symptom2 at Time 2	Activity at Time 2	Wellbeing at Time 2	MYMOP Profile at time 2	Change in symptom 1	Change in symptom2	Change in activity	Change in wellbeing	Change in profile score	Symptom 3
1	2	2	2	1.75	-2	-1	-3	2	-1	
				#DIV/0!	-4	-4	-4	-5	#DIV/0!	
				#DIV/0!	-6	-6	-6	-5	#DIV/0!	
3		3	3	3.00	0	0	0	0	0	
				#DIV/0!	-5	-5	-3	-2	#DIV/0!	
1	3	2	2	2.00	-3	0	-1	-2	-1.5	
5		6	2	4.33	1	0	0	-2	-0.33333	
				#DIV/0!	-4	-4	-4	-3	#DIV/0!	
6	5	5	4	5.00	1	-1	1	3	1	
3	3	3	1	2.50	0	0	-2	-2	-1	
4	5	5	4	4.50	0	0	0	-1	-0.25	
3	3	2	0	2.00	0	0	0	0	0	
				#DIV/0!	-5	-4	-5	-4	#DIV/0!	
				#DIV/0!	-2	0	-3	-1	#DIV/0!	
3	3	3	3	3.00	0	0	0	0	0	
				#DIV/0!	0	0	0	0	#DIV/0!	
4	3	4	2	3.25	-1	0	-1	0	-0.5	
4	3	4	3	3.50	0	0	-1	2	-1.78947	
1	2	2	4	2.25	-1	-3	-2	1	-1.25	
2	2	2	2	2.00	-2	-1	-2	0	-1.25	
5	3	5	4	4.25	0	0	0	1	0.25	
4	4	5	4	4.25	1	-1	0	0	0	
				#DIV/0!	-4	0	-3	-1	#DIV/0!	
				#DIV/0!	-3	-3	-3	-3	#DIV/0!	
4	1	3	3	2.75	0	-1	0	0	-0.25	
4		4	2	3.33	0	0	0	-3	-1	
				#DIV/0!	-5	-2	-5	-1	#DIV/0!	
				#DIV/0!	0	-6	-5	0	#DIV/0!	
3	4	3	3	3.25	-1	-1	0	0	-0.5	
				#DIV/0!	-4	-5	-6	-5	#DIV/0!	
				#DIV/0!	-5	-4	-4	-2	#DIV/0!	
				#DIV/0!	-5	-3	-6	-5	#DIV/0!	
18	15	18	18	17.25	-13	-11	-13	-12	-12.25	
3.3333333	3.0666667	3.5	2.666667	3.14	-0.505376	-0.817949	-0.72581	-0.2	-0.56228	

GP commissioned MYMOP session 1

Annexe 10

Age	Sex	Duration of problem	Symptom1 at Time 1	Symptom 2 at Time 1	Activity at Time 1	Welbeing at Time 1	MYMOP profile at time 1
26	F	3mnths - 1	4	4	6	4	4.5
62	F	3mnths - 1	5	0	6	5	4
82	F	1 - 5 yrs	3	4	4	3	3.5
60	F	1 - 5 yrs	3	4	1	6	3.5
60	M	3mnths - 1yr	4	4	5	4	4.25
62	F	over 5yrs	3	3	5	4	3.75
34	F	1 - 5 yrs	4	5	3	2	3.5
69	F	1 - 5 yrs	4	4	5	1	3.5
40	F	3mnth - 1yr	3	2	3	2	2.5
49	F	3month - 1	4	6	5	5	5
77	M	3mnths - 1	2	2	1	1	1.5
44	F	3mnths - 1	4	4	5	4	4.25
12	F	4 - 12wks	5	6	6	5	5.5
44	F	1 - 5yrs	4	4	4	3	3.75
62	M	over 5yrs	5	5	5	5	5
60	M	3mnths - 1	2	2	3	2	2.25
50	F	5 yrs +	5	3	4	4	4
51	F	3mnths - 1yr	2	4	2	0	2
62	F	3mnth - 1	5	5	5	5	5
52	F	3mnths - 1yr	6	6	6	6	6
14	M	1 - 5 yrs	5	4	3	5	4.25
48	F	3mnths - 1yr	5	3	5	3	4
56	F	1 - 5yrs	1	0	1	0	0.5
63	F	4 - 12wks	5	0	3	1	2.25
68	F	3mnths - 1yr	5	6	6	5	5.5
55	F	0ver 5yrs	4	3	4	4	3.75
76	M	1 - 5yrs	4	3	3	3	3.25
38	F	1 - 5 yrs	6	6	5	5	5.5
40	M	5yrs +	2	1	4	2	2.25
56	F	over 5yrs	3	4	5	3	3.75
24	F	3mnths - 1yr	4	4	4	4	4
45	F	3mnths -1yr	3	3	4	2	3
72	F	3mnths - 1yr	5	4	4	1	3.5
		MEAN	3.91	3.58	4.09	3.30	3.72
		STDEV	1.23	1.70	1.44	1.70	1.23

GP commissioned MYMOP -follow up

Annexe 11

FOLLOW-UP					CHANGE				
Symptom1 at Time 2	Symptom2 at Time 2	Activity at Time 2	Wellbeing at Time 2	MYMOP Profile at time 2	Change in symptom 1	Change in symptom2	Change in activity	Change in wellbeing	Change in profile score
2	4	3	0	2.25	-2	0	-3	-4	-2.25
4	0	3	5	3	-1	0	-3	0	-1
1	3	2	3	2.25	-2	-1	-2	0	-1.25
4	3	3	4	3.5	1	-1	2	-2	0
3	2	3	3	2.75	-1	-2	-2	-1	-1.5
4	4	6	5	4.75	1	1	1	1	1
3	3	2	3	2.75	-1	-2	-1	1	-0.75
4	3	4	1	3	0	-1	-1	0	-0.5
2	3	2	2	2.25	-1	1	-1	0	-0.25
4	6	6	5	5.25	0	0	1	0	0.25
0	1	1	1	0.75	-2	-1	0	0	-0.75
4	4	4	4	4	0	0	-1	0	-0.25
6	6	5	1	4.5	1	0	-1	-4	-1
5	5	5	6	5.25	1	1	1	3	1.5
5	3	5	4	4.25	0	-2	0	-1	-0.75
1	3	3	2	2.25	-1	1	0	0	0
4	2	4	2	3	-1	-1	0	-2	-1
6	5	6	6	5.75	1	0	1	1	0.75
4	4	3	4	3.75	-1	0	0	-1	-0.5
3	0	3	1	1.75	2	0	2	1	1.25
1	0	1	1	0.75	-4	0	-2	0	-1.5
4	6	3	2	3.75	-1	0	-3	-3	-1.75
4	3	4	3	3.5	0	0	0	-1	-0.25
2	3	3	0	2	-2	0	0	-3	-1.25
5	6	5	0	4	-1	0	0	-5	-1.5
3	2	1	2	2	1	1	-3	0	-0.25
1	3	4	1	2.25	-2	-1	-1	-2	-1.5
3	4	2	2	2.75	-1	0	-2	-2	-1.25
3	2	3	1	2.25	0	-1	-1	-1	-0.75
3	3	3	2	2.75	-2	-1	-1	1	-0.75
3.27	3.20	3.40	2.53	3.10	-0.60	-0.30	-0.67	-0.80	-0.59
1.51	1.69	1.43	1.76	1.25	1.30	0.88	1.42	1.77	0.90
			30						

Annexe 12

GP commissioned EQ-5D-L session1

Research ID	Mobility	Self care	Usual activities	Pain / Discomfort	Anxiety / Depression	State	Result
[redacted]	1=No problems 2= Slight 3= Moderate 4= Severe 5= Unable to 9= Missing value	1=No problems 2= Slight 3= Moderate 4= Severe 5= Unable to 9= Missing value	1=No problems 2= Slight 3= Moderate 4= Severe 5= Unable to 9= Missing value	1=No pain 2= Slight 3= Moderate 4= Severe 5= Extreme 9= Missing value	1=Not anxious 2= Slighty 3= Moderately 4= Severely 5= Extremely 9= Missing value		
2012/002	1	3	3	3	4	13334	0.372
2012/003	4	2	3	3	3	42333	0.496
2012/004	3	3	3	3	1	33331	0.587
2012/005	2	1	3	2	4	21324	0.444
2012/006	3	1	2	2	2	31222	0.666
2012/007	3	3	3	3	3	33333	0.516
2012/008	2	1	2	3	1	21231	0.71
2012/009	4	2	3	3	1	42331	0.567
2012/010	3	1	2	2	1	31221	0.723
2012/011	1	2	5	3	1	12531	0.346
2012/012	2	1	2	2	1	21221	0.735
2012/013	4	3	4	4	3	43443	0.206
2012/016	5	3	4	5	3	53453	-0.28
2012/017	1	1	1	3	2	11132	0.74
2012/018	4	1	4	4	3	41443	0.31
2012/020	4	3	4	4	3	43443	0.206
2012/021	2	2	2	3	2	22232	0.567
2012/022	1	1	2	2	5	11225	0.287
2012/023	1	1	1	1	1	11111	1
2012/024	4	1	4	4	4	41444	0.18
2012/025	4	1	4	4	4	41444	0.18
2012/028	2	1	3	3	1	21331	0.703
2012/032	1	1	2	3	2	11232	0.711
2012/035	1	1	1	1	1	11111	1
2012/040	2	2	2	3	2	22232	0.567
2013/002	3	2	4	3	4	32434	0.256
2013/003	2	1	2	3	1	21231	0.71
2013/004	1	1	1	1	1	11111	1
2013/005	4	3	4	5	4	43454	-0.134
2013/007	2	1	2	3	1	21231	0.71
2013/008	3	2	2	2	1	32221	0.636
2013/012	2	1	3	3	2	21332	0.647
2013/016	3	1	3	3	2	31332	0.635
2013/022	2	1	3	3	1	21331	0.703

Mean	0.520647
Median	0.5375
Standard deviation	0.293194

Annexe 14

Under each heading, please tick the ONE box that best describes your health TODAY

MOBILITY

I have no problems in walking about	❑
I have slight problems in walking about	❑
I have moderate problems in walking about	❑
I have severe problems in walking about	❑
I am unable to walk about	❑

SELF-CARE

I have no problems washing or dressing myself	❑
I have slight problems washing or dressing myself	❑
I have moderate problems washing or dressing myself	❑
I have severe problems washing or dressing myself	❑
I am unable to wash or dress myself	❑

USUAL ACTIVITIES *(e.g. work, study, housework, family or leisure activities)*

I have no problems doing my usual activities	❑
I have slight problems doing my usual activities	❑
I have moderate problems doing my usual activities	❑
I have severe problems doing my usual activities	❑
I am unable to do my usual activities	❑

PAIN / DISCOMFORT

I have no pain or discomfort	❑
I have slight pain or discomfort	❑
I have moderate pain or discomfort	❑
I have severe pain or discomfort	❑
I have extreme pain or discomfort	❑

ANXIETY / DEPRESSION

I am not anxious or depressed	❑
I am slightly anxious or depressed	❑
I am moderately anxious or depressed	❑
I am severely anxious or depressed	❑
I am extremely anxious or depressed	❑

Latest Results Data

Table Showing EQ-5D-5L Results for Commissioned Hydrotherapy Patients

	Before treatment N=56	At follow-up N=46
Mean EQ-Index	0.544 (0.280)	0.530 (0.314)
Median EQ-Index	0.587	0.603

Scale: 1 = full health and 0 = death

Table Showing EQ VAS Results for Commissioned Hydrotherapy Patients

	Before treatment N= 49	At follow-up N=43
Mean EQ VAS (Standard deviation)	58 (28)	65 (24)
Median EQ VAS	60	70

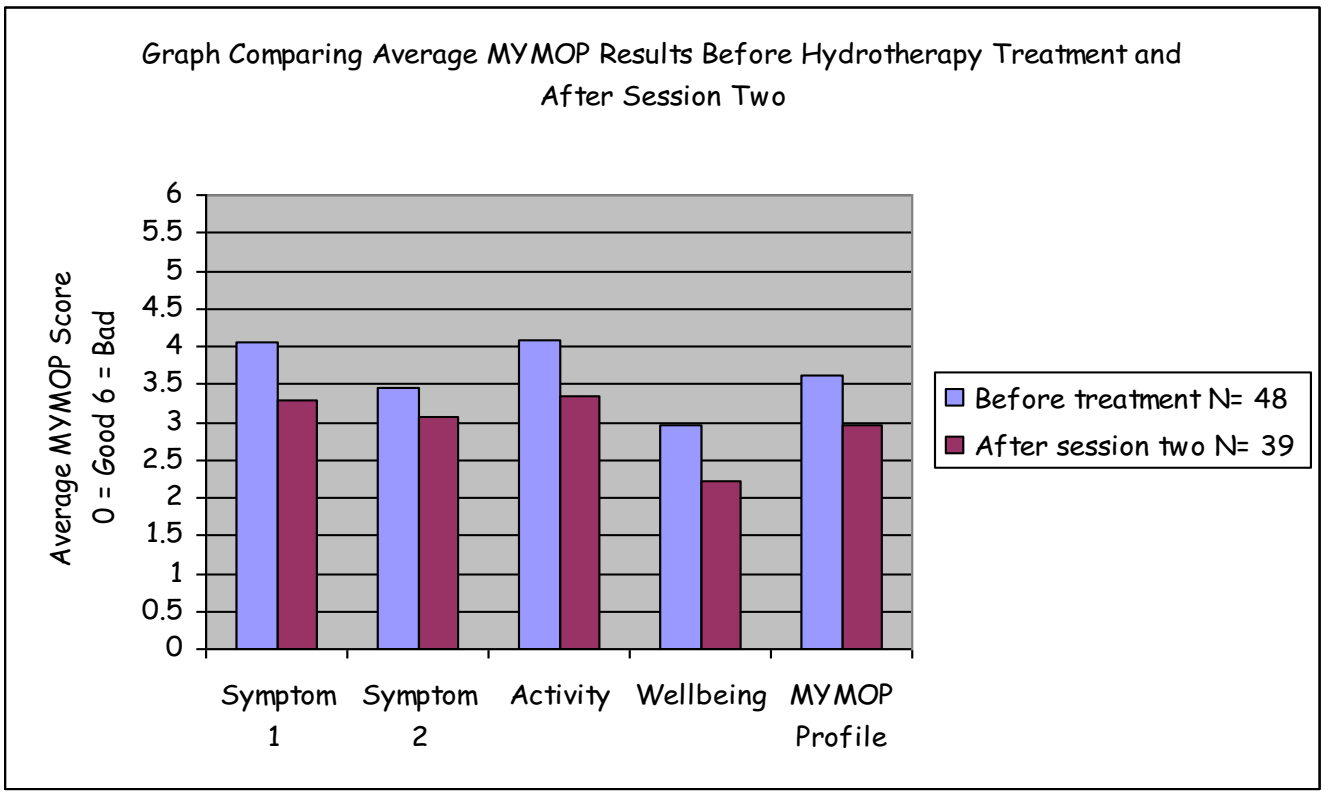
100= "The best health you can imagine"

0= "The worst health you can imagine"

Table Showing MYMOP Results for Commissioned Hydrotherapy Users

MYMOP scores	Before treatment N=48	At follow-up N=39	Change in score	
	Mean (SD)	Mean (SD)	Mean (SD)	95% confidence interval
Symptom 1	4.02 (1.21)	3.28 (1.62)	0.79 (1.40)	0.39, 1.18
Symptom 2	3.44 (1.76)	3.08 (1.66)	0.41 (1.12)	0.10, 0.72
Activity	4.08 (1.47)	3.33 (1.49)	0.72 (1.38)	0.33, 1.11
Wellbeing	2.96 (1.74)	2.21 (1.76)	0.90 (1.83)	0.38, 1.42
MYMOP profile	3.63 (1.16)	2.97 (1.22)	0.71 (1.00)	0.43, 0.99

Scale: 0 = "as good as it can be" to 6 = "as bad as it could be."
79% of patients had improved. The mean improvement was 1.04.
13% of patients had got worse. The mean was -0.95.
8% remained unchanged



Acknowledgements

Emma Valerio – Community Liaison Co-ordinator John Lewis-Peterborough, and John Lewis 'GJT board' for supporting a local community project, and funding the secondment of Mrs Sam Ring for six months.

The Inclusion Manager - Leonie McCarthy and her team at Peterborough City Council

Louise Ravenscroft, Family Voice- (Peterborough)and her team of volunteers. For their support, and the use of the database. Thanks to the families who allowed Sam to join in with some of the 'family fun' on her days away from the hydropool.

Aquatic physiotherapy specialist Mike Maynard for sharing his expertise.

The physiotherapists Pat Baker and Lee Croft for all their help and knowledge

All of the members of SURF (Service User's Rehabilitation Forum)

The Management, lifeguards of the hydrotherapy pool–for their expertise

All the users of St.George's hydrotherapy pool-without their input of information and sharing their experiences this would not have been possible

This paper could not have been written without the invaluable help of Karen and Rob Oldale who first raised the issue of lack of hydrotherapy facilities and who are full-time supporters of St George's.

Special thanks to Angela Burrows, previously working with LINks, now Chief Operating Officer for Healthwatch Peterborough, whose continued support and guidance ensured the project, ran smoothly.

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 6(a)
12 SEPTEMBER 2013		PUBLIC REPORT
Contact Officer(s):	Cathy Mitchell/Jana Burton	Tel.

SECTION 256 AGREEMENT BETWEEN THE AREA TEAM AND PETERBOROUGH CITY COUNCIL

R E C O M M E N D A T I O N S
FROM Cathy Mitchell, Local Chief Officer, Borderline and Peterborough LCG and Jana Burton, Peterborough City Council
1. The Board has asked to consider and comment upon the contents of this report prior to submission to the Area Team

1. ORIGIN OF REPORT

1.1 The Clinical Commissioning Group (CCG) and Peterborough City Council (PCC) are required to draw up a draft Section 256 and agree the outcomes that will be delivered from the funding held by the Local Area Team. The Local Area Team will release funding to PCC social services based on the evidence that the outcomes have been delivered in 2013/14.

1.2 this is additional money and is paid to Local Area Teams by the Department of Health to invest in adult social care services to promote better services, as detailed by the National Health Service (NHS) Transfer Directions 2013.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose is funding for adult social care support in the NHS to benefit social care services that have mutual benefits to health.

2.2 The attached Section 256 has been drawn up between the CCG and PCC to align with the local needs of the population across the health and social care system. The Joint Commissioning Forum has been asked to comment on the draft plan prior to it being submitted to the Area Team for their input and agreement as the budget holders who will transfer the funding to PCC. Details of the Section 256 including the metrics is attached.

2.3 There is a requirement for the Final Version of the Section 256 to be presented to the Health and Wellbeing Board in September 2013 as part of the national governance and approvals process.

3. FUTURE PLANS

3.1 In the spending review the government unveiled plans to create a £3.8bn “pooled fund” between the NHS, the Department of Health, and the Department for Communities and Local Government for the Joint commissioning of health and social care. The government is currently reviewing the creation of an Integration Fund from 2015/16. The current discussions are considering top slicing the CCG’s budgets nationally to create a new pooled health and social care budget, which would equate to approximately 3% of the CCG allocation. There are discussions regarding the role and responsibility that the Health and Wellbeing Boards will undertake in the oversight and governance of the Integrated Fund.

The Joint Commissioning Forum will be updated as the national position becomes clearer and then develop plans for the future commissioning related to the Integrated Fund in 15/16.

4. CONSULTATION

4.1 The Joint Commissioning Forum has endorsed the attached draft Section 256 prior to submission to Health and Wellbeing Board in September 2013. The draft agreement has been sent to the Area Team but no comments have been received to date from the Area Team.

5. REASONS FOR RECOMMENDATIONS

5.1 To enable final consideration and comments to be made by the Health & Wellbeing Board prior to submission to the Local Area Team for release of funds .

5.2 To request the Area Team Representative on the HWB to feedback comments on the Agreement in order that the Section 256 Agreement can be signed by PCC and the Area Team.

DATED **2013**

AREA TEAM **(1)**

and

PETERBOROUGH CITY COUNCIL **(2)**

Agreement relating to Social Care Funding 2013/14

THIS AGREEMENT is made on **2013**

BETWEEN:

(1) AREA TEAM and

(2) **PETERBOROUGH CITY COUNCIL** of the Town Hall, Bridge Street, Peterborough, PE1 1 HF (the "**Council**")

(together the **"Parties"**).

WHEREAS:

(A) The Area Team is empowered by Section 256 of the 2006 Act to make payments to the Council in certain circumstances towards expenditure incurred or to be incurred by the Council.

(B) The Area Team has agreed to make payments to the Council to contribute towards or pay the costs of the Scheme.

(C) By resolution of the Area Team dated **[*insert date*]** the Grant for the Scheme was recommended pursuant to Section 256 of the 2006 Act.

(D) The Area Team is satisfied that this Grant is in accordance with the 2006 Act and complies with the Directions.

NOW IT IS HEREBY AGREED as follows:

1 Definitions and Interpretation

1.1 In this Agreement the following expressions shall unless the context otherwise requires have the meanings herein:

"**2006 Act**" means the National Health Service Act 2006;

"**Annual Voucher**" means the statement of compliance with conditions of Grant and expenditure certification as set out in Schedule 2;

"**CEDR**" means the Centre for Effective Dispute Resolution";

"Directions" means the Directions by the Secretary of State for Health as to the conditions governing payments by health authorities and other bodies under the NHS

Bodies and Local Authorities Partnership Arrangements Regulations 2000 as attached in Appendix 1 to Schedule 1;

"**Financial Year**" means 1 April of one year to 31 March of the following year;

"**Grant**" means the amount of money set out in Section 3 of Schedule 1 payable by the Area Team to the Council in respect of the Scheme;

"**Nominated Officers**" means [***insert details***] (for the Area Team) and the Director for Adult Social Services (for the Council) or such replacements as may be notified by a Party to the other Party in writing from time to time; and

"**Scheme**" means the scheme more specifically described in Schedule 4.

1.2 The headings in the Agreement are for ease of reference only and shall not affect the construction hereof.

1.3 A reference to any Act of Parliament, Order, Regulation, Statutory Instrument, Directions or the like shall be deemed to include a reference to any amendment or re-enactment of the same.

2 Conditions relating to the Grant

2.1 The Grant shall be paid by the Area Team in accordance with Schedule 1.

2.2 The Grant for Financial Year 2013/2014 shall be paid within 30 days of the date of this Agreement.

2.3 The Council shall submit a completed and certified Annual Voucher to the Director of Finance of the Area Team by no later than the 31 July following the end of Financial Year 2013/2014.

2.4 The Council shall use the Grant:

2.4.1 in respect of the Scheme;

2.4.2 in such way as to secure the most efficient and effective use of Grant;

2.4.3 in accordance with all relevant legislation and the Directions; and

2.4.4 in accordance with any policies, performance objectives, eligibility criteria and standards set out at Schedule 4.

2.5 Peterborough City Council shall be responsible for the operational management of the Scheme. In accordance with the Section 256 agreement between the Parties dated [xxxxx] (the "**Section 256 Agreement**").

2.6 The Council shall provide the Area Team with the information detailed in Schedule 4 and access to such other information as the Area Team may reasonably request.

2.7 The Area Team and the Council shall meet at such intervals as the Parties agree, having regard to the nature of the Scheme, to review the Scheme. Any variation to this Agreement or the Scheme must be agreed in writing by both Nominated Officers.

2.8 Any complaints in relation to the Scheme shall be notified immediately to the Nominated Officers who shall agree an appropriate course of action to ensure that all such complaints are dealt with appropriately.

3 Authority

3.1 Both Parties warrant that all required approvals and any necessary delegated authority which a Party may be responsible for ensuring, shall be put in place and complied with regarding the execution and performance of this Agreement.

4 Dispute Resolution

4.1 Both Parties agree that it would be in their best interests for any dispute which arises out of or in connection with this Agreement or the performance, validity or enforceability of it (a "**Dispute**") to be resolved locally as soon as reasonably possible, firstly by the Parties' Nominated Officers or, failing agreement, by the Parties' Chief Executive Officers (or equivalent).

Mediation

4.2 If the Parties Chief Executive Officers (or equivalent) are for any reason unable to resolve the Dispute within 30 days of it being referred to them, the Parties will attempt to settle it by mediation in accordance with the CEDR Model Mediation Procedure. Unless otherwise agreed between the Parties, the mediator shall be nominated by CEDR Solve. To initiate the mediation, a Party must serve written notice (a "**Mediation Notice**") to the other Party requesting mediation. A copy of the Mediation Notice should be sent to CEDR. The mediation will start not later than 15 days after the date of the Mediation Notice. Unless otherwise agreed by the Parties, the place of mediation shall be nominated by the mediator.

4.3 Neither Party may commence court proceedings or arbitration in relation to a Dispute until it has attempted to settle the Dispute by mediation and either the mediation has terminated or the other Party has failed to participate in the mediation, provided that the right to issue proceedings is not prejudiced by a delay.

4.4 The Parties shall each bear their own costs in relation to any reference made to a mediator and the fees and all other costs of the mediator shall be borne jointly in equal proportions by both Parties unless otherwise directed by the mediator.

