PETERBOROUGH CITY COUNCIL

HEALTH AND WELLBEING BOARD

THURSDAY 10 SEPTEMBER 2015
1.00 PM

Bourges/Viersen Room - Town Hall
Contact – paulina.ford@peterborough.gov.uk, 01733 452508

AGENDA

There is an induction hearing loop system available in all meeting rooms. Some of the systems are infra-red operated, if you wish to use this system then please contact Paulina Ford on 01733 452508 as soon as possible.

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

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http://democracy.peterborough.gov.uk/documents/s21850/Protocol%20on%20the%20use%20of%20Recording.pdf

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Board Members:

Cllr J Holdich (Chairman), Vacant (Vice Chairman), Cllr D Lamb, Cllr W Fitzgerald, Andy Vowles, Cathy Mitchell, Dr Michael Caskey, Dr Paul van den Bent, Dr Gary Howsam, Dr Kenneth Rigg, David Whiles, Wendi Ogle-Welbourn, Dr Liz Robin and Adrian Chapman

Co-opted Members: Russell Wate and Claire Higgins

Substitute: Dr Harshad Mistry

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

PETERBOROUGH CITY COUNCIL

MINUTES OF A MEETING OF THE HEALTH AND WELLBEING BOARD HELD IN THE BOURGES / VIERSEN ROOMS, TOWN HALL ON 18 JUNE 2015

Members Present:

Councillor Holdich, Leader of the Council and Cabinet Member for Education, Skills and University (Chairman)
Councillor Wayne Fitzgerald, Deputy Leader and Cabinet Member for Integrated Adult Social Care and Health
Councillor Diane Lamb, Cabinet Member for Public Health
Wendi Ogle-Welbourn, Corporate Director People and Communities
Dr Liz Robin, Director for Public Health
Cathy Mitchell, Local Chief Officer
Dr Gary Howsam, Chair of the Borderline Local Commissioning Group
David Whiles, Peterborough Healthwatch

Co-opted Members Present:

Hannah Campling, Independent Chair of the Local Safeguarding Children's Board and Peterborough Safeguarding Adults Board Representative
Claire Higgins, Chairman of the Safer Peterborough Partnership

Also Present:

Gillian Beasley, Chief Executive, PCC
Will Patten, Assistant Director for Adult Commissioning
Ryan O'Neill, Public Health Analyst – Advanced
Anne McConville, Interim Consultant, Public Health
Dr Fiona Head, System Transformation Programme Director
Jennifer Hodges, Signposting and Information Officer, Healthwatch
Pippa Turvey, Senior Democratic Services Officer

1. Apologies for Absence

Apologies for absence were received from Adrian Chapman, Dr Michael Caskey, Dr Paul van den Bent, Dr Kenneth Rigg and Councillor Sheila Scott.

2. Declarations of Interest

There were no declarations of interest.

3. Minutes of the Meeting Held on 26 March 2015

The minutes of the meeting held on 26 March 2015 were approved as a true and accurate record.

4. Health and Wellbeing Board Membership

The Board received a report which followed the Peer Review in March 2014. The review suggested that the Board should consider reviewing the membership of the Board and subsequent national guidance. The report sought agreement of the revised membership and makeup of the Health and Wellbeing Board.

The Corporate Director People and Communities introduced the report and provided an overview update. Key points highlighted and raised during discussion included:

- It was considered by the Peer Review that the Board had a large representation of Local Authority Councillors.
- It was not recommended that the Cabinet Member for Children's Services become a Board Member, however if relevant issues were to arise, the Cabinet Member could attend particular meetings.
- It was proposed that a Peterborough General Practitioner be appointed as Vice-Chair of the Board. As there was none present at the meeting, for the area covered by the Board, it was suggested that this be discussed further with a wider group of GPs and brought back to the next Board meeting.

RESOLVED that the Health and Wellbeing Board:

1. Reduce number of Local Authority Councillors on the Board;

2. Appoint a GP for Peterborough as the Vice Chair at the next Board meeting;

3. Agree Health and Wellbeing Programme Board becomes a Board that brings chairs of all the boards that report into the Health and Wellbeing board together to deliver on the Health and Wellbeing Strategy; and

4. Where agencies or organisations request membership on the Health and Wellbeing Board they are to submit request in writing to the Chair and they will be asked to present their case at the Health and Wellbeing Board for consideration.

5. Clinical / Local Commissioning Groups

The Board agreed to consider agenda item 5(b) 'System Transformation Programme' ahead of agenda item 5(a) 'Primary Care Programme Update'.

a) System Transformation Programme

The Board received a report which followed on from a request for an update on the work of the Cambridgeshire and Peterborough System Transformation Programme.

The Local Chief Officer introduced the report and provided an overview update. The System Transformation Programme Director was in attendance to respond to questions. Key points highlighted and raised during discussion included:

- The local health service across Cambridgeshire and Peterborough were facing a significant financial gap, which would not be closed without change.
- Analytical work had been undertaken to identify future trends that would need to be taken into consideration.
- The programme was currently entering phase two, 'the engagement process'. This would come in two stages, with discussions on potential solutions taking place in the autumn. A formal public consultation planned for January 2016.
- It was to be considered by the Programme whether to apply again to be a "Vanguard" site, focusing on closer collaboration between hospitals.
- It was noted that the current estimates on savings were around £30 million, whereas the financial gap was £300 million.
- It was advised that possible additional ideas to cover the financial gap centred on prevention, waste between organisations and allocation uplifts. The System Transformation Programme Director was confident that a substantial portion of the gap could be covered.

- A multi-agency approach was advocated and it was confirmed that the Corporate Director People and Communities attends an officer board for System Transformation, and would continue to do so.

RESOLVED that the Health and Wellbeing Board noted the report.

b) Primary Care Programme Update

The Board received a report which followed on from a request for additional background information regarding the Cambridgeshire and Peterborough Clinical Commissioning Group's Primary Care Programme.

The Local Chief Officer introduced the report and provided an overview update. Key points highlighted and raised during discussion included:

- The vision of the programme included the transformation of primary care in Cambridgeshire and Peterborough and the development of the workforce.
- Development session have been arranged with the Joint Committee as to whether the Clinical Commissioning Group can take on full delegated commissioning for due diligence.
- It was advised that there were no saving targets attached to the programme, however efficiencies in the services would be examined.
- As part of the Prime Minister's Challenge Fund, the programme would look at the return received on its investments.

RESOLVED that the Health and Wellbeing Board noted the report.

c) Borderline and Peterborough Primary Care Transformation Programme, Including Prime Minister's Challenge Fund Delivery

The Board received a report following the successful outcome of Borderline and Peterborough Local Commissioning Group's primary care bid to the Prime Minister's Challenge Fund in March 2015. The report updated the Board on the successful bid and the development of the Primary Care Transformation Programme being established to implement this work.

The Chair of the Borderline Local Commissioning Group introduced the report and provided an overview update. Key points highlighted and raised during discussion included:

- The reduction in core funding and the work force problems faced by the GP service would have a significant impact in future performance.
- The workload of funds were now based in secondary care, through the necessary resources had not followed the work.
- Alternative methods of meeting demand were being investigated within a locally designed vision.
- The Programme had been provided with £2.6 million for the financial year, which was required to be used.
- Increased access to a primary care presence in Accident & Emergency was proposed, rather that attempting to change the existing footfall.
- The setting up of 'Federation' Hubs was currently in progress. Five hubs were intended across the Peterborough area, which were at different stages in the process.
- The use of 'Web GP' and other health care professionals was being considered to advise on health care issues.
- It was advised that if the shift in practice was successful, fewer buildings may be required.

RESOLVED that the Health and Wellbeing Board noted the contents of the report.

d) Operational Plan and Quality Premium 2015 - 2016

The Board received a report following discussion at the meeting on 26 March 2015 on the draft Clinical Commissioning Group Operational Plan. The Operational Plan had been further refined and the report sought for the Board to note the current Plan and the range of indicators identified. It was further sought for the Board to signal agreement to two out of the three proposed local indicators which would form part of the Quality Premium for 2015/16.

The Local Chief Officer introduced the report and provided an overview update. Key points highlighted and raised during discussion included:

- The final version of the Operational Plan and Quality Premium 2015/16 had been submitted and work had commenced on the local plans.
- The local quality premium work was undertaken through the election period this year and identified three local indicators. The Board were required to choose two out of the three to support as the Clinical Commissioning Group local indicators.
- Following discussion regarding which area had the most scope for improvement it was agreed that the indicators of 'prevalence of breast feeding at 6-8 weeks from birth' and 'stroke patients admitted to stroke unit within 4 hours' would be supported by the Board.

RESOLVED that the Health and Wellbeing Board:

1. Noted the current status of the NHS Cambridgeshire and Peterborough Clinical Commissioning Group Operational Plan 2015/16;

2. Noted the content of the Clinical Commissioning Group Quality Premium 2015/16; and

3. Signalled agreement to the local indicators of 'prevalence of breast feeding at 6-8 weeks from birth' and 'stroke patients admitted to stroke unit within 4 hours'.

6. Public Health

a) Annual Director of Public Health Report

The Board received a report from the Director of Public Health as part of her statutory duty to prepare an annual report on the health of the population and of the local authority to publish the report. The Board was requested to received and discuss the information provided within the report.

The Director of Public Health introduced the report and provided an overview update. Key points highlighted and raised during discussion included:

- There had been a positive move to place Public Health within the leadership context of the authority.
- The report was considered to be easy to read and identified ways in which issues could be addressed.
- It was a good blue print for communities and organisations to follow.
- Matters such as life expectancy, heart disease, smoking alcohol and obesity were highlighted.
- It was emphasised that housing and road design had an impact on public health. It would be looked into whether the work carried out by Cross Keys on their properties related to any correlation in public health improvements.
- It was noted that work needed to be done to change the expectation that the final 20 years of a person's life would be spent in ill-health.

RESOLVED that the Health and Wellbeing Board noted the key health issues raised within the Annual Report and would feed into the priorities of the boards that sit below the HWBB and SPP where appropriate.

b) Report on the Findings of the Task and Finish Groups on Bowel and Cervical Cancer Screening and Immunisations Update in Peterborough

The Board received a report which presented the findings of the task and finish groups established to investigate the poor uptake rates for the bowel and cervical cancer screening programmes, and of childhood immunisations and prenatal pertussis in Peterborough.

The Interim Consultant in Public Health introduced the report and provided an overview update. Key points highlighted and raised during discussion included:

- It was found that uptake for cervical cancer screening was lower among younger woman and in more deprived areas.
- Possible influences for this were cultural awareness, 'acceptability' of the test and the migrant population.
- The city had a lower than average take up of immunisations. It was thought this may be partly due to a lack of clarity regarding the timetable for immunisations and documentation that was incompatible with the systems used.
- There was little awareness among pregnant woman in Peterborough of pertussis immunisations and midwives did not offer the service. The service needed to be considered more important.
- The Council had a responsibility to promote the services and NHS had provided £9,000 to assist with communications.
- It was suggested that access be made via school in order to ensure the migrant population was not missed.
- With regards to Whooping Cough, the Local Chief Officer would consider whether this could be combined with the six week baby check.
- The issue was raised that many workplaces may not take up a wellbeing programmes, as they were unaware of the free availability of services. The Director of Public Health would explore this.

RESOLVED that the Health and Wellbeing Board supported the recommendations of the Task and Finish Groups to:

1. Develop and deliver targeted community engagement, health education and information programmes to raise awareness, promote uptake and to better understand health beliefs and barriers to uptake of cancer screening and immunisations, based on the findings in the reports and the best evidence of effectiveness. Consider use of community leaders, social media and 'community connectors' to achieve greater reach with the target populations;

2. Explore undertaking a Did Not Attend Analysis (DNA) pilot of those who have not taken up cancer screening to:
   - Validate data quality and continuing residence
   - Explore reasons for DNA
   - And scope resource implications to inform the development of an action plan;

3. Develop a targeted and more responsive immunisation offer through better explanation of immunisation schedules; targeted reminders to parents; regularly updating contact details and capturing documented immunisations in the home country at new patient registration; and

4. Review progress and uptakes in a year.

7. Adult Social Care

a) Adult Social Care Better Care Fund Update

The Board received a report which provided an update on the delivery and monitoring following Peterborough's successful re-submission to the Better Care Fund and the start of funding on 1 April 2015.

The Assistant Director for Adult Commissioning introduced the report and provided an overview update. Key points highlighted and raised during discussion included:

- Work was now being undertaken with health partners to carry out the implementation phase of the Better Care Fund.
- Discussion with partners had taken place to avoid any duplication of work.
- Peterborough City Council was the lead body on implementation.
- A seven day working lead had not yet been agreed, however work on this was progressing, due to be completed in the next few days.
- Some work was more advanced than others and all progress on delivery was being tracked.

RESOLVED that the Health and Wellbeing Board noted the Better Care Fund monitoring and non-elective admissions targets.

8. Children's Services

a) Peterborough 2014 / 15 Children and Young People's Joint Strategic Needs Assessment

The Board received a report which summarised the findings from the Public Health Department's Children and Young People's Joint Strategic Needs Assessment (JSNA), and requested that the Board consider the stated conclusions and recommendations for further work to address the needs identified by the JSNA.

The Director of Public Health and the Public Health Analyst introduced the report and provided an overview update. Key points highlighted and raised during discussion included:

- There was a duty on the Council to create a JSNA, which was more detailed than the Annual Report and informed strategies going forward.
- The key needs and recommendations set out in the Assessment were engaging wider groups for more broad consultations, the impact of drugs and alcohol on young people as a deep dive topic and the analysis of data regarding children in poverty.
- The key messages identified in 'Policy Context and Recommendations' were the level of disadvantaged children in Peterborough compared to the national average, issues of poverty, smoking while pregnant and education, population group, and the wide socio-economic gap within the city.
- The collection of data from doctor's surgeries with regard to registered population and resident population was queried. It was advised that it was aimed to collect data on registered population, however this issue was a common experience and there was a disparity.
- Issues surrounding neglect would be addressed within the strategic proposals.
- The content of the JSNA would need to be fed into the relevant work streams and future planning would be required in order to avoid any disconnect.

RESOLVED that the Health and Wellbeing Board:

1. Noted the information and analysis incorporated within the Joint Strategic Needs Assessment (JSNA) and approved the report for publication on the Council's public website;

2. Confirmed the Children & Families Joint Commissioning Board as an appropriate forum to review effectiveness of existing strategies, interventions and provision in meeting the needs in the Children and Young People's JSNA and improving outcomes for the children and young people in the city;

3. Agreed there should be a wider engagement strategy to share initial JSNA findings and partnership representation as appropriate on the further phases and deep dive work;

4. Confirmed the Children & Families Joint Commissioning Board as an appropriate forum to commission selected further analysis based on these JSNA findings; and

5. Approved the recommendation that the JSNA be linked to the Safer Peterborough Plan and used to underpin the delivery of priorities within the delivery plan where appropriate.

b) Healthy Child Programme

The Board received a report which provided an update on the Healthy Child Programme, Emotional Wellbeing and Mental Health, and the Joint Child and Health Commissioning Unit.

The Corporate Director People and Communities introduced the report and provided an overview update. Key points highlighted and raised during discussion included:

- It was advised the Peterborough City Council was leading the commissioning of the Child Health Commissioning, which included the Clinical Commissioning Group and Cambridgeshire County Council.
- Discussions had been ongoing with the lead service provider for child and adolescent mental health services in relation to additional spending and productivity. As yet plan has not been agreed and discussions continue.
- It was noted that concerns had been raised specifically regarding the waiting lists and trajectory for addressing these.

RESOLVED that the Health and Wellbeing Board noted the current activity and performance in child health commissioning and delivery and it was agreed that an update on of Child and Adolescent Mental Health Services waiting lists be tabled at the next meeting

9. Health Watch

a) Children / Young People Engagement

The Board received a presentation which sought to raise awareness of the strategy and activity of the engagement of children and young people in the Peterborough area.

The Signposting and Information Officer provided the Board with the presentation. Key points highlighted and raised during discussion included:

- Work had been undertaken to increase representation of key groups in areas such as mental health.
- Awareness of issues had been raised in schools through a number of Videoscribes and information packs, which had been considered a success.
- Surveys had been carried out on pupils and teachers, showing that many felt well supported and well prepared regarding health issues.
- The Signposting and Information Officer would provide information to Board Members on what had been included in the Videoscribes.
- It was considered to be a very proactive programme.

RESOLVED that the Health and Wellbeing Board noted the contents of the presentation.

10. Health and Wellbeing Strategy

The Board received a report which was submitted due to the need to update the Joint Health and Wellbeing Strategy (JHWS) 2012-15, which expired at the end of the year. The report sought the Board's agreement to update the Joint Strategic Needs Assessment (JSNA) and the JHWS, and to approve the process for doing so.

The Director of Public Health introduced the report and provided an overview update. Key points highlighted and raised during discussion included:

- The Health and Wellbeing Board Strategy was due to expire at the end of the year, and was a statutory requirement.
- The Clinical Commissioning Group and the Council must have regard to the Strategy in their actions.
- The Strategy was based on the outcomes of the JSNA.
- It was suggested that a draft document be brought to the next meeting ahead of a three month consultation period.
- It was noted that this could be linked in to the Council's Local Development Plan, and that a collaboration between directorates was underway.

RESOLVED that the Health and Wellbeing Board:

1. Update the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS) to ensure they reflect current needs and strategic priorities in Peterborough;

2. Agree new JSNA core dataset and comment on further core content required (to be updated annually);

3. Agree 2015/16 JSNA forward programme; and

4. Carry out a comprehensive review of the JHWS 2012-15 including consultation with stakeholders and the public, and deliver a new JHWS 2016-20 by the end of this year.

INFORMATION ITEMS

The remainder of the items on the agenda were for information only and were noted without comment.

11. Section 256 Agreement for Hospital Alcohol Liaison Project

The Board received a report which provided additional information regarding the joint commissioning of the Hospital Alcohol Liaison Project.

RESOLVED that the Health and Wellbeing Board noted the report.

12. Performance Report

The Board received a report which provided an update with regard to performance progress and outlined the issues and challenges following the last report presentation on the 26 March 2015.

RESOLVED that the Health and Wellbeing Board noted the next steps and key considerations under each section of the Performance Report.

13. Schedule of Future Meetings and Draft Agenda Programme

RESOLVED that the Health and Wellbeing Board noted the dates of future meetings and agreed future agenda items for the Board.

1.00pm – 3.15pm
Chairman

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 5 (a)
10 SEPTEMBER 2015		PUBLIC REPORT
Contact Officer(s):	Cathy Mitchell, Local Chief Officer, Borderline and Peterborough System, NHS Cambridgeshire and Peterborough Clinical Commissioning Group	Tel. 01733 758505

CCG COMMISSIONING INTENTIONS 2016/17

RECOMMENDATIONS	
FROM : Cathy Mitchell, Local Chief Officer, Borderline and Peterborough System, NHS Cambridgeshire and Peterborough Clinical Commissioning Group	**Deadline date : 21 September 2015**
For the Board to note the current status of operational planning for the financial year 2016/17 for the System and Borderline and Peterborough LCGs.	

1. ORIGIN OF REPORT

This report builds on discussions held by the Board at their last meeting when an update on operational planning for the financial year 2015/16 was received. Since submission of that report, work is now underway to take forward the operational planning process for the financial year 2016/17.

2. PURPOSE AND REASON FOR REPORT

The purpose of this report is to brief the Board on the current position relating to operational planning for the financial year 2016/17. The Board is requested to note the content of this report and to discuss the issues raised. The Board's views will be taken into account throughout the operational planning process.

3. CURRENT POSITION

3.1 Through the work of the System Transformation Programme, the vision and the associated culture of *One System, One Plan, One Budget* has been in development within the Cambridgeshire and Peterborough System.

3.2 In the light of this work, the historical practice of issuing annual commissioning intentions to providers was reviewed and consideration given on how operational planning in general could be developed in the longer term.

3.3 A Cambridgeshire and Peterborough Health and Care System Transformation Programme Development Event which included Local Authority representation was held on 1st July 2015 where both issues were discussed and considered. Ultimately in the longer term, the System could aim to produce one operational plan and one set of planning intentions, both of which could be developed jointly.

3.4 However, it was felt that it would be more prudent and more realistic to adopt a measured approach for operational planning in 2016/17, whilst taking the first steps towards achieving the ultimate aim of *One System, One Plan, One Budget.* The role of the Strategic Programme Boards as a means of assisting with this change through converging strategic and local issues was acknowledged.

3.5 The outcomes of the system transformation programme development event and the proposals to develop a fresh approach to planning intentions and operational planning were considered further by the System Transformation Board at their meeting on 20 July 2015. The current thinking around operational planning is described in the following paragraphs.

3.6 **Principles**: Several over-arching principles have been drawn up to guide the operational planning process:

- Encourage clinical redesign across organisational boundaries
- Opportunity to improve outcomes and/or standardise delivery
- Have a single clear lead or accountable provider
- Focus on reducing the unit cost of delivery
- Able to help reduce further demand

3.7 **Governance:** NHS Cambridgeshire and Peterborough CCG would retain overall responsibility for the 2016/17 operational planning process. The System Transformation Board (STB) would be responsible for progressing the development and finalisation of the operational plan. In order to take forward the operational planning process, the STB would most likely need to set up some time-limited task and finish groups, for example, an editorial group to write the plan and liaise with existing groups such as the Finance Directors Group.

3.8 **Stakeholders:** Contributors to the plan would comprise:

NHS Cambridgeshire & Peterborough CCG	Cambridge University Hospitals NHS Foundation Trust	Hinchingbrooke Health Care NHS Trust
Peterborough & Stamford Hospitals NHS Foundation Trust	Cambridgeshire and Peterborough Foundation Trust	Papworth Hospital NHS Foundation Trust
Uniting Care	Cambridgeshire Community Services NHS Trust	Cambridgeshire County Council and Peterborough City Council (see note below)

Note: Local Authority leads are requested to consider how best to secure engagement from the voluntary sector.

Each contributing stakeholder organisation would need to commit one or more individuals to work together on developing the plan.

3.9 **Engagement:** Sufficient and effective engagement will be required throughout the process with key stakeholders, for example, Health and Wellbeing Boards, HealthWatch and the Patient Reference Group.

3.10 **The Plan:** As stated earlier, the operational plan for 2016/17 will be a first step towards achieving the longer term vision of *One System, One Plan, One Budget.* It will be a combination of a few priority system-wide development areas and other aspects of planning which would need to be commissioner-led. The plan would also reflect the priorities identified by NHS England in the annual national planning guidance.

3.11 **The Timetable:** An initial timetable is set out in **Appendix 1**. The Board are requested to note that this may change as we gain more experience of taking forward the new approach to operational planning and to take account of emerging national timetabling requirements.

3.12 With regard to local commissioning group planning intentions, this work is being co-ordinated by the relevant CCG planning and contracts group who will hold a workshop to collate, assess and evaluate emerging local planning intentions. This work in addition to the system-wide priority areas will be formalised into a set of planning intentions to be published at the end of September 2015.

The Borderline and Peterborough Executive Partnership Board will co-ordinate the development of the Local Commissioning Intentions for the local System and feed into the System wide plan.

4. CONSULTATION

4.1 In drawing up the draft Operational Plan for 2016/17, discussions will be held with Peterborough and Cambridgeshire Health and Wellbeing Boards. Their views will be taken into account where possible during the drafting of the plan.

4.2 In addition, the CCG Governing Body will discuss the 2016/17 Operational Plan at their meetings in public.

4.3 On approval of the plan by NHS England (estimated for May 2016), the CCG will update the status of the draft plan to final and it will be published on the CCG website and shared with key stakeholders.

5. ANTICIPATED OUTCOMES

The Board is requested to note the current status of operational planning for the financial year 2016/17.

6. REASONS FOR RECOMMENDATIONS

NHS planning guidance places even greater emphasis on ensuring that plans are aligned and that they are not drawn up in isolation. In particular, there should be alignment between plans and the local health and wellbeing strategy. The views of the Board are sought, in order to ensure consistent development and implementation of operational plans for 2016/17.

7. ALTERNATIVE OPTIONS CONSIDERED

The production of an Operational Plan is required by NHS England through the national planning guidance. There is no alternative option available.

8. IMPLICATIONS

Implementation of the 2016/17 Operational Plan will require strong partnership working and input from the Board as needed throughout the year.

9. BACKGROUND DOCUMENTS

Source Documents	Location
Not applicable	

Appendix 1: Initial Timetable for the 2016/17 Operational Plan (subject to change)

TIMING	Stage 1: June to September PREPARATION	Stage 2: October to January WRITING THE PLAN	Stage 3: February to May FINALISING THE PLAN & CONTRACTS
ACTIVITIES	• Agree over-arching principles to guide system planning process • Each organisation to nominate planning lead(s) • Confirm strategic route map to guide production of the plan and alignment with longer term direction • Identify early financial and other planning assumptions • Identify key operational issues, collate and assess • Prepare,finalise and agree System Planning Intentions • Confirm format and content of System Operational Plan • Agree approach to contracts negotiations	• Agree what can be realistically delivered in year 1 of development of System Plan • Finalise and agree financial and other planning assumptions • Conduct retailed activity and financial analysis / assess / agree • Write and assess supporting Business Cases • National planning guidance issued and reflected in System Plan • Conduct Contract Negotiations • Write First Draft System Operational Plan (for January) • Early public engagement and comms conducted	• Finalise Contract Negotiations • Agree and sign Contracts (end February) • Finalise System Operational Plan and Business Cases (end March) • System Operational Plan communicated to public and wider stakeholders • Internal and External Assurance leading to formal sign off (April to May)
OUTPUTS	• Shared system planning intentions agreed which set the operational agenda for the year ahead • Resources available to undertake system planning • Structure and content of plan agreed • Clarity on how contracts will be negotiated	• Aligned activity and financial assumptions • Service change proposals quantified in business cases • Agreed changes included in contracts • Local people are kept informed and their views used to shape the system plan	• Signed contracts in place for 1st April • System Operational Plan agreed and signed off • Service change projects ready for implementation • Internal and external assurance processes completed

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 5 (b)
10 SEPTEMBER 2015		PUBLIC REPORT
Contact Officer(s):	Wendi Ogle-Welbourn, Corporate Director: People & Communities. Peterborough City Council.	Tel. 01733 863607

LA COMMISSIONING INTENTIONS 2016/17

RECOMMENDATIONS	
FROM: Wendi Ogle-Welbourn, Corporate Director: People & Communities. Peterborough City Council.	**Deadline date : n/a**
1. For the Board to note the commissioning intentions of the Local Authority for 2016/17 financial year.	

