Public Document Pack

HEALTH AND WELLBEING BOARD

THURSDAY 10 DECEMBER 2015
1.00 PM

Bourges/Viersen Room - Town Hall
Contact – philippa.turvey@peterborough.gov.uk, 01733 452460

AGENDA

		Page No
1.	Apologies for Absence	
2.	Declarations of Interest	
3.	Minutes of the Previous Meeting	3 - 14
4.	Amended Health and Wellbeing Board Membership and Terms of Reference	15 - 20
5.	Health and Care System Transformation Programme	21 - 44
6.	Prevention Work for the Health System Transformation Programme	45 - 152
7.	Substance Misuse Whole Treatment Service Retender	153 - 154
8.	Adult Social Care, Better Care Fund Update	155 - 158
9.	Draft Peterborough Joint Health and Wellbeing Strategy 2016-19	159 - 184
10.	Peterborough System Winter Plan	185 - 212
	INFORMATION AND OTHER ITEMS	
11.	Peterborough Safeguarding Children Board Annual Report and Peterborough Safeguarding Adult Annual Report	213 - 324
12.	Primary Care Programme Update	325 - 328
13.	Health and Wellbeing Partnership Delivery Board Terms of Reference	329 - 330
14.	Schedule of Future Meetings and Draft Agenda Programme	331 - 332

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 Philippa Turvey on 01733 452460 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), Cllr D Lamb, Cllr W Fitzgerald, Andy Vowles, Cathy Mitchell, Dr Moshin Laliwala, Dr Paul van den Bent, Dr Gary Howsam, Dr Kenneth Rigg, David Whiles, Dr Harshad Mistry (Vice Chairman), Wendi Ogle-Welbourn, Dr Liz Robin, Adrian Chapman and Andrew Pike

Co-opted Members: Russell Wate and Claire Higgins

Further information about this meeting can be obtained from on telephone 01733 452460 or by email – philippa.turvey@peterborough.gov.uk

MINUTES OF A MEETING OF THE HEALTH AND WELLBEING BOARD HELD IN THE BOURGES / VIERSEN ROOMS, TOWN HALL ON 10 SEPTEMBER 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 Adrian Chapman, Service Director, Adult Services & Communities Dr Liz Robin, Director for Public Health Cathy Mitchell, Local Chief Officer Dr Moshin Laliwala Dr Harshad Mistry Dr Gary Howsam, Chair of the Borderline Local Commissioning Group David Whiles, Peterborough Healthwatch
Co-opted Members Present:	Claire Higgins, Chairman of the Safer Peterborough Partnership Russell Wate, Peterborough Safeguarding Children Board, Independent Chair
Also Present:	Will Patten, Assistant Director for Adult Commissioning Lee Miller, Head of Transformation and Commissioning (Children and Maternity) Paulina Ford, Senior Democratic Services Officer

1. Apologies for Absence

Apologies for absence were received from Dr Michael Caskey, Dr Kenneth Rigg and Andy Vowles.

2. Declarations of Interest

There were no declarations of interest.

3. Minutes of the Meeting Held on 18 June 2015

The minutes of the meeting held on 18 June 2015 were approved as a true and accurate record.

The Chairman referred to item 4 of the minutes, Health and Wellbeing Board Membership and made the following statement:

"I would respectfully ask the Board to reconsider the agreement made around Councillor Representation. This is because at that time of the agreement the Conservatives had an overall majority however, following the elections they now do not. It would therefore seem right to offer the opposition a place on the Board to ensure appropriate representation"

All members of the Board present unanimously agreed to this proposal.

The Health and Wellbeing Board **RESOLVED** to amend the Health and Wellbeing Board Membership to include an opposition Councillor.

4. Appointment of Vice Chairman

Dr Harshad Mistry was nominated for the position of Vice Chairman. The Chairman asked the Board if they were in agreement with this nomination. All members of the Board present unanimously agreed to the nomination of Dr Mistry as Vice Chairman.

The Health and Wellbeing Board **RESOLVED** to agree to the appointment of Dr Harshad Mistry to the position of Vice Chairman of the Board.

5. Commissioning Intentions

a) CCG Commissioning Intentions 2016/17

The Local Chief Officer introduced the report which provided the Board with an update on the current position relating to operational planning for the financial year 2016/17.

The Local Chief Officer gave a presentation outlining initial planning intentions for 2016/17 which is attached at Appendix 1 of the minutes. Key points highlighted and raised during discussion included:

- Clarification was provided regarding the Prime Ministers Challenge Fund in that it was a General Practitioners initiative and not a Local Commissioning Group initiative.
- There was an active coronary heart disease programme in place and key priorities regarding cardio vascular disease were being looked at and when identified would be reflected within the commissioning intentions.
- An explanation was provided regarding the '*One System, One Plan, One Budget*. There was one health budget to cover all health issues and therefore there was a collective conversation between all partners on how the budget could meet all health needs.
- The final commissioning intentions will form part of the Operational Plan which will be approved by NHS England in May 2016 and would be brought back to the Health and Wellbeing Board prior to submission.

The Health and Wellbeing Board **RESOLVED** to note the current status of operational planning for financial year 2016/17 for the System and Borderline and Peterborough LCG's and that the final Operational Plan / Commissioning Intentions submission be presented to the Board prior to submission to NHS England.

b) LA Commissioning Intentions 2016/17

The Corporate Director of People and Communities introduced the report which provided the Board with an update on the Local Authority's (LA) commissioning intentions for the next financial year, 2016/17. Key points highlighted and raised during discussion included:

- The LA was still developing its commissioning intentions and there was a big transformation programme in place which would produce savings during 2016/17. Much of the work being done by the LA overlapped with the CCG and the hope was that next year a joint document could be produced.
- Health was now one of the council's strategic priorities.
- A commitment had been made to only commission services that had an effective evidence base and also to work better with providers to develop services.
- There were seven themes within the commissioning intentions. The following four were mentioned within the report:

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

- The Front Door and Investment in the Community were both about managing demand and ensuring that residents needing services could reach the services quickly and efficiently. It was currently very difficult for residents to navigate their way through to the correct service.
- The first part of the project was too completely change the way the LA operated the Front Door which was currently a physical space in Bayard Place. The intention was to enhance the service by providing a virtual Front Door to enable people to access the services from anywhere e.g. home, library, GP surgeries or other council buildings. There would be investment in digital technology and a transfer of specialist staff to the Front Door.
- There would also be investment in alternative provision. The intention would be to enhance the role of voluntary and community groups to help reduce isolation, increase community support in the home and provide local activities.
- The Operating Model (Specialist Services for children and adults). The intention was to provide specialist expertise earlier with the intention of preventing the need for further support.
- There had been difficulty in retaining and recruiting qualified social workers. It was therefore the intention to recruit alternatively qualified workers such as nursery nurses, family workers, school nurses and youth workers. It was hoped that this would reduce the demand on social workers time and provide a better service to children and families and specifically to children in need. Increasing the range of skills would improve the service. There would be an investment in training the alternatively qualified workers and they would be overseen by a qualified social worker. A pilot was currently being undertaken.
- A review of Adult Social Care operations was being undertaken with a view to integrating services with NHS multi-disciplinary teams.
- Members of the Board were encouraged to hear of the increased level of joint working.
- Members were assured that people who were not digital savvy or needed to speak to someone could bypass the system. There were multiple options and ways to access the system which would be well published.
- Budget had been set aside to support the transformation agenda plus capital investment to support the digital technology.

The Health and Wellbeing Board **RESOLVED** to note the commissioning intentions of the Local Authority for 2016/17 financial year.

6. Peterborough Cardiovascular Disease – Joint Strategic Needs Assessment

The Director of Public Health introduced the report which provided the Board with a summary of the cardiovascular disease (CVS) Joint Strategic Needs Assessment (JSNA). Key points highlighted and raised during discussion included:

- The purpose of the JSNA was to provide data and evidence to inform the development of the CVS work plan and the Health and Wellbeing Strategy, 2016-21.
- The Director of Public Health thanked Dr Anne McConville, Public Health Consultant, Ryan O'Neill, Public Health Analyst and the Steering Group for developing the JSNA.
- CVD was a long process and was not just related to heart attacks. CVD was influenced by many things e.g. alcohol, smoking, lack of exercise, obesity.
- A CVD workshop had been held and three key outcomes/issues had been identified:

    1. Under 75 death rates in Peterborough were high compared to the national average. Therefore a priority would be a reduction in under 75 mortalities.

2. There was an inequality in CVD outcomes across Peterborough. Therefore the second priority would be to look at the inequalities of CVD outcomes across Peterborough.
3. To look at reducing demand on services and in particular prevention and community management with regard to stroke and heart failure.

- Some of the wards in Peterborough with a high rate of under 75 deaths had a high Asian community, was there a link. The Board were advised that people who came to this country from South Asia were known to suffer from heart disease and that this was a national problem. The different diet and different levels of activity and exercise in this country also contributed to CVD. However this was not irreversible and could be specifically addressed within those communities.
- Clarification was sought on what was being done regarding follow up for people who have had heart attacks. The Board were advised that there was a lot of evidence regarding secondary prevention and all GP's had concentrated on this but it was ultimately the patients choice as to the lifestyle they lived.
- The Director for Public Health asked the Board to consider the recommendations within the report but not recommendation 3d), *That the CVD JSNA informs the development of the 'Healthy Peterborough' 2016 health and wellbeing campaign plan* as this was part of another work stream.

The Health and Wellbeing Board **RESOLVED** to:

1. Note the information and analysis in the CVD JSNA and support the publication of the JSNA dataset and summary on its public website.
2. Consider the verbal report from the workshop held on 9th September to inform further engagement with stakeholders and the public.
3. Support 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.

Dr Mistry left the meeting at this point.

7. Health and Wellbeing Draft Strategy Framework

This report was 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. The report provided the Board with a draft framework for an updated JHWS 2016-19, and proposals for a new timescale to allow for full engagement of key partner agencies and public consultation with local communities. The Director of Public Health introduced the report

Key points highlighted and raised during discussion included:

- The Board had a statutory responsibility to jointly assess the health and wellbeing needs of the population and then a statutory responsibility to prepare a joint Health and Wellbeing Strategy to meet the needs identified.

- The current Health and Wellbeing Strategy was due to expire at the end of 2015. Some of the data and needs on which the current Strategy was based were now out of date. There was therefore a requirement to renew the Strategy.
- The Board were informed of the potential priorities for the new Strategy. The Director of Public Health sought comments on the draft Framework which was attached at Annex A of the report.
- The Local Chief Officer commented that there were a significant number of Tuberculosis (TB) cases now in the population of Peterborough and this was increasing. Consideration should be given to including TB as one of the priorities within the Strategy.
- Clarification was sought as to how the final Strategy would be presented as it could potentially be a very large document. Consideration should be given to providing a summary of the Strategy as well as some information on a postcard size document that could be left in doctors surgeries and key public places. A pictorial presentation would also be helpful as this would be more user friendly.
- The Director of Public Health advised that an additional chapter on Health Protection and TB could be added to the Strategy. Consideration would also be given to the comments made about presentation of the Strategy and making it more user friendly.

The Health and Wellbeing Board **RESOLVED** to

1. Approve the draft framework for the Peterborough Health and Wellbeing Strategy 2016-19 as laid out in Annex A of the report but with the addition of a section being added on Health Protection and TB. The Board also requests that consideration should also be given to the comments made by the Board regarding the final presentation of the document to make it more user friendly.
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.

8. Update On Joint Commissioning Memorandum of Understanding (MOU)

The Corporate Director of People and Communities introduced the report which provided the Board with an update on the Joint Commissioning Memorandum of Understanding (MOU). The Board were informed that the MOU had now been agreed and signed by all partners.

The Health and Wellbeing Board **RESOLVED** to note the MOU agreement and priorities.

9. Child Adolescent and Mental Health Challenge (CAMHS) Update

The Head of Transformation and Commissioning (Children and Maternity) Joint Commissioning Unit introduced the report. The report provided the Board with an update on current issues in Child and Adolescent Mental Health Services (CAMHS) provision, current actions and future plans.

Key points highlighted and raised during discussion included:

- Waiting times in specialist CAMHS were up to 1 year.
- Waiting lists had been temporarily closed for Autistic Spectrum Disorders (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) referrals where there were no associated urgent Mental Health needs.
- CAMHS Emergency assessments in Emergency Department settings had increased significantly in recent years.
- A Transformation Plan was being developed which would detail local priorities and proposed investments for 2015/2016. The Transformation Plan would need to be

approved by the Health and Wellbeing Board before funding was released by NHS England. The Plan would be drafted by mid-September with a final deadline for submission by mid-October to NHS England. The approval by the Health and Wellbeing Board would need to be done electronically to meet the deadline for submission to NHS England.

- The needs of carers and their support mechanisms should be taken into consideration within the Plan.
- An Emotional Health and Wellbeing Strategic Board which covered Cambridgeshire and Peterborough was in place. A member of Family Voice was on the Board representing carers. The Strategic Board had approached Healthwatch to see how children and young people might get involved to gain their views.
- A single gateway was being developed for the Local Authority and Health Services so that all referrers could go through one point of access to a range of services. This would be piloted before March 2016.
- Funding had been provided for three psychiatric nurses from the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) to go into schools to provide support to teachers to help them identify at an early stage children with emotional difficulties.

The Health and Wellbeing Board **RESOLVED** to:

1. Agree to approve the Transformation Plan electronically.
2. Note the current challenges in CAMHS Services and actions in place to address these.

10. Adult Social Care – Better Care Fund (BCF) Update

The Assistant Director for Adult Commissioning introduced the report. The report provided the Board with an update on the delivery of the BCF Programme which included the second quarterly monitoring return for NHS England approved by the Borderline and Peterborough Executive Partnership Board, Commissioning. The Corporate Director for People and Communities commented that the Better Care Fund had made a difference to services in the area.

The Health and Wellbeing Board **RESOLVED** to note the report.

The Chairman requested that a glossary of terms be provided for the members of the Health and Wellbeing Board to assist with referencing acronyms within reports. The Director of Public Health and Corporate Director agreed to action this request.

INFORMATION ITEMS AND OTHER ITEMS

The remainder of the items on the agenda were for information only and the Health and Wellbeing Board **RESOLVED** to note them without comment.

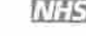
11. Healthy Child Programme

12. Winter Resilience Funding

13. Schedule of Future Meetings and Draft Agenda Programme

The Health and Wellbeing Board **RESOLVED** to note the dates of future meetings and agreed future agenda items for the Board.

1.00pm – 2.50pm
Chairman



Cambridgeshire and Peterborough Clinical Commissioning Group

Initial Planning Intentions for 2016/17

Catherine Mitchell

Local Chief Officer

Planning Intentions 2016/17

- We are adopting a different approach to previous years, emphasising joint working within the Cambridgeshire and Peterborough System and setting operational priorities for next year within the context of the strategic direction for the System
- We are at an early stage of drawing up planning intentions. As discussions develop within the System, it is likely that some or many of the examples given today will change
- The views of the Board are welcome and they will be taken into account during the planning process

Urgent Care

Aims:

Create an overarching and strongly clinically-led super-System Resilience Group, as part of the East of England Urgent and Emergency Care Network which will:

- Accelerate the pace of improvement which the three System Resilience Groups have started to deliver
- Act as the governance vehicle to deliver this rapid improvement as part of the System Transformation Programme (supported by the System Transformation Board)
- Achieve a model of best practice in line with the Keogh Review and the NHS England vision for urgent and emergency care

Examples of County-wide initiatives:

- Re-align emergency departments in terms of flows of activity and designation of units
- Configure a network of community based urgent care centres around primary care hubs, out of hours bases and Minor Injury Units
- Reduce Rates of admission of older people reduced in line with Uniting Care outcomes models plus upstream focus through new third sector driven Well-Being Service
- Reduce significantly crisis mental health presentations to A&E due to early community based intervention models
- Primary care expanded to cover 8-8 midweek and 9-9 weekends with Emergency Department frontage
- Significant progress in implementing 7 day working fully across all services with no deterioration in outcome for patients admitted at weekends.
- Voluntary sector aligned and commissioned to support early intervention and post discharge pathways
- Integration of Local Authority public health commissioned drug and alcohol services to support reduced demand on emergency services

Planned Care, Long Term Conditions, Prevention

Aims:

- Be supportive of the work on-going to develop Primary Care at scale
- Ensure that care pathways are as efficient as possible and in the most appropriate clinical setting
- Care is provided in accordance with agreed clinical policies
- Explore opportunities to encourage prevention

Examples of County-wide initiatives:

- Adopt a collaborative approach to managing demand for elective services across the System
- Review pathways and services to identify opportunities for service improvement
- Ensure that agreed clinical threshold policies are adhered to
- Identify opportunities where care could be delivered safely, more efficiently and cost effectively
- Design and implement robust commissioning arrangements for TB Services (led by Borderline and Peterborough System)
- Promote the benefits of self-care for long term conditions
- Implement the new contract for the Non-Emergency Patient Transport Service from September 2016
- Conduct a deep dive into the impacts of obesity on health services and prepare plans for implementation in 2017/18 and beyond to address the key issues identified

Borderline & Peterborough Initiatives:

- Implement the procurement of MSK services including Pain Management
- Review diabetes services and identify the options for future service provision
- Plan additional Ambulatory Care Pathways
- Ensure that Tier 3 obesity services are jointly commissioned on a whole pathway of care approach

Maternity, Children and Young People

Aims:

- Consolidate the joint commissioning arrangements agreed in 2015/16
- Build on the benefits of joint working to ensure that services are available to meet the health needs of the population
- Services integrated where this is sensible with clear benefits to the care of children and young people

Examples of County-wide initiatives:

- Consolidate and build further the work of the Joint Commissioning Unit in line with the "Future in Mind" (2015)
- Implement the service transformation priorities to take forward the redesign of Children and Maternity services, including all elements of the healthy child programme
- Take forward with service providers new specifications for Children Looked After Health services
- Complete the re-commissioning of rapid response services
- De-commission Child Protection Medicals in Peterborough from CPFT and re-commission them from PSHFT
- Paediatric pathway: develop a paediatric ACU approach linking into the current transformation work

Borderline & Peterborough Initiatives:

- Implement new CAMHS model, including strengthening Tier 2 services
- Develop integrated service, particularly in response to the SEND reforms

Primary Care

Aims:

- Improve patient experience, access to primary care, equity of access and reduce inequalities
- Develop high quality, integrated out-of-hospital services, organised around the patient, closer to home
- Develop sustainable primary care organisations through developing options, piloting and implementing primary care provision models
- Progress the workforce development and the investment in resources required to deliver the Primary Care programme objectives
- Increase the role in primary care commissioning leading to increased empowerment to improve primary care services

Examples of County-wide initiatives:

- Agree the vision for the range of services which could be commissioned from organisations offering primary care at scale
- Build on the co-commissioning of primary care arrangements in place
- Continue to address the primary care workforce gaps and priorities to secure longer term sustainability
- Explore opportunities for streamlining primary care processes for Direct Access Pathology and Radiology
- Explore the benefits of having pharmacist resource and expertise within a primary care setting
- Work with System Resilience Groups to implement improved patient triage / treatment processes in Emergency Departments

Borderline & Peterborough Initiatives:

Consolidate the implementation of the Primary Care at scale programme in Borderline and Peterborough (Prime Minister's Challenge Fund) focussing on:

a) GP extended opening hours
b) GP in front of house
c) Multi-skilled Workforce e.g. introduction of Pharmacists

Mental Health Services

Aims:

- Consolidate the service re-design initiatives started in 2015/16 to create a more resilient local mental health system
- Together with local stakeholders, revise the Adult Mental Health Commissioning Strategy for 2016-19 and ensure that the key priorities are reflected in planning intentions for 2016/17

Examples of County-wide initiatives:

- Implement improvements to the Advice and Referral Centre e.g. developing local single-points-of-access, closer links between primary care and CPFT clinicians, making more use of local community-based resources
- Roll-out the innovative model of "Recovery Coaches" and peer support workers
- Pilot "Phase 1" of an Enhanced Primary Care Service to provide an enhanced level of support to patients who no longer need to remain in secondary mental health services but have needs beyond what primary care is currently contracted to provide. "Phase 1" will initially target stable psychosis patients
- Continue to support local implementation of the Crisis Care Concordat
- Fully implement self-referral to IAPT services across all providers and build upon the progress made during 2015/16 in strengthening partnerships between IAPT-compliant providers in each locality
- Re-design pathways for services where waiting-times have become unacceptable
- Maintain improvements achieved in performance data quality to inform contract/performance monitoring
- Take forward local data-sharing initiatives to enable information to be shared between service providers and enhance the help and support that they receive

Borderline & Peterborough Initiatives:

- Have in place a more responsive service to manage and direct patients presenting in A&E who do not need physical help to an alternative service that can respond and /or be a point of contact to avert a potential crisis
- Support the Severe Mental Illness work in primary care, acknowledging that there are limitations with GP recruitment issues; the model would need to multi-disciplinary in nature

Learning Disability

Aims:

- Excellent joint working between Health and Local Authorities with the patient foremost in mind
- Services are accessible and available in the community as required
- Provide easy to read and understand information for patients

County-wide examples:

- Support local implementation of the Assuring Transformation / Winterbourne View Plans for Cambridgeshire and Peterborough
- Review local in-patient requirements in the light of the requirement that, post-Winterbourne View, all people with learning disability should be supported to live within local communities
- Support the uptake and delivery of primary care Learning Disability health checks and other primary care agreements (e.g. by offering practice-based training, promoting health check awareness etc.)
- Support the achievement of the new national accessible information standards by all commissioned providers (e.g. by the provision of easy read materials)

Better Care Fund

Aims:

Move to an operating model for the health and social care system that helps people to help themselves, where the majority of people's needs are met appropriately through family and community support.

County-wide examples:

- Together with Uniting Care, continue to develop services for older people aged 65 years and over and adults who need community services
- Continue the close partnership working already in place to ensure that services are aligned and duplication avoided
- Work with the county-wide Urgent and Emergency Care System Resilience Group to ensure that plans for optimising urgent care pathways and introducing seven day services are aligned

Borderline & Peterborough Initiatives:

- Create a new service (Community Connectors) to harness community capacity and facilitate positive change in communities
- Taking a phased approach, expand 7 day working whilst achieving greater alignment and integration of local authority discharge planning teams and progressive service transformation
- Develop housing-related support through reshaping the housing market and the 24 hour bed-based care market
- Maximise the potential of tele-health and tele-care and making this an integral part of care pathways
- Support and enable older people to lead healthy lifestyles through the work of the Ageing Healthily and Prevention Project

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 4
10 DECEMBER 2015		PUBLIC REPORT
Contact Officer(s):	Wendi Ogle-Welbourn Corporate Director People and Communities	Tel. 01733 863749

AMENDED HEALTH AND WELLBEING BOARD MEMBERSHIP AND TERMS OF REFERENCE

R E C O M M E N D A T I O N S	
FROM : Wendi Ogle-Welbourn, Corporate Director of People and Communities	**Deadline date:** N/A
That the Health and Wellbeing Board to: 1. Note the revised Terms of Reference; and 2. Appoint Councillor Ferris as a Member of the Health and Wellbeing Board as 'an opposition Councillor'.	

1. ORIGIN OF REPORT

1.1 This report is submitted to the Board following agreement at the Health and Wellbeing Board meeting on 10 September 2015 that an 'Opposition Member' position be added to the Board's Membership.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to seek the agreement of the Health and Wellbeing Board on the revised terms of reference of the Board and to appoint Councillor Ferris to the additional position, as per nomination by the Leader of the Council.

2.2 This report is for the Board to consider under its terms of reference 2.2 'to actively promote partnership working across health and social care in order to further improve health and wellbeing of residents'.

3. BACKGROUND AND SUMMARY

3.1 At its meeting held on 10 September 2015 the Health and Wellbeing Board agreed in principle the addition of 'an opposition Councillor' position to the Board, following an approach from Members. The Health and Social Care Act 2012 mandates a minimum membership of:

- one local elected representative;
- a representative of local Healthwatch organization;
- a representative of each local clinical commissioning group;
- the local authority director for adult social services;
- the local authority director for children's services; and
- the director of public health for the local authority.

3.2 Local boards are free to expand their membership beyond this to include greater number of elected representatives. It is for the executive leader of the local authority to make nominations to the Health and Wellbeing Board for approval under the Health and Social Care Act 2012.

3.3 The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 disapply the requirement for political proportionality. Cross-party engagement in Health and Wellbeing Boards, however, can assist in achieving health improvement and wellbeing objectives for the whole population.

4. CONSULTATION

4.1 The Leader of the Council consulted with all Group Leaders on the proposed nomination. Councillor Ferris was the only Councillor put forward for the position. As such, these views have informed the recommended Councillor nomination within this report.

5. ANTICIPATED OUTCOMES

5.1 That the Health and Wellbeing Board agree to appoint Councillor Ferris to the Health and Wellbeing Board and that this will assist in achieving health improvements and wellbeing objectives for the Peterborough population.

6. REASONS FOR RECOMMENDATIONS

6.1 To respond to a request for ‘opposition Councillor’ representation and to allow the Health and Wellbeing Board to be strengthened and become more effective.

6.2 The standing orders 6.2 ‘Appointment of Members to Committees in year vacancy’ do not apply in this scenario, as this relates to the appointment of an additional Committee Member. Under the Health and Social Care Act 2012 nominations to the Health and Wellbeing Board must be made, in the case of a local authority operation executive arrangements, by the executive leader of the local authority.

6.3 It is further set out in the Health and Social Care Act that, following nomination, the Health and Wellbeing Board may appoint such additional persons to be members of the Board as it thinks appropriate.

7. BACKGROUND DOCUMENTS

- Health and Social Care Act 2012
- Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013
- Local Government Association ‘Health and Wellbeing Boards: A Practical Guide to Governance and Constitutional Issues’

8. APPENDICES

- Revised Terms of Reference – Appendix A

APPENDIX A

Peterborough Health and Wellbeing Board
Purpose and Terms of Reference

1. Background and context:

1.1 The Peterborough Health & Well Being Board has been established to provide a strategic leadership forum focussed on securing and improving the health and well being of Peterborough residents.

2. The aims are:

2.1 To bring together the leaders of health and social care commissioners to develop common and shared approaches to improving the health and well being of the community.

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

2.3 To influence commissioning strategies based on the evidence of the Joint Strategic Needs Assessment.

3. Its functions are:

3.1 To develop a Health and Well Being Strategy for the city which informs and influences the commissioning plans of partner agencies.

3.2 To develop a shared understanding of the needs of the community through developing and keeping under review the Joint Strategic Needs Assessment and to use this intelligence to refresh the Health & Well Being Strategy.

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

3.4 To consider the recommendations of the Director of Public Health in their Annual Public Health report.

3.5 To consider options and opportunities for the joint commissioning of health and social care services for children, families and adults in Peterborough to meet identified needs (based on the findings of the Joint Strategic Needs Assessment) and to consider any relevant plans and strategies regarding joint commissioning of health and social care services for children and adults.

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.

3.7 By establishing sub groups as appropriate give consideration to areas of joint health and social care commissioning, including but not restricted to services for people with learning disabilities.

3.8 To oversee the development of Local HealthWatch for Peterborough and to ensure that they can operate effectively to support health and well being on behalf of users of health and social care services.

3.9 To keep under consideration, the financial and organisational implications of joint and integrated working across health and social care services, and to make recommendations for ensuring that performance and quality standards for health and social care services to

children, families and adults are met and represent value for money across the whole system.

3.10 To ensure effective working between the Board and the Greater Peterborough Partnership ensuring added value and an avoidance of duplication.

4. Membership

4.1 Membership of the Health and Wellbeing Board will be composed of the following:

Peterborough City Council:
The Leader of the Council / Deputy Leader – Chairman of the Board
Cabinet Member Adults & Health Integration
Cabinet Member Public Health
An Opposition Councillor
The Corporate Director People and Communities
Service Director Adults and Communities
The Director of Public Health

Cambridgeshire and Peterborough Clinical Commissioning Group
The Chief Operating Officer
Local Chief Officer for Peterborough City and Borderline LCG
2 GP members representing Peterborough City Local Commissioning Group (Vice Chair)
1 GP member representing Borderline Local Commissioning Group

Lincolnshire
1 GP representing South Lincolnshire CCG

National Commissioning Board
1 representative of the NCB Local Area Team

Peterborough Healthwatch
1 member

The Board will also include as co-opted members the following:
Independent Chair of Local Safeguarding Children's Board and Peterborough Safeguarding Adults Board
The Chair of the Safer Peterborough Partnership (Claire Higgins)

4.2 The membership will be kept under review periodically.

4.3 The Board shall co-opt other such representatives or persons in a non-voting capacity as it sees relevant in assisting it to undertake its functions effectively.

5. Meetings

5.1 The meetings of the Board and its decision-making will be subject to the provisions of the City Council's Constitution including the Council Procedure Rules and the Access to Information Rules, insofar as these are applicable to the Board in its shadow form.

5.2 The Board will meet in public.

5.3 The minimum quorum for the Board shall be 5 members which should include at least one elected member, one statutory director (DCS/DASS/DPH) and a CCG/LCG member.

5.4 The Board shall meet periodically and at least quarterly. Additional meetings shall be called at the discretion of the Chairman where business needs require.

5.5 Administrative arrangements to support meetings of the Board shall be provided through the City Council's Governance team.

6. Governance and Approach

6.1 The Board will function at a strategic level, with priorities being delivered and key issues taken forward through the work of the partnership organisations.

6.2 Decisions taken and work progressed will be subject to scrutiny of the City Council's Scrutiny Commission for Health Issues.

7. Wider Engagement

7.1 The Health and Wellbeing Board will develop and implement a communications engagement strategy for the work of the Board, including how the work of the Board will be influenced by stakeholders and the public.

7.2 The Board will ensure that its decisions and the priorities it sets take account of the needs of all of Peterborough's communities and groups are communicated widely.

8. Review

8.1 These Terms of Reference will be reviewed periodically.

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 5
		PUBLIC REPORT
Contact Officer(s):	Dr Neil Modha, Chief Clinical Officer (Accountable Officer), Cambridgeshire and Peterborough Clinical Commissioning Group Dr Fiona Head, Programme Director, Cambridgeshire and Peterborough Health and Care System Transformation Programme	

CAMBRIDGESHIRE AND PETERBOROUGH HEALTH AND CARE SYSTEM TRANSFORMATION PROGRAMME

R E C O M M E N D A T I O N S	
FROM: Fiona Head, Programme Director, Cambridgeshire and Peterborough Health and Care System Transformation Programme	**Deadline date:** N/A
That the Health and Wellbeing Board note the update included within the report.	

1. ORIGIN OF REPORT

1.1 This report is submitted following a request from the Health and Wellbeing Board.

2. PURPOSE AND REASON FOR REPORT

2.1 Cambridgeshire and Peterborough Health and Care System Transformation Programme last presented information to the Health and Wellbeing Board on 10 September 2015. The purpose of this report is to update the Peterborough Health and Wellbeing Board on the Cambridgeshire and Peterborough System Transformation Programme planning process.

3. BACKGROUND

3.1 Programme strategic aims and values

3.1.1 The strategic aims and values of the programme remain:

- People at the centre of all that we do;
- Empowering people to stay healthy; and
- Developing a sustainable health and care system.

3.2 Update

3.2.1. Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) is leading a process to plan changes to the health system that will improve outcomes for people and enable financial sustainability. This process involves providers, partners, and patients and has four phases.

3.2.2 The programme continues to work on the following areas:

- Detailed analysis of the issues facing the health system, working with key stakeholders about areas of challenge. The Change Document for the programme has been updated;

- Engagement with the public around the key challenges facing the health system now and into the future; and
- Getting feedback from the public about current services and how they think things could change.

3.3 Changes since the last update to the Health and Wellbeing Board on 10 September

3.3.1 Progress of the engagement work

- Pre-engagement work with the public continues on the challenges facing the health system;
- "Fact pacts" for each locality have been produced to support this. These are shown in the appendix; and
- Formal engagement with the public on the key changes facing the health system is expected to take place early in 2016.

3.3.2 Public Involvement Assembly

3.3.2.1 The second round of Public Involvement Assembly sessions took place in October and November. Everyone was welcome to the sessions, which were held in locations across our area.

3.3.2.2 The workshops were a continuation of the Cambridgeshire and Peterborough Fit for the Future NHS Saturday Cafés and Public Involvement Assembly sessions that were held this summer.

3.3.2.3 As a direct result of feedback from the last round of the Public Involvement Assembly sessions, a leaflet is being prepared to explain how people can return unwanted equipment.

3.3.2.4 Residents who attended the first sessions were invited to the second round of sessions. The sessions were advertised via the local media and social media, and an email via the CCG Stakeholder database, to encourage more people to join the sessions. Posters and flyers were displayed in venues in advance of each event. The workshops covered:

- Feedback received during the events over the summer and how that is being used; and
- Localised fact packs to allow an informed debate on shaping health services in the future.

3.3.2.5 The Programme will plan separate events to engage with people, such as those with caring responsibilities for young children, who are unable to attend early evening meetings.

3.3.3 Development of the Urgent and Emergency Care Vanguard

3.3.3.1 In July Cambridgeshire and Peterborough CCG was successful in being awarded Vanguard status for the Urgent and Emergency Care element of the NHS New Care Models (NCM) programme, bringing the 'Five Year Forward View' into action.

3.3.3.2 The CCG was one of eight sites selected nationally, tasked with implementing the recommendations set out in Sir Bruce Keogh's review of Urgent and Emergency Care (UEC). The Keogh review recommended that there be no consultation in isolation. What this means in practice is that patients accessing the urgent and emergency care system, whether by phone via 999 or 111, or digitally, should be provided with the necessary advice regarding how to manage their own condition (self-care) or be provided with seamless access to UEC services via direct booking. This could be directly into a GP/dental appointment or to a designated urgent care centre. An overview of the model is presented in appendix 2.

3.3.3.3 The CCG is in the process of setting up the Vanguard programme which is underpinned by five workstreams - see appendix 3. The Vanguard Programme has established a Strategic

System Resilience Group (SSRG) to act as the Programme Board to oversee the delivery of each of the workstreams. The board meets monthly and is comprised of clinicians, managers, and subject matter experts representing each area of work.

3.3.3.4 The programme is in the 'set up' phase and will be accountable via the SSRG to the System Transformation Programme (STP) board. Further updates will be provided in due course that describe the aims and objectives of each workstream.

3.3.4 Scoping of the prevention work that is needed to maximise wellbeing and reduce demand for services

3.3.4.1 Activity modelling undertaken as part of the programme has shown that conditions such as obesity are likely to be a cause of half of the increase in demand on health services.

3.3.4.2 The Director of Public Health is scoping a prevention workstream which aims to promote wellbeing and reduce the need for health and care services. This will be presented to the System Transformation Programme Board on 16 November.

3.3.4.3 Key messages in the Change Document

3.3.4.4 The key messages in the refreshed version focus on why the health system needs to change:

- If we do not change our health system substantially then we face a deficit of at least £250 million by 2018/19 and this will make it harder to deliver good quality care. At the moment our hospitals have significant deficits;
- The need for health services continues to increase;
- Primary care is not sustainable in its current form;
- We have a mismatch between capacity and demand which affects all parts of the system and is significantly affecting our hospitals;
- There are gaps in some parts of the workforce across the Cambridgeshire and Peterborough health system; and
- In addition we have service gaps in mental health and services for children.

4. NEXT STEPS

4.1 The System Transformation Programme Board will meet on 16 November 2015. It is expected to agree recommendations to put forward to Cambridgeshire and Peterborough Clinical Commissioning Group's Governing Body for engagement on potential ideas for change. We will update the Health and Wellbeing Board on the outcomes from that meeting.

5. BACKGROUND DOCUMENTS

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

Source Documents	Location
• Cambridgeshire and Peterborough health system Change Document/15 to 2018/19: Main text	http://www.cambridgeshireandpeterboroughccg.nhs.uk/five-year-plan.htm
• Cambridgeshire and Peterborough health system Blueprint 2014/15 to 2018/19: Appendices	http://www.cambridgeshireandpeterboroughccg.nhs.uk/five-year-plan.htm
• Cambridgeshire and Peterborough System Transformation Programme Frequently asked Questions	http://www.cambridgeshireandpeterboroughccg.nhs.uk/STP_FAQS_Feb_2015docx.pdf
• NHS England " Five Year Forward View"	http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

• NHS England " Urgent and Emergency Care Vanguard" site	http://www.england.nhs.uk/ourwork/futurenhs/5yfv-ch3/new-care-models/uec/

6. APPENDICES

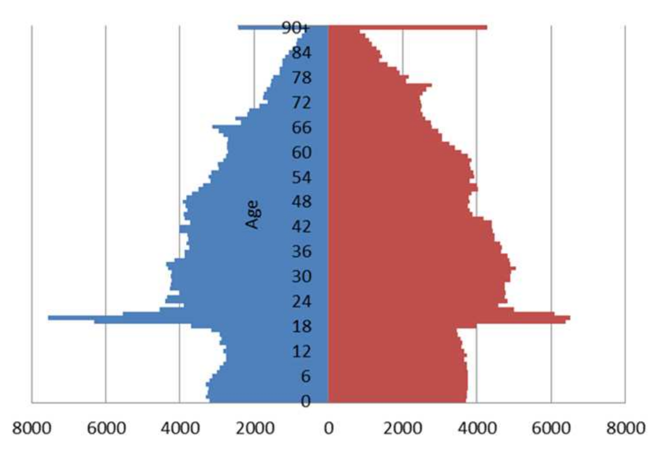
- Appendix A – System Transformation Programme Engagement Fact Packs
- Appendix B – Overview of the Vanguard Model
- Appendix C – Overview of the Vanguard Model Programme or Work

System Transformation Programme Engagement Fact Pack: Cambridge System

September 2015

This pack contains data published for different geographical areas. The closest match to the area served by the CATCH and Cam Health Local Commissioning Groups has been used throughout. Depending on the data source, this may be the locality, the local authorities of Cambridge City and South Cambridgeshire, the county of Cambridgeshire or the CCG catchment area.

Population



- The total resident population of Cambridge City and South Cambridgeshire was 278,200 in 2013 and is forecast to rise by 17% to 2023, reaching a total of 326,700.
- The population aged 65 and over is forecast to rise by 30% by 2023. The number of people aged 90 or over will rise by three quarters in this time.
- The number of children and young people aged 18 and under is forecast to rise by 21% to 2023.

Source: Cambridgeshire County Council Research Group 2013-based population forecasts

Primary Care

Local context

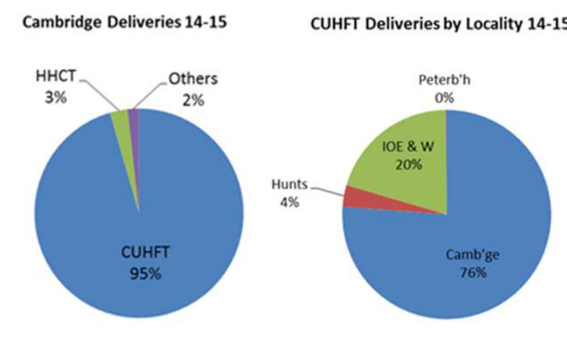
- There are 37 GP practices in CATCH and Cam Health Local Commissioning Groups, which make up the Cambridge System locality. Together these serve a registered population of 323,000. List sizes vary from 2,700 to 18,000, with an average list size of 8,700 (the same as the CCG average).
- If practice populations increase in line with expected population growth, average list size will rise to 10,200 in 2023 (an increase of 17%).

National GP pressures (source: Nuffield Trust Election Briefing 2015 - http://www.nuffieldtrust.org.uk/blog/facts-figures-and-views-health-and-social-care-resource-reporters-2015-general-election)

- 90% of NHS contacts take place in primary care (HSCIC survey 2012/13)
- Spending on core GP services fell by over 2% in real terms during the 2010-2015 parliament
- The number of people saying they had failed to get an appointment rose from 9% to 11% from 2011/12 to 2013/14
- Consultations at GP surgeries rose by 11% from 2010 to 2014, though most of the increase was in nurse consultations and consultations with ‘others’ (e.g. pharmacists) (based on a sample of 337 practices)
- Nationally, FTE GP numbers rose by 4.8% from 2010 to 2014, compared to 7% in hospital doctors
- 12% of GPs now work part-time; more than 10% of slots for new GP trainees in practices were left empty in 2014.

Births and deliveries

- There were 3,200 births to women living in Cambridge City and South Cambs in 2013. This is forecast to rise to 3,700 in 2023.
- 95% of women registered with Cambridge System GPs deliver at CUHFT. Very small proportions deliver at HHCT and other Trusts.
- Of CCG births at CUHFT, three quarters were from the locality. 61% of deliveries at the Trust were ‘normal’, 13% were assisted and 26% were caesarean sections.