Arbitration

4.5 If the Parties cannot resolve the Dispute through mediation within 30 days of the start of the mediation, or such longer period as may be agreed by the Parties, then the Dispute may be referred to arbitration in accordance with Clauses 4.6 to 4.11.

4.6 Either Party may initiate arbitration by serving a written notice of arbitration (an "**Arbitration Notice**") on the other Party.

4.7 Unless otherwise agreed in writing by the Parties, the provisions of the Arbitration Act 1996 shall govern the arbitration.

4.8 Any Dispute referred to arbitration shall be resolved under the UNCITRAL Arbitration Rules.

4.9 The arbitration panel shall consist of a sole arbitrator to be agreed by the Parties, or if the Parties cannot agree on the appointment of an arbitrator within 10 days of the date of the Arbitration Notice, as appointed by CEDR Solve.

4.10 The Parties agree that the decision of the arbitrator shall be binding on the Parties.

4.11 The Parties shall each bear their own costs in relation to any reference made to an arbitrator and the fees and all other costs of the arbitrator shall be borne jointly in equal proportions by both Parties unless otherwise directed by the arbitrator.

5 Cancellation and reimbursement

5.1 The Council shall inform the Area Team in writing should the Scheme come to an end or the Council ceases to carry out those functions in connection with which the Grant is made.

5.2 If the Scheme comes to an end or the Council ceases to carry out those functions in connection with which the Grants are made prior to the payment of any of the Grants, then the Area Team shall be under no obligation to pay further Grants.

5.3 If the Council does not use all of the Grants in connection with the Scheme, then the Council shall reimburse all residual payments made by the Area Team to the Area Team, this amount to be the subject of a further agreement between the Parties following a joint decision detailing its expenditure.

5.4 If the Area Team ceases to pay the Grants or the Council is obliged to reimburse the Grants in accordance with this Clause 5, the Area Team and the Council shall work together to ensure there is minimal disruption to individuals benefiting from the Scheme.

6 Contracts (Rights of Third Parties) Act 1999

6.1 The Contracts (Rights of Third Parties) Act 1999 shall not apply to this Agreement and nothing in this Agreement shall confer or purport to confer or operate to give any third party any benefit or any right to enforce any term of this Agreement except as expressly provided in this Agreement.

7 Communication

7.1 Any notice to be given by either Party to the other under this Agreement shall be in writing sent to the Nominated Officer of the relevant Party at the address as set out in this Agreement.

8 Governing Law

8.1 This Agreement shall be governed by and construed in accordance with English Law.

ANNEX 1

Memorandum of agreement

Section 256 transfer

Reference number: .....

Title of Scheme: Peterborough Adult Social Care Allocation

1. How will the section 256 transfer secure more health gain than an equivalent expenditure of money on the National Health Service?

1.1 This is additional money and is paid to Area Teams by the Department of Health to invest in adult social care services to promote better services, as detailed by the National Health Service (NHS) Transfer Directions 2013.

1.2 Towards this aim, the agreement for the transfer is made between the Area Team and the Council. The Council will use the monies to support the outcomes and requirements set out in the NHS Transfer directions and with regard to the White Paper "Caring for our Future; reforming care and support" published in July 2012 and as set out in this Memorandum of Agreement.

2. Description of scheme (in the case of revenue transfers, please specify the services for which money is being transferred).

2.1 Funding for adult social care support via the NHS to benefit social support services and that have mutual benefit to health.

2.2 It is a condition of the transfer that the Peterborough City Council agrees with the CCG and Area Team how the funding is best used within social care, and the outcomes expected from this investment. The Health and Wellbeing board will be the natural place for discussions between NHS England, the CCG and the Council on how the funding should be spent, as part of their wider discussions on the use of their total health and care resources.

2.3 It is a condition of the transfer that the Council and the CCG and NHS England have regard to the Joint Strategic Needs Assessment and existing commissioning plans for both health and social care, in how the funding is used

2.4 It is a condition of the transfer that the Council must be able to demonstrate how the funding transfer will improve social care services, and outcomes for service users, compared to service plans in the absence of the funding transfer.

2.5 The *Caring for our future* White Paper also set out that the transfer of funding can be used to cover the small revenue costs to local authorities of the White Paper commitments in 2013/14 (excluding the Guaranteed Income Payments disregard, which is being funded through a grant from the Department of Health).

3. Financial details (and timescales)

3.1 Total amount of money to be transferred and amount in each year (if this subsequently changes, the memorandum must be amended and re-signed).

Year(s)	Amount	Capital	Revenue
2013/14	£2,840,646	£0	£2,840,646

In the case of the capital payments, should a change of use outlined in direction 4(1)(b) of the National Health Service (Conditions Relating to Payments by NHS bodies to Local Authorities) Directions 2013 occur, both parties agree that the original sum shall be recoverable by way of a legal charge on the Land Register as outlined in direction 4(4) of those Directions.

4. Please state the evidence you will use to indicate that the purposes described at questions 1 and 2 have been secured.

The Council will keep proper records in relation to the scheme and will allow the CCG's representatives to inspect all such records and will supply copies on request.

The Parties will have regular meetings for the purpose of discussing how the Grant is spent and how it is delivering health and social care benefits in the economy.

The key outcomes to be delivered are:

a) Promoting personalisation and enhancing quality of life for people with care support needs

b) Preventing deterioration, delaying dependency and supporting recovery

c) Ensuring a positive experience of care and support

d) Protecting from avoidable harm and caring in a safe environment

e) Supporting carers in their caring role

There is good evidence that good quality and cost effective adult social care services are delivered through the following framework and all organisations are expected to base their services and plans around this. Funding identified within this Memorandum will be particularly focussed on Early intervention/targeted prevention and Personalisation:

1. Universal prevention/promoting wellbeing

Support aimed at people who have little or no immediate social care or health needs. The focus is on maintaining independence and good health and promoting wellbeing. Interventions include providing universal access to good quality information, advice services, creating safer neighbourhoods, promoting healthy and active lifestyles, delivering low level practical support and creating inclusion and social capital.

2. Early intervention/targeted prevention – enablement, reablement and recovery

Support aimed at people at risk to halt or slow down any deterioration and actively seek to improve their situation. Interventions include reablement and recovery, short term support, screening and case management for those people who are eligible or not eligible under Fair Access to Care Criteria.

3. Personalisation

Ongoing support aimed at maximising ability for people who have a complex social care and health needs and are at risk of needing further or more intensive support.

The measures of success will be that there is:

- A reduction in delayed transfers of care with social care delays continuing to be at very low levels with the aim of this being zero. There may be situations where we mutually agree that delays were unavoidable.
- A reduction in the need for longer term social care packages
- Improved social care and health outcomes for people accessing the Peterborough City Council Adult Social Care support
- A reduction in re-admissions within 30 days of discharge from hospital
- Increased universal prevention/promotion to patients identified by MDT's/ Admission Avoidance and Care Management

- Health contribution to the Adult Safeguarding Board for 2013/14 to protect Vulnerable Adults

The evidence we will use to indicate that the purposes described above have been met are:

INPUT	OUTPUT	OUTCOME
A) Interim Beds / Acute Hospital / City Care Centre Throughput Social care demand will be monitored using section 2 and section 5 process in Acute beds and LOS in Interim and CCC beds	Low Number of adult social care delays in in the acute hospital/community beds. Increased timeliness of social care assessments and reviews. Increased percentage of successful courses of reablement	Discharge in a timely fashion. Minimised adult social care discharge delays. Reduction in hospital readmissions for social care facilitated discharges
B) Patients and their carers report they were told about the other services that were available to someone in their circumstances, including local and national support organisations. Patients and their carers report that they are informed and have access to advice about their care or condition.	Number of individuals signposted to preventative and community based service Improved responses from service users and carers on survey questions relating to accessibility of information and advice.	Increased independence among people not eligible for social care funded services.
C) Increased patient awareness of care plans & access to own records (*"nothing about me without me"*). Social Workers attend MDT meetings and work proactively with the Team to maintain people outside of Hospital Patients and carers report that they were aware of, and involved in, the planning of their care.	Increased percentages of positive answers from carers and service users on quality of life survey questions Inceased positive responses in survey questions around carer and service user involvement in support planning	Reduction in emergency hospital admission rates from Social Care Services Deterioration in health and wellbeing is detected and responded to at an early stage, via proactive networks of support.

Patients and carers report that care is joined up and seamless: professionals involved talked to each other and worked as a team	Robust and accessible complaints procedure. Reduced number of complaints received by the organisation which are found to be due to poor communication.	Improving the number of positive recommendations to friends and family by people receiving treatment or care
D) Vulnerable adults are protected from harm and potential harm is detected and responded to in a timely and appropriate manner.	Key process targets are met for safeguarding investigations Social Care providers contracted by the Council comply with safeguarding training requirements A multi agency safeguarding plan is in place and regularly monitored which includes actions for health partners. Increased number of DOLs referrals and applications	Reduction in the number of repeat referrals for safeguarding concerns Improved co-ordination of adult safeguarding across the health and social care economy.
E) Patients and their carers report that carers/family had their needs considered and were given support to care for them.	Increased numbers of Carers receiving an assessment of review and a specific carers service, advice or information	Increase in Carers and Patients reporting they have been supported .

Metrics

A	Promoting personalisation and enhancing quality of life for people with care support needs	**LI413a / 2C PART 1 (NI131) - Delayed transfers of care from hospital** **Rationale** – Minimising delayed transfers of care and enabling people to live independently at home is one of the desired outcomes of social care. This indicator measures the ability of the whole system to ensure appropriate transfer from hospital and is an indicator of the effectiveness of the interface between the NHS and social care services. **Numerator** – The average number of delayed transfers of care on a particular day taken over the year. **Denominator** – Adult population in area aged 18 and over (latest estimate = 489,740) **Target** – 8.9 per 100,000 population (lower is good) **Frequency of measure** – Monthly **The Council will work with the health economy to support delivery of this target, but this is not within the Council's power to control delivery of.**
		LI413b / 2C PART 2 - Delayed transfers of care from hospital attributable to adult social care **Rationale** – Minimising delayed transfers of care and enabling people to live independently at home is one of the desired outcomes of social care. This indicator measures the ability of social services to ensure appropriate transfer from hospital. **Numerator** – The average number of delayed transfers of care attributable to adult social care on a particular day taken over the year. **Denominator** – Adult population in area aged 18 and over (latest estimate = 489,740) **Target** – 3.2 per 100,000 (lower is good) **Frequency of measure** - Monthly
		Local Indicator - The percentage of those recieving reablement who complete the service with less or no now care needs. **Rationale** –Early supported discharge – increased numbers of patients discharged to ongoing services including new and existing packages of reablement. Percentage of reablement recipients leaving the service with reduced or no care needs. Reduction in the number of non completers due to readmission to hospital . **Numerator** – Number of those leaving a completed course of reablement with less or no care needs. **Denominator** – Number of people leaving reablement for any reason in the

		period. **Target** – 60% (higher is good) **Frequency of measure** – Monthly
		Local Indicator – The percentage of new clients receiving a first assessment within 28 days. **Rationale**: A quick thorough response to crisis and urgent presenting needs prevents deterioration and promotes independence. **Numerator** – the number of social care assessments for new clients completed within 28 days **Denominator;** The number of social care assessments completed. **Target** - 90% **Frequency of measure** - monthly

B	Preventing deterioration, delaying dependency and supporting recovery	**LI402 / 1D – Carer-reported quality of life** **Rationale** – This indicator gives a view of the quality of life of carers based on responses to the biennial Carers Survey. **Numerator** – The sum of the scores of a specific set of questions in the survey questionnaire. **Denominator** – The total number of people answering the special questions. The number of people **Target** – increase **Frequency of measure** – Biennially
		LI411 / (NI135) - Carers receiving needs assessment or review and a specific carer's service or advice and information only **Rationale** – Support for carers is a key part of support for vulnerable people. Support for carers also enables carers to continue with their lives, families, work and contribution to their community. **Numerator** – The numbers of carers receiving a specific service during the period, following a carers assessment or review. **Denominator** – The number of people receiving a community based service during the period. **Target** –27% (higher is good) **Frequency of measure** - Monthly
		Local Target – number of people being signposted to universal and preventative services via the Council's first point of contact. **Rationale:** universal and preventative services can be a low cost option allowing people to maintain independence without reliance on public sector funding for longer periods. Numerator number of people contacting the Councils contact centre who are referred on to universal or preventative services **Target** – baseline year **Frequency of measure** - quarterly

C	Ensuring a positive experience of care and support	**Service User reported quality of life** **Rationale** – This indicator gives a view of the quality of life of service users based on responses to the annual service user Survey. **Numerator** – The sum of the scores of a specific set of questions in the survey questionnaire. **Denominator** – The total number of people answering the special questions. The number of people **Target** – >19.0 **Frequency of measure** – annual
		3A - Overall satisfaction of people who use services with their care and support **Rationale:** high satisfaction rates reflect effective care packages which individuals are more likely to be engage in the planning of. **Numerator**: The number of survey respondents who are giving positive (either extremely or very satisfied) responses around satisfaction with their services. **Denominator:** The total number of respondents to the annual service user survey **Target** >64.3% **Frequency** - Annual
D	Protecting from avoidable harm and caring in a safe environment	**Local Target – number of safeguarding alerts where decision to treat as referral is made within 24 hours** **Rationale** – a quick decision on identification of concern allows for the appropriate course of action to be taken quickly. **Numerator** – number of safeguarding alerts either closed or accepted as a referral within 24 hours of receipt **Denominator** – Number of safeguarding alerts received **Target** 90% **Frequency** - monthly
		Local Target – number of safeguarding investigations completed within 20 working days **Rationale** – a speedy investigation allows for protection arrangements to be put in place and should prevent re-referrals. **Numerator** – number of safeguarding investigations completed within 20 working days of referral.

		Denominator – Number of safeguarding investigations completed **Target** 80% **Frequency** - monthly

		Local Target – Percentage of safeguarding referrals which are re-referrals **Rationale:** Appropriate protection planning should minimise risk of further harm to individuals, repeat referrals might be evidence that the protection plan put in place, or the quality of the original investigation did not safeguard the person appropriately. **Numerator**: The number of repeat safeguarding referrals received **Denominator**: the number of safeguarding referrals received. **Target –** baseline year **Frequency** - monthly
		LI400g / 4B - The proportion of people who use services who say that those services have made them feel safe and secure Note – New Measure This measure is not used in 2011/12 and will be published for the first time in 2012/13 **Rationale** – Safety is fundamental to the wellbeing and independence of people using social care. There are legal requirements about safety in the context of service quality, including CQC essential standards for registered services. This measure will use a new question data from the Annual Service User Survey (ASCS) **Numerator** – In response to Question 7b those individuals who select the response "Yes". **Denominator** – All those that responded to the question. **Target** – > 72% **Frequency of measure** - Annually
E	Supporting carers in their caring role	**Local target –emergency support to carers** **Rationale** –This indicator demonstrates the number of carers receiving emergency breaks service to support them in a period of unplanned need. Emergency breaks can prevent a carer / service user relationship breaking down and can support the carer to continue in their caring role. **Numerator** The number of carers receiving emergency breaks services. **Denominator** – none **Target** – Baseline year. **Frequency of measure** – Monthly

Signed : ..... for the Board/Area Team

..... Position

..... Date

Signed : ..... For local authority / other recipient body

..... Position

..... Date

ANNEX 2 – Annual voucher and certificate for auditors

Section 256 Annual Voucher

Peterborough City Council

PART 1 STATEMENT OF EXPENDITURE FOR THE YEAR 31 MARCH 2014

(if the conditions of the payment have been varied, please explain what the changes are and why they have been made)

Scheme Reference Number Revenue Expenditure Capital Total and Title of Expenditure

Project £££

PART 2 STATEMENT OF COMPLIANCE WITH CONDITIONS OF TRANSFER

I certify that the above expenditure has been incurred in accordance with the conditions, including any cost variations, for each scheme approved by the ..... Board/Area Team in accordance with these Directions.

Signed: .....

Date: .....

Director of finance or responsible officer of the recipient (see paragraph 5(3) of the Directions).

Certificate of independent auditor

I/We have:

- examined the entries in this form (which replaces or amends the original submitted to me/us by the authority dated)* and the related accounts and records of the ..... and
- carried out such tests and obtained such evidence and explanations as I/we consider necessary.

(Except for the matters raised in the attached qualification letter dated)* I/we have concluded that

- the entries are fairly stated: and
- the expenditure has been properly incurred in accordance with the relevant terms and conditions.

Signature .....

Name (block capitals) .....

Company/Firm .....

Date .....

* Delete as necessary

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 7(a)
DATE: 12th September 2013		PUBLIC REPORT
Contact Officer(s):	Sue Mitchell, Interim Director of Public Health	Tel. 01733 207173

Pharmaceutical Needs Assessment (PNA)

RECOMMENDATIONS	
FROM : Sue Mitchell	**Deadline date :**

1. Review of the NHS Peterborough PNA has concluded that there has not been any substantial change to the pharmaceutical needs of the local population since publication of the PNA in February 2011.

2. As a result it is recommended that producing a new PNA would be a disproportionate response, at this time.

3. The HWB is required to publish a fully revised PNA by 1st April 2015. This is a significant undertaking involving at least 60 days consultation and board level sign off. It is recommended the process starts at least 12 months ahead of the publication date.

4. That in the mean time, as a separate piece of work, opportunities to further involve community pharmacies in the development and support of the Urgent Care Pathway are explored.

1. ORIGIN OF REPORT

This report is to update the Board on its statutory responsibility to maintain and publish a Pharmaceutical Needs Assessment (PNA). The full background to this was presented in a previous report to the HWB in June 2013.

2. PURPOSE AND REASON FOR REPORT

From April 1st 2013 the Health and Wellbeing Board has statutory responsibility for the PNA for its area.

- NHS Peterborough published the current PNA in February 2011
- In order to meet its statutory requirements the Health and Wellbeing Board is required to review the current PNA, identify any changes to the need for pharmaceutical services in its area and assess whether any changes are significant.
- Decide whether producing a new PNA at this time is a disproportionate response, or not.

3. HEALTH AND WELLBEING BOARD PNA REVIEW

- The key messages from NHS Peterbough's PNA are reproduced in Appendix 1 to provide background to this review.
- With the support of the public health team we considered the following aspects

The health needs of the population of Peterborough
Numbers and type of pharmacy services provided
The commissioning of public health enhanced services eg stop smoking
New housing developments planned or started since the PNA
Changes to location and nature of GP premises and primary care facilities

Review of these areas did not identify any substantial change to the pharmaceutical needs of the population.

- NHS Peterborough's PNA demonstrated that there was adequate provision of pharmaceutical services in February 2011. Appendix 2 provides the background to this conclusion.

A key indicator as to whether complete revision of the PNA is required is changes to community pharmacy provision since February 2011. This was considered to identify whether gaps in service have developed since the PNA was published. The following changes were identified.

Change	Numbers	Comment
Pharmacy Closures	0	
Pharmacy Openings	2	Both mail/internet pharmacies
Changes in Opening Hours	12	Six increases in supplementary/core hours Six decreases in supplementary/core hours

In all cases changes in community pharmacy opening hours were minor (eg changes in lunch breaks) and have not affected the overall provision of pharmaceutical services.

Particular concerns had been raised about access to pharmaceutical services and dispensing of prescriptions outside of normal working hours. Board members may wish to focus on this area as a separate strand of work as part of the review and development of the Urgent Care Pathway.

The conclusion of this review is that there has not been any substantial change in access to pharmaceutical services since February 2011.

- A second key indicator to consider is whether, or not, new housing developments have started, or been planned, since publication of the PNA. The Housing Development Plan for Peterborough UA 2013 makes the following statements

> "In this monitoring period Peterborough has continued to see housing growth, although like all other parts of the region, the level of growth is lower than that experienced between 2005 and 2010 as a result of the contraction within the construction industry in this economic climate.
>
> From 1 April 2012 to 31 March 2013 there were 772 net completions within the authority area. Of these 338 (43.8%) were built in urban extensions, 367 (47.5%) were built in the rest of the urban area, and 67 (8.7%) were built in the rural area."

Growth in housing, and any associated increase in pharmaceutical provision was considered as part of the PNA in 2011. Growth in housing has been slower than anticipated and in addition no housing developments have been planned that were not originally considered within NHS Peterborough's PNA.

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4. CONSULTATION

During the process of developing a PNA the HWB must consult organisations identified in regulations at least once. There is a minimum period of 60 days for consultation responses.

5. ANTICIPATED OUTCOMES

- Decision that the current PNA is up to date and meets requirements.
- Agreement by commissioning partners to consider increased involvement of community pharmacists within the Urgent Care Pathway.
- Development and publication of fully revised PNA by 1st April 2015

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6. REASONS FOR RECOMMENDATIONS

Statutory requirement.

7. ALTERNATIVE OPTIONS CONSIDERED

There are no alternative options.

8. IMPLICATIONS

- Resource to revise and publish updated PNA by 1st April 2015. Based on previous experience, and national guidance, it can take up to 12 months to develop a PNA that meets regulatory requirements.

- Failure to comply with regulatory requirements about production of a PNA, and produce a robust PNA, could lead to legal challenges because of the PNA's relevance to decisions about commissioning services and new pharmacy openings. The risk of challenge is significant and the HWB is advised to add the PNA to their risk register.

9. BACKGROUND DOCUMENTS

Pharmaceutical Needs Assessments – Information pack for local authority health & wellbeing boards (DH)
https://www.gov.uk/government/publications/pharmaceutical-needs-assessments-information-pack

NHS Peterborough PNA (2011)
http://www.lpc-online.org.uk/bkpage/files/46/nhs_peterborough_pna__final__board_approved.pdf

Appendix 1

Key Messages from the Pharmaceutical Needs Assessment for Peterborough, 2011

1.17 As NHS Peterborough move towards world class standards of commissioning, we recognise that our local pharmacies offer dispensing services along with a range of 'additional and enhanced services'. We wish to support and encourage the move towards greater provision of clinical services from community pharmacy while maintaining good access to provision of medicines.

1.18 Pharmacists help and support patients to understand their medicines. This reduces the problems associated with taking too much or too little or not getting the best from medicines. The advanced service Medicines Use Review (MUR) has the potential to improve understanding and use of medicines, particularly in priority areas such as cancer, respiratory and cardiovascular disease. However, it is under-utilised.

1.19 Most community pharmacies provide the local minor ailment enhanced service (Pharmacy First), which provides easy access to a range of medicines and avoids the need for GP, Walk In Centre or A/E visits, particularly in areas of Peterborough with higher levels of deprivation.

1.20 Services for those who need them such as stop smoking services, needle exchange, supervised consumption are readily available, however, there is potential for these to make a greater contribution. We have difficult issues to address regarding sexual health and in particular, teenage pregnancies. NHS Peterborough will undertake further work over the next 2 years to identify the best and most cost-effective means to deliver sexual health services.

1.21 Community pharmacies offer advice on healthy lifestyle, being active, eating well, drinking sensibly and stop smoking. However, respondents to our patient survey would like to see blood pressure monitoring, cholesterol testing and weight management programmes being provided in the future. This links with our strategic intentions.

1.22 Pharmacies offer convenient location and extended opening times. Prescriptions can be dispensed and medicines are available to buy over the counter, throughout the normal working week and well into late evenings and during weekends. We have 41 pharmacies, which is 1 pharmacy for every 4,350 people within Peterborough. Throughout England there are, on average, 20 pharmacies per 100,000 populations. Peterborough has 23 per 100,000 population.

1.23 Over 98% of those responding to our patient survey indicated that access to pharmacy services was either 'easy or ok'. Even taking into consideration our less urban areas, you are never more than 20 minutes from a pharmacy in NHS Peterborough. This, along with the above average number of pharmacies in Peterborough, demonstrates we already have adequate provision of pharmaceutical services.

1.24 Co-location of pharmaceutical services with other primary care service providers offers both patient and service delivery benefits. The future pharmaceutical services commissioning model will be co-location with other primary care service providers. Where it is of mutual interest and within regulations, we recommend relocation of existing pharmacies.

Appendix 2

Current Service Provision

There are 41 community pharmacies within NHS Peterborough (figure 1).

There are three dispensing doctor practices (Ailsworth, Thorney and Fletton practices), providing dispensing services to a total of 2,500 patients, one hospital pharmacy, one community care centre pharmacy and two dispensing appliance contractors (figure 2).

The two national dispensing appliance contractors (DACs) which together with a number of community pharmacies who also provide appliances, meet the need for this type of service within NHS Peterborough.

There are five pharmacies which are open for 100 hours or more per week (figure 2). These pharmacies are

Asda (Rivergate)
Pharmacy First (Lincoln Road)
Sainsbury (Bretton)
Boots (Bretton)
Alfa Chemists (Park Road)

Pharmaceutical services are available from these five pharmacies from 7am until midnight (Mon-Sat). On Sunday access is available for 23 hours and throughout the night until pharmacies open on Monday mornings. There are, therefore, only 36 hours per week (not including Bank Holidays) where there are no pharmaceutical services available within Peterborough. These are between the hours of midnight to 7am (Mon-Fri) and between 4-5pm on Sunday.