1. ORIGIN OF REPORT

1.1 This report is submitted to Board following a request for an update on the commissioning intentions of the Local Authority for the 2016/17 financial year.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to inform the Board of the Local Authority's commissioning intentions for the next financial year, 2016/17, and to obtain the Board's view on the report.

3. COMMISSIONING INTENTIONS

3.1 Peterborough City Council has the highest aspirations for its citizens and wants them to be safe, healthy, happy and fulfilled. We want them to enjoy and benefit from educational, training and social opportunities that maximise their skills and develop their abilities so that they can realise their ambitions in terms of employment opportunities and general life chances. We believe that citizens are best nurtured and developed within strong families and communities.

3.2 We will continue to develop preventative approaches and early interventions to help and support communities, coordinating the support of the voluntary, private, independent and public sectors and ensuring that delivery of services is joined up. We will collaborate with communities to help them find their own solutions so that problems and difficulties do not escalate, and where additional support is required we will engage with other agencies and organisations to commission or deliver and secure this help locally. We will adopt an approach that sees prevention and intervention as a continuum so that it is never deemed too late to positively intervene and prevent the deterioration in an individual's circumstances.

3.3 Our strategy is to manage demand by preventing or delaying the need for specialist services. We will ensure that when our citizens need help and support they can access a choice of appropriate services delivered close to home and focused on maximising independence.

3.4 The local authority have developed the following commissioning principles that guide decision making:-

- **Demand management** - We will prioritise the commissioning of services and solutions that will prevent or delay escalating support and service needs;
- **Efficient and effective** - we will take an evidence based approach to commissioning services and solutions that demonstrate efficient and effective use of resources. Services and solutions will be commissioned on the basis of best value;
- **Return on investment** - We will commission on the basis of a clear, whole-life costed benefits realisation for service users, PCC and other stakeholders. This will include analysis of the value of social and environmental outcomes of commissioning activities as well as financial outcomes;
- **Market Development** - We will work with providers and partners to ensure that commissioning activity across health and social care is coordinated and best value and outcomes are delivered;
- **Statutory duties** - We will ensure PCC complies with its legal duties within the statutory legislative and policy framework;
- **Collaborative commissioning** - We will work to commission services and co-produce solutions with strategic partners and service users/ parent carers where this best delivers PCC outcomes and objectives.

3.5 Oversight of our commissioning intentions sit with the People & Communities Commissioning Board, the Commissioning Board is responsible for ratifying and challenging the decisions that have been made to ensure that they are in line with the above principles. In addition, the Commissioning Board will be the responsible body for the progression of these commissioning intentions.

3.7 As outlined in Peterborough's demand management, prevention and early help strategy, co-production is an essential part of the Local Authorities approach to commissioning. The Local Authority has specifically commissioned a piece of work focussed on ensuring meaningful engagement and co-production with providers, service users and other key stakeholders.

3.8 The commissioning intentions for 2016/17 all fall under one of four themes, below, there is a further breakdown of these in appendix 1:

- Managing Demand – Front Door
- Managing Demand – Investment in the Community
- Operating Models
- New Ways of Working

4. CONSULTATION

4.1 Significant consultation has already commenced with internal partners, further consultation both by individual theme and as a whole will be undertaken with the private, voluntary and independent sectors, service users and other key stakeholders.

5. ANTICIPATED OUTCOMES

The Board is requested to note the commissioning intentions for the 2016/17 financial year.

6. REASONS FOR RECOMMENDATIONS

The commissioning intentions is part of the planning element of the commissioning cycle. Essentially it takes the form of early engagement with stakeholders informing them of the Local Authority's intentions for the coming year. It is crucial that this prior information is made available to a broad group of organisations, including both internal and external partners as well as community, voluntary, independent and private sector organisations as

these stakeholders, are able to make and shape their business planning around the proposed intentions. If these intentions were not shared with stakeholders in advance, we would not be supporting the organisations to make strategic decisions, but rather on a case by case basis.

As stated above, as a Local authority we do not and cannot deliver all the service we are responsible for, therefore we require stakeholders to be in a position to respond to our request for them to deliver services ultimately to assist us in discharging our duties as a Local Authority.

7. ALTERNATIVE OPTIONS CONSIDERED

This is the most appropriate method early notification and engagement with partners and local organisations and there would be no reasonable alternative to achieve the same outcome.

8. IMPLICATIONS

The result of these commissioning intentions will be a fundamentally different way of working with partners, agencies and organisations in the city. The success of the resulting commissioned services will provide a more sustainable offer for the people of Peterborough.

9. BACKGROUND DOCUMENTS

N/A

Theme	Managing Demand – Front Door	Managing Demand – Investment in the Community	Operating Models	New Ways of Working
Intentions	Improve self-service function Improve the 'Triage' Process to more effectively and efficiently advise the customer to reach conclusion that negates the need for specialist services Improve the information advice and guidance available to the people of Peterborough Establish an eMarket place to give better access and transparency to customers of the services available	Community empowerment – Enhance the role of voluntary and community groups to help reduce isolation, increase community support in the home and provide local activities Commission services which provide a greater support to carers Greater investment in care and repair services, adaptations and assistive technology to enable people to live independently in their homes for longer and delaying the need for high cost services Commission advocacy services to support people who are unable to represent themselves	Specialist expertise to be available earlier with the intention of preventing the need for further support Change the make-up of delivery teams by using differently qualified workers to reduce demand on social workers time Review the Adults Social Care operations with a view of integrating services with NHS multi-disciplinary teams Building on the success of the SPP and expand the number of integrated teams to better meet the needs of the people we work with Commission/Provide services that focus on whole families and communities that recognise the dependencies and impact on each other: Substance misuse Safeguarding Domestic Abuse	Expand the use of technology so that human resources are focused on direct delivery rather than duplicating recording of information and spending unnecessary time travelling Improve contract management – improve the performance of contracts and effectively manage the supply chain Jointly commission services with Clinical Commissioning Group and/or Cambridgeshire County Council – • Child health 0 – 19 services, • Adults Mental Health • Live Healthy Service

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 6
10 SEPTEMBER 2015		PUBLIC REPORT
Contact Officer(s):	Dr Liz Robin, Director of Public Health	Tel. 01733 207175

PETERBOROUGH CARDIOVASCULAR DISEASE JOINT STRATEGIC NEEDS ASSESSMENT

RECOMMENDATIONS	
FROM : Dr Liz Robin, Director of Public Health	**Deadline date : n/a**

1. That the Board notes the information and analysis in the CVD JSNA and supports the publication of the JSNA dataset and summary on its public website.
2. That the Board considers the verbal report from the workshop held on 9th September to inform further engagement with stakeholders and the public.
3. That the Board supports the recommendations that:
    a. The Health and Wellbeing Programme Board establishes a CVD programme steering group, drawing on the membership of the CVD JSNA steering group and the Inequalities in Coronary Heart Disease Programme Board, to lead the development of further work on services for prevention, treatment and care and support;
    b. The CVD programme should seek to improve the cardiovascular health of all in Peterborough whilst addressing the issues of inequality in risk, access and outcomes.
    c. The Public Health Board promotes a 'health in all programmes' approach across the local authority to address the wider determinants and risk factors for CVD;
    d. That the CVD JSNA informs the development of the 'Healthy Peterborough' 2016 health and wellbeing campaign plan.

1. ORIGIN OF REPORT

1.1 This report is submitted to Board following the decision taken by the Health and Wellbeing Programme Board (HWPB), at their May 2014 meeting, that cardiovascular disease (CVD) should be the top priority focus area. The priority was ratified by the Health and Wellbeing Board in July 2014. The HWPB tasked the Public Health Team with leading an exercise to scope CVD and to propose a work plan with key performance indicators and outcomes to be considered and signed off by the HWPB/HWB.

1.2 Following a workshop in January 2015 and further discussions, the HWB decided that a Joint Strategic Needs Assessment (JSNA) was required to inform the development of the CVD work plan and the Health and Wellbeing Strategy, 2016-21. This report presents a summary of the CVD JSNA; the full data set will be available on the Peterborough City Council website.

1.3 Cardiovascular disease (CVD) is an umbrella term for all disease of the circulatory system including coronary heart disease (CHD), heart failure, stroke and peripheral arterial disease. Heart disease and stroke and their risk factors are the focus of this JSNA.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide a summary of the information in the CVD JSNA data set and draw attention to the key findings on the prevalence of cardiovascular disease and its risk factors in the local population.

2.2 The Health and Wellbeing Board is invited to consider the findings and next steps and approve the publication of the report and data set.

2.3 The JSNA is intended to inform the health and wellbeing strategy and the commissioning of services for the prevention, treatment, and care and support of people affected by cardiovascular disease with the aim of improving population health outcomes.

2.4 This report is for the Board to consider under its terms of reference no. 2.2:

- *to actively promote partnership working across health and social care in order to further improve health and wellbeing of residents;*

And 3.3:

- *To keep under review the delivery of designated public health functions and their contribution to improving health and wellbeing and tackling inequalities.*

2.5 This report supports the Health and Wellbeing Board strategic priority of 'Preventing and treating avoidable illness' and particularly the linked outcomes of addressing disease and poor health indicators; and the HWB function

- *To develop a Health and Wellbeing Strategy for the City which informs and influences the commissioning of partner agencies*.

3. SUMMARY OF KEY POINTS FROM THE CVD JSNA

3.1 The CVD JSNA presents and analyses information from a variety of sources on the impact, and prevalence, of cardiovascular disease on the population of Peterborough, using registration with practices in the Borderline and Peterborough Local Commissioning Groups (LCGs) as the best proxy for residency as the majority of Peterborough residents are registered with these practices.17 of the 22 practices fall in the most deprived quintile (20%) for Cambridge and Peterborough Clinical Commissioning Group (CCG) based on levels of deprivation.

3.2 The population of Peterborough is growing and ageing, which will increase the need for services for the prevention and treatment of CVD. The population is predicted to rise by 23% from 2010 to 2021. Population growth is expected to be 2-4 times greater for men and women age 85+ and 70-74. The prevalence of CVD rises with age and is higher in more deprived populations. The best available data, which is not drawn from exactly equivalent populations groups or timeframes, suggests that the number of people estimated to have CVD in Borderline and Peterborough LCG will rise from 21,674 in 2015 to 24,405 by 2021 and 27,570 by 2031.

3.3 Although the mortality rates from circulatory diseases for men and women of all ages have fallen substantially in recent years, bringing Peterborough close to the national rates, the mortality rates for circulatory disease in men and women under the age of 75 remain above England rates. Mortality rates, standardised for age, for coronary heart disease are also raised compared to England for men and markedly so for women. The standardised mortality rates from stroke at all ages and for women under 75 is similar to the England rates; for men under 75, rates have fallen and were better the England rate in 2013 (though this should be monitored to see if it is sustained).

3.4 General practices collect information about the number of people with certain conditions and risk factors for CVD as part of the Quality and Outcomes Framework (QOF). There is some variation in data collection and it was not possible to analyse QOF by ethnicity nor standardise for the age and sex of the practice populations, making comparisons difficult.

3.5 The QOF data on prevalence show that CVD risk factors are relatively high in the relatively younger and more deprived population in Borderline and Peterborough LCGs, who may not be diagnosed with CVD yet, but are at high risk of developing disease and requiring services as they age.

3.6 There are significant inequalities identified within cardiovascular health. Circulatory diseases (including coronary heart disease and stroke) contribute a third of the gap in life expectancy between Peterborough and the national average for men and half for women.. Ethnicity is a risk factor for CVD, with premature coronary heart disease being more

common for South Asian populations in the UK, while stroke is more common among people of black ethnicity. Hospital admissions and deaths data for circulatory diseases in Peterborough show a correlation with wards with a high proportion of BME groups. These wards are also the most deprived, and there is a known relationship between deprivation and cardiovascular disease. Central, Park, Ravensthorpe, West, East, North and Dogsthorpe wards have higher % BME, % living in income deprived households, standardised mortality ratios for deaths from circulatory diseases and coronary heart disease (all ages) and higher standardised emergency admission ratios for coronary heart disease.

3.7 General Practitioners and others working in primary care manage the majority of treatment and prevention in cardiovascular disease and support people living with the conditions. Peterborough City Council commissions NHS Health Checks for all people aged 40-70, not known to have a condition, to identify risk factors for cardiovascular and kidney disease and diabetes with referral to a general practitioner or a lifestyle service, as appropriate, for those found to be at risk. Cambridgeshire and Peterborough Clinical Commissioning Group commissions hospital and community services. Peterborough City Council supports eligible people with continuing care needs and commissions lifestyle services e.g. smoking cessation. The level and detail of information on services varies and selected information is discussed in the JSNA.

3.8 Whilst Peterborough compares well to England in offering eligible 40-75 year olds a NHS Health Check, the conversion rate (i.e. the number of those invited who attend) is disappointing at 47.9% in 2014-5. 777 of 6042 (13%) of those attending for a Health Check in 2013-4 had a 20% 10 year risk of CVD. There is concern nationally and locally that not everyone with CVD or its risk factors is known, and if known, are treated and supported effectively.

3.9 The National Institute for Health and Care Excellence (NICE) and various professional organisations produce guidance on effective prevention (with intervention at both individual and population level) and on treatments and standards for the organisation of services. Local hospitals contribute data to national audits of services for coronary heart disease and stroke, which benchmark services against national standards. This information should be used by the proposed CVD Programme and local commissioners to inform commissioning intentions.

4 CONSULTATION

4.1 Public Health held a cardiovascular disease workshop for partners on 30 January 2015 focused on the three work streams identified by the HWPB of ‘prevention and early intervention’, ‘treatment and reablement’ and ‘continuing care’.

4.2 There was an overall commitment from those attending the workshop that a population-based approach to prevention should be adopted and that the programme should be linked with existing strategies for targeting people at particularly high risk of cardiovascular disease including promoting the uptake and appropriate referrals to services from Health Checks.

4.3 In addition to the focus on prevention, the workshop identified scope to improve treatment pathways and outcomes for those with cardiovascular disease, to include acute interventions and reablement e.g. in stroke. It recognised the work of the Coronary Heart Disease Inequalities Board and looked to learn from, and build on, this for the wider cardiovascular disease programme.

4.4 A Steering Group was established for the CVD JSNA to secure input and engagement with GPs, hospital clinicians and other service providers with the intention that Steering Group members would later provide input to the programme of work following on from the JSNA. (See annex 2 for membership; other commitments have meant that not all those invited

could attend the two meetings). There is cross membership with the Coronary Heart Disease Inequalities Board.

4.6 A briefing seminar was held for councillors on 9th June.

4.7 The JSNA Steering Group recognises that the views of service users, and those who experience barriers to accessing services, need further development in the CVD work programme.

4.8 A second stakeholder workshop is being held on 9th September and a verbal update will be available at the Health and Well Being Board meeting on 10th September.

5 ANTICIPATED OUTCOMES

5.1 The information and analysis in the CVD JSNA will inform the development of a programme of work to improve health outcomes from cardiovascular disease and address inequalities. This will require action at both an individual and a population/geographical level to address the prevalence of risk factors and support behavioural change.

5.2 The JSNA will inform the development of a collaborative programme of work to tackle CVD; and will be of interest to both commissioners and providers of services.

5.3 The Public Health Board will use the JSNA to inform how CVD and its risk factors are addressed through a 'health in all programmes' approach across the local authority.

5.4 Cardiovascular disease will be a priority in the Health and Wellbeing Strategy 2016-21 and progress will be monitored and reported.

6 REASONS FOR RECOMMENDATIONS

6.1 The above recommendations are to be considered with a view towards improving the cardiovascular health and wellbeing of the local population and improving collaborative working between appropriate stakeholders within the healthcare community to facilitate better service delivery and outcomes and address health inequalities.

7 ALTERNATIVE OPTIONS CONSIDERED

Cardiovascular disease is a major cause of death and disability in Peterborough with high levels of preventable mortality in men and women under the age of 75. Peterborough is ranked 125th out of 155 local authorities for premature deaths from heart disease and stroke. The Health and Wellbeing Board had prioritised CVD and a JSNA was seen as necessary to inform the development of a programme of work to improve prevention and treatment and so population health. Doing nothing is not an option, and a co-ordinated multi-sector, multi-intervention programme is most likely to be effective.

8 IMPLICATIONS

8.1 The CVD JSNA demonstrates that the prevalence of risk factors and the impact of CVD (deaths and number of people living with a condition) shows marked ethnic and gender differences. The development and implementation of a CVD work programme will address this leading cause of premature death in Peterborough and contribute to tackling significant inequalities in health and wellbeing.

8.2 NHS bodies –the CCG, NHS England, Monitor-have a legal duty under the Health and Social Care Act, 2012, to give due regard in the exercise of their functions to reducing inequalities between patients in access to and outcomes from health services. A local authority must, when using the public health grant, have regard to the need to reduce inequalities between people in an area with respect to the benefits that they can obtain from that part of the health service provided by the local authority.

9 BACKGROUND DOCUMENTS

None

10. APPENDICES

ANNEX 1: Peterborough Cardiovascular Disease JSNA summary

ANNEX 2: CVD JSNA Steering Group Membership

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PETERBOROUGH CITY COUNCIL

Cardiovascular Disease Joint Strategic Needs Assessment

Summary

2015

Contents -

1. INTRODUCTION AND BACKGROUND TO THE CVD JSNA

1.1 Joint Strategic Needs Assessments

Joint Strategic Needs Assessments (JSNA) analyse the health needs in a population to inform the development of health and wellbeing strategies and the commissioning of health and social care services. The JSNA process identifies current and future health and wellbeing needs and priorities. Peterborough has a programme to develop JSNAs on priority topics identified by the Health and Wellbeing Board which will inform its health and wellbeing strategy and the commissioning of services by Peterborough City Council and Cambridgeshire and Peterborough Clinical Commissioning Group (CCG).

Cardiovascular disease (CVD) was identified as a priority by the Peterborough Health and Wellbeing Board in 2014; a workshop was held in January 2015 and a JSNA requested in spring 2015.

This summary is supported by further data and analysis in the Cardiovascular Disease Joint Strategic Needs Assessment, 2015, available on the Peterborough City Council web site. It does not aim to replicate the information in the JSNA Core Data Set.

1.2 CVD

CVD is an umbrella term for all disease of the circulatory system including coronary heart disease (CHD), heart failure, stroke and peripheral arterial disease. Heart disease and stroke and their risk factors are the focus of this JSNA. CVD causes more than a quarter of all deaths (160, 000) in the UK each year and there are an estimated 7 million people living with CVD in the UK.

CVD is generally due to reduced blood flow to the heart, brain or part of the body caused by atheroma (fatty deposits) or thrombosis (blood clots) which block the arteries. Having one cardiovascular condition increases the risk of developing another. The assessment and management of risk and access to prevention and treatment services influences mortality rates and need for care and support.

1.2.1 Risk factors for CVD

A number of common risk factors are recognised as increasing the likelihood of developing CVD:

- Fixed factors such as family history, gender, ethnicity and ageing;
- Lifestyle factors such as smoking, obesity, nutrition, lack of physical activity, high alcohol consumption;
- Wider determinants such as deprivation, poverty, poor education and working conditions;
- Physiological/ metabolic risk factors, which may develop in response to those above, such as high blood pressure (hypertension), diabetes (high blood sugar), and hyperlipidaemia (high blood fats).

There is evidence that interventions at the level of the population at risk, and with individuals, can be effective in changing behaviour; clinical interventions and treatments can be effective in managing the metabolic risk factors.

1.3 Services and interventions

General Practitioners and others working in primary care manage the majority of treatment and prevention in CVD and support people living with the conditions.

Peterborough City Council commissions NHS Health Checks for all people aged 40-74, not known to have a condition, to identify risk factors for cardiovascular and kidney disease and diabetes with referral to a general practitioner or a lifestyle service, as appropriate, for those found to be at risk. Cambridgeshire and Peterborough Clinical Commissioning Group commissions hospital and community services. Peterborough City Council supports those with continuing care needs and commissions lifestyle services e.g. smoking cessation. The level and detail of information on services varies and selected information is discussed in the JSNA.

2 SUMMARY OF KEY FINDING IN THE CVD JSNA

2.1 Population

- The population of Peterborough is predicted to rise by 23% from 176,300 in 2010 to 217,000 by 2021. Population growth to 2021 is expected to be high for men aged 85+ (90%) and 70—74 (57%); and women aged 70-74 (57%) and 85+ (56%).
- The majority of the population is registered with the 20 GP practices in the Peterborough Local Commissioning Group (LCG) and the 10 practices in the Borderline LCG. 17 of these practices fall in the most deprived quintile (20%) of Cambridgeshire and Peterborough Clinical Commissioning Group based on the registered population's level of deprivation compared to England.
- 12.7% of the Peterborough registered population is aged 65+, compared to 15.9% within the CCG as a whole i.e. Peterborough has a relatively young population.
- Peterborough has a relatively high proportion of black and minority ethnic (BME) residents.
- In the 2011 census, 17.5% of residents identified themselves as BME compared to 14.6% nationally.
- The best available data, which are not drawn from exactly equivalent population groups or timeframes, suggest that the number of people estimated to have CVD in Borderline and Peterborough LCGs will rise from 21,674 in 2015 to 24,405 by 2021 and 27,570 by 2031.

To summarise, information on the composition (age, ethnicity) of the population and the best estimates for the future show that Peterborough has a growing and ageing population which will increase the need for services.

2.2 Epidemiology

- Peterborough has significantly[1] high mortality rates for cardiovascular deaths under the age of 75 and for all causes of mortality considered preventable.
- The prevalence of CVD rises with age and is also higher in more deprived populations. South Asian populations in the UK are known to have higher rates of premature coronary heart disease (CHD).
- Although the mortality rates from circulatory diseases for men and women of all ages have fallen substantially in recent years, bringing Peterborough close to the national rates, the mortality rates for circulatory disease in men and women under the age of 75 remain above England rates.
- Mortality rates, standardised for age, for coronary heart disease are also raised compared to England for men and markedly so for women.
- The standardised mortality rates from stroke at all ages and for women under 75 is similar to the England rates; for men under 75, rates have fallen and were better the England rate in 2013.
- Data on the prevalence of cardiovascular disease and risk factors from practices in Borderline and Peterborough LCGs show that whilst the prevalence of some CVD is lower in the two LCGs than the CCG as a whole, the prevalence of risk factors such as smoking, diabetes and obesity is statistically significantly higher. This may partially be explained by the relatively low proportion of the population in these LCGs over the age of 65 and the relatively higher proportion of the population in the more deprived LCGs.
- Smoking prevalence data suggests that 45,850 people registered with Borderline and Peterborough practices were smokers in 2013/14.
- The combined percentage of patients recorded by GP practices as being obese is significantly higher in Borderline and Peterborough LCG registered patients than in the CCG as a whole (10.2% vs 8.7%). However, GP recording is known to underestimate overall rates of obesity in the population. The most recent estimates released by Public Health England (based on the 2012 Active People Survey) suggest the actual percentage of adults classified as obese in Peterborough to be 24.1%, 2.5% higher than the estimate for Cambridgeshire (21.6%). The Public Health Outcomes Framework also includes an estimated percentage of adults classified as either overweight or obese; in Peterborough, this figure is 65.5% whereas in Cambridgeshire it is 65.0%.
- The data on prevalence shows that CVD risk factors are relatively high in the relatively younger and more deprived population in Borderline and Peterborough LCGs, who may not be diagnosed with CVD yet, but are at high risk of developing disease and requiring services as they age.

Statistical significance[1]

Comparisons of local values to the national average in the Health Profiles are made through an assessment of 'statistical significance'. For each local indicator value, 95% confidence intervals are calculated which provide a measure of uncertainty around the calculated value which arises due to random variation. If the confidence interval for the local value exceed the value for the benchmark, the difference between the local value and the benchmark is said to be 'statistically significant'.

The epidemiology identifies substantial inequalities in health:

- Circulatory diseases (including coronary heart disease and stroke) contribute a third of the gap in life expectancy between Peterborough and the national average for men, and half for women.
- Whilst mortality rates from all circulatory diseases under the age of 75 (premature mortality) are above the national rates for men and women, the gap appears to be widening in women.
- Borderline & Peterborough practices comprise the majority (17/22, 77.3%) of practices in the most deprived quintile within the CCG. Within this quintile, prevalence is significantly higher than the CCG for CVD, CHD and diabetes despite a lower proportion of population being aged 65 or older.
- There are also statistically significantly higher numbers of population that smoke and are recorded by GP practices as obese in comparison to the CCG within this quintile.
- In Peterborough, smoking prevalence was 34.7 % in people in routine and manual occupations, the highest in the east of England in 2013.
- Hospital admissions and deaths data for circulatory diseases in Peterborough show a correlation with wards with a high proportion of BME groups. These wards are also the most deprived, and there is a known relationship between deprivation and CVD, as well as the known relationship between South Asian ethnicity and CHD. Central, Park, Ravensthorpe, West, East, North and Dogsthorpe wards have higher % BME, % living in income deprived households, standardised mortality ratios for deaths from circulatory diseases and coronary heart disease (all ages) and higher standardised emergency admission ratios for coronary heart disease.