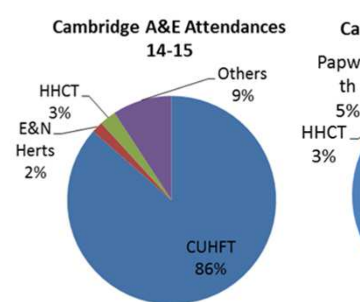


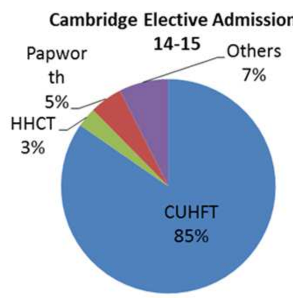
Engagement Fact Pack: Cambridge System

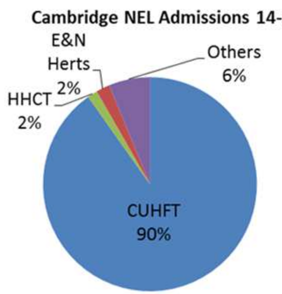
Secondary care use by patients registered with Cambridge System GP practices

Attendance patterns

- 86% of people registered with locality GPs who attend A&E do so at CUHFT. 3% attend HHCT.
- For elective inpatient care 85% of admissions are at CUHFT, with 3% at HHCT and 5% at Papworth. For non-elective care 90% of admissions are at CUHFT.







Current and projected secondary care activity

	A&E attendances	Outpatients	Elective Admissions	Non-elective Admissions	Procedures
2013/14	66,434	297,885	35,244	22,126	54,068
2018/19	79,527	356,499	42,400	27,337	66,238
% change	19.7%	19.7%	20.3%	23.6%	22.5%

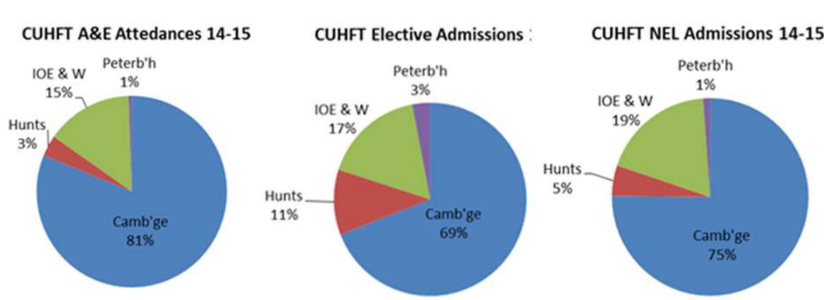
Demand for secondary care across the local population is projected to rise by around 20% over the next five years (24% for non-elective admissions). This takes into account the effect of population change and rising obesity. Types of activity with an older population profile show the greatest increase.

CCG secondary care activity at Cambridge University Hospitals Foundation Trust (CUHFT)

- The most recent monthly monitoring report (June 2015) recorded 9,126 attendances, just a little higher than the England average of 8,923.
- In 2014-15 the Trust saw around 105,500 A&E attendances compared to 93,000 at PSHFT (including minor injuries unit) and 43,000 at HHCT. The Trust is designated as the major trauma centre for the East of England and is also a hyper-acute stroke centre. Ambulance protocols divert patients requiring this level of care to CUHFT from the surrounding area.

Patient composition

- 81% of the CCG's A&E attendances at the Trust were from people registered with CATCH and Cam Health GPs. The proportion for elective admissions was 69% and the proportion for non-elective admissions was 75%. The largest flow from elsewhere in the CCG was from the Isle of Ely and Wisbech locality.



Current and projected CCG secondary care activity at CUHFT

	A&E attendances	Outpatients	Elective admissions	Non-elective Admissions	Procedures
2013/14	74,995	394,001	47,288	27,500	84,823
2018/19	89,731	469,045	56,441	33,908	104,331
% change	19.6%	19.0%	19.4%	23.3%	23.0%

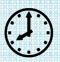
Activity at CUHFT is projected to rise by around 20% over the next five years. This takes into account the effect of population change and rising obesity. Types of activity with an older population show the greatest increase.

Data source: 13/14 data taken from SUS; projections are from the System Transformation Programme's Acute Activity Model and include the impact of planned population growth, ageing and rising obesity.

Engagement Fact Pack: Cambridge System

Local Trust Performance in 2014-15 (see glossary on final page for abbreviations)

Organisation	A&E 4hr waits	Referral to Treatment			Elective cancelled operations treated within 28 days	General & Acute Bed Occupancy	Non Elective Average Length of Stay (days)
		Admitted Pathways	Non-admitted pathways	Incomplete pathways			
Target	95.0%	90.0%	95.0%	92.0%	n/a	n/a	n/a
CUHFT	**83.9%**	**86.3%**	**95.1%**	**91.5%**	**88.6%**	**92.8%**	**4.6**
HHC	92.7%	94.7%	99.2%	96.6%	95.9%	86.3%	5.0
PSHFT	85.6%	89.6%	96.0%	96.6%	88.8%	93.2%	4.7
East Anglia Area Team	92.0%	88.2%	96.1%	93.9%	87.4%	n/a	n/a
National	93.6%	87.6%	95.3%	93.1%	93.7%	89.0%	n/a


4-hour waits
- 84% of A&E attendances at CUHFT in 2014/15 were seen within 4 hours. This was below the national target of 95%, the national average of 93.6%, the East Anglia Area Team average of 92%, and was the lowest of the Trusts in the patch.

Referral to treatment
- CUHFT performed below the national target and national and local comparators on admitted pathways. Performance on non-admitted pathways was close to the target but below the other Trusts in the patch.

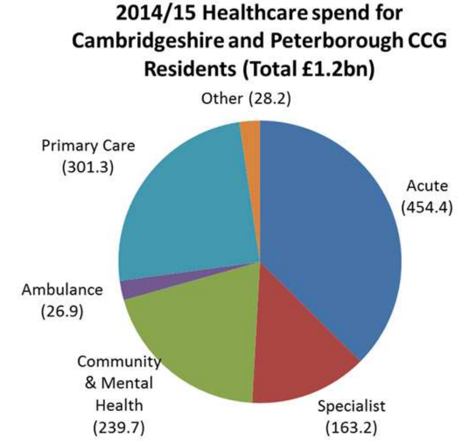
Cancelled operations
- 89% of cancelled elective operations at PSHFT were subsequently treated within 28 days. There is no national target for this but the Trust performed above the regional but below the national average.

Bed occupancy
- In 2014/15 CUHFT ran at an average bed occupancy rate of 93%, compared to a national average of 89%.

Av. length of stay
- Average length of stay for non-elective admissions at CUHFT was 4.6 days, which was the lowest of the Trusts in the patch.

Local NHS finances

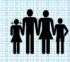
- Total healthcare spend on Cambridgeshire and Peterborough patients was £1.2 billion in 2014/15. Of this, around a half was spent on acute and specialist care and a quarter on primary care (including prescribing).
- If we do not change our health system substantially then we face a deficit of at least £250 million by 2018/19. This will make it harder to deliver good quality care. At the moment our hospitals have significant deficits.
- This deficit figure assumes good performance against local improvement plans.



Engagement Fact Pack: Cambridge System

Health determinants and health outcomes Cambridge System residents

Unless otherwise stated, these are from the Public Health England Health Profiles: http://fingertips.phe.org.uk/profile/health-profiles



Life expectancy

- In Cambridge City, life expectancy at birth is 80 for men and 84.4 for women. In South Cambridgeshire, life expectancy is 83 for men and 89 for women. These figures are all above the national averages of 74.4 for men and 83.1 for women.
- Within Cambridge, there is a life expectancy gap of around 8 years between those living in the most and least deprived areas.

Potential years of life lost

- In 2014, 1,700 potential years of life were lost across the CCG's catchment area from causes amenable to healthcare (PYLL) per 100,000 population. Cambridgeshire is among the 20% best performing local authorities on this measure, while Peterborough is among the worst performing 20%.
- Source: Public Health Information Team, Cambridgeshire County Council

Emergency admissions

CCG PERFORMANCE QUINTILE	Cambs	P'borough
Unplanned admission for chronic ambulatory care conditions	2nd best	2nd worst
Unplanned admissions for epilepsy, asthma, diabetes in under 19s	2nd best	Worst
Emergency admissions for conditions not normally requiring admission	2nd best	Middle
Emergency admissions for children with URTI	2nd best	Middle

Source: http://ccgtools.england.nhs.uk/loa/flash/atlas.html

Disease and poor health

- In Cambridge City, health is generally better than average. Emergency admission rates for hip fracture in people aged over 65 are significantly higher than nationally, as are rates of hospital stays for alcohol-related harm and self-harm.
- In South Cambridgeshire, health is generally better than average. The rate of malignant melanoma in people under 75 is significantly higher than nationally, as are hospital stays for self-harm. The rate of people reported killed or seriously injured on South Cambs' roads is 52.5 per 100,000, which is significantly higher than the national figure of 39.7.

Wider determinants

- At 2.5% in Cambridge City and 1.5% in South Cambs, long-term unemployment is well below the regional and national averages of 5% and 7.1%.
- GCSE results in both local authorities are significantly above the England average. Against this affluent picture, small areas of the City are among the most deprived in England and around 5,000 children across the locality live in poverty.

Lifestyles

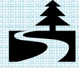
- Smoking prevalence is 9.5% in Cambridge City and 11.4% in South Cambs, which is significantly below the regional and national averages of 17.5% and 18.4%.
- Local rates of obesity are significantly below the national average in both Year 6 children (aged 10-11) and adults. 67% of adults in Cambridge City and 62% in South Cambridgeshire are physically active, which is well above the national average of 57%.

Dementia

- Prevalence estimates suggest there are around 3,260 Cambridge System residents with dementia. This is forecast to rise by 23% to 4,010 in 2023.
- Source: MRC CFAS Prevalence estimates applied to local population

Diabetes

- There are 9,400 people with diabetes in Cambridge City & South Cambs (Source: QOF 2013-14)
- Across the CCG's catchment area, just 56% of people with diabetes have good blood glucose control. The CCG is among the worst performing nationally on this measure and performs similarly poorly on measures of diabetic complications.



Mental health

- Mental health represents 23% of the national burden of disease but just 13% of NHS spend. Source: www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf
- Over 44,000 adults registered with CCG GPs had depression in 2013/14. (Source: QOF)

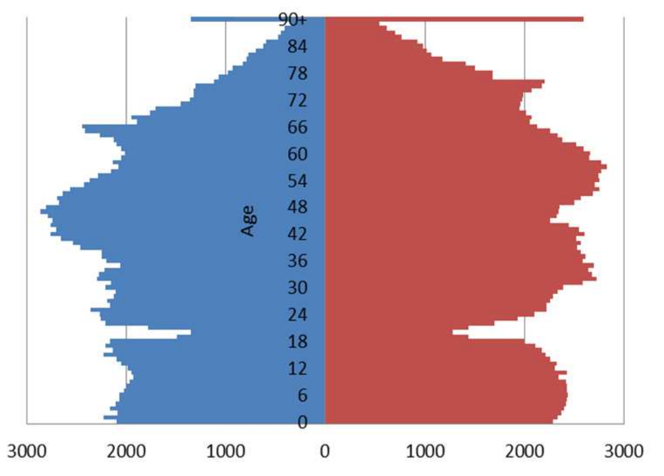
Abbreviations:
CCS: Cambridgeshire Community Services; CUHFT: Cambridge University Hospitals NHS Foundation Trust; HHCT: Hinchingbrooke Health Care NHS Trust; PSHFT: Peterborough & Stamford NHS Foundation Trust; CCG: Clinical Commissioning Group (in this case Cambridgeshire & Peterborough CCG).

System Transformation Programme
Engagement Fact Pack: Huntingdonshire locality

September 2015

This pack contains data published for different geographical areas. The closest match to the area served by the Hunts Care Partners and Hunts Health Local Commissioning Groups has been used throughout. Depending on the data source, this may be the locality, the local authority of Huntingdonshire, the county of Cambridgeshire or the CCG catchment area.

Population



- The total resident population of Huntingdonshire was 175,700 in 2013 and is forecast to rise by 12% to 2023, reaching a total of 196,900.
- The population aged 65 and over is forecast to rise by 37% by 2023. The number of people aged 90 or over will almost double in this time.
- The number of children and young people aged 18 and under is forecast to rise by 11% to 2023.

Source: Cambridgeshire County Council Research Group 2013-based population forecasts

Primary Care

Local context

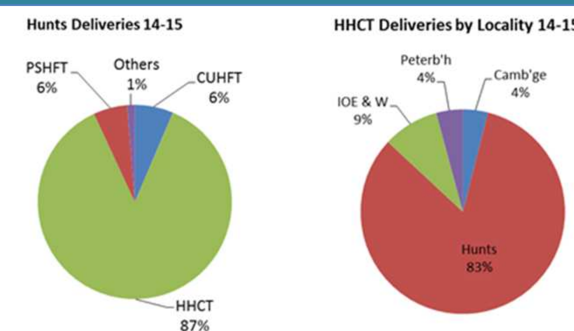
- There are 26 GP practices across Hunts Care Partners and Hunts Health Local Commissioning Groups, which make up the locality. Together these serve a registered population of 194,000. List sizes vary from 2,200 to 14,100, with an average list size of 7,500 compared to a CCG average of 8,700.
- If practice populations increase in line with expected population growth, average list size will rise to 8,400 in 2023 (an increase of 12%).

National GP pressures (source: Nuffield Trust Election Briefing 2015 - http://www.nuffieldtrust.org.uk/blog/facts-figures-and-views-health-and-social-care-resource-reporters-2015-general-election)

- 90% of NHS contacts take place in primary care (HSCIC survey 2012/13)
- Spending on core GP services fell by over 2% in real terms during the 2010-2015 parliament
- The number of people saying they had failed to get an appointment rose from 9% to 11% from 2011/12 to 2013/14
- Consultations at GP surgeries rose by 11% from 2010 to 2014, though most of the increase was in nurse consultations and consultations with 'others' (e.g. pharmacists) (based on a sample of 337 practices)
- Nationally, FTE GP numbers rose by 4.8% from 2010 to 2014, compared to 7% in hospital doctors
- 12% of GPs now work part-time; more than 10% of slots for new GP trainees in practices were left empty in 2014.

Births and deliveries

- There were 2,050 births to women living in Huntingdonshire in 2013. This is forecast to rise to 2,250 in 2023.
- 87% of women registered with Hunts locality GPs deliver at Hinchingbrooke.
- Of CCG births at HHCT, the majority (83%) were from the Hunts locality. 62% of deliveries at the Trust were 'normal', 15% were assisted and 24% were caesarean sections.

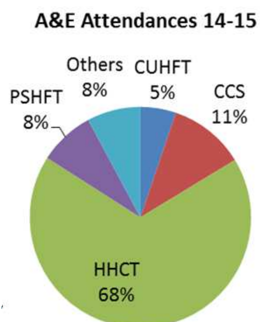


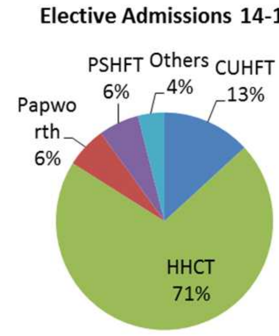
Engagement Fact Pack: Huntingdonshire locality

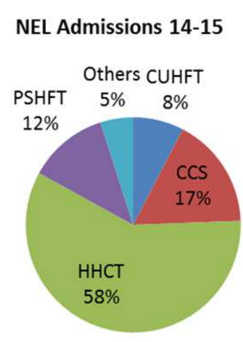
Secondary care use by people registered with Huntingdonshire locality GP practices

Attendance patterns

- 68% of people registered with Hunts GPs who access A&E do so at Hinchingbrooke Hospital.
- For elective inpatient care this proportion is 71% and for non-elective it is 58%.







Current and projected secondary care activity

	A&E attendances	Outpatients	Elective Admissions	Non-elective Admissions	Procedures
2013/14	40,353	223,194	30,371	17,615	43,482
2018/19	47,011	263,635	36,484	21,325	53,227
% change	16.5%	18.1%	20.1%	21.1%	22.4%

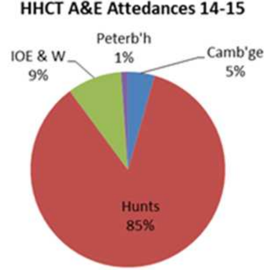
Demand for secondary care across the local population is projected to rise by 6% (A&E) to 11% (procedures) over the next five years. This takes into account the effect of population change and rising obesity. Types of activity with an older population profile show the greatest increase.

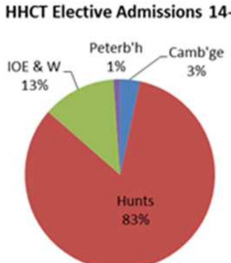
CCG secondary care activity at Hinchingbrooke Healthcare Trust (HHCT)

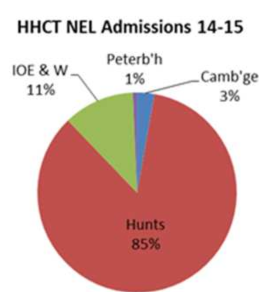
- HHCT A&E is one of the smallest in the country. The most recent monthly monitoring report (June 2015) recorded 3,826 attendances, the fourth lowest of the 140 Type 1 A&Es in England. The England average is 8,923.
- Each year the Trust sees in the region of 43,000 attendances compared to 93,000 at PSHFT (including minor injuries unit) and 105,000 at CUHFT. Ambulance protocols convey patients needing care for hyper acute stroke, primary angioplasty and poly trauma directly to PSHFT or CUHFT. Patients accessing HHCT via ambulance therefore have predominantly medical elderly conditions.

Patient composition

- 85% of the CCG's A&E attendances at the Trust are from people registered with Hunts locality GPs. The proportions for elective and non-elective inpatient admissions are similar.







Current and projected CCG secondary care activity at HHCT

	A&E attendances	Outpatients	Elective admissions	Non-elective Admissions	Procedures
2013/14	36,239	141,215	22,585	10,796	25,227
2018/19	42,096	168,311	27,392	13,755	30,688
% change	16.2%	19.2%	21.3%	27.4%	21.6%

Activity at HHCT is projected to rise by 6% (A&E) to 14% (NE admissions) over the next five years. This takes into account the effect of population change and rising obesity. Types of activity with an older population show the greatest increase.

Data source: 13/14 data taken from SUS; projections are from the System Transformation Programme's Acute Activity Model and include the impact of planned population growth, ageing and rising obesity.

Cambridgeshire and Peterborough Health System Transformation Programme Team
Working across the system, for the system

Engagement Fact Pack: Huntingdonshire locality

Local Trust Performance in 2014-15 (see glossary on final page for abbreviations)

Organisation	A&E 4hr waits	Referral to Treatment			Elective cancelled operations treated within 28 days	General & Acute Bed Occupancy	Non Elective Average Length of Stay (days)
		Admitted Pathways	Non-admitted pathways	Incomplete pathways			
Target	95.0%	90.0%	95.0%	92.0%	n/a	n/a	n/a
CUHFT	83.9%	86.3%	95.1%	91.5%	88.6%	92.8%	4.6
HHC	**92.7%**	**94.7%**	**99.2%**	**96.6%**	**95.9%**	**86.3%**	**5.0**
PSHFT	85.6%	89.6%	96.0%	96.6%	88.8%	93.2%	4.7
East Anglia Area Team	92.0%	88.2%	96.1%	93.9%	87.4%	n/a	n/a
National	93.6%	87.6%	95.3%	93.1%	93.7%	89.0%	n/a

4-hour waits

- 92.7% of A&E attendances at HHCT in 2014/15 were seen within 4 hours. This was below the national target of 95% and the national average of 93.6% but above the East Anglia Area Team average.

Referral to treatment

- HHCT performed above the national target, national average and regional average on all pathways.

Cancelled operations

- 96% of cancelled elective operations at HHCT were subsequently treated within 28 days. There is no national target for this but the Trust performed above the regional and national average.

Bed occupancy

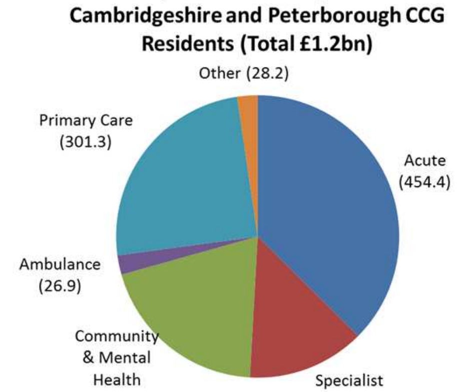
- HHCT ran at an average bed occupancy rate of 86%, compared to a national average of 89%. They had the lowest bed occupancy of any Trust in the patch.

Av. length of stay

- Average length of stay for non-elective admissions at HHCT was 5 days, which was a little longer than the average of 4.6 and 4.7 and CUHFT and PSHFT respectively.

Local NHS finances

- Total healthcare spend on Cambridgeshire and Peterborough patients was £1.2 billion in 2014/15. Of this, around a half was spent on acute and specialist care and a quarter on primary care (including prescribing).
- If we do not change our health system substantially then we face a deficit of at least £250 million by 2018/19. This will make it harder to deliver good quality care. At the moment our hospitals have significant deficits.
- This deficit figure assumes good performance against local improvement plans.



Engagement Fact Pack: Huntingdonshire locality

Health determinants and health outcomes for Huntingdonshire residents

Unless otherwise stated, these are from the Public Health England Health Profiles: http://fingertips.phe.org.uk/profile/health-profiles

Life expectancy

- Life expectancy at birth is 81.0 for Huntingdonshire men and 84.3 for women. This is significantly higher than the national averages of 79.4 and 83.1 and higher than the East of England average.

Potential years of life lost

- In 2014, 1,700 potential years of life were lost across the CCG's catchment area from causes amenable to healthcare (PYLL) per 100,000 population. Cambridgeshire is among the 20% best performing local authorities on this measure, while Peterborough is among the worst performing 20%.
- Source: Public Health Information Team, Cambridgeshire County Council

Emergency admissions

CCG PERFORMANCE QUINTILE	Cambs	P'borough
Unplanned admission for chronic ambulatory care conditions	2nd best	2nd worst
Unplanned admissions for epilepsy, asthma, diabetes in under 19s	2nd best	Worst
Emergency admissions for conditions not normally requiring admission	2nd best	Middle
Emergency admissions for children with URTI	2nd best	Middle

Source: http://ccgtools.england.nhs.uk/loa/flash/atlas.html

Disease and poor health

- The health of people in Huntingdonshire is generally better than the England average.
- The rate of people reported killed or seriously injured on Huntingdonshire's roads is 48.1 per 100,000, which is significantly higher than the national figure of 39.7.

Wider determinants

- Overall, levels of deprivation in Huntingdonshire are very low. At 2.1%, long-term unemployment is well below the regional and national averages of 5% and 7.1%.
- Against this affluent picture, GCSE results are below average, and there are small areas of relatively concentrated deprivation.

Lifestyles

- Smoking prevalence is 11.6%, which is significantly lower than the regional and national averages of 17.5% and 18.4%.
- The prevalence of obesity in Year 6 children (age 10-11) is significantly lower than national and regional averages.
- Adult obesity is higher than average at 26% compared to 23% nationally.
- 63% of adults are physically active, which is higher than nationally (57%).

Dementia

- Prevalence estimates suggest there are around 2,050 Huntingdonshire residents with dementia. This is forecast to rise by 56% to 3,200 in 2023.
- Source: MRC CFAS Prevalence estimates applied to local population

Diabetes

- There are 8,400 people with diabetes in Huntingdonshire. (Source: QOF 2013/14)
- Across the CCG's catchment area, just 56% of people with diabetes have good blood glucose control. The CCG is among the worst performing nationally on this measure and performs similarly poorly on measures of diabetic complications.

Mental health

- Mental health represents 23% of the national burden of disease but just 13% of NHS spend. Source: www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf
- Over 44,000 adults registered with Cambridgeshire & Peterborough GPs had depression in 2013/14. (Source: QOF)

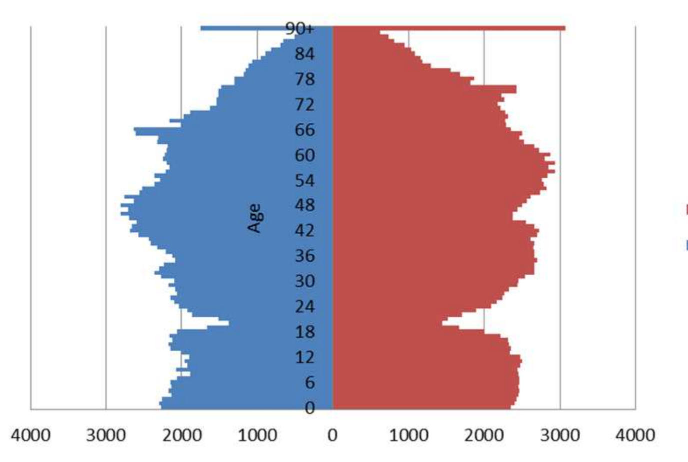
Abbreviations:
CCS: Cambridgeshire Community Services; CUHFT: Cambridge University Hospitals NHS Foundation Trust; HHCT: Hinchingbrooke Health Care NHS Trust; PSHFT: Peterborough & Stamford NHS Foundation Trust; CCG: Clinical Commissioning Group (in this case Cambridgeshire & Peterborough CCG)

System Transformation Programme Engagement Fact Pack: Isle of Ely and Wisbech

September 2015

This pack contains data published for different geographical areas. The closest match to the area served by the Isle of Ely and Wisbech Local Commissioning Groups has been used throughout. Depending on the data source, this may be the locality, the local authorities of East Cambridgeshire and Fenland, the county of Cambridgeshire or the CCG catchment area.

Population



- The total resident population of East Cambridgeshire and Fenland was 181,100 in 2013 and is forecast to rise by 14% to 2023, reaching a total of 206,800.
- The population aged 65 and over is forecast to rise by 28% by 2023. The number of people aged 90 or over will almost double in this time.
- The number of children and young people aged 18 and under is forecast to rise by 14% to 2023.

Source: Cambridgeshire County Council Research Group 2013-based population forecasts

Primary Care

Local context

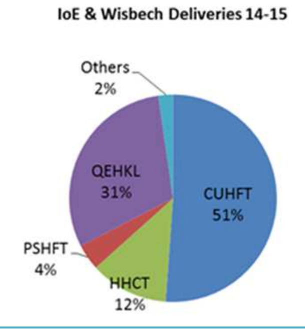
- There are 14 GP practices Isle of Ely and Wisbech Local Commissioning Groups, which make up the locality. Together these serve a registered population of 145,000. List sizes vary from 2,100 to 20,200, with an average list size of 10,400 compared to a CCG average of 8,700.
- If practice populations increase in line with expected population growth, average list size will rise to 11,900 in 2023 (an increase of 14%).

National GP pressures (source: Nuffield Trust Election Briefing 2015 - http://www.nuffieldtrust.org.uk/blog/facts-figures-and-views-health-and-social-care-resource-reporters-2015-general-election)

- 90% of NHS contacts take place in primary care (HSCIC survey 2012/13)
- Spending on core GP services fell by over 2% in real terms during the 2010-2015 parliament
- The number of people saying they had failed to get an appointment rose from 9% to 11% from 2011/12 to 2013/14
- Consultations at GP surgeries rose by 11% from 2010 to 2014, though most of the increase was in nurse consultations and consultations with ‘others’ (e.g. pharmacists) (based on a sample of 337 practices)
- Nationally, FTE GP numbers rose by 4.8% from 2010 to 2014, compared to 7% in hospital doctors
- 12% of GPs now work part-time; more than 10% of slots for new GP trainees in practices were left empty in 2014.

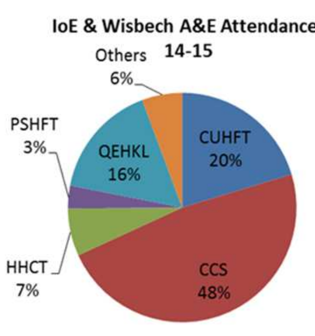
Births and deliveries

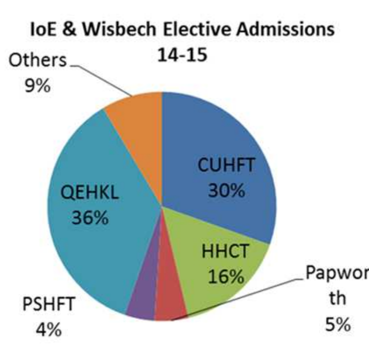
- There were 2,260 births to women living in East Cambridgeshire and Fenland in 2013. This is forecast to rise to 2,330 in 2023.
- 51% of women registered with Isle of Ely and Wisbech locality GPs deliver at CUHFT and 31% deliver at QEH in King’s Lynn.

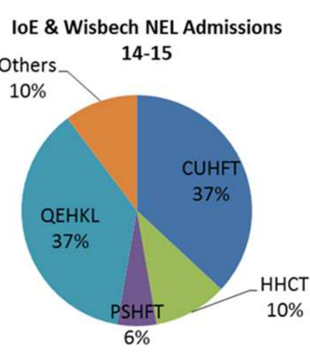


Engagement Fact Pack: Isle of Ely & Wisbech

Secondary care use by people registered with Isle of Ely & Wisbech GP practices







Attendance patterns

- Nearly half of people registered with Isle of Ely and Wisbech GPs who accessed emergency care in 2014-15 did so at minor injuries units provided by Cambridgeshire Community Services. These units were located in Peterborough, North Cambs hospital in Wisbech and the Princess of Wales hospital in Ely (note that commissioning arrangements have changed for 2015/16). Other significant attendance locations were CUHFT and QEHKL, both of which provide full ('Type 1') A&E facilities.
- For elective inpatient care, 36% of people registered with Isle of Ely and Wisbech GPs attended QEH in King's Lynn and 30% attended CUHFT in Cambridge.
- For non-elective inpatient care, both QEHKL and CUHFT took over a third of admissions, with lower proportions of admissions at HHCT and PSHFT.

Current and projected secondary care activity

	A&E attendances	Outpatients	Elective Admissions	Non-elective Admissions	Procedures
2013/14	25,021	157,574	21,857	12,719	31,325
2018/19	29,483	184,533	25,896	15,351	38,050
% change	17.8%	17.1%	18.5%	20.7%	21.5%

Demand for secondary care across the local population is projected to rise by around 20% over the next five years. This takes into account the effect of population change and rising obesity. Types of activity with an older population profile show the greatest increase.

CCG secondary care activity from a Trust perspective

- At CUHFT, 15% of A&E attendances from the CCG's registered population were from Isle of Ely and Wisbech locality. In terms of elective admissions, the proportion is 17% and for non-elective admissions it is 19%.
- At HHCT, 9% of A&E attendances from the CCG's registered population were from Isle of Ely and Wisbech locality. In terms of elective admissions, the proportion is 13% and for non-elective admissions it is 11%.
- At PSHFT, 3% of A&E attendances from the CCG's registered population were from Isle of Ely and Wisbech locality. In terms of elective admissions, the proportion is 4% and for non-elective admissions it is 3%.
- Activity at Trusts in the patch is projected to rise by around 20%, with the greatest rises in types of activity with an older population. This projection takes into account the effect of population change and rising obesity.

Data source: 13/14 data taken from SUS; projections are from the System Transformation Programme's Acute Activity Model and include the impact of planned population growth, ageing and rising obesity.

Engagement Fact Pack: Isle of Ely & Wisbech

Local Trust Performance in 2014-15 (see glossary on final page for abbreviations)

Organisation	A&E 4hr waits	Referral to Treatment			Elective cancelled operations treated within 28 days	General & Acute Bed Occupancy	Non Elective Average Length of Stay (days)
		Admitted Pathways	Non-admitted pathways	Incomplete pathways			
Target	95.0%	90.0%	95.0%	92.0%	n/a	n/a	n/a
CUHFT	**83.9%**	**86.3%**	**95.1%**	**91.5%**	**88.6%**	**92.8%**	**4.6**
HHC	92.7%	94.7%	99.2%	96.6%	95.9%	86.3%	5.0
PSHFT	85.6%	89.6%	96.0%	96.6%	88.8%	93.2%	4.7
QEHKL	**90.7%**	**88.1%**	**97.0%**	**94.8%**	**76.0%**	**88.3%**	**4.0**
East Anglia Area Team	92.0%	88.2%	96.1%	93.9%	87.4%	n/a	n/a
National	93.6%	87.6%	95.3%	93.1%	93.7%	89.0%	n/a

4-hour waits

- 90.7% of A&E attendances at QEHKL in 2014/15 were seen within 4 hours, compared to 83.9% at CUHFT. Both were below the national target of 95% and the national average of 93.6%.

Referral to treatment

- Both CUHFT and QEHKL were below target on admitted pathways but similar to or above target on non-admitted and incomplete pathways.

Cancelled operations

- 76% of cancelled elective operations at QEHKL were subsequently treated within 28 days, compared to 88.6% at CUHFT. There is no national target for this but both Trusts performed below the national average.

Bed occupancy

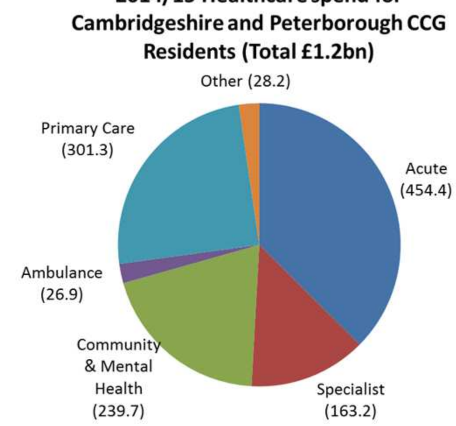
- QEHKL ran at an average bed occupancy rate of 88%, compared to 93% at CUHFT. The national average was 89%. QEHKL had lower bed occupancy than the other local Trusts.

Av. length of stay

- Average length of stay for CCG non-elective admissions at QEHKL was 4 days, which was shorter than the figure of 4.6 at CUHFT.

Local NHS finances

- Total healthcare spend on Cambridgeshire and Peterborough patients was £1.2 billion in 2014/15. Of this, around a half was spent on acute and specialist care and a quarter on primary care (including prescribing).
- If we do not change our health system substantially then we face a deficit of at least £250 million by 2018/19. This will make it harder to deliver good quality care. At the moment our hospitals have significant deficits.
- This deficit figure assumes good performance against local improvement plans.



Engagement Fact Pack: Isle of Ely & Wisbech

Health determinants and health outcomes for Isle of Ely and Wisbech residents

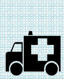
Unless otherwise stated, these are from the Public Health England Health Profiles: http://fingertips.phe.org.uk/profile/health-profiles

Life expectancy

- In East Cambridgeshire, life expectancy at birth is 81.8 for men and 85.6 for women. This is significantly higher than the national average. In Fenland, life expectancy is 79.5 for men and 82.8 for women, which is not significantly different to the national average.
- Within Fenland, there is a gap in male life expectancy of nearly 5 years between those living in the most and least deprived areas.

Potential years of life lost

- In 2014, 1,700 potential years of life were lost across the CCG's catchment area from causes amenable to healthcare (PYLL) per 100,000 population. Cambridgeshire is among the 20% best performing local authorities on this measure, while Peterborough is among the worst performing 20%.
- Source: Public Health Information Team, Cambridgeshire County Council



Emergency admissions

CCG PERFORMANCE QUINTILE	Cambs	P'borough
Unplanned admission for chronic ambulatory care conditions	2nd best	2nd worst
Unplanned admissions for epilepsy, asthma, diabetes in under 19s	2nd best	Worst
Emergency admissions for conditions not normally requiring admission	2nd best	Middle
Emergency admissions for children with URTI	2nd best	Middle

Source: http://ccgtools.england.nhs.uk/loa/flash/atlas.html

Disease and poor health

- Overall, taking account of population age structure, death rates from common causes are lower than nationally in East Cambs and not significantly different to nationally in Fenland
- The rate of people reported killed or seriously injured on our roads is 67.8 per 100,000 in East Cambs and 45.8 per 100,000 in Fenland, both of which are significantly higher than the national figure of 39.7.

Wider determinants

- At 2.4% in East Cambs and 4.3% in Fenland, long-term unemployment is below the regional and national averages of 5% and 7.1%.
- GCSE results in both local authorities are below average. Parts of the locality, particularly to the north, are among the most deprived 20% of areas of the country.

Lifestyles

- Smoking prevalence is 18% in East Cambs and 22% in Fenland, which is not significantly different to the regional and national averages of 17.5% and 18.4%.
- Local rates of obesity are not significantly different to nationally in both Year 6 children (aged 10-11) and as adults.
- 58% of adults in East Cambs are physically active, which is similar to the national average. In Fenland this is just 51%, which is significantly lower than nationally (57%).

Dementia

- Prevalence estimates suggest there are around 2,670 East Cambridgeshire and Fenland residents with dementia. This is forecast to rise by 20% to 3,210 in 2023.
- Source: MRC CFAS Prevalence estimates applied to local population

Diabetes

- There are 11,100 people with diabetes in East Cambs & Fenland. (Source: QOF 2013/14)
- Across the CCG's catchment area, just 56% of people with diabetes have good blood glucose control. The CCG is among the worst performing nationally on this measure and performs similarly poorly on measures of diabetic complications.

Mental health

- Mental health represents 23% of the national burden of disease but just 13% of NHS spend. Source: www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf
- Over 44,000 adults registered with CCG GPs had depression in 2013/14. (Source: QOF)

Abbreviations:
CCS: Cambridgeshire Community Services; CUHFT: Cambridge University Hospitals NHS Foundation Trust; HHCT: Hinchingbrooke Health Care NHS Trust; PSHFT: Peterborough & Stamford NHS Foundation Trust; CCG: Clinical Commissioning Group (in this case Cambridgeshire & Peterborough CCG); QEHKL: Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

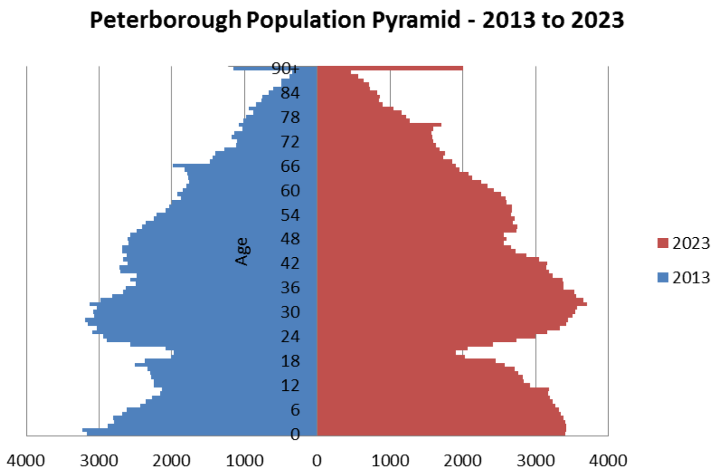
System Transformation Programme Engagement Fact Pack: Peterborough & Borderline

APPENDIX A

September 2015

This pack contains data published for different geographical areas. The closest match to the area served by the Peterborough and Borderline Local Commissioning Groups has been used throughout. Depending on the data source, this may be the locality, the local authority of Peterborough or the CCG catchment area.

Population



- The total resident population of Peterborough was 189,300 in 2013 and is forecast to rise by 19% to 2023, reaching a total of 224,800.
- The population aged 65 and over is forecast to rise by 28% by 2023. The number of people aged 90 or over will almost double in this time.
- The number of children and young people aged 18 and under is forecast to rise by 23% to 2023.

Source: Cambridgeshire County Council Research Group 2013-based population forecasts

Primary Care

Local context

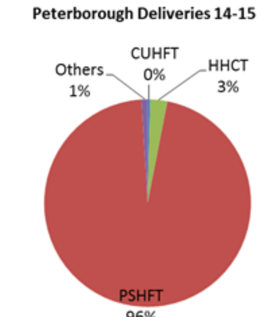
- There are 29 GP practices Peterborough and Borderline Local Commissioning Groups, which make up the locality. Together these serve a registered population of 257,000. List sizes vary from 2,000 to 25,800, with an average list size of 8,900 compared to a CCG average of 8,700.
- If practice populations increase in line with expected population growth, average list size will rise to 10,600 in 2023 (an increase of 19%).

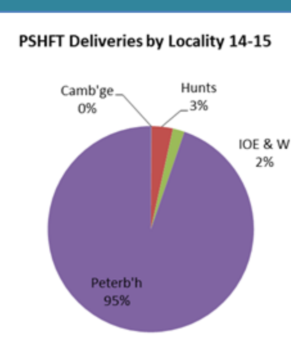
National GP pressures (source: Nuffield Trust Election Briefing 2015 - http://www.nuffieldtrust.org.uk/blog/facts-figures-and-views-health-and-social-care-resource-reporters-2015-general-election)

- 90% of NHS contacts take place in primary care (HSCIC survey 2012/13)
- Spending on core GP services fell by over 2% in real terms during the 2010-2015 parliament
- The number of people saying they had failed to get an appointment rose from 9% to 11% from 2011/12 to 2013/14
- Consultations at GP surgeries rose by 11% from 2010 to 2014, though most of the increase was in nurse consultations and consultations with 'others' (e.g. pharmacists) (based on a sample of 337 practices)
- Nationally, FTE GP numbers rose by 4.8% from 2010 to 2014, compared to 7% in hospital doctors
- 12% of GPs now work part-time; more than 10% of slots for new GP trainees in practices were left empty in 2014.

