PETERBOROUGH CITY COUNCIL

SCRUTINY COMMISSION FOR HEALTH ISSUES

TUESDAY 16 JULY 2013
7.00 PM

Bourges/Viersen Room - Town Hall

AGENDA

Page No

1. Apologies

2. Declarations of Interest and Whipping Declarations

At this point Members must declare whether they have a disclosable pecuniary interest, or other interest, in any of the items on the agenda, unless it is already entered in the register of members' interests or is a "pending notification " that has been disclosed to the Solicitor to the Council.

Members must also declare if they are subject to their party group whip in relation to any items under consideration.

3. Call In of any Cabinet, Cabinet Member or Key Officer Decisions

The decision notice for each decision will bear the date on which it is published and will specify that the decision may then be implemented on the expiry of 3 working days after the publication of the decision (not including the date of publication), unless a request for call-in of the decision is received from any two Members of a Scrutiny Committee or Scrutiny Commissions. If a request for call-in of a decision is received, implementation of the decision remains suspended for consideration by the relevant Scrutiny Committee or Commission.

10. Date of Next Meeting

Thursday, 19 September 2013

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 Paulina Ford on 01733 452508 as soon as possible.

Emergency Evacuation Procedure – Outside Normal Office Hours

In the event of the fire alarm sounding all persons should vacate the building by way of the nearest escape route and proceed directly to the assembly point in front of the Cathedral. The duty Beadle will assume overall control during any evacuation, however in the unlikely event the Beadle is unavailable, this responsibility will be assumed by the Committee Chair.

Committee Members:

Councillors: B Rush (Chairman), D Lamb (Vice Chairman), D McKean, S Allen, K Sharp, N Shabbir and A Sylvester

Substitutes: Councillors: J Peach, D Harrington and M Jamil

Further information about this meeting can be obtained from Paulina Ford on telephone 01733 452508 or by email – paulina.ford@peterborough.gov.uk

SCRUTINY COMMISSION FOR HEALTH ISSUES	Agenda Item No. 4
16 JULY 2013	Public Report

Report of the Executive Director of Public Health

Contact Officer(s) – Sue Mitchell
Contact Details - 207173

DRAFT YOUNG PEOPLES SEXUAL HEALTH AND WELLBEING: SUMMARY OF NEEDS AND COMMISSIONING STRATEGY

1. PURPOSE

1.1 This report and the accompanying draft Young People's Sexual Health and Wellbeing: Summary of Needs and Commissioning Strategy provide the Commission with an overview of the issues affecting young people's health and wellbeing in Peterborough and includes the commissioning recommendations made to ensure services that are provided address these issues.

2. RECOMMENDATIONS

2.1 The Commission is asked to: discuss the issues identified and the commissioning recommendations; advise on whether they feel the issues have been appropriately addressed within the commissioning recommendations; and highlight any further issues they wish to be explored.

3. LINKS TO THE SUSTAINABLE COMMUNITY STRATEGY

3.1 This report links to the SCS priority: Creating opportunities, tackling inequalities

4. BACKGROUND

4.1 **Transfer of Public Health in to Local Authorities**
Due to the transfer of public health into local authorities, Peterborough City Council will be required to commission a range of reproductive and sexual health services from 1st April 2013. Sexual health commissioning responsibilities across NHS organisations and LAs are set out below (adapted from Framework for Sexual Health Improvement).

Figure 2: Sexual health commissioning responsibilities April 2013 onwards

4.2

From April 2013		
Local authorities will commission	**Clinical Commissioning Groups (CCGs) will commission**	**The NHS Commissioning Board will commission**
Comprehensive sexual health Services (CaSH). These include: • contraception, including LESs (implants) and NESs (intra-uterine contraception) and all prescribing costs, but excluding contraception provided as an additional service	Most abortion services (but there will be a further consultation about the best commissioning arrangements in the longer term)	Contraception provided as an additional service under the GP contract

health aspects of psychosexual counselling; and
• any sexual health specialist services, including young people's sexual health and teenage pregnancy services, outreach, HIV prevention and sexual health promotion, services in schools, colleges and pharmacies.

Gynaecology, including any use of contraception for non-contraceptive purposes.	Promotion of opportunistic testing and treatment for STIs, and patient-requested testing by GPs
Cervical screening	Sexual health elements of prison health services Sexual Assault Referral Centres
Specialist fetal medicine services	

There are a number of key drivers which make a review of young people's sexual health and wellbeing services a timely undertaking.

4.3 In March 2013, the Department of Health published *A Framework for Sexual Health Improvement in England*, setting clear priorities and ambitions for local commissioners and providers to work towards. The overarching objectives are set out in Figure 1 (page three of
4.4 Appendix 1.

The Framework sets out 3 specific sexual health indicators within the Public Health Outcomes Framework to drive improvements:

- Under 18 conceptions
4.5 - Chlamydia diagnoses in the 15-24 age group
- Late diagnosis of HIV

Re-tendering of local sexual health services

In the light of the transfer of responsibilities, and in line with contracting regulations, the contracts for core reproductive and sexual health services will be re-tendered by Peterborough
4.6 City Council during 2013/14 providing an ideal opportunity to shape future sexual health services for young people. The raising of the participation age will mean more young people stay on in school or some form of learning until they are 18. Newly tendered sexual health services will need to take this into account to ensure services for young people remain accessible and at times and locations they want.

Government recognition of teenage intimate relationship abuse

As part of the Government's aim to end violence against women and girls the definition of domestic abuse changed in March 2013 to enable young people of 16 and 17 to be recognised
4.7 as victims. This will require a joined up response from commissioners and local partners to meet the anticipated demand for victim and perpetrator services for young people.

Child Sexual Exploitation

Awareness of child sexual exploitation (CSE) has grown due to high profile cases in the national media and the CSEGG Inquiry by the Office of the Children's Commissioner.
4.8 Procedures to identify and safeguard young people at risk of CSE have been established locally and services identified to support the small number of potential CSE victims. However, demand is likely to grow as awareness increases so a more sustainable level of service may be needed. Commissioner and providers must ensure local services are able to identify and respond to child sexual exploitation.

Review of Personal, Social and Health Education

The Department of Education review into Personal, Social and Health education (PSHE) in March 2013 confirmed that schools will continue to decide on the content of their PSHE
4.9 programme. This is important as the relationship between schools and the local authorities is changing. Schools are moving out of local authority control and funding previously administered by the local authority now directly given to schools. We must find new ways to encourage schools to invest sufficiently in SRE and preventative education and support them to

commission high quality and value for money SRE provision.

5. KEY ISSUES

5.1 Appendix 1 includes detailed sections for each of the key issues briefly summarised below.

5.2 The prevalence of STIs is increasing and presents a key challenge for public health. Young people aged 15-24 experience the highest rates of STI diagnoses. Young people are also more likely to become re-infected with STIs (In Peterborough an estimated 6.7% of 16-19 year old women and 3.6% of 16-19 year old men treated for an acute STI by the GUM clinic in 2009 were re-infected within 12 months). Prevention efforts such as greater STI screening coverage and easier access to sexual health services should be sustained with greater focus on at risk groups.

5.3 Chlamydia is the STI typically associated with young people. However rates of other less common STIs are on the increase particularly amongst young heterosexual people and gay and bisexual men. Nationally, rates of infectious syphilis are at their highest since the 1950s. Gonorrhoea is becoming more difficult to treat due to its ability to quickly develop resistance to antibiotic treatment[i].

5.4 Prevention of HIV remains a public health priority for local authorities. Early diagnosis is critical to reduce the spread of HIV in the local population. In 2011 47% of people diagnosed with HIV in the UK were diagnosed late.

5.5 **Who is most at risk?**

- Young people aged 15-24, young women in particular (no condom usage)
- Associated risk factors include deprivation, alcohol use, drug use and sexual violence
- Heterosexual males (compared to gay men)
- Nationally, Black African communities are associated with higher rates of STIs

5.6 Peterborough's historically high rates of teenage pregnancy have fallen recently but remain above national and regional averages. The negative impact on outcomes for both mother and child are well documented including increased rates of infant mortality, post-natal depression and living in poverty.

5.7 **Risky Behaviours and unsafe sexual practices**

Alcohol and drugs

The links between alcohol and risky behaviour are well reported. Also, alcohol and drugs are commonly used during the grooming process of child sexual exploitation (CSE), either as payment or 'gifts'. Professionals reported the use of cocaine as a 'love drug' to make young people more receptive to sexual activity.

5.8 **Contraception**

Contraception is vital to prevent pregnancy and transmission of STIs. In recent years, the investment has been made in promoting long acting reversible methods of contraception (LARC) to young people and making it more accessible.

5.9 **Sexual violence**

Sexual violence encompasses a range of sexual offences against children and young people in a variety of contexts including:-

- sexual abuse at the hands of family members or other trusted adults
- highly publicised 'stranger' child abductions
- sexual violence/exploitation following internet/social media grooming
- sexual bullying and sexual violence perpetrated by peers, gangs and in teenage intimate relationships

5.10 **Teenage intimate relationship abuse (TIRA)**

Teenage intimate relationship abuse refer s to the domestic abuse that occurs between young people in (or previously in) intimate relationships. In line with the national definition of domestic

abuse TIRA includes controlling, coercive or threatening behaviour, violence or abuse which may be psychological, physical, sexual, financial or emotional. It includes 'honour' based violence, forced marriage and female genital mutilation. Domestic abuse between young people in intimate relationships is a growing child welfare issue.

5.11 **Child sexual exploitation (CSE)**

Child sexual exploitation occurs when children and young people engage in sexual activity often in return for gifts (money, alcohol, drugs, mobile phones etc) or 'affection'. The child/young person may consent but in reality has little choice. Violence, coercion and intimidation are commonplace, as are exploitative relationships in which the adult has significant power over the child/young person. CSE is a form of abuse. National research suggests that young people involved in CSE have significant physical and emotional health needs too.

5.12 **Sexually harmful or inappropriate behaviours**

Some children and young people display inappropriate or harmful sexual behaviours towards their peers or others in society. In many cases developmental issues, learning disabilities or a lack of appropriate parenting contribute to inappropriate sexual behaviours. Early intervention can support these children and their families in changing their behaviour. However nearly half of adult sex offenders show the onset of sexual deviance in puberty and begin offending in adolescence. Specialist interventions are needed to manage this very small number of children and young people to prevent them becoming adult perpetrators in the future.

6. IMPLICATIONS

6.1 The recommendations included within Appendix 1 are based on a series of ambitions describing the proposed future service landscape (page 27). Commissioning recommendations are listed at pages 30 – 32. These recommendations will be used to inform the procurement exercise due to start in September 2013.

7. CONSULTATION

7.1 A SWOT analysis was undertaken as part of this review and the findings are described in Appendix 1 (Page 18 – 24). A group of stakeholders and partners was involved in the work. Young people were consulted via a range of groups and settings. The findings are described in Appendix 1 (pages 25-26).

7.2 The draft needs assessment and commissioning strategy has been considered by the children and Families Commissioning and Delivery Board.

8. NEXT STEPS

8.1 The Commissioning Strategy will be finalised and shared with partner commissioning and provider organisations. It will be used in order to inform the procurement of reproductive and sexual health services.

9. BACKGROUND DOCUMENTS

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

9.1 See the list of references in Appendix 1 of the draft Young People's Sexual Health and Wellbeing: Summary of Needs and Commissioning Strategy

10. APPENDICES

10.1 Appendix 1 - draft Young People's Sexual Health and Wellbeing Summary of Needs and Commissioning Strategy.

APPENIDX 1

Young People's Sexual Health and Wellbeing

Summary of Needs and Commissioning Strategy

April 2013

Version 3 FINAL DRAFT

Contents

What has prompted this review?

National NHS Changes

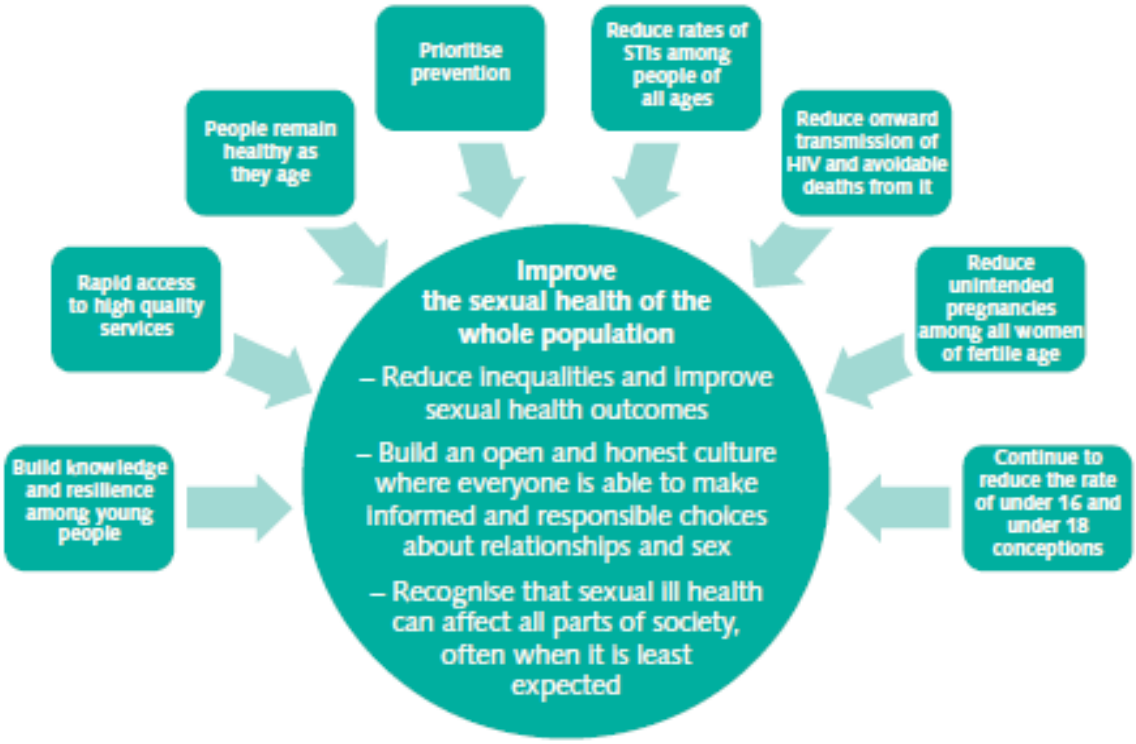
There are a number of key drivers which make a review of young people's sexual health and wellbeing services a timely undertaking:-

In March 2013, the Department of Health published *A Framework for Sexual Health Improvement in England*, setting clear priorities and ambitions for local commissioners and providers to work towards. The overarching objectives are set out in Figure 1.

The Framework sets out 3 specific sexual health indicators within the Public Health Outcomes Framework to drive improvements:

- Under 18 conceptions
- Chlamydia diagnoses in the 15-24 age group
- Late diagnosis of HIV

Figure 1: Key Objectives: Framework for Sexual Health Improvement, Department of Health



The Public Health Outcomes Framework *Healthy lives, healthy people: Improving outcomes and supporting transparency* sets out a vision for public health, desired outcomes and the indicators that will help local authorities understand how well public health is being improved and protected.

The framework concentrates on two high-level outcomes to be achieved across the public health system. The outcomes reflect a focus not only on how long people live, but on how well they live at all stages of life.

There are three specific outcome indicators for sexual health included within health protection (Chlamydia diagnosis and late diagnosis for HIV) and health improvement domains (under 18 conceptions)

Transference of Public Health in to Local Authorities
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Figure 2: Sexual health commissioning responsibilities April 2013 onwards

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• sexually transmitted infection (STI) testing and treatment, Chlamydia screening as part of the National Chlamydia Screening Programme (NCSP) and HIV testing; •
sexual health aspects of psychosexual counselling; and
• any sexual health specialist services, including young people's sexual health and teenage
pregnancy services, outreach, HIV
prevention and sexual health promotion, services in schools, colleges and pharmacies.</td><td>Most abortion services (but there will be a further consultation about the best commissioning arrangements in the longer term)</td><td rowspan="2">Contraception provided as an additional service under the GP contract</td></tr>
<tr><td>Sterilisation</td></tr>
<tr><td>Vasectomy</td><td rowspan="2">HIV treatment and care (including drug costs for post-exposure prophylaxis
after sexual exposure)</td></tr>
<tr><td>Non-sexual health elements of psychosexual health services</td></tr>
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</table>

Re-tendering of local sexual health services
The contracts for core reproductive and sexual health services will be re-tendered by Peterborough City Council during 2013/14 providing an ideal opportunity to shape future sexual health services for young people. This includes the Independent Sexual Violence Advocacy service (ISVAs). The raising of the participation age will mean more young people stay on in school or some form of learning until they are 18. Newly tendered sexual health services will need to take this into account to ensure services for young people remain accessible and at times and locations they want.

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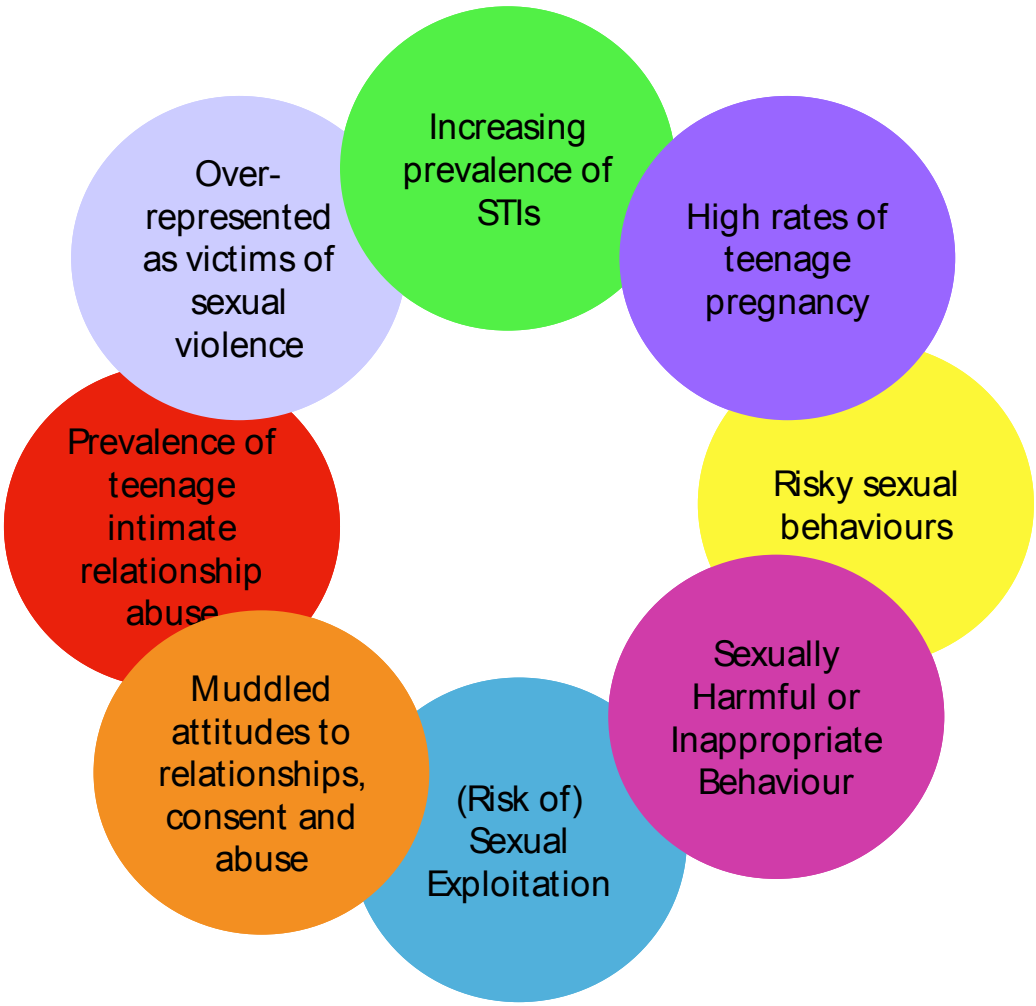
Summary of Needs - Issues affecting young people's sexual health and wellbeing in Peterborough

Adolescence is a time of exploration, experimentation and risk taking behaviour as young people begin to develop intimate relationships with others and become sexually active.

In an ideal world, all young people would enter adolescence with the knowledge and resilience to develop respectful, loving intimate relationships and safe sexual practices. However, a significant proportion of local young people do not, resulting in a number of issues. These issues are set out below and have been identified through consultation with young people and the professionals working with them. They have also been informed by local datasets and academic research. The prevalence of these issues is explored in the following pages.

Figure 3: Current issues affecting young people's sexual health and wellbeing in Peterborough



Increasing prevalence of STIs

The prevalence of STIs is increasing and presents a key challenge for public health. Young people aged 15-24 experience the highest rates of STI diagnoses. Young people are also more likely to become re-infected with STIs (In Peterborough an estimated 6.7% of 16-19 year old women and 3.6% of 16-19 year old men treated for an acute STI by the GUM clinic in 2009 were re-infected within 12 months). Prevention efforts such as greater STI screening coverage and easier access to sexual health services should be sustained with greater focus on at risk groups.

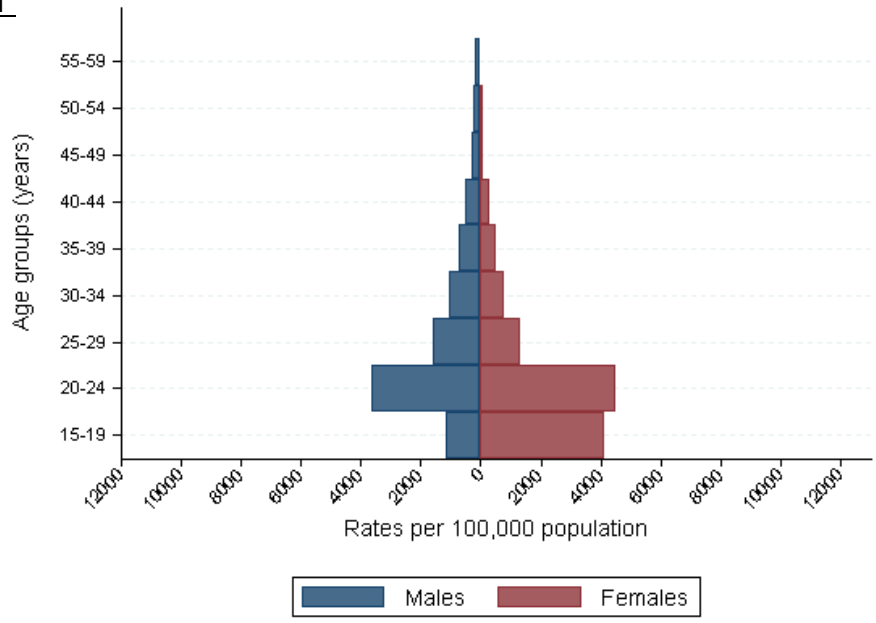
Chlamydia is the STI typically associated with young people. However rates of other less common STIs are on the increase particularly amongst young heterosexual people and gay and bisexual men. Nationally, rates of infectious syphilis are at their highest since the 1950s. Gonorrhoea is becoming more difficult to treat due to its ability to quickly develop resistance to antibiotic treatment[i].

Prevention of HIV remains a public health priority for local authorities. Early diagnosis is critical to reduce the spread of HIV in the local population. In 2011 47% of people diagnosed with HIV in the UK were diagnosed late.

Who is most at risk?

- Young people aged 15-24, young women in particular (no condom usage)
- Associated risk factors include deprivation, alcohol use, drug use and sexual violence
- Heterosexual males (compared to gay men)
- Nationally, Black African communities are associated with higher rates of STIs

Figure 4. Age group and gender of cases of acute STIs in Peterborough: 2011[ii]



Source: Data from Genitourinary Medicine Clinics and community settings (for Chlamydia only)

Local prevalence 2011
A total of 1232 acute STIs were diagnosed in Peterborough last year, a rate of 710.4 per 100,000 residents. Young people aged 15-24 accounted for 59% of all diagnoses locally. Rates of Syphilis (once relatively low) have more than doubled since 2009 and are above national and regional averages. Rates of Gonorrhoea have increased slightly since 2010 but re-infection rates amongst women in Peterborough are nearly double the national average (9.1% versus 3.8%). A HIV test was offered in 74% of attendances and a HIV test was done in 61% of attendances at GUM clinics by the residents of Peterborough. Nationally 77% of attendances at GUM clinics were offered a HIV test and a HIV test was done in 62% of attendances.
Peterborough has the 4th highest rate of Chlamydia diagnoses in the region (2201.7 per 100,000) whilst we should be aiming for a higher diagnosis rate of 2,400 per 100,000. A quarter of 15 – 24 year olds were tested for Chlamydia with a 9% positivity rate.