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 8(a)
12th SEPTEMBER 2013		PUBLIC REPORT
Contact Officer(s):	Jana Burton/Mubarak Darbar	Tel.

WINTERBOURNE – UPDATE/STOCK TAKE

RECOMMENDATIONS	
FROM : *Director, Safeguarding Adults Board, LGA, LD Section 75 Board*	**Deadline date :** Timetable attached Appendix 1

1. The Board are asked to consider and comment upon the contents of this report.

2. The DH Winterbourne View Review Concordat: Programme of Action has asked that the Health & Wellbeing Board, Safeguarding Boards and any of the Joint CCG and LA Commissioning Boards take an interest in the Winterbourne Review and the progress made. A stock take report was completed and sent to the LGA in July 2013 (See Appendix 2).

3. The Board to be reassured that Peterborough City Council with its partners will meet the timetable set by the DH that by June 2014 it will resettle all the people placed in secure hospital settings back into the community.

1. ORIGIN OF REPORT

1.1 This report is submitted to the Board following presentation at PCC Safeguarding Adults Board and the PCC Learning Disabilities Commissioning Executive Board.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide the Board with an overview of developments to date and satisfy it that appropriate action is being taken.

2.2 This report is for the Board to consider under its Terms of Reference No. 2.2 To actively promote partnership working across health and social care in order to further improve health and well being of residents.

3. BACKGROUND - LESSONS LEARNT AND IMPACT

3.1 Winterbourne View was a private hospital owned by Castlebeck. It was based in Hambrook, Bristol and was a purpose-built acute service offering assessment, intervention and support for people with learning disabilities, complex needs and challenging behaviour. It was registered with the Care Quality Commission to provide care for up to 24 patients aged 18 years and over with a learning disability. It was registered for the treatment of patients detained under the Mental Health Act 1983. The hospital opened in December 2006 and closed on 22 June 2011.

3.2 A BBC Panorama programme, broadcast on 31 May 2011, showed images of abuse and ill treatment of residents at Winterbourne View.

3.3 A review was undertaken by the Department of Health of the roles of the organisations and the lessons learnt; this included independent input from recognised experts.

3.4 Following this review and the lessons learnt and good practice has been further strengthened and implemented in Peterborough. .

3.5 A range of measures have been strengthened and new areas of work commenced in light of the lessons learned from Winterbourne View including:

- Strengthening joint working arrangement is in place between key partner agencies including the Council, Cambridgeshire and Peterborough Clinical Commissioning Group (CPCCG), Cambridge and Peterborough Foundation Trust (CPFT) and NHS Commissioning Board.
- Adult Social Care and the CPCCG have assessed, reviewed and are regularly monitoring all out of area placements that Peterborough (ASC & CCG) commissions and are actively repatriating those people back that wish to return to Peterborough in a supported living setting. Those people that wish to stay in placements out of area or for whom it is in their best interest to do so are being supported to be ordinary residents of that locality in accordance with the National Assistance Act 1948 and Ordinary Residence Guidance.
- Greater oversight of all 7 people placed in secure commissioning settings (more information in section 3 below)
- Improved transitions planning for people that move from children's services into adult services particularly when placed in out of area placements with the approval of the implementation of a 14 to 25 age transitions team. This will prevent people being placed in out of areas and secure placements and equally important when young people are placed there will be a co-ordinated plan to bring them back to Peterborough.
- Implementation of a specialist local Intensive-behavioural Support Team (IST) serviced by CPFT who will respond to people that present complex and challenging needs and ultimately prevent admissions to secure commissioning settings.

One of the major barriers in keeping people with complex needs in Peterborough has been the lack of bespoke housing needed to support people with complex needs in the community. A housing needs analysis has been completed which identifies the need and a range of accommodation required including bespoke housing which will support people with complex needs continue to live in Peterborough in a community setting and prevent the need to escalate to a secure out of area placement. The bespoke housing will also support behavioural strategies and intervention as the structure of the accommodation has been designed with input from clinical and behavioural specialist.

To avoid future out-of-area placements an Accommodation Planning Process is in place to ensure that people from Peterborough continue to live in Peterborough:

The aim of this is:

- Prevent the person being away from family and familiar environments
- Quality of care that cannot easily be monitored in out of area
- Re-settlement back in area becoming problematic
- Expensive and very difficult to control costs once out of area

The IST team are working closely with local provider services that support people with complex behaviour by supporting them to have strategies in place, ultimately minimising the risk of challenging behaviour resulting in appropriate intervention strategies. This also acts proactively by reducing the escalation to a possible secure setting environment. All local services will have access to the necessary expertise for this to happen effectively and quickly.

Since Dec 2011 the Council has resettled 30 people with a learning disability back to Peterborough. Some of these people were in secure settings; however the vast majority were in residential homes.

3.6 Adult Social Care are mid way through a major tender exercise which is due to complete by autumn 2013 with the aim to increase and strengthen the community support providers for local services and the lessons learnt from the review were incorporated within the specifications.

3.7 Further work will take place with children's services on planning from childhood and increasing local community based provider support capacity.

DEPARTMENT OF HEALTH TIMETABLE

3.8 Following the Winterbourne Review the Department of Health (DH) set out a timetable for commissioning bodies within Health and Local Authorities to work together and meet key milestones to ensure that people who may be inappropriately placed in medium and low secure settings and challenging behaviour residential settings are resettled back into their local community (See Appendix 2)

3.9 Peterborough Adult Social Care with CPCCG has met the all the milestones to date and submitted the information as required to the Department of Health (See Appendix 1)

3.10 Peterborough has in total six people that are in low to medium secure commissioning settings and one person in a challenging behaviour residential unit associated with secure settings. Of the six in secure settings, four people have been assessed in conjunction with the Secure Commissioning Group, now known as NHS Commissioning Board (NHSCB) and local services, to consider moving on to community placements. Three of these people are in low level secure units and one person is in a medium secure unit. The one person in a challenging behaviour residential unit associated with the secure setting will also be resettled back into Peterborough.

3.11 The remaining two people that are still in medium secure settings are currently assessed to remain there for the time being. However their circumstances may change during 2013/14 and will be under constant review by the local IST with NHSCB.

4. CONSULTATION

4.1 Other than our usual practice of working directly with service users, carers and family members, no formal consultation is required. However in-depth person centred plans of the people to return to Peterborough are in place and regular involvement with parent carers and advocates is also undertaken.

5. ANTICIPATED OUTCOMES

5.1 The new framework of high quality and skilled providers will ensure Peterborough City Council has both depth and breadth of providers that will support people locally and ensure their needs are met without the need to place people in out of area secure type settings.

5.2 Adult Social Care is working closely with Strategic Housing to ensure the right type of housing is available for the next 3 to 5 years.

5.3 It is estimated that the average resettlement cost of each person will be in the region of £135,000 per annum. To meet the June 2014 target date of all individuals identified to be resettled back to Peterborough and receiving personalised care and support in appropriate community settings, a significant resource will need to be found this financial year. The Learning Disabilities Executive Board is aware of this (national) cost pressure and has raised this both regionally and nationally as a major issue and concern.

5.4 All the people assessed to be resettled back into Peterborough will be living in the community by the DH timetable of June 2014.

6. REASONS FOR RECOMMENDATIONS

6.1 The board to consider the report and make comments.

7. ALTERNATIVE OPTIONS CONSIDERED

7.1 The DH Winterbourne Review sets out clear objectives that the Council and its partner agencies are to achieve by June 2014. Leaving people in secure settings was not the option.

8. IMPLICATIONS

8.1 There will be a financial implication as to resettle each person in the community will cost circa £130,000 per annum.

9. BACKGROUND DOCUMENTS

DH Winterbourne View Review Concordat: Programme of Action
DH Winterbourne View Time Table
Winterbourne Stock Take

Appendix 1

By March 2013	From April 2013	By 1 June 2013	By Dec 2013	By end 2013	From 2014	By April 2014	By 1 June 2014
The NHSCB will ensure that all PCTs develop local registers of all people with challenging behaviour in NHS-funded care.	KPIs from the DH, the Information Centre for Health and Social Care and the NHSCB to support commissioners in monitoring their progress from April 2013.	Reviews completed and a personal care plan agreed for each individual based around their and their families' needs and agreed outcomes	The DH will publish a report on progress including reporting comparative information on localities.	The DH will publish guidance on best practice around positive behaviour support so that physical restraint is only ever used as a last resort where the safety of individuals would otherwise be at risk and never to punish or humiliate	The DH and DfE will work to introduce a new single assessment process and Education, Health and Care Plan to replace the current system for young people up to the age of 25.	The audit of current services for people with challenging behaviour will be repeated.	All individuals should be receiving personalised care and support in appropriate community settings

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Winterbourne View Joint Improvement Programme

Initial Stocktake of Progress against key Winterbourne View Concordat Commitment

The Winterbourne View Joint Improvement Programme is asking local areas to complete a stocktake of progress against the commitments made nationally that should lead to all individuals receiving personalised care and support in appropriate community settings no later than 1 June 2014.

The purpose of the stocktake is to enable local areas to assess their progress and for that to be shared nationally. The stocktake is also intended to enable local areas to identify what help and assistance they require from the Joint Improvement Programme and to help identify where resources can best be targeted.

The sharing of good practice is also an expected outcome. Please mark on your return if you have good practice examples and attach further details.

This document follows the recent letter from Norman Lamb, Minister of State regarding the role of HWBB and the stocktake will provide a local assurance tool for your HWBB.

While this stocktake is specific to Winterbourne View, it will feed directly into the CCG Assurance requirements and the soon to be published joint Strategic Assessment Framework (SAF). Information compiled here will support that process.

This stocktake can only successfully be delivered through local partnerships. The programme is asking local authorities to lead this process given their leadership role through Health and Well Being Boards but responses need to be developed with local partners, including CCGs, and shared with Health and Wellbeing Boards.

The deadline for this completed stocktake is Friday 5 July. Any queries or final responses should be sent to Sarah.Brown@local.gov.uk
(Extension given by Sarah Brown till the 12th July 2013)

An easy read version is available on the LGA website

May 2013

Winterbourne View Local Stocktake June 2013			
1. Models of partnership	**Assessment of current position evidence of work and issues arising**	**Good practice example (please tick and attach)**	**Support required**
1.1 Are you establishing local arrangements for joint delivery of this programme between the Local Authority and the CCG(s).	Yes. Local arrangements are in place and have been since 2010/11 between Cambridgeshire & Peterborough NHS (now CCG) and Adult Social Care (ASC). More recently these arrangements have been revised following the Winterbourne View review and the establishment of CCGs. This is overseen by the Peterborough City Council (PCC) and Cambridgeshire and Peterborough Clinical Commissioning Group (C&PCCG) S75 Agreement.		
1.2 Are other key partners working with you to support this; if so, who. (Please comment on housing, specialist commissioning & providers).	Cambridgeshire & Peterborough Foundation Trust (CPFT), PCC Children's Services, PCC Strategic Housing Team, Education Services, Registered Social Landlords, NHS England Specialist Commissioning Team and a range of independent sector providers.		
1.3 Have you established a planning function that will support the development of the kind of services needed for those people that have been reviewed and for other people with complex needs.	There is a planning function established that considers the needs of people placed in secure settings and those with complex needs in the community. There is a needs analysis which provides sound intelligence on the type of services required to support people living in the community, both for care and support provision and pipeline housing provision.		
1.4 Is the Learning Disability Partnership Board (or alternate arrangement) monitoring and reporting on progress.	Yes. The Learning Disabilities Partnership Board (LDPB), LD s75 Executive and various sub groups of the LDPB and Safeguarding Adults Board are regularly kept up to		

	date with progress. In addition to the above, reports are regularly presented to the Adult Social Care Departmental Management Team and Peterborough City Council's Corporate Management Team meetings. We will be reporting to the next Health and Wellbeing Board (HWBB) in September.		
1.5 Is the Health and Wellbeing Board engaged with local arrangements for delivery and receiving reports on progress.	The LD s75 Executive Board is, in effect, a sub group of the HWBB. Senior executives of the council, as well as members, are also briefed on progress regularly. A progress report is scheduled to go to the HWBB in September 2013.		
1.6 Does the partnership have arrangements in place to resolve differences should they arise.	Yes.		
1.7 Are accountabilities to local, regional and national bodies clear and understood across the partnership – e.g. HWB Board, NHSE Local Area Teams / CCG fora, clinical partnerships & Safeguarding Boards.	Yes.		
1.8 Do you have any current issues regarding Ordinary Residence and the potential financial risks associated with this.	There is one person about whom PCC and CCG Commissioners are in discussion with another CCG/LA. Local commissioners have involved the Secure Commissioning Group (SCG) and National Commissioning Group (NCG) to find a resolution.		
1.9 Has consideration been given to key areas where you might be able to use further support to develop and deliver your plan.	Yes. Consideration has been given to resources to support local health and social care infrastructures to ensure the right support mechanisms are in place so people do not deteriorate once repatriated into the community. These include resources to support and ensure that providers have the right intervention strategy and the need to have access to financial resources to commission community setting providers including having capital spend for properties.		
2. Understanding the money			
2.1 Are the costs of current services understood across the partnership.	Yes.		

2.2 Is there clarity about source(s) of funds to meet current costs, including funding from specialist commissioning bodies, continuing Health Care and NHS and Social Care.	Yes. There is clarity of where the funding is available, though this does need to be worked through on a case by case basis regarding any cost pressures presented to ASC and the CCG.		
2.3 Do you currently use S75 arrangements that are sufficient & robust.	Yes. However, the LD s75 arrangements do not extend to sharing the cost as it is not a pooled budget. The risks are calculated on a case by case basis with the CCG.		
2.4 Is there a pooled budget and / or clear arrangements to share financial risk.	No pooled budget. The s75 is a fixed budget and largely staffing.		
2.5 Have you agreed individual contributions to any pool.	No pooled budget.		
2.6 Does it include potential costs of young people in transition and of children's services.	No pooled budget. However, ASC has estimated potential growth money as part of the ASC budget for young people in transition turning 18 in 2013/14.		
2.7 Between the partners is there an emerging financial strategy in the medium term that is built on current cost, future investment and potential for savings.	There is a financial strategy regarding costs and savings, though this needs to be updated in the light of structural change including the establishment of CCGs.		
3. Case management for individuals			
3.1 Do you have a joint, integrated community team.	Yes.		
3.2 Is there clarity about the role and function of the local community team.	Yes. This is a well established team.		
3.3 Does it have capacity to deliver the review and re-provision programme.	C&PCCG has commissioned the Intensive Support Team (IST) provided by CPFT to deliver support to adults with complex needs through the reprovision programme. This team works very closely with the learning disabilities and autism integrated community team by providing capacity to support the review programme.		
3.4 Is there clarity about overall professional leadership of the review programme.	Yes. The local authority is the lead learning disabilities commissioner for integrated community services and, with CPFT, provides professional operational leadership through the IST. There is some work underway about the management arrangements, which currently sit with CPFT around clinical leadership and accountability, and with the Council around social care. This is overseen by the LD s75 Executive Board.		

3.5 Are the interests of people who are being reviewed, and of family carers, supported by named workers and / or advocates.	Yes. The IST provides care co-ordination with a named worker and effective liaison between people who are being reviewed, their family carers and advocates is made available to all the service user in secure settings. Advocacy is further extended to all those people living in the community.		
4. Current Review Programme			
4.1 Is there agreement about the numbers of people who will be affected by the programme and are arrangements being put in place to support them and their families through the process.	Yes. In total there are seven people affected as part of the programme review and arrangements are being put in place to support them and their families during this process with advocacy and named worker approach. There is also carers' advocacy support to support parent and family carers in the community.		
4.2 Are arrangements for review of people funded through specialist commissioning clear.	Yes. We have been proactive, working with the regional specialist commissioning team since April 2011.		
4.3 Are the necessary joint arrangements (including people with learning disability, carers, advocacy organisations, Local Healthwatch) agreed and in place.	Yes. There is an agreement at the LDPB on joint arrangements around people with learning disabilities and family carers' support further strengthened at an operational level. More work needs to be done with Healthwatch.		
4.4 Is there confidence that comprehensive local registers of people with behaviour that challenges have been developed and are being used.	Yes. The IST and PCC commissioners are fully engaged with the providers that support people with complex needs. There are 13 people living in the community in addition to the seven people identified in secure settings as part of the review programme that have complex behaviour with challenges. The IST is very involved with all 7/13.		
4.5 Is there clarity about ownership, maintenance and monitoring of local registers following transition to CCG, including identifying who should be the first point of contact for each individual	The ownership of the registers is with the CCG. However, further development work is underway to establish which organisation is best placed to maintain		

	and update the register as progress is made.		
4.6 Is advocacy routinely available to people (and family) to support assessment, care planning and review processes	Yes. Advocacy arrangements and capacity assessments are readily accessible.		
4.7 How do you know about the quality of the reviews and how good practice in this area is being developed.	The IST team has dedicated practitioners who take part in reviews of care and support and make recommendations about future care and support arrangements and quality of existing provision. The PCC Commissioner and senior care management staff meet regularly and frequently with the IST in addition to the monthly interface meeting where progress on each service user is discussed. These reviews will also be included the planned audit checks of file and process coupled with evidence. The LA has agreed to support two people (a person with a learning disability and a family carer) on the Quality Checkers programme. The aim is to train and equip expert by experience people to be involved in the review of services.		
4.8 Do completed reviews give a good understanding of behaviour support being offered in individual situations.	Yes.		
4.9 Have all the required reviews been completed. Are you satisfied that there are clear plans for any outstanding reviews to be completed.	All required reviews have been completed by secure commissioning with the IST involved and there are no outstanding reviews.		
5. Safeguarding 5.1 Where people are placed out of your area, are you engaged with local safeguarding arrangements – e.g. in line with the ADASS protocol.	Peterborough Safeguarding Adults Board (PSAB) multi-agency policy and procedures includes a statement detailing that PSAB adopts the Association of Directors of Adult Social Services (ADASS) protocols for inter-authority investigation. The PCC, as lead agency, utilises these protocols appropriately when dealing with safeguarding cases where the individual is placed 'out of area' but also accepts its responsibilities as lead safeguarding agency when concerns arise within PCC's administrative boundaries. The PSAB has received		

	regular reports on the Winterbourne Review and this ongoing work stream.		
5.2 How are you working with care providers (including housing) to ensure sharing of information & develop risk assessments.	The IST works very closely with care and support providers sharing risk assessments and developing risk management strategies. Bespoke training is offered to the core staff team of individuals that are resettled in line with the client's specific needs as assessed by the IST. These arrangements are monitored throughout with spot and planned checks by the IST. If there are issues with the care/support, for instance providers failing to stick to the care plan or there is not staff continuity, then the PCC commissioners will meet with the provider management team to review and take necessary actions.		
5.3 Have you been fully briefed on whether inspection of units in your locality have taken place, and if so are issues that may have been identified being worked on.	There are no secure units in the Peterborough locality. We are aware of all 'in area' placements from 'out of area' authorities exclusively in residential provision in Peterborough and are satisfied that there are no issues or concerns outstanding with these providers.		
5.4 Are you satisfied that your Children and Adults Safeguarding Boards are in touch with your Winterbourne View review and development programme.	Yes. PSAB has had two papers presented on the progress of Winterbourne in the last nine months. Through the joint working with Children's transitions and strategy planning, more work is underway with Children's Services and a report will be presented to the Children's Safeguarding Board.		
5.5 Have they agreed a clear role to ensure that all current placements take account of existing concerns/alerts, the requirements of DoLS and the monitoring of restraint.	Yes. The IST has a specific role in relation to monitoring current placements including existing concerns and the monitoring of Deprivation of Liberty (DOLS) and of restraint. Local providers are offered intervention strategy planning training and intensive support planning by the IST to ensure there is a thread of consistent intervention throughout the staff supporting people in the community with complex needs.		

5.6 Are there agreed multi-agency programmes that support staff in all settings to share information and good practice regarding people with learning disability and behaviour that challenges who are currently placed in hospital settings.	Yes. The IST works with people both in hospital and community settings and shares the very specific requirements in multi-agency planning so there is a continuum of intervention and support ultimately resulting in the long term aim of prevention and deterring readmission into secure type settings.		
5.7 Is your Community Safety Partnership considering any of the issues that might impact on people with learning disability living in less restrictive environments.	ASC is a member of the Safer Peterborough Partnership Board and advocates on behalf of all service user groups including people with learning disabilities. There is a desire and active plans to reduce residential care models and increase the supported living which promotes choice and control and relies less on restrictive environments such as residential care.		
5.8 Has your Safeguarding Board got working links between CQC, contracts management, safeguarding staff and care/case managers to maintain alertness to concerns.	PCC, as the lead safeguarding agency, has quarterly meetings with the Care Quality Commission (CQC) and the CCG safeguarding leads to discuss and share information regarding care providers. These meetings include representation from commissioning and safeguarding staff from care services delivery. PCC, CPFT and CCG have representation on the PSAB.		
6. Commissioning arrangements			
6.1 Are you completing an initial assessment of commissioning requirements to support peoples' move from assessment and treatment/in-patient settings.	Yes. This is supported by the IST. Detailed needs analysis is prepared with pen pictures that inform the commissioning requirements needed for these service users.		
6.2 Are these being jointly reviewed, developed and delivered.	Yes. Tenders are currently out to invite skilled providers that are able to provide the right support and intervention in the community. In addition, work is in progress for a housing pipeline so the right type of properties can be built based on the commissioning intelligence.		

6.3 Is there a shared understanding of how many people are placed out of area and of the proportion of this to total numbers of people fully funded by NHS CHC and those jointly supported by health and care services.	Yes. This level of information has been gathered since December 2011 and is regularly kept up to date as people's circumstances change. We also have a full financial breakdown.		
6.4 Do commissioning intentions reflect both the need deliver a re-provision programme for existing people and the need to substantially reduce future hospital placements for new people.	Yes. Commissioners working with the IST and other partners are building local capacity, including housing and appropriate support providers. On a micro level, individual outcome focused support plans with a range of support from the IST is crucial to ensure people are supported in their local communities.		
6.5 Have joint reviewing and (de)commissioning arrangements been agreed with specialist commissioning teams.	Yes. Individual plans are well underway and there is regular dialogue with the specialist commissioning team.		
6.6 Have the potential costs and source(s) of funds of future commissioning arrangements been assessed.	Yes. The potential cost to repatriate all seven people will be in the region of £1m. This will be sourced through local ASC and CCG (latter subject to assessment) budgets. There has not been any new funds identified for this work stream therefore this will result in a significant cost pressure to Peterborough City Council for 2013/14 and 2014/15.		
6.7 Are local arrangements for the commissioning of advocacy support sufficient, if not, are changes being developed.	Yes. Local arrangements are in place with a redefined advocacy contract specification going out to the market in the August 2013. The new specification/contract will include the learning from the Winterbourne Review programme.		
6.8 Is your local delivery plan in the process of being developed, resourced and agreed.	Yes. A local plan is being developed for the repatriation of appropriate patients.		
6.9 Are you confident that the 1 June 2014 target will be achieved (the commitment is for all people currently in in-patient settings to be placed nearer home and in a less restrictive environment).	Yes. The out of area returnee programme is on track to meet the 1 June 2014 target. The finances to resource the local placement will remain an issue and will be a risk but the programme will continue.		

6.10 If no, what are the obstacles, to delivery (e.g. organisational, financial, legal).	As 6.9 above.		
7. Developing local teams and services 7.1 Are you completing an initial assessment of commissioning requirements to support peoples' move from assessment and treatment/in-patient settings. 7.2 Do you have ways of knowing about the quality and effectiveness of advocacy arrangements. 7.3 Do you have plans to ensure that there is capacity to ensure that Best Interests assessors are involved in care planning.	Yes. This work is undertaken by the IST. Yes. The current advocacy contract is managed and reviewed regularly and the new contract will have the same mechanisms in place. The LDPB also receives regular reports/feedback from service users/customers and parent carers on issues, concerns and good news stories. The new advocacy contract will have specific requirements to support/advocate for people with complex and multiple needs. Yes. We have recently reviewed the local management of this service moving it to the Strategic Safeguarding Adults service and have agreed additional resources.		
8. Prevention and crisis response capacity - Local/shared capacity to manage emergencies 8.1 Do commissioning intentions include an assessment of capacity that will be required to deliver crisis response services locally. 8.2 Do you have / are you working on developing emergency responses that would avoid hospital admission (including under section of MHA.) 8.3 Do commissioning intentions include a workforce and skills assessment development.	Currently the IST offers a response for the people that are living in the community. However, additional capacity is being considered to develop a crisis response by the IST/CPFT and CCG. See 8.1 above and other responses given. The new tender for the support contract covers this angle through the specification that providers need to have the workforce to reflect the needs of this client group. At the point of individual contract tender, commissioners and the contracts team will ensure the right skill set of providers is indentified and		

	commissioned. Where there are gaps, the IST will support providers to meet those requirements with individual support teams. The department is also seeking to work with providers to enhance their compliance with the National Minimum Dataset (MNDS) returns, both as a source of enhanced commissioning information around the make up of the local workforce, but also as a mechanism for providers themselves to draw down funding for vocational training and qualifications for their workforce.		
9. Understanding the population who need/receive services 9.1 Do your local planning functions and market assessments support the development of support for all people with complex needs, including people with behaviour that challenges. 9.2 From the current people who need to be reviewed, are you taking account of ethnicity, age profile and gender issues in planning and understanding future care services.	Yes. However, more work is underway with market development strategies and position statements. Yes. Assessment of need and future requirements by the IST take full account of ethnicity, age profile and gender issues. This is fed into the commissioning process.		