2.3 Services

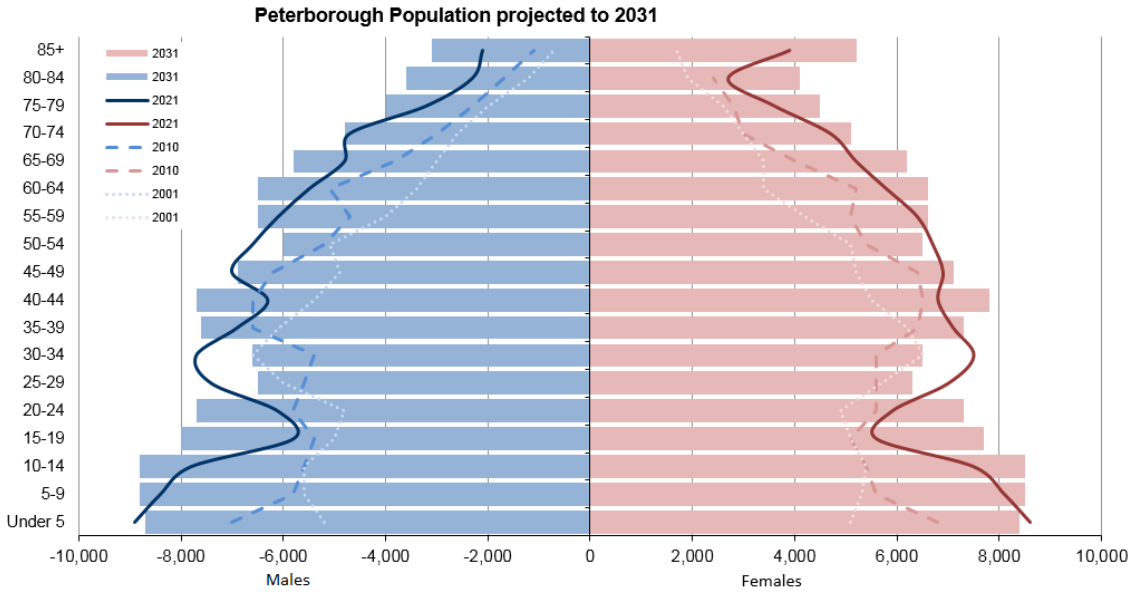
- Data on services is variable with the most robust data relating to acute care.
- National audit data provides a means to benchmark services against national standards and other organisations.
- Whilst Peterborough compares well to England in offering eligible 40-75 year olds a NHS Health Check, the conversion rate (i.e. the number of those invited who attend) is disappointing at 47.9% in 2014-5. 777 of 6042 (13%) of those attending for a Health Check in 2013-4 had a 20% 10 year risk of CVD.
- The standardised admissions rate for coronary heart disease in 2014-5 for Borderline and Peterborough LCGS is statistically similar to the CCG as a whole.
- Standardised admission rates for CHD, all ages and under 75, show a correlation with deprivation, being statistically higher for the more deprived populations.
- Emergency admission rates for coronary heart disease were highest in the areas of greatest deprivation.
- It was not possible to assess CHD hospital admission rates for different ethnic groups because of data quality issues
- There were 392 admissions with a diagnosis of stroke from Borderline and Peterborough LCGs in 2014-5.
- Admission rates for stroke are similar to those for the CCG as a whole.

- Patients with a diagnosis of stroke were discharged to their normal place of residence in 57.1% of cases. Data from Peterborough City Council Adult Social Care shows 22.1% (151/681) of assigned social care packages were necessitated by a CVA/Stroke condition, with the overall annual cost mounting to £4.02 million.
- Further work is needed to better understand the range of services for prevention, treatment, rehabilitation and continuing support for people with CVD across sectors and to map pathways of care against quality standards and needs. Consideration of user views and equity in access and outcomes will be central to this work programme.

3 PETERBOROUGH'S POPULATION

Peterborough has a growing and ageing population which will increase the need for services**.**

Figure 1: Peterborough population pyramid and projections, by age group, 2001-2031



Source: Cambridgeshire County Council Research Group

- The population of Peterborough is predicted to rise by 23% from 176,300 in 2010 to 217,000 by 2021.
- Population growth to 2021 is expected to be high for men aged 85+ (90%) and 70—74 (57%); and women aged 70-74 (57%) and 85+ (56%).
- The majority of the population is registered with the 20 practices in the Peterborough Local Commissioning Group (LCG) and the 10 practices in the Borderline LCG.
- 17 of these practices fall in the most deprived quintile of Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) based on the registered population's level of deprivation compared to England as calculated by English Indices of deprivation 2010 (which uses data on income, employment, health/disability, education, crime, housing/services and living environment).

- GP practices collect data on the number of people with CVD and the risk factors (prevalence) as part of the Quality and Outcomes Framework (QOF).
- The prevalence of CVD rises with age and is also higher in more deprived populations; this is reflected in the practice prevalence data.
- The best available data, which are not drawn from exactly equivalent population groups or timeframes, suggest that the number of people estimated to have CVD in Borderline and Peterborough LCGs will rise from 21,674 in 2015 to 24,405 by 2021 and 27,570 by 2031.

4 SUMMARY OF CARDIOVASULAR DISEASE EPIDEMIOLOGY

The Public Health Outcomes Framework (PHOF) data for 2011-13 summarises the population health outcomes and mortality rates from preventable mortality and CVD. It shows that Peterborough compares unfavourably with England and local authorities in the east of England. The under 75 mortality rate from CVD is significantly higher for both men and women living in Peterborough.

4.1 Mortality from CVD

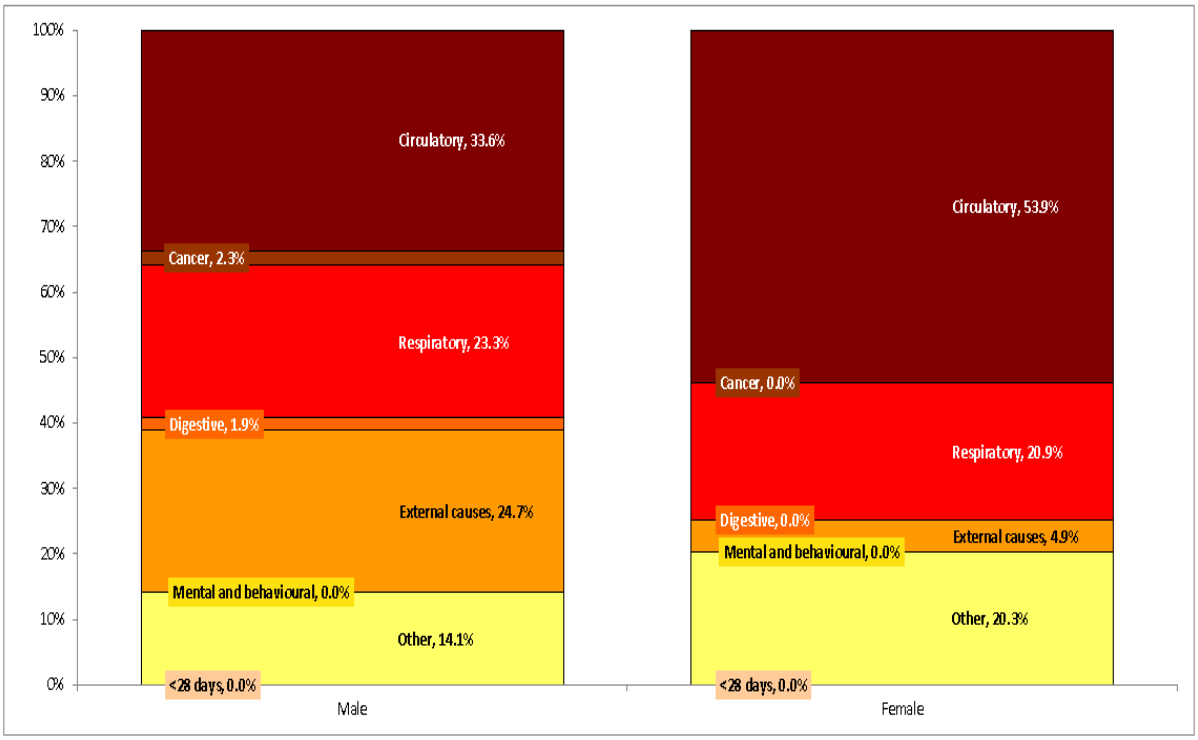
Figure 2: Public health outcome framework-health care and premature mortality

Indicator	Period	England	East of England region	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
4.03 - Mortality rate from causes considered preventable (Persons)	2011 - 13	183.9	162.4	176.5	149.1	159.7	162.3	155.5	207.2	164.0	215.1	184.5	154.1	183.9
4.03 - Mortality rate from causes considered preventable (Male)	2011 - 13	233.1	201.8	216.4	186.0	195.1	200.7	194.4	253.1	204.1	283.2	218.1	192.3	232.1
4.03 - Mortality rate from causes considered preventable (Female)	2011 - 13	138.0	125.4	138.3	113.7	125.3	127.3	120.1	161.3	126.0	150.8	153.1	118.0	138.0
4.04i - Under 75 mortality rate from all cardiovascular diseases (Persons)	2011 - 13	78.2	69.9	73.1	59.5	62.6	66.7	71.6	110.4	69.5	98.4	84.7	63.8	95.7
4.04i - Under 75 mortality rate from all cardiovascular diseases (Male)	2011 - 13	109.5	97.6	92.1	84.3	83.0	94.1	100.8	150.6	95.0	134.5	119.0	92.8	134.6
4.04i - Under 75 mortality rate from all cardiovascular diseases (Female)	2011 - 13	48.6	43.7	54.6	35.5	42.8	41.5	44.4	71.5	45.2	64.1	52.6	36.1	59.2
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Persons)	2011 - 13	50.9	45.2	49.5	38.6	43.8	42.0	43.9	79.4	45.4	68.0	55.3	41.5	62.6
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Male)	2011 - 13	76.7	67.6	64.4	59.3	59.5	64.1	65.3	113.7	67.8	104.3	78.8	63.8	98.5
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Female)	2011 - 13	26.5	24.0	35.2	18.6	28.6	21.7	24.0	46.3	24.1	33.3	33.3	20.3	29.0

Source: Public Health and Outcomes Framework

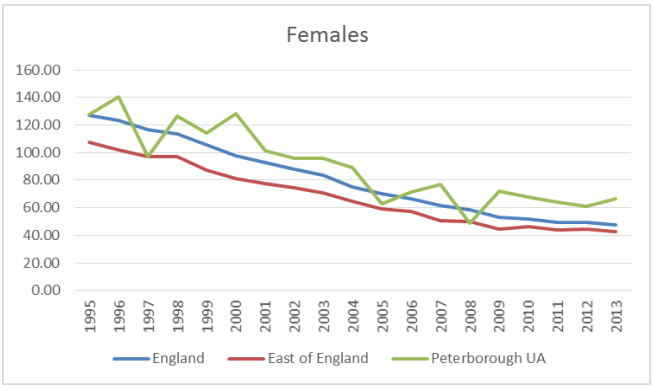
Life expectancy at birth is lower for Peterborough residents than in England. The life expectancy gap is 1.3 years for men (Peterborough 77.9 years; England 79.2) and 0.5 years in women (82.5, Peterborough; 83.0, England). Public Health England estimates that circulatory disease is a major contributing factor to the gap in life expectancy, explaining a third of the gap for men and half of the gap in women in Peterborough.

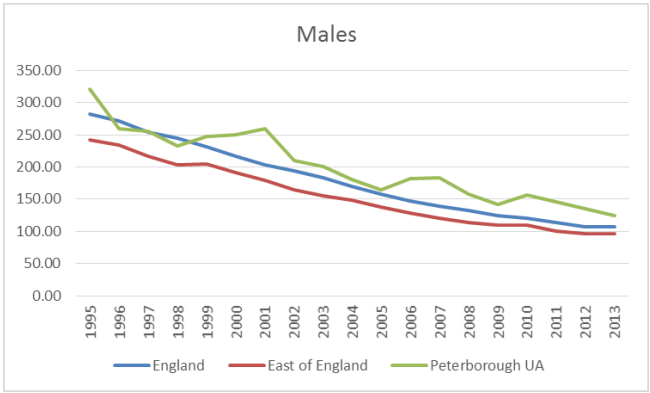
Figure 3: Breakdown of the life expectancy gap between Peterborough and England by broad cause of death, 2010-12



Source: Segment tool, PHE

Figure 4: Mortality from all circulatory diseases under age 75, DSR, 1995-2013



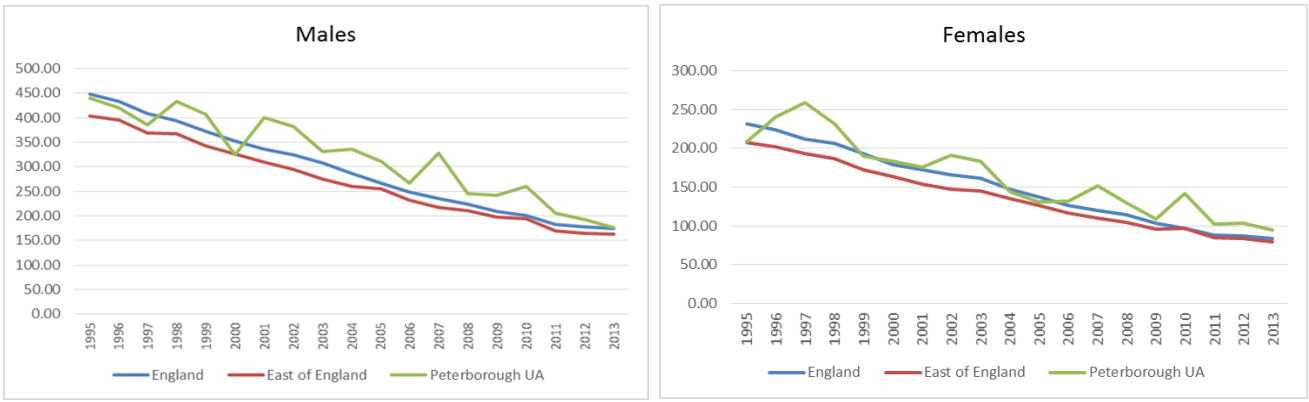


Source: Health and Social Care Information Centre, Indicator Portal

Whilst the directly age standardised mortality rates (DSR) from circulatory diseases, all ages, have fallen substantially over the last three years and are now similar to England, the mortality rates for men (124.12/100,000 vs 107.5/100,000) and women (66.4/100,000 vs 47.3/100,000) under the age of 75 in Peterborough are above the national rates.

In addition, the graph suggests a widening gap in premature CVD mortality in women which needs to be addressed and monitored.

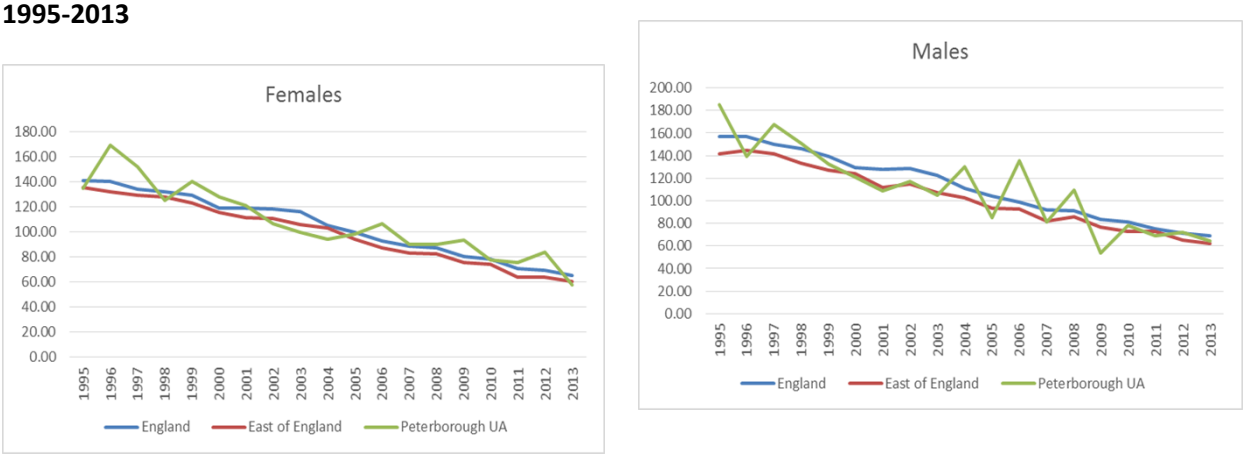
Figure 5: Mortality from Coronary Heart Disease, DSR, 1995-2013



Source: Health and Social Care Information Centre, Indicator Portal

Mortality rates (DSR) for coronary heart disease are also raised compared to England for men and markedly so for women. (Men 176.1/100,000 vs 174.7 nationally; women 94.6 vs 83.4/100,000).

Figure 6: Mortality from stroke (under 75), DSR, 1995-2013



Source: Health and Social Care Information Centre, Indicator Portal

The all age mortality rate (DSR) from stroke in Peterborough is marginally below the England rate for men (64.1 vs 68.7/100,000) and women (57.6 vs 65.1/100,000).

Peterborough mortality rates from stroke under age 75 are similar to England for females (11.8/100,000 vs 11.6/100,000 nationally).

For males, the Peterborough rate fell substantially from 17.5/100,000 in 2012 to 10.9/100,000 in 2013, which is better than the England rate of 16.0/100,000.

4.2 Prevalence of CVD

QOF (quality and outcomes framework) data are collected by primary care services (general practices). They represent GP diagnosed disease and hence GP recorded levels of illness (prevalence), rather than true population prevalence which would include undiagnosed disease. QOF data are not available by age and hence a practice, or a geographic area, with a relatively older population would expect to have a higher level of disease than an area with a younger population, for most cardiovascular diseases.

Observations are said to be statistically significant when they are unlikely to be due to chance. The threshold for calculating this is usually set at 1:20 or a probability (p) value of 5%. As such, there is a level of confidence that the value presented is an accurate estimation of the true value which falls within the range established by the confidence intervals. (Differences in observations or the results of trials may be statistically significant but not important in practice).

QOF data from general practices show that the Borderline LCG has a statistically significantly low prevalence (green) of atrial fibrillation and a statistically significantly high prevalence (red) of stroke, diabetes, hypertension, smoking and obesity in comparison to Cambridgeshire and Peterborough Clinical Commissioning Group. Peterborough LCG has a statistically significantly low prevalence of CHD, stroke, hypertension and atrial fibrillation and a statistically significantly high prevalence of diabetes, smoking and obesity. Peterborough's significantly low prevalence of conditions such as CHD and stroke may be partially explained by only 12.7% of registered population being aged 65+, compared to 15.9% within the CCG as a whole.

Table 1: Prevalence of CVD and risk factors by LCG, Cambridgeshire and Peterborough CCG, 2013/14

LCG	Age 65+	Age 85+	CVD	CHD	Stroke	Heart Failure	Diabetes	Hypertension	Atrial Fibrillation	Smoking	Obesity
BORDERLINE	16.2%	2.1%	2.6%	3.0%	1.6%	0.7%	6.2%	14.3%	1.3%	19.7%	9.6%
CAM HEALTH	13.9%	2.5%	2.1%	2.4%	1.3%	0.6%	4.3%	10.7%	1.5%	15.8%	6.1%
CATCH	15.0%	2.1%	2.4%	2.4%	1.2%	0.5%	4.0%	10.9%	1.4%	13.7%	6.1%
HUNTS CARE PARTNERS	19.2%	2.4%	3.2%	3.6%	1.7%	0.7%	6.6%	15.0%	1.9%	18.2%	10.0%
HUNTS HEALTH	16.2%	1.9%	3.0%	3.1%	1.5%	0.6%	5.8%	14.3%	1.7%	18.2%	9.3%
ISLE OF ELY	18.0%	2.2%	2.8%	3.3%	1.5%	0.7%	6.5%	13.5%	1.7%	18.5%	9.7%
PETERBOROUGH	12.7%	1.7%	2.6%	2.7%	1.3%	0.6%	6.4%	12.2%	1.0%	25.5%	10.7%
WISBECH	19.8%	2.5%	3.5%	3.9%	2.0%	0.7%	7.3%	15.1%	1.8%	26.7%	12.1%
CCG	15.9%	2.1%	2.7%	2.9%	1.5%	0.6%	5.6%	12.8%	1.5%	18.6%	8.7%

Source: QOF Prevalence data 2013/14

Borderline and Peterborough practices comprise the majority (17/22, 77.3%) of practices in the most deprived quintile within the CCG. Within this quintile, prevalence is significantly higher than the CCG for CVD, CHD and diabetes despite only 14.6% of population being aged 65 or older, 1.3% lower than the CCG. There are also statistically significantly higher numbers of population that smoke and are obese in comparison to the CCG within these quintiles. Prevalence of CVD, CHD, stroke, heart failure, hypertension and atrial fibrillation are also statistically significantly high in the least deprived quintile, although this may be in part due to having 19.1% of population aged 65 or older (vs 15.9% across the CCG). This shows that the prevalence of CVD risk factors is relatively high in the relatively younger and more deprived population in Borderline and Peterborough LCGs, who may not be diagnosed with CVD yet, but are at high risk of developing disease and requiring services as they age.

Table 2: Prevalence of CVD and risk factors by deprivation quintile, Cambridgeshire and Peterborough CCG, 2013/14

Quintile	Age 65+	Age 85+	CVD	CHD	Stroke	Heart Failure	Diabetes	Hypertension	Atrial Fibrillation	Smoking	Obesity
5 - Most Deprived	14.6%	1.9%	2.8%	3.1%	1.5%	0.6%	6.8%	13.0%	1.2%	26.7%	11.0%
4	16.1%	2.2%	2.5%	3.2%	1.5%	0.7%	6.1%	13.5%	1.5%	21.7%	10.2%
3	14.6%	2.0%	2.5%	2.7%	1.3%	0.6%	5.0%	11.9%	1.4%	16.1%	7.6%
2	16.0%	2.1%	2.6%	2.6%	1.4%	0.5%	4.7%	11.8%	1.5%	13.4%	6.6%
1 - Least Deprived	19.1%	2.6%	3.0%	3.1%	1.6%	0.7%	5.1%	14.0%	1.8%	13.4%	7.8%
CCG	15.9%	2.1%	2.7%	2.9%	1.5%	0.6%	5.6%	12.8%	1.5%	18.6%	8.7%

Source: QOF prevalence data, 2013-14

With an overall prevalence of 1.3%, Peterborough LCG is one of three LCGs to be statistically significantly better than the CCG prevalence of 1.5% for stroke. The Borderline LCG prevalence is 1.6%, statistically significantly high; collectively the two LCGs have a prevalence of 1.4%.

As we would expect, the data show evidence of a correlation between prevalence and age, with the LGCs with statistically significantly higher prevalence of stroke also having a higher percentage of registered residents aged 65+. Peterborough LCG has a stroke prevalence 0.2% lower than the CCG but also 3.2% fewer registered persons over 65 and 0.4% fewer persons over 85. Stroke prevalence is statistically significantly high in the least economically deprived quintile, potentially as a result of a high proportion of older people.

Similarly, heart failure prevalence is statistically significantly high in the least economically deprived quintile, however this may be as a result of 19.1% of the population within the quintile being aged 65 or older, compared to 15.9% across the CCG as a whole.

5 RISK FACTORS, LIFESTYLE AND CVD

A number of common risk factors are recognised as increasing the likelihood that an individual will develop CVD:

- **Fixed factors** such as family history, gender, ethnicity and ageing;
- **Wider determinants** such as deprivation, poverty, education, housing and environmental factors and (un)employment;
- **Modifiable risk factors**
    - Lifestyle factors such as smoking, obesity, nutrition, lack of physical activity, high alcohol consumption;
    - Physiological/ metabolic risk factors, which may develop in response to those above, such as high blood pressure (hypertension), diabetes (high blood sugar), and hyperlipidaemia (high blood fats).

The fact that multiple risk factors can cause CVD underpins the need for an integrated approach to prevention and risk reduction at both an individual and a population level. It is estimated that in over 90% of cases, the risk of a first heart attack is related to one or more of the potentially modifiable risk factors- smoking, poor diet, physical inactivity, obesity, high blood pressure, diabetes, alcohol consumption, high blood cholesterol and psycho-social stress.

5.1 Ethnicity and inequalities

Nationally the prevalence of CVD, and its risk factors, varies with ethnicity. For instance, Black Caribbean, Indian, Pakistani and Bangladeshi men have a higher prevalence of diabetes, a risk factor for CVD, than the general population. Premature coronary heart disease rates are higher in South Asian populations in the UK than in white ethnic groups, while stroke incidence rates are higher in Black ethnic men and women. The reasons for this are complex including genetic, cultural and behavioural factors, and are not fully understood.

Peterborough has a relatively high proportion of black and minority ethnic (BME) residents. In the 2011 census, 17.5% of residents identified themselves as BME compared to 14.6% nationally.

Hospital admissions and deaths data for circulatory diseases in Peterborough show a correlation with wards with a high proportion of BME groups. These wards are also the most deprived, and there is a known relationship between deprivation and CVD.

Central, Park, Ravensthorpe, West, East, North and Dogsthorpe wards have higher % BME, % living in income deprived households, standardised mortality ratios for deaths from circulatory diseases and coronary heart disease (all ages) and higher standardised emergency admission ratios for coronary heart disease

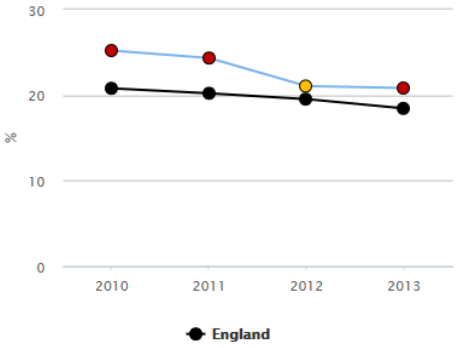
5.2 Lifestyle risk factors

5.2.1 Smoking

Smoking remains the major cause of preventable death and disease in Peterborough as in England and is a leading cause of health inequalities and ill health. It is the primary risk factor in 'years of life lost' in the United Kingdom.

Smoking rates in Peterborough have been declining in recent years but still remain high. In 2010, one in five (25.2%) adults in Peterborough smoked, whilst in 2013 this rate had declined to one in four (20.8%) adults smoking, a reduction of 4.4%. In comparison the England average rate had reduced 2.4% to 18.4% and the East of England average rate had reduced 2.1% to 17.5% over the same period.

Figure 7: Public Health Outcomes Framework 2.14 – Smoking prevalence among persons aged 18 years and over Trend 2010-2013 (%)



Period	Sig	Count	Value	Lower CI	Upper CI	East of England	England
2010		-	25.2	23.0	27.4	19.6	20.8
2011		-	24.3	22.0	26.7	20.0	20.2
2012		-	21.1	18.7	23.4	18.7	19.5
2013		-	20.8	18.6	23.1	17.5	18.4

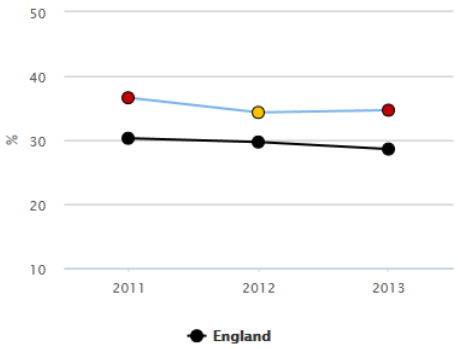
Source: Integrated Household Survey. Analysed by Department of Health and published by Public Health England.