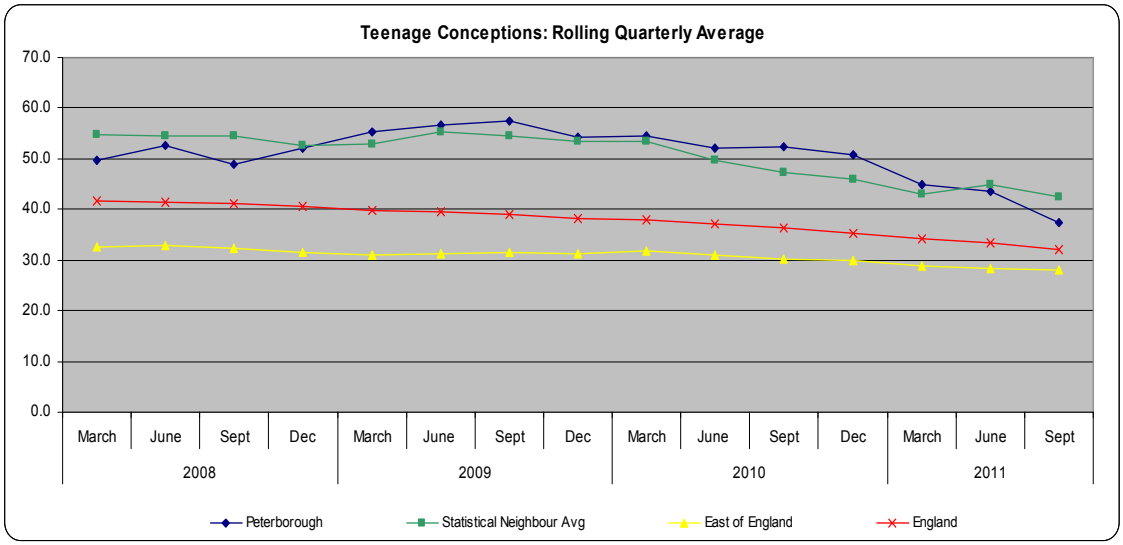
Please refer to the Health Protection Agency's report for a complete STI epidemiology for Peterborough.

High rates of teenage pregnancy

Peterborough's historically high rates of teenage pregnancy have fallen recently but remain above national and regional averages (see figure below). The negative impact on outcomes for both mother and child are well documented including increased rates of infant mortality, post-natal depression and living in poverty.

Research shows some young women who have terminations continue to have unprotected sex despite knowing the consequences and not wishing to become pregnant. Others have poor understanding of their fertility, leading to inconsistent contraceptive use and some struggle to use their preferred method of contraception effectively (e.g. the pill and condoms)[iii]

Figure 5: Comparative Analysis of Teenage Conceptions (Source: Office of National Statistics)



Nearly half of pregnancies (to women of all ages) are thought to be unplanned and the numbers of terminations have remained stable. However, the number of repeat abortions has risen during the last decade. Nationally in 2011, 26% of women under 25 having a termination had one or more previous abortions[iv].

Who is most at risk?

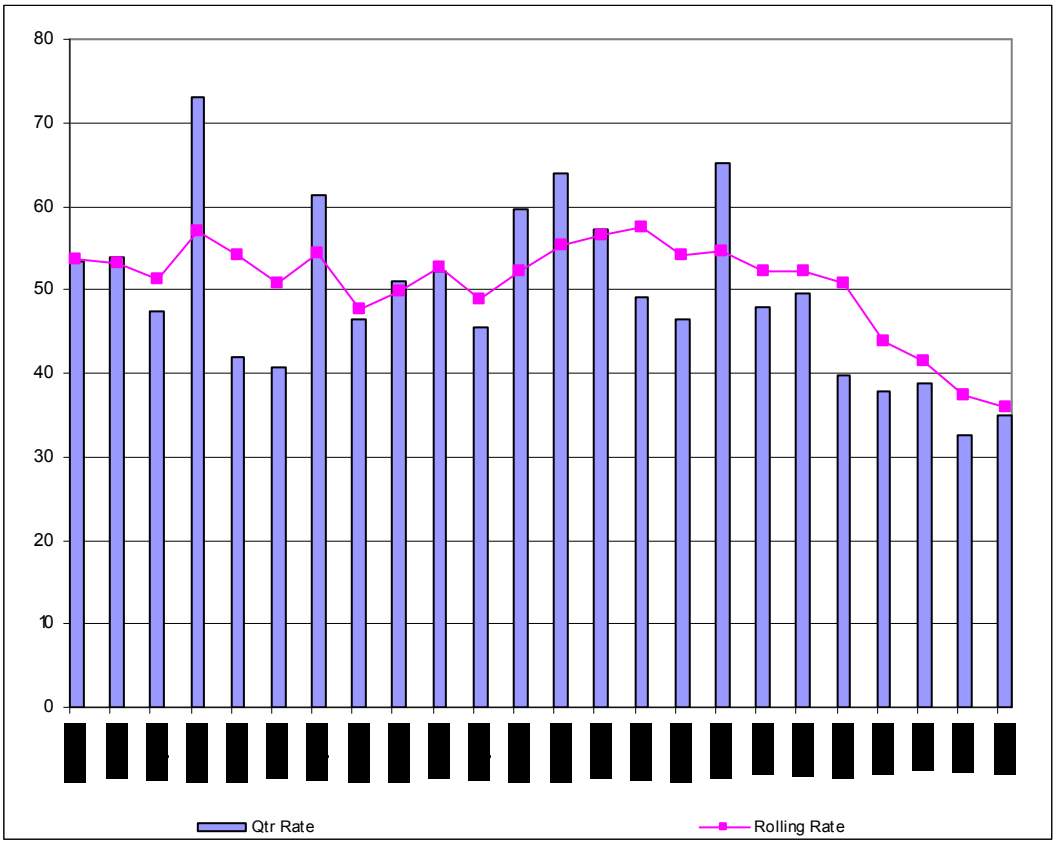
Associated risk factors for teenage pregnancy include:-

- living in a deprived area (four times more likely to become teenage parents)
- In or leaving care (three times more likely)
- Low educational attainment (twice as likely)
- Involvement in crime (twice as likely)
- History of sexual abuse (twice as likely)
- Daughter of a teenage mother
- Not in employment, education or training
- Low aspirations
- Poor school attendance/truancy
- Emotional/mental health problems

Historically, the overwhelming majority of teenage pregnancies in Peterborough were to White British young women. However, as the local community grows increasingly diverse professionals report early sexual activity and teenage parenthood amongst some newly established communities and ethnic minority groups (Lithuanian, Latvian and Portuguese) where it is culturally more acceptable.

Local prevalence
The latest data from the Office of National Statistics for December 2011 shows that the number of conceptions is remaining stable at a low rate of 34.9 in the quarter. The rolling quarterly average for 2011 is 36.0, which is what is used to compare to published data; the statistical neighbour average for the same period is 40.3 and England 30.9. Peterborough is between these two averages.
A complete set of local termination data was not available at the time of writing

Figure 6: Peterborough's rate of teenage conceptions per 1,000 females aged 15-17[v]



Risky behaviours and unsafe sexual practices

Alcohol and drugs

The links between alcohol and risky behaviour are well reported. Also, alcohol and drugs are commonly used during the grooming process of child sexual exploitation (CSE), either as payment or 'gifts'. Professionals reported the use of cocaine as a 'love drug' to make young people more receptive to sexual activity.

Local prevalence
Although alcohol admissions for under 18s in the city are below the national average professionals report a high prevalence of risky behaviours linked to alcohol. In particular is the 'YOLO' statement (you only live once) used as justification for risky and unsafe behaviour amongst young women identified by DrinkDrugSense through their work in HYPAs. The demand for alcohol education is clear. In one quarter alone over 727 pupils received alcohol risk information through HYPA clinics and a further 24 received brief interventions for problematic alcohol use.

Contraception

Contraception is vital to prevent pregnancy and transmission of STIs. In recent years, the investment has been made in promoting long acting reversible methods of contraception (LARC) to young people and making it more accessible.

Local prevalence
It is not possible to ascertain if young people's uptake of contraception has changed in recent years due to the way data is collected. We do know that the number of young people accessing the CaSH service has increased significantly following its relocation to Rivergate. The rate of emergency contraception (EHC) issued by the CaSH service has more than doubled between 2009 and 2012. HYPA clinics reached 3464 young people aged 11-19 in 2011/12 mainly for C-Cards and general advice. There has also been a steady increase in the uptake of LARC amongst young people.
Professionals report despite being signed up to the C-Card scheme, many young people still lack the motivation to use the condoms provided. Without condom usage, those fitted with LARC are not protected from the transmission of STIs and HIV. Local CaSH services report a wide range of risky sexual behaviours including 'text for sex' arrangements for casual sex, prevalence of multiple partners and a cohort of young people with multiple partners who refuse STI screening or contraception. This suggests risky sexual practices and a lack of motivation to use contraception are key issues to be addressed.

Victims of Sexual Violence and Abuse

Sexual violence encompasses a range of sexual offences against children and young people in a variety of contexts including:-

- sexual abuse at the hands of family members or other trusted adults
- highly publicised 'stranger' child abductions
- sexual violence/exploitation following internet/social media grooming
- sexual bullying and sexual violence perpetrated by peers, gangs and in teenage intimate relationships

Developments in online and social media present another context in which young people can become both victims and perpetrators of sexual violence, exploitation or abuse. Cyber-bullying in which peers post/circulate explicit images or videos of other young people is one common example. The CSEGG Inquiry has highlighted high levels of gang/group related acts of sexual violence between young people.

Sexual abuse can impact negatively on sexual behaviours in later life and increase propensity towards revictimisation. Sexual abuse in childhood is associated with high risk sexual behaviours in adolescence and adulthood including earlier onset of sexual activity, multiple partners and unprotected sex[vi]. Research shows those who experience rape or attempted rape in adolescence are nearly 14 times more likely to experience rape or attempted rape in their first year of college (age 18)[vii]. The most serious forms of sexual abuse (penetrative assault) are also associated with increased prevalence of prostitution[viii].

Theories suggest sexual abuse and violence interferes with social and emotional development, in turn creating negative coping behaviours and a lack of risk awareness[ix]. Timely, effective therapeutic support for victims can help to prevent further victimisation in adolescence and adulthood.

Who is most at risk?
Young women are at greatest risk of sexual assault[x]

Local prevalence
Children and young people make up a significant percentage of sexual offence victims. Over a third of all reported rapes are against children under 16 (36%)[xi]. An estimated 42% of victims of police reported serious sexual offences in the city between November 2011 and 2012 were under 18 with sexual assault being the most common offence. **The exact number of children and young people affected by sexual abuse and violence is not known. However we do know in 2012, 60 children and young people were seen at the SARC (of which 10 were under 13 and 50 were 13-18).**
The numbers of children on child protection plans with a category of sexual abuse range from around 8-14 in a year. They include both genders and ages range from under 1 to over 16.

Teenage Intimate Relationship Abuse (TIRA)

Teenage intimate relationship abuse refers to the domestic abuse that occurs between young people in (or previously in) intimate relationships. In line with the national definition of domestic abuse TIRA includes controlling, coercive or threatening behaviour, violence or abuse which may be psychological, physical, sexual, financial or emotional. It includes 'honour' based violence, forced marriage and female genital mutilation.

Domestic abuse between young people in intimate relationships is a growing child welfare issue. According to the British Crime Survey, young people aged 16-19 are the most likely to suffer abuse from partners. However research undertaken by the NSPCC suggests 13-15 year olds are just as likely to experience partner violence as those aged 16-19.

NSPCC research in 2009 found a quarter of girls and 18% of boys reported some form of physical partner violence and a third of girls and 16% of boys reported some form of sexual partner violence. Emotional partner abuse was widely reported by both sexes.

High levels of coercive control were noted. Surveillance via social media, online activity and location tracking was widely reported and one of the main instruments used to control and coerce partners.

The survey also highlighted the increased incidence of domestic abuse where girls have a boyfriend 2 years or more older. In these cases, 66-80% of girls reported experiencing emotional, physical and sexual partner violence.

Both national and local surveys have found the majority of young people would not report abuse to an adult or even friends.

Who is most at risk?

- Females 13-19
- Have an older boyfriend (2 years+ older)
- Same sex couples
- Generally White British with White Other (Lithuania, Poland, Portugal and Lativa) over-represented (based on local adult victim profile)[xii]

Local Prevalence
One in six teenage girls reported intimate partner violence[xiii]. However, it is likely to be an under-reported issue with demand for services for victims and perpetrators increasing as awareness grows. **In 2011-12, the Independent Domestic Abuse Advisor (IDVA) service which supports high and very high risk victims worked with 6 victims under the age of 18 (equivalent to 0.5% of overall caseload). The actual number of low, medium, high and very high risk victims under 18 is not known.** **There is no local profile of young people who are abusive or victims of domestic abuse.**
Young people aged 18-21 accounted for 18% of all Community Orders for domestic abuse cases in 2011-12. During 2011-12 the Specialist Domestic Violence Court successfully prosecuted 1 male under 18 and 44 aged 18-24. A further 18 prosecutions against young people aged 18-24 were unsuccessful. Two females

aged 18-24 where also successfully prosecuted. [xiv]

Muddled attitudes towards relationships, consent and abuse

" I've been raped so many times I'm addicted to sex"

National and local research along with feedback from professionals clearly shows many young people have confused understanding of what constitutes a healthy relationship. This may stem from a lack of appropriate intimate relationship modelling at home, prevalence of domestic abuse and the impact of learning disabilities on young people and/or parents' understanding of healthy relationship norms. It may also relate to wider societal factors such as easy access to (extreme) pornography through the internet and increasing sexualisation of media and advertising.

The legal framework around sexual activity (consent in particular) is not well understood. A significant percentage of young people (boys in particular) do not understand the law in relation to age of consent or the inability of an intoxicated female to give consent, thereby placing themselves at risk of committing offences. The wider definition of rape is not well understood (in that it now includes oral and anal rape).

There is widespread acceptance of abuse, (sexual) violence, coercion and control as norms of relationship behaviours. For example, 40% of boys surveyed locally did not think pressuring someone into sexual acts against their will was abusive[xv]. Many also minimised their use of violence as 'messing around'. Professionals report working with a minority of young people who are 'de-sensitised' to rape and interpret it as sex.

NSPCC research found that girls were unsure of the difference between caring concern and coercion. High levels of self blame where reported amongst girls who had been sexually coerced by their partners and feeling too scared to challenge. Surveillance of partners through online, social media and mobile telephones was considered normal. There is little recognition of the emotional, sexual and financial forms of domestic abuse.

Who is most at risk?

Associated risk factors may include dysfunctional family, exposure to domestic abuse, history of abuse and or violence, susceptible to negative peer and media influences, lack of positive role models, accurate information and resilience factors

(Risk of) Sexual Exploitation

Child sexual exploitation (CSE) occurs when children and young people engage in sexual activity often in return for gifts (money, alcohol, drugs, mobile phones etc) or 'affection'. The child/young person may consent but in reality has little choice. Violence, coercion and intimidation are commonplace, as are exploitative relationships in which the adult has significant power over the child/young person. CSE is a form of abuse.

CSE can occur in a number of contexts[xvi]:-

- through inappropriate relationships (where there is a significant age gap or power imbalance)
- Boyfriend model in which a perpetrator befriends and grooms a young person into a relationship before coercing them into sexual activity with associates
- Peer model in which sexual coercion occurs through peer groups or gangs
- Organised exploitation/trafficking in which young people are passed through networks and geographical areas and coerced into sexual activity with multiple men

Who is most at risk[xvii]?

- Young people aged 10-15
- Girls (six times more likely than boys)
- Have boyfriend more than 2 years older
- Experienced recent bereavement/loss
- Living in dysfunctional family
- Experienced sexual or other forms of abuse (sexual re-victimisation in adolescence appears to significantly increase the risk of sexual assault in adulthood[xviii])
- Peer or gang association with or attends the same school as young people who are sexually exploited
- Homeless or in temporary accommodation
- In residential care
- Young carer

National research suggests that young people involved in CSE have significant physical and emotional health needs too. Drug and alcohol use was found to be common, with dependence an issue for several. Many report significant mental health issues including self injury and depression along with being underweight and experiencing sexual assaults and unintended pregnancies[xix].

Sexually Harmful or Inappropriate Behaviours

Some children and young people display inappropriate or harmful sexual behaviours towards their peers or others in society. In many cases developmental issues, learning disabilities or a lack of appropriate parenting contribute to inappropriate sexual behaviours. Early intervention can support these children and their families in changing their behaviour.

However nearly half of adult sex offenders show the onset of sexual deviance in puberty and begin offending in adolescence. Specialist interventions are needed to manage this very small number of children and young people to prevent them becoming adult perpetrators in the future.

Who is most likely to exhibit inappropriate/harmful sexual behaviour?
(a.) Males aged over 11 (peak age of offending nationally is 15)

(b.) Children/ young people with Learning difficulties/disabilities or Autistic Spectrum Disorder[xx]

(c.) Children and young people who have been sexually, physically or emotionally abused[xxi]

How well does the current system meet the needs identified?

A SWOT analysis was undertaken and the strengths of the system are identified below.

Integrated and community approach to service delivery

Reproductive and sexual health services in Peterborough operate through an integrated model of provision including GPs, Walk In Centre and CaSH Service who offer a full range of contraceptive and STI screening services. The GUM department provides services from a hospital setting. This predominantly community based approach promotes ease of access and reduces stigma.

The relocation of the CaSH service from Wellington Street to the more modern and visible Rivergate complex has resulted in increased numbers of young people attending the service. The opening of Primark has drawn more young people to the city centre and a correlating increase in CaSH attendance, suggesting a highly visible city centre location is popular with young people

Easy access to termination services

Self referral routes for terminations are in place to avoid delay and offer improved accessibility and increased patient choice.

Improved support for victims of sexual violence

The Sexual Assault Referral Centre (SARC) has been in operation since 2009 set up in partnership with Cambridgeshire Constabulary and the NHS covering Peterborough and Cambridgeshire clients.
The local SARC has been a centre of excellence for partnership working to date, managed by the CASH service, however the responsibility from 1st April 2013 for commissioning of SARC lies with the National Commissioning Board and new links are currently being forged. Alongside this, there are independent sexual violence advocates to provide support to adult victims.

Robust approach to STI screening

There is a coordinated approach to STI screening as the Chlamydia Screening Programme and HIV prevention is now provided by the CaSH service (following withdrawal by Terence Higgins Trust). HIV testing is widely available for easy access through GPs, CASH and GUM services and is routinely carried out at the Maternity services. HIV testing is offered routinely with an 'opt-out' approach to all pregnant women at Peterborough City Hospital.

Young people can access STI screening and treatment through a community setting with familiar staff such as a HYPA or at the CaSH office rather attending than a hospital setting. All young people screened under through the Chlamydia Screening Programme are tested for Gonorrhoea. Results are coordinated through the CSP and treatment can be provided in community settings like HYPAs or CaSH if young people prefer.

Additional services for young people

An additional layer of interventions are targeted to those under 25, given the high proportion of STIs amongst this age group and the city's high rates of teenage pregnancy. The CaSH service has a small dedicated young people's team. Collectively they provide and coordinate:-

- A dedicated contraceptive nurse for females under 18 who have undergone terminations, miscarriages or given birth to prevent unintended repeat pregnancies
- Specialist outreach and school based clinics for young people (known as HYPAs)
- Dedicated condom distribution scheme for young people (known as C Card scheme)
- Input into sex and relationship education in schools
- Training for other professionals including schools, youth and community settings

Improved access to long acting methods of contraception

As part of the Teenage Pregnancy Strategy, long acting methods of contraception have been promoted to young people since 2009. As a result, up take has been steadily increasing. LARC fitting training and a GPSI (GP with Specialist Interest) clinic have resulted in an increased range of providers offering LARC. Further local LARC training for GPs and Practice Nurses is planned with a view to further increasing patient choice and access Further investment to improve LARC uptake has been commissioned through CaSH services which is community based and accessible to young people. In addition to be supported by by a GP champion with special interest and supported by nurse led clinics. As a result this will improve inappropriate referrals to Gynaecology department and provide consistency in provision of LARC via GP surgery or CaSH.

School based sexual health services

Most secondary schools host a HYPA clinic which provide easy access to contraception and sexual health services, information and advice. HYPAs also facilitate swift and easy access onto other services including CaSH, GUM, termination services and drug and alcohol treatment.

HYPAs are trusted and well attended by young people. Consistent staffing of HYPAs allows young people to build trusting relationships with staff and feel comfortable disclosing sexual violence, exploitation and abuse.

Easy access to free condoms

The C-Card scheme gives young people the opportunity to access free condoms easily around the city, including schools. Every young person signed up to the scheme receives good quality sexual health promotion as well as information on correct condom use. The C-Card scheme operates closely with the Chlamydia Screening service and CaSH service to give young people swift and easy referral into full sexual health services if required.

Recognition of domestic abuse

The needs of young people are visible in the Safer Peterborough Partnership's Domestic Abuse Strategy 2012-15. They include:-

- Improving input into local schools
- Provision of services for young people as victims
- Consultation with young people about their views and experience of domestic abuse

The priorities also focus on prevention and awareness raising, improving support services for victims and developing joint commissioning arrangements. Probation and Youth Offending Services are currently developing domestic abuse interventions for young adults aged 18-21 and 16-18 respectively.

Joint strategic response to Child Sexual Exploitation

Peterborough's response to child sexual exploitation has been rapid. Effective partnership working has resulted in the development of a clear procedures and identification tools. Joint working arrangements between the police and Children's Services for potential CSE cases are in place, along with a regular panel to allocate support services to victims and their families. The development of a Multi-Agency Referral Unit (MARU) 'Hub' in Peterborough will greatly improve intelligence gathering and action against child sexual exploitation.

Services for children and young people exhibiting sexually harmful or inappropriate behaviour

A pathway has been recently developed for children and young people demonstrating harmful or inappropriate behaviour. It is multi-disciplinary, working across Youth Offending Services, Children's Social Care, Adolescent Intervention Services and the Problem Sexual Behaviour Multi-Systemic Therapy (MST-PSB) team. A new policy is being developed to support this and briefings undertaken with local school headteachers.

Collaborative working

Historically, the local authority and NHS Peterborough have worked closely together on the teenage pregnancy agenda. This partnership approach continues as Public Health becomes part of the local authority. Effective joint working between Children's Services and Public Health, commissioners and providers means working together to make sure services are most responsive to young people's need.

Weaknesses

Shortage of Services

The consultation with professionals identified a number of gaps in provision:-

Lack of specialist psychological treatment for child and adolescent victims of sexual abuse or violence
Currently, there is no service in place to provide specialist treatment modalities for children and young people who have been victims of sexual abuse or violence through the SARC, CAMHs or any third sector organisation.
Lack of independent support/advocacy for children and young people (and their families) affected by sexual abuse, violence and exploitation
The SARC currently employs 1.5 Independent Sexual Violence Advisors (ISVAs) to work with adults but none to work with children and young people. The Department of Health includes Child ISVAs in its care pathway guidance[xxii]
Lack of independent support/advocacy for young people affected by teenage intimate relationship abuse
Independent domestic abuse advocates (IDVAs) provide advocacy, support and risk management advice to people experiencing domestic abuse. Currently, there are 2 IDVAs to work with adults and non to work with young people.
Lack of interventions for perpetrators of teenage intimate relationship abuse
There are no targeted level interventions to work with young people who are perpetrators of domestic abuse nor is there a specific evidence based intervention for convicted young perpetrators (such as an equivalent to the IDAP programme provided by Probation).
Shortage of sexual health promotion, education and early intervention
Following the loss of the Sexual Health Education Project (SHEP) there is limited PSHE enhancement by local agencies. Professionals report very little (if any) preventative or early intervention services for teenage intimate relationship abuse, sexual violence or sexually harmful behaviour. This is at both a targeted and universal level.

Limited access to CaSH services

According to You're Welcome, young people's CaSH services should be accessible and at times convenient to them. That means 7 days a week and at times and locations best for young people. Although 7 day a week access to free contraception is available through the integrated model of provision not all are necessarily young people friendly. However this will be addressed through new contracts for CaSH services and anticipated improvements.

The CaSH service currently operates 16.5 official hours of clinic time over 4 days (including Saturday mornings and some evenings) from its city centre base. Reception is open Mon-Fri 9-5 for appointments and condom collection. If a patient drops in outside of clinic times they will be accommodated if a nurse is available but this is described as 'hit and miss'. There is limited doctor availability and additional services tend to be ad hoc (for example nurse led LARC sessions).

HYPA clinics are term time only leaving a significant gap in holiday time. Outside of these times, young people must seek out alternative services which can be especially difficult at weekends or during school holidays.
We must remember that not all young people are motivated or confident enough to seek out alternative services such as GPs or the Walk In Centre so may go without.

HYPA Clinics – accessible and sustainable?

HYPA clinics are dedicated clinics for young people, mostly based in school settings. They are intended to be general health clinics which also offer sexual health and contraceptive services. Sustainability issues in other services such as School Nursing, and the 0-19 service has resulted in fewer agencies being present at the clinics. The CaSH service along with DrinkDrugSense (who are contracted to deliver in HYPAs) now 'hold' the HYPAs together. The commitment of other agencies is unclear meaning the HYPAs are not sustainable. There is no spare capacity to grow further HYPA clinics.