10. Children and adults – transition planning 10.1Do commissioning arrangements take account of the needs of children and young people in transition as well as of adults. 10.2 Have you developed ways of understanding future demand in terms of numbers of people and likely services.	Yes. There is a Transitions Team with which the IST and the commissioning team have been working closely to ensure that all children/young people that are in area, or placed out of area, are part of the review programme. Profiling of children and young people's needs has been identified with a needs analysis of the type of housing with support required completed. This will be part of the pipeline project for the next 3-5 years.		
11. Current and future market requirements and capacity 11.1 Is an assessment of local market capacity in progress. 11.2 Does this include an updated gap analysis. 11.3 Are there local examples of innovative practice that can be shared more widely, e.g. the development of local fora to share/learn and develop best practice.	This has been completed and tenders are underway to increase local care and support and advocacy capacity to meet the needs of people that may fall into the profiles of people who, historically, would have been placed in secure type settings. The assessment identified gaps in the local care and support provision that was limited to meet the needs of people who may have been placed in secure-type settings. Advocacy support needed to be strengthened to support people with complex and multiple needs. This has now been addressed and new tenders are out to the market to procure both of these requirements. In addition to this, the housing needs analysis identified the type and design of housing needed to meet the needs of people that fall into this profile. Work will commence in the coming weeks to negotiate with RSLs and plan for new resources in Peterborough. Good practice examples from Peterborough have been shared with the East of England LAs/CCGs via the regional commissioning group.		

Please send questions, queries or completed stocktake to Sarah.brown@local.gov.uk by 5th July 2013 (Extension given by Sarah Brown till the 12th July 2013)

This document has been completed by

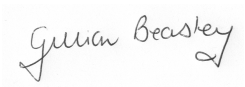
Name Mubarak Darbar

Organisation Peterborough City Council (Adult Social Care)

Contact 01733 452409 mubarak.darbar@peterborough.gov.uk

Signed by:

Chair HWB



LA Chief Executive ……..

Sohrab Panday

CCG rep…….

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 8(b)
12 SEPTEMBER 2013		PUBLIC REPORT
Contact Officer(s):	Dr Caroline Lea-Cox Claire Hodgson	Tel. 01223 725329

HOW WELL DID CAMBRIDGESHIRE AND PETERBOROUGH PROVIDE SERVICES FOR ADULTS WITH LEARNING DISABILITY 2012-2013?

RECOMMENDATIONS	
FROM : *Dr Caroline Lea-Cox, GP Mental Health Clinical Lead, Cambridgeshire and Peterborough CCG* *John Ellis & Dawn Jones, Cambridgeshire and Peterborough CCG* *Tracey Gurney, Head of Operations, Cambridgeshire Learning Disability Partnership* *Deborah Gallagher, Project Support Manager for Learning* Disability, *Peterborough City Council*	**Deadline date :** *01.10.13 to expedite named board member* *Other recommendations are ongoing.*

The HWBs of Cambridgeshire and Peterborough are asked to:

1. Have a named Board level Executive Lead with responsibility for learning disabilities
2. Support the CCG in signing up to Mencap's "Getting it right charter" which sets out the key principles of care for people with learning disabilities. http://www.mencap.org.uk/CCGcharter
3. Ensure the local JSNA includes a needs assessment and corresponding plans are in place, which reflect policy and best practice guidelines.
4. Ensure there are well functioning partnership agreements between health and social care organisations.

1. ORIGIN OF REPORT

This report is submitted to Board following a request from GP Member Mike Caskey.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is for the committee to reflect on how well as a region we have been delivering services for adults with learning disabilities, in order to further our commissioning processes to improve these services, and for consideration of the proposed recommendations.

2.2 This report is for Board to consider under its Terms of Reference No. 2.1, To bring together the leaders of health and social care commissioners to develop common and shared approaches to improving the health and well being of the community.

3. MAIN BODY OF REPORT

A report is attached that includes the following headers:

1.1 Context

1.2 The HWB of Cambridgeshire and Peterborough are asked to:
1.3 Review the summary of how services for people with learning disability were delivered in 2012-13 across:
1.3 1. Primary Care
1.3 2. Acute Providers
i Areas of good practice across the Trust
1.3 3. Local Disability Partnerships
i Areas identified for improvement

4. CONSULTATION

Adults with learning disabilities are consulted with during the annual LD self-assessment to ensure that our RAG ratings are an accurate reflection of service experience.

5. ANTICIPATED OUTCOMES

To improve our commissioning of and service delivery for adults with learning disabilities.

6. REASONS FOR RECOMMENDATIONS

It is a statutory requirement to ensure that we meet the needs of our population and make reasonable adjustments for individuals with learning disabilities to ensure equitable provision. Individuals with learning disabilities often have poorer health than the general population, (Confidential Inquiry into premature deaths of people with learning disabilities CIPOLD 2013), experience health inequalities due to the barriers people with learning disabilities face in accessing health care and health screening and are 25% more likely to be admitted to hospital as an emergency compared to other people (Admissions for Ambulatory Care Sensitive Conditions (ACSCs) for people with learning disability in the UK 2013).

7. ALTERNATIVE OPTIONS CONSIDERED

Status quo is an alternative option to the recommendations; however we feel that this will not progress the need to continually improve our commissioning of learning disabilities and ensure that adequate attention is given to this important area in line with the Winterbourne Review Report 2012.

8. IMPLICATIONS

There are no financial or legal implications expected as a result of the proposed recommendations.

9. BACKGROUND DOCUMENTS

Used to prepare this report, in accordance with the Local Government (Access to Information) Act 1985)

- Getting it Right for People with a Learning Disability, a Charter for Clinical Commissioning Groups, Mencap, March 2013 (attached).
- Peterborough 2012 LD Self-Assessment
- Cambridgeshire 2012 LD Self-Assessment

Cambridgeshire and Peterborough
Clinical Commissioning Group

How well did Cambridgeshire and Peterborough provide services for adults with learning disability 2012-2013? Report to the Health and Wellbeing Board Cambridgeshire and Health and Wellbeing Board Peterborough

Dr Caroline Lea-Cox Clinical Lead for Mental Health and Learning Disability
John Ellis, Dawn Jones, Cambridgeshire and Peterborough CCG
Tracy Gurney

Cambridgeshire County Council

Deborah Gallacher

PETERBOROUGH CITY COUNCIL

1.1 Context

With the formation of the new Cambridgeshire and Peterborough CCG and the Health and Wellbeing Boards for Cambridgeshire and Peterborough, it is opportune to reflect on how well as a region we are delivering services for adults with learning disability.

Total number of adults on the learning disability register 2012-13	Cambridgeshire		Peterborough
Age 18+	1478		701
Age 65+	Fens	25	44(5.9%)
	South	31	
	Hunts	15	
	City	21	
	East	19	
	Total	111 (7.5 %)	
Total	1589		745

Services are jointly commissioned through health and social care, with the local authority taking responsibility as lead commissioner. Well established Learning Disability Partnership Boards in both Cambridgeshire and Peterborough oversee the delivery of services for people with learning disability. However, it is the responsibility of all of us in the region to make sure that we are aware of the care of people with learning disability and know how to alert if concerns are raised. '*If we get it right for learning disability, then we get it right for everybody*'. Indeed, the ethos of care for learning disability applies to any vulnerable group of people within our society.

People with learning disabilities have often been invisible to mainstream health services and health professionals.

We need to give particular consideration to commissioning services for people with learning disabilities because they experience poorer health than the general population (*Confidential Inquiry into premature deaths of people with learning disabilities CIPOLD 2013*), differences which are to a large extent avoidable, and thus represent health inequalities.

Some health inequalities relate to the barriers people with learning disabilities face in accessing health care and health screening. These barriers are well documented in numerous reports including *Death by Indifference Mencap 2007,* which detailed the deaths of six people with learning disabilities while in the care of the NHS and the Disability Rights Commission's report Equal Treatment.

The recent report on *Hospital admissions that should not happen* (Admissions for Ambulatory Care Sensitive Conditions (ACSCs) for people with learning disability in the UK 2013) found that people with learning disability were 25% more likely to be admitted to hospital as an emergency compared to other people, and were 70% more likely to be admitted for an ASCSs. The ASCSs include

- Epilepsy and convulsions
- Constipation
- Complications of diabetes
- Influenza and pneumonia

Recent events at Winterbourne View (*Winterbourne Review Report 2012*) have also highlighted the importance of good quality commissioning for people who challenge services, and those with complex needs. We will need to work jointly with providers and others to ensure that good local services are available to support people who challenge services and those with complex needs to prevent the need for expensive and potentially risky out of area placements.

A review of how well we are delivering services cuts across public health, primary care, acute providers, learning disability partnerships, specialist learning disability teams, patient transport and ambulance system the criminal justice system and the third sector.

The health self-assessment framework (SAF) for learning disability services is a helpful tool as it involves specialist healthcare professionals as well as people with learning disabilities and family carers in assessing local services, and therefore provides good evidence of local involvement. It is used by most health communities on an annual basis and thus enables comparison on a year by year basis, and with other areas. The SAF brings together many standards for learning disability services that are in other documents, and

are included in this guidance under the appropriate section. Details of the SAF and assessment results can be found at: www.ihal.org.uk/self_assessment/

1.2 The HWBs of Cambridgeshire and Peterborough are asked to

1. Have a named Board level Executive Lead with responsibility for learning disabilities
2. Support the CCG in signing up to Mencap's "Getting it right charter" which sets out the key principles of care for people with learning disabilities. http://www.mencap.org.uk/CCGcharter
3. Ensure the local JSNA includes a needs assessment and corresponding plans are in place, which reflect policy and best practice guidelines.
4. Ensure there are well functioning partnership agreements between health and social care organisations.

1.3 Summary of how services for people with learning disability were delivered in 2012-13

Area
How well has primary care delivered health checks for people with learning disability? Since 2009 directions were published by the Department of Health that required that Primary Care Trusts to offer GPs in their area the opportunity to offer learning disability health checks as part of a Direct Enhanced Service scheme. Since the restructuring of the NHS, NHS England through the Local Area Teams is responsible for commissioning services from General Practice
How well do the acute providers provide services for people with learning disability? In the East of England the acute hospital trusts have been working with their commissioners and Learning Disability Partnerships to carry out self assessments of their services for these patients and to agree plans for 2012-14 to improve these services
How well did the Learning Disability Partnerships meet their quality standards? Learning Disability Partnerships include representation from both social care services, health professionals, voluntary organisations, people with learning disability and their family carers or support workers. The Learning Disability Partnership Board covers employment, education, leisure, person centred planning, health, housing and other issues.

1.3 1. Primary Care – Health checks for adults with learning disability who are eligible (moderate to severe learning disability)

We are currently doing fairly well across the CCG as benchmarked nationally, but we are doing less well than last year (78.5% of health checks completed) and there is wide discrepancy between practices/LCGs. However, if we include the number of patients who declined health checks then we have a 79.1% response rate. We have not reached the target of 90% except for the South Villages locality of Catch. We still have 6 practices not signed up to deliver health checks for 2013/14

LCG	Number of practices signed up for health checks	Number of patients with learning disability	Number of health checks Performed	Number of checks declined	% of patients who had a health check-Target 90%(including patients who declined a health check)
Peterborough	18/20 practices	192	169	12	88.0%(94.2)
Borderline	6/8 practices 2 Northants practices excluded	192	167	3	86.9(88.5)
Cam Health	9/9 practices	229	143	18	62.4 (70)
CATCH	24/25 3 Royston practices excluded	419	309	26	73.7 (80)
Hunts Health	10/10 practices	250	205	19	82.0 (89.6)
Hunts Care Partners	15/16 practices	350	241	33	68.8 (78.2)
Isle of Ely	10/10 practices	279	152	8	54.4(57.3)
Wisbech	3/4practices	122	101	4	82.8 (86)
Total	94% practices signed up (excluding 5 out of county practices)	2033	1487	122	73.1 (79.1)

1.3 2. Acute Providers- The Self Assessment RAG ratings for all objectives 2012

Leadership management and strategy	CUHFT Addenbrookes	HHT Hinchingbrooke	PSHFT Peterborough and Stamford
There is a clearly identifiable Board and senior management engagement in embedding a strategy for adults with a learning disability or autism			
The Trust has policies in place that meet the specific needs of adults with learning disabilities or autism			
Partnership working takes place at all levels within the organisation			
Care Standards, Reasonable adjustments and service delivery	**CUHFT**	**HHT**	**PHSHFT**
The Trust employs a registered healthcare practitioner for adults with learning disability or autism (Acute liaison Nurse) and identifies practitioners with extra skills and responsibilities			
The Trusts' plan to deliver the Public Sector Equality Duty and the NHS Equality Delivery System reflects the reasonable adjustments required for adults with learning disability or autism			
Adults with learning disability or autism receive high standards of fundamental care			
Patient safety issues are identified proactively. Risk assessment is comprehensive , taking into account individual support needs			
Adults with learning disabilities or autism receive appropriate nutrition and hydration			
Adults with learning disabilities or autism are identified prior to admission for elective cases or on admission through Emergency Departments			

Training and education on understanding the specific needs of people with learning disability and autism is provided to all hospital staff			
Pathways	CUHFT	HHT	PSHFT
Adults with learning disability or autism attend outpatients and investigations appropriately			
Adults with learning disabilities or autism attend A&E appropriately			
Adults with learning disabilities and autism are discharged home in a safe and timely way			
Women and partners with learning disability or autism have a clear pathway for use of maternity services			
Involvement and representation of people with learning disability and their carers	CUHFT	HHT	PSHFT
Adults with learning disability or autism and their family carers are fully involved in the planning of the Trusts learning disability strategy and in service evaluation			
Adults with learning disabilities or autism and their family carers are fully involved in pre admission planning, care planning and care delivery			
People with learning disability or autism are represented in the workforce			
Information for people with learning disability and their carers	CUHFT	HHT	PSHFT
People with learning disability, autism and their family carers receive appropriate information prior to planned, emergency or outpatient admissions			
All departments have access to a range of resources to help in the production of easy read information. These are available to people with a learning disability or			

autism and family carers			
People with learning disabilities or autism and family carers, have appropriate information to help them make complaints, discuss concerns and give feedback			
Keeping people safe	CUHFT	HHT	PSHFT
The Trust demonstrates learning from serious incidents, deaths of people with learning disability or autism			
The Trust demonstrates learning from other incidents involving people with learning disability or autism			
The organisation has ways of listening to adults with learning disability or autism and their family carers and learns from this			

Areas of good practice across the acute trusts

1. CUHFT have non executive Directors on the Trust board responsible for learning disability or Vulnerable Adults
2. CUHFT has agreed an Adolescent transition in Care Guideline
3. CUHFT have developed and audit tool which includes reasonable adjustments, fundamental care and the use of hospital passports
4. PSHFT have an electronic flagging system in place
5. CUHFT Maternity services use a learning difficulties screening tool, and there is a Maternity Services Learning Disability flowchart
6. PSHFT have a specialist midwife and a learning disability maternity pathway
7. CUHFT provide work placements for people with learning disabilities, some of whom have gone onto be employed in substantive posts.
8. PSHFT have volunteers with learning disabilities who act as hospital guides

1.3 3. Local Disability Partnerships

Quality Standard	Cambridgeshire LDP	Peterborough LDP
% of adults with learning disability living in appropriate accommodation i.e settled family accommodation or own/tenancy ownership reflecting personal choice	1199 of 1589 = 75.5% (Target 75%)	77% (Target 74%)
% of adults with learning disability receiving self directed support	1361 of 1589 = 88.6% (Target 80%)	271/745 = 36.4% (Target 60%)
% of adults with learning disability with paid employment	81 of 1589 = 5.1% (Target 7.5%)	49/745 = 6.6% (Target 6.0%)
% of adults with learning disability with something meaningful to do	85 of 1589 = 5.3% (unpaid voluntary work.)	73/745 = 9.9% (Voluntary work)
Timeliness of social care assessments within 28 days (Target 86%)	78 of 83 = 94%	Av 14 days (reported differently)
Timeliness of social care packages in place within 28days of assessment (Target 93%)	48 of 69 = 69.6% This is currently being closely looked at and a remedial plan in place	Av 26 days
Number of safe guarding issues/alerts	Total in the year of 266 alerts broken down as: 33 – not determined / inconclusive 61 – not substantiated 42 – partially substantiated 130 - substantiated	10 cases
Number of adults with learning disability who live out of area	Across health and social care provision the total is currently 139 of which 9 are in hospital placements (5 in secure units). There is active work with 23 people currently taking place around move on plans.	Work in progress
% of service users who live out of area who have had annual review by local team	100%	Data not available
% of Care Homes quality review	Data not available	Data not available
% of service user annual reviews	1168 of 1587 = 73.6% (Target 80%)	393/745 = 52.7% (target 100%)
% of carer reviews	327 of 1300 = 25.2% (Target 27%)	147/745 = 19.7% (Target 21%)
Number of people with transitions Plans	Data not available	Data not available

Areas identified for improvement

Area for improvement	How we move forward
Different targets for Learning Disability Partnerships in Cambridgeshire and Peterborough	This may wish to be discussed by the relevant HWB
Information sharing agreements between providers to improve quality of care	Collaboration between providers to ensure IT systems can communicate, but with firewalls to ensure confidentiality of data
Primary care contracting teams to gather data and compare with public health prevalence information.	Collaboration with public health
Maintain monitoring of improvements in services where user feedback is poor.	Look at the work by the EoE Managed Clinical Network to look at local family carer and user groups to form effective networks to feedback about services
Strengthen transitions work to prevent avoidable out-of-area placements of young adults.	EoE Managed Clinical Network led by Dr Lea-Cox is drafting standards for transition work
Implement Autism Action Plan, especially post-diagnosis support and for people not eligible for social care.	EoE Managed Clinical Network are developing guideline standards

Strengthen working relationships that have now been developed with local criminal justice agencies. Build on prison work to date and ensure continuity through transfer to NCB responsibility.	HWB
Regularly monitor individual provider plans to ensure LD-related issues are systematically reviewed.	Contracting.
Specialist care of epilepsy – whose responsibility? Quality of epilepsy reviews?	EoE Managed Clinical network Collaboration required between providers LDT and neurologists and primary care
We do not have data on the number of people with learning disability who have specific problems such as challenging behaviour, epilepsy, and dementia	LDP/CCG

Getting it right
for people with a learning disability

mencap
The voice of learning disability

A charter for Clinical Commissioning Groups

All people with a learning disability have an equal right to healthcare.

All healthcare services should be accessible to people with a learning disability, with reasonable adjustments being made where necessary to support them when they are unwell.

All NHS services should value the lives of people with a learning disability, and provide a high standard of care and treatment.

By signing this charter, we pledge to:

- ✓ **have a learning disability commissioning lead on our executive committee to monitor and coordinate service improvement**
- ✓ **provide an ongoing programme of learning disability awareness and mental capacity training to NHS staff**
- ✓ **meaningfully involve people with a learning disability and their families and carers in the planning and review of health services, and provide evidence thereof**
- ✓ **commission all NHS providers to implement reasonable adjustments, and use contracting mechanisms to check these are in place**
- ✓ **encourage and support all GP surgeries to offer annual health checks to people with a learning disability in line with the RCGP recommendations regarding process and content**
- ✓ **ensure that all acute healthcare trusts are signed up to the *Getting it right* charter**
- ✓ **participate in the National Joint Health and Social Care Self-Assessment Framework (Learning Disabilities) and work closely with social care colleagues to ensure implementation**
- ✓ **work closely with local authorities to ensure that public health, social services, housing services, education, employment and NHS commissioning are well-coordinated and, where responsibilities overlap, aim to jointly deliver services**
- ✓ **identify people with a learning disability using NHS services, closely monitor equality outcomes for people with a learning disability and act to improve them when inequalities of outcome are identified**
- ✓ **strategically plan and commission specialist learning disability services based on sound evidence and best practice**
- ✓ **commission local services for children and adults with a learning disability and behaviour that challenges, and robustly monitor their quality**
- ✓ **ensure that the recommendations set out in the Department of Health's final report of the Winterbourne review and the accompanying Concordat are implemented locally in a timely manner**
- ✓ **ensure that the recommendations set out in the Confidential Inquiry into premature deaths of people with a learning disability are implemented locally in a timely manner**

getting it right
when treating people with a learning disability

mencap
The voice of learning disability

"Recent reports and events have clearly shown that we need to have a complete change in culture about the way that people with learning disabilities are treated by our health and social care system.

Mencap's charter presents a real challenge to Clinical Commissioning Groups to help bring about these changes and I hope that all groups will consider signing up to its charter."
Norman Lamb MP, Minister of State for Care and Support

For guidance on implementing this pledge, please visit www.mencap.org.uk/CCGcharter

Developed with the Royal College of GPs, IHaL, Royal College of Nursing, College of Occupational Therapists and the Royal College of Paediatrics and Child Health

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 9(a)
12 SEPTEMBER 2013		PUBLIC REPORT
Contact Officer:	Wendi Ogle-Welbourn	Tel.

PEER CHALLENGE

RECOMMENDATIONS	
FROM : Wendi Ogle-Welbourn Assistant Director Strategy, Commissioning & Prevention Children's Services	**Deadline date N/A**
The Board is asked to note the Health and Wellbeing system improvement peer challenge methodology and guidance document and consider process for developing the Board to deliver on the required outcomes Boards are expected to achieve.	

1. ORIGIN OF REPORT

1.1 This document is submitted to Board following our initial interest in undergoing a peer challenge.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this document is to highlight to the Board what a Peer Challenge will focus on.

2.2 The Board need to consider what actions we need to take to develop the Board to deliver on the required outcomes.

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Health and wellbeing system improvement

Health and wellbeing peer challenge

Methodology and guidance

14th June 2013

1. Supporting the new health and wellbeing system

From 1 April 2013, responsibility for public health and other health services was given to local agencies, including councils, clinical commissioning groups and the new health and wellbeing boards. The Local Government Association (LGA) has been convening national partners, including the Department of Health, NHS England, the NHS Confederation, Public Health England, Healthwatch England and the Association of Directors of Public Health, to provide a 'Health and Wellbeing System Improvement Programme' for health and wellbeing boards, local authorities, clinical commissioning groups and local Healthwatch organisations. This £1.8million programme includes support for local leadership on health through a health and wellbeing peer challenge, regional support to address collective issues, bringing together information on public health via the LGA's LG Inform tool, a self-assessment tool, support to council commissioners through the regionally based Healthwatch Implementation Team, online networking via the LGA's current Knowledge Hub tool and national learning events.

The core national elements of the LGA's offer are:

Peer challenge – this tried and tested LGA sector-led improvement tool is being developed collaboratively for health and wellbeing. Councils can commission the challenge to focus on local public health, health and wellbeing board and local Healthwatch priorities.

LG Inform – this LGA on-line data and benchmarking tool, part of the LGA's core offer, is developing a specific package to consolidate key benchmarking information on public health that health and wellbeing boards, councils, local people and voluntary organisations can use to facilitate monitoring trends and for benchmarking. Data and information is also being produced to inform the peer challenges.

Knowledge Hub - supports on-line networking and the LGA continues to support the existing National Learning Network for health and wellbeing boards.

Healthwatch Implementation Team - this small, expert team deployed in each region will continue, in the immediate term, to provide 'trouble shooting' capacity and to provide tailored support to local authority commissioners.

The LGA and Healthwatch England are currently co-producing a joint work programme, which will be framed around joint events, publications for local healthwatch and local authority commissioners, troubleshooting capacity and tailored support in response to Francis Review recommendations.

National Sharing learning events – two national events have been planned for June 2013 in London and Leeds for health and wellbeing boards and partners in public health to share experiences and learning.

Regional approach driven by local choices - this has focussed on identifying as much funding as possible to devolve to the regions throughout the year so the offer is responsive to local need and builds on local networks and capacity. Regional

funding will be made available as part of a grant agreement with clearly defined criteria to demonstrate value, share learning and regularly communicates.

For more information on the offer go to:

http://www.local.gov.uk/web/guest/health/-/journal_content/56/10171/3932121/ARTICLE-TEMPLATE

2. Purpose and scope of the health and wellbeing peer challenge

A peer challenge is a voluntary and flexible process commissioned by a council to aid their improvement and learning. It involves a team of between 4 - 6 peers from local government, health or the voluntary sector who spend time on-site at a council to reflect back and challenge its practice, in order to help it to reflect on and improve the way it works. The process involves a wide range of people working with the council in both statutory and partnership roles and the findings are delivered immediately.

Peers are working as 'critical friends' or 'trusted advisors', not professional consultants or experts. Peer challenge is not inspection. The process is based on a view that organisations learn better from peers and are open to challenge. Likewise it believes that peers, in their professional capacity, challenge robustly and effectively. While the process is voluntary it is not a 'soft option'.