Smoking prevalence data suggests that 45,850 people registered with Borderline and Peterborough practices were smokers in

Source: PHOF, PHE

In Peterborough, smoking prevalence was 34.7% in 2013 (the latest available data) in people in routine and manual occupations, the highest in the east of England. Prevalence has been falling nationally over the period 2011-13 but rose in Peterborough from 34.3% in 2012 to 34.7% in 2013. The east of England average in 2013 was 28.4% and in England it was 28.6% for the same year.

Figure 8: Public Health Outcomes Framework 2.14 – Smoking prevalence among persons working in 'routine and manual' occupations Trend 2011-2013 (%)



Period	Sig	Count	Value	Lower CI	Upper CI	East of England	England
2011		-	36.6	31.4	41.8	30.9	30.3
2012		-	34.3	29.0	39.7	29.8	29.7
2013		-	34.7	29.4	40.0	28.4	28.6

Source: Integrated Household Survey. Analysed by the Department of Health and published by Public Health England

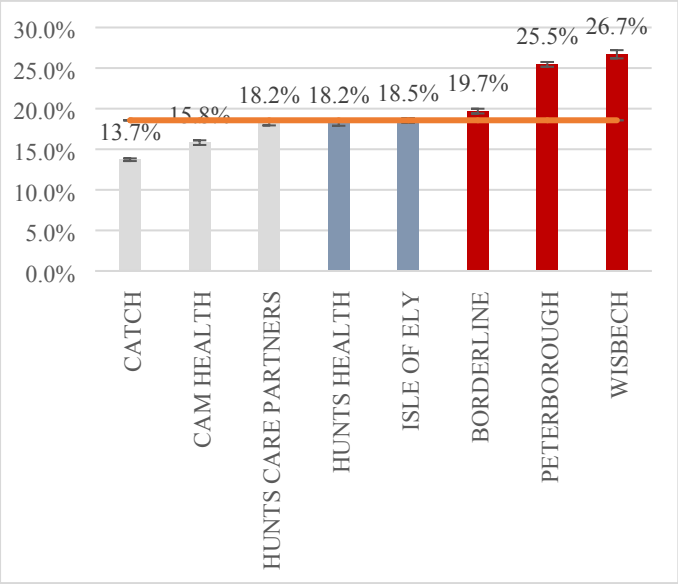
Sour

ce: PHOF, PHE

Smoking status of residents registered with GP practices in 2013/14 shows an association between high levels of deprivation and high levels of smoking.

There is also a strong relationship between smoking and people living with mental health problems. People with mental health conditions are twice as likely to be smokers; and depression is two to three times more common in people with a range of cardiovascular diseases.

Figure 9: Smoking Prevalence, Cambridgeshire & Peterborough CCG, 2013-14



Data show that both Borderline and Peterborough LCGs have a statistically significantly high level of smoking prevalence, with a collective prevalence of 22.9% vs 18.6% across the CCG as a whole.

Source: QOF data CCG CVD profiles

5.2.2 Physical inactivity

There is growing evidence that sedentary behaviours (e.g. sitting for long periods at work, for travel, study and 'screen time') is independently and adversely linked to all-cause mortality, cardiovascular deaths, type 2 diabetes, some cancers and depression[2]. The increase in sedentary behaviour is linked to a range of social and cultural factors including a decrease in manual jobs, use of technology for work and leisure and less active travel.

Studies show that doing more than 150 minutes of moderate physical activity or 75 minutes of vigorous physical activity every week reduces the risk of coronary heart disease by approximately 30%[3]. Physical activity promotes cardiovascular health through regulating weight and the body's use of insulin, as well as providing health benefits relating to blood pressure, blood lipid levels, blood glucose levels, blood clotting factors and the health of blood vessels.

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[2] 'Start active, stay active'- a report on physical activity and health from the four home countries' Chief Medical Officers, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216370/dh_128210.pdf

[3]'Start active, stay active'- a report on physical activity and health from the four home countries' Chief Medical Officers, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216370/dh_128210.pdf

The percentage of adults who are physically active in Peterborough (54.6%) is lower than the East of England average (57.8%) and the England average (56.0%).

The cost of physical inactivity in terms of expenditure on related ailments in Peterborough in 2009/10 financial year was estimated to be over £2.7 million. More than half of the estimated expenditure (£1.4 million) was on coronary heart disease.

Table 3: Health costs of physical inactivity, split by disease type, 2009-10

Disease category	Peterborough	East of England	England
Coronary heart disease	£1,463,791	£60,186,615	£491,095,943
Diabetes	£787,339	£19,484,702	£190,660,420
Cerebrovascular disease e.g. stroke	£267,574	£11,718,678	£134,359,285
Cancer lower GI e.g. bowel cancer	£133,227	£5,853,928	£67,816,189
Breast Cancer	£94,798	£5,755,887	£60,357,887
Total Cost	**£2,746,729**	**£102,999,810**	**£944,289,723**

Source: Sport England Local Sport Profiles, 2014

5.2.3 Poor diet

Evidence shows that the risk of a new major cardiac event can be reduced up to 73% by consuming a diet low in saturated fats and including substantial amounts of fresh fruit and vegetables

A diet high in trans fats (e.g. fast food, cakes) and saturated fats (e.g. cheese, butter, processed foods) increases levels of cholesterol and can contribute towards abnormal blood lipid levels, which have a strong correlation with the risk of coronary artery disease.[4] It is recommended that the average man should eat no more than 30g of saturated fat per day and the average woman no more than 20g.

Similarly, high consumption of salt/ sodium is linked to high blood pressure, a major risk factor for CVD. It has been estimated that a universal reduction in dietary intake of sodium by approximately 1g of sodium per day (about 3g of salt) would lead to a 50% reduction in the number of people needing treatment for hypertension, a 22% drop in the number of deaths from strokes and a 16% fall in deaths from coronary heart disease.

Government guidance suggests that people should consume at least 5 portions of fruit and vegetables per day to maintain their health. Local data (CVD JSNA full dataset) shows a correlation between the percentage of residents within each of Peterborough's wards who self-reported consuming at least 5 portions of fruit and vegetables per day and the number of emergency hospital admissions and deaths in under 65s and under 75s.

Of 11 wards with a lower percentage of healthy eating adults, 8 have higher rates of emergency hospital admissions and deaths amongst both the under 65s and under 75s.

Data show a clear correlation between high levels of economic affluence, high levels of healthy eating and low levels of emergency hospital admissions and deaths. Conversely, where deprivation is high, levels of healthy eating tend to be relatively low and hospital admission rates are high.

5.2.4 Obesity

Obesity, defined as a Body Mass Index (BMI weight /height^2 ≥30 for adults) can lead to ill health including type 2 diabetes, CVD and obstructive sleep apnoea as well as psychological problems and poor quality of life. Moderate obesity (a BMI of 30-35) was found to reduce life expectancy by an average of three years, while morbid obesity (a BMI of 40-50) reduces life expectancy by 8-10 years. Public Health England predicts that 70% of adults will be overweight or obese by 2034-approximatley 170,000 people in Peterborough if the Cambridgeshire Research Group population predictions prove accurate.

The most recent estimates released by Public Health England (based on the 2012 Active People Survey) suggest the actual percentage of adults classified as obese in Peterborough to be 24.1%, 2.5% higher than the estimate for Cambridgeshire (21.6%). The Public Health Outcomes Framework also includes an estimated percentage of adults classified as either overweight or obese; in Peterborough, this figure is 65.5% whereas in Cambridgeshire it is 65.0%.

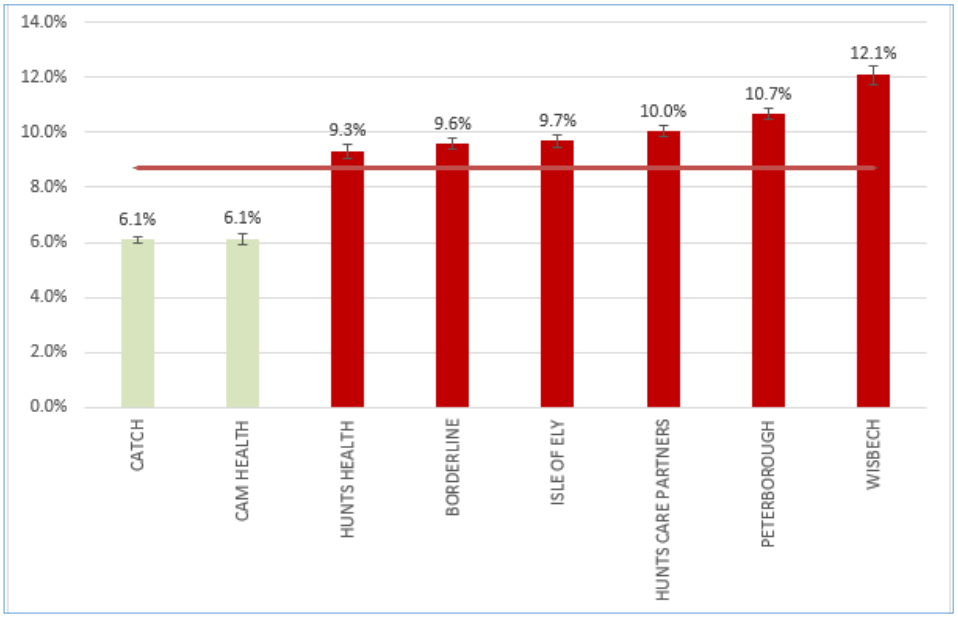
Area	% of adults classified as obese*	% of adults with excess weight**
Peterborough	24.1%	65.5%
Cambridgeshire	21.6%	65.0%

*Active People Survey 2012

**PHOF indicator 2.12, 2012

The Quality & Outcomes Framework (QOF) for GPs also includes a measure from which the prevalence of patient obesity may be calculated; however, as this is based on actual in-practice measurement within the preceding 12 months, prevalence figures are lower than the above estimates and should therefore be treated with a degree of caution.

Figure 10: Obesity Prevalence aged 16+, as recorded by GP practices, Cambridgeshire & Peterborough CCG LCGs, 2013-14



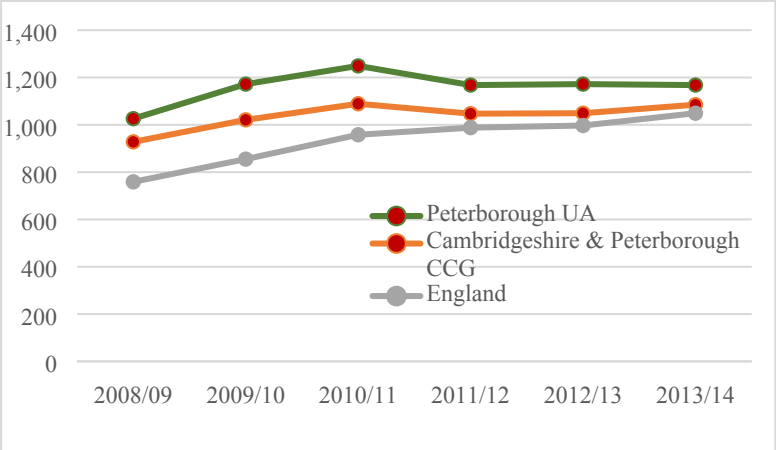
Source: QOF from local CCG CVD profiles

The prevalence of obesity as recorded by GP practices across the CCG is 8.7%.

Both Borderline & Peterborough LCGs have a prevalence recorded by GP practices which is statistically significantly higher than the CCG, with the combined prevalence for the two LCGs standing at 10.2% (19,964).

5.2.5 Alcohol Peterborough Unitary Authority's directly age standardised rate of hospital admissions for alcohol-related CVD (all persons) has been statistically significantly higher than the England rate for the six consecutive years spanning 2008/09 – 2013/14. The local rate has, however, remained relatively consistent over the past three years, during which time the England rate has increased. The rates for both males and females are each statistically significantly high in Peterborough for each year between 2008/9 and 2013/14.

Figure 11: Alcohol Related CVD Hospital Admissions, All Persons, 2008/09 – 2013/14 (Directly Standardised Rate per 100,000)[5]



SOURCE: LOCAL ALCOHOL PROFILES, PHE 1 [5]

5.2.6 Diabetes

Diabetes occurs when the body doesn't produce, or respond to, the hormone insulin which regulates blood glucose levels**.** There are two main types of diabetes. In Type I diabetes, the cells in the pancreas which produce insulin are damaged by the immune system. This type of diabetes usually develops before the age of 40 and requires insulin injections. Type 2 diabetes accounts for about 90% of cases and occurs when there is a relative lack, or resistance to, insulin. It can be managed with diet and exercise and often progresses to need drugs or insulin. It is more common with age and in people who are overweight or obese-including increasing numbers of young people.

Ethnicity is a key factor for the development of Type 2 diabetes with South Asians having a 50% higher lifetime risk than the white European population. It develops at a younger age and at a lower level of obesity.

People living in deprivation are 2.5 times more likely to develop diabetes on average –associated with higher levels of obesity and physical inactivity.

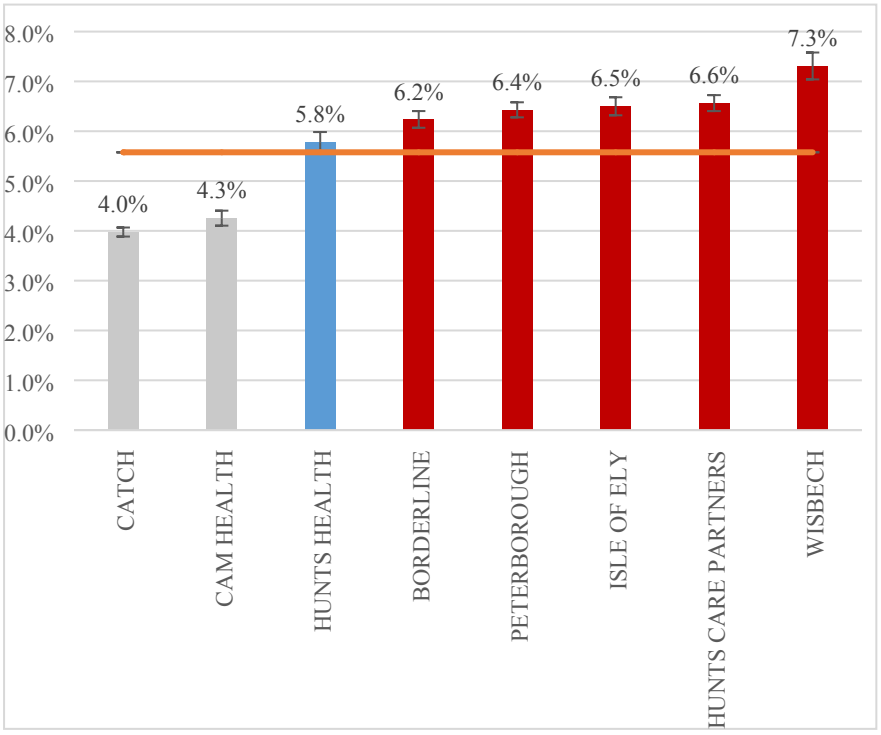
There is a strong correlation between diabetes and CVD. Heart disease and stroke are the major causes of death and disability in people with Type 2 diabetes-at least 65% of people with diabetes die from some kind of heart disease or stroke. Diabetes is often associated with other risk factors for CVD.

Figure 12: East of England Diabetes Profile, 2013-14

Indicator	Period	England	East of England region	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
Good blood sugar control in people with diabetes	2013/14	61.5	59.3	54.8	58.3	60.1	60.1	62.0	59.4	59.1	47.9	60.1	58.1	62.7
Good blood pressure control in people with diabetes	2013/14	71.9	69.9	66.4	67.2	69.6	70.6	72.4	66.1	70.5	61.5	72.0	69.4	72.5
Good cholesterol control in people with diabetes	2013/14	72.3	70.6	70.9	68.7	70.4	70.4	72.7	67.0	71.6	70.1	70.4	69.5	71.1
People with diabetes meeting treatment targets	2012	36.0	34.9*	30.8	30.2	30.8	37.3	36.2	33.4	33.9	30.2	39.7	35.9	38.7
BMI recorded in the previous 15 months	2012/13	91.7	91.6*	92.3	92.3	93.6	90.9	92.2	92.1	91.6	90.5	88.4	91.8	90.4
Foot check	2013/14	82.1	82.2	83.2	84.0	85.6	81.0	83.3	82.2	82.2	81.6	80.2	81.1	81.7
Tested for protein in the urine	2013/14	80.6	77.2	79.4	78.4	79.7	73.1	80.7	75.1	80.9	75.0	74.3	76.7	73.4
Smoking cessation advice and treatment	2013/14	93.1	-	-	-	-	-	-	-	-	-	-	-	-
Flu vaccination	2013/14	78.4	77.9	79.3	78.5	80.7	77.2	80.0	77.8	77.6	77.2	73.8	77.4	73.5
Eye screening	2013/14	82.6	82.6	84.9	79.6	84.4	82.2	88.0	79.3	83.7	74.2	74.8	81.1	83.8
People with diabetes having all check-ups	2012	59.5	54.6*	45.9	54.9	45.9	-	52.1	60.4	62.2	54.9	53.4	51.6	55.2

Source: Fingertips Diabetes Profile, Public Health England

Figure 13: Diabetes prevalence, Cambridgeshire and Peterborough CCG, 2013-14



Both Borderline and Peterborough LCGs have a statistically significantly high prevalence of diabetes compared to the CCG as a whole, with 12,244 people registered with practices in these two LCGs having diabetes in 2013/14.

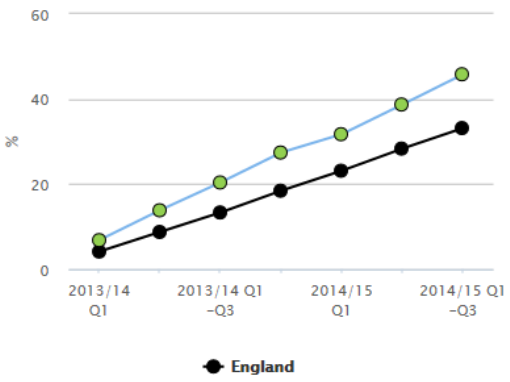
Source: QOF from CCG CVD profiles

6 SERVICES FOR CVD

6.1 Health Checks in Primary Care

Everyone aged 40-75 who does not have a pre-existing condition is offered an NHS Health Check every five years to identify those with risk factors for cardiovascular and kidney disease and diabetes. Older people, aged over 65 years, are provided with information on the signs and symptoms of dementia and on local services.

Figure 14: Observed Number of People Invited for an NHS Health Check Q1 2013/14 – Q3 2014/15



Period		Count	Value	Lower CI	Upper CI	East of England	England
2013/14 Q1		3,279	6.8	6.6	7.0	-	4.1
2013/14 Q1-Q2		6,666	13.8	13.5	14.2	-	8.7
2013/14 Q1-Q3		9,818	20.4	20.0	20.8	-	13.3
2013/14 Q1-Q4		13,216	27.4	26.9	27.9	-	18.4
2014/15 Q1		15,555	31.7	31.2	32.2	-	23.1
2014/15 Q1-Q2		18,977	38.7	38.2	39.1	-	28.3
2014/15 Q1-Q3		22,462	45.8	45.3	46.2	-	33.1

Source:
Public Health England

Source: PHOF, PHE

22,462 people have now been invited for an NHS Health Check in Peterborough; 45.8% of the eligible population. This figure is statistically significantly better than the percentage observed in England overall which stands at 33.1%.

However, the proportion taking up the tests remains disappointing. Only 10,769 eligible people in Peterborough took up an NHS Health Check in 2014/5, 47.9% of the total of invites (22,462). This number is statistically similar to England; in the previous six periods of measurement, Peterborough has been statistically significantly worse than England with regards to converting invitations in to Health Checks.

Figure 15: Outcome of NHS Heath Checks, 2013-14

In 2013/14, Peterborough planned to undertake health checks on 6,059 registered patients aged 40-74. GP practices participated in the programme with individual targets supported by clinical coaching and Public Health events across all communities.

The programme has achieved 99.7% of the target (6042 completed checks against a target of 6059). This is 12% increase on the number of completed health checks compared to the 2012/13 programme.

Based on national and regional statistics Peterborough City Council is 22nd out 151 LAs and second across Eastern LAs. This is an excellent effort from all GP practices working in partnership with the local authority to reduce the prevalence of chronic disease.

Specific outcomes for Peterborough include:

- 777 patients assessed with a CVD risk of more than 20% (10 year risk of developing a chronic disease.
- 164 Hypertensive patients identified (high blood pressure)
- 54 Diabetics diagnosed
- 495 patients referred to weight management programmes
- 1840 patients received dementia awareness advice
- 2003 patients received Alcohol Audit C assessment
- 557 patient referred to physical activity programme
- 471 patients prescribed statins to lower cholesterol.

Source: Tackling Inequalities in Coronary Heart Disease programme update 3, May 2014

6.2 Hospital Admissions

6.2.1 Coronary Heart Disease

In 2014/15, there were 1,108 admissions of patients, of all ages, from Borderline and Peterborough LCGs with coronary heart disease as the primary cause (544 of these were emergency admissions). 772 of these admissions (nearly 70%) were in people under the age of 75; and 349 of these were emergency admissions.

Table 4: Coronary Heart Disease Admissions (All Admission Types, All Ages) 2014/15, Cambridgeshire & Peterborough CCG LCGs, Directly Standardised Admission Rate per 100,000

Area	Observed Admissions	DSR	LI	UI	65+	+85+
CATCH	759	419.8	390.2	451.0	15.1%	2.1%
CAM HEALTH	294	453.1	401.9	509.0	13.9%	2.5%
PETERBOROUGH	562	556.4	510.6	605.1	12.5%	1.8%
BORDERLINE	546	568.2	521.1	618.3	16.6%	2.1%
ISLE OF ELY	528	593.7	543.9	646.9	18.4%	2.3%
HUNTS CARE PARTNERS	772	641.8	597.2	688.9	19.5%	2.4%
HUNTS HEALTH	392	645.1	582.3	712.9	16.8%	1.9%
WISBECH	335	708.9	634.7	789.3	19.9%	2.6%
BORDERLINE AND PETERBOROUGH LCGS	1,108	562.8	529.8	597.3	14.3%	1.9%
ALL OTHER LCGS	3,080	546.6	527.3	566.3	16.8%	2.3%
C&P CCG	4,188	551.2	534.5	568.2	16.1%	2.2%

Source: Cambridgeshire and Peterborough CCG Commissioning Data Set (CDS) & HSCIC GP registered population data, April 2014

The standardised admission rate for 2014/15 for CHD is statistically similar to the CCG for both Borderline and Peterborough LCGs.

The standardised admission rates for CHD, both all ages and aged under 75, show a correlation with deprivation with significantly higher rates for the more deprived quintiles and a significantly lower rate in the more affluent. Similarly, emergency admission rates for CHD are highest in areas of economic deprivation.

It was not possible to reliably assess the relationship between ethnicity and risk of admission for coronary heart disease under age 75 due to data quality issues.

Table 5: Coronary Heart Disease Admissions (All Admission Types, Under 75 Only) 2014/15, Cambridgeshire & Peterborough Quintiles of Deprivation, Directly Standardised Admission Rate per 100,000

Quintile	Observed Admissions	DSR	LI	UI	65+	85+
5 – Most deprived	727	496.2	460.5	533.9	14.6%	1.9%
4	628	440.6	406.7	476.6	16.1%	2.2%
3	573	392.9	361.1	426.7	14.6%	2.0%
2	468	347.1	316.2	380.2	16.0%	2.1%
1 – Least Deprived	412	295.4	267.4	325.6	19.1%	2.6%
C&P CCG	**2,808**	**395.6**	**381.0**	**410.6**	15.9%	2.1%

Source: Cambridgeshire and Peterborough CCG Commissioning Data Set (CDS) & HSCIC GP registered population data, April 2014

6.2.2 Stroke

There was a total of 392 stroke admissions in patients registered with Borderline and Peterborough LCGs in 2014-15 and 195 of these admissions were in patients aged under 75 years (approximately half).

The collective directly standardised admission rate for stroke for Borderline and Peterborough LCGs stands at 200.7/100,000 which is statistically similar to the CCG rate of 187.5/100,000. Although the DSR as a result of stroke falls as economic affluence increases, no quintile is statistically significantly different to the CCG admission rate of 187.5/100,000.

Table 6: Stroke Admissions (All Admission Types, All Ages) 2014/15, Cambridgeshire & Peterborough CCG LCGs, Directly Standardised Admission Rate per 100,000

Area	Observed Admissions	DSR	LI	UI	65+	+85+
CATCH	286	**159.0**	**140.9**	**178.6**	15.0%	2.1%
CAM HEALTH	113	**164.0**	**134.6**	**197.8**	13.9%	2.5%
HUNTS HEALTH	103	**177.8**	**144.9**	**215.9**	16.2%	1.9%
ISLE OF ELY	168	**191.7**	**163.7**	**223.1**	18.0%	2.2%
BORDERLINE	**186**	**197.0**	**169.5**	**227.7**	16.2%	2.1%
HUNTS CARE PARTNERS	238	**200.5**	**175.7**	**227.7**	16.2%	1.9%
PETERBOROUGH	**206**	**204.5**	**177.1**	**234.9**	12.7%	1.7%
WISBECH	120	253.4	**209.9**	**303.3**	19.8%	2.5%
Borderline and Peterborough LCGs	**392**	**200.7**	**181.1**	**221.8**	14.3%	1.9%
All Other LCGs	1,028	**182.6**	**171.6**	**194.2**	16.6%	2.2%
C&P CCG	1,420	**187.5**	**177.8**	**197.6**	15.9%	2.1%

Source: Cambridgeshire and Peterborough CCG Commissioning Data Set (CDS) & HSCIC GP registered population data, April 2014

The patient was discharged to their normal place of residence in 57.1% (872/1528) of cases. Data from Peterborough City Council Adult Social Care shows 22.1% (151/681) of assigned social care packages were necessitated by a CVA/Stroke condition, with the overall annual cost amounting to £4.02 million.