Births and deliveries

- There were 3,200 births to women living in Peterborough in 2013. This is forecast to rise to 3,440 in 2023.
- 96% of women registered with Peterborough and Borderline locality GPs deliver at PSHFT. Very small proportions deliver at HHCT and other Trusts.
- Of CCG births at PSHFT, almost all were from Peterborough and Borderline locality. 62% of deliveries at the Trust were 'normal', 12% were assisted and 27% were caesarean sections.



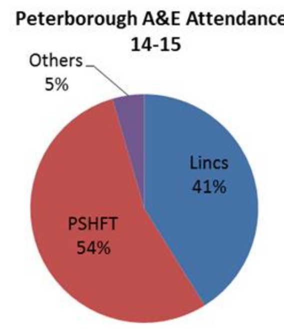


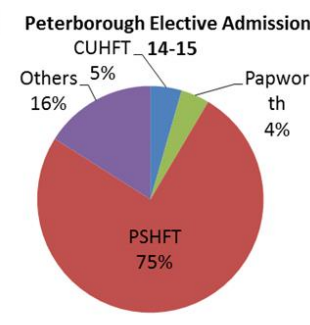
Engagement Fact Pack: Peterborough & Borderline

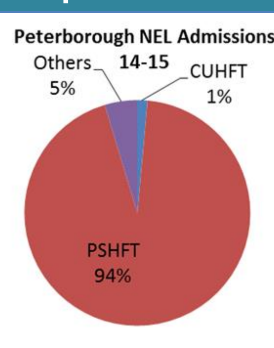
Secondary care use by people registered with Peterborough & Borderline GP practices

Attendance patterns

- 95% of people registered with locality GPs who access emergency care do so in Peterborough, either at the minor injuries unit run by Lincolnshire Community Services or at PSHFT.
- For elective inpatient care 75% of admissions are at PSHFT. For non-elective care 94% of admissions are at PSHFT.







Current and projected secondary care activity

	A&E attendances	Outpatients	Elective Admissions	Non-elective Admissions	Procedures
2013/14	57,774	307,347	28,558	22,982	33,757
2018/19	68,484	361,750	34,094	27,542	40,501
% change	18.5%	17.7%	19.4%	19.8%	20.0%

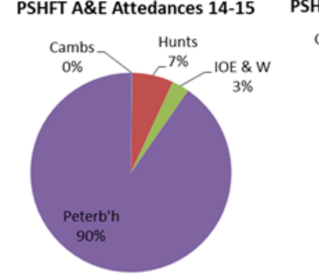
Demand for secondary care across the local population is projected to rise by around 20% over the next five years. This takes into account the effect of population change and rising obesity. Types of activity with an older population profile show the greatest increase.

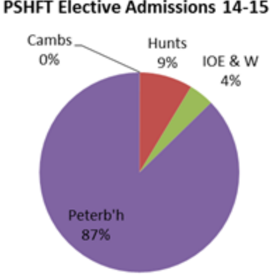
Secondary care activity at Peterborough & Stamford Hospital (PSHFT)

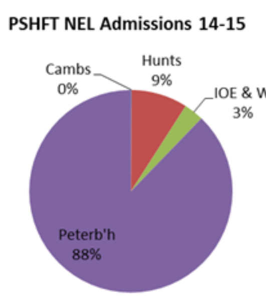
- The most recent monthly monitoring report (June 2015) recorded 7,036 attendances, which was below the England average of 8,923.
- Each year the Trust sees in the region of 93,000 attendances (including minor injuries unit) compared to 105,000 at CUHFT and 43,000 at HHCT.

Patient composition

- 90% of the A&E attendances at the Trust are from people registered with Peterborough and Borderline GPs. The proportions for elective and non-elective inpatient admissions are similar, with 9% of admissions from the Huntingdonshire locality.







Current and projected CCG secondary care activity at PSHFT

	A&E attendances	Outpatients	Elective admissions	Non-elective Admissions	Procedures
2013/14	60,435	299,621	25,737	23,902	30,955
2018/19	71,711	352,269	30,755	28,745	37,253
% change	18.7%	17.6%	19.5%	20.3%	20.3%

Activity at PSHFT is projected to rise by 18% (outpatients) to 20% (NE admissions and procedures) over the next five years. This takes into account the effect of population change and rising obesity. Types of activity with an older population profile show the greatest increase.

Data source: 13/14 data taken from SUS; projections are from the System Transformation Programme's Acute Activity Model and include the impact of planned population growth, ageing and rising obesity.

Engagement Fact Pack: Peterborough & Borderline

Local Trust Performance in 2014-15 (see glossary on final page for abbreviations)

Organisation	A&E 4hr waits	Referral to Treatment: Admitted Pathways	Referral to Treatment: Non-admitted pathways	Referral to Treatment: Incomplete pathways	Elective cancelled operations treated within 28 days	General & Acute Bed Occupancy	Non Elective Average Length of Stay (days)
Target	95.0%	90.0%	95.0%	92.0%	n/a	n/a	n/a
CUHFT	83.9%	86.3%	95.1%	91.5%	88.6%	92.8%	4.6
HHC	92.7%	94.7%	99.2%	96.6%	95.9%	86.3%	5.0
PSHFT	**85.6%**	**89.6%**	**96.0%**	**96.6%**	**88.8%**	**93.2%**	**4.7**
East Anglia Area Team	92.0%	88.2%	96.1%	93.9%	87.4%	n/a	n/a
National	93.6%	87.6%	95.3%	93.1%	93.7%	89.0%	n/a

4-hour waits

- 86% of A&E attendances at PSHFT in 2014/15 were seen within 4 hours. This was below the national target of 95%, the national average of 93.6%, and the East Anglia Area Team average of 92%.

Referral to treatment

- PSHFT performed close to the national target on both admitted and non-admitted pathways and was well above target for incomplete pathways.

Cancelled operations

- 89% of cancelled elective operations at PSHFT were subsequently treated within 28 days. There is no national target for this but the Trust performed above the regional but below the national average.

Bed occupancy

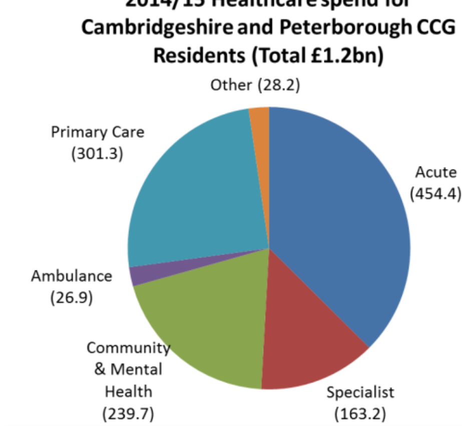
- PSHFT ran at an average bed occupancy rate of 93%, compared to a national average of 89%. They had the highest bed occupancy of any Trust in the patch.

Av. length of stay

- Average length of stay for non-elective admissions at PSHFT was 4.7 days, which was comparable to the figure at CUHFT and a little shorter than the figure at HHCT.

Local NHS finances

- Total healthcare spend on Cambridgeshire and Peterborough patients was £1.2 billion in 2014/15. Of this, around a half was spent on acute and specialist care and a quarter on primary care (including prescribing).
- If we do not change our health system substantially then we face a deficit of at least £250 million by 2018/19. This will make it harder to deliver good quality care. At the moment our hospitals have significant deficits.
- This deficit figure assumes good performance against local improvement plans.



Engagement Fact Pack: Peterborough & Borderline

Health determinants and health outcomes Peterborough & Borderline residents

Unless otherwise stated, these are from the Public Health England Health Profiles: http://fingertips.phe.org.uk/profile/health-profiles

Life expectancy

- In Peterborough, life expectancy at birth is 78.1 for men and 82.6 for women. This is significantly lower than the national average. Within Peterborough, there is a gap in male life expectancy of over 9 years between those living in the most and least deprived areas.

Potential years of life lost

- In 2014, 1,700 potential years of life were lost across the CCG's catchment area from causes amenable to healthcare (PYLL) per 100,000 population. Cambridgeshire is among the 20% best performing local authorities on this measure, while Peterborough is among the worst performing 20%.
- Source: Public Health Information Team, Cambridgeshire County Council

Emergency admissions

CCG PERFORMANCE QUINTILE	Cambs	P'borough
Unplanned admission for chronic ambulatory care conditions	2nd best	2nd worst
Unplanned admissions for epilepsy, asthma, diabetes in under 19s	2nd best	Worst
Emergency admissions for conditions not normally requiring admission	2nd best	Middle
Emergency admissions for children with URTI	2nd best	Middle

Source: http://ccgtools.england.nhs.uk/loa/flash/atlas.html

Disease and poor health

- Rates of hospital stays for alcohol related harm and self-harm are significantly higher than the national average and the prevalence of opiate and/or crack use is also high.
- The incidence of tuberculosis is significantly higher than the national average at 56.7 per 100,000 compared to 30.4 per 100,000.
- Emergency admissions for hip fracture in over 65 year olds are significantly higher than nationally. The death rate from cardiovascular disease in people aged under 75 is significantly higher than nationally. The comparable figure for cancer deaths is similar to the national average.

Wider determinants

- At 7.6%, long-term unemployment is above the national average of 7.1%.
- GCSE results are below average. Parts of the local authority are among the most deprived 20% of areas of the country.

Lifestyles

- Smoking prevalence is 21% in Peterborough, which is significantly above the regional and national averages of 17.5% and 18.4%.
- Local rates of obesity are lower than average in Year 6 children (aged 10-11) but rise to national levels in adults.
- 55% of adults in Peterborough are physically active, which is similar to the national average of 57%.

Dementia

- Prevalence estimates suggest there are around 1,950 Peterborough residents with dementia. This is forecast to rise by 33% to 2,590 in 2023.
- Source: MRC CFAS Prevalence estimates applied to local population

Diabetes

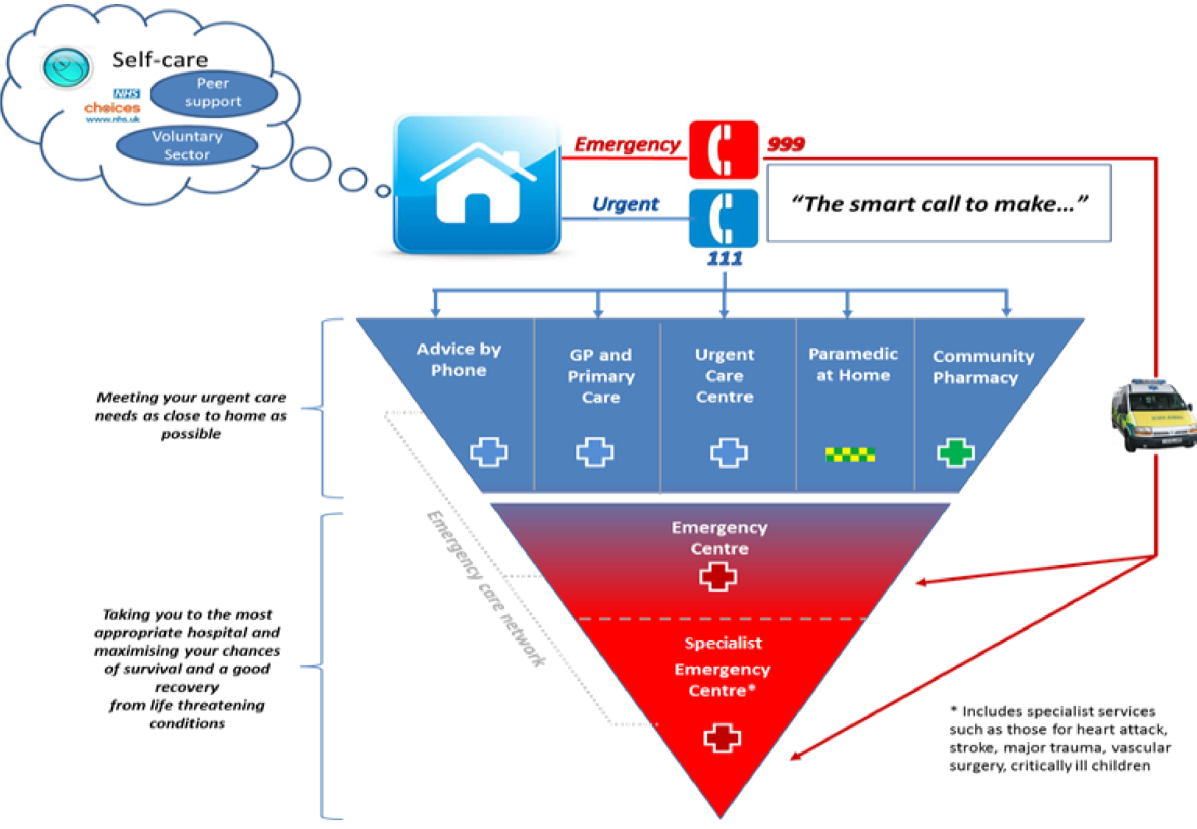
- There are 9,270 people with diabetes in Peterborough. (Source: QOF 2013/14)
- Across the CCG's catchment area, just 56% of people with diabetes have good blood glucose control. The CCG is among the worst performing nationally on this measure and performs similarly poorly on measures of diabetic complications.

Mental health

- Mental health represents 23% of the national burden of disease but just 13% of NHS spend. Source: www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf
- Over 44,000 adults registered with the CCG's GPs had depression in 2013/14. (Source: QOF)

Abbreviations:
CCS: Cambridgeshire Community Services; CUHFT: Cambridge University Hospitals NHS Foundation Trust;
HHCT: Hinchingbrooke Health Care NHS Trust; PSHFT: Peterborough & Stamford NHS Foundation Trust;
CCG: Clinical Commissioning Group (in this case Cambridgeshire & Peterborough CCG);
QEHKL: Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

OVERVIEW OF THE VANGUARD MODEL



The term 'click, call or come in' highlights the need to manage the majority of urgent care needs in the community. The use of expensive hospital services is deemed to be the last resort and reserved for those patients with life threatening conditions.

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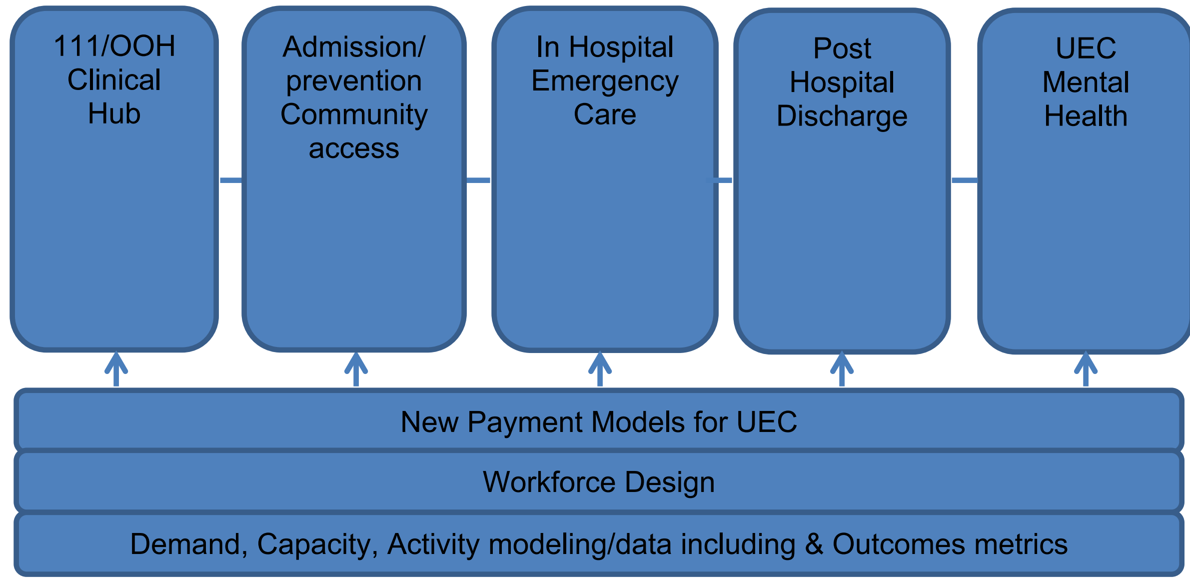
OVERVIEW OF THE VANGUARD PROGRAMME OF WORK



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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 6
10 DECEMBER 2015		PUBLIC REPORT
Contact Officer(s):	Dr Liz Robin, Director of Public Health Emma de Zoete, Consultant in Public Health	Tel. 01223 699117

PREVENTION WORK FOR THE HEALTH SYSTEM TRANSFORMATION PROGRAMME

R E C O M M E N D A T I O N S	
FROM : Dr Liz Robin, Director of Public Health Emma de Zoete, Consultant in Public Health	**Deadline date :** N/A
That the Health and Wellbeing Board note and comment on the first draft of the health system prevention plan.	

1. ORIGIN OF REPORT

1.1 The Health and Wellbeing Board has already received reports on the Cambridgeshire and Peterborough Health System Transformation Programme. This report covers the Health System Prevention Plan which forms part of the wider Health System Transformation work.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to outline the first draft of a health system prevention plan that the Health System Transformation Programme has asked the public health team to develop.

2.2 This report is for Board to consider under its Terms of Reference No. 2.8.9 'To keep under review the delivery of the designated public health functions and their contribution to improving health and well being and tackling health inequalities.'

3. OBJECTIVES OF THE HEALTH SYSTEM PREVENTION WORK AND INTERDEPENDENCIES

3.1 The objectives of the health system prevention plan are:

- To identify the savings to the NHS, where possible, from current and planned prevention initiatives to help meet the projected financial gap for the local Health System.
- To identify areas/interventions for potential additional NHS investment in prevention which would maximise savings to the local NHS over the next 3, 5, 10 year and beyond.
- Identify areas and initiatives for potential stretch and outline the strategy for delivering these including projected savings to the NHS, where possible.

3.2 The strategy incorporates the work that the Cambridgeshire and Peterborough Public Health Reference Group (PHRG) has done in identifying priority areas (obesity/diet/ physical activity and community engagement) and evaluating where there is best evidence of impact.

3.3 The work relates to the ongoing transformation of preventive services by local authorities and the CCG, including lifestyles services in both Cambridgeshire and Peterborough and new workplace health programmes.

4. RISKS AND LIMITATIONS

4.1 This health system prevention plan is focussed only on preventive interventions where there is good evidence they will deliver local NHS savings in the short to medium term. It is not a comprehensive preventive strategy for health and wellbeing in Peterborough.

4.2 Return on investment modelling for the local population requires a number of assumptions to be made and there is a degree of uncertainty, which has been expressed in the document, surrounding the findings.

4.3 There is a likelihood of double counting of impact of prevention on NHS activity, with an unknown proportion of patients with co-morbidities (more than one long term health condition) and multiple lifestyle problems receiving multiple interventions.

4.4 The complexity of estimating NHS savings, particularly given the tight timescales, has been difficult for this piece of work. Advice and support has been sought from the Public Health England local Knowledge and Intelligence Team and the national Public Health England Health Economics team. There remain a number of areas which need further work as outlined in the draft strategy. Public Health England is undertaking a similar piece of work, although it has not been possible to establish their timescale.

5. KEY POINTS

5.1 Scope of the work

5.1.1 The focus of the draft health system prevention strategy is on:

- interventions that have the best evidence;
- interventions with the greatest potential NHS savings;
- interventions where the information is available to model reasonable estimates of NHS savings, or;
- where the scale of the issue suggests interventions will have an impact (even if the evidence is not currently conclusive).

5.1.2 There are many prevention initiatives where we have a strong evidence base where we simply do not have the information to enable us to estimate savings to the NHS, but we think there are likely to be some. This strategy does not try to quantify savings, other than to the NHS.

5.1.3 It is also unlikely to be entirely comprehensive, in that there are other interventions we have not had time to address in this strategy. In particular, savings from better management for those diagnosed with diabetes, patients with transient ischaemic attack (TIA) treated within 24 hours, and early diagnosis of people with familial hypercholesterolaemia are gaps, some of which are being addressed in other CCG work programmes.

5.2 Potential overlap with other programmes

5.2.1 There are also prevention initiatives which are not within the scope of this work, as they are being taken forward through other programmes. In particular, integrating care for older people and resulting reductions in emergency admissions are not included here, as this is being taken forward through the Uniting Care Partners (UCP) contract. There are other areas within this strategy however that highlight and attempt to quantify potential opportunities which cross over with the UCP contract. The section on falls management and malnutrition screening and treatment are areas where UCP activity would play an important role in any delivery.

5.2.2 There is some overlap between this strategy and the work streams of the System Transformation Programme and the Emergency Care Vanguard. The strategy set out in this document will therefore be taken forward through a range of work programmes.

5.3 Key findings

5.3.1 The key findings are set out in the executive summary of the attached draft strategy (Appendix 1). The strategy recommends a number of actions based on interventions which produce an NHS net saving. These are:

- Maximise the opportunities for lifestyle interventions identified through health checks across Cambridgeshire and Peterborough.
- Expand Peterborough weight management services to reach NICE recommended levels.
- Extend the health check to those aged 25-39 in the Peterborough South Asian population. Focus on the most deprived areas first.
- Increase the lifestyle interventions for those with diagnosed hypertension, and at high risk of diabetes.
- Expand workplace health initiatives within NHS employers to reduce abseentism.
- Expand malnutrition screening and treatment in older people.
- Increase the number of people accessing stop smoking services (adults, older people and pregnant women).
- Increase the number of women with long acting reversible contraceptives (LARCs)
- Improve referral and uptake of IAPT services for people with long term conditions

5.3.2 We are still working on the following areas:

a) Expand falls prevention work to a greater % of the older population.

b) Increase the uptake to % of people eligible accessing and completing cardiac rehabilitation.

c) Increase the number of people receiving anti-coagulant treatment for Atrial Fibrillation.

d) Increase the numbers of people on a self-management programme with chronic obstructive pulmonary disease (COPD).

5.4 Longer term savings - Obesity, diet and physical activity

5.4.1 The system transformation programme identified that if obesity levels were kept static this could save 30% of the obesity related healthcare costs, the equivalent of £7m a year. The strategy looks at the possible interventions to keep obesity static, and found that although there is evidence of effective local programmes it is not possible to say if weight loss is maintained and therefore to quantify the impact on the NHS.

5.4.2 The headline findings for obesity, diet and physical exercise are:

- Current weight management services see approximately 1-2% of the population who are obese.
- For a variety of reasons it is not possible currently to robustly estimate the cost savings to the NHS of reductions in weight loss, although we can estimate the effectiveness of some of current programmes.
- There is little information about the long term impact of weight management programmes. However, recent health economic modelling of ‘lifestyle interventions’ focused on support to change lifestyle behaviour (notably diet, and physical

exercise) have been found to be potentially cost saving to the NHS, with the largest savings from intensive interventions over the lifetime horizon.

- Peterborough weight management services are currently limited and should be expanded to reach NICE recommended levels.
- We need to ensure that we maximise the opportunities for lifestyle interventions identified through health checks across Cambridgeshire and Peterborough.
- It is recommended that 'lifestyle interventions' are available at a much larger scale, including intensive health trainer options, for those identified as at risk of diabetes, or with hypertension through a health check or opportunistically. This should be underpinned by initiatives which help create an environment which encourages a healthy weight. These initiatives should include the promotion of active travel.

5.4.3 There is evidence looking at disease specific interventions, such as diabetes prevention and hypertension prevention and management, that lifestyle interventions that reduce the key lifestyle risks will become potentially cost saving to the NHS at 10 years and more certainly over a lifetime horizon. There is also evidence that screening and lifestyle intervention for the South Asian population aged 25-39 will generate long term savings, and this is costed in the strategy for the Peterborough population.

5.5 Overall net savings the NHS from work to date

5.5.1 The overall net savings to the NHS from the **work to date** suggest that the following savings can be made. These savings are based, in many cases, in increased investment. There is considerable costing work still underway, as listed above, so the overall net savings figure is likely to increase in the final version of the plan.

Short Term Total Potential Net Savings Summary Table (savings after costs have been removed)

	16/17	**17/18**	**18/19**
NHS activity saving	£1.1m	£1.3m	£1.26m
NHS productivity saving	£0.16m	£1.8m	£1.8m
Total	**£1.26m**	**£3.1m**	**£3.0m**

5.5.2 The additional investment needed to generate these savings would be approximately £694k over the next three years. There is a large NHS productivity saving estimated from introducing workplace health programmes.

5.5.3 As described above, it is not possible based on the current evidence base to estimate the cost reductions associated with weight loss, and much of the modelling work on improving diet and physical activity suggests that the savings to the NHS will be long term over a period of ten to twenty years or even the full lifecourse. Overall, this work does not conclude that keeping obesity static will generate the short term savings estimated by the system transformation programme, and instead focuses on where robust savings can be generated elsewhere.

5.5.4 It is also important to note that the figures above are all potential **net** savings to the NHS, having taken out the cost of the investment. In some cases the investment costs may not all fall to the NHS, and therefore the NHS will see a larger saving. Equally, funding through the NHS for preventive initiatives such as improved diagnosis and management of atrial fibrillation will generate savings for local authorities, in this case due to a reduction in the number of people having a stroke.

6. TIMESCALES

6.1 A first draft of the health system prevention strategy was presented to the System Transformation Programme Board on 16 November 2015.

6.2 The draft strategy was also presented to the Cambridgeshire Health and Wellbeing Board on 19 November 2015 and will be presented to Cambridgeshire County Council's Health Committee on 17 December 2015.

6.3 A final version of the prevention strategy will be presented to the Cambridgeshire and Peterborough Public Health Reference Group and for approval to Cambridgeshire and Peterborough Health and Wellbeing Board meetings in 2016.

7. CONSULTATION

7.1 The draft prevention plan has been developed in consultation with the Cambridgeshire and Peterborough Public Health Reference Group and Public Health England.

8. ANTICIPATED OUTCOMES

8.1 The anticipated outcome of this work is that cost effective preventive interventions will be included in the overall Cambridgeshire and Peterborough Health System Transformation Plan*.*

9. REASONS FOR RECOMMENDATIONS

9.1 The Peterborough Health and Wellbeing Board is one of a number of key stakeholders in this plan, so comments and feedback on the first draft of the plan are welcomed.

10. ALTERNATIVE OPTIONS CONSIDERED

10.1 This is an update report on a piece of work commissioned by the CCG led Health System Transformation Programme Board.

11. IMPLICATIONS

11.1 There may be implications for public health and other services commissioned/delivered by Peterborough City Council, where there is clear evidence that delivering these services in specific ways would support the wider health and care system by delivering NHS savings.

12. BACKGROUND DOCUMENTS

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

None.

13. APPENDICES

Source Documents	**Location**
See references for the attached document.	Appendix A - Health System Prevention Plan – Draft 1

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Health system prevention strategy for Cambridgeshire and Peterborough

Draft version 1.1 – 25 November 2015

Contents

1. Executive summary: headlines and recommendations....2
2. Introduction....9
3. Obesity, diet and physical activity....12
4. Diabetes....22
5. Cardiovascular disease....29
Cardiac Rehabilitation....31
Atrial Fibrillation....33
Hypertension....37
6. Long term conditions....42
7. Workplace health....51
8. Smoking....60
9. Alcohol....67
10. Falls....71
11. Malnutrition in older people....82
12. Sexual health....86
13. Breastfeeding....90
14. Appendices....94

1. Executive summary: headlines and recommendations

Headlines

Actions proposed

- Maximise the opportunities for lifestyle interventions identified through health checks across Cambridgeshire and Peterborough.
- Expand Peterborough weight management services to reach NICE recommended levels.
- Extend the health check to those aged 25-39 in the Peterborough South Asian population. Focus on the most deprived areas first.
- Increase the lifestyle interventions for those with diagnosed hypertension, and at high risk of diabetes.
- Expand workplace health initiatives within NHS employers to reduce absenteeism.
- Expand malnutrition screening and treatment in older people.
- Increase the number of people accessing stop smoking services (adults, older people and pregnant women).
- Increase the number of women with LARCs
- Improve referral and uptake of IAPT services for people with LTCs.

Work still in progress on developing these options

- Expand falls prevention work to a greater % of the older population.
- Increase the uptake to % of people eligible accessing and completing cardiac rehabilitation.
- Increase the number of people receiving anti-coagulant treatment for Atrial Fibrillation.
- Increase the numbers of people on a self-management programme with COPD.

Obesity, diet and physical activity

- Current weight management services see approximately 1-2% of the population who are obese.
- For a variety of reasons it is not currently possible to robustly estimate the cost savings to the NHS of reductions in weight loss, although we can estimate the effectiveness of some of current programmes.
- There is little information about the long term impact of weight management programmes. However, recent health economic modelling of 'lifestyle interventions' focused on support to change lifestyle behaviour (notably diet, and physical exercise) have been found to be potentially cost saving to the NHS, with the largest savings from intensive interventions over the lifetime horizon.
- Peterborough weight management services are currently limited and should be immediately expanded to reach NICE recommended levels.
- We need to ensure that we maximise the opportunities for lifestyle interventions identified through health checks across Cambridgeshire and Peterborough.
- It is recommended that 'lifestyle interventions' are available on a much larger scale, including intensive health trainer options, for those identified as at risk of diabetes, or with hypertension through a health check or opportunistically. This should be underpinned by initiatives which help create an environment which encourages a healthy weight. These initiatives should include the promotion of active travel.

Diabetes prevention

- People at high risk of developing type 2 diabetes can be identified through the NHS Health Check and the disease could be prevented in 30-60% through appropriate behaviour change support[1].
- Improve screening and lifestyle interventions for populations with high risk of hypertension, high glucose levels, South Asian population. Focus on the most deprived areas first.

Cardiovascular disease

- Current uptake for Cardiac Rehabilitation is 48.3% in line with the national average. However, there may be cost savings associated with increasing this to 65%.
- There are opportunities to improve the diagnosis and treatment of Atrial Fibrillation. This is potentially cost saving to the NHS as well as local authorities. Work should focus on increasing the numbers of patients diagnosed and treated for AF and

[1] PHE Cardiovascular intelligence pack.

reducing variation between GP practices. Peterborough should be the initial focus of this work.

- Modelling work finds the national interventions to reduce salt intake are cost saving at all time horizons including year one.
- Lifestyle interventions, general adult population and focused on those with diagnosed hypertension, have been shown to be potentially cost saving at 10 years and over a lifetime horizon.
- The opportunity provided in the health check to diagnose and treat hypertension, including through lifestyle interventions, should be maximised.
- A variety of lifestyle interventions for those diagnosed with hypertension should be available. This would mean an expansion to existing lifestyle services, such as health trainer/coaches. Work to target this group should focus initially on Peterborough.

[PH: we are doing further modelling work on hypertension, cardiac rehabilitation and AF diagnosis and management]

Long term conditions

- International evidence finds that psychological interventions for long term conditions can on average reduce health care costs by a range of 20-30% across studies.
- Self-management programmes in patients with COPD have been found to reduce all cause hospitalisations by up to 40%.
- A self-management programme should be offered to those diagnosed with COPD. This should be evaluated for its economic impact on health costs.
- Routine management of LTCs should include the identification of those requiring further assessment for depression and anxiety.
- There should be maximum utilisation of the IAPT LTC team, and there should continue to be a focus on rapidly increasing referrals. There should be a focus on those with multiple long term conditions.
- There should be an economic evaluation of the impact on healthcare costs of identification and treatment for common mental health disorders in those with multiple long term conditions.

Workplace health

- The potential mental health productivity savings, assuming no current action in this area, amount to nearly £5.7m across the large NHS employers in Cambridgeshire and Peterborough.
- The evidence and modelling is clear that investing in workforce health will generate short term productivity savings to the NHS. These are estimated, with the package

modelled here to be approximately £3.9m over three years, with an investment of £335k.

- NHS employers should see considerable productivity savings from investing in workplace health. In particular this needs to focus on improved management and awareness of mental health and illness.

Smoking

- There are an estimated 105,548 people across Cambridgeshire and Peterborough who smoke. There is a high quality, high ranking evidence that stop smoking services are cost effective, are good value for money and provide a good return on investment.
- Sub-national programme work, such as tobacco control, is critical to ensuring savings to the NHS. Nationally and locally we should continue to invest in this.
- We should maximise our prevention opportunities and increase the number of people setting a quit date through stop smoking services (adults, older people and pregnant women) in Cambridgeshire by 5%, and in Peterborough to the Cambridgeshire average.
- An additional investment of £346k, only £175k of which is new investment, is needed to generate a saving over £356k over the next two years.
- There are additional savings to the NHS to be made from stopping people smoking before operations, and this group should be a target population.

Alcohol

- Maximise opportunities to provide brief advice on alcohol to more GP practice patients. If 10,000 more patients were to receive this advice, it is estimated this would save the NHS £217k (above the cost of the intervention) over seven years with the vast majority of the savings in years 2-5.

[PH: We are doing further work to define local stretch targets and to model the cost savings]

Falls

- Injurious falls in older people have a high cost impact for health and social care services, estimated at £83million for 2016, with increasing costs forecast for the ageing population locally.
- There is important and robust evidence indicating net savings for falls interventions targeted at community dwelling older adults across a range of UK and international settings.

- In particular three areas of intervention for preventing falls in community-living older people have been trialled and indicated cost savings: home-based exercise (the Otago Exercise Programme) in over 80-year-olds, home safety assessment and modification in those with a previous fall, and specific multi-factorial programmes.
- Further development of models to estimate the cost savings to the NHS of local multi-component falls interventions accurately is in progress.
- Potential savings may require delivery of preventative approaches on a much wider scale than current provision.

[PH: Further work to develop models is in progress]

Malnutrition in older people

- An estimated 13,000 to 18,300 older people are malnourished in the Cambridgeshire & Peterborough population, and more are at risk
- Potential cost savings may be achieved by increasing proportion screened for malnutrition among inpatients, outpatients and new GP registrations to 90% and providing appropriate treatment; investment of £524k and savings in the order of £543k primarily from reducing length of stay in acute care. At worst this intervention should not cost the NHS additional funding, and will improve quality of life for older people.

Sexual health

- For every £1 invested in contraception services, there is a £11.09 saving to the NHS, rising to £13.42 for LARCs.
- It is proposed that we increase the number of women with long-acting reversible contraceptives (LARCs) by approximately 859 a year in Cambridgeshire & Peterborough. This should generate savings of £935k in 2016/17, £1.15m in 2017/18 and £1.26m in 2018/19.
- This would require an additional investment of £115k. However, the additional investment needed for Cambridgeshire, is already within the Council budget proposals for 2016/17.

Breastfeeding – promoting initiation and duration

- Low breastfeeding rates in the UK lead to an increased incidence of illness that has a significant cost to the health service. Investment in evidence-based multi-faceted

interventions has been shown to generate savings to the health economy in the short term by reducing hospital admissions for four acute childhood illnesses[2].

- There is evidence to suggest that breastfeeding can contribute to longer term savings through its impact on key health outcomes including childhood obesity, but this is difficult to quantify.
- The focus should be on joint commissioning with local authorities to improve breastfeeding support, implementing or piloting interventions in both acute and community settings. These interventions should include strengthening breastfeeding support and advice in acute settings, and easily accessible breastfeeding peer support programmes focused on the most deprived areas of the CCG.

[2] Renfrew MJ, et al. ''Preventing disease and saving resources: the potential contribution of increasing breastfeeding rates in the UK' (2012) UNICEF. Available at: http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=0CCcQFjABahUKEwjxtcW__PHIAhXLtxQKHRZqBNk

Investment and saving opportunities identified

The two tables below summarise the short term savings identified through work to date. **Work is ongoing to model potential savings from cardiac rehabilitation, atrial fibrillation diagnosis and management, hypertension management, self-support for COPD, and initiatives to reduce falls.**

Short Term Total Potential Net Savings Summary Table (savings after costs have been removed)

	16/17	17/18	18/19
NHS activity saving	£1.1m	£1.3m	£1.26m
NHS productivity saving	£0.16m	£1.8m	£1.8m
Total	**£1.26m**	**£3.1m**	**£3.0m**

				Investment				Net NHS Savings				Comments
	Lifestyle	Intervention	Area	2016/17	2017/18	2018/19	Total	2016/17	2017/18	2018/19	Total	
Short term	Smoking cessation	Increase uptake in Local Stop Smoking Services by 5% (excludes subnational £136k per year which is not new investment)	CCC	£21,904	£21,904		£43,808	£161,250	£161,250		£322,499	
		Increase uptake in Local Stop Smoking Services to CCC levels (excludes subnational £35k per year, which is not new investment)	PCC	£65,589	£65,589		£131,178	£16,307	£16,307		£32,614	
	Sexual Health	Increase uptake of LARC's	CCC	£70,000	£90,000	£100,000	£260,000	£770,000	£990,000	£1,100,000	£2,860,000	£260k of CCC LARC investment is not new NHS investment.
			PCC	£15,000	£15,000	£15,000	£45,000	£165,000	£165,000	£165,000	£495,000	
	Workplace	Mental health promotion, increase in healthy lifestyles and weight management	NHS Trust	£111,580	£111,580	£111,580	£334,741	£163,500	£1,887,070	£1,887,070	£3,937,640	NB: These are productivity savings to the NHS.
	SHORT TERM TOTAL		CCC	£91,904	£111,904	£100,000	£303,808	£931,250	£1,151,250	£1,100,000	£3,182,499	New invesment may be closer to £179,808 see above on LARCs.
			PCC	£80,589	£80,589	£15,000	£176,178	£181,307	£181,307	£165,000	£527,614	
			NHS Trust	£111,580	£111,580	£111,580	£334,741	£163,500	£1,887,070	£1,887,070	£3,937,640	
			Total	£284,073	£304,073	£226,580	£814,727	£1,276,057	£3,219,626	£3,152,070	£7,647,753	NB: 3.9m of this isnet saving is in productivity savings to the NHS.
Longer term	Diabetes	Focus on South Asian population aged 15-39 years for diabetes interventions	PCC	£33,839	£33,839	£33,839	£101,517					This includes a targetted focus using health check plus referral to a health trainer where diabetes is diagnosed
	Lifestyle interventions & environment to support healthy weight		PCC & CCC									Further work possible on potential increase in interventions for long term savings.
	LONGER TERM TOTAL			£33,839	£33,839	£33,839	£101,517	£0	£0	£0	£0	

2. Introduction

Why have we produced a health system prevention strategy?

The Cambridgeshire and Peterborough health economy has been identified as one of England's 11 most challenged health economies and faces a funding shortfall of at least £250 million by 2019.

Prevention, at all levels has been recognised as critical to building a sustainable health system, through reducing demand on the health system. NHS England's Five Year Forward View states that 'The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health.'

It is well understood, that significant proportions of ill health and health service activity are potentially preventable. A recent Public Health England Lancet publication about the global burden of disease found that 40% of the NHS workload is potentially preventable, yet the proportion of health expenditure directed at prevention, although hard to estimate reliably, is probably closer to 4%[3].

Preventing ill health involves many actions, some of which are under the control of health services and some are not. The interaction of these factors can be complex, but estimates from studies on major disease, such as coronary heart disease, show that approximately half the interventions that reduce ill health occur in the health system. So although the health system only forms part of the prevention picture, in many cases it is a critical part.

Objectives of the strategy

The objectives of producing the strategy were to do the following:

- To identify the savings to the NHS, where possible, from current and planned prevention initiatives.
- To identify areas/interventions for potential additional NHS investment in prevention which would maximise savings to the local NHS over the next 3, 5, 10 years and beyond.
- Identify areas and initiatives for potential stretch and outline the strategy for delivering these including projected savings to the NHS, where possible.

[3] Changes in health in England, with analysis by English regions and areas of deprivation, 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. John N Newton et al. The Lancet. September 15, 2015 http://dx.doi.org/10.1016/S0140-6736(15)00195-6.

What are the areas of focus?

This strategy specifically focuses on the contribution prevention can make to closing the financial gap across the Cambridgeshire and Peterborough health system. This is essentially about how we can improve the health of the population and use NHS resources for maximum impact. It focuses on initiatives where there is evidence that a particular prevention initiative can save the NHS money, and this can be quantified. It proposes areas where the NHS could 'invest to save' to maximise its prevention opportunities. It does not therefore focus on quality of life improvements which are not shown to be cost saving to the NHS, although all the proposals in this document show evidence that they will improve quality of life.

Therefore the areas of focus have been carefully chosen for the following reasons:

- The interventions have the best evidence that they work
- They are the interventions with the greatest potential to generate NHS savings
- Information is available to model reasonable estimates of NHS savings
- or, the scale of the issue suggests interventions will have an impact (even if the evidence is not currently conclusive)

This strategy does not start from a blank piece of paper. It builds on current local authority and NHS joint based Public Health Transformation programmes.

What is included and what is not in this strategy?

There are many prevention initiatives where we have a strong evidence base, however we simply do not have the information to enable us to estimate savings to the NHS, but we think there are likely to be some. Support for post-natal depression is a good example. Equally there are prevention initiatives that will produce savings in terms of reduced disability to social care, such a stop smoking initiatives or diabetes prevention, as well as to the NHS. This strategy does not try to quantify savings, other than to the NHS. It is also unlikely to be entirely comprehensive, in that there are other interventions we have not had time to address in this strategy. Equally this document does not outline the health of the local population. This is covered in depth in the Joint Strategic Needs Assessments (JSNA).