The purpose of the health and wellbeing peer challenge is to support councils, their health and wellbeing boards and health partners in implementing their new statutory responsibilities in health from 1 April 2013, by way of a systematic challenge through sector peers in order to improve local practice. In this context, the peer challenge focuses on three elements in particular while at the same time exploring their interconnectivity – the:

- establishment of effective **health and wellbeing boards**
- operation **of the public health function** to councils
- establishment of an effective local **Healthwatch organisation.**

We appreciate that the new health and wellbeing system includes many organisations, representatives and stakeholders, who are engaged in the challenge process. However, for the purpose of this peer challenge the **client is the local council**.

3. Headline questions for the peer challenge

The peer challenge focuses on a set of headline questions and more detailed prompts, from which to frame the preliminary review of materials, the interviews, and the workshops that make up a peer challenge. They are discussed and tailored in the context of each council.

A list of headline questions and prompts are at **Appendix 2** but the main four questions are:

1. How well are the health and wellbeing challenges understood and how are they reflected in Joint Health and Wellbeing Strategies (JHWSs) and in commissioning?
2. How strong are governance, leadership, partnerships, voices, and relationships?
3. How well are mandated and discretionary public health functions delivered?
4. How well are the Director of Public Health (DPH) and team being used, and how strong is the mutual engagement between them and other council teams?

4. The peer challenge process

4.1 Preparation

The purpose of pre-site work is to prepare for an effective and high impact peer challenge. We are keen to avoid unnecessary burdens on councils and try to keep information requests to a minimum. However, our experience with peer challenges shows that a degree of pre-site analysis is required for the peer challenge team to be fully operational on day 1. Similarly, feedback from councils shows that encouraging them to reflect on the effectiveness of their practice before the peer challenge helps them to define a clear focus for the on-site work and ultimately provides them with a more tangible outcome of our work.

Preparatory work involves the following:

i. Position statement

We encourage councils to prepare a short position statement outlining how they are performing against the main themes of the peer challenge (see above) and the specific focus. We do not prescribe the format or style of position statements but we can provide examples of what these can look like.

ii. Pre-site reading

We ask the council to provide us with a number of documents, many of which are likely to be in the public domain already. Key documents are likely to be:

- a local stakeholder map of 'who is who and who does what' in the health and wellbeing system
- the council business plan
- a selection of service plans to ascertain how health and wellbeing permeates into services such as housing, licensing, planning
- Joint Strategic Needs Assessments (JSNAs)
- JHWSs
- background information about the health and wellbeing board (HWB), eg agendas, minutes and papers for past meetings, and terms of reference
- information about plans for joint commissioning and service transformation, eg a joint commissioning strategy, data on pooled budgets/resources
- the clinical commissioning group's (CCG's) commissioning plan
- NHS England Local Area Team plan or equivalent, outlining what they are commissioning to meet local need

- memorandum of understanding with CCG regarding public health advice
- latest NHS patient satisfaction surveys for the area
- information on arrangements for the local Healthwatch organisation
- information about arrangements for health scrutiny, including the forward plan
- summary description of arrangements for delivering statutory local PH functions
- Health Protection Plans.

iii. Pre-site analysis

Pre-site analysis is undertaken by the LGA and includes a high level analysis presentation and a number of datasets including:

- NHS outcomes benchmarking support pack
- Public Health England Health Profile
- Public Health England Local Health Profile
- Child Health Profile
- Community Mental Health Profile
- census data
- service data through LG Inform.

iv. Pre-site survey with members of the HWB

We conduct a short on-line survey with members of the HWB to obtain some baseline data on the effectiveness of working arrangements as well as the leadership and relationships of members. We have developed a standard survey which we discuss with you and adapt to include any specific questions of value for your local HWB. The survey is administered by the LGA.

v. Timetable of activities for the peer team

The team is on site at a council for a period of 4 days.

The council needs to arrange a timetable of activity organised in advance of the visit by the peer team. The timetable should enable meetings and discussion sessions (during the remainder of day 1, day 2 and day 3) with a range of officers, members and other stakeholders enabling the peer team to explore the issues relevant to the purpose, scope and suggested terms of reference for the peer challenge.

The peer team works in teams of two with three parallel interview streams each day. This allows for 40 - 50 activities.

Suggestions (neither a prescriptive or exhaustive list) of whom the peer team need to meet with whilst on-site are:

1:1 discussions

- Leader or Elected Mayor
- Portfolio Holder for health and wellbeing and/or Adult or Children's Services

- Chief Executive (CE)
- Director of Public Health
- Council Directors (either individually or as a focus group)
- Chair of the HWB (if different from above)
- Chair and Vice Chair of Health Scrutiny
- Leader(s) of the Opposition
- Accountable Officer and Chair of the local CCG(s)
- Director/senior manager of the local PHE centres
- Director/senior manager of the local NHS England Action/Area Teams
- CE or senior managers of other key health stakeholders, eg acute trusts, community trusts, mental health trusts, primary care and other local providers, including community pharmacy and other providers
- Research/intelligence officer (JSNAs)
- Head of Human Resources/Organisational Development within the council
- Operational lead for the HWB
- Public health professionals, including consultants
- CE of the local Healthwatch organisation
- Chair of the neighbouring HWB where the health economy has a significant sub-regional configuration
- District council representation where appropriate.

Focus Groups:

- external stakeholders (eg housing, economy, police, VCS, education, universities)
- remainder of Cabinet (as one focus group)
- Heads of Service, including planning, housing, leisure, highways
- CE/lead members for health of District Councils (where appropriate)
- front line public health staff who have been transferred to the council
- voluntary and community sector providers

4.2 On-site work

The on-site challenge takes place over four consecutive days when the peer team is at the council and undertakes a range of activities, including focus groups, observations, site visits and discussions with officers, elected members, partners and stakeholders.

The timetable can include workshops on a specific area of focus the council wishes the peer challenge to explore.

The timetable is designed on the focus of the peer challenge and local arrangements. However, there are two sessions which are common to all peer challenges:

- a **'setting the scene' meeting** in the morning of the first day of the peer challenge. This provides an opportunity for the peer challenge team to meet with key officers and elected members and to receive an introductory presentation about the council and how it embraces its new responsibilities in health, together

with key opportunities and challenges as well as successes. The team uses this session to re-state the focus for the peer challenge and to establish common ground in what a good outcome of the process will be. It is also an important part in 'starting the process together' and to build relationships and trust between the council and the peer challenge team

- the **feedback session** on the last day of the peer challenge. In addition to informal feedback at the end of each day, the peer challenge team provides two types of feedback on the last day:

    - an informal 'dry run' of the formal feedback to a small group of officers and elected members (normally including the Chief Executive and Leader or elected Mayor or lead Cabinet member). This allows a check on any sensitive issues

    - a formal roundtable feedback discussion on the final day on site at the council involving an audience of the council's choosing. The team shares its views and offers advice on the main focus of the challenge and key strategic and leadership issues.

4.3 Written feedback

The council receives written feedback within 2-3 weeks after the departure of the peer challenge team. Written feedback is normally in form of a letter addressed to the Chief Executive. It elaborates on the points made in the feedback presentation, outlining the main findings and conclusions and provides recommendations for improvement and innovation.

The council has an opportunity to comment on the draft letter before it is finalised by the review manager.

The feedback letter and presentation are the property of the council. They are not published on the LGA website. However, in the interest of openness and accountability we recommend making the feedback publicly available.

4.4 Follow-up work

The peer challenge includes an offer of follow-up support. This can involve all or part of the team engaging in an activity such as:

- holding an action planning workshop with the council
- organising a workshop on a specific theme or area, involving experts or other peers as appropriate
- arranging for a follow-up visit at a later time to challenge progress.

The review manager liaises with the council to scope and manage any follow-up activity.

The peer team provides continuous feedback throughout the peer challenge process. The intelligence gained is fed back into the LGA to inform the planning of

future support. It also contributes to our sector knowledge base, which we need to prove sector led improvement works for local government.

5. The Peer Team

Composition

Peer challenges are managed and delivered by the sector for the sector. Peers are at the heart of the peer challenge process. They provide a 'practitioner perspective' and 'critical friend' challenge. Peers help build capacity, confidence and sustainability by challenging practice and sharing knowledge and experience.

The peer team includes 6 - 7 peers, including the challenge manager, and reflects the focus of the peer challenge. The review manager discusses the composition of the challenge team with the council. All peers are approved by the council.

The core team normally consists of:

- a Council Chief Executive or Strategic Director
- an elected member, normally the Chair of the HWB in their area
- a Director of Public Health
- an NHS peer, for example an officer or member of a CCG or a national peer
- an LGA challenge manager.

In addition, the team includes one or two peers with a particular specialism or expertise such as a:

- specialist health peer
- peer with national perspective, eg Healthwatch England, NHS England, Public Health England
- representative from a local Healthwatch organisation
- representative from the voluntary and community sector
- district council peer (in two tier areas)
- a local authority officer peer.

Within each team, one officer is designated the lead peer, normally the Council Chief Executive or Strategic Director.

Roles and responsibilities

The role of peers is to:

- undertake pre-reading in advance of the peer challenge
- attend and participate in an initial peer team meeting
- facilitate interviews and discussion whilst on-site at the council and to gather information via these, record and share key findings with the peer team
- draw on their relevant skills, knowledge and experience
- analyse key messages throughout the process

- work with others in the peer team to develop and deliver a feedback presentation
- contribute to the draft feedback letter within agreed timescales
- participate in the evaluation of the peer challenge
- undertake additional or specialist roles on the peer team.

The role of the challenge manager is to:

- manage the overall peer challenge process and act as the first point of contact for the client
- work with the client to identify peers and compose the peer challenge team
- work with the client to scope and design the peer challenge process including a set up meeting and advice/guidance on developing the timetable and position statement
- during the on-site process, be a full part of the team and also act as facilitator and adviser to guide the rest of the team through the on-site process
- facilitate and support the preparation of the feedback presentation, including working with the team to determine points of judgement in the process
- write the written feedback and liaise with the team and the client to finalise it
- liaise with the client to agree follow-up support.

6. Peer team requirements during the on-site period

We ask the council to provide for the peer team requirements during the on-site period. These include:

- the provision of a room at the council to use as a base for the time the peer team are on site. This would ideally be located in the main headquarters of the council. The room is for the sole use of the team members, with all interviews and focus groups being held elsewhere
- equipment for the base room, including a whiteboard or PowerPoint projector, one computer with access to the intranet and internet, and a supply of basic stationery
- catering for the team, including a lunch to be held in the base room each day.

The review manager discusses these arrangements in detail with the council.

The LGA manages and covers all expenses related to accommodation and travel for the team.

Appendix 1: Sample timetable

Day 1

Time	Council Name		Day, Date, Month
	Workstream 1	Workstream 2	Workstream 3
08:30 - 09:00	*Admin / Passes / set up in Team Room*		
09:00 - 09:45	**Setting the Scene - Committee Room 1**		
09:45 - 10:00			
10:00 - 10:45	**Margaret Smith, Chair of Health and Adults Select Committee, Room 127, Civic Hall** **Bill/Anne**	**Judith McDuffy** **Director of Public Health, Borchester Council** **Room 130, Civic Hall** **Abdul/Sam**	**Kieran Williams, Chief Executive, Borchester Council** **Chief Executive's Office, Civic Hall** **Tim//Martha**
10:45 - 11:00	***Break***		
11:00 - 11:45	**Sue McNally, Director Community Commissioning Borchester Council** **Room 127, Civic Hall** **Bill/Martha**	**Mike Thompson** **Director of Health and Social Care Commissioning, Borchester Council** **Room 130, Civic Hall** **Anne/Abdul**	**Brenda Tarbuck, Leader of Labour Group, Borchester Council, Room 104a, Civic Hall** **Tim/Sam**
11:45 - 12:00	***Break***		
12:00 - 1.30	**Local Healthwatch Focus Group** **Felpersham Room** **Edes Mansion** **Abdul/Martha**	**Senior Management Team Focus Group** **Committee Room 1, Civic Hall** **Tim/Bill**	**Heads of Service Focus Group - Youth Services, Road Safety, Learning and Education, and Economic Development)** **Halnaker Room, The Grange** **Sam/Anne**
13.30 - 14.00	***Break***		
14:00 - 14.45	**Jeannie Chesterman, Clinical Director Woman & Children, Borchester Health Trust, Room 127** **Tim/Sam**	**Claire Gregory, Head of Integrated Adult Care Commissioning, Borchester Council and Member of Health and Wellbeing Board** **Room 130, Civic Hall** **Abdul/Martha**	**Frances Abraham, Non Executive Director Health Watch Borchester (Chair) and Health & Wellbeing Board Member with David O'Donnelly, Regional Manager HealthWatch, Room 104a, Civic Hall** **Bill/Anne**
14:45 - 15:00	*Break*		
15:00-16:00	**Samantha Merton** **Head of Policy and Communications Borchester Council, Room 127, Civic Hall** **Abdul/Bill**	**Public Health Consultants Focus Group, Loxley Room, Edes Mansion** **Martha/Sam**	**Borchester All Party Elected Members Focus Group** **Gables Room, Edes Mansion** **Anne/Tim**
16:00-16:30	*Team working and feedback preparation*		
16:30-17:30	*Daily Feedback*		

Day 2

Time	Council Name		Day, Date, Month
	Workstream 1	Workstream 2	Workstream 3
08:30 - 09:00	*Team Time*		
09:00 - 9.45	**Dr Katie Bilbau, Accountable Officer, Brookfield Clinical Commissioning Group Telephone interview Peer to ring 02746 349672**	**Peter Samston, Cabinet Member for Children, Borchester Council Room 130, Civic Hall**	**Sean Matthews, Chief Fire Officer, Borchester Council Peer to call Sean on 07129 683641**
09.45 - 10.00	*Break*		
10:00 - 10:45	**Matthew Kershaw, Head of Legal Services, Borchester Council, Room 127 Civic Hall**	**Stuart Dawson, Director of Children's Services, Borchester Council, Room 130, Civic Hall**	**Christopher Macclesfield, Cabinet Member for Health and Community, Borchester Council, Member of Health and Wellbeing Board, Room 140**
10:45 - 11:00	*Break*		
11:00 - 12:30	**Dr James Partridge - Leader of Conservative Party, Borchester Council Room 127, Civic Hall**	**Christine Barnaby, East Gables Community and Voluntary Services (Voluntary Services Representative on Health and Wellbeing Board) and Martin Shoesmith, Room 130, Civic Hall**	**Service Leads Focus Group Martello Room, Edes Mansion**
12:30 - 13:30	*Team Lunch*		
13:30 - 14:45	**Patrick Orson, Head of Business Improvement, Martin Hammerstein, Business Change Programme Manager, Borchester Council, Room 127, Civic Hall**	**Jennifer Tatley, Head of Health and Social Care Practice, Borchester Council, Room 130, Civic Hall**	**Alan Jefferies, Head of Emergency Management, Borchester Council, Room 104a, Civic Hall**
14:45 - 15:00	*Break*		
15:00 - 16:00	**Hardeep Shah, Leader Borchester Council, Room 127, Civic Hall**	**Sarah Southill Director of Commissioning Borchester and Loxley Area Team (NHS England) Telephone interview. Peer (Room 130) to ring 07599 338561**	**Dr Parson Bilton Director of Local PHE Centre Peer to call 07227 485459**
16:00 - 17:00	*Team working and feedback preparation*		
17:00 - 17:30	*Daily Feedback*		

Day 3

Time	Council Name		Day, Date, Month
	Workstream 1	Workstream 2	Workstream 3
08:30 - 09:00	*Team Time*		**TEAM TRAVELLING**
09:00 - 9.45	**Catherine Tilton & Tia Mistry, Borchester Council JSNA Lead Room 127, Civic Hall**	**Jamie Huntley, HR Business Partner & Jo Churchfield, Business Change Manager, Borchester Council, Room 130, Civic Hall**	**Travelling to Loxley (Abdul and Sam in Abdul's car)**
9.45 - 10.00			
10:00 - 10:45	**Loxley hub visit**		**Travelling to Gables**
10:45 - 11:00	*Break*		**Travelling to Gables**
11:00 - 12.30	**Public Health Focus Group Commissioning Bridge Room, Edes Mansion**	**Voluntary Sector Focus Group, Chief Executive's Board Room, Civic Hall**	**11.00 - 12.00 Dr Vishal Dhaliwal Clinical Chief Officer NHS Gables Clinical Commissioning Group, Vishal's Office, Gables Hospital** **then travel to Wellbeing Hub 12.00-12.30 - hub visit 12.30**
13.00 - 14.00			Gables Wellbeing hub visit - 12.30-13.30 Travel back to Gables hospital 13.30-14.00
14.00 - 14.45	**Justine Mitchell, Director of Nursing and Quality NHS England Borchester and Loxley Area Team), Member of Health and Wellbeing Board, Telephone Interview, Peer to call 07339 037362, Room 127, Civic Hall**	**Katie Butley, Commissioning Manager, Learning Disabilities, Borchester Council Phone interview, peer to call Katie on 07226 944626**	**Dr Agnieszka Laskowsa, Clinical Chairman Loxley CCG, Vice Chair of Health and Wellbeing Board Agnieszka's office, Gables Hospital**
14:45 - 15:00	*Break*		
15:00 - 16:00	**Detective Chief Inspector Pierre Lautrec, Borchester Police, telephone interview, peer to call 07394 339575**	**Public Health Staff (Other public health activities) Focus Group Leoni Room, Civic Hall**	**Travel back to Borchester for team working and feedback**
16:00 - 17:30	*Team working and feedback preparation*		
	No feedback session today		

Day 4

Time	Council Name		Day, Date, Month
	Workstream 1	Workstream 2	Workstream 3
09:00 - 12:30	Team prepares feedback		
12.30-13.30		**Dry run with Chief Executive, Leader and Director of Public Health, Committee Room 2, Civic Hall**	
13.30-14.30	*Lunch*		
14.30 - 15.30		**Feedback Committee Room 2, Civic Hall**	
15.30 - 16.00	*Team debrief and departure*		

Appendix 2: Headline questions for the peer challenge

The peer challenge focuses on a set of headline questions, and more detailed prompts, from which to frame the preliminary review of materials, the interviews, and the workshops that make up a peer challenge. They are discussed and tailored in the context of each council.

1. **How well are the health and wellbeing challenges understood and how are they reflected in JHWSs and in commissioning?**

   - Is there a vision for the health and wellbeing of the local population? Is it shared between key partners in the local system?
   - How strong are the analyses on which JSNAs are based? Do they reflect the population needs across health and care?
   - Do JSNAs cover the wider-determinants of health?
   - How well articulated and presented is the analysis?
   - How clear are the priorities and timelines in JHWSs? Is there an appropriate balance between preventative and responsive interventions? Is there clarity over any areas of disinvestment from historic provision?
   - How clearly are health inequalities, and their relationships with other inequalities, understood? Do JHWSs contain convincing strategies for closing gaps?
   - How clearly are the delivery programmes related to available resources? How well are resources combined and pooled?
   - Is there evidence of HWB members together finding the best uses of their collective spend across the system?
   - How well are the potential contributions of the third sector and community structures reflected in strategies?
   - How have local priorities been related to the national outcomes frameworks and strategies for public health, adult social care, children, and the NHS?
   - How clear is the linkage through JSNAs, to JHWSs, and then to commissioning?
   - How well combined are the analyses available from locality-based sources with those of the commissioning support unit?
   - How clear is the relationship between JHWS and CCG commissioning plans and strategies?
   - How well-used are national learning, benchmarking information, summaries of effective practice and value for money approaches, and the experiences of others responding to similar challenges?
   - How clearly are health and wellbeing priorities reflected in broader community strategies and in the delivery strategies of individual agencies, including district council strategies in two-tier areas?
   - How ambitious are the strategies and are they deliverable? To what extent is the balance of local service delivery being challenged?
   - How well are actions, impacts and cost-effectiveness reviewed? To what effect? Is the local health system a learning system?

2. **How strong are governance, leadership, partnerships, voices, and relationships?**

- How well does the membership of the HWB reflect the need to align power and influence around the JHWS?
- How effective is the grip of the board on its programme and agenda? How well informed are its members? How effective are discussion, challenge, commitment and review? How is conflict managed?
- How strongly do members commit to the board and its actions? How well-shared is the core analysis to challenges and the commitment to priorities and actions?
- How well developed are relationships in the board? How effective has the development of the board been and a mutual understanding of how it can be most effective in achieving key impacts?
- What is the quality of the relationship between the HWB and the CCG(s)?
- What is the quality of the relationship between the local public health team and CCGs? Is it able to meet its statutory function in giving the CCG public health advice?
- How effective are relationships with Health Providers? The local schools system? Local housing agencies? Other public sector providers?
- How well is the council considering the impact of its services, plans and strategies on health and wellbeing (eg considering the impact of planning decisions on health and wellbeing)?
- How well engaged are local politicians, beyond those directly involved in the HWB? How strongly do health and wellbeing challenges influence political ambitions and vice versa? How strong is the commitment to JHWSs across the local political landscape?
- How effectively are local voluntary and community organisations engaged in advocacy, strategic direction, and delivery?
- How effective are the local Healthwatch arrangements?
- How well are the experiences of service users, patients and members of the public heard and reflected on, both through the local Healthwatch organisation and wider?
- How effective is the local Overview and Scrutiny function?
- How effective is collaboration with the Public Health England and NHS England regional and local teams?
- In two tier areas, how well are district authorities engaged in analysis and setting priorities? Do strategies make best use of the functions of both tiers?
- Are there shared arrangements for any element of the public health functions? How well do they work?

3. **How well are mandated and discretionary public health functions delivered?**

- How well are sexual health services commissioned and delivered?
- How effective are local arrangements for screening and immunisation?

- How well is the population healthcare advice service delivered locally? What is the quality of the relationship between the local public health team and the CCG(s)?
- How well is the local Health Check programme being commissioned and delivered?
- Is there a clear and appropriate Health Protection arrangements? Is there clarity over relative roles, responsibilities, and leadership arrangements in the context of an incident or outbreak?
- How effective are Emergency Preparedness, Resilience and Response relationships? How well are key roles understood? How strong are the connections to wider emergency planning and resilience arrangements?
- What discretionary functions, including drugs and alcohol interventions, are provided in the locality? On what rationale?
- How effectively has the Board encouraged integrated working between commissioners of health and social care services?

4. How well are the DPH and team being used, and how strong is the mutual engagement between them and other council teams?

- How has the organisational design of the council been adapted to make best use of the public health team?
- Do the local arrangements ensure that the DPH is able to fulfil the statutory functions of the role effectively?
- How well is the DPH able to contribute to the wider leadership of the place and council?
- How well are JHWS priorities reflected in service plans and change programmes across the council?
- How well are the strengths of the professional public health team used across the council and its partnerships?
- How is the public health team's use of evidence and analysis being incorporated with the place-based sensitivity of the councillors?
- How aware are key staff across the council of the contributions that the public health team can make?
- How aware is the public health team of the full range of the functions of the council, their spheres of influence, and their particular areas of expertise?
- How strong are the arrangements for the development of the public health profession, including continuous professional development and accreditation?
- How influential is the public health team across the wider local health system?

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 9(b)
12 SEPTEMBER 2013		PUBLIC REPORT
Contact Officer(s):	Wendi Ogle-Welbourn	Tel.

HEALTH AND WELLBEING STRATEGY - DELIVERY PLAN

RECOMMENDATIONS	
FROM : Wendi Ogle-Welbourn Assistant Director Strategy, Commissioning & Prevention Children's Services	**Deadline date N/A**
The Board is asked to note the first draft of the Health and Wellbeing Strategy Delivery Plan and consider the wider determinants of health that the Board may want to focus on to deliver on the priorities in the strategy, for example housing.	

1. ORIGIN OF REPORT

1.1 This report is submitted to Board following the development of the Health and Wellbeing Strategy.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to:

2.2 Present the Delivery Plan that supports the Health and Wellbeing Strategy

2.3 Consider the wider determinants of health that the Board may want to focus on to support delivery of the priorities in the Health and Wellbeing Strategy.

3. BACKGROUND AND SUMMARY

Following the development of the Health and Wellbeing Strategy we have developed a delivery plan that details work across adult, children and health services that will support delivery of the priorities in the Strategy. The Board is required to consider the wider determinants of health, how these impact on the priorities and what the Board want to do to address these.

4. CONSULTATION

4.1 In the consultation events that supported the development of the Health and Wellbeing Strategy housing was an area that many participants considered to be a wider determinant of health outcomes. List here any consultations already undertaken and completed, with dates and outcomes and including consultation where relevant, to avoid the Board duplicating work already completed.

5. ANTICIPATED OUTCOMES

The Board may want to consider the development of a task and finish group to consider the wider determinants of health and how the Board can support work to address these determinants or the board may want to identify specific wider determinants for the task and finish group to focus on.

6. REASONS FOR RECOMMENDATIONS

The guidance about health and wellbeing system improvement identifies the need for Health and Wellbeing Boards to focus on the wider determinants of health and not just the more obvious determinants and actions of agencies such as the Local Authority and Health.