6.3 Hospital services –quality standards and national audit data

The majority of Peterborough residents are admitted to Peterborough and Stamford Hospitals NHS Foundation Trust with cardiovascular conditions. The hospital participates in the national audits of treatments for heart disease and stroke.

However, patients with acute chest pain are taken to Papworth Hospital, the specialist cardiac hospital. Peterborough doesn't offer emergency treatment to restore the blood flow in the coronary arteries and there is some evidence that specialist centres, with high numbers of cases, achieve better outcomes for patients.

6.3.1 Coronary heart disease

MINAP, the Myocardial Ischaemia National Audit Project, analyses data from ambulance and hospital services on the process and outcomes of care to inform the public, clinicians and commissioners on the quality of local care by publishing an annual report.

Heart attack or myocardial infarction is part of a spectrum of conditions know as acute coronary syndrome. The term includes both ST-elevation myocardial infarction (STEMI- named for the ECG changes seen) where emergency re-perfusion of the coronary arteries with primary percutaneous intervention (PCI) or thrombolytic drugs is indicated in eligible patients; and non-ST-elevation myocardial infarction (nSTEMI) which is more common and requires different treatment.

The vast majority of patients (99.8%) with STEMI admitted to Papworth, (not just Peterborough residents) received primary PCI in 2013-14 (1) and 30 day mortality unadjusted rates were below the national average (6.3% vs 7.2% in primary PCI capable centres, 2011-14). [(1)]

Data for non-STEMI patients is more likely to be incomplete, particularly if they are not admitted to a cardiac ward. In Peterborough, as in England, 94% were seen by a cardiologist or a member of their team. Of those admitted to Peterborough hospital, all who were eligible were referred for angiography with increasing numbers receiving this during their admission.

Table 7: Primary PCI in hospitals in England, Wales and Belfast (extract of local data)

	Proportion of nSTEMI patients seen by a cardiologist or a member of team	Number of all nSTEMI patients	Proportion of nSTEMI patients admitted to cardiac unit or ward	Number of all nSTEMI patients	Proportion of nSTEMI patients who were referred for or had angiography during admission	Number of all nSTEMI patients eligible for angiography	Proportion of nSTEMI patients who were referred for or had angiography during admission including angiography planned after discharge	Number of all nSTEMI patients eligible for angiography		Proportion of nSTEMI patients seen by a cardiologist or a member of team	Number of all nSTEMI patients	Proportion of nSTEMI patients admitted to cardiac unit or ward	Number of all nSTEMI patients	Proportion of nSTEMI patients who were referred for or had angiography during admission	Number of all nSTEMI patients eligible for angiography	Proportion of nSTEMI patients who were referred for or had angiography during admission including angiography planned after discharge	Number of all nSTEMI patients eligible for angiography
Year	2012/13									2013/14							
	Seen By Cardiologist (%)	Out of (N)	Admitted To Cardiac Ward (%)	Out of (N)	Had Angiography Before Discharge (%)	Out of (N)	Had Angiography At Any Time (%)	Out of (N)		Seen By Cardiologist (%)	Out of (N)	Admitted To Cardiac Ward (%)	Out of (N)	Had Angiography Before Discharge (%)	Out of (N)	Had Angiography At Any Time (%)	Out of (N)
Papworth Hospital, Cambridge		<20		<20		<20		<20									<20?
Peterborough City Hospital, Peterborough	94.2	411	63	411	26.4	394	60.2	394		93.9	461	58.1	461	33.7	457	58.2	457

Source: MINAP 2014

Use of secondary prevention medication after the acute admission is proven to improve outcomes for patients with either STEMI or n-STEMI by reducing the risk of a further heart attack or complications such as heart failure. NICE Clinical Guidance 48 supports the use of combinations of drugs in all eligible patients who have had a heart attack. The audit also collects information on the percentage of patients with an acute coronary syndrome and eligible for each secondary prevention medication who are discharged on that treatment. (Patients are not included if they die, are transferred to another hospital, are not eligible for a medication or decline treatment).

Table 8: Secondary prevention medication eligibility, 2012/13 and 2013/14 (extract of local data)

	Proportion of all patients who were **not** eligible to receive any secondary prevention medication	Proportion of patients who were eligible for **one** secondary prevention medication who received it	Proportion of patients who were eligible for **two** secondary prevention medications who received them	Proportion of patients who were eligible for **three** secondary prevention medications who received them	Proportion of patients who were eligible for **four** secondary prevention medications who received them	Proportion of patients who were eligible for **five** secondary prevention medications who received them	Proportion of patients who received **all** secondary prevention medications for which they were eligible	Number of all patients eligible to receive secondary prevention medication	Proportion of all patients who were **not** eligible to receive any secondary prevention medication	Proportion of patients who were eligible for **one** secondary prevention medication who received it	Proportion of patients who were eligible for **two** secondary prevention medications who received them	Proportion of patients who were eligible for **three** secondary prevention medications who received them	Proportion of patients who were eligible for **four** secondary prevention medications who received them	Proportion of patients who were eligible for **five** secondary prevention medications who received them	Proportion of patients who received **all** secondary prevention medications for which they were eligible	Number of all patients eligible to receive secondary prevention medication
Year	2012/13								2013/14							
	None	1 (%)	2 (%)	3 (%)	4 (%)	5 (%)	All (%)	N	None	1	2	3	4	5	All	N
England & Wales	**1.1**	**10.2**	**55.7**	**68**	**78**	**84.2**	**81.2**	**60012**	**2.7**	**68.5**	**86.2**	**85.4**	**88.5**	**88.2**	**87.9**	**59368**
England	**1.1**	**10.2**	**56.2**	**68.3**	**78.6**	**84.4**	**81.5**	**57959**	**2.1**	**67.9**	**87.2**	**85.6**	**88.7**	**88.6**	**88.3**	**57301**
Addenbrooke's Hospital, Cambridge	0.4	0	27.3	77.8	73.3	82.3	73.4	268	2.4	100	78.6	93.3	89.3	77.8	83	247
Papworth Hospital, Cambridge	0.4	100	75	81.2	88.4	85.5	85.7	686	0	16.7	75	83.3	87.9	91.7	90.2	687
Peterborough City Hospital, Peterborough	0	0	76.9	91.9	88.4	95.5	89.2	332	0.9	0	41.2	76.5	92.9	97.1	89.1	343

Source: MINAP 2014

6.3.2 Stroke

The Sentinel Stroke National Audit Programme (SSNAP) aims to improve the quality of stroke care by auditing stroke services against evidence based standards, and national and local benchmarks.

There are six domains for acute stroke care, each scored into five bands. The total organisational score is obtained by calculating the average of the 6 domain scores, which are divided into bands A-E, with A as the highest performance band. These results reflect the stroke service audit data of July 2104.

Table 9: The six domains of stroke services organisation, SNAPP, 2014

6 domains of stroke service organisation
D1-Acute care: Presence of up to 7 features representing quality of care of stroke units treating patients within the first 72 hours of stroke; level of thrombolysis provision; nurse staffing levels at 10am weekends per ten beds
D2-Specialist roles: Frequency of consultant ward rounds; presence of senior nurses and/or therapists; access within 5 days to all of: social work expertise, orthotics, orthoptics, podiatry; palliative care patients treated on Stroke unit; access to clinical psychologists and aspects of care provided; provision of services which supports stroke patients to remain in, return to or withdraw from work and/or education or vocational training; patients staying in bed until assessed by physiotherapist
D3-Interdisciplinary services: Ratio of nurses and therapists to beds on the stroke unit(s); 6 or 7 days working for therapists; frequency and membership of formal team meetings
D4-TIA/Neurovascular clinic: Time TIA service can see, investigate and initiate treatment for all high- and low-risk patients; waiting time for carotid imaging (high- and low-risk patients)
D5-Quality improvement, training & research: Report on stroke services produced for trust board; presence of a strategic group responsible for stroke and membership; funding for external courses and number of days funded for nurses and therapists; clinical research studies; formal links with patients and carer's organisations; patient/carer views sought on stroke services; report produced in past 12 months which analysed views of patients
D6-Planning and access to specialist support: Patient information on: social services, benefits agency, secondary prevention advice and patient version of stroke guidelines/reports; personalised rehabilitation discharge plan given to patients; access to stroke/neurology specialist early supported discharge and community team for longer term management

Source: Sentinel Stroke National Audit Programme (SNAPP), RCP, regional results, 2014

Local hospitals, including Peterborough and Stamford Hospitals NHS Foundation Trust participate in the audit. Peterborough City Hospital provided acute stroke care, including thrombolysis available 24/7 for eligible patients, a 36 bed stroke unit with access to a range of specialist staff and prompt access to investigate and initiate treatment in high risk transient ischaemic attacks (TIA).

Table 10: Stroke national acute organisational audit, east of England, 2014

Acute Organisational Audit 2014 Performance Table	Total stroke unit beds	Total organisational band	Domain 1‡ Acute care organisation	Domain 2 Specialist roles	Domain 3 Interdisciplinary services	Domain 4 TIA/ Neurovascular clinic	Domain 5 Quality improvement, training & research	Domain 6 Planning & access to specialist support
East of England - East of England SCN								
Basildon and Thurrock University Hospitals NHS Foundation Trust	47	B	B	D	B	A	C	A
Bedford Hospital NHS Trust	16	D	D	D	D	C	C	C
Cambridge University Hospitals NHS Foundation Trust	36	D	D	C	D	C	A	E
Colchester Hospital University NHS Foundation Trust	33	B	C	C	B	A	A	A
East and North Hertfordshire NHS Trust	26	E	D	D	C	A	E	D
Hinchingbrooke Health Care NHS Trust	25	E	E	D	E	A	E	D
Ipswich Hospital NHS Trust	32	B	B	B	C	A	A	B
James Paget University Hospitals NHS Foundation Trust	30	C	C	D	E	A	D	A
Luton and Dunstable University Hospital NHS Foundation Trust	30	D	C	D	E	A	C	E
Mid Essex Hospital Services NHS Trust	25	C	B	C	D	A	D	C
Norfolk and Norwich University Hospitals NHS Foundation Trust	48	C	E	B	C	B	A	A
Peterborough and Stamford Hospitals NHS Foundation Trust	36	E	D	D	D	D	E	B
Princess Alexandra Hospital NHS Trust	22	D	D	E	C	B	C	B
Queen Elizabeth Hospital King's Lynn NHS Trust	29	A	B	A	B	A	A	A
Southend University Hospital NHS Foundation Trust	40	A	A	A	B	A	A	A
West Hertfordshire Hospitals NHS Trust	36	C	C	D	C	C	B	D
West Suffolk NHS Foundation Trust	24	D	D	D	C	C	A	E

Source: Sentinel Stroke National Audit Programme (SNAPP), RCP, regional results, 2014

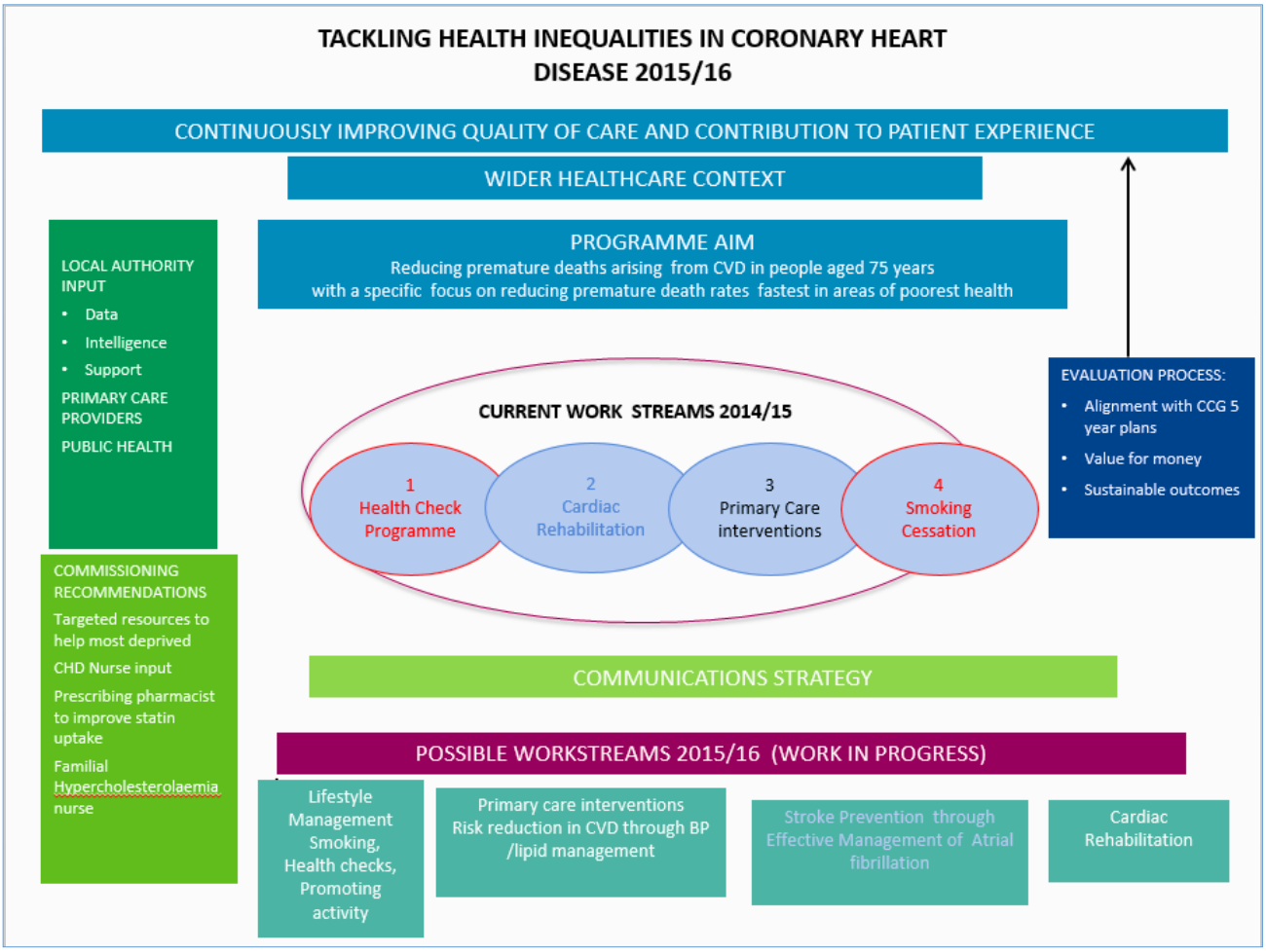
6.4 Tackling Coronary Heart Disease inequalities programme

Recognising the challenge in inequalities in coronary heart disease, the Borderline and Peterborough LCGs instigated a programme of work to improve population outcomes. The programme had four areas of activity:

- Smoking cessation
- Health checks
- Cardiac rehabilitation
- Primary care and prevention.

Physiological/metabolic risk factors are generally managed in primary care with support from hospital services and clinicians. It was not possible to include information on the management of high blood pressure, hypercholesterolaemia, atrial fibrillation etc. or these services in this JSNA although some data is included in the quality and outcomes framework.

Following Peterborough City Council prioritising CVD, the programme is reviewing its remit and with a view to including the detection and management of atrial fibrillation, a risk factor for strokes and transient ischaemic attacks. Across Cambridgeshire and Peterborough CCG, the East Midlands Strategic Clinical Network model suggests that 348 strokes and 115 deaths per year could be prevented by optimum management of atrial fibrillation compared to the 134 strokes and 44 deaths per year prevented by current management.



Source: Tackling Inequalities in Coronary Heart Disease Board, 2015

6.5 Service Gaps

Further work is needed to better understand the range of services for prevention, treatment, rehabilitation and continuing support for people with CVD across sectors and to map pathways of care against quality standards and needs.

Consideration of equity and inequalities in access and outcome should be central to this work.

The views of users –and those who don't take up services, such as the offer of an Health Check-and an understanding of barriers to accessing services particularly for BME and deprived communities should be considered.

The process of engagement through the CVD JSNA steering group and workshops is central to developing this programme of work.

7 EVIDENCE

Guidance for local authorities on developing joint strategic needs assessments references the need to consider evidence of effectiveness-good practice reviews, literature and the National Institute for Health and Care Excellence guidelines and quality standards. These inform the quality standards for

the national service audits, local commissioning specifications and professional practice. Evidence of effectiveness and guidance is available for population interventions and individual treatment and care. Interventions are needed at individual and population level to tackle the burden of CVD, its risk factors and inequalities in health in the population.

7.1 Population Level Interventions

These are interventions also focusing on modifiable risk factors but at population-level which could lead to further substantial reduction in cardiovascular disorders. These can be achieved in a number of ways but must be supported by national and/or local policies and legislation.

Table 11: Summary of NICE guidance: Prevention of CVD (PH25)

Issue	Summary of rationale	Policy Goal
Salt	High levels of salt in the diet are linked with high blood pressure which, in turn, can lead to stroke and coronary heart disease. High levels of salt in processed food have a major impact on the total amount consumed by the population.	To reduce population-level consumption of salt.
Saturated Fats	Reducing general consumption of saturated fat is crucial to preventing CVD.	To reduce population-level consumption of saturated fats including the continued promotion of semi-skimmed milk for children aged over 2 years.
Trans fats	Industrially-produced trans fatty acids (IPTFAs) constitute a significant health hazard..	Ensure all groups in the population are protected from the harmful effects of IPTFAs. This includes establishing guidelines for local authorities to monitor independently IPTFA levels in the restaurant, fast-food and home food trades using existing statutory powers (in relation to trading standards or environmental health).
Marketing and promotions aimed at children	Eating and drinking patterns get established at an early age so measures to protect children from the dangers of a poor diet should be	Ensure children and young people under 16 are protected from all forms of marketing, advertising and promotions (including product placements) which encourage an

and young people	given serious consideration.	unhealthy diet.
Commercial Interests	If deaths and illnesses associated with CVD are to be reduced, it is important that food and drink manufacturers, retailers, caterers, producers and growers, along with associated organisations, deliver goods that underpin this goal.	Ensure dealings between government, government agencies and the commercial sector are conducted in a transparent manner that supports public health objectives.
Product labelling	Clear labelling which describes the content of food and drink products is important because it helps consumers to make informed choices. It may also be an important means of encouraging manufacturers and retailers to reformulate processed foods high in saturated fats, salt and added sugars.	Evidence shows that simple traffic light labelling consistently works better than more complex schemes and should be encouraged.
Health impact assessment	Policies in a wide variety of areas can have a positive or negative impact on CVD risk factors and frequently the consequences are unintended. The Cabinet Office has indicated that, where relevant, government departments should assess the impact of policies on the health of the population.	Use a variety of methods to assess the potential impact (positive and negative) that all local policies and plans may have on rates of CVD and related chronic diseases. Take account of any potential impact on health inequalities.
Physically active travel	Travel offers an important opportunity to help people become more physically active. However, inactive modes of transport have increasingly dominated in recent years.	Ensure guidance for local transport plans supports physically active travel. This can be achieved by allocating a percentage of the integrated block allocation fund to schemes which support walking and cycling as modes of transport. Create an environment and incentives which promote physical activity, including physically active

		travel to and at work. Consider and address factors which discourage physical activity, including physically active travel to and at work. An example of the latter is subsidised parking.
Public sector catering guidelines	Public sector organisations are important providers of food and drink to large sections of the population. It is estimated that they provide around one in three meals eaten outside the home. Hence, an effective way to reduce the risk of CVD would be to improve the nutritional quality of the food and drink they provide.	Ensure publicly funded food and drink provision contributes to a healthy, balanced diet and the prevention of CVD. Ensure public sector catering practice offers a good example of what can be done to promote a healthy, balanced diet.
Take-aways and other food outlets	Food from take-aways and other outlets (the 'informal eating out sector') comprises a significant part of many people's diet. Local planning authorities have powers to control fast food outlets.	Encourage local planning authorities to restrict planning permission for take-aways and other food retail outlets in specific areas (for example, within walking distance of schools). Help them implement existing planning policy guidance in line with public health objectives.
Monitoring	CVD is responsible for around 33% of the observed gap in life expectancy among people living in areas with the worst health and deprivation indicators compared with those living elsewhere in England.	Independent monitoring, using a full range of available data, is vital when assessing the need for additional measures to address such health inequalities, including those related to CVD. Use available data to assess the need for additional measures to address health inequalities related to CVD.

Source: https://www.nice.org.uk/guidance/ph25

7.2 Individual Level Interventions

These are interventions focussing on modifiable (CVD) risk factors and aim at changing an individual's behaviour. They are supported by a range of existing NICE guidance listed below.

Table 12: NICE guidance: CVD prevention, individual level interventions

Risk Factor	Rationale	NICE guidance
Alcohol	Excessive alcohol can cause abnormal heart rhythms, high blood pressure, damage to heart muscle and lead to a stroke.	Alcohol-use disorders: preventing harmful drinking. NICE public health guidance 24 (2010). https://www.nice.org.uk/guidance/ph24
Physical Activity	Lack of regular exercise increases the risk for developing high blood pressure, high cholesterol levels, high stress levels and being overweight. All of which are risk factors for CVD.	Promoting physical activity for children and young people. NICE public health guidance 17 (2009). https://www.nice.org.uk/guidance/ph17 Promoting physical activity in the workplace. NICE public health guidance 13 (2008). https://www.nice.org.uk/guidance/ph13 Physical activity and the environment. NICE public health guidance 8 (2008). https://www.nice.org.uk/guidance/ph8 Four commonly used methods to increase physical activity. NICE public health guidance 2 (2006). https://www.nice.org.uk/guidance/ph2
Obesity in BME groups	The prevalence of conditions such as Type 2 diabetes , CHD and stroke is up to 6 times higher (and they occur at a younger age) among BME groups. Lifestyle interventions targeting sedentary lifestyles and weight have reduced the incidence of diabetes	Body mass index thresholds for intervening to prevent ill health among black, Asian and other minority ethnic groups 2014 http://www.publications.nice.org/lgb13

	by 50% in high risk individuals. BMI thresholds recommended as a trigger to intervene to prevent ill health among adults from black, Asian and other ethnic groups : • Increased risk chronic conditions BMI 23 kg/m^2 • High risk of chronic conditions BMI 27.5KG/m^2	
Hypertension	High blood pressure (hypertension) can damage artery walls and increase the risk of developing a blood clot and eventually a stroke. Usually a normal blood pressure reading should be below 130/80mmHg.	Hypertension: Clinical management of primary hypertension in adults. NICE clinical guideline 127 (2011). https://www.nice.org.uk/guidance/cg127

Health Checks	Local authorities and their partners should encourage people to have NHS health checks and support them to change their behaviour to reduce their risk factors. • NHS health checks should be offered to each eligible person aged 40-75 once every 5 year, with recall every 5 year if still eligible; • People having a health check should be told their cardiovascular risk score and other results; • And provided with individually tailored advice which will motivate them and support any necessary lifestyle changes to help them manage risk.	Encouraging people to have NHS Health Checks and supporting them to reduce risk factors [LBG15] 2014 https://www.nice.org.uk/advice/lgb1
Identifying and supporting people most at risk of dying prematurely	Aims to support the identification and provision of services to people who are disadvantaged and most at risk of dying early from heart disease. The risk of dying early can be reduced by providing services to help people stop smoking and the treatment of high cholesterol and other conditions which increases the risk of heart disease. • GPs and other NHS staff and local authorities should set up systems to identify people who are disadvantaged and at high risk of heart disease. • NHS organisations and the local authority should work	Identifying and supporting people most at risk of dying prematurely [PH15] 2008 https://www.nice.org.uk/guidance/ph15

	together to provide flexible services to improve the health of these people; • The NHS and local authorities should ensure that services aiming to improve the health of people who are disadvantaged are coordinated and that there are enough people trained to run them.	

7.3 Clinical guidance and quality standards

Clinical guidelines, based on the evidence of effectiveness of treatments and interventions, inform clinical practice and quality standards for services.

Table 13: NICE clinical guidelines and quality standards for the management of CVD

Issue	Summary of rationale and recommendations	Guidance
Atrial Fibrillation (AF)	AF is the most common heart irregularity and prevalence increases with age. It is a risk significant risk factor for strokes. Personalised packages of care should be offered to those in AF to include consideration of • Anticoagulants • Drugs or cardio-version to correct heart rhythm • Those with a CHA_2DS_2-$VASC_2$ score of 2 or above should be offered anticoagulation with a NOVAC, taking risk of bleeding into account • Do not offer aspirin monotherapy solely for stroke prevention.	Atrial fibrillation: the management of atrial fibrillation [CG180] http://www.nice.org.uk/guidance/cg180
Acute coronary events	Makes recommendations on referral, assessment, diagnosis, investigation and management.	Chest pain of recent onset: assessment and diagnosis of recent onset chest pain and discomfort of suspected cardiac origin [CG95] 2010

		https://www.nice.org.uk/guidance/cg95
Unstable angina and STEMI	Guidance on the investigation, management and assessment of risk and prevention of future events in angina and non-ST segment elevation myocardial infraction.	Unstable angina and STEMI [CG 94] 2010 https://www.nice.org.uk/guidance/cg94
Myocardial infarction with ST-segment elevation	Guidance on assessment & investigation (coronary angiography) for immediate reperfusion by percutaneous coronary intervention [PCI] within 120 minutes or fibrinolysis within 12 hours of presentation.	Myocardial infarction with ST-segment elevation: the acute management of myocardial infarction with ST segment elevation [CG 167] 2013 https://www.nice.org.uk/guidance/cg167
Myocardial infarction - secondary prevention	Recommends cardiac rehabilitation (with an exercise component) and lifestyle changes, psychological support and medication following an MI.	MI-secondary prevention: secondary prevention in primary and secondary care for patients following a myocardial infarction, 2013 https://www.nice.org.uk/guidance/cg172
Chronic Heart Failure	Recommends evidence –based management and treatment for people with chronic heart failure, including offering a group based exercise programme as part of the cardiac rehabilitation programme and planning for end of life care.	Chronic heart failure: management chronic heart failure in adults in primary and secondary care [CG108] 2010 https://www.nice.org.uk/guidance/cg108 NICE Clinical knowledge summaries, Heart Failure-chronic, revised May 2015 http://cks.nice.org.uk/heart-failure-chronic#!changes
Stroke and TIA –initial management	Stroke is preventable and treatable. Half of the people living with a stroke need assistance with activities of everyday living. In a TIA (transient ischaemic attack, symptoms	Stroke: diagnosis and acute management of stroke and TIA [CG 68] https://www.nice.org.uk/g

	resolve within 24 hours. • A screening test such as FAST (the Face, arm, speech test) should be used outside hospital; • People who have had a TIA should be assessed for stroke risk with a validated scoring system such as ABCD^2 and referred for specialist assessment and prevention • People with acute stroke should be cared for in specialist acute stoke units; receive urgent brain imaging and be assessed for thrombolysis with alteplase and anti-platelet drugs.	uidance/cg68
Stroke – rehabilitation	Makes recommendations on organising health and social care for people needing rehabilitation after a stroke • Initially in a dedicated stroke inpatient unit • From a specialist stroke team in the community • Offering early supported discharge • 6 month and then annual reviews • Strength, fitness, speech and language training; assessment of cognitive and visual impairment; depression; return to work and long term health and social support.	Stroke rehabilitation: long term rehabilitation after stroke [CG 162] https://www.nice.org.uk/guidance/cg162
Stroke services-quality standard	Services should be commissioned from and coordinated across agencies. An integrated approach to service provision is fundamental to high quality care. 11 quality statements including: 1.ambulance staff to screen those with neurological symptoms with a validated tool for stroke and TIA and transfer to stroke unit within 1 hour 2. acute stroke patients to receive brain imaging within 1 hour of arrival ; 3. admit to a specialist stroke unit assess for	Stroke quality standard[QS2] 2010 https://www.nice.org.uk/guidance/qs2

	thrombolysis 4. screen for swallowing reflex within 4 hours 5. assessment and management by a specialist stroke team 6. in-patient rehabilitation on a specialist stroke unit.	