HYPAs are in most but not all secondary schools. One or two of our secondary schools with high need do not have any form of HYPA clinic. Specials Schools and alternative learning settings do not have HYPA clinics suggesting there is inequality of access, particularly amongst vulnerable and disadvantaged groups.

Sustainability of paediatric service for child victims of sexual violence

Historically, the acute paediatric service for child victims of sexual violence at the SARC was provided by CPFT. This service is currently being provided by the Forensic Medical Examiners (G4S) whilst a sustainable, long-term solution is being explored. Young people over 13/14 are also seen by FMEs at SARC. A routine child protection clinic delivered by CPFT has ceased but a long-term solution is being explored.

Limited health promotion and service publicity

Health promotion and service publicity is limited due to lack of capacity. Until 2010, Peterborough benefitted from a multi-agency Sex Health Education Project (SHEP) and Sexual Health Education Outreach Project (SHOP). SHEP and SHOP provided a coordinated programme of education, health promotion and targeted outreach for young people. It was delivered by youth workers, CaSH nurses, School Nurses, Drug and Alcohol Workers and HIV workers. It was offered free to schools and undertook an annual calendar of outreach events. In doing so, it engaged vulnerable groups and publicised local services directly to young people.

The capacity issues affecting CaSH mean there is limited health promotion work or service publicity. DrinkDrugSense are currently funded to promote the 'Z Card' service directory for young people via a separate alcohol contract with Public Health.
There is no annual calendar of events to raise awareness or promote services to young people. Feedback from some direct consultation with young people, particularly those who are vulnerable or newly arrived show a lack of awareness of where to access CaSH services.

Targeting of at risk groups

It is unclear from data returns how well sexual health services engage with at risk and diverse groups. There is limited evidence of targeted or differentiated approaches to publicity, health promotion and service delivery. Delivery is characterised by universal or open access settings which may exclude young people with physical, cultural, learning or communication barriers.

Services need to demonstrate a more proactive approach to engaging and meeting the specific needs of vulnerable young people. Innovation is needed to reach out to at risk groups and make better use of alternative settings in the community rather than relying on schools alone.

Variable quality and content of PSHE in Secondary School

Schools are required to deliver the basic biology of reproduction and contraception. Inclusion of wider sexual health and wellbeing topics depends on the school and can

vary significantly in content and quality. Since SHEP ended, there has been no coordinated multi-agency input into PSHE offered to schools. Instead, schools opt to spot purchase input (or not) from local agencies.

Professionals have noted concerns about the rigour of SRE for pupils with learning difficulties and disabilities (both in mainstream and special schools). They felt input wasn't suitably tailored to the level and learning styles of this particular cohort. One Special School has developed excellent partnership arrangements with the CaSH service and School Nursing Service, this should be reflected across all settings.

Informal discussions with some local secondary schools suggest there is a worrying lack of awareness of emerging sexual health and wellbeing issues including CSE, sexual violence and teenage intimate relationship abuse. Schools would welcome briefings guidance and materials to ensure their PSHE content was reflective of current issues

Unclear if sufficient support is available for children and young people affected or infected with HIV

Until April 2013, Peterborough had a specialist HIV service in Adult Social Care, part funded by Children's Services. It undertook significant work with children and young people affected by HIV (e.g. where a parent/carer has HIV) and for children infected with HIV. The service ended and its work is now undertaken by Adult Social Care. There is a significant risk that the needs of children and young people affected or infected with HIV may lose visibility in an adult only service. This would limit any early intervention to support vulnerable children and HIV prevention public health work. We must ensure sufficient provision and clear pathways to support children affected or infected with HIV is available and actively used by all services.

Visibility of sexual health and wellbeing issues in safeguarding policies/practices

There is limited use of CAF and Team Around the Child to identify and support vulnerable young people with sexual health and wellbeing issues. This is particularly important for health professionals such as CaSH Nurses and School Nurses who may be first approached by young people for advice or treatment. Completion of CAF/TAC are essential to identify and tackle the causes of young people's risky behaviours that are a 'cause for concern' but do not reach safeguarding thresholds.

There is a lack of awareness amongst the children's and wider workforce of CSE, teenage intimate relationship abuse, sexually harmful behaviour and sexual violence.

There is no LSCB safeguarding guidance in relation to teenage intimate relationship abuse. LSCB guidance and safeguarding training should be revised to include sexually harmful behaviour, teenage intimate relationship abuse and sexual violence. Action is needed to raise awareness of these issues as safeguarding issues amongst wider settings including schools, GPs and hospitals. There is a need for 'whole school' awareness, not just the designated Child Protection lead.

Complex Commissioning and Delivery Model

The future landscape will operate in a four tiered commissioning structure. In addition to the formally designated commissioners (Local Authority, Clinical Commissioning Groups and National Commissioning Board) schools and third sector agencies will increasingly function as grassroots commissioners, purchasing and developing services themselves.

With the range of providers involved and multiple layers of commissioners, it is possible the wishes and preferences of local children and young people may be lost. Strategic

coordination, partnership working and involvement of children and young people in service design and delivery is needed to prevent this from happening.

Informatics and performance monitoring

It is difficult to obtain overall figures of young people's contraceptive and sexual health uptake due to the number of providers, different data collection methods and lack of a common dataset. This makes analysis of service demand, uptake and waiting times difficult. A more robust system which includes recording of age, gender, ethnicity, sexual orientation would be more informative for future service planning and commissioning.

At present, there is no Home Office code for CSE making identification and recording difficult. The Safer Peterborough Partnership has already identified the need to develop an offender profile analysis for CSE.

What do young people think?

Young people were asked about their experiences of sex and relationship education (SRE) through discussions and a simple questionnaire completed in youth clubs and HYPA clinics.

A total of 47 surveys were completed by young people from aged 11-20. The findings echo earlier, national surveys in many ways. Most young people rely on school as their main form of education about sex and relationships, followed by friends, the media and internet. This reinforces the importance of school-based SRE as the accuracy of the other SRE sources is variable. Few benefit from family or parent provided SRE.

Nearly all young people surveyed had received SRE and assessed it's quality as average to good. However, its not clear if this refers solely to school delivered SRE or additional input through youth clubs and HYPAs.

When asked where they would like to go for SRE HYPAs, sexual health centres and health clinics were more popular amongst those who already attended HYPAs. Those surveyed in youth clubs preferred youth clubs and sexual health clinics. This may reflect the trust and credibility built through forums such as HYPAs and youth clubs. A small number of respondents would like to go to their GP surgery. In terms of professionals, young people unanimously prefer school nurses, sexual health nurses and youth workers to deliver SRE than teachers.

More in depth discussions were held with the Youth Council, girls youth group, PYA Pakistani youth group and Voyager Dance & Century Arts group.

The Youth Council felt the quality of SRE is not good enough, that 'you are lucky if you get a teacher who can deliver it without being embarrassed and muddling through it'. Where positive experiences of SRE exist it is often due to outside agencies coming in to deliver. However, this 'whole school in one day' approach can mean students who are off miss out. Emphasis on staff training is needed, along with embedding SRE as a core part of PSHE curriculum – a curriculum for life.

Feedback from the girls group (which targets girls with risky behaviour) suggests they do not recall any of the SRE they received in Year 8. They did not know where to get tested/treatment for STIs and discussed pregnancy and abortion in a very casual sense, suggesting they did not appreciate the life changing effects of either. The girls also reported feeling unable to ask questions in mixed gender SRE sessions.

The discussion of SRE for this consultation was a first at the PYA Pakistani youth group. Although a mostly male group, they still considered sex a taboo subject and were fearful of discussing due to worries about confidentiality. They preferred not to discuss with the subject with professionals who are part of the Muslim community. The youth worker suggested future sessions would benefit from professionals from outside agencies including Islamic scholars to educate young people to make informed choices, rather than relying on prohibition.

The Voyager Dance and Century Arts group has a high proportion of young males from Eastern European/Roma cultures. Prohibition of sex before marriage is a religious and cultural norm, to the extent the youth worker had been advised not to discuss the issue. However, a number of the young men have approached the youth worker for information and advice about sex. Those who have been educated in the UK recall the basic reproduction aspect of SRE in Year 8/9 and had some limited understanding of STIs and contraception. They did not know about STI symptoms or how to get free

contraception. Most of them admitted to buying condoms from toilets in Tesco's or stealing them from shops. They also had some gaps in knowledge around sex and the law, not fully understanding consent or that it is illegal to have sex in public. They also showed tolerant attitudes towards domestic abuse saying 'it's the man's job to punish a woman if she's done something wrong'.

A Facebook survey completed by over 300 young people in 2009 in the city provides insight into how we can best raise awareness of contraception. Responses centred around:-

'Show us the consequences'

- Use graphic images/pictures
- Share people's real life stories/ experiences
- Give us the stats!

'Use the media'

- Use Facebook and other social networking
- Use viral emails/ videos etc
- Advertise in public spaces with posters and leaflets aimed at young people (with humour)
- TV advertising

'Use big events'

- Bring Embarrassing Bodies or The Sex Education Show to the city
- Have fun, interactive events in the city centre with free giveaways

'Education!'

- Do SRE earlier
- Deliver better SRE – regular talks in school not by teachers, use MTV programmes like Teen Mom or 16 and Pregnant

Learning Points for Commissioners
Use school as the main forum for SRE but enhance delivery by use of School Nurses, Sexual Health Nurses, Youth Workers and other outside agencies. The teenage pregnancy pilot (2009) showed that a programme of SRE delivered in school by these professionals raised the profile and uptake of their services, including a significant increase in HYPA attendance. These professionals appear to be more trusted and credible to young people than teaching staff when it comes to sexual health and wellbeing.
Health promotion and service publicity are much needed both universally and in a targeted way. Attention should be given to reaching vulnerable young people and those of different cultures and nationalities. Messages should be tailored reflect the different cultural and religious beliefs

What should the future service landscape look like?

We want all children and young people to have the knowledge and resilience to develop respectful and loving relationships and engage in safe sexual practices when they are ready. This requires significant emphasis on prevention, building resilience and targeting of at risk groups.

The range of services we provide for children and young people must evolve to reflect this. The proposed service landscape for 2014 onwards is illustrated in Figure 8. It is based on the ambitions of the Department of Health's Framework for Sexual Health Improvement in England.

Figure 7: Ambitions (relevant to under 25 population), Framework for Sexual Health Improvement in England, 2013

Sexual health up to age 16

AMBITION: Build knowledge and resilience among young people

- All children and young people receive good-quality sex and relationship education at home, at school and in the community.
- All children and young people know how to ask for help, and are able to access confidential advice and support about wellbeing, relationships and sexual health.
- All children and young people understand consent, sexual consent and issues around abusive relationships.
- Young people have the confidence and emotional resilience to understand the benefits of loving, healthy relationships and delaying sex.

Young people aged 16–24

AMBITION: Improve sexual health outcomes for young adults

- All young people are able to make informed and responsible decisions, understand issues around consent and the benefits of stable relationships, and are aware of the risks of unprotected sex.
- Prevention is prioritised.
- All young people have rapid and easy access to appropriate sexual and reproductive health services.
- All young people's sexual-health needs – whatever their sexuality – are comprehensively met.

Prevention

AMBITION: Prioritise prevention

- Build a sexual health culture that prioritises prevention and supports behaviour change.
- Ensure that people are motivated to practise safer sex, including using contraception and condoms.
- Increased availability and uptake of testing to reduce transmission.
- Increase awareness of sexual health among local healthcare professionals and relevant non-health practitioners, particularly those working with vulnerable groups.

Our future service landscape should continue to have an early intervention and prevention focus to reduce the number of young people with STIs, unwanted pregnancies and experiencing sexual violence or relationship abuse. However, our approach to sexual health and wellbeing should become holistic, taking account of the underlying and accompanying issues which contribute to sexual risk taking and victimisation.

It is proposed to align services around a stepped care model which reflects the universal, targeted and specialist tiers in the Vulnerability Matrix. Pathways are needed to ensure access to appropriate services is clear.

The key universal foundations of our service model are:-

- High quality PSHE and SRE
- Easy access to reproductive, sexual health and wellbeing services
- Widespread sexual health promotion and service publicity

Additional targeted approaches and interventions are needed to engage and support 'at risk' groups. These include:-

- Additional learning needs
- English as an additional language and/or newly arrived
- Lesbian, gay, bisexual and transgender
- Physical disabilities
- Cultural/religious beliefs
- Gender specific needs
- Experiencing high levels of deprivation
- Homeless
- Victims of sexual violence
- Victims of domestic abuse (including female genital mutilation)
- Those who demonstrate abusive behaviours in relationships
- Drug or alcohol misuse
- Mental health problems

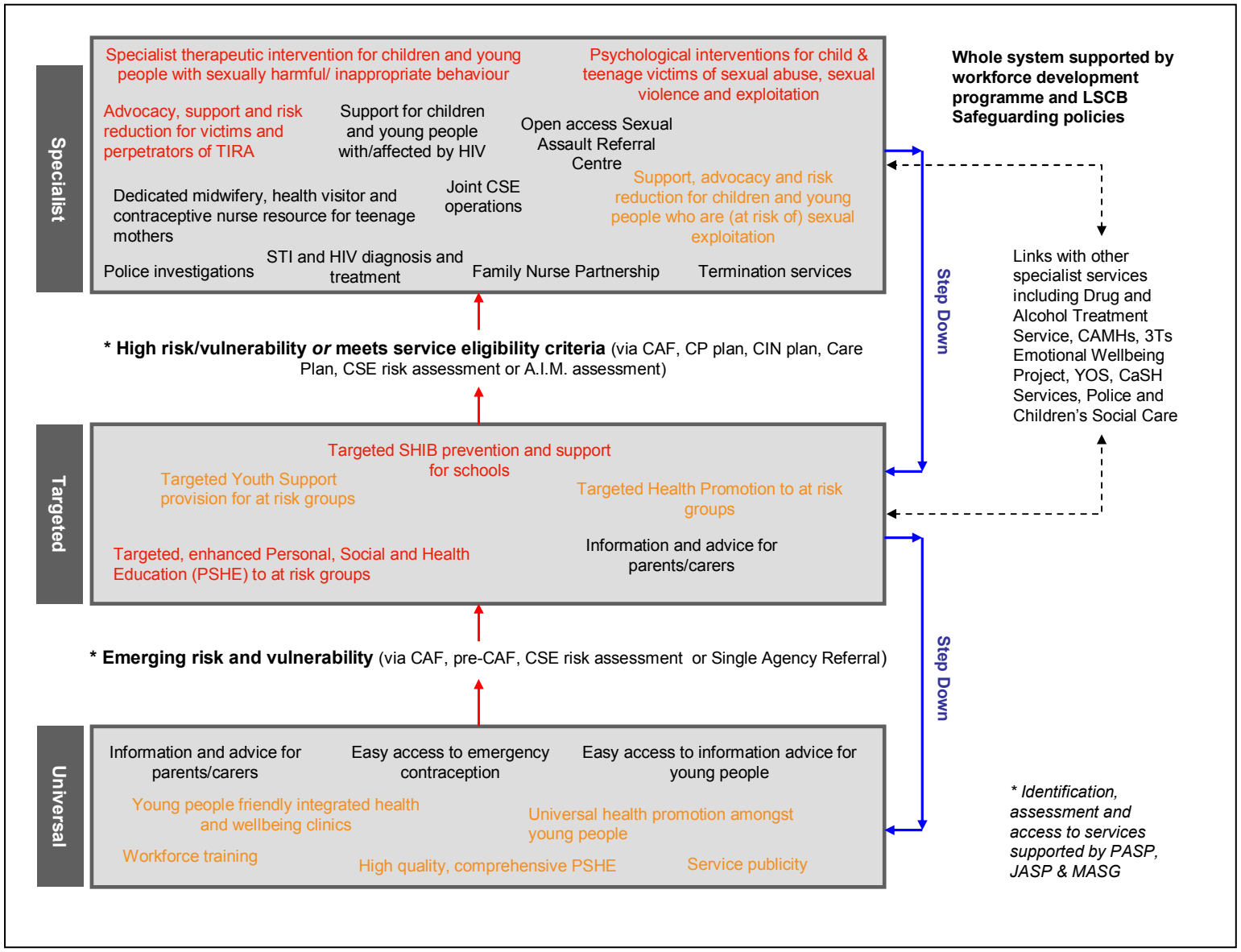
Targeted approaches should be differentiated to meet the needs of each group and take account of the risk taking and experimental behaviours associated with adolescence. Effective interventions should be based on behaviour-change theory[xxiii] and utilise the resilience [xxiv] and active choice of the young person[xxv].

We acknowledge young people are vulnerable to sexual violence and coercion by their peers (through bullying or intimate relationship abuse). Services to support young people to change abusive patterns of behaviours need to be developed.

Specialist interventions for children and young people who experience sexual violence, exploitation or relationship abuse should be developed to reduce distress and prevent repeat victimisation.

Central to our working model is effective early identification of needs and the use of recognised assessment processes to ensure young people receive the right intervention at the right time.

Figure 8: Future service landscape – young people's sexual health and wellbeing



Current gaps in provision are coloured red. Interventions shown in orange either lack capacity or require further development to meet the current needs of local young people.

Pathways need to be developed to ensure access to newly developed services is clear.

Commissioning recommendations

Develop sufficient and accessible sexual health and reproductive services for young people.
This should include:-
7 day a week and out of hours CaSH provision including:- • dedicated provision for young people during school holidays • assertive outreach and use of learning and community settings
Easier and timely access to emergency contraception and long acting contraception (including choice of provider)
Greater STI screening coverage and focus on high risk groups. Easier and timely access to STI screening and treatment. Focus on repeat screening
All provider settings to meet You're Welcome Quality Criteria
Support SRE delivery in secondary schools, specials schools and alternative learning settings (contraception, STIs, HIV prevention, delay)
Continued presence in Young People's Health and Wellbeing Clinics (HYPAs)
Further development of C-Card scheme
HIV prevention
Use of CAF and Team Around the Child/Family processes to assess need and broker support for vulnerable young people
Marketing and service publicity campaign to young people and local partners including digital/social media and assertive outreach methods
Annual programme of health promotion activity using digital/social media and assertive outreach methods
Targeted interventions (including assertive outreach) to reach vulnerable and at risk groups and tailored to the preferences of both genders
Young people's involvement in service design and development
Comprehensive data recording and analytics of demand & outcome
'Every Contact Counts' approach embedded in CaSH and primary care service specifications
Continued development of local National Chlamydia Screening Programme
Psychosexual counselling provision for young people
Increased HIV testing and prevention programmes (HPE)

Develop a multi-agency model of sexual health promotion and preventative education for young people
a. Open access YP health and wellbeing clinics in or clustered around every secondary school, college or learning centre offering information, advice and access to services for a wider range of health and wellbeing issues including:- • sexual health and reproduction, HIV, drug and alcohol use, emotional wellbeing/mental heath, obesity, smoking cessation, respectful

relationships and domestic abuse
- Meets You're Welcome
- Robustly recorded and monitored for demand and outcome

b. Targeted group, 1:1 or gender specific interventions for vulnerable/at risk young people based on behaviour change and lutogenesis approach

c. Promoted by integrated publicity campaign with annual calendar of events

d. PSHE guidance and supporting materials for schools, and list of programmes or speakers

Provide timely and effective support to children and young people (and their families) affected by sexual violence, abuse or exploitation

- Develop specialist support and advocacy service for children and young people affected by sexual exploitation, violence or abuse
- Commission clinical psychology interventions for children and young people experiencing distress as a result of sexual abuse/violence, exploitation or coercion:-
  - ✓ Provide a range of treatment modalities dependent on the child/young person's secondary problem[1]
  - ✓ Promote parental support/involvement
  - ✓ Clear, well promoted pathway to allow children quick access to therapy

Safer Peterborough Partnership and Children and Families Commissioning Board develop a comprehensive response to teenage intimate relationship abuse

- Develop targeted level interventions for young perpetrators providing education, support and risk reduction via targeted youth support
- Home Office approved intervention for convicted young perpetrators
- Develop specialist support and advocacy service for young people who are victims of domestic abuse

Review provision and pathways for children/young people affected by or with HIV

Undertake a review to identify need, current service provision and effectiveness of current pathways. Ensure robust pathways are in place with partners including midwifery, Dept of GUM, Adult Social Care, Children's Social Care, Kids (Young Carers Project), Contraceptive and Sexual Health Services and Public Health.

[1] CBT/abuse specific/supportive therapy in group or 1:1 formats for **behavioural problems**; CBT or family therapy for **psychological distress** and abuse specific/CBT/group therapy for **low self concept** - based on research by Hetzel-Riggin et al (2007)

Address sexually harmful behaviour exhibited by children and young people
Embed MST Problematic Sexual Behaviour programme and care pathway

Raise awareness of young people's sexual health and wellbeing issues
• Refresh workforce development programme to include CSE, teenage intimate relationship abuse, sexually harmful/inappropriate behaviour, STIs and risky sexual behaviour. Embed across wider partners (including schools)
• Consider dissemination of written 'briefing' for GPs and other clinical settings
• Create and embed LSCB procedures for dealing with teenage intimate relationship abuse

Development of new commissioning relationships
Establish working relationships with CCGs, schools and Local Area Team of the National Commissioning Board.

Consultation List

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Hampton College
Ken Stimson Community School
Kath Leakey, Independent Sexual Violence Advisor, Peterborough SARC
Karrryann Beeby, Public Protection Unit, Cambridgeshire Police
Darryl Freeman, Service Manager, Children's Social Care
Jenny Goodes, Service Manager, Children's Social Care
Iain Easton, Team Manager, Youth Offending Service, PCC
Alison Sunley, Head of Commissioning, Targeted Services, PCC

Young people in HYPAs, Voyager Dance & Century Arts Group, PYA Pakistani Youth Group and Central Locality girls youth group.