7. BACKGROUND DOCUMENTS

7.1 Health and Wellbeing Delivery Plan and the Health and Wellbeing System Improvement document.

Health and Wellbeing Board
Strategic Delivery Plan 2013/14
August 2013

Priority One: Securing the foundations of good health
Accountable Lead: Wendi Ogle-Welbourn / Adrian Chapman/ Maggie McCutcheon/Malcolm Bishop
Aims: 1. Ensure that children and young people, including those with complex needs and disabilities have the best opportunities in life to enable them to become healthy adults and make the best of their life chances

Number	Action	Performance Measure	By whom	By when	Progress	RAG
1.1.1	Pregnant mothers who smoke are identified and supported to stop smoking.	• Reduced smoking rates in pregnancy • Reduced numbers of children born with low birth rates	Conception to Five Pathway Group (part of the Children & Families Joint Commissioning Board work) – Janet Dullaghan	Ongoing Quarterly	Within the Family Nurse Partnership (FNP) service there has been a 70% increase in referrals in 2012/13 from community midwives since introducing routine CO monitoring 34 pregnant quits 89% increases from last year with a 65% quit rate. Within midwifery services the antenatal pathway specifically targets pregnant women and refers to smoking cessation services. Baseline data and targets to be identified.	
1.1.2	Implement targeted activities to promote breastfeeding	• Increased rates of breastfeeding initiation • Increased breast feeding continuation rates	CCG – Maggie McCutcheon NHS England – Tracey Cogan	Ongoing Quarterly reporting on current data	Maternity Services are commissioned by the CCG whilst Health Visiting Services are commissioned by NHS England. Issues concerning support to new mothers to continue breastfeeding are being addressed through CPFT contract monitoring process. Baseline data to be set and targets . A review of licensed Baby Cafes (offering specific evidence-based support to breastfeeding mothers) will be undertaken during the autumn. Breastfeeding peer supporters working with new breastfeeding mothers continue to offer consistent accessible support at the maternity unit and in the community.	

Number	Action	Performance Measure	By whom	By when	Progress	RAG
1.1.3	Implement the Healthy Child Programme	• Improve childhood immunisation rates • Reducing rates of childhood obesity at age 4-5 years.	Conception to Five Pathway Group (part of the Children & Families Joint Commissioning Board work) – Janet Dullaghan	Ongoing targets reporting Quarterly	The health child programme has been developed and is currently being implemented by Health Visitors. A number of workshops have been held with the early years workforce, including children's centres, midwifery and health visitors to develop a pre-birth to 5 pathway, this is linked to the Healthy Child Programme and the need for early identification of difficulties and access to early help services across children, adults and health services. Baseline data to be set and targets : • Improve childhood immunisation rates • Reducing rates of childhood obesity at age 4-5 years.	
1.1.4	Implement effective programmes to reduce rates of teenage pregnancy	• Reduce rates of teenage conceptions • Reduce rates of teenage mothers	Public Health – Sue Mitchell	Quarterly reporting on data	Teenage pregnancy rates have recently dropped in Peterborough although higher than England average. At Dec 2011 rates still remaining stable at a low rate of 34.9 compared to 50.9 in the previous year with England average at 30.9. The rolling quarterly average for 2011 is 36.0, the SN average for the same period is 40.3 and England 30.9. Peterborough is between these 2 averages. The first meeting of the Early Years Working group has taken place. Through the emerging Early Years Working group ensure that the methodology associated with Family Nurse Partnership is drawn on to impact on teenage pregnancy rates across Peterborough. Contraceptive and sexual health services are to be re-procured during the second half of 2013/14.	
1.1.5	Ensure delivery of the childcare sufficiency strategy and that provision is of a high quality.	• Number of available child care places • Number of children	Pam Setterfield Karen Hingston	Ongoing	An Early Years Sufficiency Report has been written identifying the areas of need for early childhood provision.	

Number	Action	Performance Measure	By whom	By when	Progress	RAG
		accessing child care settings • Percentage of child care settings assessed as good or outstanding by OFSTED.			Opportunity Peterborough is working with this document to develop a new marketing strategy to attract new providers into the market place. Support for settings, particularly child minders, continues to focus on improving the quality of provision and to meet expectations of Ofsted's criteria for Good and Above current rating for good and above 74%. In July there were 15 inspection reports published; (4 Outstanding settings identified this month) **Settings ;** Outstanding 3 Good 3 Satisfactory 4 Inadequate 0 **Childminders;** Outstanding 1 Good 3 (two of which were first inspections) Satisfactory 1 Inadequate 0	
1.1.6	Continued effective implementation of the Family Nurse Partnership.	• Number of families referred to FNP • Rate of families referred to FNP and who go on to engage with the programme increases.	Kirsty Lynn	On-going	The FNP team have been in post for just over a year and deliver the FNP Programme. FNP have received referrals from a range of agencies including Children's Social Care and Primary Care. As the Family Nurse's develop their skills and the parallel expansion of the Health Visiting service is completed, allowing implementation of progressive pathways, Family Nurses will be in a position to support Health Visitor skills and allow services to support all venerable	

Number	Action	Performance Measure	By whom	By when	Progress	RAG
					families, using motivational interviewing and mirroring some of the FNP Nurses ways of working. Therefore improving engagement with all venerable families in the city. FNP exceeded the national target for % recruited Under 16 weeks. Slightly under national target (3%) for recruitment of eligible referrals.	
1.1.7	To develop and deliver the Connecting Mums (peri-natal) project, in conjunction with the roll out of the Solihull parenting programme.	• Number of mothers engaged in the programmes; • Percentage of those engaging with the programmes who report an improved quality of relationship with their child.	Pam Setterfield Fiona Bauke	Sept 13	Barnardos have been working with the Midwifery service to develop the Solihull approach as a pilot, if this is successful it will roll out across all children's centres. This approach focuses on pre-birth to two year olds and the importance of attachment. Alongside this Fenland Mind have secured funding for a project to work peri-natally with parents around improving maternal mental health. This work is now part of the conception to 5 pathway work with partners. Solihull Pilot will commence in September 2013.	
1.1.8	Ensure two-year funding programme targets those most in need	• Numbers of children accessing two-year funding; • Percentage of those identified as being eligible for a place who take up the offer; • Narrowing the achievement gap between the most vulnerable children and all children at foundation stage	Pam Setterfield Karen Hingston	Sept 2013	The trajectory funding available for the financial year 2013 to 2014 will be used to secure continuity of childcare and to support the most vulnerable families with provision before funding is rolled out in September. Text back system informing families of their entitlement highly successful. To help narrow the gap between the most vulnerable children and all children at foundation stage the following support has been provided to early settings: • Birth – 3 early childhood specialist to work within settings. • Childhood specialist for inclusion to support settings for children with additional needs. • Senco to work within settings to help	

Number	Action	Performance Measure	By whom	By when	Progress	RAG
					identify and support vulnerable children.	
1.1.9	Ensure Children's Centres successfully target the most vulnerable children in our community and secure improved outcomes for them	• Engagement by families where children subject to Child Protection or Child in Need Plan;	Pam Setterfield	Monitoring ongoing Review October 2013	Currently a re-visioning of the roll and function of the children's centres is in operation. The Children's Centres to move towards supporting the most vulnerable families. Base line data to be set and targets.	
1.1.10	Ensure that families routinely provide feedback on the effectiveness of services within an evidence based framework and that this data is used to inform service delivery	• Implementation of the Outcomes Star across all service delivery; • Data captured demonstrates improving effectiveness of services and is used in commissioning process.	Karen Hingston	October 2013	Staff currently receiving training in Outcomes Star and Family Star. This tool will be used from Sept 2013. Contracting process will monitor gathering of information on effectiveness as well as Ofsted inspections.	
1.1.11	Deliver the Connecting Families Programme	• 350 families 'turned around' in the three years of the programme.	Wendi Ogle-Welbourn	Quarterly reporting	Programme on track.	

What difference has this made

Priority Two: Preventing and treating avoidable illness
Accountable Lead: Sue Mitchell/Adrian Chapman/ Cathy Mitchell
Aims: 1. Narrow the gap between those neighbourhoods and communities with the best and the worst health outcomes, whilst improving the health of all.

Number	Action	Performance Measure	By whom	By when	Progress	RAG
2.1.1	Develop and implement a Smokefree Plan comprehensive tobacco control	• Smoking during pregnancy • Smoking among young people • Smoking among adults • Reduction in exposure to secondhand smoke • Effective communication of the harm caused by tobacco use • Effective local enforcement of tobacco legislation	Julian Base	Dec 2013	Smokefree Plan prepared, Smokefree Alliance established, implementation underway. Highest number of smoking quitters recorded since 2000 achieved during 2012/2013. Current year on course to meet challenging 13/14 target. Plans are now in place for 'stoptober' campaign and in development for New Year and March 2014 No Smoking day campaigns. New initiatives with PSHFT launched this year, including direct web-based referral system in place at City Hospital. Health Champion programme implemented. Increased numbers of smoking quitters resulting in a reduction prevalence during the last three years from over 27% down to 23.7% (England rate 21%).	
2.1.2	Develop and implement a Change 4 Life Plan targeted physical activity and weight management interventions for children and adults	• Number of referred adults accessing and completing physical activity programmes • Number of referred children and families accessing and completing weight	Julian Base	Dec 2013	Change 4 Life prepared, Change 4 Life Alliance established, implementation underway. National C4L road-show visited Peterborough during August, local summer campaign underway and working with Children's Centres.	

Number	Action	Performance Measure	By whom	By when	Progress	RAG
		management programmes • National Child Measurement Programme data			Specific programmes implemented – Carnegie Weight Management Programme, 'Lets Get Moving', 'Lets Keep Moving' plus other physical activity interventions such as walking for health, recreational cycling, promoting use of 'green' gyms in partnership with Vivacity and others. Peterborough short-listed for the National Sustainable Food City Initiative. Base line data to be set and targets.	
2.1.3	Develop health champion programme within schools, workplaces and neighbourhoods and communities supported by RSPH health awareness programmes	• Number of people accessing and completing RSPH programmes • Number of people registered as health champions • Number of workplaces signing Responsibility Deal	Julian Base	Dec 2013	RSPH accreditation established. Health champion programme implemented. Plans are in place to work with Public Heath England to bring the PH Local Responsibility Deal to Peterborough during autumn starting with the City Council and rolling out to local employers.	
2.1.4	Reduce level of non-communicable disease through NHS Health Check programme	• Delivering 6059 Health Checks by GP Practices during 2013/14 to identify patients at higher risk of cardiovascular disease and diabetes, and offer lifestyle modification interventions and treatment to reduce risk • Evaluation of programme to include Number patients with	Chas Ryan	April 2014	Programme established in local GP Practices, additional targeted development to further reduce health inequalities required. During April-June 2013, 1411 health checks were delivered, on track to achieve the annual target. This programme is very closely aligned to the CCG priority of reducing the burden of coronary heart disease and stroke in the city. There is a specific focus on ensuring the programme is accessible for people with	

Number	Action	Performance Measure	By whom	By when	Progress	RAG
		existing disease/at high risk identified; number of onward referrals to treatment/ preventative services • The programme prioritises GP practices with higher levels of deprivation and burden of cardiovascular disease			Learning Disabilities.	
2.1.5	Develop Peterborough as a Sustainable City including the development of a Food for Life programme to support schools and communities to improve diet and nutrition.	• Increased understanding and awareness of healthy and seasonal foods • Number of schools engaged to improve food and food culture	Julian Base / PECT	Review Apr 2014	Programme established in targeted schools and communities, Sustainable Cities bid submitted and approved.	

What difference has this made

Priority Three: Healthier older people who maintain their independence for longer
Accountable Lead: Tim Bishop/ Ewan Kelsall
Aims: 1. Enable older people to stay independent and safe and enjoying the best possible quality of life

Number	Action	Performance Measure	By whom	By when	Progress	RAG
3.1.1	Ensure the transformation of Adult Social Care leads to better outcomes for customers	• New front door established • Better access to information and advice • Better preventative offer in place • Greater access to reablement and transition services • Refocused personalisation offer for people who need longer term support	Tina Hornsby, Debbie McQuade, Tim Bishop	March 2013	Transformation in progress.	
3.1.2	Deliver a dementia resource centre for The City	• Improved outcomes for people with dementia and their carers • Higher carer satisfaction	Nick Blake	01.03.13	Procurement underway.	
3.1.3	Agree and implement the joint health and social care carers strategy	• Better outcomes for carers • % increased of carers recognised and supported • % in crease in carer satisfaction in annual national survey	Nick Blake	31. 03.13	Strategy written. TO be signed off and published by 01.09.13.	
3.1.4	New transport options delivered for ASC customers	• More personalised transport options in place	Nick Blake	31.03.13	New relationship begun with Enterprise as transport partner.	

Number	Action	Performance Measure	By whom	By when	Progress	RAG
		• Better use of community options • Better use of contracted services (less down time for vehicles) • Better co-ordination across all transport commissioned by PCC			Exploring more fully integrated commissioning options with PCC transport team.	
3.1.5	To re-commission home care services	• New home care services in place	Nick Blake, Terry Prior, Mubarak Darbar, Serco contracts and procurement team		Procurement process underway. Evaluation to take place in September.	
3.1.6	To develop a Market Position statement for ASC commissioning	• Statement written and published • Providers understand the commission intentions for ASC in Peterborough	Tim Bishop	31.12.13	Work commenced.	

What difference has this made

Priority Four: Supporting good mental health
Accountable Lead: Tim Bishop/ Wendi Ogle – Welbourn/ Jon Ellis/Cathy Mitchell/Maggie McCutcheon
Aims: 1. Enable good child and adult mental health through effective, accessible mental health promotion and early intervention and rapid response services to impact upon early signs of mental ill health or deterioration

Number	Action	Performance Measure	By whom	By when	Progress	RAG
4.1.1	Review of operation of ARC single point-of-access	• CQUIN milestones	John Ellis	Dec 2013	Regular updates to Mental Health Stakeholder Group.	
4.1.2	Re-establish local suicide prevention group	• Improved risk assessment and clarity of where to signpost people in crisis	Dr Panday	Apr 2014	Regular updates to Mental Health Stakeholder Group.	
4.1.3	Universal settings support children and young people effectively and promote their resilience	• Information from the SHU survey of Peterborough pupils and other surveys of young people undertaken in the city and inform needs assessment and delivery of services	Maggie McCutcheon and Janet Dullaghan		The new specification for school nurses now highlights the role of the school nurse in supporting emotional health and wellbeing. Mental health awareness training to be developed for universal services e.g. schools Comprehensive CAMHs strategy being developed.	
4.1.4	Services are commissioned to support children and young people with developing additional mental or emotional health needs at tier 2, preventing need for accessing services at Tier 3	• Number of children and young people accessing Tier 2 services within the city • Waiting times between point of referral and child first being seen within tier 2 services; • Waiting time from assessment appointment to treatment; • Clinical outcomes	Janet Dullaghan/Maggie McCutcheon		There is a gap in adequate services for tier 2. Cambridge and Peterborough Foundation Trust (CPFT) the provider of child and adolescent mental health services (CAMH) currently do not support tier 1 or tier 2 services. Work with all partners to develop and improve access to tier 2 services will be part of the CAMH strategy work. School and other professions can now refer directly into 3T's services (short term counselling therapy).	

Number	Action	Performance Measure	By whom	By when	Progress	RAG
		measures show improvements in the emotional and mental health and well being of children and young people accessing tier 2 services; • Referrals to tier 3 and 4 services is reduced. • Use of the Child and Young Person Outcomes Star as these become available to measure effectiveness of services in building resilience; • Feedback from schools				
4.1.5	Tier 3 CAMH services are commissioned such that children and young people with more complex needs are able to access tier 3 services in a timely way with resultant improvements in their mental health and emotional wellbeing	• Number of children and young people referred to the tier 3 service; • Percentage of referrals to tier 3 service resulting in appointments being offered and kept; • Waiting time between referral and first appointment • Waiting time between assessment appointment and treatment; • Clinical outcomes measures show demonstrable impact	Maggie McCutcheon		Comprehensive CAMHs Strategy being developed. Performance reporting to lead commissioner now in place.	

Number	Action	Performance Measure	By whom	By when	Progress	RAG
		of intervention; • Reduced numbers of children and young people admitted to hospital because of mental health issues.				
4.1.6	Development of PCC/LCG MH Commissioning Strategy. This will include making links with: Suicide Strategy Development Public Health MH Strategy Police MH Strategy MH Employment Strategy Accommodation Strategy Joint CCG MH Strategy	• To be determined	T. Prior / S. Panday	October	First draft completed and emerging theme identified. Housing, Employment, Offender Health.	
4.1.7	Revising policy on parents and carers with mental health problems	• Identification of number of parents and carers • Identification of numbers of children	CCG	Monthly reporting to CPFT/CCG performance monitoring meeting	Jon Chapman PSCB and Carol Davis CPFT taking this forward. CCG to agreed with CPFT performance measures.	
4.1.8	Developing a specific and holistic reablement response within mental health services that incorporates BME and hard to reach communities Services targets most deprived political wards	• No of people accessing the service • No of referrals by political ward	CPFT	Monthly performance management	Currently in discussion with CPFT regarding the refocus of resources.	

What difference has this made

ARC Review: The ARC has been well – received but all involved recognise the need after one year of operation to review how it operates, how GPs, carers, local agencies and patients might more easily access help when required urgently.

Suicide Prevention: The group is developing its priorities but these will include guidance where to signpost people in need oh help and improved risk assessment for GPs.

Priority Five: better health and wellbeing outcomes for people with life-long disability and complex needs
Accountable Lead: Tim Bishop/ Wendi Ogle – Welbourn / Jon Ellis/Sue Jestice
Aims: 1. Maximise the health and wellbeing and opportunities for independent living for people with life-long disabilities and complex needs. This is through robust, integrated care pathways, care planning and commissioning arrangements from early years into adulthood and old age

Number	Action	Performance Measure	By whom	By when	Progress	RAG
5.1.1	Provide training to health and social care staff on NHS continuing Healthcare and use of the Joint Funding Tool	• Improved working bewteen Local Authority and Health	Sue Jestice	Dec 2013	150 people trained in the use of the JFT and CHC process. Increase 15% of patients with MH and LDP receiving joint funding. Improved knowledge of CHC process and increase in numbers being found eligible to receive CHC 100% health funding.	
5.1.2	Quarterly Transition Meetings between LA and health	• Children with complex health needs are identified at 16 and CHC assessed or reviewed prior to 18th birthday and transfer to adult services	Sue Jestice	On going	Assessment being completed within agreed time period. Smoother transition to adult services.	
5.1.3	Ensure the delivery of a range of short break services that reduce or delay the need for more specialist services; needs	• Increase in number of children and young people accessing short breaks; • Increase in number of	Janet Dullaghan	March 2013	A flexible range of short breaks have just been agreed with local providers. '0-19 activities', '8-19 activities'. 'Disability Sports', 'Siblings (emotional health and wellbeing)' and 'Information, Advice and Guidance.'	

Number	Action	Performance Measure	By whom	By when	Progress	RAG
		families accessing direct payments; • Reduction in number of children and young people with disabilities who are placed in out of city placements • Feedback from children, young people and their families about the effectiveness of services			The plans for the procurement of 'wrap around' services have progressed to consider a framework arrangement for 'one to one support' providers, contracted support for families who access their support package via Direct Payments and the provision of tickets and passes distributed through local parent/carer forums. This has maximised the Short Breaks financial allocation. The Short Breaks 'capital' allocation is currently out for bids. Direct payments actively encouraged at CWD allocation panel resulting in 10% increase in take-up. CWD eligibility criteria and short breaks offer out to consultation with parent/carer forums, linked to "Healthwatch" locally who are doing workshops on access to services for CWD. 2 workshops held locally for parents/carers and CWD on what they thought of the Short Breaks offer. Increase in Link and retained carer scheme, 6 link and 2 retained carers. Outreach and domiciliary care services also developed to provide more flexible approach to meet the needs of families of CWD.	
5.1.5	Improve transitional arrangements for young people with disabilities and continuing care needs;	• Children with complex health needs are identified at 16 and CHC assessed or reviewed prior to 18th birthday and transfer to adult services	Mubarak Darbar, Jenny Goodes, Janet Dullaghan	Sept 2013	Transitions working group set up as a work stream of the CWD Strategy Group. Agreed to develop a 14-25 transitions team with adult social care team. Proposal sent to Children and Adult Departmental Management Teams for agreement.	
5.1.6	Improve joint commissioning and joint working arrangements	• Review of the CC arrangements in	Maggie McCutcheon	Sept 2013	Review commenced.	

Number	Action	Performance Measure	By whom	By when	Progress	RAG
	between health and the local authority for children with continuing care	Peterborough				
5.1.7	Eligible adults with a learning disability to receive an annual health check through the NHS funded Directed Enhanced Service	• 95% completion	DG	31 March 2014	Q1 data identifies 23 health checks out of 337 completed.	
5.1.8	Commission a learning disability accommodation strategy to establish robust pathways into independent accommodation.	• Accommodation strategy approved by various boards and pipeline re housing needs to the procurement phase	Mubarak Darbar	30 September 2013	1 draft completed and reviews by Learning Disability Partnership Board.	
5.1.9	Undertake of visioning exercise around learning disability day opportunities to ensure services are person centred and provide community based opportunities and access to employment.	• New model approved by various boards and the implementation phase underway.	Mubrak Darbar		Service User and carer engagement underway. Dialog with independent sector commences. Various options and models considered with staff and wider stakeholders.	
5.1.10	Implement the SEN and Inclusion Strategy including requirements for all children to have a single plan where appropriate and development of the local offer.	• Development of Single Plan and Local Offer	Janet Dullaghan/Jenny Goodes	September 2015	Task and finish group set up, governed by the Children with Disabilities Strategy Group.	

What difference has this made

Improved knowledge, understanding and relationship between health and social care. As a result of this customers health and social care needs are addressed jointly. Feedback from customers and carers are positive.

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 10
DATE: 12 SEPTEMBER 2013		PUBLIC REPORT
Contact Officer(s):	Sue Mitchell, Interim Director of Public Health	Tel. 01733 207175

Longer Lives Tool-kit: a Peterborough Perspective

RECOMMENDATIONS	
FROM : Sue Mitchell	**Deadline date :**
The Health and Wellbeing Board is asked to note the information provided in the summary attached.	

1. ORIGIN OF REPORT

This report has been prepared following the publication of the Longer Lives Tool-kit by Public Health England (PHE).

2. PURPOSE AND REASON FOR REPORT

The attached report at Appendix A was requested by members of the Health and Wellbeing Board following the publication of the Longer Lives Tool-kit. It comes to the Board for information/discussion. The report will also be taken to the Health Scrutiny Commission in September. We would be grateful for your views and to understand and respond to any further, more in-depth, analysis the Board required.

3. MAIN BODY OF THE REPORT

Public Health England (PHE) has launched a new website, Longer Lives, which illustrates how premature mortality (deaths under 75) varies between local authorities in England. Longer Lives displays premature mortality from all causes, and also from some of the most common causes: cancer, heart disease and stroke, lung disease and liver disease. The statistics show that Peterborough has higher rates of premature mortality than the average for England for all causes, and specifically for heart disease and stroke, lung disease (mainly chronic obstructive lung disease) and liver disease. These causes of death share many common risk factors, such as smoking, obesity, poor diet, and high alcohol consumption. The website also shows how local authorities rank with regard to levels of socio-economic deprivation. Due to the high levels of publicity given to the launch of this website, and Peterborough's position against other upper tier LAs a report was requested by both the HWB and Health Scrutiny Commission.

The summary attached at Appendix A focuses on mortality and Life Expectancy (LE) data, and illustrates a snap shot of this data from 2000 through to 2010, and then trajectories up to 2016. It should be noted that premature mortality is reducing for both males and females, and that LE is increasing.

3. ANTICIPATED OUTCOMES

A further piece of in-depth analysis will be undertaken by Public Health Intelligence as part of the overall refresh of the Joint Strategic Needs Assessment.

9. BACKGROUND DOCUMENTS

Appendix A includes all references used to produce this report.

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Longer Lives – An overview for Peterborough. Appendix A

INTRODUCTION

This national tool-kit was published by Public Health England (PHE) on the 11th June 2013. Both the data and report are available here: http://longerlives.phe.org.uk/#are//par/E92000001. The report is presentation of mortality rates from the analysis of data on the four most common causes of premature deaths in England - heart disease and stroke, lung disease, liver disease, and cancer. Variation in the patterns of mortality across the 150 upper tier local authorities for 2009-2011, is presented. The report also describes the variations in each of the four disease groups, and by socio-economic deprivation.

This brief summary examines the pattern for Peterborough; in addition, reports (and data) on associated indicators are reviewed in order to present a comprehensive analysis of mortality for Peterborough.

SUMMARY

The key messages on mortality patterns in Peterborough are as follows:

- Premature mortality from all causes in Peterborough was relatively higher than the national average; with Peterborough ranked 87th nationally. Death rates for both sexes in was 293.7 per 100,000 compared to 267.7/100,000 in England. At Cluster[1] level, Peterborough is ranked 6th out of the 15 local authorities; the cluster average was 294.9/100,000.

- The dataset below is a spine chart summary of the position of Peterborough compared to other areas at national, and cluster level (and level of significance compared to England).