Additionally there are many initiatives, often for children and young people, which are cost saving to the wider public sector (employment, economy and criminal justice) although not necessarily directly to the NHS, but will undoubtedly improve overall health. Parenting programmes focusing on the early identification and management of conduct disorder are a good example. Initiatives for children with strong evidence of an NHS saving have been hard to identify although there are many that show a benefit to longer term life chances which will in turn impact on long term health.

There are also prevention initiatives which are not within the scope of this work, as they are being taken forward through other programmes of work. In particular integrating care for

older people and resulting reductions in emergency admissions not included here, as it is being taking forward through the Uniting Care Partners (UCP) contract. There are other areas within this strategy however that highlight and attempt to quantify the potential opportunities with the UCP contract.

There is an overlap between this strategy and the work streams of the System Transformation Programme and the Emergency Care Vanguard. The strategy set out in this document will therefore be taken forward through a range of work programmes.

Details of the prevention initiatives considered in this work and the reasons for including or not including them are provided in the table at Appendix A.

3. Obesity, diet and physical activity

Headlines

- Current weight management services see approximately 1-2% of the population who are obese.
- Peterborough weight management services are currently limited and should be immediately expanded to reach NICE recommended levels.
- We need to ensure that we maximise the opportunities for lifestyle interventions identified through health checks across Cambridgeshire and Peterborough.
- For a variety of reasons it is not currently possible to robustly estimate the cost savings to the NHS of reductions in weight loss, although we can estimate the effectiveness of some of current programmes.
- There is little information about the long term impact of weight management programmes. However, recent health economic modelling of 'lifestyle interventions' focused on support to change lifestyle behaviour (notably diet, and physical exercise) have been found to be potentially cost saving to the NHS, with the largest savings from intensive interventions over the lifetime horizon.
- It is recommended that 'lifestyle interventions' are available on a much larger scale, including intensive health trainer options, for those identified as at risk of diabetes, or with hypertension through a health check or opportunistically. This should be underpinned by initiatives that help create an environment which encourages a healthy weight. These initiatives should include the promotion of active travel.

Background

Excess weight, diet and physical activity all have a significant impact on health. Obesity is a major determinant of premature mortality and avoidable ill health, increasing the risk of diabetes, heart disease, cancer, muscle and joint problems and depression.

Key Facts

- It is estimated that being moderately obese reduces life expectancy by about three years and being severely obese by 10 years or more.
- In England, and in Cambridgeshire and Peterborough, most people are overweight or obese.
- Obesity is estimated to cost the NHS £5 billion a year and type 2 diabetes (often caused by obesity) a further £9 billion.
- Physically active people have a 20-35% lower risk of cardiovascular disease, reduced risk of diabetes, obesity, osteoporosis and colon/breast cancer, and better mental health.

Current position

What is the scale of the problem?

Overall levels of adult obesity in Cambridgeshire and Peterborough are in line with the national average. This masks variation within the CCG. For example there are higher than average percentages in Fenland (72%) and Huntingdonshire (69%) and lower than average percentages in Cambridge (54%), and there is similar variation within Peterborough. Obesity is highly correlated with deprivation and black and Asian ethnic backgrounds associated with higher risks of obesity and obesity related co-morbidities.

Table 1 - Proportion of adults and children overweight or obese in Cambridgeshire and Peterborough

Age	Classification	Time period	Source	Cambridgeshire	Peterborough	England
Adults	Excess weight *	2012	1	65%	66%	64%
	Obese only	2012	1	23%	24%	23%
Children (4-5 years old)	Excess weight *	2013/14	2	21%	25%	23%
	Obese only	2013/14	2	8%	11%	10%
Children (10/11 years old)	Excess weight *	2013/14	2	29%	30%	34%
	Obese only	2013/14	2	16%	17%	19%

Source:
1. Public Health Outcome Framework, Fingertips, PHE
2. NCMP Local Authority Profile, Fingertips, PHE

How is the prevalence of obesity expected to change locally?

- The prevalence of obesity (BMI≥30) is forecast to continue to rise, however the latest data suggest the increase may be slower than previous national forecasts suggested.
- The projected rise for Cambridgeshire and Peterborough is from a baseline of 22.2% in 2012 to 23.8% in 2018, reaching nearly 28% by 2031.
- The greatest increase will be in the over 75s and 45-54s, with the prevalence in adults aged 25-44 remaining relatively stable.

The following figure and table show the proportional increase and the number of people this represents in our population. The estimates in table 2 below take account of the fact that our population is growing.

Table 2: Projected prevalence of obesity (BMI>30) and overweight (BMI>25) in C&P (% of >16s)

	2012	2013	2014	2015	2016	2017	2018	2021	2026	2031
% adults with BMI >30	22.2	22.5	22.8	23.1	23.3	23.6	23.8	24.6	26.0	27.7
% adults with BMI >25	65.1	65.4	65.6	65.8	66.0	66.1	66.3	66.9	68.1	69.4

Source: Cambridgeshire and Peterborough CCG estimates based on 2003-2012 data.

Table 3: Estimates of the number of people who will be obese by 2021 in Cambridgeshire and Peterborough

2012 Actual	2013	2014	2015	2016	2017	2018	2019	2020	2021
165,820	167,839	171,389	174,991	178,687	182,265	185,789	189,287	192,874	196,502

The health consequences and costs of rising obesity

Sixteen percent of NHS costs relate to diseases associated with overweight/obesity. Of these, 60% relate to diabetes, coronary heart disease and stroke; 30% to osteoarthritis and 10% to cancers. These diseases are complex and their causes are multi-factorial. While around 80% of the disease burden due to diabetes can be attributed to overweight/obesity, for heart disease and stroke the proportion is closer to one third and for osteoarthritis it is around 20%.

The population attributable fraction (PAF) below (an estimate of the proportion of the burden of that disease that is attributable to obesity) illustrates how we cannot think about tackling obesity separately from preventing diabetes, hypertension and other diseases. Diabetes has the highest obesity PAF; nearly 80% of the burden of the disease can be attributed to overweight and obesity (note that the PAF for Type 1 Diabetes alone would be low; this figure is driven by the predominance of Type 2 Diabetes).

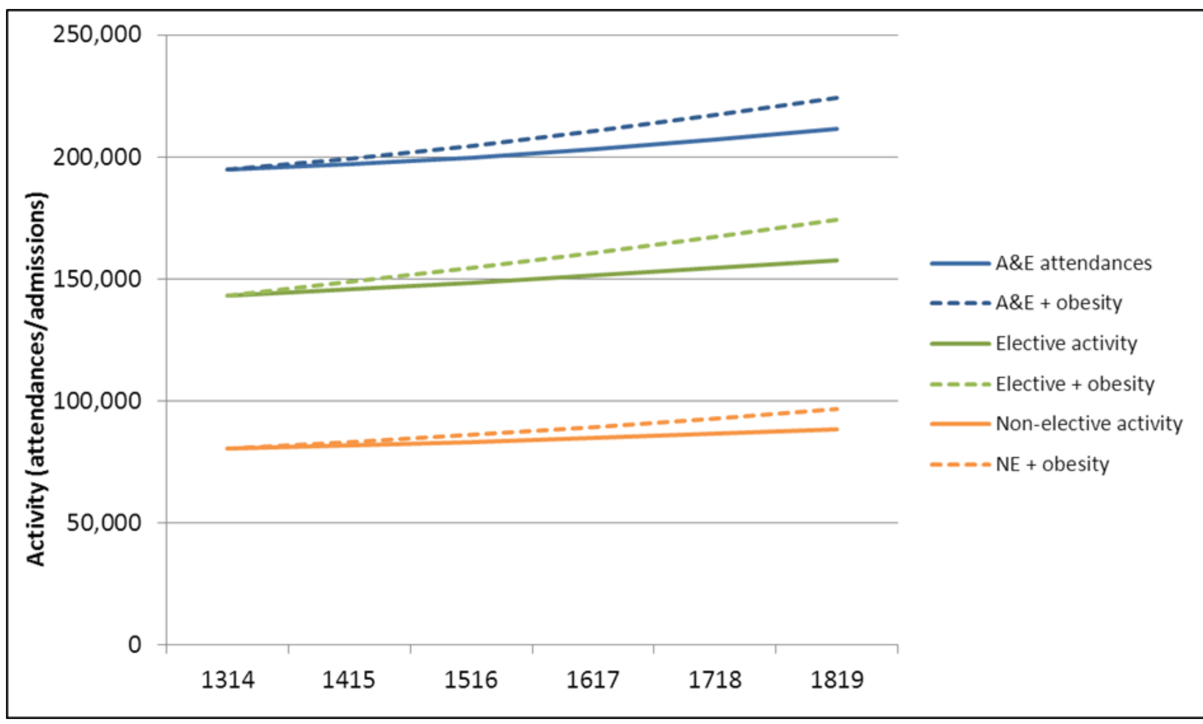
Table 4: Fraction of disease attributable to overweight and obesity (from WHO Burden of Disease, based on PAF for DALYs lost for specific diseases to overweight and obesity)

Disease	PAF
Ischaemic heart disease	34
Ischaemic stroke	34
Breast cancer	12
Colon/rectum cancer	16
Hypertensive disease	58
Corpus uteri cancer	49
Osteoarthritis	21
Diabetes mellitus	79

Overall, 6.3% of NHS costs can be attributed to overweight and obesity specifically. No single disease accounts for the majority of obesity-related NHS costs. There is little published research on the relative use of health services by obese patients, however the evidence suggests that excess use of services relates to the consequences of obesity, rather than to obesity per se. A recent systematic review found that obese individuals have 30% higher health costs than individuals of a healthy weight[4]. This estimate has been used to estimate 30% higher health service usage.

The demand for health services is rising faster than can be explained by demographic change alone. Rising acuity results, in part, from population ageing, but the increasing prevalence of obesity is also a key factor. The figure below presents a forecast of the CCG-commissioned A&E, elective and non-elective activity across all providers, and the estimated impact of obesity.

Figure 1: Forecast acute activity to 2018/19 with projected obesity related activity



The table below shows how many people would need to be moved out of the obese category to keep obesity levels static, and reduce related NHS costs. For 2016 the number of people is 5,524 and for 2019 it would be 11,216.

[4] Withrow D & Alter DA. The economic burden of obesity worldwide: a systematic review of the direct costs of obesity. obesity reviews 2011;12:131–141

Table 5: Obesity prevalence

	2012 Actual	2013	2014	2015	2016	2017	2018	2019	2020	2021
Static prev	165,820	167,519	169,393	171,256	173,163	174,911	176,534	178,071	179,646	181,208
Increase prev	165,820	167,839	171,389	174,991	178,687	182,265	185,789	189,287	192,874	196,502
Difference	0	320	1,995	3,734	5,524	7,354	9,255	11,216	13,228	15,294
	0.0%	0.2%	1.2%	2.2%	3.2%	4.2%	5.2%	6.3%	7.4%	8.4%

Interventions and cost savings to the NHS

Current public health spend and activity

There are an estimated 165,820 people within the CCG population who are obese. We know the following about our current weight management services:

- Weight management services in Cambridgeshire are multi-component in design and offer services to people with obesity as outlined in NICE guidelines and Department of Health (2006).
- Services much more limited in Peterborough. NICE estimates of activity levels are based on average national activity at 2011 and so do not address the scale of the issue described above.
- We estimate that current weight management services (Tiers 2 and 3) are currently reaching 1-2% of the obese population across the CCG.
- We know that there is activity taking place within GP practices in relation to diet, weight and physical activity. Approximately 20,000 health checks are undertaken a year across Cambridgeshire and Peterborough.
- In Cambridgeshire 2014/15, 83% of the target was achieved and the percentage of health checks offered and converted into completed was 38%. There has been a considerable improvement in the quality of data returned and numbers referred onwards to services following a health check; which has been attributed to the ongoing training programme.
- Health check completion (45.8% of eligible population) and uptake (48%) in Peterborough is above or on average with England, with good onward referral to available lifestyle services.
- Many people choose to access evidence based commercial weight management programmes (such as Weight Watchers) independently of anything offered through the NHS.

In Cambridgeshire, annual Public Health spend on diet, physical activity and obesity is £1,005,000.

An evaluation of weight management services (Tiers 1-3) in Cambridgeshire (June 2011-May 2013) found that:

- All services have good outcomes as far as weight loss in people completing the programmes, and the results are comparable with those reported in studies used for benchmarking obesity services.
- On average 25-30% of participants achieved over a 5% weight loss on completion (average of approx. 4kg), as well as an increase in active days and average daily vegetable consumption.
- The cost effectiveness of the services is difficult to determine without long term follow up. However, the services are likely to be cost effective if weight loss >5% of body weight is maintained.

Current weight management and obesity services are limited in Peterborough.

A return on investment model for health trainers developed by a lecturer at the Judge Institute found that for the £488k invested by Cambridgeshire, they estimated that there would be a net saving to the NHS of £372k. The savings were largely from behaviour change processes. The vast majority of the work of the health trainers is on weight management, promoting physical activity and diet.

The cost effectiveness of weight management programmes

Significant health benefits can be achieved from modest amounts of weight loss. Realistic targets for weight loss for adults are usually seen to be a maximum weekly weight loss of 0.5–1 kg, and a total loss of 5–10% of original body weight over the period of the intervention.

The NICE economic models estimate that a 12-week programme costing £100 or less will be cost-effective for adults who are overweight or obese under 2 conditions. First, the weight loss, compared with what it would have been without the intervention, must be maintained for life. Second, at least 1 kg of weight is lost and this weight difference is maintained for life (that is, the person's lifetime weight trajectory is lowered by at least 1 kg). [PH42 costing report]

In a hypothetical scenario, only used to give an indication of the scale of the issue, where we wanted to reduce the weight in an additional obese 11,216 people by 2019, the number to keep obesity static, there would need to be an additional 37,386 referrals to weight management services and services would need to be seven and a half times the size they are now. This would not necessarily lead to a situation where obesity would be kept static; it would instead lead to some weight reduction within this group. It is not possible to estimate what proportion of the additional 30% health costs associated with obesity would be reduced through this weight loss. It is also not clear from the evidence whether this weight loss would be maintained.

Physical Activity

Illness as an outcome of physical inactivity has been conservatively calculated to be between £0.9-1 billion per annum in direct costs to the NHS (in 2006-07 prices), mainly based on costs associated with ischaemic heart disease and stroke (Scarborough 2011).

Active transport (cycling or walking to work) is a key way of increasing individual daily activity. Active travel schemes have been found to have a cost benefit of between 5 -6 to one (DfT 2014).

However many cost benefit models focus on reductions in premature mortality (e.g. WHO Health Economic Assessment Tool) or wider benefits such as absenteeism, productivity and quality of life rather than specific cost savings to the NHS. It has been possible to model the impact of brief advice to improve physical activity in the workplace section of this report, as the cost savings are in improved productivity to the NHS.

Jarrett (2012) estimated the NHS costs that could be averted by a large shift towards active travel in England and Wales, based on reducing incidence of key diseases and therefore the costs of treating these conditions. A shift in walking from 0.6 km/day to 1.6 km/day, and in cycling from 0.4 km/day to 3.4 km/day (similar to current levels in Copenhagen) could result in changes in numbers of incident cases of type 2 diabetes, dementia, cerebrovascular disease, breast and colorectal cancer, depressions and ischaemic heart disease. The study estimated that over 20 years, the expenditure averted would be over £17 billion. Most of these savings are due to a decrease in the expected number of cases of Type 2 diabetes. Reductions in incidence of Type 2 diabetes, cerebrovascular disease, depression and ischaemic heart disease would be seen over a shorter time period than cancers and dementia. The model did not include any impact for existing diagnosed patients.

Work already planned

Peterborough weight management services

An obesity needs assessment for the Peterborough and Borderline system has been completed, and outlines the tiered weight management services needed to meet NICE standards in Peterborough. The model proposed builds upon existing services in Peterborough that encourage physical activity, weight loss and healthy lifestyles. A CCG investment of £100k has been agreed to support the development of tier 3 weight management services and this will be taken forward as part of broader integrated lifestyle and behaviour change service developments over the coming year.

Encouraging a healthy weight

It is widely recognised that at the whole population level, obesity prevention and health promotion advice, support, information and incentives should be available to encourage a

healthy weight. These should include factors that affect the wider determinants of health including environment design and planning.

The model should work across the life course and therefore include support to children and young people for weight management from tier 1 through to tier 3.

Many partners, including district councils and the voluntary sector, fund initiatives to promote healthy lifestyle and reduce the number of people who are overweight and obese.

A Public Health Reference Group (PHRG) has been set up in Cambridgeshire and Peterborough to provide whole system leadership and multi-agency co-ordination for public health initiatives), focused on improving outcomes for residents and reducing health inequalities. Its membership includes District Councils, local academics, the voluntary sector, Police and Crime Commissioners office, Health Watch, the CCG and both local authorities. It reports to the Health and Wellbeing Boards.

The PHRG has chosen to focus on obesity, diet and physical exercise initially. Working with the public health team the PHRG has undertaken a review of the evidence in these areas. The summary of this is attached at Appendix B. Given the gaps in evidence around long term impact, the group has chosen to focus on a wide range of initiatives that will support creating an environment that promotes a healthy weight.

This review has led to a draft action plan for the next 6 months (October 2015-March 2016), which is currently being refined. Currently this work programme focuses on Cambridgeshire only.

The draft plan includes work in the following areas:

- Commissioning of a package of initiatives that will enable early years' services to provide children/families/carers with access to and information about a healthy diet.
- A package of interventions as part of a Workplace Programme for Local Authorities over two years.
- Increasing community engagement in physical activity programmes through a range of initiatives that could be supported or provided by different organisations.
- Training of staff in primary care to make brief interventions for lifestyle behaviour change

This work is funded through the Public Health grant, as outlined in the Cambridgeshire County Council business plan and is subject to council approval of the budget early next year.

Point of Care testing for lipids and HbA1c has been commissioned and will be available in all GP practices providing health checks from 2015/16. This will improve patient experience through the whole health check being completed in one practice visit and enable better recording. Secondly the introduction of a new data collection system in practices will

improve the accuracy of the patient invite system, data recording and collation. A range of outreach health checks is also being provided, there is staff training from a commissioned Coronary Heart Disease specialist nurse, and in Fenland a mobile service has been established and is visiting factories to offer health checks especially to those more hard to reach groups.

Where should the strategic focus be to reduce obesity related NHS service demand?

- We need to continue to provide high quality weight management programmes within Cambridgeshire and to maximise the opportunity of health checks to refer people onto weight management programmes.
- We need to provide multi-component weight management services to people with obesity as outlined in NICE guidelines to people living in Peterborough
- It is clear that these current weight management programmes, which reach 1-2% of the obese population, are not provided to a scale which would mean they could influence obesity related demand curves.
- The Public Health Reference Group has developed a strategy influencing the wider determinants of obesity. Many of the initiatives the group is taking forward may not show evidence of short term or direct NHS savings, but overall will help create an environment which supports a healthy weight. Again, arguably these current initiatives are not at a scale where they will be large enough to influence the overall obesity and overweight prevalence level within the population.
- Initiatives to create a wider environment that supports a healthy weight should include active travel initiatives.
- Some of the most cost saving interventions are more effective when introduced as national initiatives, such as reducing salt content within food and sugar levels within drinks.

Recommendation

That the health system consider investing in 'lifestyle' interventions, to reduce the overweight and obese population, including weight management, so that the scale of the interventions available better reflects the needs of the population.

The details of how lifestyle interventions influence diabetes and hypertension and have been found to be cost saving are outlined in the following sections.

The overall changes reflect the best evidence of where lifestyle interventions are cost saving to the NHS and the proposal would consist of:

A range of lifestyle interventions, including intensive health trainer options, available for those identified as at risk of diabetes, or with hypertension through a health check.

In Cambridgeshire this would mean scaling up the current health trainer service, to provide more 'health coaches' and a range of other initiatives for people to access to reduce and maintain a healthy weight. A corresponding increase in specialist weight management services would also be needed.

In Peterborough this would mean:

- A health trainer/coach programme introduced as well as a wide range of initiatives to help people maintain a healthy weight. Specialist weight management services would also need to be expanded to meet the additional population entering the pathway.
- Ensuring full GP practice engagement with MECC and Let's Get Moving initiatives.
- Exploring point of care testing for Peterborough GP practices providing health checks, as this makes onward referral to other services quicker and easier.

[PH: We can develop investment options in these types of models – it will not be possible to model savings, other than in terms of specific diseases (see sections on diabetes and hypertension)]

4. Diabetes

Headlines

- People at high risk of developing type 2 diabetes can be identified through the NHS Health Check and the disease could be prevented in 30-60% through appropriate behaviour change support[5].
- Improve screening and lifestyle interventions for populations with high risk of hypertension, high glucose levels, South Asian population. Focus on the most deprived areas first.

Background

Diabetes mellitus is a chronic and complex multi-system disorder of glucose metabolism requiring medical input throughout the life-course. Diabetes is associated with serious complications including coronary heart disease, stroke, peripheral vascular disease and retinopathy, nephropathy, and neuropathy. It is important to note that there are two predominant types of diabetes.

Key Facts

- **Type 1 diabetes** typically occurs in children and young adults, is due to absolute insulin deficiency and contributes to approximately 10% of total diabetes prevalence; **type 2 diabetes** makes up approximately 85-90% of total diabetes prevalence, is associated with obesity and insulin resistance, and typically occurs in older adults aged over 35 years. Type 2 diabetes is the type of diabetes discussed here.
- If current trends persist, one in three people will be obese by 2034 and one in ten will develop Type 2 diabetes.
- Type 2 diabetes is often preventable. People at high risk of developing type 2 diabetes can be identified through the NHS Health Check and the disease could be prevented in 30-60% through appropriate behaviour change support[6].
- There is strong international evidence which demonstrates how behavioural interventions, which support people to maintain a healthy weight and be more active, can significantly reduce the risk of developing the condition.
- The cost of treating overweight patients with diabetes is about one and a half times that of treating normal-weight patients with diabetes. The cost of treating patients with diabetes who are obese is more than three times as high as for treating patients without diabetes who are of normal weight[7].

[5] PHE Cardiovascular intelligence pack.
[6] PHE Cardiovascular intelligence pack.
[7] PHE Cardiovascular intelligence pack.

Current position

In 2013/14 5.4% of people aged 17+ years were recorded as having a diabetes diagnoses in Cambridgeshire and 6.3% in Peterborough. It is estimated that there are 7,304 people with undiagnosed diabetes in NHS Cambridgeshire and Peterborough CCG. GP practice prevalence of observed diabetes ranges from 1.2% to 12.0%.

The focus here is on the prevention of diabetes rather than the management of diabetes once diagnosed. However, the National Diabetes Audit Data shows that many of the eight care processes recommended by NICE do not appear to be being provided in Cambridgeshire and Peterborough to the same level as elsewhere in the county, and the CCG does not rank well in comparison with other areas. Overall in 2012/13 54.9% of people with diabetes had the eight recommended care processes in NHS Cambridgeshire and Peterborough CCG compared to 59.5% in England. This means that at least 12,953 people did not receive the 8 care processes.

For example reporting on people with diabetes whose blood glucose levels are well controlled for 2013/14 there were 58.3% of people in this group in Cambridgeshire, and 47.9% in Peterborough. Cambridgeshire ranked 128th out of 152 counties and Peterborough was the bottom of the table nationally. The England average was 61.5%. There were similar results for blood pressure control in people with diabetes.

The focus here is on diabetes prevention however, intensive blood glucose control can reduce the risk of diabetic complications and decrease treatment costs over periods from 10 years to a lifetime, and some US studies showing a quicker return on investment[8]. There may therefore be opportunities related to intensive blood glucose control and blood pressure control amongst diabetics, to improve care and reduce overall NHS costs.

Interventions and cost savings to the NHS

NICE guidance on diabetes prevention highlights many interventions which are cost effective in the short term. It was not able to estimate long-term savings for the guidance.

However, it argues that the main savings are anticipated to arise as a result of providing intensive lifestyle-change programmes. Some and, in time, possibly all the costs of assessment and lifestyle interventions may be offset by delaying someone's progression to type 2 diabetes. In the short term, savings will relate mainly to the costs that would otherwise have been incurred in monitoring and treating people who have progressed to type 2 diabetes. Savings will increase in the longer term, as the number of complications and related medical conditions (such as stroke and heart disease) are reduced.

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[8] Evidence based diabetes care in Cambridgeshire: clinical and cost issues for a diabetes service. A commentary based on a review of the literature, Nita Forouhi

There are a couple of interventions which the costing and modelling work commissioned for the development of the guidance, and some more recent work, which show interventions which are potentially cost saving.

a) Large-scale, region-wide multi-component programme (Hartslag Limburg) was found to be highly cost-effective but possibly cost-saving (depending on assumptions around cost of maintenance intervention[9]). Hartslag Limburg was a programme which targeted a regional population of 185,000 with a mix of 590 lifestyle programmes including low cost lifestyle seminars and cycle tours to high cost exercise and diet programmes. Sixty percent of the investment was on improving exercise. The more intensive interventions produced the greatest weight loss, and significant improvements in health were found between the intervention and reference group after five years.

b) A US study (Zhou et al. 2012) projected long-term savings from implementing a community-based diabetes prevention programme nationwide. The modelling in this study identified that a cumulative break-even point would be achieved in year 13.

c) Recently, Breeze et al [10]compared the cost-effectiveness of lifestyle interventions, designed to prevent diabetes, across different high-risk population sub-groups and different intervention intensities. Overall, they found the diabetes prevention interventions are likely to be cost-saving. The six population sub-groups defined as at high risk for diabetes used were adults aged 40-65 years, low socio-economic status, HbA1c>42mmol/mol (6%), Finnish Diabetes Risk score >0.1, BMI >35 kg/m2, South-Asian.

   They found that diabetes prevention programmes are potentially cost-saving over a lifetime horizon, regardless of risk criteria or intervention intensity. Cost-effectiveness increases with intervention intensity. The most cost-effective options were to target South-Asian people and those with HbA1c levels >42 mmol/mol (6%) over a lifetime. However, there are net savings in the first ten years from targeting people with HbA1c and with high value Finnish risk score, but the other groups targeted cost more than their savings over ten years. However, all the groups targeted offer a return on investment over a lifetime. The low socio-economic status and South Asian groups take longer to recover costs despite generating high lifetime costs savings.

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[9] SHAR Prevention of type 2 diabetes: preventing pre-diabetes among adults in high-risk groups
Report on Use of Evidence from Effectiveness Reviews and
Cost-effectiveness Modelling

[10] SHAR Prevention of type 2 diabetes: preventing pre-diabetes among adults in high-risk groups
Report on Use of Evidence from Effectiveness Reviews and
Cost-effectiveness Modelling

They argue that combining criteria could optimise health savings. They found that interventions for individuals identified by FINDRISC score>0.1 or HbA1c>42 mmol/mol(6%) have the greatest cost savings after 1-10 years.

The long term benefits are as much about reducing the risk of other diseases as well as diabetes. The health benefits of interventions in the South Asian population had a large impact on reducing cardiovascular disease but less impact on lifetime diabetes. By contrast, intervening with those with HBA1c>42 mmol/mol (6%) has a large impact in reducing diabetes diagnosis, but it is slightly less effective in reducing CVD events.

They used a meta-analysis of lifestyle interventions (Dunkley et al), which means that their exact definition of a lifestyle intervention is difficult to establish, as there was a large range of interventions included in the meta-analysis. However, intervention costs, with intensive lifestyle support costing £157 per person, are broadly in line with our existing tier 2 health trainer costs.

d) Risk assessment and intervention in South Asians of 25-39 years of age appears to be cost-effective and cost-saving over the longer term (20 years +), with future cost savings more than offsetting the cost of finding, testing and undertaking intensive lifestyle-change interventions with this group. NICE modelling found that even assuming a 50% higher intervention cost (to take account of longer course delivery times for non-English speaking participants) makes little difference to the results and would not alter the conclusion.[11]

Work already planned

The NHS Diabetes Prevention Programme aims to identify those at high risk and refer them into an evidence-based behavioural intervention to help them reduce their risk. The CCG and Local Authority public health team submitted an expression of interest to be part of the first wave of national implementation of the Programme.

There is also an Integrated Community Diabetes Service which has been introduced in CamHealth LCG. The service consists of a number of inter-related components including a diabetes specialist nurse (DSN) clinic at all practices, home visits by a DSN and Healthcare Assistant when requested by the practice, dietician clinics at all practices, podiatrist support and access to Podiatrist's clinics, virtual case reviews and MDT clinics both led by consultant diabetologist. Supporting work in primary care includes the identification, review and

[11] NICE PH38 and SHAR Prevention of type 2 diabetes: risk identification and interventions for individuals at high risk

referral of at risk patients, diabetes prevention and management work, and self-management through personal health plans.

Where should the strategic focus be?

The evidence suggests that interventions that:

- maximise the opportunity that the health check provides to identify people at risk of diabetes, particularly with HbA1c>42mmol/mol (6%)
- provide intensive lifestyle change programmes for those at high risk
- and focus on high risk population groups such as those from the South Asian, and low socio-economic status population.

What would this mean for Cambridgeshire and Peterborough?

Table 6 - Numbers in the South Asian population in Cambridgeshire and Peterborough aged 25-39

	South Asian population aged 25-39
Cambridgeshire	4,512
Peterborough	4,854
Total	9,366

Source: 2011 census resident population

The highest concentration of the South Asian population, also in the more deprived areas of the CCG with the poorest health, are in Peterborough. This would therefore be the priority group to focus on initially.

A health check currently costs approximately £26, so it would cost approximately £126,204 to extend health checks to the South Asian population aged 25-39. Given the scale of the additional checks this is likely to be split across 3-5 years with people in the South Asian population reaching age 25 joining the cohort to receive a heath check. The aim would be for all those in the age group to receive one health check over the next 3-5 years.

Table 7 – estimate of diabetes prevalence in South Asian populations aged 25-39

		Diabetes	Type II (90%)
Estimate of Diabetes in South Asian pops 25-39	Cambridgeshire	632	569
(Diagnosed and Undiagnosed)	Peterborough	680	612
	Total	**1311**	**1180**
	Rounded up	**1300**	**1200**

Source: Holman 2010 for diagnosed/undiagnosed within South Asian population

The model assumes that an additional 4,854 health checks would be offered, and based on current take up rates, 2,354 would be undertaken. From these we estimate that there will be 165 cases of potential future diabetes identified and that 50% of this group will accept a health trainer style intervention. The figures below are all approximate costs.

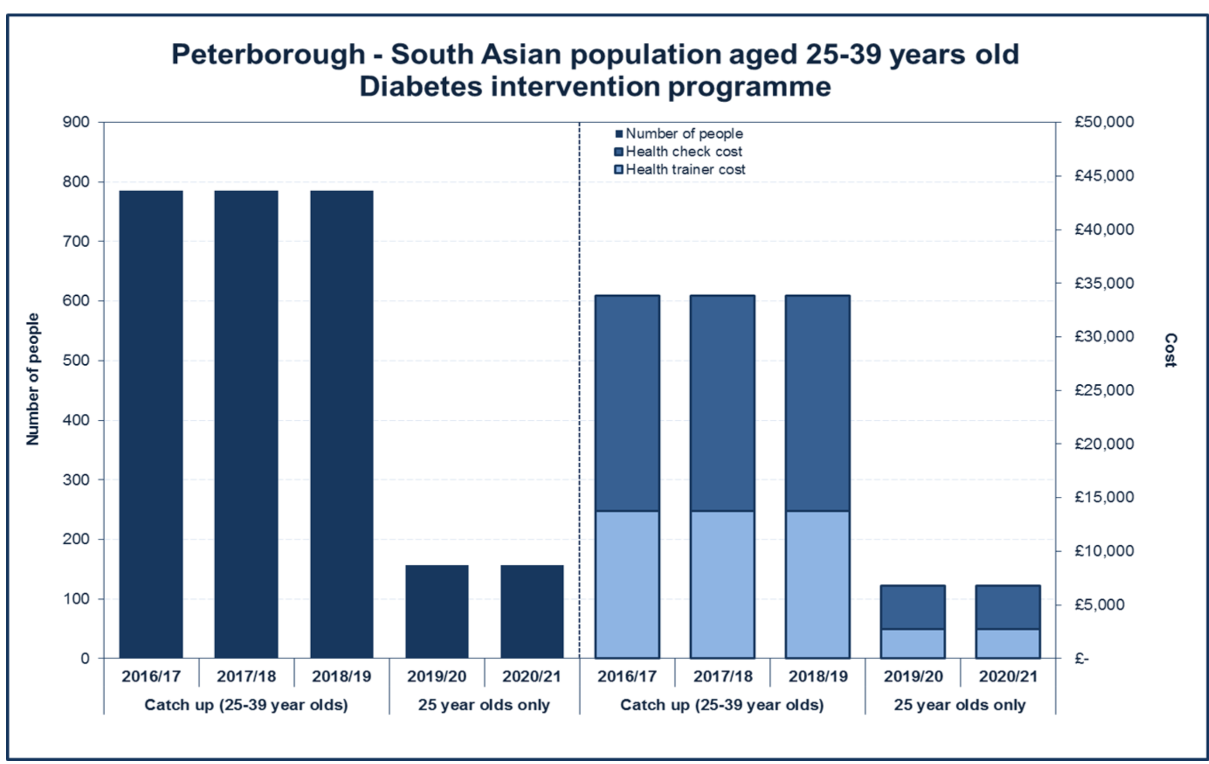
There would also need to be point of care testing available for health checks. This would cost approximately £243k over 3 years (£81k a year), based on Cambridgeshire costs, for all 25 practices.

Table 8 – costs of health checks

Peterborough	Number
South Asian population aged 25-39 years	4,854
Annual uptake of health check 2014/15	48.5%
Estimated number of health checks	2,354
Average cost of a health check	£25.60
Total cost for health checks	**£60,267**
Estimated prevalence of diabetes in South Asian population	14.0%
Estimated number of people to refer to health trainers	330
Assume 50% uptake to health trainer	165
Average cost of health trainer (caseload approx 110 people per trainer)	**£41,250**
Total cost of package	**£101,517**

The figure below shows how the 'catch up' for the 25-39 year olds in Peterborough could be spread over three years. After then the numbers drop to only those reaching the age of 25.

Figure 2 – Peterborough – South Asian population, diabetes intervention



The evidence suggests that this programme may prevent over 470 cardiac events, and 10 diabetes diagnosis, and certainly be cost saving over a lifetime.

Where should the strategic focus be?

People at high risk of developing type 2 diabetes can be identified through the NHS Health Check and the disease could be prevented in 30-60% through appropriate behaviour change support[12]. The strategic focus and recommendations in the obesity section should help prevent diabetes.

In addition, it is clear that there are long term NHS savings to be gained from screening and providing an intensive lifestyle intervention for the South Asian population aged 25-39.

Recommendations

- Health checks should be extended to those aged 25-39 years from the South Asian population in Peterborough, with the initial focus in the GP practices with the highest concentration of the South Asian population in the most deprived areas. This will cost approximately £100k over the first three years (excluding point of care testing) but will be cost saving in the long term.

[12] PHE Cardiovascular intelligence pack.

5. Cardiovascular disease

Headlines

- Current uptake for Cardiac Rehabilitation is 48.3% in line with the national average. However, there may be cost savings associated with increasing this to 65%. **[PH: Work is being undertaken to calculate the potential savings from reductions in re-admissions costs from the eligible population locally].**
- There are opportunities to improve the diagnosis and treatment of Atrial Fibrillation. This is potentially cost saving to the NHS as well as local authorities. Work should focus on increasing the numbers of patients diagnosed and treated for AF and reducing variation between GP practices. Peterborough should be the initial focus of this work. **[PH: We are developing a model to estimate local costs saved to the NHS and Social Care from improved AF diagnosis and management]**
- Modelling work finds the national interventions to reduce salt intake are cost saving at all time horizons including year one.
- Lifestyle interventions, general adult population and focused on those with diagnosed hypertension, have been shown to be potentially cost saving at 10 years and over a lifetime horizon.
- Maximising the opportunity provided in the health check to diagnose and treat hypertension, including through lifestyle interventions, should be maximised.
- A variety of lifestyle interventions for those diagnosed with hypertension should be available. This would mean an expansion to existing lifestyle services, such as health trainer/coaches. Work to target this group should focus initially on Peterborough. **[PH: we are doing some further work to try to apply the savings identified in the hypertension modelling work to the local population]**

Background

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. 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.

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 factor[13]s.

Current position

Cambridgeshire

CVD causes around 300 deaths every year in people aged under 75 in Cambridgeshire, and we estimate that 190 of these are preventable. This rate is lower than the national average, other than in Fenland.

Peterborough

Peterborough has significantly 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).

The data on prevalence shows that CVD risk factors are relatively high in the 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.

The figure below illustrates the position in Peterborough.

[13] https://www.peterborough.gov.uk/upload/www.peterborough.gov.uk/healthcare/public-health/CardiovascularDiseaseJSNASummary-October2015.pdf?inline=true)

Figure 3: 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	126.1	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	54.5	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

Interventions and cost savings to the NHS

Cardiac Rehabilitation

Key Facts

A range of NICE guidelines and quality standards recommend cardiac rehabilitation (CR) for specific cardiac conditions and treatments based on range of research evidence demonstrating the positive outcomes of CR. These include:

- a 26% relative reduction in cardiac mortality over five years
- a reduction in cardiac-related morbidity
- an improvement in functional capacity and quality of life.

Current activity

In Cambridgeshire and Peterborough in 14/15:

- 62% of the population eligible for CR are being referred appropriately

- Of in-scope and appropriate referrals, 78% started CR
- Uptake is 48.3%, similar to the uptake for England reported by NACR 2014 (46%) Around 66% of patients starting CR complete the programme in-year; this is 31% of the eligible (baseline) population.

Research has also suggested that the delivery of a comprehensive CR service has the potential to reduce unplanned cardiac readmissions by 30%. However, uptake rates remain well below this 65% nationally and locally. The indicative cost of delivering good quality CR is £498 per patient. The Department of health's 'Cardiac Rehabilitation Commissioning Pack' gives the average weighted cost of a cardiac re-admission as £3,637.

Potential cost savings

There has been national work which modelled the potential impact of increasing uptake on unplanned cardiac re-admissions [14]estimating the number and cost of emergency cardiac readmissions reduced by increasing uptake to 65%. It estimated that in the cohort of eligible patients for CR in the East of England the cost of re-admissions was approximately £37m (2009/10), and that with a 65% uptake this would fall by £11.2m. These savings are offset by the cost of this increased uptake which is estimated to be £8.2m. This suggests there is a potential net saving of approximately £3m across the East of England from a 0% uptake baseline. The table below shows the results of this modelling work.

Table 9: Modelled reduction in cardiac readmissions and associated financial savings

Table 3: Modelled reduction in cardiac readmissions and associated financial savings as a result of delivering a 'gold standard' CR service to 65% of eligible patients

Region	Cohort of patients eligible for CR	Total numeric reduction in readmissions	Readmission rate with new model	Financial savings from readmissions	Total financial savings from new service including readmission savings
East Midlands	21,710	2,626	24%	£9,549,307	£2,818,121
East of England	26,604	3,093	24%	£11,248,150	£2,999,580
London	28,412	3,769	27%	£13,706,398	£4,897,257
North East	14,304	1,863	27%	£6,776,822	£2,341,867
North West	35,546	4,595	26%	£16,711,288	£5,690,251
South Central	16,256	1,589	20%	£5,779,557	£739,384
South East	19,455	2,102	22%	£7,646,429	£1,614,406
South West	26,451	2,937	23%	£10,681,869	£2,480,736
West Midlands	25,324	3,254	26%	£11,835,162	£3,983,456
Yorkshire and the Humber	24,719	2,954	24%	£10,745,153	£3,081,027
England	238,781	28,782	24%	£104,680,135	£30,646,086

Source: Hospital Episode Statistics, the NHS Information Centre for Health and Social Care. Analysis provided by the National Cancer Services Analysis Team (NatCanSAT) www.natcansat.nhs.uk

[14] Making the Case for cardiac rehabilitation: modelling potential impact on readmissions. NHS Improvement. March 2013.

Recommendation

There should continue to be a focus on increasing the CR uptake to 65% and number of eligible people who complete a cardiac rehabilitation programme.

[PH: Work is being undertaken to calculate the potential savings from reductions in re-admissions costs from the eligible population locally].

Atrial Fibrillation

Key Facts

- Atrial fibrillation increases the risk of stroke by about 6 fold, and strokes caused by AF are often more severe with higher mortality and greater disability. Anticoagulation substantially reduces the risk of stroke in people with AF.
- Despite this, AF is underdiagnosed and undertreated. Around 25-30% of people with AF are unaware they have the condition and less than half of patients are adequately treated – many do not receive anticoagulants and of those who do, many are undertreated.
- AF is an important risk factor for stroke and is associated with about 15% of all strokes. Only 30% of people with known AF admitted with a stroke are on anticoagulant treatment at the time of their stroke.
- Atrial Fibrillation (AF) is one of the top 10 reasons for hospital admissions in the UK, and the prevalence of AF roughly doubles with each decade from age 50-59.