7.4 Effective CVD Prevention Programmes

NICE recommends the following six components for effective CVD prevention programme.

Table 14: NICE good practice principles for an effective CVD prevention programme

1. Good practice principles

Programmes should comprise intense and multicomponent interventions that address identified risk factors.

They should be sustainable for a minimum of five years and should be allocated adequate resources.

2. Preparation

Programme leads should gain a good understanding of local CVD prevalence, existing risk factors and ongoing intervention's.

3. Programme development

Programmes should adopt a population based approach underpinned by a proven theoretical model.

Programmes should link with other existing interventions e.g. NHS Health Checks.

Programmes should take account of existing NICE guidance.

4. Resources

Ensure programmes last a minimum of 5 years and are allocated adequate financial and human resources.

5. Leadership

Identify senior figures in the local community and request them to act as champions for CVD prevention.

6. Evaluation

Ensure evaluation is built in and results are freely available and are shared with partner organisations.

NICE: Prevention of CVD: https://www.nice.org.uk/guidance/ph25

8 References

References are included in the full CVD JSNA data set available on the PPC website.

Additional references for this summary document are listed below:

- Statutory Guidance on Joint Strategic Needs Assessments for Joint Health and Wellbeing Strategies, Department of Health, 2012.

- Atrial Fibrillation, Cambridgeshire and Peterborough CCG; based on modelling from the CVD Group, East Midlands Strategic Clinical Network and QOF data, March 2014. Personal communication.

9 Key contacts

Dr Liz Robin, Director of Public Health liz.robin@peterborough.gov.uk

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Editor

Dr Anne McConville, Interim Consultant in Public Health

31/08/15

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CVD JSNA Steering Group **Annex 2**

Dr Anne McConville, Interim Consultant, Public Health, Peterborough City Council (Chair)
Dr Amrit Takhar, Clinical Lead for Coronary Disease
Julian Base, Head of Health Strategy, Peterborough City Council
Debbie Beales, Lead Nurse CHD Service, CPFT
Lisa Carson, Cardiac Rehabilitation Co-ordinator, Peterborough and Stamford Hospitals NHS Foundation Trust
Teresa Gooch, Service Improvement Manager, Uniting Care Partnership
Philip Hammond, Performance Manager, Peterborough City Council
Julie Holroyd, Heart Failure Specialist Nurse, Peterborough and Stamford Hospitals NHS Foundation Trust
Karen Key, Cambridge & Peterborough Clinical Commissioning Group System Transformation Team (CCG)
Mary Leen, PA to Director of Public Health, Peterborough City Council
Dr Steven Martin, Consultant Chemical Pathologist, Peterborough and Stamford Hospitals NHS Foundation Trust
Jon Moore, Public Health Intelligence, Cambridgeshire County Council
Ryan O'Neill, Public Health Analyst, Peterborough City Council
Rebecca Perry, Cambridge & Peterborough Clinical Commissioning Group System Transformation Team (CCG)

The following have been invited but were unable to attend:

Angela Burrows, Chief Operating Officer, Healthwatch
Dr Peter Owusu-Agyei, Trust Stroke Physician, Peterborough and Stamford Hospitals NHS Foundation Trust
Jo Porter, Cardiologist, Peterborough and Stamford Hospitals NHS Foundation Trust

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 7
10 SEPTEMBER 2015		PUBLIC REPORT
Contact Officer(s):	Dr Liz Robin, Director of Public Health	Tel. 01733 207175

DRAFT FRAMEWORK FOR PETERBOROUGH JOINT HEALTH AND WELLBEING STRATEGY 2016-19

RECOMMENDATIONS	
FROM : Director of Public Health	**Deadline date :** N/A

The Health and Wellbeing Board is asked to:

1. Comment on and approve the draft framework for the Peterborough Health and Wellbeing Strategy 2016-19 as laid out in Annex A.

2. Approve the timetable for drafting and consulting on the Health and Wellbeing Strategy 2016-19 as laid out in sections 4 and 5 of this paper.

3. Approve the extension of the existing Peterborough Health and Wellbeing Strategy 2012-2015 until March 2016.

1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing Board following agreement at the June Health and Wellbeing Board meeting that the Joint Health and Wellbeing Strategy (JHWS) 2012-15 should be updated. This paper provides a draft framework for an updated JHWS 2016-19, and proposes a new timescale to allow for full engagement of key partner agencies and public consultation with local communities.

2. PURPOSE AND REASON FOR REPORT

2.1 Production of a Joint Health and Wellbeing Strategy (JHWS) to meet the needs identified in the Joint Strategic Needs Assessment (JSNA) is a statutory function of the Peterborough Health and Wellbeing Board. The JHWS is a significant strategic document, and both NHS Commissioners and Local Authorities are required to have regard to the JHWS in their service plans. The purpose of this report is for the Health and Wellbeing Board to steer and agree the framework for the updated JHWS 2016-19.

2.2 This report is for Board to consider under its Terms of Reference No.3.1: 'To develop and implement the Health and Wellbeing Strategy for the City which informs and influences the commissioning plans of partner agencies.

3 MAIN BODY OF REPORT

Peterborough Joint Health and Wellbeing Strategy 2012-2015

3.1 The Peterborough JHWS 2012-2015 is available on web link https://www.peterborough.gov.uk/healthcare/public-health/health-and-wellbeing-strategy/

The current JHWS priorities are:

- 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.

Further developments

3.2 Following a peer review the Peterborough Health and Wellbeing Board further developed its priorities to focus on:

- The health and wellbeing of children and young people
- Cardiovascular disease

The HWB Board agreed a programme for further Joint Strategic Needs Assessment work:

- Children and Young People JSNA (approved June 2015)
- Cardiovascular disease JSNA (for approval September 2015)
- Mental Health JSNA (for approval December 2015)
- Primary prevention for older people (for approval March 2016)
- Health and wellbeing of Eastern European migrants (for approval March 2016)

An updated core JSNA dataset was approved by the HWB Board in June 2015. It is available on weblink https://www.peterborough.gov.uk/healthcare/public-health/JSNA/

Developing the JHWS 2016/19 – Potential priorities

3.3 The statutory requirement is for a JHWS to be agreed between Health and Wellbeing Board members to meet the needs identified in the JSNA. The Peterborough JSNA Core Dataset highlights the following health and wellbeing needs:

- Population growth: forecasting health and care needs, planning healthy infrastructure
- Inequalities: Health in areas of deprivation, diverse communities, people with disabilities
- Children and young people: child poverty, range of health issues
- Preventing disease (lifestyle behaviours): smoking, alcohol and obesity
- Premature mortality and long term conditions: cardiovascular disease/diabetes
- Mental health and community safety: self harm, substance misuse
- Ageing well: growing older population, prevention and service needs, dementia

The JSNA Core Dataset is focussed on statistics with very little information on the views of stakeholders and local communities. Therefore there will need to be a strong engagement and consultation process to add to the information in JSNA Core Dataset, when developing the JHWS.

Strategic service context

3.4 The JHWS needs to plan for an environment when health and care providers are facing increasing demand and significant resource constraints. There are plans such as the NHS System Transformation Programme, the City Council Customer Experience Strategy and the City Council Prevention and Demand Management strategy, which will help to address this. The JHWS could add value by making explicit how the Council and the local NHS will work together to address resource constraints.

3.5 It may be appropriate to adopt a joint set of service design principles across HWB Board partners as part of the JHWS work. The current design principles for Peterborough City Council for commissioning and delivery of services could be a starting point, together with any similar principles agreed within the local NHS.

The JHWS document

3.6 It is proposed to keep the main JHWS document short and readable. Potential Section and Chapter headings are laid out in the draft JHWS Framework at Annex A. Chapters should be 1-2 page summaries covering key JSNA needs, existing joint work, 'we will..' statements, and target improvements for outcomes. The overall document should be no more than 25 pages long, and should hyperlink to more detailed joint strategies (when available) which could be adopted as annexes to the JHWS.

4 CONSULTATION

4.1 It is proposed to spend the next three months working with key partners to develop the draft JHWS for 2016-19. For health and wellbeing issues where a lot of joint work has already been done and partnerships are strong, the JHWS will reflect this and link through to existing strategies and plans. If gaps are identified and more joint strategic work is needed, this can be included in the 'We will…' statements in the JHWS.

4.2 A consultation version of the draft JHWS will then be taken to the HWB Board in December, to be followed by a period of public and stakeholder consultation from December 2015 to February 2016.

4.3 To allow time for the public and stakeholder consultation, the period covered by the current Peterborough JHWS 2012-2015 will need to be extended until March 2016.

5 ANTICIPATED OUTCOMES

5.1 The consultation outcome report, together with a final draft of the JHWS will be taken to the March 2016 meeting of the HWB Board for approval.

6 REASONS FOR RECOMMENDATIONS

6.1 The recommendations will support the HWB Board to deliver its statutory duty to prepare a Joint Health and Wellbeing Strategy to meet the needs outlined in the Joint Strategic Needs Assessment. The proposed JHWS framework provides a clear outline and direction for the strategy, and the proposed timeline allows for engagement of key stakeholders and partner organisations to draft the JHWS, and for public consultation with local communities.

7 ALTERNATIVE OPTIONS CONSIDERED

7.1 An alternative option would be to extend the current Joint Health and Wellbeing Strategy to cover a further three years. This is not recommended because:

- The JSNA data used to inform the 2012-2015 JHWS is now out of date, and new JSNA information reflecting current health and wellbeing needs in Peterborough is available.
- The HWB Board has reframed its key priorities since the 2012-2015 JHWS was drafted.
- Partnership work has been carried out on HWB Board priorities since 2012, and the JHWS needs updating to recognise this.

8 IMPLICATIONS

8.1 The approval of a draft framework for the renewed JHWS 2016-19 does not have immediate financial or legal implications. The extension of the current JHWS 2012-2015 until March 2016 ensures that the Health and Wellbeing Board will be able to deliver its statutory duties in relation to the JHWS.

9.0 BACKGROUND DOCUMENTS

ANNEX A: Draft Framework: Peterborough Joint Health and Wellbeing Strategy 2016-19.

ANNEX A

DRAFT FRAMEWORK: PETERBOROUGH JOINT HEALTH AND WELLBEING STRATEGY 2016-19

Proposed Section and Chapter headings (each Chapter should be one or two pages A4):

INTRODUCTION – outlining the JWHS 2012-15, achievements to date, and explaining the need to renew the strategy.

SECTION 1: KEY JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) FINDINGS

1.1 Peterborough health profile on a page
1.2 Outline of key JSNA findings and weblinks to detailed JSNAs

SECTION 2: IMPROVING HEALTH AND WELLBEING OUTCOMES THROUGH THE LIFECOURSE

2.1 Children and Young People

2.2 Health behaviours and lifestyles

2.3 Long term conditions and premature mortality – focus on cardiovascular disease

2.4 Mental health and community safety

2.5 Ageing well

SECTION 3: PLANNING FOR POPULATION GROWTH

3.1 Forecasting health and care needs

3.2 Housing growth – Health and the Local Plan/Housing Strategy

3.2 Health and transport planning

SECTION 4: HEALTH INEQUALITIES

4.1 Geographical inequalities e.g. between electoral wards,

4.2 Diverse communities

4.3 Equalities groups under legislation – including people with disabilities

SECTION 5: PLANNING SERVICES WITHIN RESOURCE CONSTRAINTS

5.1 Financial forecasts for services

5.2 Health system transformation work

5.3 City Council customer experience and demand management strategies

5.4 Joint points of access and communications strategies

5.5 Joint 'principles' for service commissioning and delivery

ANNEX A

Content of a typical 'Chapter on a page'

NEEDS IDENTIFIED IN THE JSNA:

Local health and wellbeing outcome(s) identified as priorities for improvement

Relevant population changes

Key health inequalities

CURRENT JOINT WORK:

NHS and Local Authority responsibilities

Agreed joint strategies – key points with weblinks to the detail

List current joint procurements and section 75 or section 256 agreements.

FUTURE PLANS:

We will work together to …….e.g.

Carry out a JSNA on…

Develop a joint strategy to……

Carry out a joint procurement to…

Manage demand by ……..

Make savings by…….

OUTCOMES

We will aim to achieve these improvements in outcomes:

Target trajectories for outcome (or related process) measures

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 8
10 SEPTEMBER 2015		PUBLIC REPORT
Contact Officer(s):	Wendi Ogle-Welbourn - Corporate Director, People and Communities Lee Miller Head of Transformation and Commissioning (Children and Maternity)	Tel. 863749 Tel. 07538276106

UPDATE ON JOINT COMMISSIONING MEMORANDUM OF UNDERSTANDING (MOU)

RECOMMENDATIONS	
FROM: Wendi Ogle-Welbourn - Corporate Director	**Deadline date :** *N/A*
1. To note the MOU agreement and priorities. 2. Comment on the priorities and work plan.	

1. ORIGIN OF REPORT

1.1 This report is submitted to Board following a request from Director of People and Communities to provide an update on the Joint Commissioning Memorandum of Understanding. (MOU).

2. PURPOSE AND REASON FOR REPORT

2.1 **Purpose**

This MOU sets out the role of each partner organisation and explains how they intend to work together towards the common objective of commissioning high quality services which meet the health and wellbeing needs of children and young people, across Cambridgeshire and Peterborough, whilst demonstrating value for money.

This joint commissioning arrangement is based on three guiding principles:

1. **Clear accountability;** each party must be accountable for its actions, so each must have unambiguous and well defined responsibilities;

2. **Transparency;** each party, together with the public, must know who is accountable for what; and

3. **Regular information exchange**; this helps each party to discharge its responsibilities as efficiently and effectively as possible.

The arrangements for joint commissioning shall be effective as of the 1st June 2015 subject to the approval of the work plan and the contents of this memorandum of understanding.

3. STATEMENT OF INTENT

All three organisations are committed to working together to develop integrated services for children and families that reduce health inequalities and promote better outcomes. Whilst each of the parties has its own explicit mandate, and remains separately accountable for its actions, the agreed strategic direction will be through the Maternity, Children and Families Programme Board for the CCG, the Children and Families Joint Commissioning Board for PCC and the

Joint Commissioning Board for CCC.

3.1 It is envisaged that a shared commissioning function will offer a more integrated approach to the commissioning of services for children, young people and their families and link to the wider whole system approach to developing services for children, families and communities.

4. BACKGROUND

4.1 This Memorandum of Understanding (MOU) has been developed in recognition of the requirement for a jointly commissioned approach for children and young people's services, which is widely accepted as key to a progressive, system-led commissioning landscape.

4.2 The creation of a Joint Commissioning Unit will achieve an improved and more comprehensive analysis of need, a whole system approach to planning and investment, ultimately leading to the clear alignment of commissioning cycles and commissioning intentions which will ensure the effective use of resources. In turn, this will enable improved pathways and early intervention solutions to increase efficiencies and prevent duplication, improving the quality and performance of commissioned services.

4.3 This MOU establishes a framework for cooperation and collaboration between Peterborough City Council (PCC) Cambridge County Council (CCC) and, NHS Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and sets out how the organisations will work together to maintain and strengthen joint working arrangements, including furthering joint commissioning of services to meet identified health and well-being needs, and ensuring, wherever practicable, the promotion of integrated service models.

4.4 The MOU is a statement of intent largely for internal purposes for each organisation but it is intended that it is noted and supported by the Health & Well Being Boards across Cambridgeshire and Peterborough and periodically reviewed. It is not intended to be legally binding or create any legal obligation.

4.5 Peterborough City Council is the lead for the JCU and the Corporate Director for People and Communities is the lead officer

Roles

4.6 **Peterborough City Council**

The Corporate Director for People and Communities will be the lead officer for Peterborough City Council, and shall lead on the commissioning of the health and wellbeing services for children and young people

The Head of Commissioning for Children's Health and Wellbeing and the Head of Business and Commercial Operations, will undertake the necessary commissioning activity

The Head of Commissioning for Children's Health and Wellbeing, along with the Head of Business and Commercial Operations will monitor service provision to ensure performance is in line with service specification.

The Head of Business and Commercial Operations, along with the Head of Commissioning for Children's Health and Wellbeing will report quarterly to CPCCG, CCC and PCC advising on the performance of the commissioned services

4.7 **Cambridge County Council**

PCC will, on behalf of CCC undertake the performance monitoring and joint commissioning responsibility for the services

CCC will provide specialist Public Health Consultant (children and families) input to the JCU

through the shared public health arrangements. This consultant will provide a strategic link to the Director of Public Health, who has statutory responsibility for the Council's public health services in both CCC and PCC.

The strategic lead and accountability will remain with CCC under the Service Director of Strategy and Commissioning and for statutory public health commissioned services, under the Director of Public Health, delegated to the Public Health Consultant (children and families).

The Service Director of Strategy and Commissioning and Public Health Consultant (Children and families) will review the work plan every 6 months to ensure it reflects the needs of CCC.

4.8 **Cambridgeshire and Peterborough Clinical Commissioning Group (CPCCG)**

The Director of Quality and Nursing will review the work plan every six months to ensure it reflects the needs of the CCG.

The Director of Quality agrees to the Head of Business and Commercial Operations and the Head of Commissioning for Children's Health and Wellbeing being named as the authorised representatives in the contracts for the services.

5. KEY ISSUES

The Main key priorities in the work plan for the JCU are:
A redesign of Emotional Health and Wellbeing Services, including:

- Addressing waiting times for specialist Child and Adolescent Mental Health Services (CAMHS).
- Addressing waiting times for assessment of Autistic Spectrum Disorders and Attention Deficit Hyperactivity Disorder.
- Develop robust crisis support for emergency CAMHS assessment.
- Multiagency single point of referral for early help and CAMH.
- Review of service specifications to reflect current needs and service redesign.
- Review Children Looked after service (CLA) against new statutory guidance.
- Transitions for children to adult services.
- Lead Children and Maternity Workstream for System wide Transformation Programme
- Embed health services within SEND pathway
- Develop clear pathways for Child Protection medicals
- Ensure Continuing Care pathway is effective

6. STRATEGIC FUNCITIONS

6.1 The strategic aim for the JCU will be to align commissioning activity and improve children's provider performance by:-

6.2 **Integrating and co-ordinating the commissioning intentions of CCG/LCG's and Councils to reflect local priorities:** commissioning intentions and priorities will be aggregated and will form the basis for developing the overall commissioning strategy of the JCU. This will ensure the JCU strategy is grounded in local priorities and reflects local development needs and fully aligns to the Health and Wellbeing Board strategies and action plans. In addition, NHS Commissioning Board chid health developments will be reflected in the strategy ensuring comprehensive commissioning.

6.3 **Ensuring equity and quality of service delivery:** the JCU will determine the required delivery approach to deliver on the integrated commissioning intentions. This goal ensures that the children's services are aligned to meet the needs of the local population, close gaps in current service provision and enables children and young people to receive quality services in their community. Achieving this goal will also mean that children and families experience a seamless pathway regardless of the different organisations providing services or who commissions them. All those services in the pathway of care will be involved in shaping the work of JCU.

6.4 **Increasing children's services performance and delivering improved health outcomes:** the JCU will work with providers and develop a performance framework by which local and national targets and outcome based performance indicators will be measured. Quality and experience of early access and appropriate support will be monitored while effective delivery models will be explored reduce admission rates to acute and specialist services and address inequalities in access. This will enable an effective delivery of QIPP plans as a system wide approach to commissioning and delivery will be adopted.

6.5 **Ensuring services offer quality and value for money:** by developing close collaboration and commissioning relationships with a variety of providers, the JCU will be able to drive up quality and value for money through identification and dissemination of best practice.

6.6 **Ensuring that the children, young people & families/carers experience continually improves:** through improved feedback mechanisms the JCU will fully understand children & young people's concerns such as dignity, choice and quality of care, access, clean and safe environments, and the JCU will be able to address these priorities through improved commissioning relationships and more effective performance management of providers.

6.7 **Delivery of effective children's commissioning function to the partners:** the JCU will enable all partners to significantly improve their commissioning competencies relating to children's commissioning. The JCU will operate as a delivery vehicle, which serves its partners equally whilst recognizing their varying needs. It will consider and align its functions with other commissioning priorities and cycles i.e. Health and Well Being Board and Children's Joint Commissioning and Delivery Board and work with Public Health and the NHSCB to deliver on the Outcomes Framework, inform the JSNA and facilitate the Healthy Chid Programme.

7. CONSULTATION

7.1 All Partners were consulted with during the development of the JCU. The Leads of the JCU are working with Healthwatch and local parent partnership groups to ensure the priorities are taken forward with strong Parent/service user involvement.

8. NEXT STEPS

8.1 The JCU will monitor the work plan and priorities and will receive a bi monthly report on progress.

9. BACKGROUND DOCUMENTS

9.1

- JSNA Performance and Delivery plan.
- Cambridge and Peterborough's Emotional Wellbeing and Mental Health Strategy 2014.
- "Future in mind" 2015.

10. APPENDICES

10.1 Appendix 1 – Memorandum of Understanding between Peterborough City Council, Cambridgeshire County Council and Cambridgeshire and Peterborough Clinical Commissioning Group for Children and Young People Services.

MEMORANDUM OF UNDERSTANDING BETWEEN PETERBOROUGH CITY COUNCIL, CAMBRIDGESHIRE COUNTY COUNCIL AND CAMBRIDGESHIRE AND PETERBOROUGH CLINICAL COMMISSIONING GROUP FOR CHILDREN AND YOUNG PEOPLE SERVICES MAY 2015

THIS AGREEMENT is made the day of 2015

BETWEEN:

(1) **Peterborough City Council (PCC)** of Town Hall, Bridge Street, Peterborough, PE1 1HQ
(2) **Cambridgeshire County Council (CCC)** of Shire Hall, Castle Hill, Cambridge CB3 0AP
(3) **Cambridgeshire & Peterborough Clinical Commissioning Group (CPCCG)** of Lockton House, Clarendon Road, Cambridge, CB2 8FH

WHEREAS:

The Councils are each local authority established under the Local Government Act 1972 (as amended) and each is a local social services authority by virtue of section 2 of the Local Authority Social Services Act 1970. The Councils commission and provide social care and education services for children in Cambridgeshire and Peterborough and discharge their obligations through the Children's Directorate. The Councils deliver statutory public health functions under the Health and Social Care Act (2012).

The CCG is a Clinical Commissioning Group (CCG) established under The Health and Social Care Act 2012 and is a commissioner of health services in the County of Cambridgeshire.

The three organisations have agreed that PCC will lead the commissioning of services on behalf of itself, CCC and the CCG and that the PCC will be the host partner in respect of any joint commissioning for specific services laid out in Schedule 2 or that may be established throughout the term of this Agreement.

Introduction and background

This Memorandum of Understanding (MOU) has been developed in recognition of the requirement for a jointly commissioned approach for children and young people's services, which is widely accepted as key to a progressive, system led commissioning landscape.

It is envisaged that a shared commissioning function will offer a more integrated approach to the commissioning of services for children, young people and their families. The creation of a joint commissioning unit will achieve a better and more comprehensive analysis of need, a whole system approach to planning and investment, ultimately leading to the clear alignment of commissioning cycles and commissioning intentions which will ensure the effective use of resources. In turn, this will enable improved pathways and early intervention solutions to increase efficiencies and prevent system wide duplication, improving the quality and performance of commissioned services.

This MOU establishes a framework for cooperation and collaboration between Peterborough City Council (PCC) Cambridge County Council (CCC) and, NHS

Cambridgeshire and Peterborough Clinical Commissioning Group (CPCCG) and sets out how the organisations will work together to maintain and strengthen joint working arrangements, including furthering joint commissioning of services to meet identified health and well-being needs, and ensuring, wherever practicable, the promotion of integrated service models.

The scope of this MOU includes the relationship between the PCC, CCC and the CP CCG across all areas of child health and wellbeing for children and young people.

The MOU is a statement of intent largely for internal purposes for each organisation but it is intended that it is noted and supported by the Health & Well Being Boards across Cambridgeshire and Peterborough and periodically reviewed. It is not intended to be legally binding or create any legal obligation.

Statement of Intent

All three organisations are committed to working together to develop integrated services for children and families that reduce health inequalities and promote better outcomes. Whilst each of the parties has its own explicit mandate, and remains separately accountable for its actions, the agreed strategic direction will be through the Maternity, Children and Families Programme Board for the CCG, the Children and Families Joint Commissioning Board for PCC and the Joint Commissioning Board for CCC.

Purpose

The purpose of this MOU sets out the role of each party and explains how they intend to work together towards the common objective of commissioning high quality services which meet the health and wellbeing needs of children and young people, across Cambridgeshire and Peterborough, whilst demonstrating value for money.

This joint commissioning arrangement is based on three guiding principles:

1. Clear accountability; each party must be accountable for its actions, so each must have unambiguous and well defined responsibilities;

2. Transparency; each party, together with the public, must know who is accountable for what; and

3. Regular information exchange; this helps each party to discharge its responsibilities as efficiently and effectively as possible.