Bibliography

Allnock and Hynes, NSPCC, 2011, *Therapeutic Services for Sexually Abused Children and Young People: Scoping the Evidence Base*

Barnardo's, *Puppet on A String: The Urgent Need to Cut Children Free from Sexual Exploitation*

Barnardo's, *Tackling Child Sexual Exploitation*

Barter, McCarry, Berridge and Evans, 2009, *Partner Exploitation and Violence in Teenage Intimate Relationships*

Berelowitz, Firmin, Edwards, Gulyurtlu, 2012, *Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation In Gangs and Groups, Interim Report*

Blumint Youth, 2012, *Domestic Abuse: Consultation with Peterborough's Young People*

Department of Health, 2011, *Quality Criteria For Young People Friendly Health Services*

Department of Health, 2012, *Protecting People, Promoting Health: A Public Health Approach to Violence Prevention for England*

Department of Health, 2012, *Public Health functions to be exercised by NHS Commissioning Board: Service Specification no.30 Sexual Assault Services*

Department of Health, 2013, *A Framework for Sexual Health Improvement in England*

Health Protection Agency, *Peterborough Local Authority Sexually Transmitted Infections Epidemiology Report 2011*

Lalor & McElvaney, Dublin Institute of Technology, 2010, *Child Sexual Abuse, Links to Later Sexual Exploitation/High risk Sexual Behaviour, and Prevention/Treatment Programmes*

Local Government Association & Public Health England, 2013, *Sexual Health Commissioning: Frequently Asked Questions*

Lovell, E, 2002, NSPCC, *Children and young people who display sexually harmful behaviour* http://www.nspcc.org.uk/inform/research/briefings/sexuallyharmfulbehaviour_wda48213.html

McClelland, G, University of Bedford, *'Meeting the physical & psychological health needs of young people involved in or vulnerable to sexual exploitation'* PowerPoint presentation

Melrose, M, Professor of Social Policy and Applied Social Research, University of Bedfordshire, *Young People as Victims of Trafficking and Sexual Exploitation PowerPoint presentation*

NHS Peterborough, 2010, *Sexual Health Needs Assessment*

NHS Peterborough, *Review of HIV and Sexual Health Services in Peterborough 2011-13*

NICE, 2010, NHS *Provision of Contraceptive Services for Socially Disadvantaged Young People Up to the Age of 25*

North West Public Health Observatory, *Local Alcohol Profile - Peterborough*

Peterborough Safeguarding Children Board, *Child Sexual Exploitation Matrix and Referral Flowchart*

Prevent (USA), 2012, *National Plan to Prevent the Sexual Abuse and Exploitation of Children*

Safer Peterborough Partnership, 2013, *Safer Peterborough Partnership Strategic Assessment*

Safer Peterborough Partnership, *Domestic Abuse Needs Audit 2012*

Safer Peterborough Partnership, *Domestic Abuse Strategy 2012-2015*

Williams, L, 2013, *Children & Young People displaying Sexually Harmful Behaviour: Prevention and Pathways to Intervention v1.1*

Glossary

CAF	Common Assessment Framework
CAMHs	Child and Adolescent Mental Health services
CaSH	Contraceptive and Sexual Health Services
CCG	Clinical Commissioning Groups
CSE	Child sexual exploitation
EHC	Emergency hormonal contraceptive (e.g. morning after pill)
GUM	Genitourinary medicine
HIV	Human immunodeficiency virus
HYPA Clinic	Health and Young People's Advice Clinic (HYPA for short)
IDVA	Independent Domestic Violence Advocate
ISVA	Independent Sexual Violence Advocate
LARC	Long acting reversible contraception (e.g. Implant, Injection)
LES	Local enhanced scheme
LSCB	Local safeguarding children's board
MASG	Multi agency support groups
NCSP	National Chlamydia Screening Programme
NES	National enhanced service
PSHE	Personal, Social, Health and Emotional Education
SARC	Sexual Assault Referral Centre
SHEP	Sexual Health Education Programme
SHOP	Sexual Health Outreach Project
SRE	Sex and relationships education
STI	Sexually transmitted infections
TAC	Team Around the Child
TIRA	Teenage intimate relationship abuse

References

[i] GRASP 2011 Report cited in Department of Health, A Framework for Sexual Health Improvement in England, 2013
[ii] Health Protection Agency, Peterborough Local Authority Sexually Transmitted Infections Epidemiology Report 2011
[iii] Hoggart and Phillips, 2010 cited in A Framework for Sexual Health Improvement in England
[iv] Department of Health, Abortion Statistics England and Wales 2011
[v] Adapted from ONS data by Performance Management & Information Team (Children's Services), Peterborough City Council

[vi] Lalor & McElvaney
[vii] Humphrey & White cited in Lalor & Mc Elvaney, Child Sexual Abuse, Links to Later Sexual Exploitation/High Risk Sexual Behaviour and Prevention/Treatment Programmes, Dublin Institute of Technology
[viii] Fergusson, Horwood and Lynskey (1997); Zierler et al (1991); Steel & Herlitz (2005) and Widom & Kuhns (1996) cited in Lalor & McElvaney
[ix] Ibid
[x] Smith, Coleman, Eder et al: Homicides, firearm offences and intimate violence 2009/10: Supplementary Vol 2 to Crime in England and Wales 2009/10, Home Office
[xi] Cambridgeshire and Peterborough Victim and Offender Needs Assessment July 2012
[xii] Safer Peterborough Partnership Domestic Abuse Needs Audit 2012
[xiii] Ibid
[xiv] Cambridgeshire and Peterborough Probation Trust, Safer Peterborough Partnership Domestic Abuse Needs Audit
[xv] Blumint Youth, 2012, Domestic Abuse: Consultation with Peterborough's Young People
[xvi] Adapted from Barnardo's, Puppet On A String
[xvii] Adapted from The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups, November 2012.
[xviii] Lalor and McElvaney,
[xix] Gabrielle Tracy McClelland Senior Lecturer and Research Fellow, 'Meeting the physical & psychological health needs of young people involved in or vulnerable to sexual exploitation', University of Bradford
[xx] Data from Children's Services Direct Intervention Service 2011
[xxi] Elizabeth Lovell, 2002, NSPCC Children and young people who display sexually harmful behaviour

[xxii] Department of Health, 2012, Public Health Functions to be Commissioned by NHS Commissioning Board – Sexual Assault Services
[xxiii] Downing, Jones, Cook and Bellis cited in A Framework for Sexual Health Improvement in England, 2013
[xxiv] Lutogenesis – identifies 'assets' of young people with resilience to help vulnerable young people develop these 'assets' (Prof Antonovsky) cited in A Framework for Sexual Health Improvement in England
[xxv] Margaret Melrose (Professor of Social Policy and Applied Social Research, University of Bedfordshire), Young People as Victims of Trafficking and Sexual Exploitation,

SCRUTINY COMMISSION FOR HEALTH ISSUES	Agenda Item No. 5
16 JULY 2013	Public Report

Report of the Executive Director of Corporate Support, Cambridgeshire and Peterborough Clinical Commissioning Group

Contact Officer(s) – Jessica Bawden
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CAMBRIDGESHIRE AND PETERBOROUGH CLINICAL COMMISSIONING GROUP - PRIORITIES

1. PURPOSE

1.1 To update Peterborough Scrutiny Commission for Health Issues on the work on the three priority areas for Cambridgeshire and Peterborough Clinical Commissioning Group.

2. RECOMMENDATIONS

2.1 For information

3. BACKGROUND

3.1 In July 2012, members of the Shadow Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) Governing Body selected three strategic priorities for the organisation to focus on:

- Improving out of hospital care for frail older people
- Improving End of Life Care (EoLC)
- Tackling health inequalities in coronary heart disease (CHD)

This report is an update on the work of these three priority areas since Cambridgeshire and Peterborough Clinical Commissioning Group became a statutory organisation in April 2013.

4. UPDATES

4.1 Older People's Programme

4.1.1 **Background**

The rationale for change in how care for older people is commissioned and provided has been discussed many times over recent months, but it is always important to keep the reasons in mind when going through major change processes.

Significant transformation is needed to deliver the vision of 'joined up care focused around the patient' described above in the context of forecast demographic change (see figures below for 2010 – 2016)

Peterborough	Cambridgeshire
23% growth in 65+ population	25% growth in 65+ population
23% growth in 80+ population	18% growth in 80+ population
32% growth in 85+ population	22% growth in 85+ population

- Minimal, if any, financial growth in the health sector, alongside likely reductions in funding for Local Authorities.

- Shortcomings in current service provision. There is evidence of a lack of 'joined up working' between acute, community, primary care and social care organisations. The way in which services are organised is reactive to illness rather than proactive to prevent crises and maintain independence. This results in known current service issues – pressure on Emergency Departments, high occupancy in hospital beds, delayed transfers of care, extended lengths of stay in hospital, and pressure on limited resources in community and primary care services. In addition, there are issues with information sharing, financial incentives not being aligned to support effective care, and short term contracts.

- Cambridgeshire Community Services transition. In 2012 the CCG advised the Strategic Health Authority that it was not able to support progress to Foundation trust status for Cambridgeshire Community Services. The main rationale was that this would provide flexibility over future service configuration to improve outcomes in the context of significant demographic and financial pressures. This has led to the CCS Transition Programme, and whilst the main driver is our strategic focus on older people's services, we are also currently coordinating the process for determining future arrangements for other CCS functions with partner organisations (note that the Trust Development Authority may take on some aspects of this coordination role in future).

All these factors lead to the conclusion that we need to engage with providers and stakeholders to re-design how services are commissioned and provided - no change would be a very high risk option.

4.1.2 **The Programme Overview**

The first part of the programme has focused on work to specify local aims and outcomes for the future of services for older people. This work has involved many stakeholders, and the specifications reflect local issues, but some common themes have emerged such as:

- providing better care in a consistent way for patients who are at higher risk of serious illness, anticipating and preventing crises. For example, GPs being able to get rapid access to a consultant geriatrician to ask for advice over the phone about a patient who they may be concerned about which can prevent an unnecessary admission into hospital. Another example would be a responsive and robust community support service involving GPs, nurses, therapists and carers working together to offer safe care in the community for older people if a crisis occurs.

- improving care for older people when they are admitted to hospital and enabling them to return home safely when they are well enough with the right support. For example, better discharge planning by having community matrons working more closely with hospital nurses.

These are not necessarily new, but what is different is the clinical drive to **organise care around the patient by commissioning a joined up hospital and community service specifically for older people, and using NHS funds in ways which support staff to work better together.**

Focus on Outcomes

A key aspect of the Programme is its focus on outcomes: preparatory work has been carried out on the CCG's main headline outcome measures: patient reported outcomes, patient satisfaction and emergency bed days. Emergency bed days give an indication of how well health services are working to avoid unnecessary hospital admissions, reduce delayed transfers of care and emergency readmissions to hospital. Work to analyse current spend on services for older people has also been taken forward.

The next phases cover refinement of these workstreams, further engagement with stakeholders, and dialogue with providers. The programme plan is to deliver new services from July 2014.

4.1.3 Stakeholder Engagement

There has been substantial engagement to date on local visions, outcome specifications, the case for change and the overall programme. We are now entering into the next phase of dialogue on options for service delivery and funding.

Wider stakeholder engagement will be needed to set out the case for change and the overall approach, currently programmed for June – August. The Department of Health 'Gateway Review' team has reviewed the overall programme and this has helped to determine the extent of further engagement needed.

In addition to local stakeholder engagement work, a CCG wide event was held on 5th March, facilitated by Chris Ham, CEO from the King's Fund. Over 100 delegates attended from Local health care providers, health and social care commissioners, voluntary organisations and patient representative organisations.

4.1.4 Provider Engagement

As part of the process, the CCG wished to assess the level of provider interest in the opportunities to deliver older peoples services. A Provider Engagement Event was held on 16th April which was attended by approximately 100 people representing 50or more organisations, which demonstrates a strong level of potential engagement from local, national and out of area providers. The Older People Programme was presented followed by a questions and answers session, and time for providers to discuss possible collaborations. Local providers all recognised the need for major change in the context of current service issues and forecast demographic and financial scenarios.

One recurrent theme was that the provisional programme did not allow sufficient time for dialogue with local commissioners or collaboration discussions between providers, and it was recommended this phase of the programme was extended through to the end of May. The 'May roadshow' covering all LCGs and various other stakeholder groups has now been completed. The follow up Provider Engagement event was held on 21st May facilitated discussions between LCG / CCG teams and 27 individual providers, as well as providing an opportunity for continuing provider – provider conversations. One further event was held on 3rd June to accommodate discussions with more potential providers.

4.1.5 Critical Success Factors

It is very important that there is clarity regarding how success of the Programme will be measured, as this drives the assessment of options for service delivery and funding, the assessment of bids which may be received as part of a procurement process, and also informs the longer term evaluation of the programme.

Draft Success Criteria

The following success criteria were discussed at a CCG Options Workshop involving LCG clinical leads and social care commissioners, and then developed by the Programme Board for recommendation to the CCG Governing Body.

The extent to which any option or proposal will deliver the vision and specifically:

a. *Improve patient experience and service quality for older people and their carers through care organised around the patient.*

b. *Deliver services which are sensitive to local health and service need, as defined in local outcome specifications.*

c. *Move beyond traditional organisational and professional boundaries, so front-line staff can work effectively and flexibly together to deliver seamless care.*

d. *Supporting older people to maintain their independence, and reducing avoidable emergency admissions, re-admissions and extended stays in acute hospitals (including delayed transfers of care)*

e. *Deliver an organisational solution for the older people's care which can demonstrate strong leadership, sound governance, resilience, and the confidence of commissioners and provider partners*

f. *Demonstrate credible approach to engaging patients and representative groups in design and delivery of services*

g. *Provide a sustainable financial model (see financial principles below)*

4.1.6 **Creating Conditions for Investment: Length of Contract**

A key consideration in this new approach will be how to create the right conditions for investment by providers. The current 3 year standard NHS contract with annual re-negotiation does not provide an environment in which providers will feel confident to invest in (for example) improving community services with a view to deriving health outcome and financial benefits later down the line.

It is therefore proposed that a longer term contract (5 years with an option to extend by a further 2) would be offered which would provide more confidence and the conditions for providers to manage significant service improvement programmes which may take 18 – 24 months to implement.

4.1.7 **Funding Options**

The purpose of dialogue with providers is to explore and develop options which could meet the financial principles, including how financial risk is shared.

One alternative to Payment By Result and block contracts which arguably fits with the financial principles is a 'year of care' budget for older people or 'capitation budget'. There are several possible approaches, such as defining a group of patients who are at highest risk of serious illness and/or admission to hospital, assessing the annual cost and using this as the basis for funding. A simpler alternative would be a 'population approach' which takes the total annual cost for a defined range of older people's services and divides by a weighted population such as over 65's to produce an average cost per year per patient. This is based on two principles:

1. If the fundamental aim is to ensure care is organised around the patient in the most cost effective and efficient way possible, and a single organisation or provider alliance is responsible for providing that care, then they should receive funds to pay for all elements of it.

2. If the provider can use the funding as it sees fit across the whole pathway, it will have the incentive to use it effectively to achieve LCG specified outcomes and cost efficiency. This could include investment in community services and services to help patients manage chronic conditions for example.

Work is in progress to cost and model various 'year of care' funding approaches.

Feedback from engagement indicates that there is recognition that current funding arrangements need to change, and that capitation approaches have potential but also risks which need to be worked through with providers.

4.1.8 **Lead Provider**

The CCG's preferred approach is that there should be a clear 'Lead Provider' which is accountable

for delivery of the defined service scope for older people in each local system. This may be a single organisation or alliance as described previously, but our preferred approach is for Lead Providers to directly provide some patient services for older people, and that they must be capable of coordinating care both at individual patient level and through contracts with 'supplier organisations'.

4.1.9 Scope of Services

Acute hospital unplanned care and community services

The underlying principle for the programme is to join up the whole pathway. Within this the major components are **acute hospital unplanned care for over 65's and community services**. The initial scoping exercise has focused on unplanned acute hospital care for older people as the area which presents the greatest challenges locally and which we want to include in scope.

Older People's Mental Health Services

Our preferred approach is to also include **Older People's Mental Health Services** in scope on the grounds that integrating physical and mental health is one of the key themes of our OPMH joint commissioning strategy and a key OPMH priority.

Voluntary Sector Grants / Contracts

The CCG commissions a number of services from the voluntary sector which are relevant to older people's services and believes that the voluntary sector has a vital role to play in improving out of hospital care for older people in the future. Our preferred approach is the Lead Provider(s) should be responsible for commissioning services from the main voluntary sector organisations delivering services to older people, as well as being able to invest in voluntary sector provision to strengthen services. Lead Providers would need to work with other commissioning organisations to manage / develop joint funding arrangements where appropriate.

End of Life Care

End of life care is an important element of the care pathway for many older people, and is included in the CCG's preferred funding approach.

Specified primary medical services

At this point, the Care Home enhanced service is included in scope. An option to include primary care prescribing for older people will be developed as part of dialogue.

Older People – Adult Services

Estimates have been made regarding the percentage of older patients served by each CCS community service, based on samples or querying patient records. Even where this is high – such as district nursing – some patients are younger and still need the service. The CCG's preferred approach is to commission one service from the same provider, but with different funding approaches. For example, a relatively simple solution would be to apply the capitated year of care approach for the older population (over 65), with an 'adult community services premium' or 'top up' to cover the costs of providing services to the minority adult care group.

Social Care

Both Cambridgeshire County Council and Peterborough City Council have stressed that they see close alignment between health and social care leadership and frontline staff as essential for older people' services , but neither currently wish to include social care funds in any new pooling arrangement, or integrate social care staff with health provision (with some specific exceptions in Cambridgeshire). This does not preclude the possibility that social care may be negotiated in at a later stage in the contract subject to agreement by all parties.

4.1.10 Next Steps

The next steps are taking forward the procurement process (commenced 1st July), developing the next iteration of the outcome specification including outcome measures, further engagement with stakeholders and development of the contract and funding workstreams.

4.2 End of Life Programme Board

4.2.1 Background

The rationale for selecting End of Life Care acknowledged that enabling patients to die in their preferred place of death is an area in which the CCG already does relatively well, but there is significant variation across the CCG geographically and in terms of disease. In Cambridge City 38% of deaths are in hospital, whereas in Peterborough/ Fenland the figure is 48%. Whilst 40% of people with cancer die in hospital, for respiratory disease it is around 60%.

4.2.2 The Programme Board

A clinically-led programme has been established to take forward EoLC. The Programme Board met for the first time in December 2012 and subsequent meetings have been scheduled to take place every two months. The Board is chaired by a clinical lead and its voting members include patient representatives, clinicians from across the CCG, and managers. Non-voting members include representatives from provider, charitable and voluntary sector organisations.

Terms of Reference were signed off by the Programme Board in December and Board members have agreed a vision for the programme and a broad approach to the work. The role of the Board is to oversee delivery of the CCG strategy to improve EoLC whilst enabling and supporting LCGs to deliver the programme locally, and to provide an overview across the CCG. As delivery of the programme objectives will be locally driven, approach is likely to differ from LCG to LCG.

The Programme is supported by a management team which includes expertise in key business areas (clinical EoLC, public health, finance, informatics, communications, IM&T and project management). A programme plan setting out the various workstreams and timescales has been developed and a risk register has been developed and is being regularly reviewed by the Programme Management Team.

4.2.3 The Vision

At its inaugural meeting in December the Board agreed on the following vision for the programme:

> *'To optimise the experience of care for patients approaching the end of their lives (and their carers) in all settings and at all times of the day and night'*

The Programme is basing its approach on the *End of Life Care Strategy: Promoting High Quality Care for all Adults at the End of Life* and *NICE Quality standards for End of Life Care for Adults*.

4.2.4 The Programme so far

Phase 1 of the programme has recently been completed. This phase involved undertaking scoping work to inform the design and finalise the programme objectives. There were three main elements to the scoping work:

(i) GP survey

In January and February a survey was circulated to all GP practices in the CATCH, Cam Health, Hunts Care Partners, Hunts Health, Isle of Ely, Wisbech and Borderline LCGs. Practices were asked to comment on various aspects of EoLC service provision.

(ii) LCG workshops

To help facilitate local review and development of EoLC services, the Programme Management Team ran workshops, externally facilitated by Marie Curie Cancer Care, for each LCG between March and May.

Provider organisations were invited to attend the workshops and the broad remit was to identify what was working well in terms of EoLC services, what was not working well and what the LCG's ideal vision/ pathway for EoLC services was. Detailed reports were produced following each workshop giving the EoLC Board a comprehensive picture of provision and need across the CCG.

(iii) Topic specific scoping groups

The final strand of scoping work consisted of groups looking at specific areas considered by members of the EoLC Board to be of particular importance:

Topic	***Lead***	***Remit***	***Ultimate aim***
Admission avoidance/ discharge planning	Dr Stuart Shields (Hunts Care Partners)	To review discharge planning, crisis avoidance and day to day community care (including district nursing, hospital at home and social care)	Increase in community support enabling avoidance of hospital admission where this is the patient's preference
Acute/ Secondary Care	Dr Richard Partidge (PSHFT/ Thorpe Hall)	To look at the quality of palliative care in acute setting	Increased quality of EoLC in acute and secondary care settings
Support for Carers	Sandy Ferrelly (Hunts Health)	To look at the role of the carer and the support required to enable carers to perform this role effectively	Improved support to carers supporting patients in their last months/ days of life
Bereavement	Dr Stephen Barclay (CATCH)	To look at support required for those who are bereaved	Improved support and care for those who are bereaved

The results of all elements of the scoping work were presented to the EOLC Board on 5th June 2013. Draft deliverables were agreed at the meeting, and follow-up meetings will be taking place with each LCG in June and July to finalise local and CCG-wide delivery plans for EOLC.

4.3 Coronary Heart Disease programme Board

4.3.1 Background

National evidence demonstrates that progress has been made over the previous decade in reducing morbidity and mortality rates for coronary heart disease both nationally and locally. However there remains a variation in mortality rates for defined geographical areas across the CCG. (See Appendix C)

As of 1 April 2013, Clinical Commissioning Groups took on a statutory duty to *"have regard to the need to reduce inequalities between patients with respect to their ability to access health services and the outcomes achieved for them".*

This programme aims to reduce premature deaths and unnecessary emergency admissions arising from coronary heart disease in people aged under 75 years, with a focus on reducing premature death rates fastest in areas of poorest outcome ('leaving no-one behind') To reduce the inequality in coronary heart disease this programme has chosen to focus on populations resident in Peterborough LCG, Borderline LCG and Wisbech LCG and other practices identified in 20% more deprived areas across the other LCGs

4.3.2 Overall programme outcome

The overall programme outcome is to reduce the premature mortality rate from coronary heart disease in the population's resident in Peterborough, Borderline and Wisbech to the same rate as that in the rest of the CCG. The baseline for this overall outcome measure is shown as Figure 1 Appendix C.

This outcome will be monitored on a three year rolling average at 6 monthly intervals by the Public Health data team. Data can be dis-aggregated by LCG area but will be difficult to interpret for smaller LCGs because of the low numbers involved.

The programme will focus on coronary heart disease (CHD) rather than the wider remit of cardiovascular disease (CVD). However, primary prevention strategies for identifying and effectively managing risk factors will have a positive impact on both the local programme and the national CVD strategy launched by the Department of Health January 2013.

4.3.3 Programme Structure

The Clinical Lead has recently been recruited. The Board has been established and has met twice since January 2013. The Board brings together all key stakeholders including CCG and LCG representatives, public health colleagues, community and secondary care clinicians, local authority and patient representatives.

In the first two meetings the Board has:

- Agreed membership and Terms of Reference.
- Drafted a Communication Strategy and developed specific communication tools to be shared across patient forum groups, public websites and internal communications to member practices and commissioning teams.
- Reviewed the Public health evidence in more detail to quantify the impact of the major risk factors in causing coronary heart disease in our local area.
- Considered the different levels of prevention that will reduce coronary heart disease and the relative impact these factors have had on the fall in coronary heart disease mortality that has been observed nationally over the last 30 years.
- On the basis of this analysis four work streams have been identified that will focus on specific interventions highlighted as critical factors in improving outcomes and reducing inequalities for coronary heart disease.

4.3.4 **Change Principles**

The programme is underpinned by 5 change principles:

- Partnership working to address environmental risk factors
- Partnership working to address the key socio-economic factors
- Monitor modifiable risk factors and offer interventions
- Secondary prevention will be systematically offered in line with national guidance
- Systematic management of people with established disease including cardiac rehabilitation programme and access to heart failure services where appropriate.
-

4.3.5 **Programme Approach**

Appendix B, 'Plan on a Page' presents a high level overview of the programme priorities and key milestones for each work stream planned over the next 6 months.