Current activity

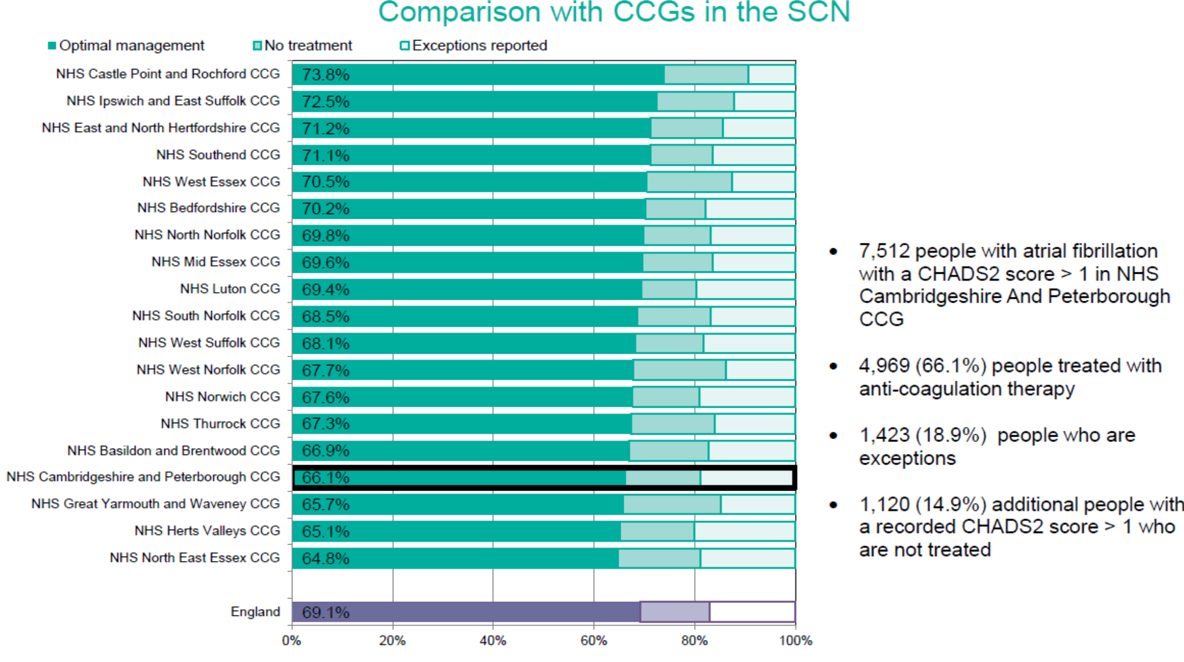
In 2013/14 there were 12,941 people diagnosed with a stroke within Cambridgeshire and Peterborough CCG, with around 7,500 people with undiagnosed atrial fibrillation, known to be one of the significant contributory factors of stroke in patients.

The diagnosed prevalence of AF in the CCG is 1.5% and the estimated prevalence is 2.3%, therefore there is some opportunity to improve diagnosis and management of AF with the expectation of reducing the incidence of stroke in our local population. The figures below benchmark the CCG against other CCGs and illustrate that:

- There are 1,120 people diagnosed with AF who appear to be untreated in Cambridgeshire and Peterborough.
- There were 147 strokes in 14/15 in people with known AF not on anticoagulation.
- The CCG appears to be a low user of GRASP-AF.

Figure 4: inpatients with AF

In patients with AF with a $CHADS_2$ > 1, the percentage treated with anti-coagulation therapy by CCG



Source: CVD Intelligence Pack. PHE March 2015

Figure 5: AF strokes in CCG

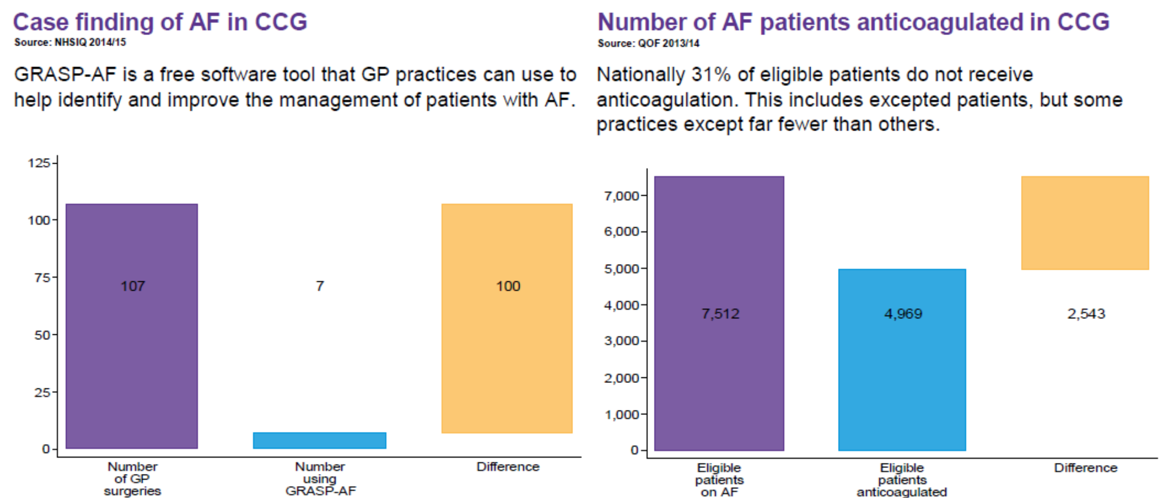
AF Strokes in CCG

Source: SSNAP 2014

AF is a major risk factor for stroke and a contributing factor to one in five strokes. Treatment with an oral anticoagulant medication (e.g. warfarin) reduces the risk of stroke in someone with AF by two thirds.

Strokes in people with known AF in 2014/15:	210
Strokes in people with known AF not on anticoagulation:	147

Figure 6: Case finding of AF



Source: AF How can we do better? Stroke Association Partnership

Potential cost savings

NHS England estimates the cost of increasing the prescription of anti-thrombotics (warfarin) by supporting GPs to identify patients with atrial fibrillation, to be £169k per 100,000 population.

Warfarin tablets are inexpensive. The main costs of anti-coagulation with warfarin relate to the cost of anti-coagulant monitoring. NICE estimates that the total cost of maintaining one patient on warfarin for one year, including monitoring, is £383. The number of patients needed to treat (NNT) for one year to prevent one stroke is approximately 37 for primary prevention and 12 for secondary prevention. NNT for one year for a mixed population comprising primary and secondary prevention patients is 25.

Based on these figures and the cost of one year's anti-coagulant therapy, the cost of preventing one stroke is estimated at £10,000 to £14,000 per annum.

The cost benefits of stroke prevention are more difficult to calculate. The management of patients following a stroke is very expensive for the NHS and Personal Social Services (PSS). The Department of Health estimate that the total costs in the first year of care for treating the 12,500 strokes in England that are attributable to AF to be £148 million. This comprises:

- £103 million of direct hospital costs
- £45 million of additional costs for care requirements post-discharge, such as district nursing, community based rehabilitation and pharmaceuticals prescribed in the community.

The National Audit Office reported in 2005 that stroke care costs the NHS about £2.8 billion a year in direct care costs. This is more than the cost of treating coronary heart disease and costs the wider economy some £1.8 billion more in lost productivity and disability. In

addition, the annual informal care costs (costs of home nursing and care borne by patient's families) are around £2.4 billion.

Based on the above figures, it is estimated that the cost of each stroke due to AF is £11,900 in the first year after stroke. These figures suggest that anti-coagulant treatment of AF is not only cost effective but that it is associated with an overall cost saving when its benefits in stroke prevention are taken into account.

More recent analysis of the acute and long-term costs of a stroke in atrial fibrillation patients (add ref) found that the costs for the three months post stroke on average were £10,413, and annual health care costs after this time were non-significantly smaller than those incurred before the event (£2400 vs. £3356). After stroke 13% of patients were newly admitted into long-term warden, nursing, or residential care, resulting in annual costs of £6880 (averaged across the 136 patients surviving past the acute period).

The work concluded that although annual post-acute phase hospital and primary health-care costs in stroke patients with prior atrial fibrillation were not significantly different to those incurred before the stroke, long-term nursing/residential care costs were substantial[15].

[PH: We are developing a model to estimate local costs saved to the NHS and Social care from improved AF diagnosis and management]

Recommendation

There are opportunities to improve the diagnosis and treatment of Atrial Fibrillation. This is potentially cost saving to the NHS as well as local authorities. Work should focus on increasing the numbers of patients diagnosed and treated for AF, and reducing variation between GP practices. Peterborough should be the initial focus of this work.

[PH: We are developing a model to estimate local costs saved to the NHS and Social care from improved AF diagnosis and management].

Hypertension

Key Facts

In England it is estimated that:

- Hypertension, or high blood pressure, affects more than 1 in 4 adults in England.

[15] Population-based study of acute- and long-term care costs after stroke in patients with AF. Luengo-Fernandez R1, Yiin GS, Gray AM, Rothwell PM. Int J Stroke. 2013 Jul;8(5):308-14.

- 5 million people have undiagnosed and untreated hypertension
- 40% of people with diagnosed hypertension receive sub-optimal treatment
- Only one in five people whose 10 year CVD risk exceeds 20% receive statins

Hypertension means that blood pressure is consistently higher than the recommended level. If it is not treated, it can lead to heart failure, and/or increases the chance of having a heart attack or stroke.

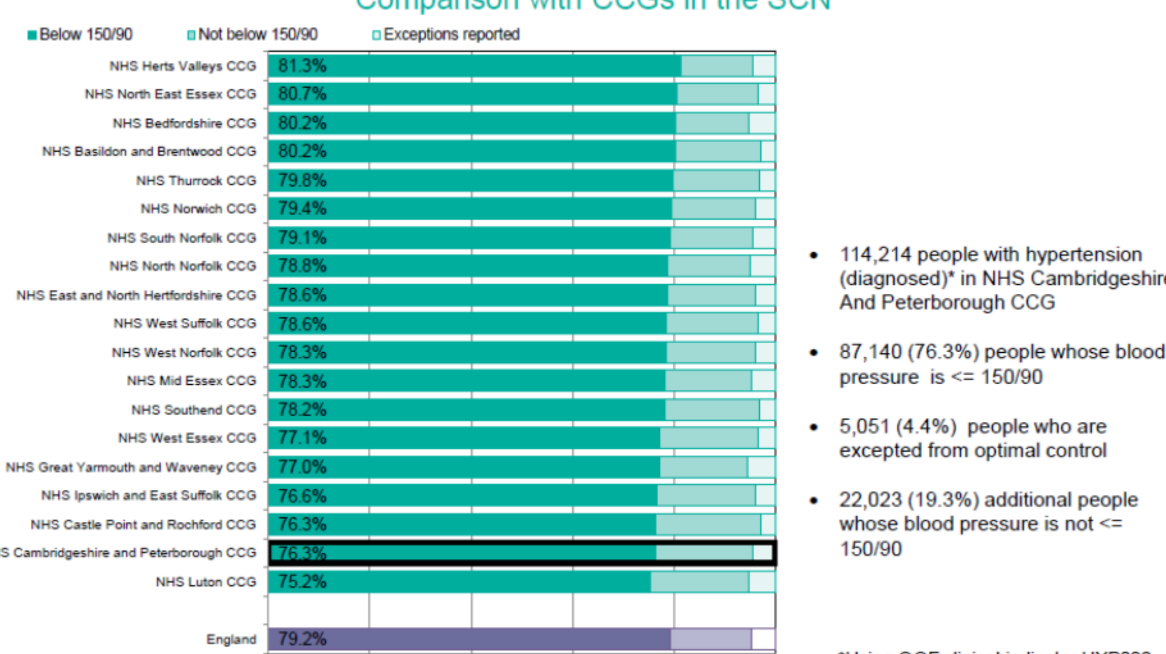
Coronary heart disease (CHD), stroke, vascular dementia (VaD) and chronic kidney disease (CKD) are the main conditions attributable to hypertension. The NHS cost burden resulting from hypertension in England is estimated to be £2.1 billion, looking at these four diseases.

Current Activity

In 2013/14 approximately 55% of people with hypertension were diagnosed in Cambridgeshire and Peterborough, compared to 56% nationally. It is estimated that there are 92,241 people with undiagnosed hypertension in NHS Cambridgeshire and Peterborough CCG. There is considerable variation in GP practice diagnosis of hypertension.

In total, including exceptions, there are 22,023 people (excluding exemptions) whose blood pressure is not <= 150/90 in Cambridgeshire and Peterborough at their latest blood pressure reading. There is a GP practice range of between 10.2% and 44.9%. If all practices were to achieve as well as the average of the best achieving practices, in terms of treating hypertension, then an additional 6,641 people would have their hypertension controlled.

Figure 7: Percentage of patients with hypertension whose last blood pressure reading is 150/90 mmHg or less by CCG



Source: Cardiovascular Intelligence pack March 2015

In 2013/14 there were 889 people with a new diagnosis of hypertension who have been given a CVD risk assessment whose CVD risk exceeds 20%. 125 of these people were not already on statins, or exempted from statins. If all practices were to achieve as well as the average of the best achieving practices, then an additional 195 people would be treated (this is above 125 as it includes exceptions).

Potential cost savings

Looking at cost effectiveness work on hypertension prevention, there is recent work which demonstrates the potential impact of lifestyle change interventions across the population and within high risk groups.

A cost-effectiveness review of blood pressure interventions (A Report to the Blood Pressure System Leadership Board), finds that models of 'lifestyle interventions' focused on support to change lifestyle behaviour (notably diet, and physical exercise), are potentially cost saving to the NHS at 10 years and over the lifetime horizon. National interventions to reduce salt in food were found to be cost saving at all time horizons, including at one year.

The cost effectiveness findings of the review are summarised below:

Based on commonly accepted thresholds of value for money for health investments, the key findings in relation to cost effectiveness are that:

- The ICERs (see below for definition) for many of the included interventions increase

substantially over longer time horizons.

- National interventions to reduce salt in food are cost saving across all time horizons, both in the general adult population and in adults diagnosed with high blood pressure.
- **In the general adult population, health lifestyle changes are potentially cost-effective at 10 years and cost saving over the lifetime time horizon.** Testing is more cost effective in GP and Pharmacy settings rather than in community settings. Education and awareness campaigns are cost effective over a lifetime time horizon.
- **In adults with diagnosed high blood pressure health, lifestyle improvement interventions become cost effective within 5 years, and potentially cost saving within 10 years.** Drug therapy adherence interventions become cost saving over a lifetime but are not cost effective in shorter time horizons. Similarly, self-management support programmes are only cost effective over the lifetime time horizon. Surprisingly primary care management programme interventions (over and above standard care) are not cost-effective at any time horizon. This appears to be due to their high cost in the studies found.
- Sensitivity analysis found that the vast majority of the ICER findings were robust when the costs and benefits were varied.

Source: Cost Effectiveness Review of Blood Pressure Interventions. A report to the Blood Pressure System Leadership Board. November 2014.Optomity Matrix.

ICER: Incremental cost effectiveness ratio - the ratio of the change in costs of a therapeutic intervention (compared to the alternative, such as doing nothing or using the best available alternative treatment) to the change in effects of the intervention.

This paper also modelled three implementation scenarios and found the following:

Implementation scenarios
Modelling of the impact of three implementation scenarios specified by the BPSLB found that in England, over 10 years:

1. A 5mmHg reduction in average population blood pressure would result in a gain of 45,000 QALYs and 140,000 life years, and a reduction of £800m in health care costs and £60m in social care costs.

2. A 15% increase in the proportion of adults who have had their high blood pressure diagnosed would result in a gain of 7,000 QALYs and 22,000 life years, and a reduction of £112m in health care costs and £11m in social care costs.

3. A 15% increase in the proportion of adults on treatment controlling their blood pressure to 140/90mmHg or less would also result in a gain of 7,000 QALYs and 22,000 life years, and a reduction of £112m in health care costs and £11m in social care costs.

The interventions to achieve health lifestyle changes found to be potentially cost saving at ten years are a mixture interventions (largely from a meta-analysis of 105 trials in 2006)

including a mixture of advice and supervised activities, related diet, physical activity, relaxation, alcohol restriction, and salt restriction.

Recommendations

- Lifestyle interventions, general population, and focused on those with diagnosed hypertension have been shown to be potentially cost saving at 10 years and over a lifetime horizon.
- Maximising the opportunity provided in the health check to diagnose and treat hypertension, including through lifestyle interventions, should be maximised.
- A variety of lifestyle interventions for those diagnosed with hypertension should be available. This would mean an expansion to existing lifestyle services, such as health trainer/coaches. Work to target this group should focus initially on Peterborough.

[PH: we are doing some further work to try to apply the savings identified in the hypertension modelling work to the local population]

Work already planned

Work to date

The CCG Tackling Health Inequalities in Coronary Heart Disease Programme Work stream priorities for 2015/16 are:

a) **Lifestyle Management** (including monitoring of the health check programme and smoking cessation programme)
b) **Primary Care interventions**. Risk reduction in CVD through BP/lipid management.
c) **Stroke Prevention** through effective management of Atrial Fibrillation.
d) **Cardiac Rehabilitation** - The Programme Board will continue to have a watching brief on this programme of work until full transfer of the data and reporting to Uniting Care from April 2016. Further work has already been identified for 15/16 on data and reporting, developing a further understanding of referral patterns, reasons for non-referral of eligible patients, up-take and non-completion of the programme also needs to be addressed across providers.

Where should the strategic focus be?

The evidence suggests that CR, AF diagnosis and management, and hypertension diagnosis, management and prevention are potentially cost saving and there is scope to improve performance locally.

Recommendations

- There should continue to be a focus on increasing the CR uptake to 65% and number of eligible people who complete a cardiac rehabilitation programme. **[PH: Work is being undertaken to calculate the potential savings from reductions in re-admissions costs from the eligible population locally].**
- There are opportunities to improve the diagnosis and treatment of Atrial Fibrillation. This is potentially cost saving to the NHS as well as local authorities. Work should focus on increasing the numbers of patients diagnosed and treated for AF and reducing variation between GP practices. Peterborough should be the initial focus of this work. **[PH: We are developing a model to estimate local costs saved to the NHS and Social Care from improved AF diagnosis and management]**
- Lifestyle interventions, general population, and focused on those with diagnosed hypertension, have been shown to be potentially cost saving at 10 years and over a lifetime horizon.
- Maximising the opportunity provided in the health check to diagnose and treat hypertension, including through lifestyle interventions should be maximised.
- A variety of lifestyle interventions for those diagnosed with hypertension should be available. This would mean an expansion to existing lifestyle services, such as health trainer/coaches. Work to target this group should focus initially on Peterborough. **[PH: we are doing some further work to try to apply the savings identified in the hypertension modelling work to the local population.]**

6. Long term conditions

Headlines

- International evidence finds that psychological interventions for long term conditions, can reduce average health care costs in the range of 20-30% across studies.
- Self-management programmes in patients with COPD have been found to reduce all cause hospitalisations by up to 40%.
- A self-management programme should be offered to those diagnosed with COPD. This should be evaluated for its economic impact on health costs.
- Routine management of LTCs should include the identification of those requiring further assessment for depression and anxiety.
- There should be maximum utilisation of the IAPT LTC team, and there should continue to be a focus on rapidly increasing referrals. There should be a focus on those with multiple long term conditions.
- There should be an economic evaluation of the impact on healthcare costs of identification and treatment for common mental health disorders in those with multiple long term conditions.

Background

Long Term Conditions

Long term conditions (LTCs) include any ongoing, long term or recurring condition requiring constant care that can have a significant impact on people's lives, limiting their quality of life[16]. Those with multiple long term conditions are at a higher risk of poor health outcomes. Recent studies have found the prevalence of multi-morbidity (the co-existence of two or more LTCs) varied from 12.9% in participants 18 years and older, to 95.1% in a population aged 65 years and older. The Department of Health estimates that those with multiple LTCs are due to rise from 1.9 million in 2008 to 2.9 million in 2018.

Long Term Conditions and Mental Health

Common mental disorders (CMD's), which include depression and anxiety, are highly prevalent with long term conditions. Evidence consistently demonstrates that people with long term physical health conditions (LTC's) are two to three times more likely to experience mental health problems than the general population, with much of the evidence relating to common mental health disorders such as anxiety and depression.
Compared with the general population, people with diabetes, hypertension and coronary artery disease have double the rate of mental health problems, and those with chronic obstructive pulmonary disease, cerebrovascular disease and other chronic conditions have

[16] CCC/C&P CCG (2015). Long Term Conditions Across the Life Course JSNA

triple the rate. People with two or more long term conditions are seven times more likely to have depression[17].

The additional impact of mental illness, which can exacerbate physical health problems, is estimated to raise the total health care costs by at least 45% for each person with a long-term condition and co-morbid mental health problem. This would result in 12-18% of all NHS expenditure on long-term conditions being linked to poor mental health (£8-13 billion each year[18]).

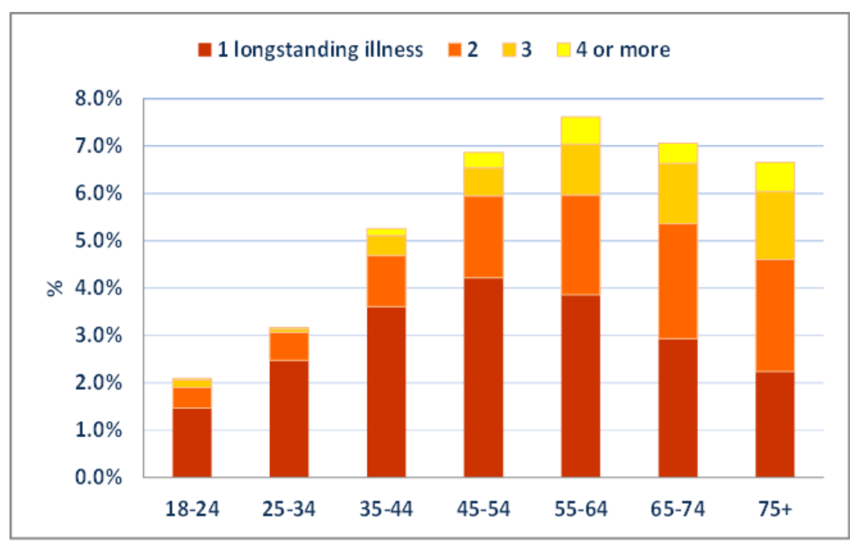
Current position

Local context

Long Term Conditions

Based on national prevalence data applied to the CCG population, 108,700 (18.8%) 18-64 year olds are living with one longstanding illness, a further 56,800 (9.8%) are thought to be living with two or more[19]. Long term conditions are more prevalent in older age groups, and Figure 8 shows the proportion of people with 1 or multiple longstanding illnesses by age group. The proportion of people living with more than one longstanding illness rises with increasing age.

Figure 8: The proportion of people with one, two, three or four or more longstanding illnesses by age group, Health Survey for England (2012)



Source: Health Survey for England (2012)

[17] The King's Fund. (2012) Long-term conditions and mental health: The cost of co-morbidities.
[18] The King's Fund. (2012) Long-term conditions and mental health: The cost of co-morbidities.
[19] Health Survey for England (2012) estimates applied to registered population. FHS Registration System (Exeter) April 2015.

Long Term Conditions and mental health

Those with LTCs are at a higher risk of developing a mental illness; Table 10 shows the proportion of the CCG population aged 18-64 years that have multiple longstanding illnesses with and without limitation and/or mental ill health. 3.4% (1,900 people) are estimated to have two or more LTCs and mental ill health, whereas 28.4% (16,100 people) are thought to have two or more LTCs, mental ill health and limitation.

Table 10: Proportion of people aged 18-64 years with multiple (two or more) long standing illnesses with and without limitation and/or mental ill health (based on GHQ-12 score of four or more)

People aged 18-64 years with 2+ LTC	%	95% CI	Estimate of number of people in C&PCCG aged 18-64 years (2015) and range (95% CI)	
Two or more LTCs only	30.7	(26.7 - 34.9)	17,400	(15,200 - 19,800)
Two or more LTCs, mental ill health only	3.4	(2.1 - 5.3)	1,900	(1,200 - 3,000)
Two or more LTCs, limitation	37.6	(33.4 - 42.0)	21,300	(19,000 - 23,800)
Two or more LTCs, limitation + mental ill health	28.4	(24.6 - 32.5)	16,100	(1,400 - 18,400)
Total	100		56,700	

Source: Health Survey for England (2012) estimates applied to registered population. FHS Registration System (Exeter) April 2015.

Figure 9 shows data from a local study for over 65s with two or more LTCs. The data suggests that there are around 38,600 people aged 65 and over with two or more LTCs and limitation, an additional 3,600 people with mental ill health and an additional 6,900 with multiple LTCs, limitation and mental ill health (dementia, anxiety and depression). In total, it is estimated that 65,800 people aged 65 and over in C&P CCG have two or more LTCs.

Figure 9: Proportion of people aged 65 and over with multiple (two or more) LTCs with and without limitation and/or depression or anxiety (based on GMS AGECAT)

Source: MRC Cognitive Function and Ageing Study (CFAS II) (100% = people with two or more LTCs)

Overall this means that locally there are an estimated 18,000 adults with two or more long term conditions with mental ill health and/or limitation, and a further 10,500 people aged 65 and over in these groups. Prevalence of common mental health disorders is 16% in the adult population, and 10.6% in those aged 65-75 years[20]. Even at the population level of risk 3,993 people (2,880 adults and 1,113 older people) amongst this group will have common mental health disorder. Given that the risk of common mental health disorders in this group is a minimum of two of three times higher than the general population, these figures are likely to be much higher than this estimate.

Interventions and cost savings to NHS

Self-Management for Long Term Conditions

There are substantial costs associated with long-term conditions that will vary depending on the setting and condition, for example the total annual cost of COPD to the NHS is over £800 million[21]. COPD is the second most common cause of emergency admissions to hospital and one of the most costly inpatient conditions to be treated by the NHS[22]. Asthma is also responsible for large numbers of attendances to Emergency Departments, and admissions,

[20] Psychiatric Morbidity Survey 2010.
[21] NHS Medical Directorate (2012). COPD Commissioning Toolkit A Resource for Commissioners.
[22] Department of Health (2011) An Outcomes Strategy for Chronic Obstructive Pulmonary Disease (COPD) and Asthma in England.

the majority of which are emergency admissions, and 70% of which may have been preventable with appropriate early interventions[23].
An evidence review was carried out as part of the Long Term Conditions JSNA to consider self-management support interventions, particularly exploring which self-management support interventions may improve health outcomes for those with multiple conditions[24]. The review highlighted that evidence for significant reductions in utilisation following self-management support interventions was strongest for respiratory disorders and cardiovascular disorders. The evidence surrounding cost savings was more limited.

Chronic Obstructive Pulmonary Disease (COPD)
Locally, self-management programmes for COPD have been run as part of a Health Foundation funded programme. The evaluation does not provide detail on the cost-effectiveness or cost savings of this work, and indicates that this is an area for further work. A Cochrane review has, however, shown that self-management programmes in patients with COPD are associated with improved health-related quality of life and a reduction in respiratory-related and all cause hospital admissions[25]. They looked at a range of self-management programmes in this work. Respiratory-related hospital admissions were 43% less likely in the intervention compared to control groups, and all cause hospitalisations were 40% less likely. Since this Cochrane review, several studies have been published regarding the contents of self-management interventions for patients with COPD, it is now thought education alone is not sufficient to achieve behaviour change[26].
The use of psychological interventions for those with COPD is being utilised in some areas of the UK. Data from unpublished work shows a respiratory wellbeing clinic in the London Borough of Sutton and Merton using cognitive behavioural therapy, psycho-education and physical health promotion for people with COPD. The service has reported a reduction in depression and anxiety symptoms, improved quality of life and better management of the condition. Cost savings have also been reported that, if applied to high-cost users, could save £5 for every £1 invested in the clinic[27]. This data is not from a published study, therefore should be interpreted with caution.

COPD is costly to the local health care system; around 14,400 people (aged 40 and over) are recorded on disease registers for COPD in general practices across the CCG[28]. Within the CCG, of the 1,660 hospital episodes where COPD was the primary diagnosis, 1,480 (89%) were emergency admissions. Emergency admissions with COPD as primary diagnosis

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[23] An Outcomes Strategy for COPD and Asthma in England (2011)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216139/dh_128428.pdf
[24] CCC/C&P CCG (2015). Long Term Conditions Across the Life Course JSNA.
[25] The Cochrane Collaboration (2014) Self management for patients with chronic obstructive pulmonary disease (Review).
[26] The Cochrane Collaboration (2014) Self management for patients with chronic obstructive pulmonary disease (Review).
[27] Mental Health Network NHS Confederation (2012). Long-term health gains. Briefing Issue 237.
[28] Quality and Outcomes Framework (2013/14).

resulted in 9,150 bed days and a cost of £3.6m in 2013/14, and 52% of emergency admissions occur in people aged under 75 years.

This suggests there may be a potential reduction in healthcare costs of up to £1.4m by introducing self-management interventions in patients with COPD. The NHS savings would depend on the cost of the intervention put in place.

Asthma
Studies have shown that education or self-management programmes can have a significant impact on hospital admissions for adults with asthma in particular. However, not all studies of self-management demonstrate reduced hospital or A&E department use, and it is as yet unclear as to what the key elements of a self-management intervention for Asthma are.

Diabetes
DAFNE and DESMOND are structured education programmes for diabetic management. There is some evidence to suggest that DAFNE may be cost effective and cost saving for type 1 diabetes mellitus, although the evidence is limited and not sufficiently robust to model for the local population.

Psychological Interventions for those with Long Term Conditions
Those with long term conditions are known to be at higher risk of developing a mental illness which contributes to greater costs to the health service. Poor mental health, in the presence of a long term physical health condition, is associated with an approximate 45% increase in service usage costs to the NHS[29]. In terms of type 2 diabetes, £1.8 billion of the cost can be attributed to poor psychological health. Mental health co-morbidity increases physical costs by 50% per diabetes patient.
Robust UK evidence establishing cost savings for psychological interventions and screening for those with long term conditions is not available. However, on the basis of studies undertaken outside of the UK it is evident that savings sufficient to cover the cost of the intervention are likely. From a large US meta-analytical study of psychological interventions for long term conditions, average health care cost savings were found to be in the range of 20-30% across studies[30]. Psychological interventions ranged from psycho-education treatments to those categorised as behavioural medicine interventions. Only a small proportion of studies reported that the costs of psychological treatment exceeded the cost savings. Most of the psychological interventions lead to reductions in health care costs, and these reductions were typically large enough to fully cover the costs of the psychological interventions themselves.

[29] The King’s Fund. (2012) Long-term conditions and mental health: The cost of co-morbidities.
[30] Chiles et al. (1999) The Impact of Psychological Interventions on Medical Cost Offset: A Meta-analytic Review. American Psychological Association.

A recent local review of the evidence base for the inclusion of mental health interventions in the management of long term physical health conditions (LTC) recommended that:

- The routine clinical management of long term health conditions should include the successful identification of those requiring individual assessment for depression /anxiety. NICE recommend the use of depression identification questions for this purpose and these should be incorporated into the initial patient assessment within pathways of care for long term health conditions.
- Across most of the conditions, evidence supports the beneficial role of psychological interventions, but is inconclusive in determining the most effective intervention for a specified patient group.
- It is recommended that NICE guidance be applied, offering a choice of psychological intervention dependent on patient preference and assessed severity of depression /anxiety.
- Access to commissioned psychological interventions directly from care pathways for long term health conditions should be reviewed to ensure that direct and timely access is available.
- Pulmonary Rehabilitation has been shown as an effective management strategy to improve symptoms of depression/anxiety in those with Chronic Obstructive Pulmonary Disease (COPD). Evidence would support a recommendation that patients diagnosed with COPD should have un-delayed access to a programme of Pulmonary Rehabilitation.
- The use of a multicomponent cardiac rehabilitation programme for those patients with heart failure and post myocardial infarction will improve quality of life. Evidence supports the inclusion of exercise and psychological interventions to improve outcomes for depression and anxiety.

A full list of the review findings are attached at Appendix B.

Work already planned

Current Public Health spend and activity

There is no direct Public Health spend on self-management of long-term conditions or mental health interventions for those specifically with LTCs, however, there is a range of assets available to support self-management, as identified in more detail in the Long Term Conditions JSNA[31]. The CCG also commission an IAPT Long Term Conditions Team.

Self-Management for Long Term Conditions

There are a range of assets available for supporting self-management in Cambridgeshire including, but not limited to:

[31] CCC/C&P CCG (2015). Long Term Conditions Across the Life Course JSNA. Section 8.4.

- Support groups for specific conditions in the county and regionally e.g. Breathe Easy and Diabetes groups. These groups operate in different ways and provide many different arrays of support.
- A strong and active voluntary and community sector that provide social and practical support in multiple forms.

IAPT Long Term Conditions Team

Since February 2014, Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) 'Increasing Access to Psychological Therapies' (IAPT) service has included the IAPT Long Term (physical health) conditions team to offer specialist input. The IAPT LTC team includes three high intensity CBT therapists and three psychological wellbeing practitioners, working to address psychological needs in patients with LTCs.

Early service data shows in total, 690 IAPT patients had an LTC recorded against their case from April to October 2014. Of the 690 patients, 575 were seen by CPFT Adult IAPT and 197 were seen specifically by the specialist LTCs team in IAPT.

Where should the strategic focus be?

The evidence suggests that there is a high level of common mental health disorders amongst those with long term conditions, and particularly those with multiple long term conditions.

The evidence to date, which is largely non-UK evidence, finds that psychological interventions can reduce healthcare costs by 20-30%. There is good evidence that rehabilitation programmes such as cardiac rehabilitation and pulmonary rehabilitation which include psychological and physical exercise components can be cost saving.

Where a common mental health disorder is identified treatment as usual, through psychological therapies, such as IAPT, and drug treatment should be maximised.

Recommendations

- A self-management programme should be offered to those diagnosed with COPD, this should include psychological interventions and a clear pathway to IAPT. This should be evaluated for its economic impact on health costs.
- Routine management of LTCs should include the identification of those requiring further assessment for depression and anxiety.
- There should be maximum utilisation of the IAPT LTC team, and there should continue to be a focus on rapidly increasing referrals. There should be a focus on those with multiple long term conditions.

- There should be an economic evaluation of the impact on healthcare costs of identification and treatment for common mental health disorders in those with multiple long term conditions.

7. Workplace health

Headlines

- The potential mental health productivity savings, assuming no current action in this area, amount to nearly £5.7 across the large NHS employers in Cambridgeshire and Peterborough.
- The evidence and modelling is clear that investing in workforce health will generate short term productivity savings to the NHS. These are estimated, with the package modelled here to be approximately £3.9m over three years, with an investment of £335k.
- NHS employers should see considerable productivity savings from investing in workplace health. In particular this needs to focus on improve management and awareness of mental health and illness.

Background

Workplace health is a significant public health issue. Every year more than a million working people in the UK experience a work-related illness. This leads to around 27 million lost working days, costing the economy an estimate £13.4 billion. Estimates from Public Health England put the cost to the NHS of staff absence due to poor health at £2.4bn a year – accounting for around £1 in every £40 of the total budget. This figure is before the cost of agency staff to fill in gaps, as well as the cost of treatment, is taken into account.

There are a number of large NHS employers in Cambridgeshire and Peterborough:

- Cambridge University Hospitals NHS Foundation Trust
- Peterborough and Stamford Hospitals Trust
- Cambridgeshire and Peterborough NHS Foundation Trust
- Cambridgeshire Community Services NHS Trust
- Papworth Hospital
- Hinchingbrooke Health Care NHS Trust

As of June 2015, in total these organisations employed 22,738 people[32].

There is a high level of evidence that workplace initiatives can improve people's health and wellbeing, and deliver cost savings. NICE has developed and issued a series of guidance documents on workplace health and in September 2015, Simon Stevens, Chief Executive of NHS England announced the launch of a programme to improve the health of the NHS workforce.

[32] Health and Social Care Information Centre - http://www.hscic.gov.uk/

"Health-promoting workplaces are obviously good for millions of employees and ultimately for taxpayers too, so the time is right for all employers – including the NHS – to raise our game."

Simon Stevens, Chief Executive of NHS England

Current position

The table below shows the number of people employed in each of the main NHS employers in Cambridgeshire and Peterborough, as of June 2015.

Table 11 – Headcount of NHS employees by NHS organisation, as of June 2015

NHS employer	Abbreviation	Headcount as of June 2015
Cambridge University Hospitals NHS Foundation Trust	CUHFT	9,509
Peterborough and Stamford Hospitals Trust	PSHFT	4,021
Cambridgeshire and Peterborough NHS Foundation Trust	CPFT	3,665
Cambridgeshire Community Services NHS Trust	CCS	1,955
Papworth Hospital	Papworth	1,899
Hinchingbrooke Health Care NHS Trust	Hinchinbrooke	1,689
TOTAL	-	22,738

Source: Health and Social Care Information Centre

Table 12 shows the average absence rate by organisation, as well as the estimated prevalence rates for smoking, excess weight, obesity, physical inactivity, alcohol, not eating five a day and mental illness.

Table 12: average absence rate by organisation, with estimated prevalence

Trust	Headcount	Absence % Average 12 months (Jun14 - May 15)	Estimated number						
			Smoking	Excess weight	Obese	Inactive	Higher risk drinking	Estimated not eating 5 a day (CCG level)	Mental Illness
CUHFT	9,509	3.0%	1,284	6,181	2,054	2,339	2,273	6,514	1,540
CPFT	3,665	4.5%	556	2,386	813	957	851	2,511	594
Hinchingbrooke	1,689	3.8%	256	1,100	375	441	392	1,157	274
PSHFT	4,021	3.9%	836	2,634	969	1,255	844	2,754	651
CCS	1,955	4.7%	297	1,273	434	511	454	1,339	317
Papworth	1,899	3.6%	288	1,237	421	496	441	1,301	308
Total	22,738		3,518	14,810	5,065	5,999	5,256	15,576	3,684

Interventions and cost savings to NHS

Mental health interventions

There is strong evidence that mental health interventions in the workplace can improve people's wellbeing and there is potential to deliver cost savings.

The NICE business case tool for promoting mental wellbeing at work estimated that mental ill health costs UK employers almost £1 million per year. For an organisation with 1000 employees, the annual cost of mental ill health was estimated to be more than £835,000. Identifying problems early – or preventing them in the first place, could result in cost savings, largely as a result of reduced absenteeism, of 30%. This is equivalent to cost savings of more than £250,000 per year.

Knapp (2011)[33] looked at a workplace-based enhanced depression care intervention consisting of the completion by employees of a screening questionnaire, followed by care management for those found to be suffering from, or at risk of developing depression and/or anxiety disorders. Using a model based on a white collar organisation of 500 employees, this found that in year 2 there is a cost saving of £63,578. This figure incorporates health and social care costs, absenteeism and presenteeism, and productivity losses.

Weight management and physical activity

In 2010, 26% of adults in England were obese. On average, obese people take 4 extra sick days per year[34]. In an organisation of 1000 employees who work the national average week of 39.1 hours[35] and are paid the national average hourly wage of £15.52[36], this equates to more than £126,000 a year in lost productivity.

Physical activity counselling and activity programmes are modelled in two ways: disease-specific cost effective evidence, and cost savings are based on the absenteeism model. York Health Economics has identified a study that modelled a 20% to 25% level of improvement in physical activity as cost saving for the employer at 1 year (absenteeism only)[37].

Smoking

NICE advice suggests reducing levels of smoking among workers will help reduce cardiorespiratory diseases, which is one of the largest causes of sickness absence. Some evidence suggests that, on average, a person who smokes will have 33 more hours off sick per year than a non-smoker[38]. For an organisation of 1000, in which 25% smoke and are

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[33] Knapp, 2011: Mental health promotion and mental illness prevention: The economic case. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215626/dh_126386.pdf
[34] Obesity and sickness absence: results from the CHAP study.
[35] 2011 annual survey of hours and earnings.
[36] NICE business case tool for workplace interventions to promote smoking cessation.
[37] An Economic Analysis of Workplace Interventions that Promote Physical Activity, 2008 - https://www.nice.org.uk/guidance/ph13/evidence/economic-modelling-report-369939277
[38] NICE business case tool for workplace interventions to promote smoking cessation.

paid the national average hourly wage of £15.52, this absence equates to a loss of more than £128,000 a year.

There is a high quality, high ranking evidence that stop smoking services are cost effective, good value for money and have a good return on investment.

Figure 10 below, produced by the Work Foundation in 2014, illustrates the outputs and outcomes of broad interventions such as lifestyle change and line manager awareness of mental health.