The arrangements for joint commissioning shall be effective as of the 1st June 2015 subject to the approval of the work plan and the contents of this memorandum of understanding.

Roles

Peterborough City Council

The Corporate Director for People and Communities will be the lead officer for Peterborough City Council, and shall lead on the commissioning of the health and wellbeing services for children and young people detailed in Appendix 1.

The Head of Commissioning for Children's Health and Wellbeing and the Head of Business and Commercial Operations, will undertake the necessary commissioning activity as detailed in Schedule.

The Head of Commissioning for Children's Health and Wellbeing, along with the Head of Business and Commercial Operations will monitor service provision to ensure performance is in line with service specification.

The Head of Business and Commercial Operations, along with the Head of Commissioning for Children's Health and Wellbeing will report quarterly to CPCCG, CCC and PCC advising on the performance of the commissioned services detailed in Appendix 1, including any remedial action undertaken.

Cambridge County Council

PCC will, on behalf of CCC undertake the performance monitoring and joint commissioning responsibility for the services set out in Schedule 2.

CCC will provide specialist Public Health Consultant (children and families) input to the JCU through the shared public health arrangements. This consultant will provide a strategic link to the Director of Public Health, who has statutory responsibility for the Council's public health services in both CCC and PCC.

The strategic lead and accountability will remain with CCC under the Service Director of Strategy and Commissioning and for statutory public health commissioned services, under the Director of Public Health, delegated to the Public Health Consultant (children and families).

The Service Director of Strategy and Commissioning and Public Health Consultant (Children and families) will review the work plan every 6 months to ensure it reflects the needs of CCC.

Cambridgeshire and Peterborough Clinical Commissioning Group (CPCCG)

The Director of Quality and Nursing will review the work plan every six months to ensure it reflects the needs of the CCG.

The Director of Quality agrees to the Head of Business and Commercial Operations and the Head of Commissioning for Children's Health and Wellbeing being named as the authorised representatives in the contracts for the services detailed in Schedule 2.

The community services contract lead will provide NHS contract management support to the PCC team.

Guiding Principles

The following core principles will guide the actions of the Joint Commissioning Unit (JCU) in their collaborative working:

Alignment – The JCU will positively choose working together, e.g. joint commissioning, joint community engagement, resource-sharing, commissioning integrated service provision/ pathways.

Equivalence – CPCCG recognises that PCC and CCC are local government partners who have comparable statutory responsibilities, and that the decisions made by the JCU recognise the equal status of all 3 parties. PCC and CCC recognise that the CPCCG has statutory responsibilities under the Health and Social Care Act and that the CCG needs to commission in line with the NHS Constitution, Mandate from the Secretary of State and direction from NHS England.

Putting children and young people at the centre – The JCU will jointly engage and involve children and young people and parent/carer groups and develop services which empower children, families and communities.

Delivering the best – The JCU will take the lead in adopting and diffusing best practice and innovation.

Safeguarding – The JCU acknowledges that safeguarding and promoting the welfare of children and young people is a shared responsibility and a high priority and will work together to ensure safeguarding is paramount in all their work.

Public Health and health improvement
The JCU will follow legislation and regulations under the Health and Social Care Act (2012) for the statutory public health services it commissions, including the public health ring-fenced grant conditions and the mandated aspects of 0-5 public health services. Statutory responsibility for public health 0-19 services in Cambridgeshire sits with the DPH and the Health Committee, in Peterborough it sits with the DPH and the Cabinet portfolio holder for Public Health.

Health and Wellbeing Board

The JCU will support the development and revision of a Joint Strategic Needs Assessments (JSNA's) and will contribute data and intelligence to relevant JSNAs.

The JCU will work with Public Health in reviewing how well commissioning plans and delivery have contributed to the delivery of the joint Health and Wellbeing Boards strategies.

Delivery

The JCU will agree the work priorities between the partners, and design, implement and review progress on the work programme. The JCU will develop and agree a set of performance metrics by which it reviews its progress.

Information sharing

The parties will agree appropriate information-sharing principles and protocols in accordance with best practice and 'Caldicott' principles. Each party will treat any information received from the other with the same standard of care it would reasonably treat its own. All parties are signatories to the Cambridgeshire and Peterborough Multi-Agency Information Sharing Framework and are committed to building a positive culture of sharing information.

Governance

Arrangements for governance is highlighted in (Schedule 1).

The Head of Business and Commercial Operations and the Head of Commissioning for Children's Health and Wellbeing are responsible leads for the JCU and reporting will be bi-monthly both to the CPCCG led Programme Board and quarterly to the respective CPCCG's Children's Commissioning Groups and the CCG's Governing Body via the CCG's Clinical and Management Executive Team (CMET).

Any concerns arising from the relevant forums as a result of the delivery of this MOU should in the first instance be raised with the Corporate Director: People & Communities.

If the Corporate Director: People & Communities is not able to reach a resolution, they will decide if a process of mediation with an independent mediator (selected by agreement between the parties and appointed in writing) is required to resolve the issue. The findings of the mediator shall be binding upon both parties, with costs borne equally.

In agreeing to work jointly in partnership we will:

- Continuously identify opportunities to increase joint planning and joint commissioning, and align resources, both people and budgetary when appropriate
- Act transparently and always in the knowledge of the strategic intent of and impact on the other partners
- Seek to minimise duplication of effort between partners.

Governance for 0-19 public health functions and sign off for 0-19 public health budgets in Cambridgeshire County Council sits with the Director of Public Health and Health Committee. In Peterborough the DPH has statutory responsibility for 0-19 public health functions and provides professional assurance of public health grant spend. The public health consultant (children & families) will represent the DPH and provide strategic input at the Cambs Children's Health Joint Commissioning Board and the C&PCCG led programme board.

Contract Management

The JCU will manage contracts that are within the work plan, attached in schedule 2, in a pragmatic way, focussing on and resolving the issues without unnecessary escalation. However, there are a clear set of contractual levers within the NHS standard contract, including but not limited to a Contract Performance Notice, and clauses for Managing Activity and Referrals. - these will be applied as necessary to provide remedy on specific issues to ensure matters are swiftly resolved.

The Lead Director will inform the Chief Executive of any provider where a contractual lever is being considered prior to this being executed.

Freedom of Information (FOI)

Requests regarding partnership workings or collective decisions of the parties will be responded to by the party first approached for the request within the legal time frame, with the response agreed by the other party. Each agency will manage this through their responsible lead for FOI.

Commencement, duration and changes to agreement

This MOU commences on the date signed by all parties, and will continue until the end date of the agreement or terminated by the individual organisation or all of the parties. The scope of partnership working under the MOU and its effectiveness will be formally reviewed annually, and reported to both CPCCG CMET and the PCC/CCC CMT/CCC/SMT Any changes recommended to the scope of working will be recommended to the CCG Governing Body and PCC CMT and CCC CFA Management CCC/SMTfor approval.

Termination

Parties to this MOU may terminate by giving at least six months' notice in writing to the other partners. Ideally, termination should coincide with year-end. Termination can be agreed at any time by mutual consent.

Data Sharing

All parties to the MOU may provide information or data to each other or to the Authority where that is necessary to do so in connection with their respective roles. Each must observe the requirements of the Data Protection Act 1998 and the Freedom of Information Act 2000 in relation to any such information or data.

Signed for and on behalf of Peterborough City Council

Authorised signatory …….

Date……

Signed for and on behalf of NHS Cambridgeshire and Peterborough Clinical Commissioning Group

Authorised signatory …….

Date……

Signed for and on behalf of Cambridgeshire County Council

Authorised signatory …….

Date……

Schedule 1

GOVERNANCE STRUCTURE

1. **General**

(a) This Schedule will show how the Partners will retain proper influence and control over the joint commissioning function with Peterborough City Council by assuming the lead commissioning role on behalf of Cambridgeshire County Council and NHS Cambridgeshire and Peterborough Clinical Commissioning Group (CPCCG).

(b) Governance will be in accordance with a framework, with a strategic Programme Board made up of representatives of each Partner (as set out below) which together formulate proposals which eventually are put to each of the Council's and the CPCCG Governing Body.

(c) The decision making powers of the Councils are vested in their Corporate Management Team and Cabinet (Peterborough) and accountable Directors and Committees (Cambridgeshire), taking into account the Council's formal "scrutiny" process and where appropriate full Council.

(d) The decision making powers of the CCG are set out in the CCG's Constitution, with ultimate decisions being taken by the CCG Governing Body.

2. **Framework for decision making**

(a) Children, Young People and Maternity Programme Board

This is a partnership body at the head of the framework. On the Programme Board, the Councils are represented by the Directors who hold the portfolio for these services or their representatives and the CCG is represented by its Director of Quality, who is the executive lead for these services. Other partners are also represented in this strategic Programme Board. .

It will provide the overall framework and direction for partnership working across Cambridgeshire and Peterborough. The Programme Board will agree the outcome requirements to be satisfied by joint commissioning through a Memorandum of Understanding and Annual Work Programme agreed by all decision making bodies.

The Programme Board is not a body with legal decision making powers. The relevant decision making powers are vested in the Council's, the CPCCG and other statutory partners.

(b) CP CCG Clinical and Management Executive Team ("CMET")

The Clinical and Management Executive Team (CMET) is a sub-committee of the CPCCG's Governing Body. CMET will receive regular reports from the Joint Commissioning Unit (JCU) and, as and when required, recommend to

the Governing Body whether to proceed with JCU proposals and seek CP CCG Governing Body approval to these. Performance and quality reporting for these services is also routed through CMET to the Governing Body through an Integrated Performance and Quality Report.

(c) Cambridgeshire Children's Health Joint Commissioning Board (CCHJCB)

The Head of Joint Commissioning will present quarterly reports to the CCHJCB around performance, quality and progress to targets and improved outcomes which will inform Cambridgeshire's Children's Committee and Health Committee.

(d) Emotional Health & Wellbeing Board and Commissioning Board

The JCU will report to PCC's Emotional Health and Wellbeing Board and the People and Communities Commissioning Board, as and when required, for approval to be sought on proposals from the JCU.

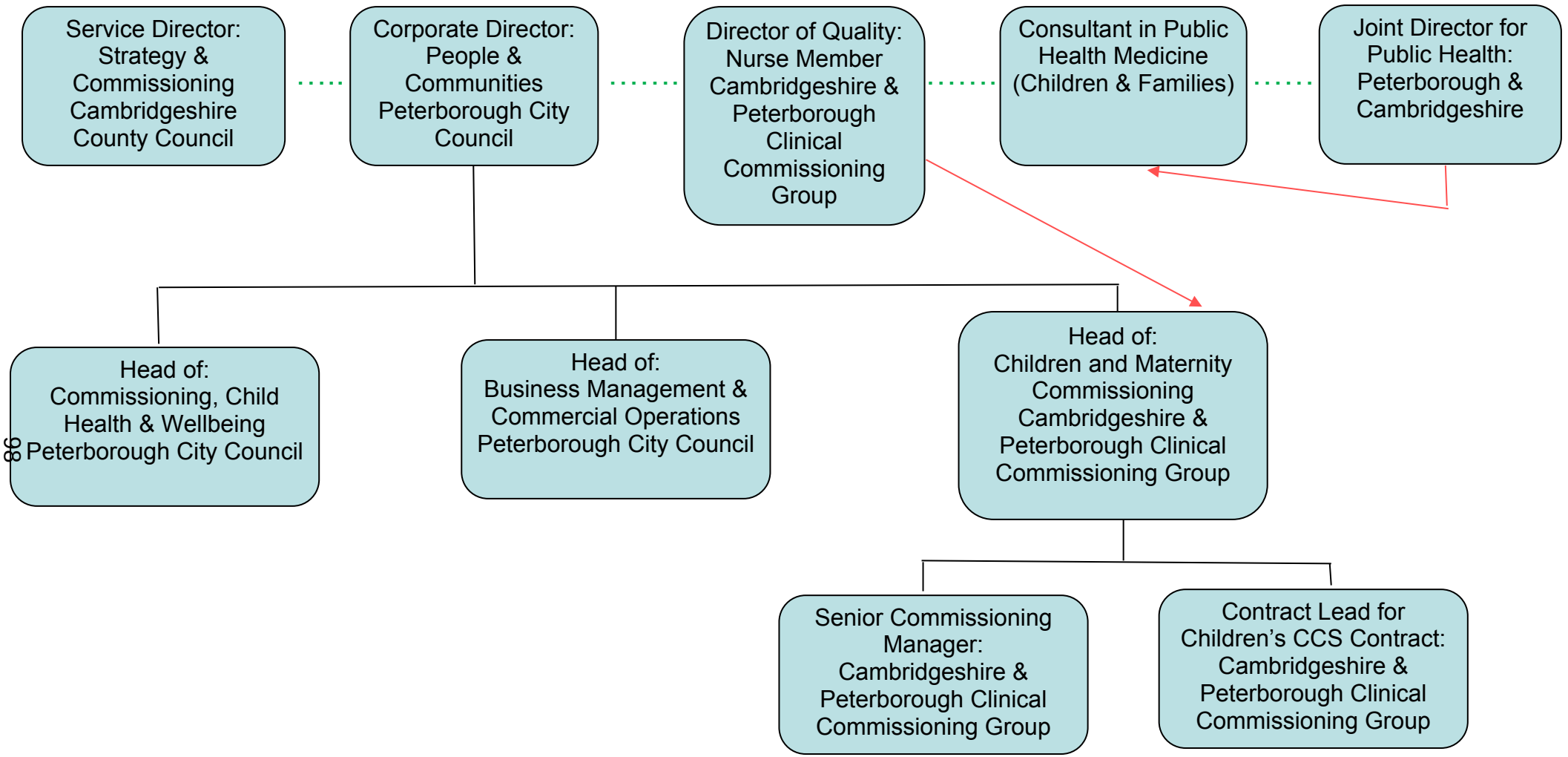
(e) Children, Families and Adults Management Team, Public Health and Joint Commissioning Board

The JCU will report to the CCC's Joint Commissioning Board, Public Health and the Children, Families and Adults Management Team, as and when required, for approval to be sought on proposals from the JCU.

The framework for decision making can be illustrated in Schedule 4.

(f) Joint Commissioning Unit

The Joint Commissioning Arrangement is responsible for children and young people health and maternity services commissioned by either Council or the CCG; as defined in the work programme. It is made up of personnel from Peterborough City Council and the CCG. Funding is provided by the CPCCG, PCC and CCC. The JCU is headed up by the Corporate Director for People and Communities, who will act as the lead Director.



Key

- Green dotted line = Strategic input to the JCU on behalf of the organisation
- Red line = Line management relationship outside of the JCU

(g) JCU Team Meeting

The JCU officers will meet with the lead Director on a monthly basis, supported by the Service Director: Strategy & Commissioning and Consultant in Public Health (Children and familes) from CCC to report on progress against the agreed work plan (Schedule 2).

(h) Delegated Authority

The Joint Commissioning Arrangement is able to take decisions to commission services and use budgets within delegated authority, and subject to the CCG and the Council's internal procedures existing from time to time, and the other provisions of this Agreement. Issues beyond that authority would be escalated to the Programme Board and if appropriate on from there to the Councils and the CCG as per the above. This structure will enable managers to ensure that services and budgets can be flexible to respond to changing needs.

(i) Governance in relation to Clinical Safety and Performance

The CCG has responsibility for providing assurance on the quality and safety of the health services it commissions to the Patient Safety and Quality Committee.

Public Health has the statutory responsibility for commissioning of public health services including health visiting and school nursing in both councils, including assurance of clinical governance and safety.

Schedule 2

WORK PLAN

The Joint Commissioning Unit (JCU) work plan consists of ten key areas which are listed below, this is further defined in a detailed work plan that will be reported to the JCU team meeting on a monthly basis. The primary focus of the work plan is to establish strategies, pathways, commissioning intentions and service specifications for each of the ten key areas. There is also a need for transformational change to drive prevention and early intervention, efficient, effective and economic service delivery across the child health and wellbeing landscape.

- Emotional Health & Wellbeing
- Looked After Children
- Child Protection Medicals
- Healthy Child Programme – School nursing currently, plus Health Visiting and Family Nurse Partnership from October 2015
- Special School Nurses
- SEND
- Contract & Performance Management
- Continuing Care
- Maternity
- Acute
- Children's Community Nursing Services
- Children's Services commissioned via CCS and CPFT, including CAMHs

Schedule 3

CCC Letter of Engagement

CCC Letter of Engagement

CFA Management Team Integration Pa

Cambridgeshire Children's Health Joint Commissioning Board

Terms of Reference

1. Purpose and Remit

Health and Local Authority Commissioners will work together to improve the quality and provision of services delivered to children and families.

2. Objectives/Tasks and Duties

2.1 Analyse health and local authority data to identify health and wellbeing needs

2.2 Plan, procure and evaluate the commissioned and provided health services making sure these reflect the changing needs of families and have capacity at the right level to meet needs and prevent escalation into crisis

2.3 Monitor and ensure delivery of all relevant targets and quality of services

2.4 Ensure service users' and carers' views are properly represented in the planning and evaluation of services

2.5 Ensure best value for money through effective commissioning

2.6 Monitor the management of any Aligned and/or Pooled Funds to ensure the Funds do not overspend and review the financial position of these budgets.

2.7 Approve minor service redesign and pathways and recommend major service redesign to the CCG Children's Programme Board where there is a need

for an impact assessment and subsequent public and staff consultation

2.8 Oversee the work of Commissioners in the management of contracts with all relevant providers, providing challenge and ensuring agreed actions are undertaken within individual organisations.

2.9 Review monthly and quarterly performance management information, agreeing areas of performance that need to be investigated and remedial actions to improve performance in relation to commissioned services. This could lead to making recommendations for contract variations.

2.11 To contribute to the Annual Review process and inform an annual report to the CCG Children's Programme Board and the Children's health and wellbeing board

2.12 To respond to contract queries and performance issues from the CCG Children's Programme Board

2.13 To respond to requests for audit/inspection/investigation or research information from the CCG Children's Programme Board in relation to the service.

2.14 To work with partners to meet the statutory requirements of the Children's and Families Bill 2013 and the Health and Social Care Act (2012)

2.15 To contribute to a system wide approach in supporting emotional wellbeing and mental health needs alongside the monitoring of specialist mental health provision

2.16 To align the work within key agendas such as joint outcomes, SEND, Mental Health, Healthy Child Programme and Children in Care

3. Accountability

3.1. The Cambridgeshire Children's Health Joint Commissioning Board (CCHJCB) will report to the Cambridgeshire and Peterborough Children's Programme Board to which CCG will be represented and provide regular reports on the implementation and performance against targets

3.2 The Cambridgeshire Children's Health Joint Commissioning Board will also inform members by reporting to the Local Authority Children's and Young People's Committee and the Health Committee

3.3 In order to ensure a coherent flow of communication but also inform partnership planning and commissioning the Cambridgeshire Children's Health Joint Commissioning Board will provide regular reports to the Children Trust Board.

4. Financial Governance

4.1. The CCHJCB will consider any in year financial variations in response to changed service specifications or resources and propose action required to the Cambridgeshire and Peterborough CCG Children's Programme Board and implement as agreed. For in-year financial variations to public health services, action required should be proposed to DPH and Health Committee.

4.2 Obtains agreement from the CCG Children's Programme Board to further align or pool funding to improve outcomes, quality and achieve financial savings.

5. Members

- Elected Member – Children's and Health Committee (2)
- Director of Strategy and Commissioning, Cambridgeshire County Council – Children Families and Adults Services
- Cambridgeshire and Peterborough CCG Children's Commissioning
- Director of Enhanced and Preventative Services
- Public Health Consultant for Children and families, CCC
- GP Children's Lead
- NHS England
- Representative District Council officer
- Head of Children's Joint Commissioning

Representatives from service user for a will be attend as and when required

5.1. The Chair

Elected Member either Children's or Health Committee

6. Link with Local Commissioning Groups

6.1 The CCHJCB will ensure to interface with Local Commissioning Groups in Cambridgeshire and engage with them throughout the whole commissioning cycle

Needs Analysis:
- JSNA interpretation at LCG level
- Local intelligence shared

Plan:
- Reflect LCG commissioning intentions in joint commissioning plan -Combined priorities
- Engagement with LCG's children's champion (s)
- Identify joint commissioning opportunities with LCGs and link to Area Partnership commissioning
- Specify outcomes
- Identify resource allocation

Do :
- Jointly Commission with LCG and Area Partnerships if required
- Procure if needed
- Ensure pathways are working and further enhanced if required

Review :
- Performance manage and measure impact
- Review budget and joint commissioned activity

6.2 The Cambridgeshire Children's Health Joint Commissioning Board will also ensure to make the appropriate links with Area Partnerships

7. Frequency of meetings

The CCHJB will meet every other month

8. What will be included within the remit of Joint Commissioning

- The Looked After Children Heath Team
- Therapy services including Occupational therapy, physiotherapy & speech and Language therapy
- Nursing Services including community and special school nursing.
- Community Paediatrician services
- Children's and Adolescent Mental Health Services
- Early support (jointly commissioned)
- Residential Short breaks (jointly commissioned)
- Health Visiting
- School Nursing
- Healthy Child Programme 0-18 years
- Relevant VCS contracts (counselling/bereavement)
- Clear links will be made with continuing health care, maternity and specialists provision i.e. Tier 4 mental health
- Other joint commissioned activity within S256 arrangements
    - Family Intervention Programme
    - Multi Systemic Therapies
    - Home and Community Support

10. What will not be included under the Joint Commissioning remit

- Children's acute and maternity services
- Specialist services commissioned by NHS England and Specialist Commissioning

Schedule 4

FORUMS FOR DECISION MAKING

Member of JCU	CPCCG		PCC		CCC	
	Function of JCU	Content of JCU	Function of JCU	Content of JCU	Function of JCU	Content of JCU
Decision Making Group/Board	CMET / CPCCG Governing Body	CYP & Maternity Programme Board	CMT/Committee Structure	People & Communities Commissioning Board	CFA and Public Health management teams / committee structure	Joint Commissioning Board

Function = The formation of the JCU
Content = Work plan undertaken by JCU

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 9
10 SEPTEMBER 2015		PUBLIC REPORT
Contact Officer(s):	Wendi Ogle-Welbourn – Corporate Director People and Communities Lee Miller – Head of Transformation and Commissioning (Children and Maternity) Joint Commissioning Unit	Tel. 863749 Tel.

CHILD ADOLESCENT AND MENTAL HEALTH CHALLENGE (CAMHS) UPDATE

RECOMMENDATIONS	
FROM : Wendi Ogle-Welbourn – Corporate Director People and Communities	**Deadline date : n/a**
1. To note and comment on current challenges in CAMHs services and actions in place to address these.	

1. ORIGIN OF REPORT

1.1 This report is submitted to Board following a request from the Corporate Director of People and Communities to provide an update on current issues in Child and Adolescent Mental Health Services (CAMHS) provision, current actions and future plans.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to:-

- Outline the current services and issues in CAMHS
- Identify what has already taken place to address the issues
- Highlight future Plans
- To inform the Board on the above and gain the Boards views on the future plans

3. Current position

3.1 Key Points

- Waiting times in specialist CAMHS are up to 1 year.
- Waiting lists have been temporarily closed for Autistic Spectrum Disorders (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) referrals where there are no associated urgent Mental Health needs.
- CAMHS Emergency assessments in Emergency Department settings have increased significantly in recent years.

3.2 There are significant demand and capacity issues within CAMHS:-

- Emergency assessments in Emergency Department settings have increased significantly in recent years, because there is no specific Psychiatric Liaison service for under 18 year olds, this is causing significant additional demand for specialist CAMHS and puts pressures on Acute settings (Peterborough City Hospital).

- There are not enough inpatient CAMHS beds (commissioned by NHS England) to meet demand. Young people have to often stay in acute settings for a number of days, whilst waiting for a bed to become available. When a bed is available, this could be anywhere in the country.
- General referrals to specialist CAMHS have also significantly increased in recent years (18% in 2014/15).
- With the result that waiting times for non-emergency cases are at unacceptable for Attention Deficit Hyperactive Disorder (ADHD) and Autistic Spectrum Disorder (ASD) cases in particular.
- Patient journeys and Pathways are unclear to referrers and to families.
- Psychiatric Liaison services in acute settings do not cover those below the age of 18.

4. What we have done so far

- Waiting lists have been temporarily closed for ASD and ADHD referrals where there are no associated urgent Mental Health needs.
- Additional resources have been invested into specialist CAMHS for 15/16, (£600k recurrent and £150k non recurrent across Cambridgeshire and Peterborough) which is equivalent to an 11% increase in funding. The primary focus is to clear the waiting list backlog and sustain this going forward.
- A CAMHS Summit was held in March 2015, with good stakeholder attendance to identify the key issues and develop a plan to address these.
- An Action plan was developed to address the key issues raised at the summit and work undertaken to address these areas of concern:-

1. **Waiting times** – CPFT are leading on work to reduce waiting times to below 18 weeks.
2. **ASD and ADHD pathways** – work between, LAs, Cambridgeshire Community Services and CPFT is underway to ensure that pathways and processes are effective. A redesigned integrated ASD/ADHD has been agreed between CPFT, CCS and both Local Authorities. ASD/ADHD waiting lists to be reopened in November 2015 after redesigned pathway has been implemented.
3. **Combined Single point of access for CAMHS and Local Authority services** – work with both LAs is ongoing to ensure that those with additional needs are assessed for a range of services, not just specialist CAMHS. To support this, a CQUIN (Commissioning for Quality and Improvement) Payment with CPFT for 15/16 has been agreed which focuses on development of single point of access for CAMHS and local Authority Services
4. **Emergency Assessments and support** – A 'task and finish' group has been set up to develop proposals for providing Emergency assessment services for Children and Young people. Due to report in Sept 2015

4.1 However, it is widely agreed, that the work above will not fully address the systemic problems and urgent redesign work is required across the whole pathway for Emotional Health and Wellbeing.