10. APPENDICES

10.1 *Appendix A Older People's Programme Plan on a Page. pdf.*
10.2 *Appendix B Coronary Heart Disease Programme, Plan on a Page. pdf.*
10.3 *Appendix C Figures for Coronary Heart Disease Programme Board (Below)*
10.4 *Appendix D Older People's Programme on a page.pdf.*

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Overview of Older People Programme 2013-2014

Joined up service transformation in how care is provided and commissioned for older people to deliver better outcomes

NHS
Cambridgeshire and Peterborough Clinical Commissioning Group

Potential integrated service

PROGRAMME VISION:

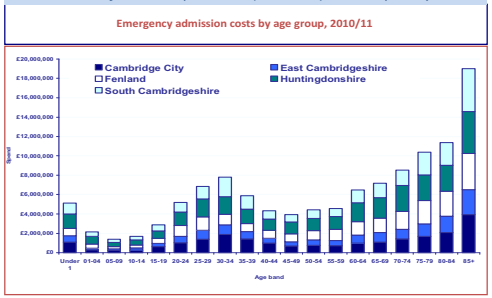
- For older people to be proactively supported to maintain their health, wellbeing and independence for as long as possible, receiving care in their home and local community wherever possible
- For care to be provided in an integrated way with services (health, social care and voluntary) organised around the patient
- To ensure that services are designed and implemented locally, building on best practice
- To provide the right contractual and financial incentives for high quality care and outcomes
- To work with patients and representatives groups, to codesign how we commission services

PROGRAMME AIM:

To design and procure health and social care services for a defined population of older / vulnerable patients within Cambridgeshire & Peterborough CCG, which will deliver improved outcomes defined in terms of patient experience; investment in better care out of hospital; prevention; reduced length of stay in an acute hospital, where care can be better provided elsewhere; reduced unplanned admissions to acute hospitals where these can be safely avoided

Evidence for change:

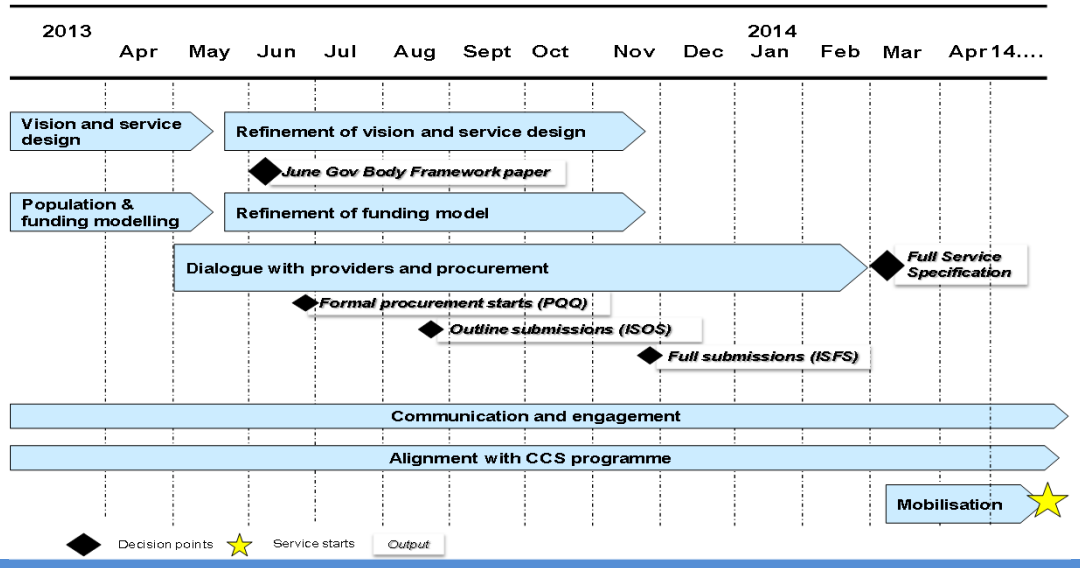
Two thirds of acute hospital beds (and costs) are occupied by 65+



STRATEGIC CONTEXT – Evidence for Change

- Frail elderly identified as a CCG wide commissioning priority
- Current model has serious shortcomings where it is a reactive service
- Changes to community service provision give us an opportunity to redesign
- A growing and ageing population with a 32% increase in the over 65s by 2021 in Cambridgeshire & Peterborough
- Increasing financial pressures: changes are required to reduce inappropriate secondary care activity

PROGRAMME MILESTONES



HEADLINE OUTCOMES

Improvement in patient experience measures as care provided with services organised around the patient

A reduction in avoidable emergency admissions, re-admissions and extended stays in acute hospitals (including delayed transfers of care)

Increase in the number of frail older people cared for "out of hospital" and improvement in quality of these services

Better partnership working between different parts of the health and social care system and other partners

WORKSTREAMS

Engagement: communication and engagement is a workstream through all phases of the programme and includes public consultation
Designing the service: each of the four local commissioning systems will redesign services in their local areas and produce a local vision outcome specification
Innovation and early pilots: early pilots are being implemented during the programme
Defining the target population and funding methodology: define the target population for the services agreed locally and develop a capitated budget and funding methodology. The capitated budget will include acute and community services
Developing the delivery model: the delivery model will be developed for the whole older people service with different service specifications for each of the four local commissioning systems. A procurement process will follow defining the service requirements
Mobilisation: having decided on the delivery model, a period of mobilisation will take place where the service is put in place
Evaluation: following mobilisation, the programme will be evaluated to check the programme objectives were achieved and the benefits realised
IM&T and information governance requirements: information technology and governance is a workstream through all phases of the programme
Alignment with Community Services programme of change: the Cambridgeshire Community Services programme of change will run in tandem and therefore will be working to the same / similar end date

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Overview of End of Life Care Programme 2013-2014

NHS

Cambridgeshire and Peterborough Clinical Commissioning Group

Our vision is *'to optimise the experience of care of patients approaching the end of their lives (and their carers) in all settings and at all times of the day and night'*

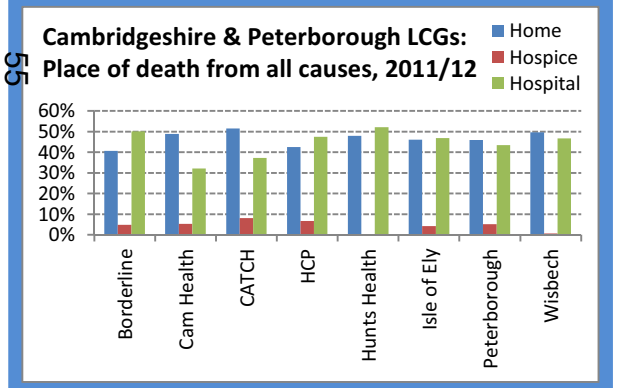
Programme overview

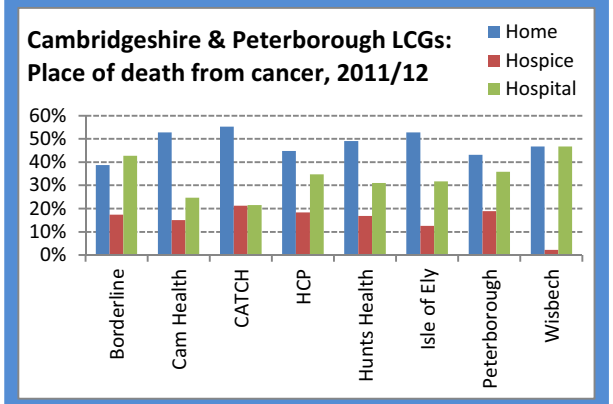
- This programme of work, driven by clinicians from across the CCG, patients and project managers, has been established to improve End of Life Care services for individuals with life-limiting illness in their last 6 to 12 months of life.

Provisional programme aims

- Increase number of patients enabled to die at home and in care homes and corresponding reduction in deaths in hospital
- Increase in family experience/ satisfaction from established baseline
- Increase in number of patients with preferred priorities of care (PPC) recorded
- Increase in number of patients with recorded preferred priorities of care (PCC) who achieve this
- Increase in number of patients in their last year of life recorded on an EoLC register

Evidence for change

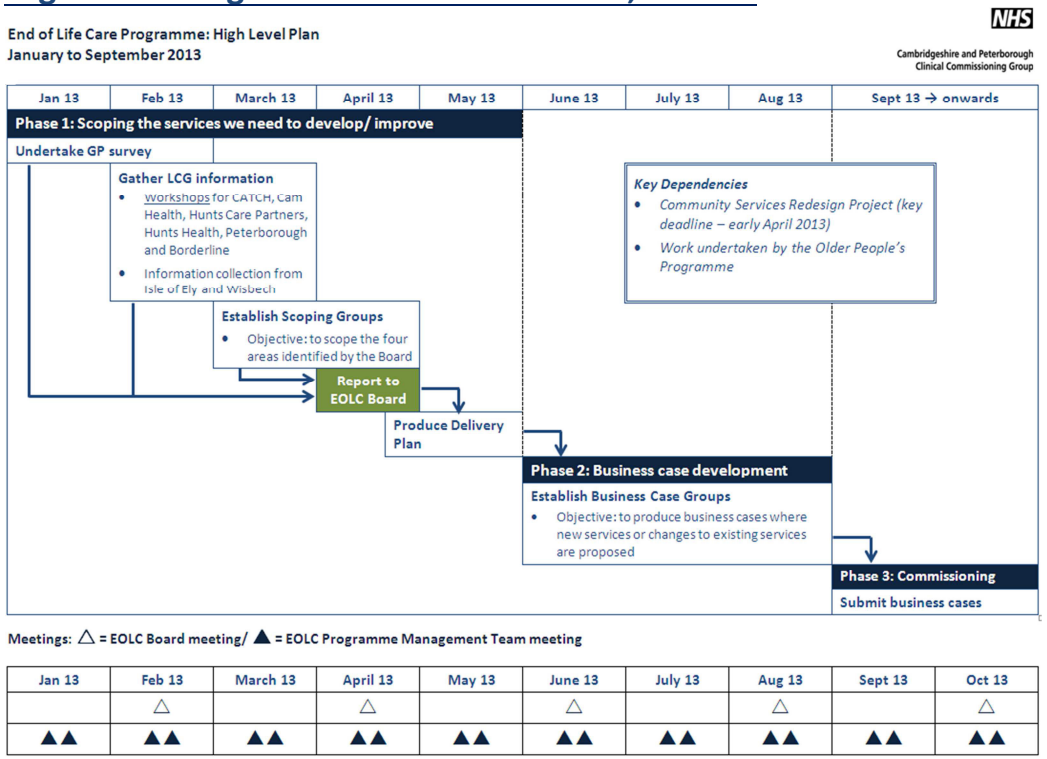




Strategic Context

- End of Life Care has been identified as a CCG-wide commissioning priority
- Whilst the CCG performs well at enabling patients to die in their preferred place of death, there is significant variation across the CCG and by disease type
- The CCG performs less well than other CCGs for pain management in the last two days of life The CCG faces increasing financial pressures; changes are required to reduce inappropriate secondary care activity

High Level Programme Plan for Phases 1, 2 and 3



Focus

- The End of Life Care Programme Delivery Plan will take into consideration the NICE Quality standards for End of Life Care for Adults and the national End of Life Care Strategy).
- This programme aims to deliver initial improvements in 2013/14 and subsequent improvements from 2014 onwards.

Headline Outcome

The Programme Board is working with GPs and with LCGs to identify and clarify their visions and headline outcomes for End of Life Care services, as well as scoping four areas determined by the End of Life Care Programme Board.

- Increase in **community support** enabling avoidance of hospital admission where this is the patient's preference
- Improved **support to carers** supporting patients in their last months/ days of life
- Improved support and care for those who are **bereaved**
- Increased quality of end of life care in **acute and secondary care** settings

Results of the scoping will inform the Programme Delivery Plan.

Contacts

Dr Liz Robin: SRO (Executive Lead)
Dr Stephen Barclay: Clinical Lead
Dr Fiona Head: Prog. Lead
Catherine Boaden: Prog. Manager

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Appendix C

Peterborough Scrutiny Commission for Health Issues
Update report on CCG priorities

Appendix C

Figure 1 shows that coronary heart disease mortality has decreased but that the gap in mortality between Cambridgeshire and Peterborough remains.

Figure 1

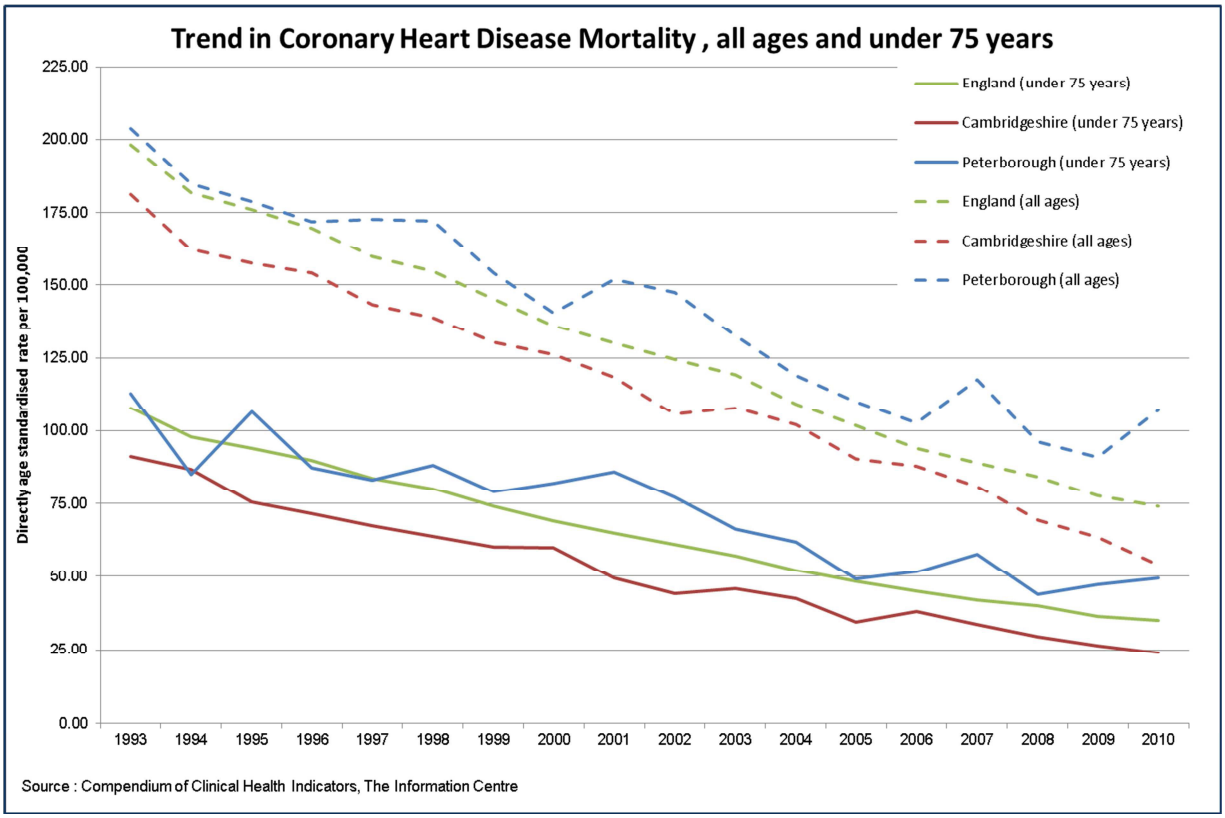


Figure 2 shows coronary heart disease admission rates for people aged under 75 by LCG for 2011/12.
The rates for Peterborough and Wisbech (but not Hunts Health) are statistically higher than the CCG average.

Figure 2

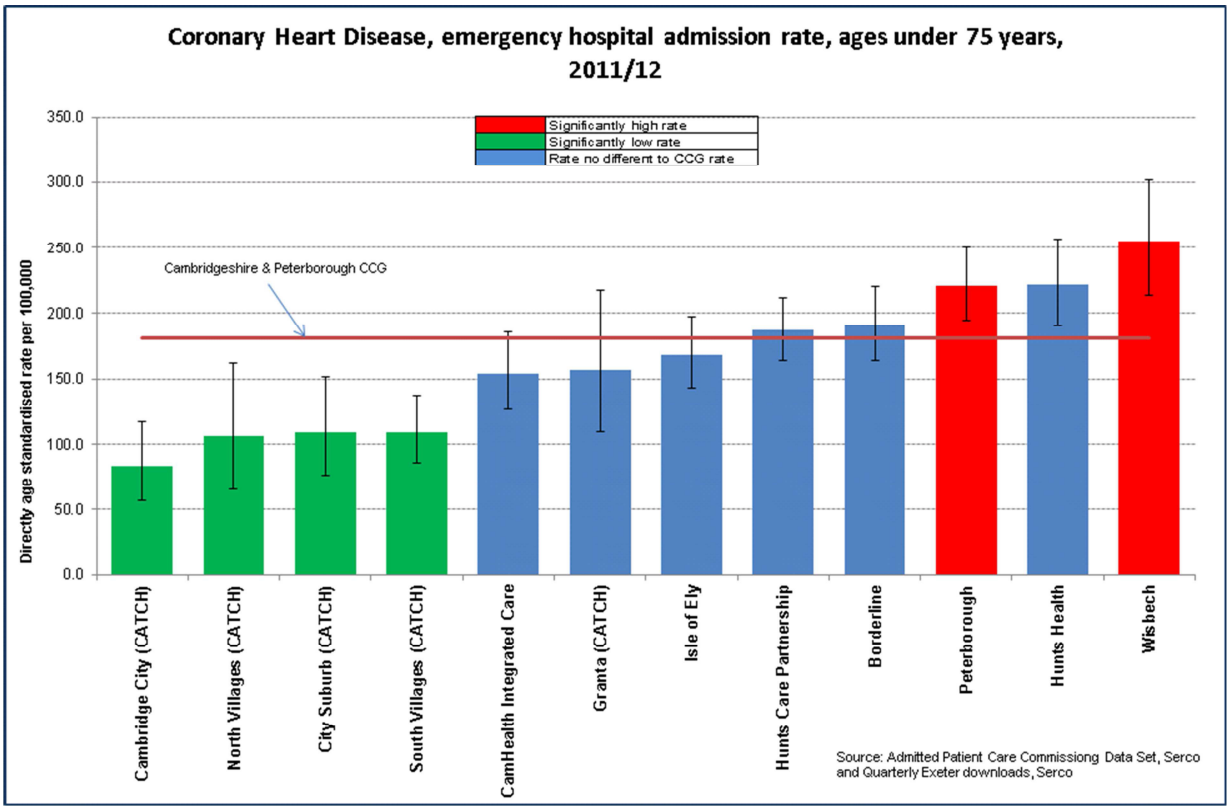
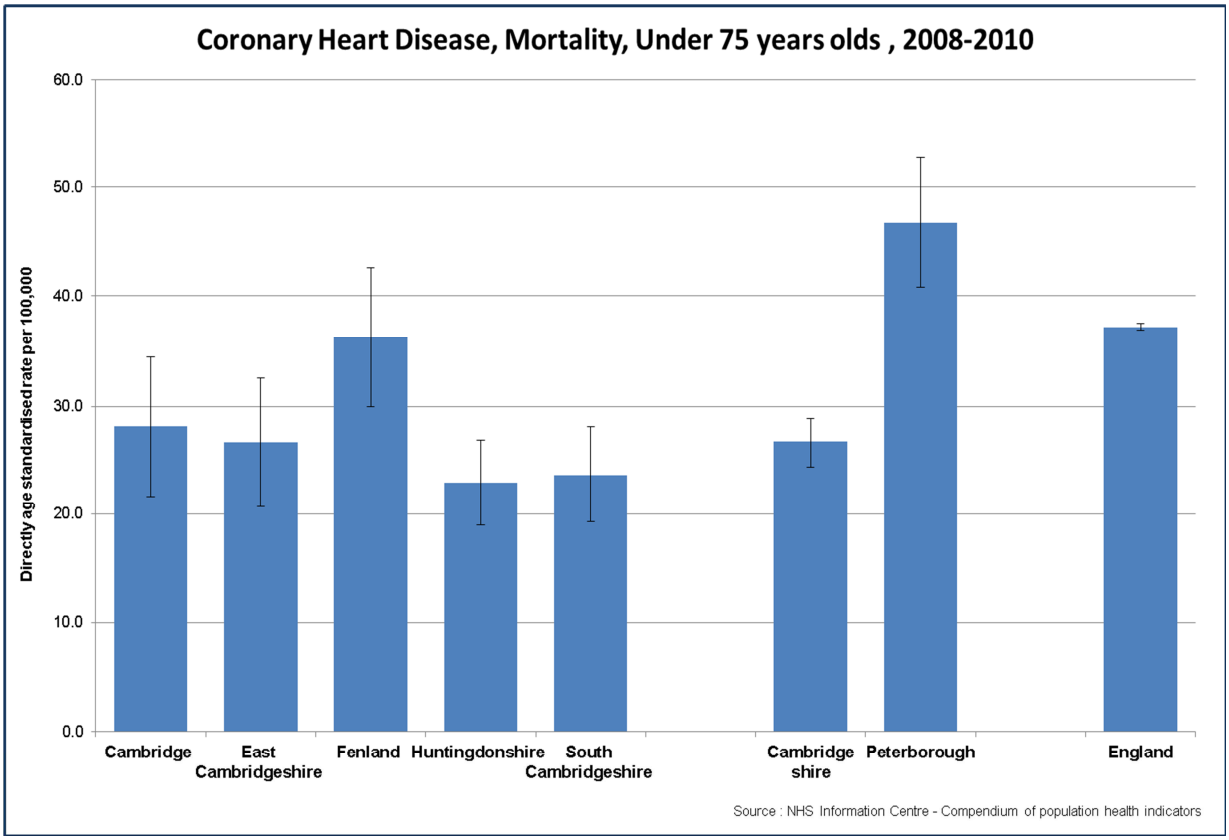


Figure 3 shows the variation in premature mortality due to coronary heart disease by old PCT area.
Peterborough has a mortality rate statistically higher than both England as a whole and Cambridgeshire.

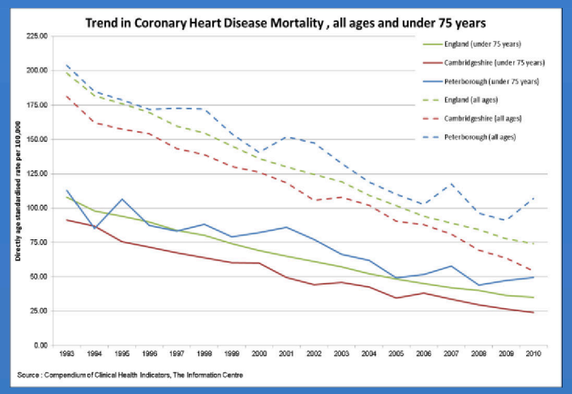
Figure 3



Overview of CHD Programme 2013-2014

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Tackling Health Inequalities – Reducing CHD mortality rates across C&P CCG for people aged under 75 yrs.



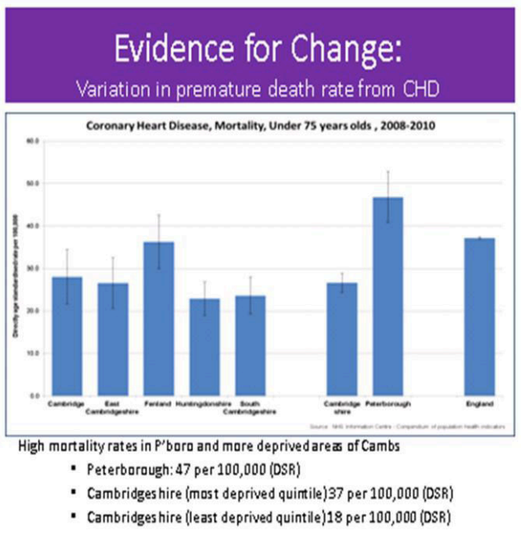
Programme Overview:

Progress has been made over the previous decade in reducing morbidity and mortality rates for CHD. The challenge now is to reduce variation across the CCG and reduce inequalities in health care outcomes

Programme Aim:

Reducing premature deaths arising from CHD in people aged under 75 years, with a specific focus on reducing premature deaths rates fastest in areas of poorest health outcome **('leaving no-one behind')**

Successful outcomes will require a joined-up approach across the NHS, Local Authorities and Voluntary Sector; including adult social care, community leisure services and local p[planning departments



High mortality rates in P'boro and more deprived areas of Cambs

- Peterborough: 47 per 100,000 (DSR)
- Cambridgeshire (most deprived quintile)37 per 100,000 (DSR)
- Cambridgeshire (least deprived quintile)18 per 100,000 (DSR)

STRATEGIC CONTEXT – Evidence for Change

- CHD identified as a CCG wide commissioning priority
- Evidence of improved mortality rates in CHD nationally but local variations in mortality rates between LCGs
- Peterborough, Wisbech , Borderline LCGs identified as a priority focus to deliver improvements in CHD mortality rates
- A growing and ageing population with evidence of health inequalities - 'Leave no-one behind'
- Variation between practices in statin prescribing rates, recorded prevalence rates and Health Checks completed
- Increasing financial pressures; required to reduce inappropriate secondary care activity
- National CVD Strategy 2013 - compliments local commissioning priority
- Quality premiums for CCG include indicators to support cardiovascular risk assessment and maternal smoking rates

Programme Milestones

Establish Programme Board (supported by Management Group)	✓	
Recruit CCG Clinical lead for CHD	✓	
Establish high level plan for CHD Programme (including 1yr, 5yr, 10yr outcomes)	✓	reflects work stream priorities
Identify immediate work streams from evidence to date	✓	
Scope the Work Plan required to deliver outcomes for each work stream identified		
Health Check Programme 13/14	✓	
Cardiac rehabilitation	✓	
Primary Care Interventions	**in progress**	**(July 2013)**
Smoking Cessation	**in progress**	**(July 2013)**

The Board will meet every other month to monitor progress, review evidence and identify additional priority work streams required to reduce modifiable risk factors and improve health interventions with a specific focus on tackling inequalities through partnership working with key stakeholders.

Commitment from the Programme Board

- To be accountable to the Clinical Commissioning Group (CCG) Governing Body for programme / project delivery.
- To take into account and ensure that the work of the Programme Board is consistent with the Health & Well-Being strategies as they develop.
- To be held to account indirectly by Local Commissioning Group (LCG) Boards through their representatives on the Governing Body.
- To facilitate the resolution of any issues raised by the CCG and to enable and support LCGs to deliver required changes in the CHD pathway locally.
- To ensure that clear outcomes for the programme and associated projects are agreed, monitored (in accordance with standardised CCG reporting processes) and delivered, including evaluation and links to research where applicable. The outcomes measures will include baselines for both modifiable and non-modifiable influencing factors. The programme will ensure a targeted approach, involving a wide range of partners to deliver priority projects.
- To provide leadership and coordination on projects or CCG wide issues where it is efficient to 'do once' across the organisation.
- To identify innovation and good practice, and ensure effective diffusion across the CCG
- To maintain an overview of work within LCGs to improve CHD service provision and health outcomes
- To establish project groups as required; to link with any existing Cardiac Networks across the region and other relevant project groups
- To raise the profile of the national CVD Strategy 2013 and lead on key areas of work related to CHD specifically

Page 2 presents a high level plan for the priority work streams currently identified in this programme approach

PROGRAMME HEADLINES

Addressing inequalities in health outcomes across our CCG by focussing on reducing premature death rates from coronary heart disease in people aged <75yrs

Focus of activity in Peterborough LCG, Borderline LCG and Wisbech LCG and other practices identified in 20% more deprived areas across Cambridgeshire

Partnership approach to address identified health needs (underpinned by JSNA evidence) promoting examples of best practice

	2013					
	Apr	May	June	July	Aug	Sep
Priority Work Stream 1: **Health Checks (Mandatory Local Authority Programme 13/14)**						
2yr Programme Commences: GP Practices main providers. Targets agreed in contract with LA	★	→	→	→	→	→
Monthly reporting of completed health checks CHD programme request quarterly updates, per practice against target			★	3/12 reporting →	→	★
Mapping exercise of lifestyle management services across CCG			★			
Share recommendations with key partner's opportunities; commission services differently?				★		
Priority Work Stream 2: **Cardiac Rehabilitation (Opportunities to maximise current services and future redesign)**						
Identify with CHD Board priorities for this work stream, acknowledging changes in community service provision and tariff changes (end of block contract arrangements)		★				
Review of activity data for current commissioned pathway. Identify any evidence of inequalities within current service provision/uptake rates / completed episodes				★		
Work with LCG teams to ensure referral processes for Cardiac services are well publicised, promote use of Personal Health Plans and share local stories of good practice			★	→	→	→
Share recommendations with LCG contract leads / CCG lead for cardiac services					★	
Priority Work Stream 3 : **Primary care Intervention**						
Confirmation of CCG plans to monitor and support GP practices to achieve 90% recording of PP1 (required in identified 46 practices to achieve quality premium) – monthly reporting			★	1/12 reporting →	→	★
Review of prevalence data and evidence of inequality		★				
Identify with CHD Board priorities for this work stream				★		
Priority Work Stream 4: **Smoking cessation**						
Review of activity data for current commissioned pathway. Identify any evidence of inequalities within current service provision/uptake rates/ cessation rates			★			
Identify with CHD Board priorities for this work stream				★		

SCRUTINY COMMISSION FOR HEALTH ISSUES	Agenda Item No. 6
16 JULY 2013	Public Report

Report of the Executive Director of Corporate Affairs, Cambridgehshire and Peterborough Clinical Commissioning group

Contact Officer(s) – Jessica Bawden
Contact Details – 01223 725584

UPDATE REPORT ON THE CAMBRIDGESHIRE COMMUNITY SERVICES (CCS) TRANSITION PROGRAMME

1. PURPOSE

1.1 To update Peterborough Scrutiny Commission for Health Issues on the work of the Cambridgeshire Community Services (CCS) Transition Programme.