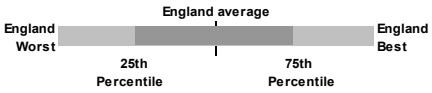
[1] Cluster comprises areas of similar socio-economic and deprivation profiles – Enfield, Camden, Sheffield, Torbay, Plymouth, Peterborough, Hammersmith and Fulham, Darlington, Brighton and Hove, Leeds, County Durham, Luton, Wakefield, Wirral and Wigan.

PETERBOROUGH KEY DATASET - LONGER LIVES 2013

The chart below shows how Peterborough compares with the rest of England. Peterborough's result for each indicator is shown as a circle. The average rate for England is shown by the black line at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that Peterborough is significantly worse than England for that indicator; however, a green circle may still indicate an important public health

- Significantly worse/higher need than England average
- Not significantly different from England average
- Significantly better/lower need than England average
- No significance can be calculated

Cluster average



The 1 and 3 year trend columns show the change in Peterborough's position on the spine.

	Domain	Indicator	P'Boro	Cluster	England	England Range	1 Year Trend	3 Year Trend	Time Period	Outcome Frameworks
Healthy life	All cause mortality	5 Early deaths from cancer considered preventable (rate per 100,000 population aged under 75)	106.1	115.5	108.1		no data	no data	2009-11	n/a
		6 Early deaths from cardiovascular diseases considered preventable (rate per 100,000 population aged	77.7	68.2	60.9		no data	no data	2009-11	n/a
		7 Early deaths from lung diseases considered preventable (rate per 100,000 population aged under 75)	30.2	26.4	23.4		no data	no data	2009-11	n/a
		8 Early deaths from liver diseases considered preventable (rate per 100,000 population aged under 75)	14.8	17.8	14.4		no data	no data	2009-11	n/a
		9 Early deaths from all diseases considered preventable (rate per 100,000 population aged under 75)	294	295	268		no data	no data	2009-11	n/a

- Of the top four conditions, cancer is the most common cause of death in Peterborough, and across the country. Comparative figures for all cancer death rates in Peterborough, (ranked 65th nationally) is 106.1/100,000, which is slightly lower (but not statistically significant) than that for England, 108.1/100,000. Within its Cluster[2], Peterborough is ranked the third lowest within its Cluster, which has an overall average rate of 115 /100,000.

- The next most common cause of death is heart disease and stroke, with death rates for Peterborough at 77.7/100,000. Peterborough is however, ranked in the top 25% of relatively high death rates nationally (123 out of 150), and ranked the highest in the Cluster.

- Lung disease death rates at 30.2/100,000 ranks Peterborough in the top 25% of highest rates nationally (113 out of 149), and 2nd highest in the Cluster.

- Liver disease death rates for Peterborough are 14.8/100,000. At national level, the council is ranked 74th (out of 149), and ranked the highest within the Cluster.

- Death rates from liver disease is around 15/100, 000, significantly higher than the national rate of 14.2/100,000 but lower than that for the Cluster, 17.8 per 100,000.

CONCLUSION

Peterborough is ranked as one of the more deprived local authorities across England, and the snapshot of premature mortality as presented in the *Longer Lives* report indicates the area has one of the poorer health outcomes from the top four causes of death. These messages, in

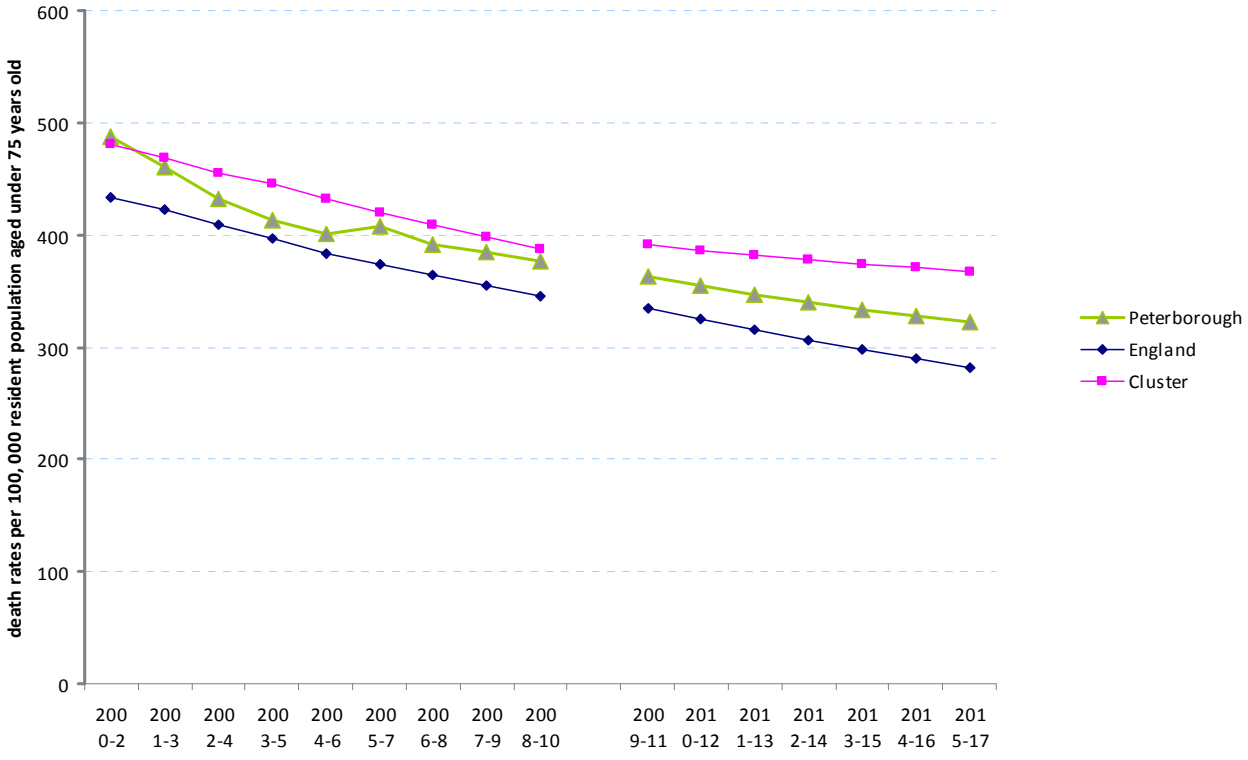
[2] Cluster is areas of similar socio-economic and deprivation profiles – Enfield, Camden, Sheffield, Torbay, Plymouth, Peterborough, Hammersmith and Fulham, Darlington, Brighton and Hove, Leeds, County Durham, Luton, Wakefield, Wirral and Wigan.

isolation, are insufficient evidence of the health of the local population, and it would be appropriate to review the evidence from the analysis of related data to enable a more complete reflection of the current health profile in Peterborough to be presented. Some of the findings are indicated as follows:

- Analyses of data over a longer period indicate a declining trend in mortality in Peterborough, which is consistent with the pattern observed nationally (although at variable rates).

- In the last decade up to 2010, premature mortality in men was down by almost 23% - death rates of 488 per 100,000 in 2000 to 376 per 100,000 in 2010. This rate of decline was observed to be relatively faster than that for England (21%) and the Cluster (19%) in the same period. However, the inequality in mortality (as indicated by the death rates) between Peterborough and England persist, with the rates per 100,000 projected to increase from 31 male deaths in 2010 to 41 male deaths by 2016 suggesting a relatively faster declining mortality trend in England compared to Peterborough. This is in contrast to comparisons with the Cluster – the difference in mortality rates per 100,000 in 2010 (11 male deaths) is projected to get even wider, with 45 more male deaths per 100,000 at Cluster level compared to Peterborough by the year 2016.

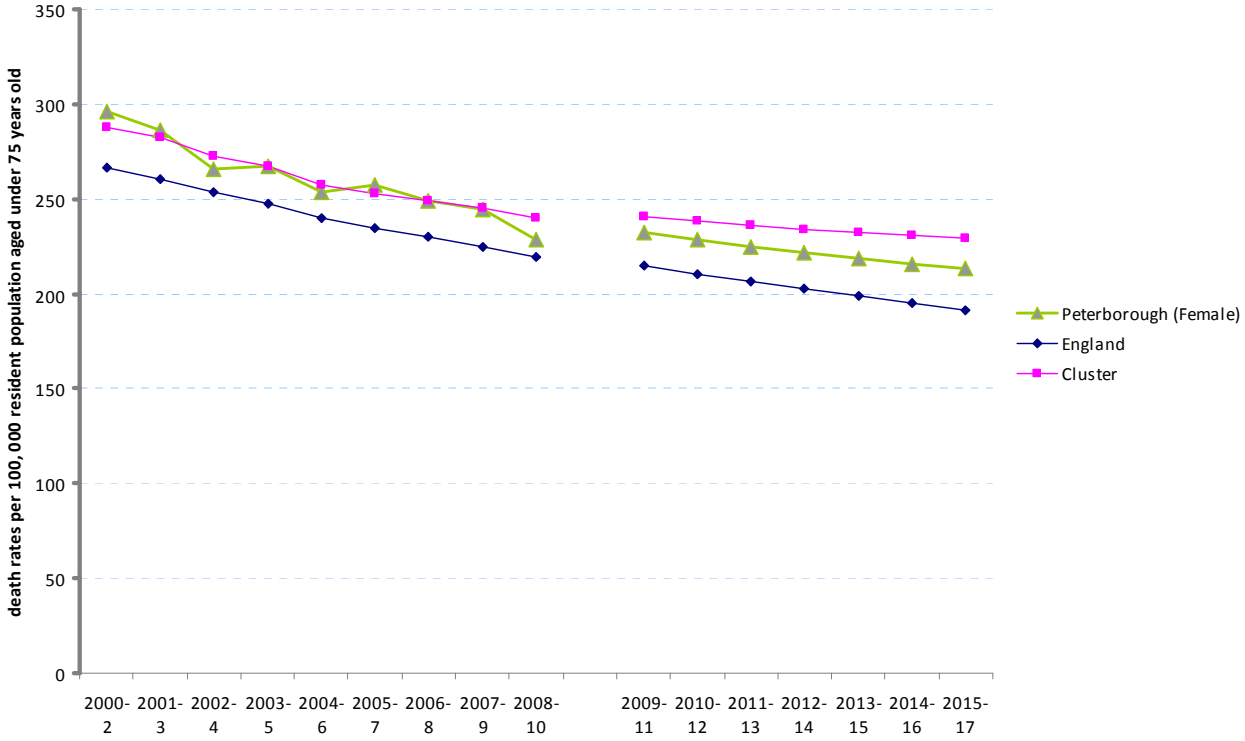
Fig 1: Male premature mortality trend in Peterborough, Cluster and England
Directly standardised rates. 2000-2 to 2008-10. And projections up to 20015-17



Source: https://indicators.ic.nhs.uk/webview/

- The decreasing trend (fig 2) is also mirrored for females; and projections indicate an even faster rate of decline nationally (10.5%) than for Peterborough (5%), which suggests a wider inequality in the mortality pattern between Peterborough and England by 2016.

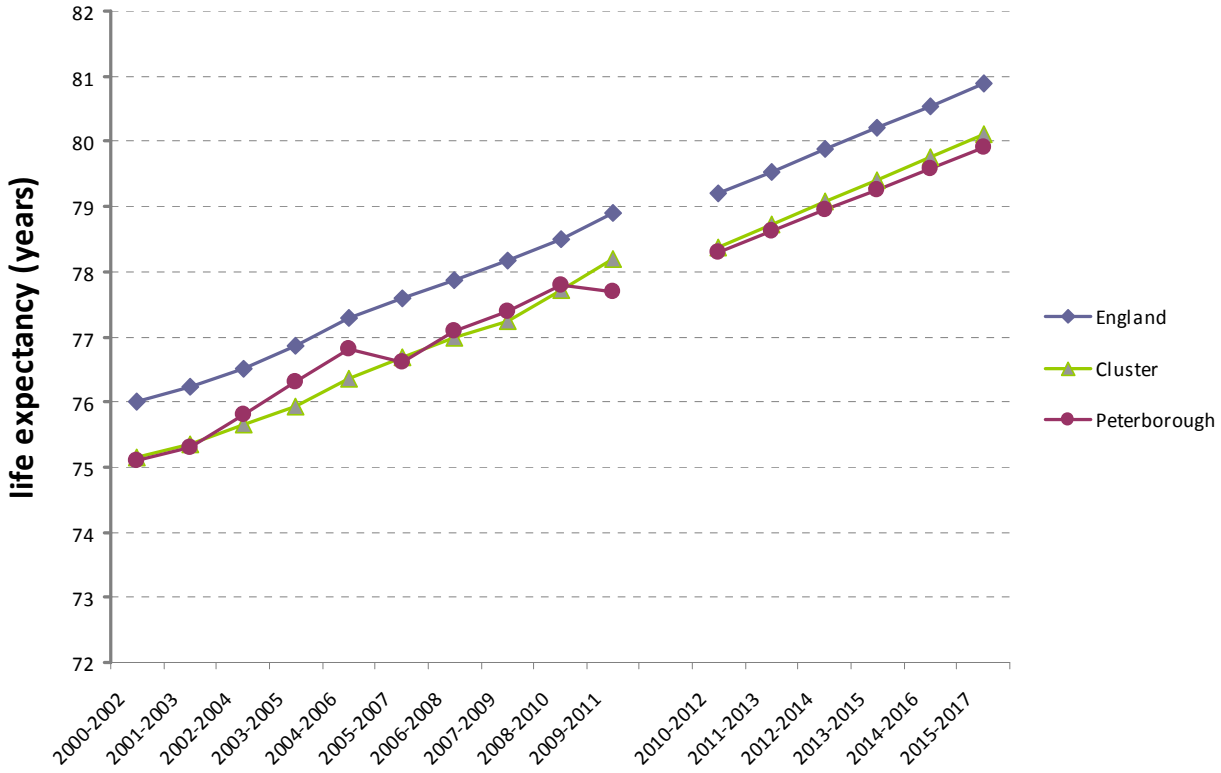
Fig 2: Female premature mortality trend in Peterborough, Cluster and England
Directly standardised rates. 2000-2 to 2008-10. And projections up to 20015-17



Source: https://indicators.ic.nhs.uk/webview/

- **Male life expectancy (LE)**: a male child born today in Peterborough (fig 3) is expected to live an estimated 77.7 years, a 3.5 percent increase from nearly a decade ago. It is projected that by the year 2016, these figures will increase by up to a further 3 percent to an estimated 79.9 years by 2016. This will result in a reduced difference in LE between Peterborough and England from about 1.2 years now to around 1 year by 2016. Corresponding figures at Cluster level for males indicate higher LE rates than for Peterborough, at an estimated 78.2 years, with the gap between the Cluster and England expected to narrow by about 0.2 years by 2016.

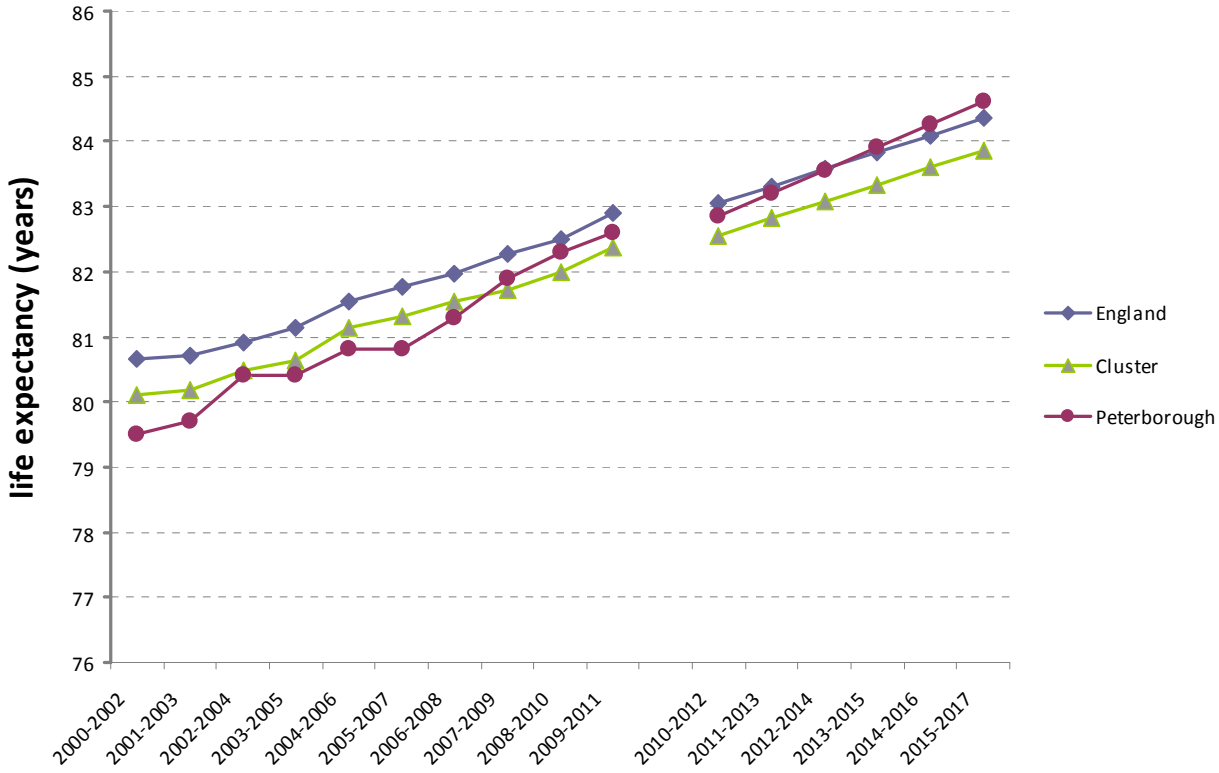
Fig 3 Male life expectancy at birth in Peterborough, Cluster and England. Trends and Projections. 2000-2 to 2009-11 (and 5-year projection)



Source: http://www.ons.gov.uk/ons/rel/subnational-health4/life-expectancy-at-birth-and-at-age-65-by-local-areas-in-england-and-wales/2009-11/stb.html

- **Female life expectancy**: a female child born today in Peterborough (fig 4) is expected to live an estimated 82.6 years, a 3.9 per cent increase in LE from 2000-2, a pattern that has remained consistently higher than that for the cluster (and lower than for England. This increasing improvement in Peterborough, and indeed as in other parts of the country, is projected to continue. As indicated in the chart (fig 4), the trend suggests that from 2014 onwards, female life expectancy in Peterborough is likely to overtake that for England, going up a further 2.5% to an estimated 84.6 years by 2016 compared to 84.3 years and 83.9 years for England and the Cluster respectively.

Fig 4. Female life expectancy at birth in Peterborough, Cluster, and England. Trends and Projections. 2000-2 to 2009-11 (and 5-year projection)



Source: http://www.ons.gov.uk/ons/rel/subnational-health4/life-expectancy-at-birth-and-at-age-65-by-local-areas-in-england-and-wales/2009-11/stb.html

The message on Peterborough's health as suggested from the *Longer Lives* publication would need to be associated with other sources of information so as to provide a complete picture of health in Peterborough. Further work will be undertaken and presented as part of the JSNA refresh.

Author: Remi Omotoye
Senior Public Health Analyst

30 August 2013

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 11
12 SEPTEMBER 2013		PUBLIC REPORT
Contact Officer(s):	Wendi Ogle-Welbourn	Tel.

JOINT COMMISSIONING – CHILD HEALTH UPDATE

RECOMMENDATIONS	
FROM : Wendi Ogle-Welbourn Assistant Director Strategy, Commissioning & Prevention	**Deadline date :**
The Board is asked to note the report on the recommendations for the future arrangements for Child Health Commissioning.	

1. ORIGIN OF REPORT

1.1 This report is submitted to Board following a previous report recommending the development of a Joint Health and Local Authority Child Health Commissioning Unit.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to keep the Board appraised of the progress in moving towards gaining agreement for a Peterborough Joint Health and Local Authority Child Health Commissioning Unit.

3. MAIN BODY OF REPORT

3.1 The attached report was presented to the Peterborough and Cambridgeshire Clinical Management Executive Team and the Peterborough and Borderline Commissioning Forum. The bodies agreed that a draft Section 75 agreement should be developed to then be considered by the appropriate governance forums within the Local Authority and Clinical Commissioning Group.

4. ANTICIPATED OUTCOMES

4.1 It is anticipated that a draft Section 75 report will be completed by the end of September. 2013.

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NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

MEETING: **CLIINCAL AND MANAGEMENT EXECUTIVE TEAM**

AGENDA ITEM: **6.5**

DATE: **31 JULY 2013**

TITLE: **BORDERLINE AND PETERBOROUGH LCG'S FUTURE OF CHILDREN'S COMMISSIONING AND SERVICES**

FROM: **CATHY MITCHELL**
LOCAL CHIEF OFFICER

FOR: **APPROVAL**

1 ISSUE

1.1 Cambridgeshire County Council and Peterborough City Council commissioned a Children's Health Services Review in early 2013 to offer an analysis on the current budget spend, presenting pressures and performance and quality of these services**.** Evidencefrom the Reviewclearly showsthe need to harness the commissioning work of the CCG in respect of child health and wellbeing, to increase the critical mass and economies of scale of children's commissioning, reduce duplication of work, manage high risk areas and improve performance, quality and capacity.

Establishing a team in each Local Authority and oversight from the CCG with a strong understanding of the strategic commissioning and procurement frameworks for children will enable resources to be balanced more efficiently whilst building sustainable local expertise to maximize benefits and value for money.

1.2 The CCG have given notice to CPFT on the Children's Services Contract which ends on the 31 March 2014. The CCG is not in a position to be able to procure the Children's Services within this time period and therefore agreement is required to approach CPFT to extend their contract for up to 12 months. The Borderline and Peterborough LCGs would want CPFT to agree to an improvement plan with timescales in order to be assured that current concerns are being addressed during the contract extension.

Vision

The vision is to establish a Joint Commissioning Unit (JCU) in each Local Authority, (in respect of Peterborough and Borderline LCGs there will be consideration of arrangements with Northants and Cambridgeshire County Councils., The aim would be to improve the delivery, quality and experience of services for children, young people and their families.

This includes improved health outcomes, keeping children and young people safe, treating them with respect and responding to their needs by having them and their families at the centre of service design and delivery.

The vision will be achieved through a shared commissioning function which will enable the Clinical Commissioning Group and the two Local Authorities to commission integrated pathways and services from Providers working withchildren, young people and their families. By developing and delivering integrated services we will strengthen our commissioning based on comprehensive analysis of need, leading to a whole system approach to planning and investment, alignment of commissioning cycles and intentions with effective use of resources. This will mean that we can redesign pathways,early intervention solutions, increase efficiencies and prevent duplication. There will be one 'virtual' JCU across Cambridgeshire and Peterborough with a JCU in place in each Local Authority in partnership with the localLCG's.

The model of JCUs has the flexibility to encompass other commissioners as part of the membership and would want to engage NHS England throughthe Area Teams to achieve a fully integrated approach to commissioning for children and young people.

The Borderline and Peterborough LCG's would want to ta~~k~~esk the Joint Commissioning Unit to carry out needs analysis and make proposals for future commissioning options and produce a service specification prior to any formal procurement.

2 STRATEGIC AIM / CCG ASSURANCE FRAMEWORK / /EQUALITY AND DIVERSITY GOALS AND BOARD ASSURANCE FRAMEWORK LINK

The paperis linked to Strategic Aims 1 (Quality & Patient Safety) and 3 (Change Management and Transformation. It also links to the following risks on the CCG Governing Body Assurance Framework and Risk Register: QPS 1 – Failure to Safeguard Children and QPS 3 – Risk of potential poor quality services from providers which the CCG Commissions

The paper also links to EDS Goal 3 – Improved patient access and experience and EDS Goal 4 – Inclusive leadership at all levels.

3 INVOLVEMENT AND VIEWS OF APPROPRIATE LCGS

The Borderline and Peterborough LCG's support the development of a Joint Commissioning Unit with the Peterborough City Council Children's services which is formalised with a section 75 agreement which outlines the Commissioning Functions that have been delegated and has a robust governance arrangement to monitor the work streams using the local Boards .

The LCG Boards support the extension of the CPFT contract for up to 12 months but wish to task the Joint Commissioning Unit to develop a integrated Service Specification as part of preparation prior to procurement which would require approval to be gained at LCG's and CCG level .

4 KEY POINTS

- The JCU will commission services to improve the experience and outcomes for children, young people, family/carer at every possible opportunity by improving provider

performance. Commissioning is the key lever to ensure children and young people receive quality services and care. The JCU will be expected to commission services which deliver and empower children & young people.

- The JCU will identify where there are opportunities to minimise bureaucracy and maximise value for money, within the financial resources available from the CCG and The Council's Children's Services.
- The governance structure of the JCU must not add to bureaucratic procedure; the design will ensure the JCU management structure is lean and the governance is robust and will be clearly laid out a section 75 which delegates the commissioning function only to the Council.
- A delivery vehicle that serves the CCG and Council Children's Services as equal customers and can expand to encompass the Area Team. The joint arrangement is a commissioning delivery vehicle and does not challenge the statutory basis of the CCG and Councils Children's Services remain accountable through the section 75 forcommissioning. The JCU will undertake commissioning functions to deliver the CCG/LCG's and Council's children's Services strategic outcomes. In this role, the JCU will serve its partners equally and be responsive to their respective needs.
- The JCU will incorporate the LCG's Children's Clinical Lead into the model and, recruit additional resource or buy in external support, as necessary. To achieve effective commissioning, the CCG and Councils Children's Services are committed to harnessing plus enhancing their joint capabilities and expertise within the JCU by developing expertise as required, to deliver its objectives.