Figure 10 – Change diagram illustrating outputs and outcomes of interventions to improve line manager awareness and lifestyle change programmes

Activities (interventions)	Outputs (improvements in health and wellbeing)	Outcomes (improvements in business KPIs	Impact (financial and increased productivity)
Line manager awareness - Training of managers - Implementing new management practices	Stronger awareness of issues amongst line managers resulting in better support for staff and a stronger ability to adapt role. This includes changes in job demands, deadlines etc. Resulting in: - Higher levels of staff satisfaction / engagement - Lower levels of psychological distress - Improved health	- Reduced staff absence - Lower staff turnover - Improved productivity of workers - Reduced presenteeism	

Activities (interventions	Outputs (improvements in health and wellbeing)	Outcomes (improvements in business KPIs)	Impact (financial and increased productivity)
Lifestyle change interventions - Costs depend on specific initiatives, schemes or changes in choice architecture	Depending on interventions can result in staff with more / better: - Energy and viability - Hydration - Sleep - Concentration	Interventions target long-term health rather than particular workplace-relevant health conditions. We would therefore expect direct health effects on staff absence, turnover and productivity to be lower. However, indirect effects through increased job satisfaction may be high.	→

Current public health spend and activity

In Cambridgeshire, annual public health spend on general workplace health in the population is £45,000.

Peterborough carried over a small reserve, £90,000 of which is committed in principle for a workplace health programme over the next two years.

Interventions and cost savings to the NHS

Information in this section sets out the costs and potential savings for potential interventions in the workplace. It should be noted, however that the savings figures presented in this section are based on the assumption that organisations do not currently deliver preventative interventions. This may not be the case, as it is possible organisations already invest in similar initiatives via occupational health departments. The information presented below also does not take into account the potential impact of increasing stress levels in the workplace. **All the figures below are provisional.**

Table 13 shows the estimated productivity loss for mental ill health, obesity and smoking to each of the main local NHS employers and, the potential savings related to mental health. It is only possible to calculate these robustly for mental health. Broad potential savings are given for smoking and obesity above. The potential mental health productivity savings,

assuming no current action in this area, amount to nearly £5.7 across the large NHS employers in Cambridgeshire and Peterborough.

Table 13: estimated productivity loss for mental ill health, obesity and smoking

Productivity costs	Costs / Loss of productivity			Potential savings
	Mental Ill Health	Obesity	Smoking	Mental Ill Health
CUHFT	£7,940,015	£995,373	£657,262	£2,382,005
CPFT	£3,060,275	£383,641	£253,325	£918,083
Hinchingbrooke	£1,410,315	£176,799	£116,744	£423,095
PSHFT	£3,357,535	£420,906	£277,932	£1,007,261
CCS	£1,632,425	£204,643	£135,130	£489,728
Papworth	£1,585,665	£198,781	£131,259	£475,700
Total	£18,986,230	£2,380,144	£1,571,651	£5,695,869

Mental health

Based on our local experience, and the evidence base, we have put together a suggested mental health intervention package. The package would include:

- Mental Health First Aid Lite Training (a cost of £450 per 25 people). This is an evidence based package that raises awareness of mental health and illness.
- Health Champions (training costs £1000 per day for 20 people). A Health Champion is a volunteer who acts as a point of contact and health promoter within the organisation. They are trained to have a basic understanding of the principles of health and wellbeing and how best to promote them with their colleagues. There would also be a health champions' peer support network.
- ACAS training for managers. This is to enable managers to support people with a long term condition (including mental health) to make a successful return to work and manage their condition within their working lives. Training costs £1000 per day for 12 people and the figures below are based on 25 people being trained for every 500 employees.

Physical activity

The package also includes physical activity interventions. Physical activity has been shown to improve productivity and the savings from a programme to increase physical activity by 10% in the inactive are estimated below. This assumes there are no current interventions in place to address this inactive proportion.

The ROI tool classes a brief intervention as 'verbal advice, discussion, negotiation or encouragement with or without written or other support or follow up. It could be opportunistic and can take between 1-20 minutes'.

Table 14: Estimated savings from a programme to increase physical activity by 10% in the inactive

			Productivity savings			Net productivity savings		
Trust	Number of targetted people	Cost (@ £9.92 per person)	2 year	5 year	10 year	2 year	5 year	10 year
CUHFT	234	£2,321	£31,496	£76,693	£137,002	£29,175	£74,372	£134,681
CPFT	96	£950	£12,140	£28,789	£52,804	£11,190	£27,839	£51,854
Hinchingbrooke	44	£438	£5,595	£13,267	£24,335	£5,157	£12,829	£23,897
PSHFT	125	£1,245	£13,319	£31,585	£57,933	£12,074	£30,340	£56,688
CCS	51	£507	£6,476	£15,357	£28,167	£5,969	£14,850	£27,660
Papworth	50	£492	£6,290	£14,917	£27,360	£5,798	£14,424	£26,868
Total	600	£5,951	£75,314	£178,608	£327,599	£69,363	£172,657	£321,648

Weight management

The table below estimates the number of obese people in each organisation. It makes a number of assumptions about the proportion who might wish to attend weight management services. The costs here reflect a combination of group weight management as well as one to one health trainer costs.

Table 15: Estimated number of obese people in each organisation

Trust	Estimated number of obese people	Estimated cost of weight management Tier 1-2 service
CUHFT	2054	£41,079
CPFT	813	£16,254
Hinchingbrooke	375	£7,491
PSHFT	969	£19,381
CCS	434	£8,670
Papworth	421	£8,422
Total	5065	£101,298

The table below provides a summary of the costs and savings to the NHS of implementing a workforce health programme.

There are a number of key assumptions behind this table:

- That there is no current activity in these areas.
- That savings are spread over three years with 20% of savings in year 1, and remaining savings split between years 2 and 3.
- That physical activity is increased by 10% in the inactive.

Table 16: summary costs/savings of workforce health programme

NHS Trust	Training	Investment				Net NHS savings based on Mental Health savings and productivity savings from increased physical activity			
		2016/17	2017/18	2018/19	Total	2016/17	2017/18	2018/19	Total
Cambridge United Foundation Trust	Mental Health First Aid Lite	£11,411	£11,411	£11,411	£34,232	£115,483	£762,354	£762,354	£1,640,192
	Health champions	£7,924	£7,924	£7,924	£23,773				
	ACAS	£13,207	£13,207	£13,207	£39,621				
	Weight management	£13,693	£13,693	£13,693	£41,079				
	Total cost	£46,235	£46,235	£46,235	£138,705				
Cambridgeshire and Peterborough Foundation Trust	Mental Health First Aid Lite	£4,398	£4,398	£4,398	£13,194	£44,364	£311,622	£311,622	£667,609
	Health champions	£3,054	£3,054	£3,054	£9,163				
	ACAS	£5,090	£5,090	£5,090	£15,271				
	Weight management	£5,418	£5,418	£5,418	£16,254				
	Total cost	£17,961	£17,961	£17,961	£53,882				
Hinchingbrooke	Mental Health First Aid Lite	£2,027	£2,027	£2,027	£6,080	£20,445	£143,610	£143,610	£307,665
	Health champions	£1,408	£1,408	£1,408	£4,223				
	ACAS	£2,346	£2,346	£2,346	£7,038				
	Weight management	£2,497	£2,497	£2,497	£7,491				
	Total cost	£8,277	£8,277	£8,277	£24,831				
Peterborough and Stamford Foundation Trust	Mental Health First Aid Lite	£4,825	£4,825	£4,825	£14,476	£48,137	£341,790	£341,790	£731,718
	Health champions	£3,351	£3,351	£3,351	£10,053				
	ACAS	£5,585	£5,585	£5,585	£16,754				
	Weight management	£6,460	£6,460	£6,460	£19,381				
	Total cost	£20,221	£20,221	£20,221	£60,663				
Cambridgeshire Community Services	Mental Health First Aid Lite	£2,346	£2,346	£2,346	£7,038	£23,665	£166,227	£166,227	£356,119
	Health champions	£1,629	£1,629	£1,629	£4,888				
	ACAS	£2,715	£2,715	£2,715	£8,146				
	Weight management	£2,890	£2,890	£2,890	£8,670				
	Total cost	£9,581	£9,581	£9,581	£28,742				
Papworth	Mental Health First Aid Lite	£2,279	£2,279	£2,279	£6,836	£22,987	£161,465	£161,465	£345,918
	Health champions	£1,583	£1,583	£1,583	£4,748				
	ACAS	£2,638	£2,638	£2,638	£7,913				
	Weight management	£2,807	£2,807	£2,807	£8,422				
	Total cost	£9,306	£9,306	£9,306	£27,918				
Total	Mental Health First Aid Lite	£27,286	£27,286	£27,286	£81,857	£163,500	£1,887,070	£1,887,070	£3,937,640
	Health champions	£18,948	£18,948	£18,948	£56,845				
	ACAS	£31,581	£31,581	£31,581	£94,742				
	Weight management	£33,766	£33,766	£33,766	£101,298				
	Total cost	£111,580	£111,580	£111,580	£334,741				

Work already planned

The Cambridgeshire and Peterborough Public Health Reference Group has already identified workplace interventions as a priority area, with a number of projects and programmes outlined in the group's action plan for the next six months, which is currently being refined.

The plan includes the offer of a package of interventions as part of a Workplace Programme for Local Authorities over two years. It will include policy development, leadership and capacity development, direct provision, and network facilitation. Although the programme will promote diet and physical activity it will also offer obesity, mental health, smoking and alcohol related initiatives as part of an holistic workplace programme. It will also include the development of individual workplace champions and a peer support network. This is also the type of model which is we have used to estimate costs here.

The package of interventions suggested by the Public Health Reference Group is broadly in line with those outlined in the NHS England workplace programme.

Where should the strategic focus be?

The evidence and modelling is clear that investing in workforce health will generate short term productivity savings to the NHS. These are estimated, with the package modelled here to be approximately £3.9m over three years.

Recommendations

- NHS employers should see considerable productivity savings from investing in workplace health. In particular this needs to focus on improve management and awareness of mental health and illness.

8. Smoking

Headlines

- There are an estimated 105,548 people across Cambridgeshire and Peterborough who smoke. There is a high quality, high ranking evidence that stop smoking services are cost effective, are good value for money and provide a good return on investment.
- Sub-national programme work, such as tobacco control, is critical to ensuring savings to the NHS. Nationally and locally we should continue to invest in this.
- We should maximise our prevention opportunities and increase the number of people setting a quit date through stop smoking services (adults, older people and pregnant women) in Cambridgeshire by 5%, and in Peterborough to the Cambridgeshire average.
- An additional investment of £346k, only £175k of which is new investment, is needed to generate a saving over £356k over the next two years.
- There are additional savings to the NHS to be made from stopping people smoking before operations, and this group should be a target population.

Background

Smoking is still one of the most important causes of preventable ill health and early death in the UK. A recent study found that in the UK out of 40% of the potentially preventable NHS workload, 10% was attributable to smoking. This was the highest contributing factor along with sub-optimal diet[39]. Additionally we know that high numbers of hospital admissions are caused by smoking related conditions.

Local context

In Cambridgeshire, around 16% of adults are estimated to smoke. Although this is below the national average of 18%, it represents around 79,000 smokers across the county. There are approximately 27,000 smokers in Peterborough.

The prevalence of smoking in Cambridgeshire has fallen, as it has nationally. Rates are consistently higher though in Fenland, compared to the other districts, and up until 2012 were increasing, although more recent data suggests a fall in 2013 and 2014.

Smoking is more common among people working in routine or manual professions. 27% of these workers are estimated to smoke in the county, similar to the national average of 29%.

[39] PHE Lancet Changes in health in England, with analysis by English regions and areas of deprivation, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013. September 15, 2015 http://dx.doi.org/10.1016/S0140-6736(15)00195-6

Data suggests smoking rates have been higher in this group in Fenland and East Cambridgeshire. In Peterborough, 35% of routine and manual workers smoke.

Data from GP practices across the county also show us that smoking prevalence is strongly linked to levels of deprivation. Practices serving more deprived areas, regardless of district, tend to have higher rates 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.

Smoking is a major risk factor for many diseases, such as lung cancer and many other cancers, chronic obstructive pulmonary disease and heart disease. Over 200 people in Peterborough die due to smoking every year, including 45 people from lung cancer.

Current position

What is the scale of the problem?

The data in table 17 shows the estimated prevalence of smoking amongst adults (aged 18 years and above) in Cambridgeshire and Peterborough between 2010 and 2014, compared to the average for England.

The red, amber and green status indicates whether local prevalence is statistically significantly higher, similar or lower than the average for England.

Table 17 – Estimated smoking prevalence in Cambridgeshire and Peterborough

Year	ENGLAND	CAMBRIDGESHIRE		PETERBOROUGH	
	Estimated prevalence	Estimated prevalence	95% CI	Estimated prevalence	95% CI
2010	20.8	19.0	17.4 to 20.6	25.2	23.0 to 27.4
2011	20.2	19.2	17.3 to 21.0	24.3	22.0 to 26.7
2012	19.5	17.9	15.8 to 19.9	21.1	18.7 to 23.4
2013	18.4	13.5	11.7 to 15.3	20.8	18.6 to 23.1
2014	18.0	15.5	13.5 to 17.4	18.6	16.4 to 20.8

Source: Public Health England Public Health Outcomes Framework (using data from the Integrated Household Survey)

Statistical significance compared with the England average:

- Lower
- Similar
- Higher

CI = confidence interval: a range of values so defined that there is a specified probability that the value of a parameter lies within it.

For 2014, these prevalence rates equate to the following estimated numbers of smokers of:

- Cambridgeshire - 78,791
- Peterborough - 26,757

There are high smoking in pregnancy rates in Peterborough. In 2014, the most recent data showed that 18% of mothers were smokers at the time of delivery in Peterborough compared to 13% in Cambridgeshire and in England as a whole[40].

A local survey undertaken by over 8,500 Year 8 and Year 10 pupils in Cambridgeshire every two years found that in 2014, 1% of Year 8 and 7% of Year 10 pupils reported that they smoked regularly, with around half wishing to give up. Prevalence is higher in girls than boys, in children in care and in children in single parent families. One out of ten young people in Peterborough are regular smokers by the age of 15, and two out of three smokers began smoking before they were 18.

The proportion of Year 10 children in Cambridgeshire who reported never having smoked, however, has increased from 54% in 2008 to 65% in 2014 and positive trends are seen across the districts.

Future smoking prevalence

It is difficult to predict the future behaviour of smokers given new innovations such as e-cigarettes and their unknown effect on smoking behaviours. The current trend nationally is a reduction in smoking prevalence; however the pace of this reduction is likely to slow as the smoking population contracts to include mostly determined smokers. GP practices and community pharmacies report continued difficulty with recruiting smokers to make quit attempts.

We have seen a fall, which is reflected nationally, in the number of people setting a four week quit date, and the number of four week quitters. There were 1,805 less four week quitters in 2014/15 compared to 2012/13 across Cambridgeshire and Peterborough. The number setting a quit date in 2014/15 is projected to be lower than the previous two years. This is particularly the case in Peterborough, where the number setting a quit date is projected to be 850 by the end of 2015/16 compared to 1,213 in 2014/15. This is in part due to a reduction in specialist stop smoking provision, as well as the impact of e-cigarettes.

Current public health spend

In Cambridgeshire, annual public health spend on smoking and tobacco control is £1,167,000. In Peterborough, spend per head on smoking and tobacco control is £1.84 per head, compared with a national average of £3.36 and an average for Peterborough's deprivation decile of £3.38. Despite this the number of people who set a quit date and go on to quit in Peterborough is above the Cambridgeshire rate.

[40] Public Health Outcomes Framework, available at http://www.phoutcomes.info. Accessed 10/04/15

Interventions and cost savings to the NHS

There is a high quality, high ranking evidence that stop smoking services are cost effective, and provide a good return on investment. As well as savings to the NHS, there are also wider savings to social care through reduced disability resulting in lower social care need in later life. These are outlined in multiple NICE guidance documents.

We have used the NICE smoking return on investment tool to estimate the savings to the NHS from the current programme, and to estimate what an increase in activity would generate in savings.

Cambridgeshire

For Cambridgeshire we have modelled the impact of increasing local stop smoking service uptake up 5% from 2014/15, as well as continuing to invest in the sub-national programme which focuses on tobacco control and other prevention initiatives.

The figure and table below show that an investment of £157k a year generates a net saving (above this cost) of £161k. It is important to note that £136k of this investment is already invested, and remains part of the local authority budget, and therefore the actual new investment needed is approximately £22k. The mix of sub-national programme work as well as specialist stop smoking work is critical to generate savings for the NHS. The impact of specialist stop smoking work is not estimated by the tool to generate savings until year 5, but the investment in the sub-national programme generates the early savings. It is therefore critical that local authority investment levels in sub-national work remain at this level to generate NHS savings. We have only modelled two year savings as there is a fast changing smoking pattern and the tool allows for a calculation of two years of isolated NHS savings.

To increase smoking uptake we plan to focus on groups within the population with higher prevalence levels, such as those with serious mental illness and also those people about to have an operation. There is high quality, high ranking evidence that stopping smoking prior to an operation can reduce the risks associated with surgery. There is also evidence that short term costs, such as length of stay can be reduced.

Some studies have found that stopping smoking before an operation can reduce operative and post-operative hospital costs. Extrapolating one such study on hip and knee replacement surgery we found a short-term cost-benefit per patient can be estimated as £65 per patient undergoing intervention (not per patient quitting) in Cambridgeshire and Peterborough. This would be in addition to any savings estimate through the NICE ROI tool modelling below.

There is also evidence from the trials of pre-operative smoking cessation interventions,2,4 that the quit rate at 12 months follow up was 30% versus 10% in the intervention and

control groups respectively, showing that some difference in long-term quit rates is likely to be maintained.

Using the rewards intervention for pregnant women, which gave quit rates of 9% versus 3% for intervention versus control at 1 year, as a conservative proxy for pre-operative quits, the cost-benefit to women (excluding child cost-benefit and excluding the cost of the intervention) was £144 per patient undergoing the intervention. A conservative estimate of the total cost benefit of pre-operative smoking cessation intervention is £209 per patient undergoing the intervention.

Figure 11 – expected impact of increasing local stop smoking service uptake in Cambridgeshire by 5% and investing £136,000 in the sub-national programme

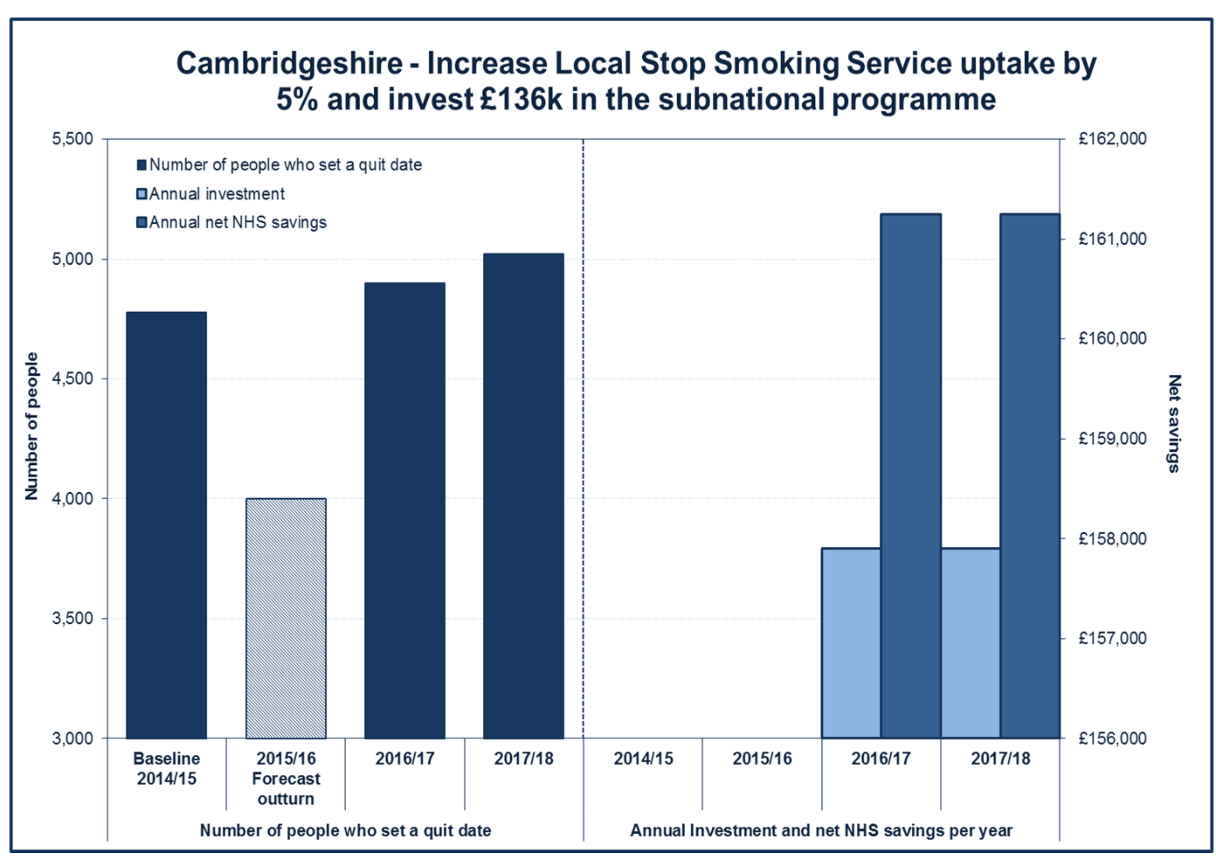


Table 18 – quit date information for Cambridgeshire

	Baseline 2014/15	2015/16 Forecast outturn	2016/17	2017/18
Number of people who set a quit date	4,777	*4,000*	4,900	5,022
Annual investment			£157,904	£157,904
(Annual new investment)			£21,904	£21,904
Annual net NHS savings			£161,250	£161,250

Smoking rates are much higher in Peterborough than in Cambridgeshire and so the model proposed here is to increase the number of people setting a quit date in Peterborough to

the same as the Cambridgeshire average. The table and figure below show how new investment of £65,589 a year, will lead to a saving of £16,307.

Peterborough

Figure 12 – expected impact of increasing local stop smoking service uptake the current Cambridgeshire levels and investing £35,000 in the sub-national programme

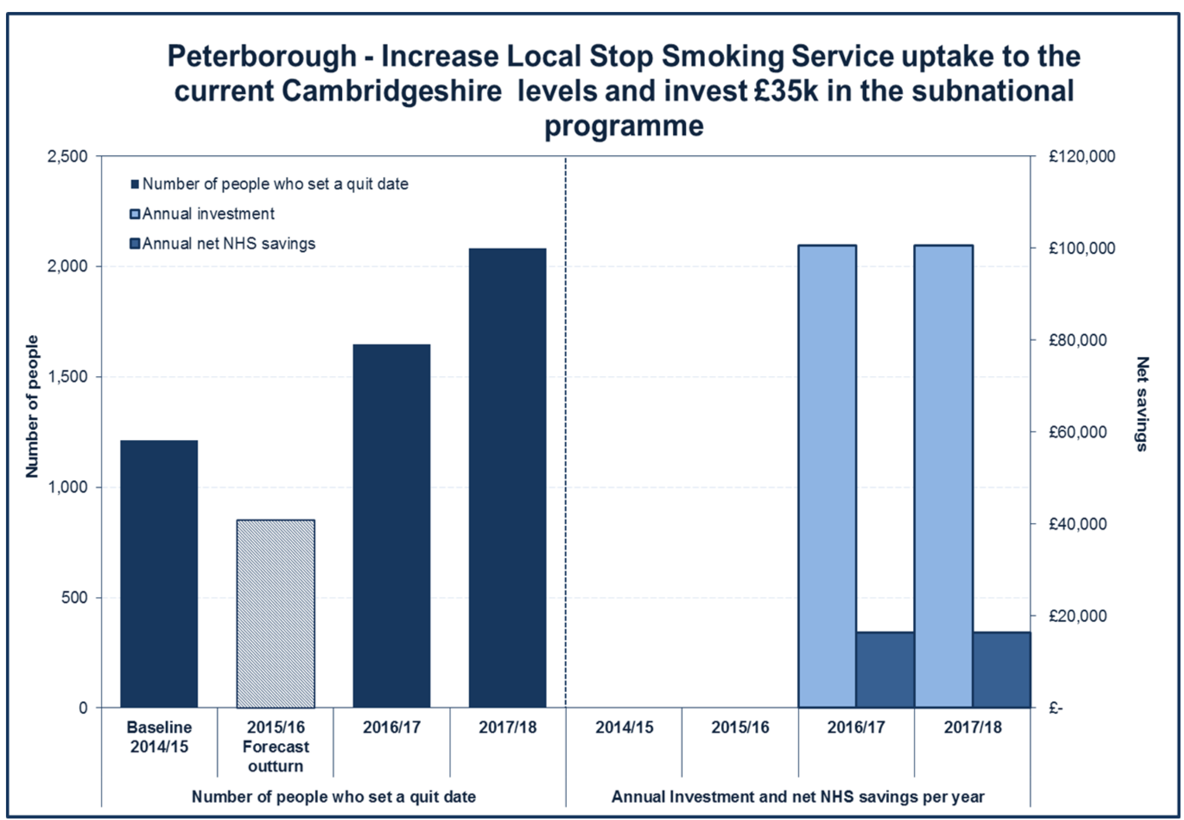


Table 19 – quit date information for Peterborough

	Baseline 2014/15	2015/16 Forecast outturn	2016/17	2017/18
Number of people who set a quit date	1,213	*850*	1,648	2,082
Annual investment			£100,589	£100,589
(Annual new investment)			£65,589	£65,589
Annual net NHS savings			£16,307	£16,307

It is important to note that our projections suggest that the number of people setting a quit date in Cambridgeshire and Peterborough will fall considerably from 2014/15, which is used as the baseline in these projections in terms of activity and investment. Given the scale of the projected fall in numbers in Peterborough the increase needed to reach the Cambridgeshire average requires the service to more than double its activity. The overall drop in activity, and associated investment, in 2015/16 is a risk to achieving targets for 2016/17 and 2017/18.

Work already planned

There is an ongoing programme to improve performance that includes targeting routine and manual workers and the Fenland area. CamQuit, the core Stop Smoking service in Cambridgeshire, is providing increasingly higher levels of support to the other providers along with promotional activities. Practices and community pharmacies are regularly visited with poor performers being targeted. During 2014/15 social marketing research was undertaken which is informing activities to promote Stop Smoking Services. Other activities introduced recently include a mobile workplace service, a migrant worker Health Trainer post that will target these communities where smoking rates are high, a wide ranging promotional campaign and the recruitment of an additional Stop Smoking Advisor to focus upon Fenland.

Going forward, Cambridgeshire and Peterborough will be working with neighbouring local authorities on tobacco related campaigns and engagement work, including a focus on illicit tobacco sales.

Where should the strategic focus be?

There are an estimated 105,548 people across Cambridgeshire and Peterborough who smoke. There is a high quality, high ranking evidence that stop smoking services are cost effective, are good value for money and provide a good return on investment.

Recommendations

- Sub-national programme work, such as tobacco control, is critical to ensuring savings to the NHS. Nationally and locally we should continue to invest in this.
- There are additional savings to the NHS to be made from stopping people smoking before operations, and this along with sub-groups in the population with high prevalence levels should be a focus for the additional numbers setting a quit date.
- An additional investment of £346k, only £175k of which is new investment, is needed to generate a saving over £356k over the next two years.

9. Alcohol

Headlines

- Maximise opportunities to provide brief advice on alcohol to more GP practice patients, at new registrations and/or next appointment. If 10,000 more patients were to receive this advice, it is estimated this would save the NHS £217k (above the cost of the intervention) over seven years with the vast majority of the savings in years 2-5. **[PH: further work is needed to define local stretch targets, including A&E as well as GP practices, and to model the cost savings]**

Background

The consumption of alcohol contributes to a range of health conditions and admissions to hospital. Alcohol-related conditions include liver disease, hypertension, oesophageal and other cancers and mental and behavioural disorders. Drinking alcohol is also linked to hospital admissions due to accidents and injuries and toxic effects of consumption, and causes considerable costs to the NHS.

It is estimated that 6.6m adults in England currently consume alcohol at hazardous levels and 2.3m at harmful levels. The total costs of alcohol misuse in England are estimated to be around £23.1bn of which £0.3m is NHS costs. Overall average annual costs of a harmful drinker are around 3.4 times that of a hazardous drinker.

Current position

Cambridgeshire context

In 2012/13, alcohol-related hospital admissions for men were lower than the national average across Cambridgeshire but highest in Cambridge and Fenland. In 2012/13, alcohol-related hospital admissions for women were higher than the England average in Cambridge and Huntingdonshire.

In Cambridgeshire it is estimated that there are 114,000 hazardous drinkers and 40,000 harmful drinkers.

Peterborough context

1 in 5 people in Peterborough (23,000 people) drink above the recommended levels. 7,500 people in Peterborough drink heavily at levels which have, or risk, damaging their health.

There were 1,171 alcohol-related hospital admissions in Peterborough in 2012-13, which is the highest in the East of England. The cost to the local NHS system is £1.8 million a year or £244 per person for the 7,500 people in Peterborough who drink heavily.

Interventions and cost savings to NHS

Current public health spend and activity

In Cambridgeshire, annual Public Health spend on drug and alcohol services is £5,964,000. This breaks down for specific spend on alcohol as:

- Adult alcohol treatment - £961,000
- Young people's drug and alcohol service - £315,000
- Inpatient beds, recovery hub, service users' network, controlled drinkers project

Alcohol screening takes place through NHS Health Checks, and for all new adult patients of GP practices through a national DES.

The Cambridgeshire Drug and Alcohol Action Team (DAAT) records show that during 2014/15, 106 individuals were trained in identification and brief advice during the year. This comprised of 12 health and 94 non-health staff. In addition, there was a large scale health session in September 2014 (contributed to, but not organised by, the DAAT) at Hinchingbrooke Hospital which was attended by approximately 70 health staff. Two smaller sessions during the year were held with GP practices. The DAAT has been active in delivering identification and brief advice training in 2015/16. In October 2015, 35 staff from CPFT were trained in a single session. Further training dates are planned for 2016 and will be promoted widely, including to primary care.

In Peterborough, combined spend on substance misuse (drug, alcohol and young people) is £16.73 per head, compared with a national average of £17.36 and a deprivation decile average of £21.25.

Peterborough commission Drink Sense as an alcohol interventions service, which inevitably includes brief and extended interventions. In 2014/15 190 people were referred for Brief Advice and a further 152 received Brief interventions.

The Hospital Alcohol Liaison Project (HALP) also commissioned through CCG, set a target for 480 Brief Advice interventions at PCH , and in fact 2014/15 made 746 interventions. This service then follows up relevant patients with further brief interventions.

DrinkSense adult service is commissioned primarily to deliver alcohol treatment interventions, of which Brief Advice and Brief Interventions form only a part. Activity in Q1 shows 160 people receiving brief interventions.

Work already planned

HALP target for Brief Advice increased to 720, with Brief Interventions increased to 1200.

Work is currently underway on a Drugs and Alcohol JSNA in Cambridgeshire. This detailed analysis is due to be completed in July 2015.

Cost saving prevention initiatives – possible areas of focus

There are a number of national initiatives such as minimum unit pricing that have been shown to be potentially cost saving to a range of organisations, and would reduce alcohol consumption. A recent NICE evidence update (PH24) on Alcohol-use disorders highlighted evidence that affordability, minimum pricing, taxation and location of outlets can all influence drinking levels.

Minimum Unit Pricing has been recommended in Scotland as a way of increasing the price of drinks such as own-brand spirits and white cider, which have high alcohol content but are usually very cheap. Minimum unit pricing would set a floor price for a unit of alcohol, meaning it cannot be sold for lower than that. The more alcohol a drink contains, the stronger it is and therefore the more expensive it would be.

The Alcohol (Minimum Pricing) (Scotland) Act 2012 was passed in June 2012. It has not yet been implemented due to a legal challenge led by the Scotch Whisky Association.

Scotland's Chief Medical Officer concluded that - like the smoking ban - minimum unit pricing would save lives within a year. Research by the University of Sheffield estimated that the proposed minimum price of 50p per unit would result in the following benefits:

- Alcohol related deaths would fall by about 60 in the first year and 318 by year ten of the policy
- A fall in hospital admission of 1,600 in year 1, and 6,500 per year by year ten of the policy
- A fall in crime volumes by around 3,500 offences per year
- A financial saving from harm reduction (health, employment, crime etc) of £942m over ten years

In terms of local initiatives we have focused here on the cost effectiveness of screening and brief advice for alcohol.

The costs and benefits of GPs using the Alcohol use disorders identification test (AUDIT) have been modelled using a representative sample of 1,000 adults attending their next GP consultation, followed by 5 minutes of advice for those identified as hazardous or harmful drinkers (£17.41 cost per person screened). The model assumes that 20% of relevant individuals are missed in the screening, and the effectiveness of the intervention is assumed to decline to zero in seven years.

Table 20: Costs/pay off per head for screening and brief advice based on a representative sample of 1000 adults attending their next GP consultation (2009/10 prices)

Table 5: Costs/pay-offs per head for screening and brief advice based on a representative sample of 1,000 adults attending their next GP consultation (2009/10 prices)

	Year 1 (£)	Years 2–5 (£)	Years 6–7 (£)	Total (£)
NHS	-10.55	-24.61	-3.91	-39.07
Crime	-28.49	-66.02	-10.49	-105.00
Productivity losses	-16.20	-38.24	-6.05	-60.48
Total	-55.23	-128.87	-20.45	-204.55

Source: Mental health promotion and prevention: the economic case. 2011. Knapp & Parsonage.

Taking these figures, if 10,000 more people in Cambridgeshire and Peterborough were screened and received brief advice, it is estimated that there would be net savings at over seven years of £216,600 with the vast majority of these in years 2-5. The overall cost of the programme would be £174k and the total return £390,700.

The existing activity and capacity within the health system to take on this additional work (roughly 2 additional patients per week for 50 weeks of the year per practice), would need to be considered in any model. This model also assumes this activity is undertaken by GPs, not practice nurses, and it is also not clear if the costs include any initial training costs.

More recent modelling work[41] continues to find that screening and brief interventions at registration are potentially cost saving to the NHS and social services, with the majority of savings in the NHS.

Where should the strategic focus be?

There is good evidence that brief interventions for alcohol are cost saving to the NHS in the short term. The focus should be on maximising opportunities to ensure this screening takes place with as big a proportion of the population as possible.

Recommendation

- Maximise opportunities to provide brief advice on alcohol to more GP practice patients, at new registrations and/or next appointment. If 10,000 more patients were to receive this advice, it is estimated this would save the NHS £217k (above the

[41] Modelling the Cost-Effectiveness of Alcohol Screening and Brief Interventions in Primary Care in England. Purshouse, R et al (2012) Alcohol and Alcoholism Vol.48, no 2 pp 180-188.

cost of the intervention) over seven years with the vast majority of the savings in years 2-5.

[PH: further work is needed to define local stretch targets, including A&E as well as GP practices, and to model the cost savings]

10. Falls

Headlines

- Injurious falls in older people have a high cost impact for health and social care services, estimated at £83 million for 2016, with increasing costs forecast for the ageing population locally.
- There is important and robust evidence indicating net savings for falls interventions targeted at community dwelling older adults across a range of UK and international settings.
- In particular three areas of intervention for preventing falls in community-living older people have been trialled and indicated cost savings: home-based exercise (the Otago Exercise Programme) in over 80-year-olds, home safety assessment and modification in those with a previous fall, and specific multi-factorial programmes.
- Further development of models to estimate the cost savings to the NHS of local multi-component falls interventions accurately is in progress.
- Potential savings may require delivery of preventative approaches at a much wider scale than current provision.

Background

A fall is defined as an unplanned descent to the floor with or without injury to the patient[42]. Falls are the commonest cause of accidental injury in older people and the commonest cause of accidental death in the population aged 75 and over in the UK. The majority of fractures in older people occur as a result of a fall from standing height. These are low trauma fragility fractures commonly affecting the pelvis, wrist, upper arm or hip.

Falls in older people can be predicted by assessing a number of risk factors including conditions that affect balance, chronic health conditions, physical and cognitive impairments, and multiple medications[43][44][45]. Multi-faceted interventions can prevent falls in the general community, in those at greater risk of falls, and in residential care facilities[46]. Well organised services, based on national standards and evidence-based guidelines can prevent future falls, and reduce death and disability from fractures[47].

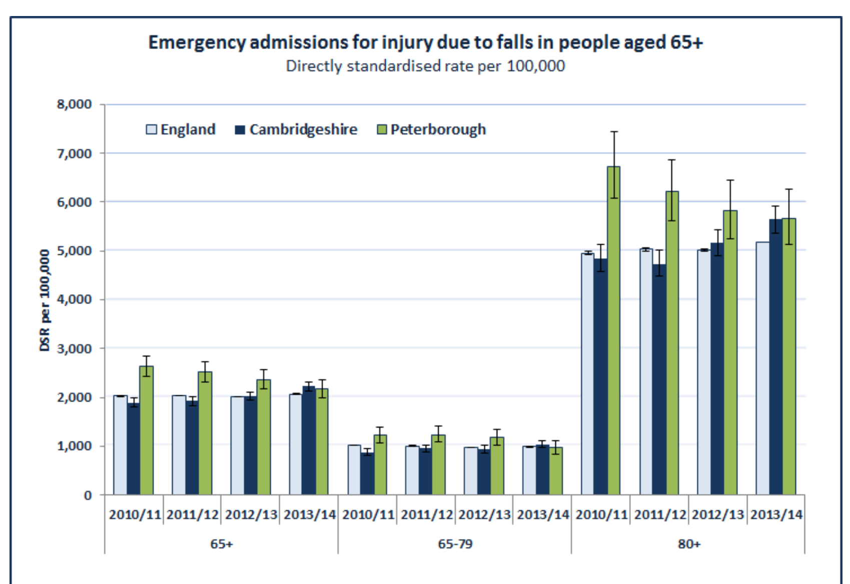
[42] National Database of Nursing Quality Indicators (2011).
[43] Gillespie LD, Gillespie WJ, Robertson MC et al. Interventions for preventing falls in elderly people. Cochrane Database Syst Rev 2003;Issue 4.
[44] Ganz DA, Bao Y, Shekelle PG et al. Will my patient fall? JAMA 2007;297:77–86.
[45] Clinical Guideline 21. Falls: The Assessment and Prevention of Falls in Older People. London, UK: National Institute for Clinical Excellence, 2004.
[46] Gillespie LD, Gillespie WJ, Robertson MC et al. Interventions for preventing falls in elderly people. Cochrane Database Syst Rev 2003;Issue 4.
[47] Royal College of Physicians. Falling standards, broken promises. Report of the national audit of falls and bone health in older people 2010. Available at: http://www.rcplondon.ac.uk/sites/default/files/national_report.pdf

Current position

What is the scale of the problem?

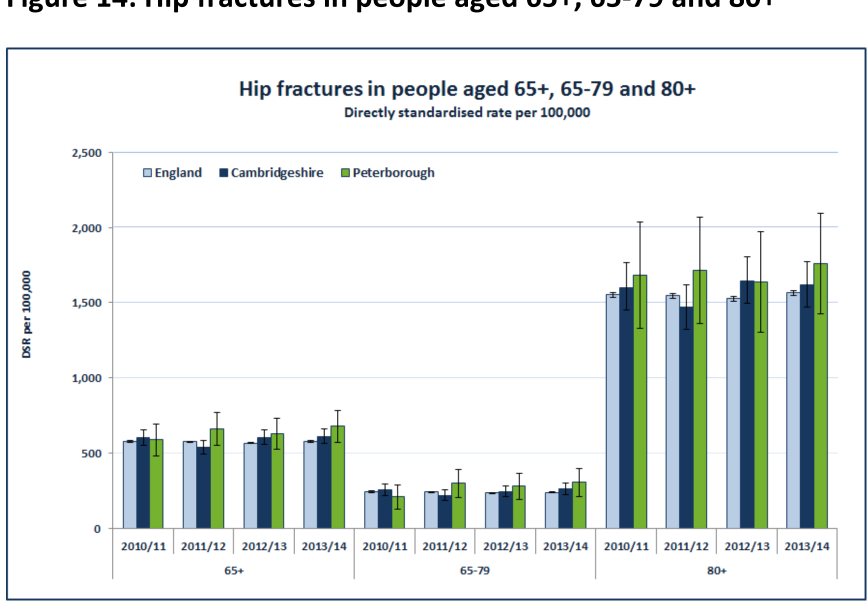
Figures 13 and 14, show rates of emergency admission for injuries due to falls, and for fracture of the hip between 2010/11 and 2013/14. Rates are generally higher in women than in men (data not shown) and increase substantially with age. Rates for emergency admissions in Cambridgeshire as a whole are similar to the national average whilst rates in Peterborough have been higher than the national average.

Figure 13: Emergency admissions for injury due to falls in people aged 65+



Source: Public Health England (PHE) Fingertips http://www.phoutcomes.info/
Primary diagnosis code for Injury (ICD 10 S00-T19) with falls code (WOO-W19) anywhere in diagnostic string.

Figure 14: Hip fractures in people aged 65+, 65-79 and 80+



Source: Public Health England (PHE) Fingertips http://www.phoutcomes.info/
Primary diagnosis ICD 10 S72.0, S72.1, S72.2.

From the above data it is clear that in Cambridgeshire the impact of falls is disproportionately greater in those aged 80 years and above which accentuates the case for preventive interventions targeted at age-bands preceding the rise in incidence of hip fractures and frailty.