2. RECOMMENDATIONS

2.1 For information

3. BACKGROUND

3.1 In 2012 Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) advised the Strategic Health Authority that it was not able to support progress to Foundation trust status for Cambridgeshire Community Services. The main rationale was that this would provide flexibility over future service configuration to improve outcomes in the context of significant demographic and financial pressures. The Strategic Health Authority took account of this view when making the decision at the time that CCS would not be supported to progress towards Foundation Trust status.

As a consequence of this decision, and in the light of the developing work on Older People's services as led by the Older People's Programme, it was decided to establish a CCS Transition Programme Steering Group. The role of the Steering Group has been to ensure that the commissioners of services provided by CCS work in close collaboration with the Trust in co-ordinating the processes of procurement through competitive tender and through the agreed transfer of services. We recognise the need to do this in a way that sustains the quality of existing services during what will inevitably be a challenging transitional period.

Cambridgeshire and Peterborough Clinical Commissioning Group (the CCG) and Cambridgeshire Community Services (CCS) see it as critical that we work together to achieve local high quality community health services. There are a number of other important commissioners of services from CCS including NHS England (Local Area Team) and both Local Authorities in Cambridgeshire and Peterborough. They are therefore members of the Transition Steering Group.

The objectives agreed for the Steering Group were to:

- identify and decide upon the community health services that the Commissioners wish to see in place from April 2014;
- clearly specify these services;
- undertake appropriate procurement / transfer processes in a timely fashion to achieve new arrangements in place from April 2014;
- successfully transfer the CSS assets (staff, estates, etc.) to new organisations as determined by the above process;
- maintain and sustain the quality of community health services during this transitional period.

4. UPDATES

4.1 Community services for older people and adults

It was acknowledged at an early stage that the future of the largest group of services provided by CCS would be determined through the work of the Older people's Programme Board. The decision to move to a competitive tender process for services for Older People and adult community services means that the outcome of this exercise will have a significant effect on CCS.

Information on the details of progress with this work can be found in the separate report going to this Scrutiny Committee meeting. As indicated in this report we are about to start this formal process with an issue of an Office Journal European Committee (OJEC) advertisement. The timetable that accompanies this advert indicates that any new providers of services would commence in July 2014.

4.2 Community Services for children and young people

Responsibility for commissioning services for children and young people in Cambridgeshire and Peterborough changed as from April 2013 both in relation to the CCG and other bodies. There are now a number of different commissioners for these services:

Community Child Health – CCG

Health Visiting – NHS England (Area Team)

School Nursing – Cambridgeshire County Council and Peterborough City Council (Public Health)

SCBU / NICU at Hinchingbrooke Hospital – NHS England (specialised commissioning)

Acute Paediatrics at Hinchingbrooke Hospital

In Peterborough the community child health, health visiting, and school nursing services are all commissioned from Cambridgeshire and Peterborough Foundation Trust (CPFT). We have a 3 year contract with CPFT with 2013/14 being the final year.

After CCS services for adults and older people which are being addressed through the Older People's Programme the largest remaining group of services are for children and young people.

A Children and Young People's Service task and finish group has been established as part of the CCS Transition Programme. The commissioners of these services have been working together to identify the scope of this work, the options available, and the recommended way forward. Decisions will need to be taken by the respective governing bodies/boards of each of the commissioning organisations. The purpose of this group is to co-ordinate this activity.

The Overview timetable is attached as Appendix A. The initial phase of the programme has focused on engagement and dialogue with a range of commissioners/stakeholders. At this stage decisions on procurement and / or transfer of services have not been made and there are separate timetables drawn up for each of these pathways.

The initial work on developing a vision has been guided by the work of the East of England Children and Young People's Health Outcomes Forum.

"The starting point is how the service is experienced by the child, young person or family – not based around the system, professionals or institutions or the location of services. The aim is improved integration of care as experienced by the child, young person and family."

The report of the forum describes how Integrated Care Pathways between different initiatives and organisations can ensure that resources are focused in where there is greatest need, opportunities for early intervention are maximised and duplication minimised.

The commissioners have recognised that whilst it may not be desirable or indeed feasible to achieve integration purely through the provision of services by a single organisation they should work together to commission services through agreed integrated pathways so that these are delivered both within organisations and across organisational boundaries.

4.3 Other services provided by CCS

In addition to the above services there are a small number of CCS service commissioned by NHS England (Community Dentistry services) and Peterborough City Council (Sexual Health services). Each commissioner of these services is currently considering their options for the future to ensure that they can continue to secure these services locally.

4.4 Changing Roles and Responsibilities

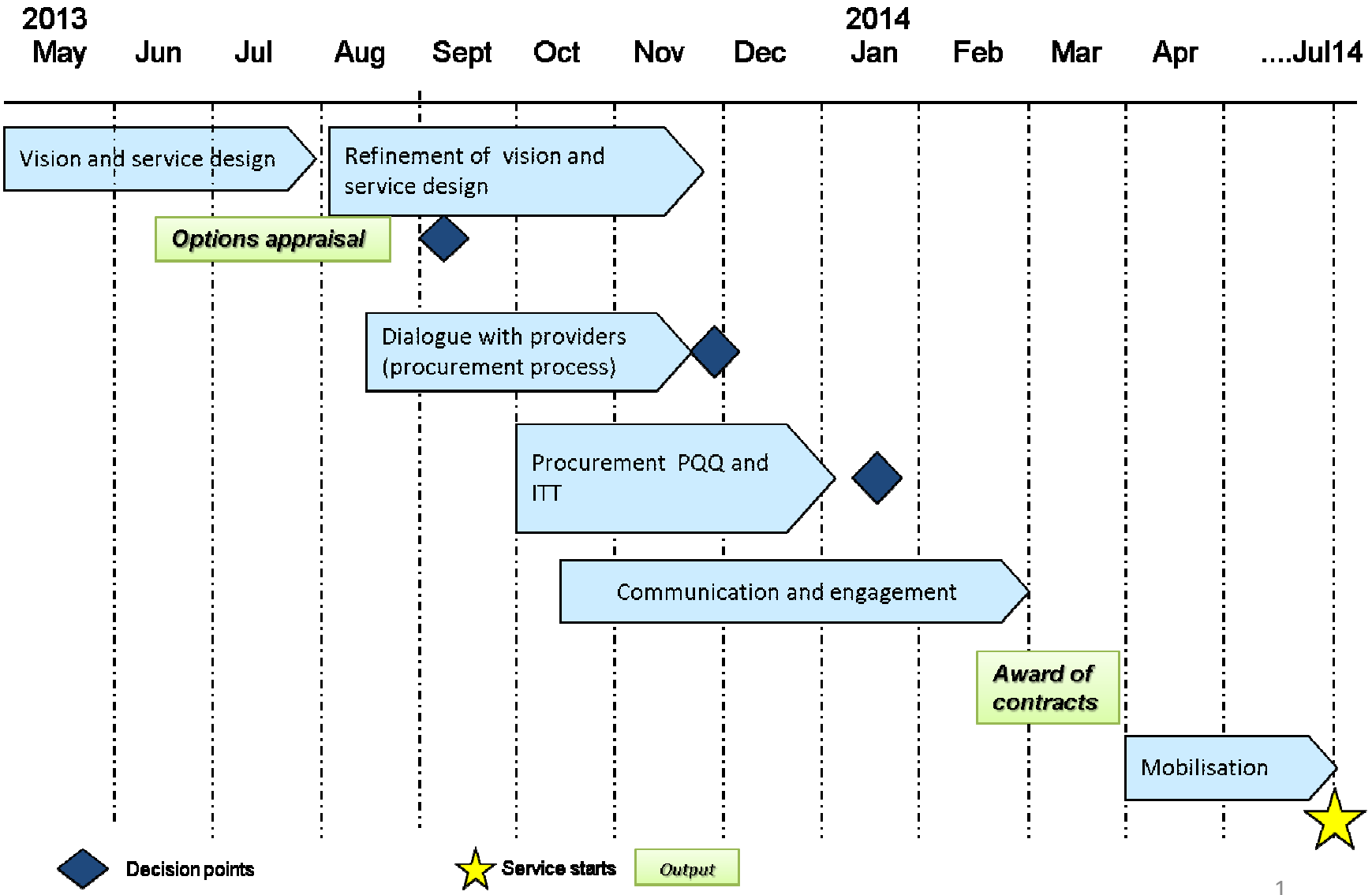
There has been a recent change in the national roles and responsibilities for NHS Trust organisations such as CCS. The Trust Development Authority (TDA) now has the overall responsibility for overseeing the current position and future plans for all NHS Trusts. They are responsible for assessing the current viability of NHS Trusts and determining their future path. They have not yet indicated their view in relation to CCS although we expect to hear about this in the near future.

Whilst this may effect the continuation of the CCS Transition Programme Steering Group it does not change the current procurement plans that the CCG has in relation to Older People's and adult community services, or the work being carried out by all the commissioners on services for children and young people.

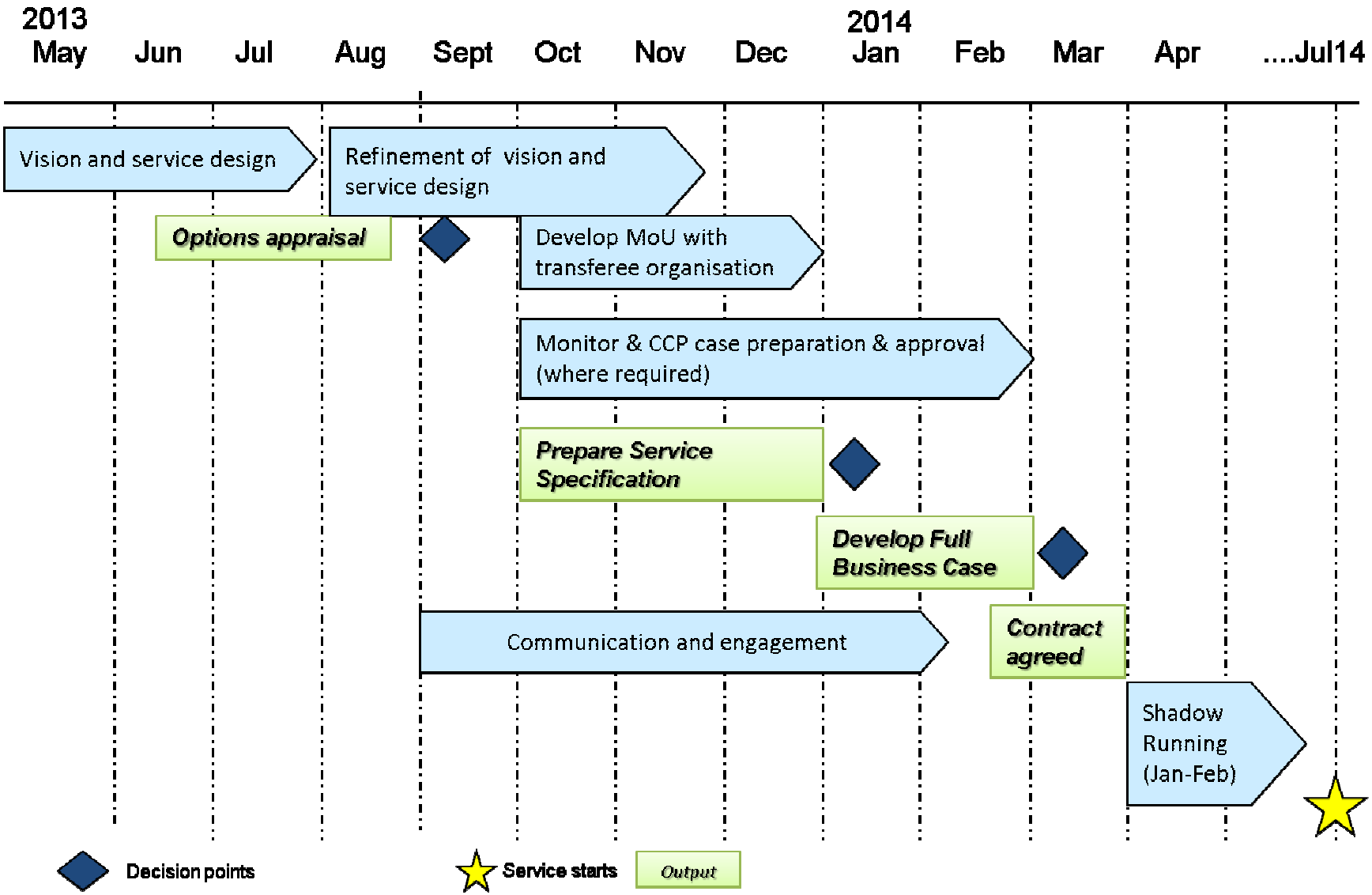
APPENDICES

Appendix A Children's Services Plan

Workplan For Procurement Option (through competitive tender)



Workplan
For Transfer of Services



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SCRUTINY COMMISSION FOR HEALTH ISSUES	Agenda Item No. 7
16 JULY 2013	Public Report

Report of the Executive Director of Adult Social Care

Contact Officer(s) – Nick Blake
Contact Details – 01733 452486

ADULT SOCIAL CARE PREVENTION STRATEGY

1. PURPOSE

1.1 To update the Scrutiny Commission on progress with developing an adult social care Prevention Strategy.

2. RECOMMENDATIONS

2.1 For the Scrutiny Commission to note and comment on the contents of this report and the draft Prevention Strategy (attached as appendix 1).

3. LINKS TO THE SUSTAINABLE COMMUNITY STRATEGY

3.1 The development of a strategic approach to commissioning prevention services supports the delivery of the key outcome *Creating opportunities – tackling inequalities*, specifically in relation to improving health and supporting vulnerable people.

3.2 The strategy and resource centre also support the key outcome to *Create strong and supportive communities* in terms of empowering local communities and in supporting people with social care support needs to engage in and be part of their local community.

4. BACKGROUND

4.1 Work to develop a Peterborough City Council Prevention Strategy has been undertaken jointly with partners, service users and carers over the last six months and further work will be done during July to finalise the strategy.

4.2 The development of the strategy arises from the consultation on eligibility and charging which was approved by Cabinet on 25 February 2013. The Prevention Strategy aims to set out the Council's offer to people who are not eligible for statutory social care support but who would benefit from support to maintain their independence and wellbeing.

5. KEY ISSUES

5.1 The development of the preventative offer is central to the Council's Adult Social Care Transformation Programme. The Transformation Programme will ensure that people are supported to maintain their independence, are safe and can exercise choice and control over their support.

5.2 The draft Care and Support Bill (DH, 2013) sets out proposed population level duties upon local authorities to provide information and advice and to develop preventative services. The Prevention Strategy seeks to set out how the Council will prepare to meet these duties in anticipation of the Bill passing into statute.

5.3 In line with the draft Care and Support Bill, implementation of the Prevention Strategy will involve taking an asset based approach to community development. Specifically, this will involve working with communities and groups of people to understand their strengths and to

identify opportunities to develop support within those communities. The department is currently consulting with national leads in asset based community development and will be considering how this could best work in Peterborough.

6. IMPLICATIONS

6.1 Financial implications

An additional £160K per annum revenue investment has been identified to support the delivery of the strategy.

7. CONSULTATION

7.1 Feedback and data specifically relating to preventative services from the Adult Social Care eligibility consultation was used in the development of the strategy.

7.2 A consultation event was undertaken on 30 April 2013 attended by people who use adult social care services, carers, service providers from the voluntary and independent sectors and health and social care professionals.

7.3 Consultation has been undertaken with the Older People's Partnership Board, and further consultation is planned with the Carers' Partnership Board, Learning Disability Partnership Board, Mental Health Stakeholders' Group and Healthwatch Peterborough.

7.4 The Adult Social Care Co-production Group is a made up of people who use adult social care services and carers. The group has been involved with drafting the strategy and will be working to co-produce the final version of the strategy with the Council.

8. NEXT STEPS

8.1 Further consultation with colleagues in the Clinical Commissioning Group, Public Health and Housing will be undertaken to ensure that the strategy is aligned with developments across the local health and social care system.

9. BACKGROUND DOCUMENTS

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

9.1 None.

10. APPENDICES

10.1 Appendix 1 - Peterborough Adult Social Care, Living My Life, Draft Prevention Strategy 2013 - 2015.

Appendix 1

PETERBOROUGH CITY COUNCIL

Peterborough Adult Social Care
Living My Life

Prevention Strategy
DRAFT
2013 - 2015

Contents

FOREWORD

INTRODUCTION

The Prevention Commissioning Strategy

This strategy seeks to address the range of preventative approaches that will influence health, wellbeing and independence for the needs of adults in Peterborough. It seeks to achieve a balance between support developed for specific and complex population needs and the development of our approach to a 'universal offer'; enabling people to be informed, proactive and responsible in maintaining their own health, wellbeing and independence.

The aims of the strategy are:

1) Development of a proactive, preventative and partnership approach to support provision across existing systems and extending beyond health and social care.

2) Develop access to information and advice for all regardless of level of need and financial position.

3) Ensure equal access to universal support in the community. Universal support is available to everyone i.e. leisure centres, transport, libraries.

4) Identify those at risk of social isolation or in need of support, in order to enable them to maintain their health, independence and well being.

5) Empower and enable people to exercise choice and control in accessing support.

6) Embed self care in the approach to working with individuals that allows them to feel empowered and to take control thereby maximising their independence and well-being.

7) Create opportunities for people to make improvements in their own lives and avoid premature dependency on care.

8) Promote engagement with citizens of Peterborough and increase 'social capital'.

9) Provide flexible individualised support to carers.

10) Ensure a much stronger focus on the commissioning based on outcomes across the health and social care economy.

11) Ensure preventative support is sustainable and effective.

The Strategy also presents recommendations for prioritising commissioning interventions.

This strategy should be read in conjunction with the current Older Peoples Accommodation strategy (OPAS 2012), the Carers Strategy and the Dementia Strategy alongside other developing strategies for adult social care.

What is prevention?

At its simplest, taking a prevention approach means building a stronger community infrastructure in neighbourhoods/localities that reduces and delays adults from becoming socially excluded and needing more intensive, costly support. Its primary focus is not personal care for those with substantial and complex needs and it is not a simple re-labelling of existing traditional low level services, e.g. laundry services, meals-on-wheels.

A holistic or whole-systems approach to prevention carries within it both the idea of inclusion and engagement. It adds value to the social cohesion agenda, by delivering services and support that help to create and strengthen the 'glue' that binds communities together. People are enabled and supported to maintain and improve their own wellbeing, that of their families, neighbours and local communities.

The Department of Health in its paper 'Improving care and saving money: learning the lessons on prevention and early intervention for older people' identified four important elements of prevention which can be summarised as:

1. Promoting independence and wellbeing
2. Reducing the risk of crises and the harm arising from them
3. Maximise people's ability to live independently
4. Provide the appropriate level of support to meet people's needs

Commissioning should address all four aspects of prevention in order to fully optimise the local system. The diagram on the next page gives an indication of the nature of this range of needs and examples of the support that can be available.

Support to sustain people and prevent their needs growing can be grouped together in there areas, which run across the three ASC areas of:

1. Universal prevention/promoting wellbeing

This is 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

Prevention here aims to identify people at risk and 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.

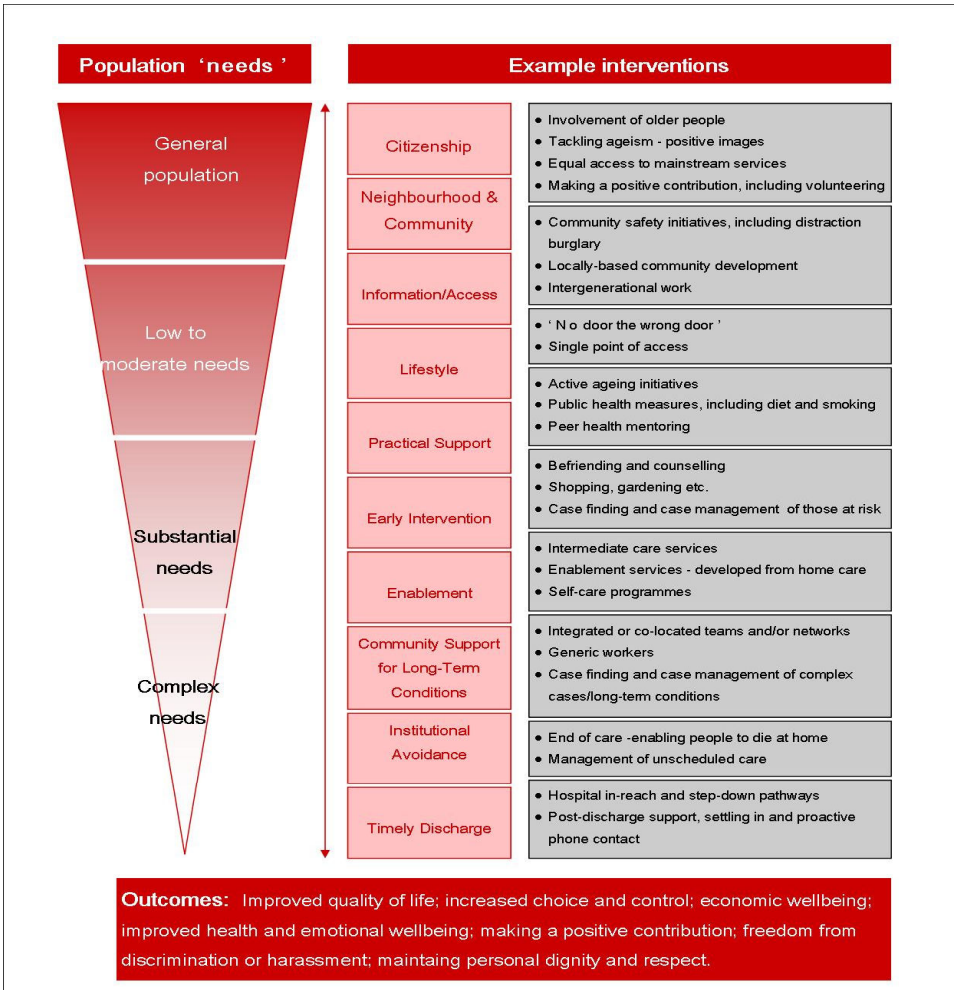
3. Personalisation

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

Interventions are required across all three categories of prevention in order to deliver the wellbeing outcomes to which people aspire. The spectrum of prevention is illustrated diagrammatically in figure 2 below.

It is important to note that people may not move through tiers of preventative services in a linear way, for example, someone with complex needs in a specialist service will still benefit from timely and accurate information. A general principle within this strategy is that independence will be maximised by meeting a person's needs within the least specialist tier of support.

Figure 2 The Spectrum of Prevention



(Reference: 'Improving care and saving money: learning the lessons on prevention and early intervention for older people' DH, January 2010)

Why are we writing this strategy?

Health and Social Care is going through a time of unprecedented change. The self-directed support agenda and the reforms contained in the Health, Social Care and Public Health White Papers will completely transform the way in which health and wellbeing services are commissioned and delivered.