- A 9 Month 0.5 WTE Project manager post to lead on CAMHS redesign has been agreed, advertised and appointed. Start date 3rd August
- A project brief for CAMHS redesign has been developed and First Children and Young Peoples Emotional Health and Wellbeing Board set up

5. What do we propose to do about it?

5.1 It is therefore proposed that work on redesigning the Emotional Health and Wellbeing pathway takes place as soon as possible. This will involve services currently commissioned by the CCG and Local Authority commissioned services. The principles behind this will include:-

- Integration of services – including Multi agency teams, single entry point for CCG and Local Authority commissioned services.
- A single seamless pathway experienced by Children and their families.
- Over time, shifting resources from specialist to early Intervention and prevention.
- Appropriate Emergency assessment and support services.
- Improving communications and information systems.

5.2 The work will be overseen by the Children and Maternity Transformation Programme lead to ensure any redesign fits with the general direction of travel for Children's services. Currently, work is being undertaken to identify specific resources to enable this redesign work to take place quickly and effectively. To support this work, a CCG wide Emotional Health and Strategy Group is being set up to have a strategic overview of all local Emotional Health and Wellbeing work and to be the responsible strategic group for the redesign work.

In recent weeks additional Department of Health funding for CAMHS has been detailed. For Cambridgeshire and Peterborough, the allocations are as follows.

Initial allocation of funding for eating disorders and planning in 2015/16	Additional funding available for 2015/16 when Transformation Plan is assured	Minimum recurrent uplift for 2016/17 and beyond if plans are assured
£429,479	£1,074,527	£1,503,806

5.3 A Transformation Plan is currently in development, which will detail our local priorities and proposed investments for 15/16. It is a requirement that our Transformation Plans receive Health and Wellbeing Board approval before funding is released by NHS England. We will be drafting plans by mid September, with final deadline for submission of plans by mid October 2015.

6. ANTICIPATED OUTCOMES

The outcome of this work is that we will have a CAMHS which effectively meets the needs of the local population and makes efficient use of current and additional resources.

7. ALTERNATIVE OPTIONS CONSIDERED

The alternative option is to invest the additional resource into the current ineffective model which may help in the short term, but with demand for specialist services increasing, will lead to a recurrence of long waiting times and greater demand than capacity in the future.

8. IMPLICATIONS

The implications are that with significant additional funding invested locally, we will be able to address some of the key issues in CAMHS and design and put in place services which work effectively and as early as possible to address the needs of children and young people with Emotional Health and Wellbeing problems.

9. BACKGROUND DOCUMENTS

Future in Mind – National Childrens Mental Health Strategy - 2015
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

Local Transformation Plans for Children and Young People's Mental Health and Wellbeing: Guidance and support for local areas
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 10
10 SEPTEMBER 2015		PUBLIC REPORT
Contact Officer(s):	Will Patten, Interim AD Adult Commissioning, Peterborough City Council	Tel. 07919 365883

ADULT SOCIAL CARE, BETTER CARE FUND (BCF) UPDATE

RECOMMENDATIONS	
FROM : Will Patten, Interim AD Adult Commissioning,	**Deadline date :** N/A
Board members are requested to: 1. Note the update of BCF delivery and the second quarterly monitoring return for NHS England; and 2. Comment on the development of the projects where required.	

1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing Board at the request of the Corporate Director for People and Communities.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide information for the Board; it sets out an update on the delivery of the BCF Programme and presents the second quarterly monitoring return for NHS England which was approved by the Borderline & Peterborough Executive Partnership Board, Commissioning (BPEPB) and submitted on the 28th August 2015.

2.2 This report is for the Board to consider under its Terms of Reference No. 3.6 *'To identify areas where joined up or integrated commissioning, including the establishment of pooled budget arrangements would benefit improving health and wellbeing and reducing health inequalities.'*

3. BCF BACKGROUND

3.1 As previously reported, Peterborough's BCF has created a single pooled budget to support health and social care services (for all adults with social care needs) to work more closely together in the city. The BCF was announced in June 2013 and introduced in April 2015. The £11.9 million budget is not new money; it is a reorganisation of funding currently used predominantly by Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and Peterborough City Council (PCC) to provide health and social care services in the city.

3.2 GOVERNANCE:

3.2.1 At a previous meeting, the Health and Wellbeing Board confirmed that the Joint Commissioning Forum, now the BPEPB, would oversee the delivery of the BCF Programme and management of the pooled budget on behalf of the Peterborough Health & Wellbeing Board.

3.2.2 Following approval by this Board in March 2015, the Section 75 Agreement between PCC and CCG was in place by 1st April 2015 when BCF funding began.

3.2.3 All necessary formal governance arrangements for the BCF were in place by April 2015.

3.3 MONITORING:

3.3.1 The Health and Wellbeing Board agreed to delegate responsibility for reporting to the BPEPB. The process and templates for reporting of local areas' BCF progress is defined by NHS England and the Local Government Association (LGA) arrangements.

3.3.2 Since the last report, the second quarterly monitoring return for NHS England has been approved by the BPEPB and submitted on the 28th August 2015. Given the significant joint working across Cambridgeshire and Peterborough, the returns between the two Health and Wellbeing Board areas were closely aligned. This return covered the first quarter of 2015/16 and required information on the national conditions, local metrics, revised non-elective admission data, income and expenditure, and local metrics (falls and friends and family test) – please refer to the attached document entitled *BCF Quarterly Data Collection Template Q1 15-16 Peterborough (final).*

3.4 WORKSTREAM UPDATES:

3.4.1 As previously reported, five projects have been established reporting to the BPEPB. These project areas are aligned across Cambridgeshire and Peterborough and the following table demonstrates the design and delivery owners for each as well as the programme management in place:

Project	Lead Org.	Design		Delivery	
		Accountable Officer	Project Support	Accountable Officer	Project Support
Data Sharing	CCC	Charlotte Black, CCC	Isla Rowland and Geoff Hinkins CCC	Alex Gimson, UC	Isla Rowland, CCC
7 Day Working	SRGs	SRG 7DW lead - Peterborough	Peterborough – WP/EH	SRG 7DW lead - Peterborough	Peterborough – WP/EH
		SRG 7DW lead - Cambs and Ely	Cambs and Ely – GK/CCC	SRG 7DW lead - Cambs and Ely	Cambs and Ely – GK/CCC
		SRG 7DW lead - Hunts	Hunts – GK/CCC	SRG 7DW lead - Hunts	Hunts – GK/CCC
		SRG 7DW lead - Wisbech/Norfolk	Wisbech/Norfolk – GK/CCC	SRG 7DW lead - Wisbech/Norfolk	Wisbech/Norfolk – GK/CCC
Person Centred Systems	UC	Sandra Myers (Integrated Neighbourhood Teams, Risk Assessment and Accountable Professional/Single Assessment Process) Alex Gimson (Risk Stratification Tool)	Isla Rowland and Geoff Hinkins CCC	Peterborough – via ICB leads - Sandra Myers	Peterborough – WP
				Cambs and Ely – via ICB leads - K Connick	Cambs and Ely – GK
				Hunts – via ICB leads - A Gimson	Hunts – GK
				Wisbech/Norfolk – via ICB leads - D Morgan	Wisbech/Norfolk – GK
					Risk Stratification Tool – GH
Information Advice and Guidance	PCC & CCC	Adrian Chapman & Charlotte Black	Eve Holder, PCC	Adrian Chapman & Charlotte Black	Eve Holder, PCC
Ageing Healthily & Prevention	Public Health	Angelique Mavrodaris (Overall workstream and Pre-Statutory Assessment) Deborah Cohen (Universal Offer)	CCC (Overall workstream and Pre-Statutory Assessment) GK (Universal Offer)	Angelique Mavrodaris (Overall workstream and Pre-Statutory Assessment) Deborah Cohen (Universal Offer)	CCC (Overall workstream and Pre-Statutory Assessment) GK (Universal Offer)
Overall BCF Programme Management and Reporting	PCC and CCC	WP/GH (PCC/CCC)	GK	PCC and CCC	GK

3.4.2 <u>Data Sharing</u>

The Data Sharing project has gathered momentum and activities are underway. A Board meeting takes place bi-monthly, with the most recent meeting being held in August 2015. The Board has agreed a comprehensive project plan and dashboard which covers all of the objectives outlined in both Peterborough and Cambridgeshire BCF submissions. This plan will steer the project going forward. It was agreed that the dashboard will be updated and shared with the Board monthly.

In August, additional outcomes and statements were added to the plan to ensure there is a clear service user focus:

- Patients and service users will have a better experience of care and improved outcomes;
- Patients and service users will have access to their own data;
- Statement - *"My privacy and wishes will be respected";*
- Statement - *"Professionals will be able to access my information when it is to my benefit, if and when they need to";* and
- Statement - *"I won't have to keep telling my story to different professionals from different places".*

It was also decided that the appropriate workstream would consider the subject of consent in detail, to review how clarity is achieved in order to convey to patients and service users what their data will be used for and how to highlight the consequences if they do not allow sharing.

In addition, a piece of work will be developed to ensure that patients and service users are consulted and their feedback collected on the development of data sharing models. This is being considered as part of the social care service user groups, CCG patient groups and HealthWatch. These outcome measures may augment those within the original Peterborough submission, if agreed.

UnitingCare (UC) are making progress with the Single View of the Patient Record (SVPR), which has been renamed 'OneView'. Data sharing agreements have been sent to all 106 GP practices in Cambridgeshire and Peterborough for signature and, so far, 40% have been returned.

A recent UC workshop invited Cambridgeshire County Council (CCC) & PCC to view the progress of OneView to date; the presentation was positively received. Internally, PCC have consulted with four teams (reablement, therapy OT, admission avoidance, transfer of care) to understand what health information would be valuable from a social care perspective and also what social care information may be available that would be useful to share from a health view point. The next steps are to consider the technical requirements to enable the uploading of social care data into OneView.

Agreed Project Themes:

- Sharing data between UC and PCC/CCC for frontline staff - Phase 1;
- Future planning;
- Standardisation of data sharing IT systems and processes across Cambridgeshire and Peterborough;
- Data sharing for risk stratification, early intervention and links to other BCF programmes;
- NHS number;
- Patient access / portals;
- Evaluating the impact of data sharing; and
- Ensuring that information is used to inform commissioning and strategic planning.

3.4.3 <u>7 Day Working</u>

There is an inclusive project plan and a dashboard established that can be used to report on the achievements of the activities involved in the 7 Day Working project. The plans include all of the actions set out in the BCF submission in line with the intentions of all the nominated health and social care partners.

Governance via a monthly monitoring process has been agreed to include all updates via the Systems Resilience Group (SRG), UC and PCC projects to ensure that all relevant information is fed into the dashboard and a live status of progress can be available to the BPEPB on a monthly basis. UC have reported that Joint Emergency Teams (JET) and OneCall have now been rolled out 24 hours a day, seven days a week across all localities.

Agreed Project Themes:

- Service re-design to support an integrated approach for health and social care to avoid unnecessary admissions to hospital and reduce the number of excess bed days and delayed transfers of care;
- Re-Shaping the housing market, minor & major adaptations;
- Re-Shaping the 24 hour bed-based care market - residential care, nursing care and reablement / rehabilitation bed based; and
- Telecare / Telehealth / Assistive Technology.

3.4.4 Person Centred Care

Following the review of a gap analysis on the Peterborough BCF submission and project scope, a project plan has been drafted which is aligned with the UC mobilisation plans. A monthly project Steering Group is in the process of being formed, to commence in September 2015, which will provide governance and monitoring for this project.

UC reports that feedback from the staff consultation on developing neighbourhood and integrated care teams will be available once reviewed, at which point the location for the teams will be confirmed. Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) have also consulted with community and mental health staff as the new neighbourhood teams will be fully integrated, comprising of health professionals with the training, skills and experience to provide seamless care for people over 18 with long-term conditions and everyone over 65. The new teams are expected to be up and running from the beginning of October.

Agree Project Themes:

- Development of a Multi-Disciplinary Team (MDT) Approach;
- Development of a shared assessment process for health, social care and other partners;
- Development of a shared risk tool;
- Customer experience and customer journey;
- Reablement review; and
- PCC areas of focus.

3.4.5 Information and Communication

Monthly core group meetings are now in place for this project workstream. The meeting held in July agreed that the chair for the group would remain shared between Charlotte Black (CCC) and Adrian Chapman (PCC). The group gave direction for the next steps and a series of work has commenced, including identifying what actions could be considered for a shared project across Cambridgeshire and Peterborough. Both will also produce a health check against each of the identified actions.

Draft Project Themes:

- Review front doors;
- Develop an Information, Advice and Guidance strategy;
- Establish and schedule evaluation process;
- Determine technology requirements and options;
- Determine solution for independent financial advice sign posting;
- Develop a community service model;
- Develop plan for the publicity and training for both staff and the public; and
- Develop and embed process for content update.

3.4.6 Ageing Healthily & Prevention

Public Health produced an initial scope of work with the intention of leading the BCF activities across Cambridgeshire and Peterborough (please refer to the attached document entitled *Cambridgeshire Executive Partnership Board (CEPB) Healthy Ageing and prevention: proposed project scope).* The scope was compared to the Cambridgeshire and Peterborough BCF submissions and a draft project plan was compiled, which has since

been review by Public Health. Further work is required to agree the final project themes and actions.

A Steering Group for this project area is currently being pulled together which will provide the governance and monitoring. There are a number of PCC only actions that are being monitored internally and will be reported using the same documentation.

Draft Project Themes:

- Co-ordination of public and 3rd sector activity to prevent or reduce isolation and loneliness;
- Review of current provision and development of integrated approach to ensure people are living in appropriate housing with provision of accessible services and opportunities to foster community engagement, independence and resilience;
- Co-production of prevention strategy for older people and embedding of preventive approach across organisational and sectorial workstreams;
- Development and implementation of a series of targeted evidence-based health programmes and interventions for key priority areas;
- Identification of those at higher risk of admission to health and social care and approaches responsive to those at high risk of future care;
- Delivery of programmes to support carers and older people to retain or regain the skills and confidence to be independent and active in their communities;
- Alignment with collaborative and integrated care agendas with a focus on promotion and provision of support to facilitate effective and appropriate self-management; and
- PCC only workstreams.

4. CONSULTATION

4.1 As previously reported, in the developing and drafting of the BCF Plan there were detailed discussions and workshops with partners. The purpose of these discussions and workshops was to create the vision, goal, objectives and scope of the Strategic Level Plan for BCF and the specific delivery projects/schemes.

This joint working across Cambridgeshire and Peterborough continues and each of the five projects has now achieved clarity on what it is to deliver. The project plans and dashboards are in various stages of completion and focus will be given to ensure absolute clarity on milestones, target end dates and dependencies.

Regular monitoring activities will be solidified across all five projects to ensure that clear and regular standardised reporting can take place on a monthly basis. Cambridgeshire and Peterborough have agreed to take a joint approach to all programme management documentation and are currently confirming risk and issue logs and communication plans.

5. IMPLICATIONS

FINANCIAL

5.1 Delivery assurance through the Board will enable the Council and the CCG to continue to meet NHS England's conditions for receiving £11.9m BCF.

5.2 The BCF funding is in line with the Council's Medium Term Financial Strategy (MTFS).

6. BACKGROUND DOCUMENTS

i) BCF Quarterly Data Collection Template Q1 15-16 Peterborough (final).
ii) BCF Quarterly Data Collection Template Q1 15-16 Peterborough (final) – Tab 8 Narrative (this is a word document of the exact text displayed in the original Q1 15-16 submission)

iii) Cambridgeshire Executive Partnership Board (CEPB) Healthy Ageing and prevention: proposed project scope.

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 11
10 SEPTEMBER 2015		PUBLIC REPORT
Contact Officer(s):	Wendi Ogle-Welbourn Corporate Director People and Communities	Tel. 863749

HEALTHY CHILD PROGRAMME

RECOMMENDATIONS	
FROM : Wendi Ogle-Welbourn, Corporate Director People and Communities	**Deadline date :** n/a
The board is asked to: • Note that from the 1st October 2015 responsibility for the commissioning of Health Visiting (HV) and family nurse partnership (FNP) transfers from NHS England to the LA. • Note the proposed changes in boundary's and how this will be managed. • Comment on how the LA proposes to address the effect the reduction in public health funding will have in these areas.	

1. ORIGIN OF REPORT

1.1 This report is submitted to the HWBB through the joint child health and wellbeing commissioning unit.

2. PURPOSE AND REASON FOR REPORT

2.1 To update the health and wellbeing board on the issues arising from the transfer of commissioning responsibilities for health visiting (HV) and family nurse partnership (FNP) from NHS England to PCC on the 1st October 2015.

2.2 Advise and receive comment on the action plan to address the changes in boundary issue.

2.3 Advise and receive comment on the process to address the reduction in the public health budget.

3. BACKGROUND

In January 2014 the Government confirmed that the commissioning of health visitors and family nurse partnerships would transfer to local government on the 1 October 2015. Health Visitors and Family Nurses will continue to be employed by their provider organisations.

The transfer marks the final part of the overall public health transfer. It will join up commissioning for 0 to 19 (and up to 25 years for young people with Special Educational Needs and Disabilities) and will improve continuity for children and their families. It presents a unique opportunity for local authorities to transform and integrate health, education, social care and wider council led services and to focus on improving outcomes for children, young people, families and communities.

For 2015/16, the transfer of commissioning responsibilities is in effect a 'lift and shift' arrangement. From 2016/17 onwards, the health visiting and family nurse partnership budget will be added to the public health grant allocations to local government to form an overall public health grant allocation.

3.1 **NHS England**

The following commissioning responsibilities will be retained by NHS England:

- Child Health Information Systems (CHIS) in order to improve systems nationally. This will be reassessed in 2020
- The six to eight week GP check (also known as the Child Health Surveillance) because of its complex commissioning arrangements.

The Department of Health plans to mandate local authorities for 18 months to provide the following five universal checks:

- Antenatal health promoting visits new baby review
- six to eight week assessment of the baby
- one year assessment
- two to two and a half year review

A review involving Public Health England will take place after 12 months and will inform arrangements going forward. The rationale for this is to make sure a national, standard format for universal coverage of the checks is delivered.

3.2 **HV specification**

The 15/16 national service specification for health visiting and family nurse partnership was developed in conjunction with key stakeholders. At a local level the specification has been tailored to shape needs and partner arrangements. It is designed to be used during the transition of commissioning responsibility to the local authority, in joint commissioning arrangements. The specification is outcomes focussed and encourages the health visiting service to work in partnership to deliver the healthy child programme.

NHS England and Peterborough City Council have been working very closely to facilitate the transfer and have had joint contracting and performance meetings with Cambridgeshire and Peterborough Foundation Trust, the provider. A number of issues have been identified that will need addressing these are highlighted below with plans on how they will be addressed.

4. ISSUES

4.1 **Change in Boundaries**

Health Visiting and Family Nurse Partnership services have been asked to align their current service provision to the local authority boundaries during 15/16.
This work is intrinsically linked with the Child Health Information Service (CHIS) as the system that tasks Health Visiting services. CHIS services were asked to analyse and compare their current allocation based on GP registered data to allocating based on LA boundary postcodes and report on potential differences for a snapshot in time. This information was collated by NHS England to enable an understanding of the numbers coming in and out for each provider.

Cambridgeshire and Peterborough Foundation Trust (CPFT) who are the provider of services for Peterborough faces a particular challenge looking to receive a net gain of around 650 children. There are no additional resources allocated for this

This will require some discussions and negotiations between CPFT and Cambridge Community Services, (CCS) the provider in Cambridgeshire. By far the most significant concern is the risk to *safeguarding provision*. CPFT and CCS have been asked to adopt a phased approach to transfer that ensures children who are on the Universal Partnership Plus and Universal Partnership pathways, Children in Need, Children in need of Protection, Children Looked After and children with an Early Help Assessment or Family Support Plan are prioritised.

While NHS England expected the transition to have occurred prior to transfer of commissioning responsibility in October 2015, in recognition of the challenge this will be to manage the risk and plan appropriately, this will not be feasible. Following a discussion with both CPFT and CCS it has been agreed that the current boundaries will remain the same for these 2 area with a plan that the full transition will have occurred by the end of the March 2016.

4.2 **Reduction in public health grant funding allocation**

The original baseline funding agreement for HV's was for 54 WTE this was later revised to 57 to reflect the increase in population for Peterborough. However in the final calculation, the offer of the funding was revised to reflect the original trajectory of 54 WTE's which meant a loss of 3 WTE H/V posts this year. In addition NHS England funded 0.5 Multi – Agency Safeguarding Hub (MASH) post and up lift from band 6-7 for a breast feeding co-ordinator. The breakdown of funding is highlighted below.

HV £m	13/14	14/15	15/16	16/17
54 WTE's	2,639	2,530	2,697	2,697

NB: Figures include 0.5 agreed for Band 7 HV for MASH and uplift from a band 6 to band 7 for a breast feeding co-ordinator

FNP £000	13/14	14/15	15/16	16/17
Funded for 125 places. 1 Supervisor, 5 Family Nurses and p/t admin	341	398	398	398

Also15k has been allocated for the additional commissioning responsibilities total of £3,111,000.

The effect this will have on HV this year is the reduction of 3.5 WTE HV posts to reflect the revised trajectory plus 0.5 MASH post and the upgrade post for the breast feeding co-ordinator.

In addition there is a reduction in the public health grant for 16/17 and a need to identify savings this year. Therefore saving from the Health Vising and Family Nurse Partnership will need to be identified.

This has been formally raised at a contractual meeting with providers and agreement to start working on the impact of any reduction. This will be monitored by the Joint Child Health and Wellbeing Commissioning Unit.

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 12
10 SEPTEMBER 2015		PUBLIC REPORT
Contact Officer(s):	Cath Mitchell	Tel. 01733 776189

WINTER RESILIENCE FUNDING

R E C O M M E N D A T I O N S	
FROM : Cath Mitchell, Local Chief Officer, Borderline and Peterborough System, NHS Cambridgeshire and Peterborough Clinical Commissioning Group	**Deadline date : n/a**
1. For Information	

1. ORIGIN OF REPORT

1.1 This report is submitted to Peterborough Health and Wellbeing Board as an information item from the Peterborough System Resilience Group (SRG) who are responsible for the allocation and monitoring of Winter Funding.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to keep the HWB up to date with the decisions made by the SRG to provider Winter Funding to services which can deliver additional capacity in the system to meet the needs of the local population.

3. KEY POINTS

- The annual budget for 2015/16 allocated to the Peterborough and Borderline system is £1.169m.

- The following schemes have been agreed:
    - Twelve discharge to assess beds £552k
    - Therapy and reablement support £128k
    - 6 day heart failure service £52k
    - 7 day services for diabetes inpatient cover £29k
    - 6/7 day enhanced respiratory services £31k
    - Enhanced 7 day services for respiratory/cardiac physiotherapy £40k
    - Enhanced weekend discharge team £23k
    - Enhanced weekend therapy services £24k

- The SRG is undertaking a Community Breaking the Cycle project commencing 03 September 2015. On completion of this project with system partners, the SRG will then consider how to allocate the remaining winter funding based on the evidence from the project.

- The amount allocated to the Borderline and Peterborough system which has been top-sliced by the CCG is £216k. This funding is being used to appoint an Escalation Lead and Project Manager for the Peterborough system. Plus the System is contributing to the introduction of a GP into the 111 service to triage calls which have a disposition to be advised to attend AE. This has resulted in patients being directed to alternative services and reduces pressure on AE.

- Each month a Winter Resilience Tracker is completed. This is submitted to the SRG for monitoring as part of the monthly reporting process.

4. ANTICIPATED OUTCOMES

The Peterborough System has delivered above 95% of patients seen within 4 hours in A&E during May/June/July 2015. The System wants to ensure patient flow and sustain their performance throughout the year. Therefore the remaining funding will be invested in those services that help the system to achieve this outcome.

UPDATED: 1 SEPTEMBER 2015

HEALTH AND WELLBEING BOARD
PROPOSED AGENDA PLAN 2015/2016

MEETING DATE	ITEM	CONTACT OFFICER
18 June 2015	**CCG**	
	Primary Care Commissioning	**Andy Vowles**
	System Transformation Programme	**Andy Vowles**
	Prime Minister Challenge Fund	**Gary Howsam**
	CCG Operational Plan and local quality premium	**Cathy Mitchell**
	Public Health	
	Annual DPH report on health of the local population	**Liz Robin**
	Task group report – screening and immunisations	**Anne McConville**
	Adult Social Care	
	Better Care Fund update on implementation plan	**Will Patten**
	Children	
	Children's JSNA	**Ryan O'Neil**
	Joint Child Health Commissioning Unit update	**Wendi Ogle - Welbourn**
	Other	
	Health and Wellbeing Board Membership and Terms of Reference	**Wendi Ogle Welbourn**
	Health and Wellbeing Strategy	**Liz Robin**
	For Information:	
	S75 HALP	**Oliver Hayward**
	Performance Report	**Helen Gregg**
10 September 2015	Commissioning Intentions	
	(a) Clinical Commissioning Group Commissioning Intentions	**Cathy Mitchell**
	(b) Local Authority Commissioning Intentions	**Wendi Ogle – Welbourn**
	Cardiovascular disease JSNA	**Liz Robin**
	Health and Wellbeing Draft Strategy Framework	**Liz Robin**
	Updated on Joint Commissioning Memorandum of Understanding (MOU)	**Wendi Ogle – Welbourn**
	Child and Adolescent Mental Health Challenge (CAMHS)Update	**Wendi Ogle-Welbourn**
	Adult Social Care - Better Care Fund (BCF) Update	**Will Patten**
	For Information:	
	Healthy Child Programme	**Janet Dullaghan**
	Winter Resilience Funding	**Cathy Mitchell**

UPDATED: 1 SEPTEMBER 2015

MEETING DATE	ITEM	CONTACT OFFICER
10 December 2015	System Transformation Programme Operational planning 2016/17 Mental Health JSNA Drug and Alcohol Tender Results Better Care Fund update Report from Adult Safeguarding Board Report from Local Safeguarding Childrens Board Draft Health and Wellbeing Strategy 2016-19 for Consultation **For Information:** Joint Winter/System Resilience Planning	**Andy Vowles** **Cathy Mitchell** **Liz Robin** **Andy Barringer** **Will Patten** **Wendi Ogle – Welbourn / Russell Wate** **Russell Wate** **Liz Robin** **Cathy Mitchell**
24 March 2016	System Transformation Programme Operational planning 2016/17 Older people – prevention of ill health JSNA Migrant workers JSNA Health protection Annual Report Better Care Fund update **For Information:**	**Andy Vowles** **Cathy Mitchell** **Liz Robin** **Will Pattern**