How is this expected to change locally?

The number of older people aged 65 and over is forecast to increase significantly across the CCG population, with an increase of 42% in Peterborough and 48% in Cambridgeshire by 2031. In Cambridgeshire, amongst the oldest, the number of people aged 90 years and over is forecast to nearly double in the next 15 years.

Table 21: number of older people

Peterborough

	2013	2016	2021	2026	2031	Change 2016-31
65-74	14,000	15,300	17,200	18,300	20,700	35%
75-84	9,000	9,200	10,200	12,600	13,900	51%
85+	3,500	3,900	4,800	5,500	6,600	69%
65+	28,513	30,416	34,221	38,426	43,231	42%
All ages	189,300	198,300	220,700	231,000	235,300	19%

Cambridgeshire

	2013	2016	2021	2026	2031	
65-74	59,400	65,400	70,400	72,500	82,700	26%
75-84	34,700	36,600	44,700	56,300	60,400	65%
85+	15,000	17,000	21,000	25,900	33,300	96%
65+	109,100	119,000	136,100	154,700	176,400	48%
All ages	621,200	627,200	653,400	713,800	752,800	20%

Source: CCC R&PT 2013-based population forecasts

The health consequences and costs

[PH: This section replicates previous work for Cambridgeshire using CCG populations. At present it is an under-estimate of total 'health' costs since it does not include the breakdown, post discharge from the acute sector, or costs associated with community health services. These need to be estimated.]

In 2013, results were published from a Scottish study which aimed to estimate the costs for health and social care services in managing older people in the community who fall[48]. The study used predominantly national databases and cost of illness methodologies and the authors noted that costs, while specific to Scotland, were anticipated to generalise to other parts of the UK. The study found that 34% of people aged 65 years and over living in the community fall at least once a year and 20% of these people contacted a medical service for assistance. Applying the results from the Scottish study to local population figures for Cambridgeshire & Peterborough CCG, we can estimate the costs of falls across health and social care.

In the CCG, in 2016 these falls result in over 5,500 GP attendances, over 8,700 ambulance call outs, and more than 6,300 A&E attendances resulting in over 3,000 inpatient admissions annually. The associated costs are high and estimated to be over £78 million. Costs at discharge are predominantly associated with social care but not from the funder perspective.

The table 22 shows the figures from the Scottish study applied to the forecast population of Cambridgeshire and Peterborough Clinical Commissioning Group in 2016.

Table 22: Estimated number and cost of fall related events, Cambridgeshire & Peterborough CCG 2016, based on study estimates applied to local population figures.

Clinical event			Number	Cost per event	Total cost (2016)	Total percentage
Population aged 65+			166,039			
Total people falling	34%	of population	56,453			
Of whom serious	7%	of population	11,623			
GP attendances	51%	of serious falls	5,928	£36	£213,393	0.3
Ambulance callouts	61%	of serious falls	7,090	£257	£1,822,090	2.2
A&E attendances	80%	of serious falls	9,298	£101	£939,114	1.1
Inpatient admissions	35%	of A&E attendances	3,254			
Falls (non hip fractures)	69%	of admissions	2,246	£7,406	£16,630,208	20.1
Hip fracture	31%	of admissions	1,009	£14,528	£14,656,572	17.7
Discharge falls						
Home	64%		1,439	£1,776	£2,556,323	3.1
Residential: short term	21%		480	£8,406	£4,033,619	4.9
Long term	15%		326	£65,942	£21,515,799	25.9
Discharge fractures						
Home	34%		345	£1,776	£612,321	0.7
Residential: short term	47%		470	£8,406	£3,952,282	4.8
Long term	19%		194	£65,942	£12,786,202	15.4
Re-admissions	7%	of admissions	391	£7,406	£2,892,210	2.1
Mortality at one year	12%	of admissions	228	£3,703	£843,561	1.8
Total cost					**£83,453,695**	**100**

[48] Craig J, Murray A, Mitchell S et al. The high cost to health and social care of managing falls in older adults living in the community in Scotland. Scottish Medical Journal 2013;58(4):198-203. Available at: http://scm.sagepub.com/content/58/4/198.

Source: CCC PHI. ONS population projections applied to FHS Registration System (Exeter) April 2015 (Costs and estimates modelled using Craig et al.).

The next table gives an additional breakdown of the NHS costs associated with falls and fractures and shows the financial impact assuming no change in prevention to 2020.

Table 23: Estimated number and NHS costs of fall related events, Cambridgeshire & Peterborough CCG 2016, based on study estimates applied to local population figures.

Breakdown of costs to NHS - Cambridgeshire & Peterborough CCG - no change in prevention

	2016	2020	2016	2017	2018	2019	2020
Population 65+	166,039	181,667					
Estimated falls in the community	56,453	61,767					
of which serious	11,623	12,717					
GP attendances	5,928	6,486	£.2M	£.2M	£.2M	£.2M	£.2M
Ambulance callouts	7,090	7,757	£1.8M	£1.9M	£1.9M	£2.M	£2.M
A&E attendances	9,298	10,173	£.9M	£1.M	£1.M	£1.M	£1.M
Costs GP/Amb/A&E			**£3.M**	**£3.M**	**£3.1M**	**£3.19M**	**£3.25M**
Inpatient admissions	3,254	3,561					
Of which non hip fx	2,246	2,457	£16.6M	£17.M	£17.4M	£17.8M	£18.2M
Of which hip fractures	1,009	1,104	£14.7M	£15.M	£15.4M	£15.7M	£16.04M
Costs of admission			**£31.3M**	**£32.1M**	**£32.8M**	**£33.5M**	**£34.2M**
Readmissions	228	249	**£.8M**	**£.9M**	**£.9M**	**£.9M**	**£.9M**
Total			**£35.1M**	**£36.M**	**£36.8M**	**£37.6M**	**£38.4M**

Source: CCC PHI. ONS population projections applied to FHS Registration System (Exeter) April 2015 (Costs and estimates modelled using Craig et al

Interventions and cost savings to the NHS

The cost implications for the system of falls are evident and a do nothing option incurs increasing costs.

Table X below demonstrates the impact of conservative estimates of reduction on costs by applying a 10% and 15% reduction on the overall costs. Potential cost reductions are substantial as shown in Table 5. Using the 10% reduction results in a reduction of NHS costs of over £3.5 million.

Table 24: Potential cost savings across health from 10% and 15% reduction in falls related events

Clinical event			Total cost (2016)	10% reduction	15% reduction
Population aged 65+					
Total people falling	34%	of population			
Of whom serious	7%	of population			
GP attendances	51%	of serious falls	£213,393	£192,053	£181,384
Ambulance callouts	61%	of serious falls	£1,822,090	£1,639,881	£1,548,776
A&E attendances	80%	of serious falls	£939,114	£845,202	£798,247
Inpatient admissions	35%	of A&E attendances			
Falls (non hip fractures)	69%	of admissions	£16,630,208	£14,967,187	£14,135,677
Hip fracture	31%	of admissions	£14,656,572	£13,190,915	£12,458,086
Re-admissions	7%	of admissions	£2,708,552	£2,892,210	£2,302,270
Total cost			£36,969,929	£33,272,936	£31,424,440

Source: (Costs and estimates modelled using Craig et al

Falls prevention is multi-faceted with phases of need across the population, ranging from older people who are well and mobile, with no risks identified, those complaining of unsteadiness, those who have fallen and injured themselves, and those with significant frailty and multi-morbidities that may have already had interventions related to falls.

Therefore an array of evidence-based interventions is required, as appropriate, to specific population groups, such as:

Effective Interventions[49]	Target Group
Strength and Balance (community)	All population >65
Tai chi (community)	Low/medium risk of falling
Home improvements (hazard assessments)	Medium/high risk of falling
Multi-factorial risk screening and intervention	Medium/high risk of falling
Medication review (withdrawal of psychotropic medication)	Taking multiple medications
Expedited cataract surgery	Patients with cataracts
Vision and eye exam	All population >65
Vitamin D and calcium	All population >65
Cardiac pacing	Patients with carotid hypersensitivity

[49] Interventions drawn from Day et al., (2009) Modelling the impact, costs and benefits of falls prevention measures to support policy-makers and program planners. MONASH University Accident Reduction Centre; Church J, Goodall S. Norman R. Haas M. An economic evaluation of community and residential aged care falls prevention strategies in NSW. Sydney. NSW Ministry of Health 2011.

'Gold standard' falls preventions interventions/packages typically include strong pathways between the relevant services. The Greater Glasgow and Clyde model[50], which has evidence of actual realised savings, includes the following key components[51]:

- A single point of referral in each locality for triage and onward referral
- Multi-factorial falls assessments (all assessment in the home)
- Data recording of patients using the service
- A programme of exercise classes run in community centres by trained specialist therapists (held immediately after rehabilitation classes)
- Integration: there is close partnership between the NHS and local council
- The service is widely promoted in GP practices, libraries, and other public settings

It is not yet clear from the evidence which, and at what scale, of the interventions and components, are required to achieve the 10% or 15% reduction in the costs of falls related injuries.

Current public health spend and activity

The majority of interventions to reduce falls in older people are not funded directly by Public Health. Detailed mapping of stakeholder activity is underway, so descriptions of current provision must be considered estimates; falls are events rather than conditions or diseases so health data coding is problematic.

Community exercise provision (strength and balance and tai chi) across the county (not all funded by PH) may currently reach about 500 people aged 50 and over across the county. Adaptations to reduce hazards in the home environment are delivered through handyperson schemes, or funded by disability facilities grants, and other local provision. GPs provide an important coordination role in primary care, ensuring medication reviews, hearing and sight checks, foot health and other key risk factors. Secondary preventative work with fallers (falls prevention services/intervention) is held within Older People health services (CPFT/UCP) neighbourhood teams.

Work already planned

The business case for Cambridgeshire County Council April 2015 – March 2017 (£300,000 per annum) includes:

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[50] This programme is the only UK model to have evidence of realised savings, finding over a 10 year period the service has achieved a reduction in falls in the home of 32%, a reduction of falls in residential institutions of 27% and a reduction of falls in the street of almost 40%. However there may be some concerns about the analysis, and the ability to extrapolate for local models.

[51] Greater Glasgow and Clyde Falls Prevention and Osteoporosis Services. Available at: http://www.nhsggc.org.uk/CONTENT/default.asp?page=s1361

- Increasing provision of evidence-based community exercise to increase reach and uptake in the over 65 population, particularly targeted at those aged 75 and over.
- Primary preventative awareness raising (campaigns, information) to reach those 75 years and over, and their family and carers
- Training and awareness raising of actions to reduce falls for the health, social care, VCO and wider workforces
- Building system level partnership to reduce falls

UnitingCare are currently considering pathways and approaches for the provision of multi-factorial assessments and interventions.

Cost saving prevention initiatives – possible areas of focus

A Cochrane review in 2012[52] on interventions for preventing falls in community-living older people identified thirteen trials providing a comprehensive economic evaluation. Three of these indicated cost savings for their interventions during the trial period: home-based exercise (the Otago Exercise Programme) in over 80-year-olds, home safety assessment and modification in those with a previous fall, and one multifactorial programme targeting eight specific risk factors. In the multi-factorial programme, total average costs were approximately US$2000 [~GBP £1310] less per subject in the intervention group than the usual care group, largely reflecting lower hospitalisation costs in those who received the intervention[53].

A prior review in New Zealand identified the same three cost-saving approaches as Cochrane, and found that best value for money came from effective single factor interventions such as the Otago Exercise Programme in adults 80 years and older[54]. A cost-benefit analysis in 2014 of three specific exercise interventions demonstrated positive net benefits for each programme[55]. The Otago Exercise Programme provided a return on investment of 36% for each dollar invested when delivered to persons aged 65 and over, and an ROI of 127% when delivered to 80 year olds and over (comprising a net benefit of $429.15). The highest ROI was found for Tai Chi at 509%. The ROI for the Australian Stepping On programme (21 hours of occupational therapist-led group exercises, and falls prevention advice) was 64%.

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[52] Gillespie LD, Robertson MC, Gillespie WJ, Sherrington C, Gates S, Clemson LM, Lamb SE. Interventions for preventing falls in older people living in the community. Cochrane Database of Systematic Reviews 2012, Issue 9. Art. No.: CD007146. doi: 10.1002/14651858

[53] Rizzo JA, Baker DI, McAvay G, Tinetti ME. The cost effectiveness of a multi-factorial targeted prevention program for falls among community elderly persons. Medical Care 1996;34(9):954–69.

[54] Davis JC, Robertson MC, Ashe MC, Liu-Ambrose T, Khan KM, Marra CA. Does a home-based strength and balance programme in people aged > or =80 years provide the best value for money to prevent falls? A systematic review of economic evaluations of falls prevention interventions. Br J Sports Med 2010; 44: 80–9.

[55] Carande-Kulis V, Stevens JA, Florence CS, Beattie BL, Arias I. 2015 A cost-benefit analysis of three older adult fall prevention interventions.J Safety Res. 2015 Feb;52:65-70. doi: 10.1016/j.jsr.2014.12.007.

Alongside the evidence for single factor interventions, modelling by the Center for Disease Control has identified that community-based multi-disciplinary programmes are well tolerated and their potential offer in terms of health economics is great[56].

Cost savings associated with the implementation of interventions have been reported at population scale; a multi-disciplinary programme in a population of 400,000 in New South Wales, Australia showed a benefit to cost ratio of 20.6:1[57]. Over a 4-year period, the programme generated savings of up to A$16.9 million [~GBP £7.91million].

In the US, a cohort study demonstrated savings of US$938 [~GBP £615] per person at 1 year among older people participating in the 'Matter of Balance' intervention which addresses fear of falling and activity limitation[58]. The majority of the savings (US$517) amount from reduced unplanned hospitalisations. The programme is currently delivered in 38 of the 50 United States. A study modelling the potential for savings from Matter of Balance for Massachusetts calculated a return on investment of 144%. As there is no current uptake data available, savings were calculated for three participation levels: 25%, 50% and 75%, and found to range from US$2.79million to $8.37million.

Further detail from economic modelling for a population health falls prevention programme[59] shows a high incremental cost-effectiveness ratio (ICER) of $A28,631 [GBP£13577] per QALY gained. Sensitivity analyses indicated that the public health outcomes were greater and less costly than no programme, when programme costs were $A500 or lower and risk ratio for falls was 0.70 or lower, indicating that a population-wide approach will be most appropriate, and cost-saving, with effective and relatively low cost interventions.

Where should the strategic focus be?

There is clear evidence that falls prevention interventions are cost effective when modelled across the population. Any cost saving benefits may be realised only by working at population scale, however, concerted action will be required to avoid increases in service utilisation. Specific components of falls prevention e.g. medication reviews are likely to also be cost saving but our current models are not sufficiently sophisticated to identify this. Further detail will need to be added to inform the development local work.

Recommendation

- Further development of models to estimate the cost savings to the NHS of local multi-component falls interventions accurately is in progress.

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[56] Hanley, A., Silke, C., & Murphy, J. (2011). Community-based health efforts for the prevention of falls in the elderly. Clinical Interventions in Aging, 6, 19–25. doi.org/10.2147/CIA.S9489
[57] Hanley, A., Silke, C., & Murphy, J. (2011). Community-based health efforts for the prevention of falls in the elderly. Clinical Interventions in Aging, 6, 19–25. doi.org/10.2147/CIA.S9489
[58] Ghimire E, Colligan EM, Howell B, Perlroth D, Marrufo G, Rusev E, Packard M. (2015) Effects of a Community-Based Fall Management Program on Medicare Cost Savings. Am J Prev Med. 2015 Sep 15. doi: 10.1016/j.amepre.2015.07.004.
[59] Farag I., Howard K., Ferreira ML., Sherrington C. (2015) Economic modelling of a public health programme for fall prevention. Age and Ageing 2015; 44: 409–414. doi: 10.1093/ageing/afu195

- Potential savings may require delivery of preventative approaches at much wider scale than current provision.

11. Malnutrition in older people

Headlines

- An estimated 13,000 to 18,300 older people are malnourished in the Cambridgeshire & Peterborough population, and more are at risk
- Potential cost savings may be achieved by increasing proportion screened for malnutrition among inpatients, outpatients and new GP registrations to 90% and appropriate treatment; with investment of £524k and savings in the order of £543k primarily from reducing length of stay in acute care. At worst this intervention should not cost the NHS additional funding, and will improve quality of life for older people.

Background

Malnutrition is measured as a Body Mass Index (BMI) lower than 18.5kg/m2 or unintentional 10% weight loss. The annual health care costs associated with malnutrition are primarily due to more frequent and expensive hospital in-patient admissions, more primary care consultations and the greater long-term care needs of malnourished individuals. About two thirds of cases of malnutrition are not recognised.

Current position

What is the scale of the problem?

It is estimated that there are around one million older people in the UK who are malnourished or at risk of malnutrition. The vast majority (93%) of people who are malnourished or at risk of malnutrition are living in the community, with a minority in care homes (5%) or in hospital (2%). It is estimated that 25-28% of admissions to hospital and 30-41% of admissions to care homes are at risk of malnutrition.

There is a paucity of local data about the prevalence or costs of malnutrition, so local estimates are drawn from risk factors, or applying national estimates to the population; it is estimated that 10-14% of the population aged 65 years and over in England are malnourished.

Cambridgeshire

In Cambridgeshire life expectancy at birth is significantly higher for both males and females compared to the national average, so there is potential for high prevalence of malnutrition. Applying national estimates there is an estimated 10,000 to 14,000 older residents of Cambridgeshire, or about one in 50 people in the general population, who are malnourished. In terms of lifestyle and psychosocial risk factors, approximately 29% of older people live alone in Cambridgeshire (29,000 people), and these people may also be at increased risk of malnutrition.

Peterborough

In 2016 in Peterborough 15% of the population will be aged 65 years and over (30,416 people), indicating an estimated 3000 to 4300 older people who are malnourished.

Population changes in older people are described in the section on falls.

The health consequences and costs

Disease-related malnutrition costs in excess of £13 billion per annum based on malnutrition prevalence figures and the associated costs of both health care and social care[60]. The annual health care costs associated with malnutrition are primarily due to more frequent and expensive hospital in-patient admissions, more primary care consultations and the greater long-term care needs of malnourished individuals[61].

Interventions and cost savings to the NHS

On a national level in 2013 NICE identified malnutrition as the sixth largest source for potential NHS savings[62]. Early identification and treatment of malnutrition in adults could save the NHS £45.5 million a year even after costs of training and screening[63].

The interventions centre on screening eligible population groups, and for those identified, dietetic assessments and interventions. The cost impact of modelling for increasing the proportion of the local population screened is shown in table 25.

[60] Brotherton A, Simmonds N & Stroud M. Malnutrition Matters. Meeting Quality Standards in Nutritional Care. BAPEN. 2012.
[61] Brotherton A, Simmonds N & Stroud M. Malnutrition Matters. Meeting Quality Standards in Nutritional Care. BAPEN. 2012.
[62] Benefits of Implementation: Cost saving guidance, NICE, (updated) 2013
[63] National cost impact report to accompany CG32, NICE, 2006

Table 25: Cost impact of increasing proportion screened to 90% from current (national) estimates of 65% of inpatients 15% of outpatients and 10% of GP new registrations. National estimates based on expert opinion (NICE)

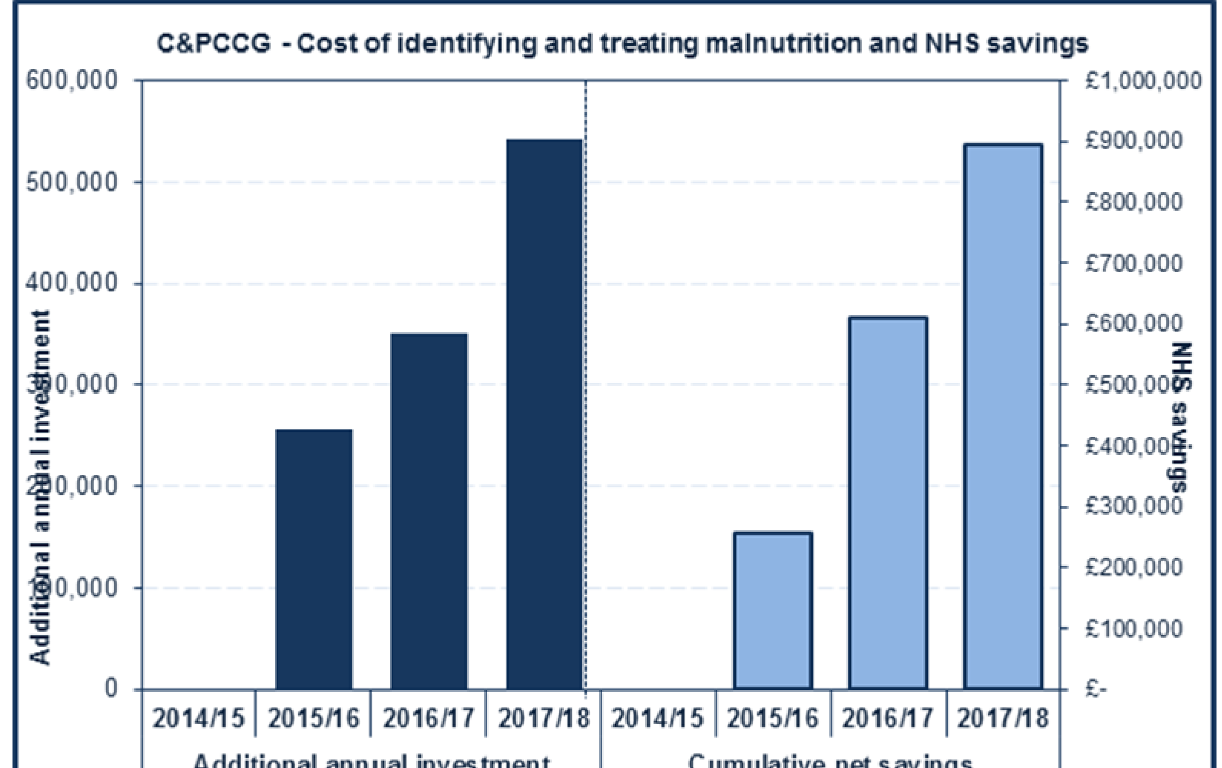
	Cost impact (£000s)	Cost impact C&P CCG (£)
Increase in screenings - direct costs 5-minute 'MUST' screening by a nurse in various settings	£38.9	£294,528
Increase in nutritional assessments - direct costs 45 minute assessment by a dietician, in the community or secondary care	£10.8	£81,771
Increase in nutritional interventions Includes net ingredient costs and costs associated with administration of oral supplements, enteral and parenteral nutrition	£22.0	£166,571
Additional annual investment cost		£542,870
Decrease in secondary care activity Primarily from decreased length of stays	£143.6	£1,087,254
Net cost	**£71.8**	**£543,627**

Source: Implementation Programme: NICE support for commissioners using the quality standard on nutrition support in adults November 2012. Applied to CCG Population April 2015 (FHS Registration System (Exeter)

There are important limitations in the model. As noted, the baseline screening proportions are based on national expert opinion; it is not known how well these align with local practice. The cost savings are realised through improved secondary care outcomes i.e. a reduction of the level of malnutrition in the population. The NICE template does not detail the inter-relationship of the elements e.g. proportion screened and proportion referred for a nutritional assessment, to allow more precise adjustments in line with local activity. The costing model does also not take into account specific interdependencies, such as the fact that those who are malnourished are less likely to respond well to treatment for other conditions, and therefore are likely to cost the NHS and social care more.

An indicative trajectory may be described as:

Figure 15: Cost of identifying and treating malnutrition and NHS savings



Work already planned

Current activity to identify malnutrition and improve nutritional status in older people is not known in detail. Good practice in acute settings was highlighted in the work on malnutrition for the Cambridgeshire JSNA Primary Prevention of Ill health in older people 2014. The training of care staff and the provision of general services in the community by VCOs such as transport schemes, hot meal delivery schemes, and lunch clubs, are significant local assets.

Cost saving prevention initiatives – possible areas of focus

As suggested by the model, focus is required on screening at key junctures, referral for assessment, and the appropriate interventions.

Recommendations

- Potential cost savings may be achieved by increasing proportion screened for malnutrition among inpatients, outpatients and new GP registrations to 90% and appropriate treatment; investment of £524k and savings in the order of £543k primarily from reducing length of stay in acute care. At worst this intervention should not cost the NHS additional funding, and will improve quality of life for older people.

12. Sexual health

Headlines

- For every £1 invested in contraception services, there is a £11.09 saving to the NHS, rising to £13.42 for LARCs.
- It is proposed that we increase the number of women with long-acting reversible contraceptives (LARCs) by approximately 859 a year in Cambridgeshire & Peterborough. This should generate savings of £935k in 2016/17, £1.15m in 2017/18 and £1.26m in 2018/19.
- This would require an additional investment of £115k. However, the additional investment needed for Cambridgeshire, is already within the Council budget proposals for 2016/17.

Background

Long-acting reversible contraception (LARC) is a method of contraception that requires administering less than once per cycle or month. Included in the category of LARC are the copper intrauterine devices (non-hormonal) and three progestogen-only methods of contraception (intrauterine system, injectables and the implants).

It is clear that investment in contraception services not only helps to avoid the personal and social costs of unintended pregnancies, but is also economically effective. According to the Government, the prevention of unintended pregnancy by NHS contraception services probably saves the NHS over £2.5 billion a year, and research has shown that every £1 spent on contraception services saves the NHS £117.

There is widespread agreement that increasing use of long-acting reversible contraception (LARC) in women at all stages of their reproductive lives is a vital component of the strategy to reduce unwanted fertility. Improving both access to and provision of LARC methods was recommended by the 2005 NICE guideline on LARC,1 which was updated in 2014. It highlighted that these contraceptive methods were both more effective and cost efficient when compared with the most popular user-dependent methods. Long-acting reversible contraceptive methods consistently achieve superior efficacy by reducing user error.

Current position

In 2015/16 we have seen a considerable drop in LARC activity in Cambridgeshire. This is largely due to a gap in trained GPs retiring and a new cohort of GPs being trained. This has brought the rate of LARCs down in Cambridgeshire to 68 per 1000 population, or 8,168 LARCs, compared to 82 per 1000 population, or 3,101 LARCs in Peterborough.

Interventions and cost savings to the NHS

For every £1 invested in contraception services there is a £11.09 saving, rising to £13.42 for LARCs[64]. NICE estimated in 2005 that 8% shift to the use of LARCs from other types of contraception would result in £102 million savings nationally (more if those not using any contraception were factored in) e.g. population of 40,000 15-49 year old females could produce £300,000 savings at one year.

There are also costs saved to social care and longer term educational and employment outcomes.

Work already planned

The shortfall in the sexual health budget related to the decrease in LARC activity in Cambridgeshire has been identified by the Health Committee as an area of focus, where they would like to see increased activity. The saving from this drop in activity is not anticipated for 2016/17.

Cost saving prevention initiatives – possible areas of focus

The following two graphs and tables set out the planned future activity for LARC, the additional investment and the NHS savings per year. We have used conservative estimates of the impact of costs saved to the NHS.

For Cambridgeshire where activity levels have fallen, the ambition is to increase the number of LARCs by approximately 747 a year by 2018/19. The additional investment needed for Cambridgeshire has already been identified within the 2016/17 Public Health budget, and the savings to the NHS are estimated to be £1.1m by 2018/19.

Cost saving prevention initiatives – possible areas of focus

The following two graphs and tables set out the planned future activity for LARC, the additional investment and the NHS savings per year. We have used conservative estimates of the impact of costs saved to the NHS.

For Cambridgeshire where activity levels have fallen, the ambition is to increase the number of LARCs by approximately 747 a year by 2018/19. The additional investment needed for Cambridgeshire has already been identified within the 2016/17 Public Health budget, and the savings to the NHS are estimated to be £1.1m by 2018/19.

[64] The Cost Effectiveness of family planning service provision. D Hughes and A McGuire. Journal of Public Health medicine vol 18 No 2, pp189-196 (1996).

Figure 16: Cambridgeshire planned number of LARCs, investment and NHS savings

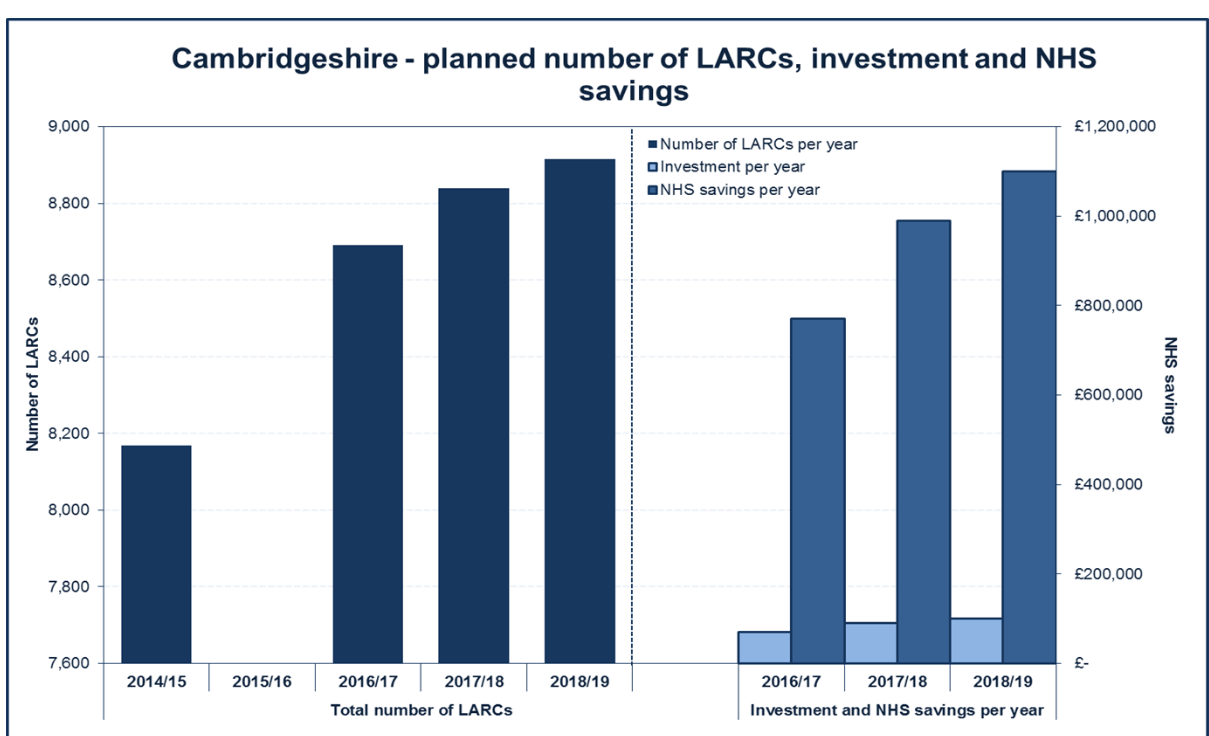


Table 26: Cambridgeshire planned number of LARCs, investment and NHS savings

<table>
<tr><th>Cambridgeshire</th><th>2014/15</th><th>2015/16</th><th>2016/17</th><th>2017/18</th><th>2018/19</th></tr>
<tr><td></td><td></td><td rowspan="8">Projections suggest that this years activity will be broadly in line with 2014/15 or marginally lower.</td><td></td><td></td><td></td></tr>
<tr><td>Current activity</td><td>8,168</td><td></td><td></td><td></td></tr>
<tr><td>Current investment</td><td>£1,094,125</td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Additional number of LARCs</td><td>-</td><td>523</td><td>672</td><td>747</td></tr>
<tr><td>Additional investment</td><td>-</td><td>£70,000</td><td>£90,000</td><td>£100,000</td></tr>
<tr><td>Savings</td><td>-</td><td>£770,000</td><td>£990,000</td><td>£1,100,000</td></tr>
<tr><td>Number of LARCs per year</td><td>-</td><td>8,691</td><td>8,840</td><td>8,915</td></tr>
</table>

Peterborough activity on LARCs is already fairly high and so this additional activity is based on a small increase in LARC activity of 112 LARCs a year, and additional investment of £15,000 a year. The net savings (savings after the investment costs) are £165m by 2018/19.

Figure 17: Peterborough planned number of LARCs, investment and NHS savings

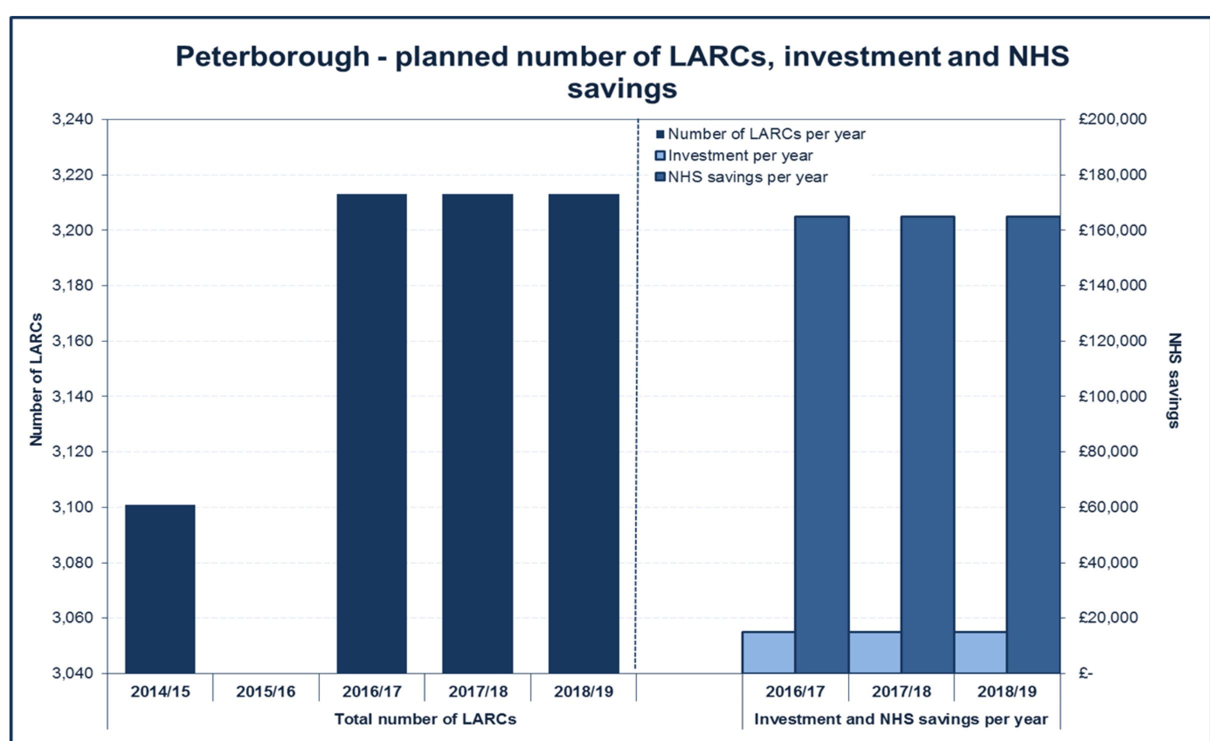


Table 27: Peterborough planned number of LARCs, investment and NHS savings

Peterborough	2014/15	2015/16	2016/17	2017/18	2018/19
		Projections suggest that this years activity will be broadly in line with 2014/15.			
Current activity	3,101				
Current investment	£415,387				
Additional number of LARCs	-		112	112	112
Additional investment	-		£15,000	£15,000	£15,000
Savings	-		£165,000	£165,000	£165,000
Number of LARCs per year	-		3,213	3,213	3,213

It is important to note that the estimated number of additional LARCS is based on an average cost for the device and fitting and therefore the final number will vary depending on the type of LARC chosen.

Recommendations

LARCs are highly cost saving to the NHS. An additional investment of £115k will generate savings of £935k in 2016/17, £1.15m in 2017/18 and £1.26m in 2018/19.

13. Breastfeeding

Headlines

- Low breastfeeding rates in the UK lead to an increased incidence of illness that has a significant cost to the health service. Investment in evidence-based multi-faceted interventions has been shown to generate savings to the health economy, in the short term, by reducing hospital admissions for four acute childhood illnesses[65].
- There is evidence to suggest that breastfeeding can contribute to longer term savings through its impact on key health outcomes, including childhood obesity, but this is difficult to quantify.
- The focus should be on joint commissioning with local authorities to improve breastfeeding support, and implementing or piloting interventions in both acute and community settings. These interventions should include strengthening breastfeeding support and advice in acute settings, and easily accessible breastfeeding peer support programmes focused on the most deprived areas of the CCG.

Background

Breast milk is the best form of nutrition for infants, and exclusive breastfeeding is recommended for the first six months (26 weeks) of an infant's life[66].

Breastfeeding contributes to various important public health outcomes including[67]:

- reduction of the infant mortality rate;
- reduction of preventable infections and unnecessary paediatric admissions in infancy;
- the halting of the rise in obesity in under 11s;
- improving children's life outcomes and general wellbeing; and
- breaking the cycle of deprivation and reducing the impact of health inequalities.

[65] Renfrew MJ, et al. ''Preventing disease and saving resources: the potential contribution of increasing breastfeeding rates in the UK' (2012) UNICEF. Available at: http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=0CCcQFjABahUKEwjxtcW__PHIAhXLtxQKHRZqBNk

[66] http://www.nhs.uk/conditions/pregnancy-and-baby/pages/why-breastfeed.aspx

[67] NICE. Dyson, L. et al. 'Promotion of breastfeeding initiation and duration Evidence into practice Briefing' (2006). Available at: https://www.nice.org.uk/proxy/?sourceUrl=http%3a%2f%2fwww.nice.org.uk%2fnicemedia%2fpdf%2fEAB_Breastfeeding_final_version.pdf

Despite the overwhelming health benefits and cost savings of breastfeeding, initiation rates in the UK are around the lowest in Europe, and worldwide, with rapid discontinuation rates for those who do start[68].

Young mothers with a lower level of education and low income are the least likely to breastfeed their baby. Across the UK, at three months, the number of mothers breastfeeding exclusively was 17% (up from 13% in 2005) and at four months, it was 12% (up from 7% in 2005). Breastfeeding initiation and prevalence of breastfeeding at 6-8 weeks is a key health improvement indicator measured in the Public Health Outcomes framework[69].

Key Facts

- Breastfed babies have a reduced risk of respiratory infections, gastroenteritis, ear infections, allergic disease and Sudden Infant Death Syndrome. Breastfed babies may have better neurological development and be at lower risk of tooth decay and cardiovascular disease in later life.
- There is evidence to suggest that breastfed babies may experience benefits that continue into later life, including being less likely to be overweight or obese.
- Breastfeeding has been shown to have benefits for both mother and baby including promoting emotional attachment between them. Women who breastfeed are at lower risk of breast cancer, ovarian cancer and hip fractures/reduced bone density.

Current position

Breastfeeding rates at 6-8 weeks after birth are monitored through the Health Visiting contract and reported nationally to Public Health England.

Figures for quarter 1 of 2015-2016 show that; 55.4% of mothers in Cambridgeshire, and 44% in Peterborough, report that they are breastfeeding at 6-8 weeks compared to 43.4% in England. Breastfeeding levels remain lowest in areas of highest deprivation. Therefore, although rates in Cambridgeshire are better than the England average, there remains significant room for improvement.

Interventions and cost savings to the NHS

NICE Public Health Guidance 11 on maternal and infant nutrition[70] identifies key interventions to improve breastfeeding initiation and duration as a priority and recommends the following. These include adopting a multi-faceted approach or a co-

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[68] DH/DCSF. (2009) 'Commissioning local breastfeeding support services'. Available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_106497.pdf

[69] Public Health Outcomes Framework web tool: 2.02 Breastfeeding. Available at: http://www.phoutcomes.info/public-health-outcomes-framework#page/7/gid/1000042/pat/6/par/E12000006/ati/102/are/E10000003/iid/20202/age/170/sex/4

[70] NICE Guidance PH11: Maternal and child nutrition (2008). Available at: http://www.nice.org.uk/guidance/ph11/chapter/1-Key-priorities#breastfeeding

ordinated programme of interventions across different settings to increase breastfeeding rates.

A systematic review published by UNICEF in 2012 identified economic savings from a multi-faceted intervention based on evidence-based guidelines including this NICE guidance. The study made a conservative estimate that assuming a moderate increase in breastfeeding rates, if 45% of women exclusively breastfed for four months, and if 75% of babies in neonatal units were breastfed at discharge, every year there could be an estimated £17 million gained nationally by avoiding the costs of treating four acute diseases:

- 3,285 fewer gastrointestinal infection-related hospital admissions and 10,637 fewer GP consultations, with over £3.6 million saved in treatment costs annually;
- 5,916 fewer lower respiratory tract infection related hospital admissions and 22,248 fewer GP consultations, with around £6.7 million saved in treatment costs annually;
- 21,045 fewer acute otitis media (AOM) related GP consultations, with over £750,000 saved in treatment costs annually;
- 361 fewer cases of NEC, with over £6 million saved in treatment costs annually.