Looking to the future, the need for health services, social care support and related services are expected to rise. Predicted population growth over the next 10 years shows that, along with general population growth, there will be a growth in people living with a range of health and social care support needs. This additional demographic pressure will mean that adult social care funding becomes increasingly focussed on meeting the needs of a smaller group of

people with complex needs unless a more preventative approach to commissioning and support delivery is developed.

There are a number of issues where data[1] suggests that growth in prevalence in Peterborough will increase above and beyond general population growth: for example, for people aged 65 and over:

Group (aged 65+)	**Percentage rise 2014 - 2020**
Peterborough population	12%
People predicted to have a fall	13%
People unable to manage at least one domestic task on their own	13%
People with dementia	20%

Growth in prevalence[2] of conditions likely to lead to social care need for people aged 18-64 is also predicted to increase over the next six years:

Group (18-64)	**Percentage rise 2014 - 2020**
Peterborough population	8%
Moderate to serious learning disability	10%
Moderate physical disability	9%
Common mental health issue	7%

In summary there are two key challenges that must be addressed:

- Increased demands on health and social care associated with an ageing population
- A reduction in the growth of public funding for health and social care

This strategy is one of several responses to these changes and has a foundation in:

The Care and Support Bill 2012 (draft)[3]

Building on the Government's Vision for Adult Social Care, the Care and Support Bill will require local authorities to provide help earlier to try to prevent, delay or reduce people's needs for care and support; more specifically, the following requirements will be placed on local authorities:

- population-level duties to provide information and advice, prevention services, and shape the market for care and support services. These

[1] Projecting Older People's Population Information system (POPPI): http://www.poppi.org.uk/
[2] Projecting Adult Needs and Service Information (PANSI): http://www.pansi.org.uk/
[3] DH: http://careandsupportbill.dh.gov.uk/home/download/

will be supported by duties to promote co-operation and integration to improve the way organisations work together

- support the broader needs of local communities as a whole, by giving them access to information and advice, and promoting prevention and earlier intervention to reduce dependency, rather than just meeting existing needs

The focus of care and support will be transformed to promote people's wellbeing and independence, instead of waiting for people to reach a crisis point. Care will support people to maintain their independence and to stay connected to their communities, and will treat people with dignity and respect. Clearer entitlements, more and better information and support to navigate the care system, and a new statutory entitlement to personal budgets will mean that people are able to exercise real choice over their care and support, making the right decisions for them and their families.

The Adult Social Care Outcomes Framework (ASCOF)

"The ASCOF, with its clear focus on promoting people's quality of life and their experience of care, and on care and support that is both personalised and preventative, will be a key tool to track progress locally and nationally towards the realisation of our ambitions for care and support"[4]

ASCOF sets out how progress and performance in adult social care should be monitored and measured and is made up of four key areas or domains. ASCOF Domain 2: delaying and reducing the need for care and support focuses on preventative outcomes. ASCOF 2013/2014 highlights the challenges in measuring prevention outcomes and details progress made in defining how this could be done. Key outcomes detailed in ASCOF Domain 2 are:

- Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs

- Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services

- When people develop care needs, the support they receive takes place in the most appropriate setting, and enables them to regain their independence.

Think Local, Act Personal – Living My Life

Think Local, Act Personal is a national, cross sector leadership partnership focused on driving forward work with personalisation and community-based social care.

[4] ASCOF (DH, 2012)

Think Local, Act Personal establishes a collaborative approach to transforming adult social care. The City Council, in partnership with a wide range of organisations and agencies, is challenged to ensure there is personalised support for people with multiple and complex needs, for people to maintain their independence and for people with emerging needs.

Living My Life - aims to ensure that for local people:

- It's quick and easy to find your way through the care and support system
- I've been the one deciding what care works for me – it's been my choice
- I've been able to find the right kind of care and support to meet my needs

This commissioning strategy is one element of a much wider programme designed to introduce a new system of care and support. This system will enable people to live their lives as they wish by promoting independence, choice, well-being and dignity.

Sustainable Community Strategy 2008-21

Peterborough's Sustainable Community Strategy is quite simply the plan for the future of our city and the surrounding villages and rural areas.

It is an ambitious and far reaching plan. It aims to substantially improve the quality of life of the people of Peterborough and to raise the profile and reputation of our city as a great place in which to live, visit and work.

This plan is very specifically designed to bring clear benefits to the people of Peterborough. Where we have advantages already, we want to build on them. We will seek to inject quality into everything we do, ensuring that as we build the bigger Peterborough, it is also very much a better Peterborough.

The Sustainable Community Strategy is the plan that will guide the work of all the partners in Peterborough – public, private, voluntary and community. It is also the plan for every individual. We all have a role to play if we are to build a Peterborough that is not only bigger, but very noticeably better – a Peterborough we can be even more proud of.

Peterborough Health and Wellbeing Strategy 2012-15Residents are being given the opportunity to comment on a new draft strategy which has been published by Peterborough City Council and NHS Peterborough and aims to improve the health and wellbeing of the public. The strategy allows the Health and Wellbeing Board to identify health and wellbeing priorities and set clear markers for NHS and Local Authority commissioners to meet the needs of the population.

The draft Health and Wellbeing Strategy 2012-15

This locally developed strategy includes five targeted areas, which are a priority to improve the health and wellbeing of everyone in Peterborough.

This strategy has been produced on behalf of the new Shadow Health and Wellbeing Board and is underpinned by the findings and recommendations from the refreshed Joint Strategic Needs Assessment for Peterborough. Our draft priorities are to:

- Ensure that children and young people have the best opportunities in life to enable them to become healthy adults and make the best of their life chances.
- Narrow the gap between those neighbourhoods and communities with the best and worst health outcomes.
- Enable older people to stay independent and safe and to enjoy the best possible quality of life.
- Enable good child and adult mental health through effective, accessible health promotion and early intervention services.
- Maximise the health and wellbeing and opportunities for independent living for people with life-long disabilities and complex needs.

The Joint Strategic Needs Analysis (JSNA)

The strategy considers the findings of the JSNA. Headlines include:

Peterborough is growing and so is the proportion of elderly residents. According to the Office for National Statistics, (2011 Census) Peterborough's estimated population was 184,500 and will increase to an estimated 192,400 by 2021. This represents an 11 per cent growth in population between 2010 and 2021. The number of people aged 85 and over is set to increase by 52 per cent during this period.

There are approximately 2,650 people with a learning difficulty in Peterborough. Almost 40 per cent are thought to have an autistic spectrum disorder and a third of these (28 per cent) have moderate to severe learning difficulties and all of these people need varying levels of support.

There are almost 15,000 people living in the city with a disability. More than half of those residents (8,103 people) are estimated to have a moderate physical disability and about one sixth (2,340 people) are seriously disabled. About a third are estimated to have a physical disability requiring some element of support with personal care.

During the coming year about 20,000 people are expected to suffer from some kind of mental health disorder, including 1,000 people who are suffering with dementia. Many of these people may need to access our mental health support services. Supporting people with dementia is a growing pressure on Adult Social Care budgets.

Safeguarding

No Secrets (2009) recognised that safeguarding adults focussed mainly on responding to issues and not preventing them and found that prevention should be the foundation of safeguarding services. Effective prevention in safeguarding is not about paternalism or risk-aversive practice. Preventing abuse should occur in the context of person-centred support and personalisation, empowering individuals to make choices and supporting them to manage risks. This should lead to the services that people want to use, with the potential to prevent crises from developing.

The Social Care Institute for Excellence notes that some of the most common prevention interventions for adult at risk include training and education of adults at risk and staff on abuse in order to help them to recognise and respond to abuse. Other approaches include identifying people at risk of abuse, awareness raising, information, advice and advocacy, policies and procedures, community links, legislation and regulation, interagency collaboration and a general emphasis on promoting empowerment and choice.

The inclusion of safeguarding within the development of all preventative approaches will form a central part of the implementation of this Prevention Strategy.

Our departmental priorities

1. Promote and support people to maintain their independence
2. Delivering a personalised approach to care
3. Empowering people to engage with their communities and have fulfilled lives

What Customers and Service Users tell us

Through a range of consultations, engagement events and our partnership boards we continue a conversation with our customers about what it is they need.

What they consistently tell us and what organisations and groups say nationally is that people need:

- Maximised independence of living
- Real choice over what care they receive, from who, and when
- Support to lead a “normal” life, particularly opportunities for social interaction

A number of common themes were raised, including:

- **Clear, easily accessible, and readily available information and advice**

People want to know that there is a reliable, single source of information and advice they can go to, to help them with all aspects of their health and social care needs. Every point of contact for any needs should at the very least be sign-posting to this single source, particularly GPs and other medical professionals.

- **A simple, supported system for assessments**

People recognise that assessments are necessary, but they want them to follow a clear and quick process that they can understand. Not everyone can identify their care-needs, or carer-needs, and some find it difficult and stressful to fill out forms, so people want to be supported through an assessment by a professional in their home environment. Joint "one off" assessments incorporating the needs of whole families and care networks should also be available, to capture a more complete picture of what support is required by whom. It is important to note that assessments should be available to people who fund their own support as well as people whose support is funded by the Council.

- **Support to make and manage choices**

There is enthusiasm for personal budgets, and the flexibility and choice these will offer, but people want to know they'll be supported to make and manage the choices on offer. People want the council to be alert to where a person might not have the capacity to fully understand the options available or their own role in controlling their budget, or when a person might not be making their own choice freely, or is being unfairly influenced by people around them. However, it is clear that people wanted independent sources of support available to them too – like peer support groups and advocates, who are outside of the system but can help support people to find their way through it.

- **Flexible and responsive service options**

People want to know they can access services quickly and at short notice when they need them in a crisis or emergency, even if this is in the middle of the night or on a weekend. They also want clearly communicated, flexible options so they can maintain their independence without needing friends and family to help out all the time, including support for social contact and activity like going to the cinema or meeting friends in the evening. Services that are locally available and easily accessible are vital.

The consultation on changes to the Council's adult social care eligibility criteria and charging policy in January 2013 provided an opportunity to better understand what people thought about preventative services more

specifically. The feedback on prevention covered a wide range of issues, key points that were raised were:

- Prevention means that resources can be focussed on people with most need
- 90% of people (675) felt that reablement should be offered to everyone who could benefit from it

When people were asked how money should be spent to support people who do not meet eligibility criteria the top five responses were:

- Easy access to equipment that helps you stay healthy and safe (87% or 659 respondents)
- Help with keeping the home safe, clean and in good repair (75%)
- Breaks for carers (74%)
- Support getting out and about in the community (70%)
- Help with shopping (70%)

A range of comments were also received. Key themes were:

- Access to information, advice and advocacy including information and guidance in relation to financial issues and health issues
- An increased range of day and leisure opportunities
- Support for carers
- Access to transport

The full details of responses from the consultation relating to prevention are included in Appendix XX of this strategy.

People who use services, carers and a range of provider organisations have reviewed current preventative services and explored prevention outcomes as part of the development of this strategy. This has identified a broad range of preventative services that have developed within the City alongside existing challenges to delivering and developing the preventative agenda. Key issues raised were:

- People may require assistance to access preventative support initially

- Professionals should be aware of the full range of support available and consider innovative, personalised approaches

- Integration and coordination of prevention support is critical

- Tackling social isolation is very important; people living in rural areas find it more difficult to access support

More detail on feedback from event is included at Appendix YY.

Carer involvement

We recognise that carers are vital to ensuring that vulnerable people receive the care that they need. In more recent years there has been more emphasis on providing support to carers. The culmination of this work has been the development of a Carers Strategy alongside a range of service developments.

Despite these developments it is apparent that existing support is only reaching a minority of carers in the City - identifying “hidden” carers is a priority. The number of informal carers is expected to increase significantly in future years as the number of older and disabled people increases. Research indicates that there is evidence of unmet needs in terms of the provision of short-term breaks for carers.

Carers are central to the success of any preventative approach to social care so understanding the needs of carers within the context of prevention and the potential consequences for carers of developing prevention will be critical.

The consultation on and development of the Council’s Carer’s Strategy has highlighted a number of issues that relate to prevention, carers told us that:

- Good information and advice is invaluable
- Carers want to know where they can turn to for support
- Carers need breaks from their caring responsibilities

Local feedback from the National Carers Survey (2012) suggests:

- A large number of long term carers are juggling caring responsibilities with work, or caring for more than one person, and often have health issues of their own

- Nearly half the carers who responded care for someone for over 100 hours per week and 20% have cared for someone for more than 20 years. The likelihood of becoming a carer increases after the age of 44

- 74.6% of carers were extremely, very or quite satisfied with social services and 88.7% have no worries about their personal safety. However, 75.4% of carers are not able to do enough or any of the things they value or enjoy and 51.3% don’t have enough or little social contact and feel socially isolated.

The Council is committed to supporting carers to identify themselves as carers at an early stage and to recognising the critical part they play in supporting the people they care for. It is vitally important that carers are considered at all points in the development and delivery of the Council’s Prevention Strategy.

CURRENT POSITION

The Council commissions a wide range of preventative support, the Adult Social Care department funds around £1million of community services from the voluntary sector. This includes information and advice, day opportunities and support for carers.

Service area	Funding 2012/2013 (£K)
Voluntary and Community Services	
Information, advice and advocacy	392
Day and community opportunities	188
Carers support	221
Other	175
Sub-total	**976**
Statutory and independent sector	
Reablement service	800
Community equipment	420
Sub-total	**1,220**
TOTAL	**2,196**

The Council has approved an additional £260,000 funding to deliver enhanced prevention outcomes in 2013/2014, this will be used to support the delivery of this strategy.

Voluntary and Community Services
The Council commissions a broad range of support from voluntary and community sector organisations including:

- Lunch clubs
- Information and advice services including benefits advice
- Advocacy services
- Befriending services
- Carers support including short-term respite and breaks
- Access to social, leisure and community opportunities

Reablement
The Council's reablement service offers a period of free social care support provided through the Council's reablement team and through independent sector providers. The cost of delivering this service is supported by funding from NHS Peterborough. Total cost to deliver the service for 2012/2013 is expected to be around £800K, this will increase in 2013/2014 as the service is expanded. The Peterborough Locality Commissioning Groups also support the reablement service through joint funding arrangements and will be contributing £445,000 in 2013/2014.

The service received 455 referrals over April to December 2012, of those people completing a period of reablement 68% did not require ongoing social care support and 23% had reduced support needs.

As mentioned above, the Council's intention is to expand the provision of reablement capacity to 800 people annually so the service becomes the 'front door' for adult social care. Reablement will provide an extended period of assessment and support that maximises people's independence: assessment for eligibility will be carried out at the end of a period of reablement. It is anticipated that around 25% of people accessing the reablement service will not meet substantial or critical eligibility thresholds.

Community Equipment

The Council provides a community equipment service offering access to a range of equipment that supports people to live independently at home. The cost of providing the service over 2012/2013 was £420K.

The Operations Department also commissions and funds a range of services that support the Adult Social Care preventative agenda amounting to around £180K of funding; this includes support to new and developing voluntary sector services.

The Council's Care and Repair Team is a Home Improvement Agency which assists disabled and vulnerable people to adapt and maintain their homes and where appropriate access funding for work. Care and Repair's aim is to assist people to continue living independently in their own homes and ensure those homes are safe and warm. Care and Repair can support people to access a range of grants including Disabled Facilities Grants and also offers a Handy Person scheme that offers a minor repair service to older and more vulnerable people. More information on care and Repair is available through the Council's website.

The Council's budget proposals for adult social care identify a range of savings and some shifting of investment. In relation to further developing a preventative approach, additional investment related to the costs associated with the social care white paper of £260K is proposed. This will support a range of investment, final amounts allocated towards developing preventative approaches are to be agreed.

MAKING IT HAPPEN

We will use a commissioning approach to deliver improved prevention and early intervention outcomes.

Commissioning is the means to secure the best value for local citizens. It is the process of translating service and support aspirations and need by specifying and procuring provision for users which achieves the desired outcomes within the best possible use of available resources.

This strategy will guide the commissioning of prevention and early intervention services and support. Some services and support are and will be 'universal' and available to all adult citizens. There are and will be services and support that are specifically for older people, people with physical disabilities and sensory impairments, people with learning difficulties, people with mental health problems, people with substance misuse problems and their carers who:

- are deemed at risk of social isolation and social exclusion or of needing more intensive health and social care support
- require access to information and advice, and from that, access to relevant services that will assist them to retain/regain their independence and wellbeing.

Services and support will be available for those people who fund their own support as much as it is for those whose personal social care and support services are funded by the City Council. This is a key element of the Adult Care universal offer for Peterborough citizens.

In the provision of a range of prevention support, there is a need to work with local partners from all sectors to ensure there is a good balance in respect of support available for:

- the general population (universal support); generally equating to primary preventative services and support
- low level preventative support for more vulnerable groups of people; generally equating to secondary preventative services and support
- people with high level, more complex needs; generally equating to personalised services and support.

Programme of Action

From the support outlined above, it is apparent that a good range of preventative provision is already in place. However, there are gaps in provision, some support opportunities are not available city wide, and access can be difficult and something of a postcode lottery. So we know that we have work to do to improve equity and extend the availability of certain provision, to better meet the needs of people across all cultures and communities; and to continue to grow our prevention package of services and support.

We will have succeeded, if by 2014:

- People can easily and reliably access health and wellbeing information and advice and community resources

- People are well informed about options available to them when faced with potential risks and support needs.

- More people are accessing preventative support as an alternative to a Personal Budget.

- More people have been supported to maintain their independence.

- More people have been supported to maintain or become involved in a range of cultural activities.

- More people are helped to avoid a crisis that could lead to unnecessary admissions to hospital or into longer term care, through joined up early intervention.

Actions are outlined in Appendix ZZ, these are the areas of work on which we want to focus our efforts and resources and seek to influence and work with our public and voluntary community sector partners to deliver. Actions are set out under functional headings derived from the menu of services and support stated above.

PRIORITIES FOR PREVENTION

To achieve our goal of improving the wellbeing of adults in Peterborough and supporting them to stay active and live as independently as possible in their home and community of choice, there must be pre-investment in preventative and community based services that meet identified needs. This investment will deliver future savings. The reconfiguration of certain existing services will generate potential revenue for reinvestment in preventative and early interventions.

Timely, early intervention not only improves outcomes for people but also reduces the longer term costs of care, for example by reducing the need for support by carers, hospital bed use and delaying the need for more intensive long term care services.

The Department of Health's POPP's Programme findings suggest that small services providing practical help and emotional support can significantly affect the health and wellbeing of older people, alongside more sizeable services designed to avoid the need for hospital admission. We also have a body of evidence that early intervention can cut need for residential and nursing care by 22% (National Dementia Strategy, DH, 2009). Plus, there is strong evidence of the benefits of exercise in older people reducing circulatory

disease, which causes up to 50% of dementia cases. (Under Pressure, Audit Commission, 2010)

As such, evidence is that prevention and early interventions should be focused on:

- Information and advice, so people are well informed, can help themselves, particularly by accessing benefits advice. It is also needed to support people who do not meet social care eligibility criteria, or who fund themselves.

- Effective signposting to information, services and community resources

- Specific proven early interventions e.g. falls prevention, Telecare, and housing related support

- Situations where someone has a major life change or is going through a life transition and may need support to help them remain independent

- Low level, practical support that enable people to continue to live in their own homes if they choose to do so, e.g. maintenance services to keep the home safe and in good repair, support with shopping

- Reducing social isolation as loneliness and depression are recognised as major factors in the quality of life for people, particularly older people

- Tackling low income e.g. benefits information and advice services

- Promoting mobility and the accessibility of community facilities, e.g. adequate transport services

- Support that promotes peoples engagement in their community and social cohesion, e.g. volunteering, intergenerational practice

- Healthy living advice and support, e.g. exercise classes, dietary advice.

We think that the above outlined menu of provision offers the right balance of preventative services and is the right focus for our continued investment in prevention and the commissioning of services. This menu of provision is supported by feedback from consultation work.

MARKET DEVELOPMENT

In recognition of the views of the local providers and national government we need to develop a role in:

- Shaping the local health and social care market and
- Stimulating providers by providing the flexibility to develop innovative solutions.

With the increased pressures on all local authorities to reduce public spending, the City Council and its commissioning partners must look at the delivery of adult social care and redefine the health and social care market.

Strategic planning is necessary to ensure that the local health and care market becomes a dynamic mixed-economy. Market development activity should aim to improve the quality, mix and affordability of a wide range of preventative interventions.

The City's social care providers will need assistance to enable them to compete effectively in commissioning and procurement processes, including the development of lists of registered providers, identification of potential suppliers and redesign of procurement approaches. For example, there is potential to realise value for money by stimulating the voluntary sector and realising the energy and knowledge of local communities to provide innovation in delivery.

In addition, commissioners must clearly demonstrate full consideration of costs and benefits and take into account the impact on local providers and the sustainability of provider diversity.

Commissioners will strive to ensure that procurement is packaged in a manner that actively encourages local Small and Medium Enterprises or Voluntary and Community Sector organisations to participate.

Commissioners will take every opportunity to involve potential providers in developing service specifications.

Commissioners will recognise that consortia approaches are the preferred method for making larger contracts accessible to smaller local third sector providers.

Emerging Prevention Market

Health and social care markets face the same pressures and trends as economic markets, with an increasing emphasis on providing individualised or customised services that can adapt to the individual user's different and often changing expectations.

Areas for future development include:

- Activities to address social isolation.
- Practical help with shopping, gardening, minor repairs and adaptations in the home.
- Advice and support to promote healthy lifestyle choices.
- Community safety – fire safety, victim support and crime prevention.
- Supporting housing choices and home improvements.
- Alternatives to existing specialist transport services.

- Supporting volunteering – enabling people to make a positive contribution
- Timely responses to short-term escalation in need, such as telecare, community equipment and reablement.

It is anticipated that many of these interventions will be provided by the voluntary and community sector. Others will provided by a range of by a multi-agency approach including statutory organisations, private organisations and social enterprises across the housing, public health and social care sectors.

INTEGRATION

Given the challenges in relation to population growth and increased demand for health and social care support there is a growing expectation that commissioners will work together to identify local solutions that maximise outcomes for all. There are a range of local examples where this is happening such as the development of reablement and intermediate care services. There is evidence that closer working with housing services will deliver enhanced outcomes. More integrated planning and commissioning of prevention across health, social care and housing has the potential to:

- transform local services to provide greater quality and choice
- increase productivity through integrated service delivery
- offer greater personalisation of support
- achieve efficiencies to enable funding to be reinvested where there is greatest need[5]

The Health and Wellbeing board will provide the strategic forum and leadership to develop more integrated approaches to delivering outcomes and providing effective preventative and personalised support across Peterborough.

CONCLUSION

What is clear is that for prevention and early intervention to be effective requires a joined-up, strategic approach which can, in turn, deliver the desired outcomes and make best use of the available resources. This requires a new way of thinking within and engaging across local care economies that rewards closer integration, encourages innovation and market development, supports investment in physical (housing and environment) and social (people and community) capital and realises longer term rewards.

[5] Caring for our Future - consultation exercise, Department of Health (2011)

ACTION PLAN

	What are we trying to achieve	Where are we now?	What are we going to do?	Who is going to do it?	When will it be done?	We will know we have been successful when…
Universal Services						
1	**Improved access to information, advice and advocacy**	A range of information, advice and advocacy services are commissioned through the voluntary sector. The Council has implemented an online service directory.	Develop the Adult Social Care element of the Peterborough Direct service to provide enhanced information advice and signposting. Work with Healthwatch Peterborough to provide a broader range of opportunities for people to access information about health and social are services. Commission a range of information and advice services; ensure that, where appropriate, commissioned services include a clearly identified information and advice element. Information for carers an essential element. Work with other partners to link information and advice provision more effectively, particularly around finance,	PCC LCG HWP	April 2014	People can directly access information, advice and advocacy services. There are minimal hand offs between organisations before people get the service they need. People know where to turn to for advice and support. Services offer high quality information.

			entitlements and benefits Key partners include: • Locality Commissioning Group • Public Health • Children's Services • Neighbourhoods • Healthwatch • Employers and occupational health services			
2	**Developing community resources**	Time banking and volunteering opportunities are available. Community development work in relation to care and support is uncoordinated. The Disability Forum are actively developing sport and leisure opportunities.	Support the development of community resources such as: • Time banking and volunteering • Assist communities and groups to provide a network of support • Developing skills and knowledge • Supporting user led organisations • Support the set up of social enterprises Develop peer support opportunities alongside groups such as the Disability Forum.	PCC DF	April 2014	Innovative, new, community led services are developed and sustained. Communities are supported to develop local solutions to health and social care issues. Successful service development can be shared and replicated.