5 RECOMMENDATION

The Clinical and Management Executive Team is asked to:-

- CMET are asked to endorse the creation of a joint commissioning unit between Peterborough City Council and the CCG for children and Young People's services underpinned by a section 75 agreement that delegates the CCG commissioning function only to Peterborough City Council.

- CMET are asked to endorse the extension of the Children's Contract held by CPFT for up to a maximum of 12 months to enable the CCG and Council to develop a service specification in preparation for a future procurement of Children's services.

6 REASON FOR RECOMMENDATION

The Borderline and Peterborough LCGs and the Peterborough City Council wish to establish a Joint Commissioning Unit (JCU) which will provide an integrated commissioning function for Children and Young People's services with clearly defined parameters and governance laid out in a section 75, whereby the CCG delegates it's commissioning function to PCC. Note this arrangement excludes pooling budgets.

The aim is to design and specify integrated services and pathways which can form the basis of future procurement of a range of children's services with the exclusion of acute paediatric services.

7 BACKGROUND INFORMATION

The Provision of Children's Health Service in Peterborough

Current children's health services are being provided by Cambridge and Peterborough Foundation Trust (CPFT) to the Peterborough population. During all recent formal and informal consultations with the LCG's and commissioning colleagues within the Peterborough City Council, high levels of concern and dissatisfaction with the waiting times and patient experiences have been expressed with the provider who was awarded the three year contract after an open tender exercise in 2010/11. Recent changes in senior management seem to have prompted a change in attitude and a promised improvement in levels of transparency from the provider. Data quality has improved and action plans to address such issues as the ADHD Assessment waiting list, have been developed and are already being applied.

Accepting that it may take some time and effort to restore a level of trust and confidence in the organisation, this may be achieved by the following:

a) an in depth analysis of service delivery and satisfaction amongst patients and carers,
b) careful scrutiny and clarification of reported data
c) Face to face meetings between commissioners and providers outside of the normal contract performance meetings
d) A clear steer on the improvements required and by which date

There is currently no obvious provider who would be able to deliver services when the current contract expires so it is essential that a decision as to the immediate future provision of services is reached quickly.

Notice was given to the provider and their contract comes to an end on 31st March 2014. This, of course, can be relatively easily extended and CPFT have already indicated their willingness to do this in order to fit with the timetable of any procurement exercise.

Short Term Options
Extend or issue new contract with CPFT for up to a year

Long Term Options
Include services in full CCG wide procurement exercise at the end of the Contract Extension period or part of Peterborough/Borderline option

The Borderline and Peterborough LCGs wish to extend the contract with CPFT for up to 12 months whilst holding the Provider to a robust improvement plan with timeframes to mitigate against the concerns and risks. Plus would support CPFT to be required to work with Senior Managers in CCS Children's Services during that same period.

During this extension period we would task the new Joint Commissioning Unit to draw up an integrated children's service specification which would feed into the procurement and consider other contracts outside of the CPFT contract that could be redesigned to deliver improved outcomes across CCG and PCC. The evaluation

of this approach to joint commissioning could then be feedback into the CCG to consider the CCG wide approach to joint commissioning of children's services.

8 IMPACT ASSESSMENT

Financial

- The CCG and PCC remain responsible for their own budgets for the delivery of services in the model. Either party could enter into a section 256 whereby an agreed sum of money is transferred to the respective organisation to commission a jointly procured service for the life and cost of the contract. Current examples of this arrangement exists between Cambridge County Council and the CCG for children's respite services
- The CCG and PCC would need to consider the respective contributions to JCU in their resources and/or finances to deliver the commissioning functions which would be contained in the section 75.

Performance

- The JCU would aim to improve Provider performance and undertake to report through to the LCG/CCG on performance and outcomes as set down in the section 75.

Governance

- The CCG would require clear and robust governance to be laid out in the section 75 reporting to the LCG/CCG and stating the necessary approvals and signoff processes required by the CCG prior to publishing strategies, commissioning plans or going out to tender.

Equality and Diversity

- The CCG will expect PCC to adhere to all relevant legislation and local policies that the CCG has to ensure are in place to deliver it's statutory duties.

Legal

- The CCG will need to seek legal advice on the content of the section 75 and any future changes to services which the JCU are proposing to redesign as and when required.

Patient Experience

- The CCG/LCGs will expect the JCU to ensure that children, young people and their families are part of the commission and contract monitoring process to deliver improved patient experience and outcomes.

9 CONCLUSION

The Borderline and Peterborough LCG's propose to develop a Joint Commissioning Unit with Peterborough City Council for Children and Young People's services which is governed through a Section 75 for the delegated Commissioning Function only.

The LCG's will task the Joint Commissioning Unit to review the local needs and propose future commissioning options for Children's services leading to the development of an integrated service specification .

The learning from this model can then be feedback into the CCG Children's Strategic Board to inform future ways of working and commissioning services.

Author ***Cathy Mitchell***
Local Chief Officer
25/7/13

Department of Health | Local Government Association | RCPCH Royal College of Paediatrics and Child Health Leading the way in Children's Health | Public Health England

20 July 2013

Dear Lead Member for Children's Services and Chair of the Health and Wellbeing Board,

Improving health outcomes for children and young people: Delivering and commissioning children and young people's public health services and invitation to sign the pledge

You will be as shocked as we are that childhood mortality in this country is among the worst in Europe. You will also want to know how poor many outcomes are for children and young people with long-term physical and mental conditions as well as those who are acutely sick. April 2013 marked the transfer of public health from the NHS to local authorities. Local authorities are now responsible for delivering and commissioning a range of children and young people's public health services for five to 19-year-olds, with responsibility for children under five following from 2015. This puts local authorities and health and wellbeing boards in a prime position to tackle the poor health outcomes experienced by children and young people.

We are writing jointly to you to share the resources available to assist councils with this increased responsibility and to invite you to sign up to the "Better health outcomes for children and young people pledge". The pledge is a part of the February 2013 system wide response to the Children and Young People's Health Outcomes Forum Report (2012).

Health and wellbeing boards are a crucial part of the new health landscape. Each board will want to ensure there is a proper focus on children within its priorities, that it has a thorough assessment of their needs through the Joint Strategic Needs Assessment, as well as from engagement with children and young people themselves. With a well-informed Joint Health and Wellbeing Strategy, services can be commissioned that will give children the best start in life. The resources outlined in Appendix A will help you to make this a reality.

We hope that signing up to the pledge will demonstrate a commitment to giving children the best start in life. We also hope it will start local conversations about how health and wellbeing boards, local authorities, health and wider partners can work together to improve health outcomes for children and young people, and tackle the unacceptable variation in the quality of care for children and young people across the country and reduce health inequalities. The Local Government Association (LGA), the Royal Colleges, the Department of Health and Public Health England are proud signatories of the pledge. We encourage you to work with partners and to engage with local children and young people to adapt the pledge to reflect local needs. A copy of the pledge is available at Appendix B.

Lead Members for Children's Services play a key role in these conversations and in ensuring that the health needs and wellbeing of all children and young people, including the most disadvantaged and vulnerable, and their families

and carers, are addressed. Lead Members will want to ensure they are working closely with their health and wellbeing boards in doing this.

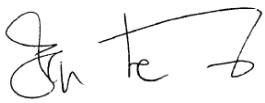
We recognise that many local authorities are already doing important work to prioritise children's health outcomes through integration and partnership working. If all local areas were as good as the best, together we could improve children and young people's quality of life now, and their ability to live fulfilling lives as they move through childhood. We are inviting local authorities, health and wellbeing boards, health, schools and wider partners to share examples of good practice so that learning can be promoted nationally. If you would like to share what your local authority is doing or planning to do to improve health outcomes for children and young people email a short description to Samantha.Ramanah@local.gov.uk. All examples will be published on the LGA's website and Knowledge Hub for the National Learning Network for Health and Wellbeing Boards to share learning.

Not all change is an improvement, but there is no improvement without change. We ask you to make a commitment to using the information and resources attached to challenge the status quo and to signing the pledge. Bold and brave decisions will be needed if we are to give children, young people and families the services they deserve.

Dan Poulter MP,
Parliamentary Under Secretary of State for Health,
Department of Health

Cllr David Simmonds,
Chair of the Children and Young People Board,
Local Government Association

Christine Lenehan, Director, Council for Disabled Children and Co-Chair of the Children and Young People's Health Outcomes Forum



Professor Ian Lewis, Medical Director, Alder Hey Children's NHS Foundation Trust and Co-Chair of the Children and Young People's Health Outcomes Forum

Dr Hilary Cass,
President,
Royal College of Paediatrics and Child Health

Duncan Selbie
Chief Executive
Public Health England

Appendix A – Further resources

The Pledge can be accessed at:
www.gov.uk/government/publications/national-pledge-to-improve-children-s-health-and-reduce-child-deaths

Knowledge Hub for the National Learning Network for Health and Wellbeing Boards (HWBs)
The Knowledge Hub for HWBs is a free online platform, it shares information, resources, ideas and learning on Health and Wellbeing Boards. Members can ask for help from other members and participate in live question and answer sessions.
Join here:
https://knowledgehub.local.gov.uk/group/nationallearningnetworkforhealthandwellbeingboards
Email Samantha.Ramanah@local.gov.uk for help or further information

LGA dedicated children's health webpage
The LGA works with local authorities, including lead members for children's services to deliver better health and wellbeing outcomes for children and young people. Access the full range of support tools and latest information on children's health issues including safeguarding in the reformed NHS system, Health and Wellbeing Boards, local Healthwatch and public health issues.
www.local.gov.uk/childrens-health

The LGA has a dedicated webpage on health with tools and resources on public health, Healthwatch and health and wellbeing boards.
www.local.gov.uk/health

Child Protection Information Sharing project
The Children and Young People's Health Outcomes Forum welcomed the Department of Health's child protection – information sharing project, which Dan Poulter MP announced in December 2012. This will enhance national IT systems in emergency departments and other unscheduled health care settings to include information, fed securely from local authority systems, on the child protection status of individual children.

Local authorities are encouraged to express interest in the project now and to be ready to come on stream when it starts to roll out next year. More information can be found at:
www.gov.uk/government/news/child-protection-information-sharing-project

Child Health Profiles
Child Health Profiles provide a snapshot of child health and well-being for each local authority in England using key health indicators, which enable comparison locally, regionally and nationally. By using the profiles local organisations can work in partnership to plan and commission evidence-based services based on local need. The profiles allow local authorities to

compare the outcomes in their local population with others in order to identify and share best practice. Find your local profile at: www.chimat.org.uk/profiles

Atlas of Variation in Healthcare for Children and Young People
The Atlas of Variation provides information to allow clinicians, commissioners and service users to identify priority areas for improving outcome, quality and productivity.

Variations in healthcare exist for many legitimate reasons. Populations and individuals have distinct needs, and some of the variation observed is a reflection of the responsiveness of the service to meeting particular needs. However, the degree of variation demonstrated in the Child Health Atlas cannot be explained solely on that basis. Identifying and tackling variations in healthcare will improve both the quality and efficiency of the care provided, and deliver the best possible health outcomes for all children and young people.
www.rightcare.nhs.uk/index.php/atlas/children-and-young-adults

Establishing Local Healthwatch: Engaging with Children and Young People
Local Healthwatch's duties extend to involving children and young people in their work. It includes the need to develop strategies for effectively involving children and young people, and particularly those who are most disadvantaged. This is covered in one of a series of briefings produced by the Local Government Association to assist local authorities and their partners in local communities and the NHS to support the commissioning, setting up and early development of local Healthwatch. http://tinyurl.com/kxartmk

Factsheets for School Governors and Health and Wellbeing Boards and Children, Young People and Families
The Children and Young People's Health Outcomes Forum has published a range of factsheets. Local authorities may find the factsheets for school governors and health and wellbeing boards and children, young people and families of particular interest.
www.gov.uk/government/publications/independent-experts-set-out-recommendations-to-improve-children-and-young-people-s-health-results

Factsheet on School Nursing
In addition the Department of Health has published a school nurse factsheet for head teachers and governors. The factsheet sets out details of the model and vision for school nursing which will positively impact on standards in all schools and improve health and wellbeing of school aged children and young people. http://tinyurl.com/kwpqvo2

Department of Health | Local Government Association | RCPCH Royal College of Paediatrics and Child Health Leading the way in Children's Health | Public Health England

Briefing on School Health Service
The Department of Health and Local Government Association have produced a briefing for Lead Members for Children's Services (LCMS) providing an overview of the School Health Service and sharing top tips to help LCMS think about how they can use the School Health services to deliver better health outcomes for 5-19 year olds.
www.gov.uk/government/publications/school-health-service-briefing-for-local-council-members

From transition to transformation in public health
The LGA and Department of Health has produced a set of online resource sheets. The purpose of this resource is to assist local authorities and public health to develop a local public health system that is designed to have the greatest potential for improving health, not just in councils but with all local partners. The focus is on transformation, showing how councils and public health are going beyond the practical steps of transition to develop a local vision public health, supported by new models for implementation.
http://tinyurl.com/kdk5w9t

National Child Measurement Programme: Briefing for elected members
These frequently asked questions for elected members have been jointly produced by the Local Government Association and Public Health England. They address a number of transitional issues relating to the transfer of responsibility for delivering the National Child Measurement Programme, which moved from PCTs to local government in April 2013.
http://tinyurl.com/n5etuj8

'Must Knows' for lead members for children's services
The 'Must knows' are a long-standing source of information and support for lead members for children's services (LMCS). The suite of information has been comprehensively revised for 2013 and focuses on the key issues facing lead members for children's services and the current and planned reforms impacting on children's services.
http://tinyurl.com/n3pdwt3

Teenage pregnancy resources for elected members and officers
The LGA has launched a number of resources on teenage pregnancy to help local authorities understand and address the key issues. The resources include: Relationships and sex education: a briefing for councillors and a briefing on local government's role in tackling teenage pregnancy.
http://tinyurl.com/l5ekp56

The council's role in tackling public health issues – resources for local authorities
The LGA has launched a number of resources on key public health issues including obesity, mental health, drugs and alcohol.
http://tinyurl.com/cod86q6

The 2012 report of the Children and Young People's Health Outcomes Forum
www.gov.uk/government/publications/independent-experts-set-out-recommendations-to-improve-children-and-young-people-s-health-results

The system wide response to the Forum's Report
http://tinyurl.com/msaupsh

Statutory guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies
http://healthandcare.dh.gov.uk/jsnas-jhwss-guidance-published/

Safeguarding children in the reformed NHS system
The Department for Education has published revised statutory guidance 'Working together to safeguard children' (2013)
http://tinyurl.com/brwtm77

NHS England has published an updated accountability and assurance framework for safeguarding vulnerable children and young people which sets out the responsibilities of each of the key players for safeguarding in the new NHS system. http://tinyurl.com/c57dca4

A guide for new councillors 2013/14
This Councillors' Guide, produced by the Local Government Association is designed to provide new councillors with all the information they need to know. It explores some of the key issues and challenges facing local government today and includes useful hints and tips from experienced councillors.
http://tinyurl.com/l95trlg

National Health Visitor Plan: progress to date and implementation 2013 onwards
The 'National Health Visitor Plan' is a joint DH, NHS England, Public Health England and Health Education England document. It sets out how these partner organisations will work with the health profession, families, local authorities and communities to achieve the government's health visiting commitment to increase the workforce by 4,200, transform the service by April 2015 and support its sustainability beyond 2015.

In 2011 the 'Health Visitor Implementation Plan 2011-15' set out action to revitalise the health visiting service, to help an expanded workforce to provide a new health visitor service model. We are now at the half-way point of a 4 year programme of recruitment and retention, professional development and improved commissioning linked to public health improvement.

'The National Health Visitor Plan: progress to date and implementation 2013' celebrates the successes of the programme so far and sets out how partner organisations within the new health landscape will work with the profession, families and communities in delivering the national commitment up to and beyond 2015. www.gov.uk/government/publications/health-visitor-vision

Better health outcomes for children and young people

Our pledge

> “The foundations for virtually every aspect of human development – physical, intellectual, and emotional – are laid in early childhood.”
>
> **(Marmot)**

Children and young people growing up in England today are healthier than they ever have been before. Health care and social changes have had dramatic impacts. Previously common killer diseases are now rare. More children with serious illnesses and disabilities are surviving into adulthood and the infant mortality rate has fallen to less than a quarter of what it was at the beginning of the 1960s.

But international comparisons and worrying long-term trends demonstrate there is room for improvement, with poor health outcomes for too many children and young people compared with other countries. A smaller group of more vulnerable children – such as looked after children – suffer much worse outcomes. The variation in outcomes and quality of healthcare for children and young people is unacceptable. The clear evidence that pregnancy and the earliest years are critical to the future health and wellbeing of children and adults and that evidence-based early interventions can have significant positive impacts does not always inform how services are commissioned.

The need for improvement is not new; numerous reports have highlighted the issues. Individual initiatives have led to improvements in specific areas, but have not resulted in the system wide changes required to improve outcomes. What is new is the opportunity to ensure the focus on outcomes in the new health and care system includes children and young people clearly and explicitly, from conception through to adulthood.

We are committed to improving the health outcomes of our children and young people so that they become amongst the best in the world.

System-wide change is required to achieve this and each part of the system, at each level, has a vital contribution to make. To this end we pledge to work in partnership, both locally and nationally, with children, young people and their families.

Our shared ambitions are that:

1. Children, young people and their families will be at the heart of decision-making, with the health outcomes that matter most to them taking priority.
2. Services, from pregnancy through to adolescence and beyond, will be high quality, evidence based and safe, delivered at the right time, in the right place, by a properly planned, educated and trained workforce.
3. Good mental and physical health and early interventions, including for children and young people with long term conditions, will be of equal importance to caring for those who become acutely unwell.
4. Services will be integrated and care will be coordinated around the individual, with an optimal experience of transition to adult services for those young people who require ongoing health and care in adult life.
5. There will be clear leadership, accountability and assurance and organisations will work in partnership for the benefit of children and young people.

We all have a part to play in promoting the importance of the health of our children and young people.

Through our joint commitment and efforts we are determined to:

- **reduce child deaths** through evidence based public health measures and by providing the right care at the right time;
- **prevent ill health for children and young people and improve their opportunities for better long-term health** by supporting families to look after their children, when they need it, and helping children and young people and their families to prioritise healthy behaviour;
- **improve the mental health of our children and young people** by promoting resilience and mental wellbeing and providing early and effective evidence based treatment for those who need it;
- **support and protect the most vulnerable** by focusing on the social determinants of health and providing better support to the groups that have the worst health **outcomes**;
- **provide better care for children and young people with long term conditions and disability** and increase life expectancy of those with life limiting conditions.

Because

- **the all-cause mortality rate for children aged 0 – 14 years has moved from the average to amongst the worst in Europe**[1]
- **26% of children's deaths showed 'identifiable failure in the child's direct care'**[2]
- **more than 8 out of 10 adults who have ever smoked regularly started before 19**[3]
- **more than 30% of 2 to 15 year olds are overweight or obese**[4]
- **half of life time mental illness starts by the age of 14**[5]
- **nearly half of looked after children have a mental health disorder and two thirds have at least one physical health complaint**[6]
- **about 75% of hospital admissions of children with asthma could have been prevented in primary care**[7]

Building momentum

At national level a new **Children and Young People's Health Outcomes Board**, led by the Chief Medical Officer, will bring together key system leaders in child health to provide a sustained focus and scrutiny on improving outcomes across the whole child health system.

A new **Children and Young People's Health Outcomes Forum** will provide both ongoing expertise in child health and offer constructive challenge to the next phase of this work. The Forum will hold an annual summit involving the CMO to monitor progress on child health outcomes and make recommendations for their improvement.

The Children and Young People's Health Outcomes Forum report and system response can be found at **http://www.dh.gov.uk/health/2012/07/cyp-report/**

For the very first time, everyone across the health and care system is determined to play their part in improving health outcomes for children and young people.

1 Wolfe I, Cass H,Thompson MJ et al. Improving child health services in the UK: insights from Europe and their implications for the NHS reforms. BMJ 2011; 342:d1277
2 CEMACH report 2008
3 Healthy Lives, Healthy People – our strategy for public health in England. Department of Health (2010)
4 Health Survey for England 2010
5 Kessler R, Angermeyer M, Anthony J et al. Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative. World Psychiatry 2007 Oct; 6(3):168-76
6 DfE Outcomes for children looked after as at 31 March 2012
7 Asthma UK. Wish you were here – England (2008).

DRAFT: Working together to deliver integrated health and social care in the East of England

Outline
A full-day event in the region for up to 60 delegates by Personal Invitation.

The event will aim to will help local government and NHS colleagues think through what arrangements – locally and regionally - are needed to support am integrated approach to health and social care and address the collective challenges and opportunities arising from the NHS reforms.

There will be opportunities to learn about what is happening locally across the East of England to implement integrated health and social care, but also to contribute to the priorities and design of a collaborative approach to improvement across Managed Clinical Networks, local government regional improvement networks and Public Health England within the east of England.

The event will be facilitated by Richard Humphries from the Kings Fund.

Objectives for the event are to bring together partners from across the system to:

- To identify the big challenges for the East of England arising from national developments (organisational change, austerity and demography)
- To better understand the agendas facing social care, public health and CCG leaders
- To showcase examples of innovation/transformation across the East of England
- To debate options for how organisations and disciplines work together across the East of England in the context of the national architecture and what new regional/ sub-regional arrangements are needed.

Audience

- Health and Wellbeing Board Chairs
- County and Unitary Authority chief Executives
- CCG Chairs and Chief Operating Officers
- Directors of Adult Social Services
- Directors of Children's Services
- Directors of Public Health
- NHS Commissioning Board Area Team Directors
- Public Health England senior team
- Key partner and stakeholder organisations
- Representatives of national policy support teams eg LGA/DH

Timing
Early December 2013, 10.30am – 3.30pm (arrival and refreshments from 9.15 am)

Venue
Tbc, Cambridge.

Suggested agenda

9.30	**Registration**
10.00	**Welcome & introduction to day** Richard Humphries – Kings Fund
10.05	**The national picture** Summary of new national structures, financial challenge, demography & social change - the big challenges facing health and local government over next decade. (Richard Humphries/ national leads)
10.20	**What's it like for you?** Panel discussion - perspectives on the integration agenda and expectations for today's event: *What is on the top of your in tray in relation to health and social care?* *How can we create better arrangements across NHS and LG to improve Health and Wellbeing in the East of England - what would you hope to get out of today?*

	Panel discussion with HWB Chair, CEX, DASS, DPH and CCG Lead describe the top issues for them & what they want to get out of today (5 minutes each)
10.45	**Health and social care integration 'pioneers'** Feedback on the National Health and social care integration 'Pioneers' programme and short presentations from the East of England Pioneers.
11.30	**Refreshments**
11.45	**Building relationships and changing behaviours - examples of innovation & transformation** 10 minute inputs from three examples of integration in the East of England, followed by a table discussion. *What have you done to build relationships and change behaviours?* *What achievements have these changes lead to?* *What lessons have you learnt that you share with others?* *What is your top tip going forward?* **Short Q & A with feedback from table discussions - facilitated by Richard Humphries to focus on top tips**
12.55	**Lunch and Refreshments**
1.35	**Making it work in the East of England – <u>practical session</u>** **Building the map :10 minute inputs from NHS England, CCGs, Clinical Senates, Local Government (DASSs, DPHs etc)** which review how existing regional structures are supporting sector-led improvement, what can be learnt from these arrangements; the implications of new national structures (e.g. Senates, Health and Wellbeing Boards) for the East of England; and options for how local organisations, sectors and professional disciplines work together on **improvement** across the region.
2.15	**Table discussions of options** What do we need to do locally, sub regionally and across East of England? What needs to be joined up and how can we achieve it?
2.45	**Feedback from table discussion**
3.15	**Action Planning & next steps** Summary of key points arising from day 1. Agree how this work will be taken forward and by whom? 2. Agree to share practical information that can be shared to facilitate good working relationships 3. Agree to come together again in the autumn to review progress
3.45	**Close** Richard Humphries to facilitate collate outputs from table discussions and produce report.

UPDATED: 12 August 2013

HEALTH AND WELLBEING BOARD
AGENDA PLAN 2013/14

MEETING DATE 2PM	ITEM	CONTACT OFFICER
16 January 2014	Commissioning Issues: CCG/LCG Public Health Children's Services Adult Social Care Health Watch (annual report) Health & Well Being Strategy Review	Board Members Wendi Ogle-Welbourn
27 March 2014	Commissioning Intentions: Priorities for 2014/15 CCG/LCG Public Health Children's Services Adult Social Care Health & Well Being Strategy Review	Board Members Wendi Ogle-Welbourn

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