			Engage with neighbourhoods to better understand how support can be developed and delivered by communities. Work with partners to develop intergenerational approaches that reduce or mitigate social isolation and develop social capital.			
3	**Market development**	General market review has begun, development of market information planned. Working with strategic partners to develop a whole system approach is key.	Support the market to develop and provide a range of innovative, responsive and personalised services. This will include support to develop small voluntary groups and social enterprises. Better understand how people who fund their own support access services.	PCC LCG	December 2013	The market for preventative services is dynamic and responsive to the needs of the whole community.
4	**Low level support** Ensure people can easily access a range of low-level and practical support including: • Simple equipment and adaptations	Simple aids and adaptations alongside community equipment is available through the Council and through voluntary sector and independent providers. Voluntary sector agencies	Review voluntary sector practical support services and map against need. This will inform commissioning of new services. Work with stakeholders to coordinate practical support e.g. linking in fire service	PCC LCG	April 2014	People can readily and quickly access simple aids, adaptations and community equipment. Services are working together to support people to maximise their wellbeing at home. People are supported to maintain

	• Trusted traders and services • Housing related support • ASC transport	offer practical support services. The Council has developed an ASC transport policy aimed at supporting access to personalised transport options.	home checks with information on equipment. Improve access to simple aids and adaptations.			their homes to maximise their wellbeing.
Targeted Services : reablement and enablement						
5	**Further develop evidence based early interventions** Work with partners to ensure effective services are targeted at those who need them, including: • Telecare • Falls prevention	ASC working with health partners on falls prevention. Telecare infrastructure is developed and equipment is available.	Increase awareness in relation to telecare and assistive technology. Review falls and finalise falls prevention approach with health commissioners and providers. Work with housing providers to coordinate housing and social care support to more pro-actively support people to remain living in their homes. Work with agencies and services to raise awareness around prevention and support pro-active identification and signposting of people who would benefit from targeted interventions.	PCC LCG RSL	September 2013	People at risk of future social care support needs are identified and offered enabling support.

6	**Enhance access to reablement**	The reablement service supported around 600 FACS eligible people over 2012/2013. This has significantly reduced the need for long term support for those completing reablement.	Ensure that reablement is offered to people who do not meet adult social care eligibility but who would benefit from it. This could include working with voluntary sector and independent providers to mainstream the reablement approach across a broader range of services. Work with health partners to better integrate reablement with intermediate care, admission avoidance and hospital discharge services. Support people through transitional points in their lives to ensure that they are able to be as independent as possible. This includes developing longer term reabling approaches for people with learning disabilities, physical disabilities sensory impairment.	PCC LCG RSL	September 2013	Reabling service across health and social care are integrated and seamless. Reablement values are central to all social care support delivery. A whole lifespan approach to maximising people's independence is taken by all services.
Personalisation						
7	**Further develop integrated multi-agency approaches**	The reablement service is part of primary care based Multi-Discpilinary Teams aimed at reducing hospital	Ensure that health, social care and associated services can pro-actively respond to changing needs:	PCC LCG	April 2014	Health and social care services are integrated and seamless.

		admissions.	• Review and develop multi-disciplinary team approaches • Explore more effective joint working to support people with long-term-conditions			
8	**Prevention is central to health and social care interventions**	There are a range of services offering reabling and rehabilitation approaches to supporting people across health and social care.	Service specifications include maximising independence and proactive delivery of preventative interventions as core requirements. Work force development plans include raising awareness of and training staff in preventative approaches. Joint training around prevention across sectors to be developed. Develop a local professional prevention network to share practice.	PCC LCG RSL	September 2013	Prevention is central to all health, social care and related interventions. Prevention and integration are central to professional practice.
9	**Self-directed support**	The Council has developed self-directed support systems and commissioning approaches that support personalisation. Personal budget are the default method for providing	Review personalisation processes to ensure they are delivering the required outcomes. Work with health and other stakeholders to integrate personalisation and support	PCC LCG	March 2015	People have choice and control over their health and social care support. People have integrated, outcome focussed health and social care support plans.

		community support. The Council commissions a range of voluntary sector services focussed on supporting the personalisation agenda.	choice across the health and care economy. Promote Direct Payments as the preferred way to take a Personal Budget. Review the integration of health Personal Budgets with Social Care Personal Budgets.			People are enabled to commission their own, personalised support.

Key:
PCC Peterborough City Council
LCG Peterborough Local Commissioning Groups
HWP Healthwatch Peterborough
DF Disability Forum
RSL Residential Social Landlords

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SCRUTINY COMMISSION FOR HEALTH ISSUES	Agenda Item No. 8
16 JULY 2013	Public Report

Report of the Solicitor to the Council

Report Author – Paulina Ford, Senior Governance Officer, Scrutiny
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NOTICE OF INTENTION TO TAKE KEY DECISIONS

1. PURPOSE

1.1 This is a regular report to the Scrutiny Commission for Health Issues outlining the content of the Notice of Intention to Take Key Decisions.

2. RECOMMENDATIONS

2.1 That the Committee identifies any relevant items for inclusion within their work programme.

3. BACKGROUND

3.1 The latest version of the Notice of Intention to Take Key Decisions is attached at Appendix 1. The Notice contains those key decisions, which the Leader of the Council believes that the Cabinet or individual Cabinet Member(s) can take and any new key decisions to be taken after 25 July 2013.

3.2 The information in the Notice of Intention to Take Key Decisions provides the Committee with the opportunity of considering whether it wishes to seek to influence any of these key decisions, or to request further information.

3.3 If the Committee wished to examine any of the key decisions, consideration would need to be given as to how this could be accommodated within the work programme.

3.4 As the Notice is published fortnightly any version of the Notice published after dispatch of this agenda will be tabled at the meeting.

4. CONSULTATION

4.1 Details of any consultation on individual decisions are contained within the Notice of Intention to Take Key Decisions.

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

None

6. APPENDICES

Appendix 1 – Notice of Intention to Take Key Decisions

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PETERBOROUGH CITY COUNCIL'S NOTICE OF INTENTION TO TAKE KEY DECISIONS

PUBLISHED: 28 JUNE 2013

NOTICE OF INTENTION TO TAKE KEY DECISIONS

In the period commencing 28 days after the date of publication of this notice, Peterborough City Council's Executive intends to take 'key decisions' on the issues set out below. Key decisions relate to those executive decisions which are likely to result in the Council spending or saving money in excess of £500,000 and/or have a significant impact on two or more wards in Peterborough.

If the decision is to be taken by an individual cabinet member, the name of the cabinet member is shown against the decision, in addition to details of the councillor's portfolio. If the decision is to be taken by the Cabinet, it's members are as listed below:
Cllr Cereste (Leader); Cllr Elsey; Cllr Fitzgerald; Cllr Holdich; Cllr North; Cllr Seaton; Cllr Scott; and Cllr Walsh.

This Notice should be seen as an outline of the proposed decisions for the forthcoming month and it will be updated on a fortnightly basis. Each new notice supersedes the previous notice and items may be carried over into forthcoming notices. Any questions on specific issues included on the Notice should be included on the form which appears at the back of the Notice and submitted to Alex Daynes, Senior Governance Officer, Chief Executive's Department, Town Hall, Bridge Street, PE1 1HG (fax 01733 452483). Alternatively, you can submit your views via e-mail to alexander.daynes@peterborough.gov.uk or by telephone on 01733 452447.

Whilst the majority of the Executive's business at the meetings listed in this Notice will be open to the public and media organisations to attend, there will be some business to be considered that contains, for example, confidential, commercially sensitive or personal information. In these circumstances the meeting may be held in private, and on the rare occasion this applies this is indicated in the list below. A formal notice of the intention to hold the meeting, or part of it, in private, will be given 28 clear days in advance of any private meeting in accordance with The Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012.

The Council invites members of the public to attend any of the meetings at which these decisions will be discussed (unless a notice of intention to hold the meeting in private has been given).

You are entitled to view any documents listed on the notice, or obtain extracts from any documents listed or subsequently submitted to the decision maker prior to the decision being made, subject to any restrictions on disclosure. There is no charge for viewing the documents, although charges may be made for photocopying or postage. Documents listed on the notice and relevant documents subsequently being submitted can be requested from Alex Daynes, Senior Governance Officer, Chief Executive's Department, Town Hall, Bridge Street, PE1 1HG (fax 01733 452483), e-mail to alexander.daynes@peterborough.gov.uk or by telephone on 01733 452447. For each decision a public report will be available from the Governance Team one week before the decision is taken.

All decisions will be posted on the Council's website: www.peterborough.gov.uk/executivedecisions. If you wish to make comments or representations regarding the 'key decisions' outlined in this Notice, please submit them to the Governance Support Officer using the form attached. For your information, the

contact details for the Council's various service departments are incorporated within this notice.

KEY DECISIONS FROM 25 JULY 2013

KEY DECISION REQUIRED	DECISION MAKER	MEETING OPEN TO PUBLIC	RELEVANT SCRUTINY COMMITTEE	CONSULTATION	CONTACT DETAILS / REPORT AUTHORS	DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER (IF ANY OTHER THAN PUBLIC REPORT)
A1260 Longthorpe Bridge Works - KEY/25JUL13/01 To award the contract for the works, via the Eastern Highways Alliance Framework; to carry out essential strengthening and improvement works to Longthorpe Bridge.	**Councillor Gr. Uff. Marco Cereste Leader of the Council and Cabinet Member for Growth, Strategic Planning, Housing, Economic Development and Business Engagement**	**N/A**	Sustainable Growth and Environment Capital	Ward councillors and relevant internal stakeholders.	Simon Machen Head of Planning, Transport and Engineering Services Tel: 01733 453475 simon.machen@peterborough.gov.uk	It is not anticipated that there will be any further documents.
The Expansion of Fulbridge Academy to four forms of entry - KEY/25JUL13/02 Award of Contract for the Expansion of Fulbridge Academy, including the approval of property, legal and	**Councillor John Holdich OBE Cabinet Member for Education, Skills and University, Cabinet Member for Resources**	**N/A**	Creating Opportunities and Tackling Inequalities	Relevant internal and external stakeholders.	Brian Howard Programme Manager - Secondary Schools Development Tel: 01733 863976 brian.howard@peterborough.gov.uk	It is not anticipated that there will be any further documents.

financial arrangements for various enabling agreements with third parties.						

Fletton Parkway Widening Jn17-2 - KEY/25JUL13/03 To award the contract for Site Supervision and Contract Administration.	**Councillor Gr. Uff. Marco Cereste Leader of the Council and Cabinet Member for Growth, Strategic Planning, Housing, Economic Development and Business Engagement**	**N/A**	Sustainable Growth and Environment Capital	Relevant internal and external stakeholders.	Simon Machen Head of Planning, Transport and Engineering Services Tel: 01733 453475 simon.machen@peterborough.gov.uk	It is not anticipated that there will be any further documents
PREVIOUSLY ADVERTISED DECISIONS						
Moy's End Stand Demolition and Reconstruction - KEY/03APR/12 Award of Contract for the Demolition of the Moy's End Stand and Reconstruction	**Councillor David Seaton Cabinet Member for Resources**	**N/A**	Sustainable Growth and Environment Capital	Internal and External Stakeholders as appropriate.	Richard Hodgson Head of Strategic Projects Tel: 01733 384535 richard.hodgson@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Delivery of the Council's Capital Receipt Programme through the Sale of Dickens Street Car Park - KEY/03JUL/11 To authorise the Chief Executive, in consultation with the Solicitor to the Council, Executive Director – Strategic Resources, the Corporate Property Officer and the	**Councillor David Seaton Cabinet Member for Resources**	**N/A**	Sustainable Growth and Environment Capital	Consultation will take place with the Cabinet Member, Ward councillors, relevant internal departments & external stakeholders as appropriate.	Richard Hodgson Head of Strategic Projects Tel: 01733 384535 richard.hodgson@peterborough.gov.uk	It is not anticipated that there will be any further documents.

Cabinet Member Resources, to negotiate and conclude the sale of Dickens Street Car Park.						
Rolling Select List - Independent Fostering Agencies - KEY/01JUL/12 To approve the list for independent fostering agencies.	**Councillor Sheila Scott OBE Cabinet Member for Children's Services**	**N/A**	Creating Opportunities and Tackling Inequalities	Internal and external stakeholders as appropriate.	Oliver Hayward Commissioning Officer - Aiming High Tel: 01733 863910 oliver.hayward@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Clare Lodge Service Review Outcome - KEY/13NOV12/06 To approve the outcome of the service review of Clare Lodge Secure Unit.	**Councillor Sheila Scott OBE Cabinet Member for Children's Services**	**N/A**	Creating Opportunities and Tackling Inequalities	Internal and External Stakeholders as appropriate.	Oliver Hayward Commissioning Officer - Aiming High Tel: 01733 863910 oliver.hayward@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Residential Approved Provider List - KEY/13NOV12/08 Create a compliant Approved Provider List for Residential units for children and young people.	**Councillor Sheila Scott OBE Cabinet Member for Children's Services**	**N/A**	Creating Opportunities and Tackling Inequalities	Internal and external stakeholders as appropriate.	Oliver Hayward Commissioning Officer - Aiming High Tel: 01733 863910 oliver.hayward@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Future of Children's Play Services - KEY/13NOV12/09 To determine the future of Play Services in the city	**Councillor Sheila Scott OBE Cabinet Member for Children's Services**	**N/A**	Creating Opportunities and Tackling Inequalities.	To be undertaken with key stakeholders.	Oliver Hayward Commissioning Officer - Aiming High Tel: 01733 863910 oliver.hayward@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Care and Repair Framework Agreement - KEY/18DEC12/01 To approve a framework agreement and schedule of	**Councillor Nigel North Cabinet Member for Environment Capital and**	**N/A**	Strong and Supportive Communities	Relevant Internal Departments.	Russ Carr Care & Repair Manager Tel: 01733 863864 russ.carr@peterborough.gov.uk	It is not anticipated that there will be any further documents.

rates to deliver disabled facility grant work. specifically providing disabled access to toilet and washing facilities and associated work in domestic properties.	**Neighbourhoods**					
Award of Contract for the 413 Bus Service - KEY/27DEC12/01 Award of Contract for Route 413 (Maxey to City Centre) from 1 April 2013.	**Councillor Gr. Uff. Marco Cereste Leader of the Council and Cabinet Member for Growth, Strategic Planning, Housing, Economic Development and Business Engagement**	**N/A**	Sustainable Growth and Environment Capital	Relevant internal departments and external stakeholders.	Mark Speed Transport Planning Team Manager Tel: 317471 mark.speed@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Environment Capital Action Plan - KEY/24JAN13/02 Approve the Plan for public consultation.	**Cabinet**	**YES**	Sustainable Growth and Environment Capital	Four week public consultation.	Charlotte Palmer Climate Change Team Manager charlotte.palmer@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Fletton Parkway Junction 17 to 2 improvement scheme - KEY/24JAN13/07 To agree funding is brought forward between 2012 and 2015 in Medium Term Financial Strategy and the	**Councillor Gr. Uff. Marco Cereste Leader of the Council and Cabinet Member for Growth, Strategic Planning,**	**N/A**	Sustainable Growth and Environment Capital	Relevant internal and external stakeholders.	Mark Speed Transport Planning Team Manager Tel: 317471 mark.speed@peterborough.gov.uk	It is not anticipated that there will be any further documents.

contract awarded for the works.	**Housing, Economic Development and Business Engagement**					

Sale of Craig Street Car Park - KEY/25MAR13/01 To approve the sale of land known as Craig Street Car Park.	**Councillor David Seaton Cabinet Member for Resources**	**N/A**	Sustainable Growth and Environment Capital	Relevant Internal and External Stakeholders and ward councillors.	David Gray Capital Projects Officer Tel: 01733 384531 david.gray@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Short Breaks Service - KEY/08APR13/01 Approval to award a contract for the provision of short break services for families with children and young people with disabilities.	**Councillor Sheila Scott OBE Cabinet Member for Children's Services**	**N/A**	Creating Opportunities and Tackling Inequalities	Relevant internal departments.	Oliver Hayward Commissioning Officer - Aiming High Tel: 01733 863910 oliver.hayward@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Peterborough Highway Services 2013-2023 - KEY/18APR13/01 To approve the preferred bidder and award the contract for Peterborough Highway Services.	**Councillor Gr. Uff. Marco Cereste Leader of the Council and Cabinet Member for Growth, Strategic Planning, Housing, Economic Development and Business Engagement**	**N/A**	Sustainable Growth and Environment Capital	Relevant Internal and External Stakeholders.	Andy Tatt Transport and Engineering Group Manager Tel: 01733 453469 andy.tatt@peterborough.gov.uk	It is not anticipated that there will be any further documents.
The Expansion of Gladstone Primary School onto the site of the Gladstone Community Centre - KEY/18APR13/02 Award of Contract for the Expansion of Gladstone	**Councillor John Holdich OBE, Cabinet Member for Education, Skills and University**	**N/A**	Creating Opportunities and Tackling Inequalities	Relevant internal and external stakeholders, ward councillors and public.	Brian Howard Programme Manager - Secondary Schools Development Tel: 01733 863976 brian.howard@peterborough.gov.uk	It is not anticipated that there will be any further documents.

Primary School on the site of the Gladstone Community Centre.						
Passenger Transport - Subsidised Service Provision - KEY/30MAY13/02 To decide on the level of subsidised services to be provided by Peterborough City Council from the 1st of October 2013 in line with the revised budget allocation.	**Cabinet**	**Yes**	Sustainable Growth and Environment Capital	Cross-group advisory group.	Mark Speed Transport Planning Team Manager Tel: 317471 mark.speed@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Future Cities Demonstrator - KEY/11JUL13/01 To re-affirm the council's commitment to delivering the 'Peterborough DNA' programme as set out in the submission to the Technology Strategy Board (TSB) which attracted the award of £3M to Peterborough City Council on the 31 March 2013.	**Councillor Gr. Uff. Marco Cereste Leader of the Council and Cabinet Member for Growth, Strategic Planning, Housing, Economic Development and Business Engagement**	**N/A**	Sustainable Growth and Environment Capital	Consultation has taken place with the Leader of the Council, the Chief Executive, Cabinet Member for Environment Capital and Neighbourhoods, the Peterborough DNA Delivery Team and approximately fifty partnership representatives at a workshop on 14th May 2013.	Charlotte Palmer Climate Change Team Manager charlotte.palmer@peterborough.gov.uk	It is not anticipated that there will be any further documents

CHIEF EXECUTIVE'S DEPARTMENT Town Hall, Bridge Street, Peterborough, PE1 1HG

Communications
Strategic Growth and Development Services
Legal and Governance Services
Policy and Research
Economic and Community Regeneration
HR Business Relations, Training & Development, Occupational Health & Reward & Policy

STRATEGIC RESOURCES DEPARTMENT Director's Office at Town Hall, Bridge Street, Peterborough, PE1 1HG

Finance
Internal Audit
Information Communications Technology (ICT)
Business Transformation
Strategic Improvement
Strategic Property
Waste
Customer Services
Business Support
Shared Transactional Services
Cultural Trust Client

CHILDRENS' SERVICES DEPARTMENT Bayard Place, Broadway, PE1 1FB

Safeguarding, Family & Communities
Education & Resources
Strategic Commissioning & Prevention

OPERATIONS DEPARTMENT Director's Office at Town Hall, Bridge Street, Peterborough, PE1 1HG

Planning Transport & Engineering (Development Management, Construction & Compliance, Infrastructure Planning & Delivery, Network Management, Passenger Transport)
Commercial Operations (Strategic Parking and Commercial CCTV, City Centre, Markets & Commercial Trading, Tourism)
Neighbourhoods (Strategic Regulatory Services, Safer Peterborough, Strategic Housing, Cohesion, Social Inclusion, Neighbourhood Management)
Operations Business Support (Finance)
Public Health

ADULT SOCIAL CARE Director's Office at Town Hall, Bridge Street, Peterborough, PE1 1HG

Care Services Delivery (Assessment & Care Management; Integrated Learning Disability Services and HIV/AIDS; Regulated Services)
Strategic Commissioning (Mental Health & Integrated Learning Disability; Older People, Physical Disability & Sensory Impairment; Contracts, Procurement &

Compliance)

Quality, Information and Performance (Performance & Information; Strategic Safeguarding; Business Support & Governance; Business Systems Improvement; Quality and Workforce Development)

Updated: 8 JULY 2013

SCRUTINY COMMISSION FOR HEALTH ISSUES
WORK PROGRAMME 2013/14

Meeting Date	Item	Progress
20 June 2013 *Draft report 4 June* *Final report 11 June*	**Quarterly Performance Report on Adult Social Care Services in Peterborough** To scrutinise the performance on adult social care services and make any appropriate recommendations. **Contact Officer: Tina Hornsby, Assistant Director Quality Information and Performance**	
	Peterborough and Stamford Hospital NHS Foundation Trust - Update **Contact Officer: Jane Pigg**	
	Introduction to Public Health **Contact Officer: Sue Mitchell, Interim Director of Public Health**	
	Review of 2012/13 and Future Work Programme 2013/14 To review the work undertaken during 2012/13 and to consider the future work programme of the Committee. **Contact Officer: Paulina Ford, Senior Governance Officer**	
16 July 2013 *Draft report 28 June* *Final report 5 July*	**Adult Social Care Prevention Strategy** To scrutinise the development of an Adult Social Care Prevention Strategy. **Contact Officer: Jana Burton, Interim Director of Adult Social Care**	

Meeting Date	Item	Progress
	Cambridgeshire Community Services Transition To receive and comment on a report on the work of the Cambridgeshire Community Services Transition Programme. **Contact Officer: Jessica Bawden, Cambridgeshire & Peterborough Clinical Commissioning Group**	
	Cambridgeshire & Peterborough Clinical Commissioning Group – Priorities and Older Peoples Programme To receive a report and comment on the work on the three priority areas for Cambridgeshire and Peterborough Clinical Commissioning Group. **Contact Officer: Jessica Bawden**	
	Young Peoples Sexual Health and Wellbeing Strategy To scrutinise the Sexual Health & Wellbeing Strategy and receive an update on Teenage Pregnancy. **Contact Officer: Sue Mitchell**	
19 September 2013 *Draft report 3 Sept* *Final report 10 Sept*	**Safeguarding Vulnerable Adults board Annual Report 2012/2013** **Contact Officer: Tina Hornsby**	
	Performance Report for Public Health **Contact Officer: Sue Mitchell**	
	Learning Disability Review	

Meeting Date	Item	Progress
	Contact Officer: Tim Bishop	
	Cambridgeshire & Peterborough Clinical Commissioning Group – Response to Francis Report **Contact Officer: Jessica Bawden**	**Adult Social Care – Local Account**
	Health and Wellbeing Board – Delivering the Health and Wellbeing Strategy **Contact Officer: Wendi Ogle-Welbourn, Assistant Director**	
12 November 2013 Draft report 28 Oct Final report 4 Nov	**Quarterly Performance Report on Adult Social Care Services in Peterborough** To scrutinise the performance on adult social care services and make any appropriate recommendations. **Contact Officer: Tina Hornsby, Assistant Director Quality Information and Performance**	
	Longer Lives **Contact Officer: Sue Mitchell**	
	Dementia Resource Centre **Contact Officer: Jana Burton, Interim Director of Adult Social Care**	
	Transformation Programme for Adult Social Care and Business Plan	

Meeting Date	Item	Progress
	Contact Officer: Jana Burton, Interim Director of Adult Social Care	
22 January 2014 *Draft report 7 Jan* *Final report 14 Jan*	**East of England Ambulance Service – Annual progress report**	
	Suicide Prevention Strategy **Contact Officer: Kathy Hartley – NHS- Cambs CC**	
(Joint Meeting of the Scrutiny Committees and Commissions)	**Budget 2014/15 and Medium Term Financial Plan** To scrutinise the Executive's proposals for the Budget 2014/15 and Medium Term Financial Plan. **Contact Officer: John Harrison/Steven Pilsworth**	
25 March 2014 *Draft report 7 March* *Final report 14 March*	**Quarterly Performance Report on Adult Social Care Services in Peterborough** To scrutinise the performance on adult social care services and make any appropriate recommendations. **Contact Officer: Tina Hornsby, Assistant Director Quality Information and Performance**	
	Cabinet Member for Adult Social Care – Portfolio Progress Report	
	Minor Injury and Illness Unit (MIIU) To scrutinise the implementation and impact of the new Minor Injury and Illness Unit. **Contact Officer: Jessica Bawden**	

Updated: 8 JULY 2013

Possible Items for Scrutiny: 2013/14

Adult Social Care • Quality Framework • Quality Care Commission • Quarterly update report on Dementia Resource Centre • Portfolio Progress Report from the Cabinet Member for Adult Social Care • Implementation of the Electronic Call Monitoring System.	From March 2013 meeting. From March 2013 meeting.
Healthwatch	From July meeting
Public Health Transfer • Quarterly Report on outcome Framework • Portfolio Progress Report from the Cabinet Member for Community Cohesion, Safety and **Public Health**	From March 2013 meeting
The Cambridgeshire & Peterborough Clinical Commissioning Group • Business Plan Six monthly progress report	From March 2013 meeting
Peterborough and Stamford Hospital NHS Foundation Trust - Response to Recommendations from the Francis Inquiry	From June 2013 meeting.

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