There were also found to be cost savings to the NHS of over £21 million nationally, due to fewer cases of breast cancer, if half of those mothers who currently do not breastfeed were to do so for up to 18 months of their lifetime. This was based on an estimated 865 fewer cases of breast cancer nationally.

Further evidence suggests that savings could be made in relation to reducing obesity, although insufficient data was available for sophisticated economic modelling. It was estimated that increasing breastfeeding rates could lead to around a 5% reduction in childhood obesity, which would save around £1.6million each year across the UK.

Very crude modelling using these conservative national figures can be used to extrapolate possible cost savings per head of the UK population to our local population. In total the savings from the UNICEF report for the UK is £17.1 million if 45% of mothers were to exclusively breastfeed at 4 months. If this is divided by the number of UK births (45% of 776,352) you could estimate £48.80 would be saved for every baby exclusively breastfed to 4 months. If we assume an average breastfeeding rate of 15% at 4 months at present (based on the UNICEF report), it could be extrapolated that £155k might therefore be saved across Cambridgeshire and Peterborough by increasing this rate to 45%. It should be emphasised that this is a very crude calculation and estimate, and also that the economic modelling on which it is based was very conservative.

A case study in the UNICEF report of multi-faceted interventions in Lancashire (population 1.5 million, 13,000 births, deprivation, breastfeeding initiation rates 66-68%, and rates 32-39% at 6 weeks) found there was an annual cost saving of between £82-553K depending on

the range of improvement in breastfeeding rates, assuming approximately £446K was spent on interventions.

Work already planned

Promotion and support for breastfeeding is one of six key high impact priorities for health visitors and is specified in the Health Visiting Contract for Cambridgeshire and Peterborough services[71].

Currently in Peterborough, the NCT are commissioned to co-ordinate the provision of 4 Baby Cafés across Peterborough and to train and manage peer supporters, working in partnership with midwifery and health visitors. In Cambridgeshire, peer support groups are largely volunteer run and led, with focus on Cambridge city and there is limited support in areas of deprivation.

However, key opportunities exist to build on the support from health visitors and provide community support and actions across health and other agencies to achieve maximum impact, and a multi-agency forum in Cambridgeshire has been working on a draft Breastfeeding strategy for Cambridgeshire.

With significant budget cuts to local authority funding, there are important opportunities for the Clinical Commissioning Group (CCG), to jointly commission relatively low cost interventions to invest in training and workforce development in acute trusts, to build community resilience and support and to focus on areas of high deprivation.

Where should the strategic focus be?

Strategic focus should be on the core objectives outlined in NICE to achieve a multi-faceted intervention programme, which also focuses resources on parents in the most deprived areas.

Recommendations

The focus should be on joint commissioning with local authorities to improve breastfeeding support and, implementing or piloting interventions in both acute and community settings. These interventions should include strengthening breastfeeding support and advice in acute settings, and easily accessible breastfeeding peer support programmes focused on the most deprived areas of the CCG.

[71] NHS England. '2015 – 16 National Heath Visiting Core Service Specification ' (2014) Available at: https://www.england.nhs.uk/wp-content/uploads/2014/12/hv-serv-spec-dec14-fin.pdf

14. Appendices

Appendix A: What is included and what is not in this strategy

Areas of focus and rationale

Area in scope	Intervention in scope	Rationale
Obesity, weight management, diet and physical activity (adults and older people)	Adult weight management services (non-surgical) tiers 2 and 3	• Evidence strength – High • Cost saving to NHS • Can calculate short term effectiveness
	Breastfeeding support	• Evidence strength – High • Can calculate global savings only.
	Physical activity and brief advice	• Evidence strength – High • Cost saving to NHS • Savings long term to NHS, majority of savings in increased productivity.
	Physical activity and walking interventions	• Evidence strength – Medium • Cost saving to NHS • Savings long term to NHS, majority of savings in increased productivity
Diabetes prevention	Management of hyperglycaemia	• Management once diagnosed not addressed here. However, high level evidence supports impact of lifestyle interventions.
	Focused screening/lifestyle interventions with South Asian population.	• High level evidence from NICE guidance economic modelling and subsequent modelling that this is cost saving in the long term.
Cardiovascular disease	Cardiac rehabilitation	• High level evidence can reduces readmissions by 30%. Can model potential savings.
	Atrial fibrillation (AF) management	• High level evidence can reduce stroke risk. Can model potential savings.
	Hypertension management	• High level evidence can manage risk through lifestyle management. Can model potential savings.
Supported self-care for long term conditions (LTCs)	Mental health screening and treatment for comorbid LTCs	• Currently insufficient evidence to support the implementation of routine screening for depression/anxiety. • Medium level evidence from outside of the UK that psychological interventions for those with LTCs may be cost saving, or at least cost neutral.

	Other LTC self-management programmes – diabetes, asthma management / chronic obstructive pulmonary disease (COPD), cardiac best evidence	• Evidence strength – full range from low to high. • High level evidence COPD and cardiac rehab can reduce healthcare costs. • Possible to model potential COPD savings.
Workplace health for NHS as an employer	Mental health interventions	• Evidence strength – High • Potential saving to NHS • Can calculate NHS productivity savings
	Stop smoking interventions	• Evidence strength – High • Cost saving to NHS • Savings in line with smoking section
	Physical activity interventions in the workplace	• Cost saving to NHS as an employer • Can calculate productivity savings
Smoking and tobacco control	Specialist smoking cessation services	• Evidence strength – High • Savings to NHS • Can calculate savings
	Stop before the op	• Evidence strength – High • Likely to be cost saving above standard smoking cessation
	Smoking cessation in pregnancy	• Evidence strength – High • Savings to NHS • Can calculate savings
Alcohol	Screening for the identification of people at risk of or misusing alcohol and brief interventions and extended brief interventions.	• Evidence strength – High • Potentially cost saving to NHS • Can calculate savings
Falls in older people	Falls in older people	• Evidence strength – High • Cost saving to NHS • Can model potential savings
Malnutrition in older people	Malnutrition in older people	• Evidence strength – Medium • Can model potential savings using NICE tool.
Sexual health	Contraception – Long-acting reversible contraception (LARC)	• Cost saving to NHS • Can calculate savings

Areas and interventions out of scope

There are also a number of areas and interventions that have been considered, but are not within the scope of this plan. These areas and interventions are generally where the evidence base is not so strong, where there is less potential financial impact (or savings are not to the NHS), and/or the information is not available to model reasonable estimates of NHS savings, within the timescales of this work.

Area out of scope	Intervention out of scope	Rationale
Mental health	Preventing postpartum depression through psychosocial and psychological interventions	• Evidence strength – High • Limited cost effectiveness evidence. • Savings wider than NHS.
	Physical health interventions for those with severe mental illness e.g. smoking cessation/diet/physical activity	• Evidence strength – Medium • No specific additional NHS savings above general lifestyle management interventions.
	Tier 2 & 3 mental health services for children and young people.	• Evidence strength – High • Possibly cost saving (early intervention) but levels of unmet need high • Not possible to model NHS cost reduction as a result of intervention. Early intervention in psychosis an exception to this.
	Suicide prevention – GP Suicide Prevention Training	• No cost saving to NHS • Vast majority of savings to wider economy.
Obesity and weight management	Oral health	• NICE didn't find initiatives cost saving.
	Children's weight management programmes	• Evidence strength – Medium • Potentially cost saving to NHS, but no long term evidence to base this on. • Can calculate intervention effectiveness but not long term savings.
	Physical activity and school playgrounds	• Evidence strength – Medium • Evidence of cost savings to NHS inconclusive.
Physical activity	Brief intervention and referral in primary care	• Evidence strength – High • Cost saving • Cost saving in v long term potentially. Can't quantify currently.
Other Older people	Reablement	• Lack of robust evidence of NHS savings.
	Flu uptake in workforce	• Lack of robust evidence of NHS savings

Children	Early years centres' nutrition policy	• Evidence strength – High • Probable cost savings to NHS, but no evidence • No economic modelling
	Parenting programmes	• Cost savings but mainly to criminal justice, education and social services
Other parenting support in early years – intensive home visiting/FNP	Family Nurse partnership	• Recent evidence finds FNP not cost effective.
Diet	Domestic violence interventions (IDVAs)	• Evidence strength – medium. • Small cost savings to the NHS, majority to CJS.
	Chronically excluded adults	• Evidence strength – Medium Possible savings to NHS but very small. Majority savings to criminal justice system.
Social prevention	Debt advice	• Evidence strength – Medium (Low for primary care) • Small savings to NHS but majority to wider economy.
	Warm homes / reduction in fuel poverty	• Evidence strength – high. • NHS savings difficult to calculate (are some related to COPD). Majority wider savings, and difficulties with varying intervention definitions.
	Local Sugar Tax	• Issues with local implementation
	Local alcohol licensing approaches	• Issues with local implementation, particularly costs of legal challenge.
	Reducing social isolation	• Medium level evidence. • Likely to be some NHS savings, but evidence not strong enough to model these. Community navigator type programmes promising.

Appendix B: Public Health Reference Group evidence review - matrix indicating Agency Involvement and quality of evidence (Nesta Scale)

Note: Lower quality of evidence may be due to the nature of the intervention and how easy it is to research, rather than its overall effectiveness and impact.

Key: Quality of Evidence
High Ranking **H** Middle Ranking – **M** Lower Ranking - **L**

No.	Intervention	CCG/NHS	CCC Public Health	CCC Children's Services	CCC Adult Services	CCC Environ-Ment/ Planning	District Councils	Voluntary Sector	Police
1	**Diet**								
1.1	Breastfeeding peer support	**H**	**H**	**H**				**H**	
1.2	Early years centres nutrition policy		**H**	**H**				**H**	
1.3	*Reducing socio-economic inequalities in obesity in children and adults*								
1.3.1	Targeted school based approaches		**M**	**M**					
1.3.2	Workplace health (as employer)	**M**	**M**	**M**	**M**	**M**	**M**	**M**	**M**
1.3.3	Workplace health as commissioner for private sector workplaces	**M**	**M**				**M**		
1.4	Targeted primary care-delivered weight loss programmes	**M**	**M**						
1.5	Group based counselling and community engagement approaches	**L**	**L**				**L**	**L**	
2	**Weight Management**								

	Interventions								
2.1	Weight Management during and after pregnancy	**M**	**M**						
2.2	Children's Weight Management Services	**M**	**M**						
2.3	Adult Weight Management Services (non-surgical)	**H**	**H**						

	Intervention	**CCG/NHS**	**CCC Public Health**	**CCC Children's Services**	**CCC Adult Services**	**CCC Environ-ment & Planning**	**District Councils**	**Voluntary Sector**	**Police**
3	**Physical Activity programmes**								
3.1	Physical Activity and Young Children		**M**	**M**		**M**	**M**		
3.2	*Physical Activity and Workplaces*								
3.2.1	Workplace health (as employer)	**M**	**M**	**M**	**M**	**M**	**M**	**M**	**M**
3.2.2	Workplace health as commissioner for private sector workplaces	**M**	**M**				**M**		
3.3	Physical activity in the community Increasing accessibility/community engagement	**L**	**L**				**L**	**L**	
3.4	Exercise Referral	**L**	**L**				**L**		
3.5	Physical Activity and Brief Advice	**H**	**H**				**H**		
3.6	Physical activity and technology	**L**					**L**		
3.7	Physical activity and walking	**M**	**M**				**M**	**M**	

	interventions								
4	**Physical Activity and the Physical Environment**								
4.1	Physical Activity and Planning		**L**	**L**		**L**	**L**		
4.2	Physical Activity and Transport		L			**L**	**L**		
	Intervention	**CCG/NHS**	**CCC Public Health**	**CCC Children's Services**	**CCC Adult Services**	**CCC Environ-ment & Planning**	**District Councils**	**Voluntary Sector**	**Police**
4.3	Physical Activity and Cycling					**L**	**L**		
4.4	Physical Activity and Walking (infrastructure)		**L**			**L**	**L**		
4.5	Physical Activity and Public Open Spaces		**L**			**L**	**L**		
4.6	Public Open Spaces and Public Paths					**L**	**L**		
4.7	Physical Activity and Workplaces								
4.7.1	Workplace health (as employer)	**M**	**M**	**M**	**M**	**M**	**M**	**M**	**M**
4.7.2	Workplace health as commissioner for private sector workplaces	**M**	**M**				**M**		
4.8	Physical Activity and School Playgrounds		**M**	**M**			**M**		
5.	**Older People – prevention**								
5.1	Older People and Malnutrition	**M**			**M**				
5.2	Older People and Physical Activity interventions	**H**					**H**		

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 7
10 DECEMBER 2015		PUBLIC REPORT
Contact Officer(s):	Wendi Ogle-Welbourn, Corporate Director People and Communities	Tel. 01733 863749

SUBSTANCE MISUSE WHOLE TREATMENT SERVICE RETENDER

R E C O M M E N D A T I O N S	
FROM: Wendi Ogle-Welbourn, Corporate Director People and Communities	**Deadline date:** 10 December 2015
That the Health and Wellbeing Board: 1. Note the contents of the report, understanding that it will receive regular reports and presentations if requested during the mobilisation period; and 2. Ensure members support to relevant elements of mobilisation as required.	

1. ORIGIN OF REPORT

1.1 This report is submitted to Board following the retender and contract award of substance misuse treatment services for young people and adults in Peterborough.

2. PURPOSE AND REASON FOR REPORT

2.1 This paper describes the result of the re-tender of substance misuse services and the timetable to mobilise the new contract to commence April 2016.

2.2 Describes the strategic intent for tackling substance misuse in the city using the opportunity provided by the retender of treatment services.

3. BACKGROUND

3.1 Adult alcohol treatment services had never been tendered in Peterborough, while the adult drug treatment and young people substance misuse contracts were scheduled for re-tender in 2015. In order to achieve ambitions of rebalancing alcohol interventions in the treatment system and achieving efficiencies through working with a single provider, all were included in a single specification, to which CCG officers contributed. The new service will include access to in-patient detoxification, residential rehabilitation as well as all community-based substance misuse services for young people and adults.

3.2 Discussion with the CCG resulted in agreement to include within the specification the hospital alcohol liaison project (HALP) currently commissioned by the CCG. The formal mechanism for this is a Section 256 agreement which transfers funds to Peterborough City Council to commission this service on the CCG's behalf.

3.3 The whole substance misuse contract - value c£12.5m in total - is awarded for five years. The decision to award the contract was finalised in September 2015 with the mobilisation period commencing in late October. An initial mobilisation meeting has taken place between the Public Health commissioning team in PCC and CRI senior management. We have agreed to work closely and transparently through the mobilisation period, identifying and mitigating any problems as they emerge.

3.4 CRI is keen to engage with stakeholders at every appropriate opportunity and would like to attend a Board meeting in the near future to describe their vision and discuss any questions Board members might have. A subsequent presentation and communication to all GPs setting out pathways and referral arrangements from 1 April 2016 are also proposed.

3.5 The PCC commissioning team is in communication with CCG officers and expects to engage them appropriately throughout the period, recognising that of particular interest to the CCG will be the continued impact of HALP upon alcohol-related hospital admissions and pathways involving primary care. As with most changes in service delivery we anticipate risks relating to continuity which we will be working to minimise.

3.6 Further details and updates from the PCC Public Health commissioning team will be supplied to the Board as required. Any queries may be directed to Rod Grant, interim commissioning manager, rod.grant@peterborough.gov.uk .

3.7 Due to the new opportunities provided by a single provider in the city, the strategies for drugs and alcohol have been reviewed and updated alongside a new action plan.

3.8 The action plan works along the defined structure in the national strategies of:

- Disrupting supply
- Reducing demand
- Building recovery

3.9 Each section requires a multi-agency response which brings together different skills and knowledge to help tackle the overall objective of reducing substance misuse and contributing to a safer city in which to live, work and visit.

3.10 The action plan and strategic intent cannot be delivered in isolation and needs support from a variety of quarters to ensure its success. This paper requests the continued and increased awareness and participation from the board to deliver against the action plan and strategy objectives and ensure that substance misuse is aligned to the outcomes of the Health and Well Being board and the health needs of the city.

4. CONSULTATION

4.1 There was wide consultation with providers, partners and service users as part of the tender process.

5. REASONS FOR RECOMMENDATIONS

5.1 Regular updates on the delivery of the mobilisation plan for transition of existing services to the new provider CRi on request, with follow on reports once the contract goes live on the 1 of April 2016 to ensure all agencies and members are supporting the new service provider as required.

6. ALTERNATIVE OPTIONS CONSIDERED

6.1 No notification report – Health and Wellbeing Board are unsighted on the new service provider and the implementation success of the mobilisation plan

7. BACKGROUND DOCUMENTS

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

7.1 None.

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 8
10 NOVEMBER 2015		PUBLIC REPORT
Contact Officer(s):	Will Patten, Interim AD Adult Commissioning, Peterborough City Council	Tel. 07919 365883

ADULT SOCIAL CARE, BETTER CARE FUND UPDATE

R E C O M M E N D A T I O N S	
FROM: Will Patten, Interim AD Adult Commissioning,	**Deadline date:** N/A
That the Health and Wellbeing Board: 1. Note the update of Better Care Fund 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 Better Care Fund (BCF) Programme and future key activities.

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.'

2.3 The third quarterly monitoring return for NHS England was submitted on the 27 November 2015 after being approved by the Borderline and Peterborough Executive Partnership Board (BPEPB) in line with their delegated authority.

2.4 NHS England have confirmed that funding for the BCF will continue into 2016/17. This will require our plans to be re-submitted. The level of funding is expected to be the same as this year, with guidance expected by Christmas (post spending review). Plans will need to be developed and signed off by mid-Feb 2016.

2.5 Meetings have been arranged between the Peterborough Clinical Commissioning Group and Peterborough City Council to agree the continuation of the Section 75 Agreement.

3. BETTER CARE FUND 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 1 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 We have received notification from NHS England of the need to re-submit our plans for the continuation of the BCF into 2016/17. The submission is required in early February 2016, we are awaiting further details.

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 Organisation	Design		Delivery	
		Accountable Officer	Project Support	Account Officer	Project Support
1. Data Sharing	CCC	CCC	CCC	UC	CCC
2. 7 Day Working	SRG Peterborough Cambs & Ely Huntingdon Wisbech & Norfolk	SRG Peterborough Cambs & Ely Huntingdon Wisbech & Norfolk	PCC CCC	SRG Peterborough Cambs & Ely Huntingdon Wisbech & Norfolk	PCC CCC
3. Person Centred System	UC	UC	CCC	ICB Peterborough Cambs & Ely Huntingdon Wisbech & Norfolk	PCC CCC
4. Information, Communication & Advice	PCC	PCC	PCC	PCC	PCC
5. Ageing Healthily & Prevention	Public Health	Public Health	CCC	Public Health	CCC

3.4.2 <u>Data Sharing</u>

There is an inclusive project plan and a dashboard established. This project is being led by the Cambridgeshire County Council. Priorities have been established and a plan has been developed.

The immediate focus of this project is on expanding the UnitingCare's (UC) 'OneView' to include social care teams, with a particular focus in the first instance on discharge planning

and reablement teams. A social care dataset has been agreed and discussions are underway on the technical aspect of bringing social care data into OneView.

3.4.3 7 Day Working

There is an inclusive project plan and a dashboard established. This project is being led by the System Resilience Group (SRG) in Peterborough. Priorities have been established and a plan has been developed by the Peterborough SRG.

The 7 Day working team are currently reviewing the delivery of services across the county, defining pathways / customer journeys and considering the effective use of resources and economies of scale.

3.4.4 Person Centred Care

Neighbourhood Teams
The new neighbourhood teams that were launched 1 October. The 4 Peterborough and Borderline Neighbourhood Teams have been appointed, and consist of district and mental health nurses, therapists, and specialist services to support GP practices and their patients.

The next stage in the community services development will take place from November 2015, when the consultation for the four Integrated Care Teams (located in Huntingdon, Peterborough, Cambridge and Fenland/Ely) begins.

These Integrated Care Teams will provide specialist support delivered by consultants, geriatricians, psychiatrists, cardiologists, respiratory physicians and palliative care consultants alongside housing co-ordinators. These teams will be officially launched from January 2016.

Case Management
Supporting people, who are at the greatest risk of deterioration or future hospital admission, with intensive case management. The aim is to increase the numbers of people receiving case management and care co-ordination from the top 2% to the top 15%, to help reduce the number of preventable admissions to hospital.

JET
JET is now established and has been running for 5 months. It is available to GPs and all nursing homes. The service is planned to shortly be offered to care home and to selected patients and their carers.

The JET was launched on the 6th May 2015 to GPs in its first phase. From August, access to JET and OneCall was extended to nursing homes, and then from October to residential homes. The next stage will make the services available to selected patients and their carers, which includes their family carers, sheltered housing, domiciliary carers, etc.

Wellbeing and Prevention

UC are facilitating work with the voluntary organisations and social care across Cambridgeshire with a view to bring together a network of 3rd sector providers. The Health and Wellbeing Network will provide the services throughout Peterborough, with Peterborough Plus covering the locale.

3.4.5 Information and Communication

There is an inclusive project plan and dashboard established. This project is being led jointly by the Cambridgeshire County Council and Peterborough City Council. The priorities are to;

Understand the options for an Information Hub

The focus of the group is on scoping the development of a joint Information Hub which would bring together health and social care information in one place, to be used across the system.

Define a joint charter, agree shared language and understanding
A set of principles and outcomes has been developed. It was agreed to define and agree joint terminology (glossary of terms) to be used within scheme across all partner organisations. A first draft of the glossary has been developed and shared with ongoing work to develop and refine it.

3.4.6 Ageing Healthily & Prevention

There is an inclusive project plan and dashboard established. This project is being led Public Health in Peterborough and Cambridgeshire. The group has agreed a series of targeted evidence-based health programmes and interventions for the following key priority areas:

- Falls prevention;
- Mental Health & Dementia;
- Primary prevention;
- Incontinence and Urinary Tract Infections (UTI's); and
- Early triggers of increased need.

The project will also incorporate the development of the Voluntary Sector-led Wellbeing Service, which forms part of the new UC service model.

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.

4.2 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).

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 9
10 NOVEMBER 2015		PUBLIC REPORT
Contact Officer(s):	Dr Liz Robin, Director of Public Health	Tel. 01733 207175

DRAFT PETERBOROUGH JOINT HEALTH AND WELLBEING STRATEGY 2016-19

R E C O M M E N D A T I O N S	
FROM: Dr Liz Robin, Director of Public Health	**Deadline date:** N/A
That the Health and Wellbeing Board comment on and approve the text of the draft Peterborough Joint Health and Wellbeing Strategy 2016-19 as laid out in Appendix A, as the basis for further stakeholder engagement and consultation.	

1. ORIGIN OF REPORT

1.1 It was agreed at the Health and Wellbeing Board in June 2015 meeting that the Joint Health and Wellbeing Strategy 2012-15 should be updated. An outline framework and chapter headings for the Strategy were agreed at Health and Wellbeing Board in September 2015.

2. PURPOSE AND REASON FOR REPORT

2.1 Production of a Joint Health and Wellbeing Strategy to meet the needs identified in the Joint Strategic Needs Assessment (JSNA) is a statutory function of the Peterborough Health and Wellbeing Board. Both NHS Commissioners and Local Authorities are required to have regard to the Joint Strategy in their service plans. The purpose of this report is for the Health and Wellbeing Board to approve the text of the draft Strategy, as the basis for further stakeholder engagement and consultation.

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

3.1 The draft Joint Health and Wellbeing Strategy has been developed collaboratively, with a wide range of local authority and NHS officers involved in drafting chapters for their lead area of responsibility.

3.2 The Strategy follows the framework agreed in September with sections on:

- Health needs analysis;
- Health and wellbeing through the lifecourse;
- Creating a healthy environment;
- Tackling health inequalities; and
- Working together effectively.

3.3 The Strategy is not able to cover every service which promotes or delivers heatlh and wellbeing in Peterborough. As outlined in the statutory guidance – the main focus of the Strategy is on joint work between the local authority, NHS commissioners and other partner organisations to meet local health and wellbeing needs.

3.4 The Partnership Boards represented on the Health and Wellbeing Partnership Delivery Board (see agenda item 13) will be key to delivery of the Joint Health and Wellbeing Strategy. The Strategy will be discussed further by these Partnership Boards which represent a wide range of stakeholders, in order to ensure that their priorities and forward plans for joint working are fully represented.

3.5 The Strategy will be taken to the Health Scrutiny Commission in January 2016 and discussions are taking place with Health Watch on how best to consult with patient groups and the wider public.

3.6 The draft Strategy as presented today to the Health and Wellbeing Board will need some further work on lay out and illustrations to make it more user friendly for the engagement and consultation process.

4. ANTICIPATED OUTCOMES

4.1 Following engagement and consultation, a final draft of the JHWS will be taken to the March 2016 meeting of the HWB Board for approval.

5. REASONS FOR RECOMMENDATIONS

5.1 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.

6. IMPLICATIONS

6.1 The approval of a draft Joint Health and Wellbeing Strategy 2016/19 for further engagement and consultation does not have immediate service change, financial or legal implications. It supports the Health and Wellbeing Board in delivering its statutory duty to prepare this Strategy.

7. BACKGROUND DOCUMENTS

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

None.

8. APPENDICES

- Appendix A – Draft Peterborough Joint Health and Wellbeing Strategy 2016-19

DRAFT

JOINT HEALTH AND WELLBEING STRATEGY 2016/19

PETERBOROUGH HEALTH AND WELLBEING BOARD

TABLE OF CONTENTS

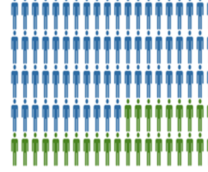
Section Number	Section	Page Number
1	Introduction	3
	HEALTH NEEDS ANALYSIS	
1.1	Peterborough JSNA Findings on a page	4
1.2	Forecasting Future Needs For Health And Care In Peterborough • Maternity Services • Primary Care • Hospital (Secondary) Care	5
	HEALTH AND WELLBEING THROUGH THE LIFECOURSE	
2.1	Children and Young Peoples Health	6
2.2	Health Behaviours and Lifestyles	8
2.3	Long Term Conditions and Premature Mortality – Cardiovascular Disease (CVD)	9
2.4	Mental Health For Adults Of Working Age	10
2.5	Ageing Well	11
2.6	Protecting Health – Communicable Diseases	12
	CREATING A HEALTHY ENVIRONMENT	
3.1	Growth, Health and the Local Plan	13
3.2	Health and Transport Planning	14
3.3	Housing and Health	15
	TACKLING HEALTH INEQUALITIES	
4.1	Geographical Health Inequalities	16
4.2	Health and Wellbeing of Diverse Communities	17
4.3	Health And Wellbeing of People with Disability and/or Sensory Impairment	18
	WORKING TOGETHER EFFECTIVELY	
5.1	Partnership Boards	19
5.2	Commissioning Principles	19
5.3	Cambridgeshire and Peterborough Health System Transformation Programme	20
5.4	Peterborough City Council Customer Experience Programme	21
5.5	A vision for Health and Wellbeing 2016/19	22
Appendix A	Peterborough City Council Commissioning Design Principles	23

1. INTRODUCTION – CHAIR OF HEALTH AND WELLBEING BOARD

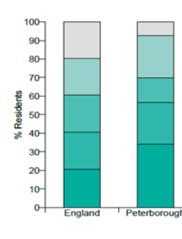
To be included in final version of Strategy

Peterborough JSNA findings on a Page

Peterborough is the UK's second-fastest growing city with a relatively young, ethnically diverse population.

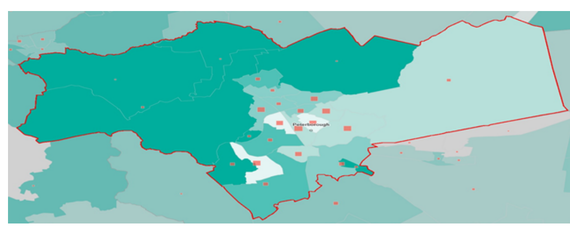


71% of our residents are White British and 29% are from an ethnic minority group.



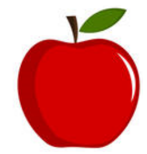
Peterborough has a higher proportion of residents living in deprivation than England, with more local areas in the most deprived fifth nationally, and fewer in the least deprived fifth. Levels of deprivation highest in Dogsthorpe (28%), North (27%) and Central (26%) wards.

Peterborough has a lower average life expectancy and 'healthy life expectancy' than England. On average in Peterborough a man can expect to live in good health to the age of 61 years with a total lifespan of 78 years. A woman can expect to live in good health to the age of 59 with a total lifespan of 83 years.



There are significant inequalities in health and life expectancy between different areas of the Peterborough, which are clearly linked to economic deprivation. This is shown on the map above, in which darker green areas = higher life expectancy and red dots = areas of high deprivation.

A few other key facts



One in four 4-5 year olds are overweight or obese, and seven in ten adults

Our rate of under 18 pregnancy is 38% higher than England.

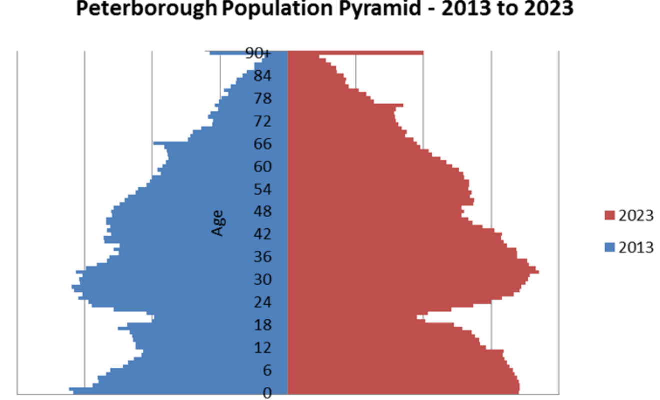
Of 150 local authorities in England, Peterborough is ranked:

106th for premature mortality (death rate under age 75) from heart disease and stroke

98th for premature mortality from lung disease

94th for premature mortality from cancer

1.2 FORECASTING FUTURE NEEDS FOR HEALTH AND CARE IN PETERBOROUGH



The total resident population of Peterborough was 189,300 in 2013 and is forecast to rise by 19% to 2023, reaching a total of 224,800.

•The population aged 65 and over is forecast to rise by 28% by 2023. The number of people aged 90 or over will almost double in this time.

•The number of children and young people aged 18 and under is forecast to rise by 23% to 2023.

MATERNITY SERVICES

There were 3,200 births to women living in Peterborough in 2013. This is forecast to rise to 3,440 in 2023.

PRIMARY CARE

There are 29 GP practices in Peterborough and Borderline Local NHS Commissioning Groups (LCGs), which cover the Peterborough City Council area and also some neighbouring GP practices in Cambridgeshire and Northamptonshire. Together these serve a registered population of 257,000 people. GP practice list size (the number of patients registered with one GP practice) varies from 2,000 to 25,800, with an average list size of 8,900. If practice populations increase in line with expected population growth, average list size will rise to 10,600 in 2023 (an increase of 19%).

HOSPITAL (SECONDARY) CARE

Annual hospital care attendances and admissions for people registered with Peterborough and Borderline LCGs is shown in the table below. Most but not all of these attendances and admissions are at Peterborough and Stamford Hospitals Foundation Trust (PSHFT) Demand for hospital services is forecast to rise by about 20% over the next five years. This takes into account the effect of population change and rising obesity. Types of hospital services used more by older people show the greatest increase, in line with the rapid rise in the older population.

FORECAST INCREASES IN HOSPITAL USE BY PETERBOROUGH AND BORDERLINE PATIENTS 2013/14-2018/19

	A&E attendances	Outpatients	Elective Admissions	Non-elective Admissions	Procedures
2013/14	57,774	307,347	28,558	22,982	33,757
2018/19	68,484	361,750	34,094	27,542	40,501
% Change	18.5%	17.7%	19.4%	19.8%	20.0%

2.1 CHILDREN AND YOUNG PEOPLE'S HEALTH

NEEDS IDENTIFIED IN THE JSNA

Peterborough children and young people are more likely to live in areas where there are high levels of deprivation than England or East of England averages. Areas of Peterborough with the highest levels of deprivation, which are concentrated in the central and eastern areas, are also those where birth rates are highest. Overall around 22% of children and young people aged 0-16 are living in poverty.

Peterborough is a young, fast growing and increasingly diverse City. Population forecasts indicate that numbers of children and young people in the 5-15 age group will increase by around 30% between 2013 and 2021. Increasing population diversity brings considerable cultural richness, but also leads to some challenges in ensuring that families form newly arrived communities are aware of and are able to access prevention and early help services that can support them and prevent any additional needs from coming more serious.

Other key priority areas include:

- High rates of teenage conceptions in the City;
- High numbers of children aged 4-5 who are obese;
- High levels of teeth decay;
- Relatively fewer young people achieving well in education compared with England and regional averages, although this position is improving;
- High levels of hospital admissions among 10-24 year olds for self-harm

Issues such as obesity and tooth decay may be associated with neglect, and there are indications from referrals into Children's Services and other softer measures that relatively high numbers of children and young people are impacted by neglect.

CURRENT JOINT WORK:

The Joint Commissioning Unit has been established to bring together commissioning activities across Peterborough and Cambridge in relation to children's health and wellbeing. Current priorities include:

- Managing the transition of commissioning arrangements for health visiting from NHS England to the Local Authority;
- Developing a healthy child programme that ensures that emerging needs for support are identified early and are acted upon effectively in partnership with children and families;
- Reviewing the Child and Adolescent Mental Health offer across the area, including overseeing action related to reducing waiting list for specialist CAMH services and remodelling support for children and young people with emotional health and wellbeing needs to make the best use of the additional funding from Central Government of £1M per annum.

The Children and Families Joint Commissioning Board includes local authority, local health commissioning and provider bodies, key partners such as social landlords, education services and voluntary organisations and is working to address a number of areas of needs. Priorities for the board are:

- Child Health, including emotional health and wellbeing, and children and young people who have special educational needs and disabilities;
- Children and young people in care performance group;
- Primary school age children: behaviour and emotional wellbeing;
- Education and Skills post 16;
- Vulnerable adults as Parents;
- Developing approaches to addressing neglectful parenting.

FUTURE PLANS:

Key priority future plans include:

- Developing a child and adolescent mental health pathway that better meets need and manages demand so that pressures on specialist services are minimised;
- Continuing a pilot approach where additional CPN capacity is aligned with schools to enable better support to be offered to children and young people with emerging emotional and mental health difficulties;
- Working with the Peterborough Safeguarding Children Board to develop a more effective multi-agency response to neglect, focused particularly on addressing early indications of neglectful parenting and offering support to prevent patterns becoming established;
- We will also renew the Child Poverty Strategy in 2016.

HOW WILL WE MEASURE SUCCESS?

Key indications of success include:

- Bringing waiting times for assessment and treatment for specialist CAMH services in line with national targets;
- Reducing childhood obesity and bringing in line with statistical neighbour and then national averages [latter is a stretch target];
- Continued good performance in relation to young people Not in Education, Employment or Training [NEET];
- Successful implementation of a multi-agency neglect strategy resulting in increased early intervention to prevent such patterns becoming entrenched.

2.2 HEALTH BEHAVIOURS AND LIFESTYLES

Our lifestyles influence the way our health develops over our lifetime. Local research in East Anglia has shown that people with four key 'healthy' behaviours – not smoking, taking regular exercise, eating 5 fruit and vegetables a day and drinking alcohol within recommended limits, stay healthy for longer and live on average 14 years more than people with none of these behaviours.

NEEDS IDENTIFIED IN THE JSNA:

In Peterborough:

- Smoking rates are similar to the national average – about one in five adults smoke.
- Two in three adults are overweight or obese.
- Fewer people than average are physically active.
- Hospital admissions directly resulting from alcohol consumption are higher than average.

Key health inequalities

- Smoking is more common among routine and manual workers - about one in three adults' smoke.
- Hospital admissions for alcohol are higher in some parts of the City than others.

CURRENT JOINT WORK

The Health and Wellbeing Board is aware of the need to ensure that people in Peterborough can access clear information about what a healthy lifestyle means and how to achieve it. Some people will also benefit from services, which specialise in helping people to stop smoking, manage their weight, or their alcohol consumption. To support local people to have healthy lifestyles the Health and Wellbeing Board is working together to:

- Develop a joint 'Prevention Strategy' to ensure that supporting people to improve and maintain their own health is a key part of managing demand on local NHS services.
- Commission a Joint Drug and Alcohol Service through the Clinical Commissioning Group and Peterborough City Council, which reaches into the Hospital to work proactively with patients identified as requiring support to reduce their intake of alcohol.

FUTURE PLANS

- We plan to commission an integrated healthy lifestyle service – with the aim that people can access one service for help and support with stopping smoking, healthy eating, physical activity, weight management and mental wellbeing.
- We plan to improve our communication with local residents on health issues and to develop local campaigns and access to health information sources, which can be trusted to provide reliable advice on healthy lifestyles.
- We would like to recognise the vital role schools play in supporting the health and wellbeing of children and young people through a Healthy Schools Peterborough programme.
- We would like to reduce the number of local people developing Type 2 Diabetes.

HOW WILL WE MEASURE SUCCESS?

We will aim to achieve improvements in the following outcomes:

- The percentage of adults in Peterborough who smoke.
- The percentage of children and adults in Peterborough who are overweight or obese.
- The percentage of adults in Peterborough who are active.
- The numbers of attendances to sport and physical activities provided by Vivacity
- The percentage of adults in Peterborough admitted to hospital for alcohol-related conditions.
- The annual incidence of newly diagnosed Type 2 diabetes.

2.3 LONG TERM CONDITIONS AND PREMATURE MORTALITY – CARDIOVASCULAR DISEASE (CVD)

Since the early twentieth century there have been great improvements in life expectancy and in medical treatments. There are now many people who manage one or more long-term health conditions such as diabetes or heart disease as part of their lives. Cardiovascular disease (CVD) describes a range of conditions including coronary heart disease and stroke. CVD takes many years to develop, is influenced by a number of factors, including lifestyle and health behaviours, and is more common among people living in relative deprivation. Having diabetes is associated with an increased risk of CVD. The Health and Wellbeing Board prioritised addressing CVD in 2014.

NEEDS IDENTIFIED IN THE JSNA

In Peterborough:

- Premature deaths (age under 75) from CVD and from respiratory disease are higher than the national average.
- Preventable deaths from CVD are higher than average.
- The percentage of adults with diabetes is higher than the national average.

KEY HEALTH INEQUALITIES

- Emergency hospital admissions and premature deaths from coronary heart disease are higher in electoral wards in the City which have higher levels of deprivation.
- Diabetes and coronary heart disease rates are known from national research to be more common in South Asian communities.

CURRENT JOINT WORK

- The Health and Wellbeing Board commissioned a detailed CVD JSNA for Peterborough, which is now completed. https://www.peterborough.gov.uk/healthcare/public-health/JSNA/
- The local NHS Clinical Commissioning Group 'Tackling Health Inequalities in Coronary Heart Disease Programme Board' has worked closely with City Council's public health services to improve uptake of CVD 'health checks' for 40-74 year olds and to promote smoking cessation services for people at risk of heart and respiratory disease.

FUTURE PLANS

- The Health and Wellbeing Board has set up a Cardiovascular Steering Group, and this will develop and implement a joint strategy to address cardiovascular disease in Peterborough.
- The potential for a specific programme to work with South Asian communities to address higher rates of diabetes and coronary heart disease is being explored.
- Options are being explored to reduce the risk of stroke within the local population by improved identification of atrial fibrillation (an irregular heart rate which can lead to formation of blood clots and cause a stroke)

HOW WILL WE MEASURE OUR SUCCESS?

We will aim to achieve improvements in the following outcomes:

- Premature death rates from CVD (under age 75).
- Inequalities between electoral wards in emergency CVD hospital admissions.
- The upward trend in the prevalence of diabetes.
- The rate of hospital admissions for stroke and heart failure.

2.4 MENTAL HEALTH FOR ADULTS OF WORKING AGE

Mental ill health is the largest cause of disability in the UK, representing 23% of the burden of illness. People with severe mental illness die on average 20 years earlier than the general population. Peterborough has its own challenges with mental illness, particularly around prevention and management of mental health crisis and support to those with severe mental illness and their carers.

NEEDS IDENTIFIED IN THE JSNA:

There is need to reduce mental health crisis, self-harm and suicide. In Peterborough:

- Hospital admission rates for self-harm are 40% above expected.
- Suicide rates were consistently higher than England rates until a drop was seen in 2012/14
- Referral rates to Crisis Resolution Home Treatment services for mental health problems are higher than Cambridgeshire.
- Use of police powers to take a person in mental health crisis to a place of safety (section 136) occurred at a much higher rate in Peterborough population than in Cambridgeshire.

Demand for mental health acute care occurs at a higher rate than all other areas in Cambridgeshire and mental health hospital admission rates are also higher.

Enablement – Data indicates that the proportion of people in Peterborough with severe mental illness who live independently or are in employment is consistently below the England rates.

Data indicate that carers of people with mental health disorders in the Peterborough community have unmet needs for services, information and advice.

CURRENT JOINT WORK

- The Joint Suicide Prevention Strategy and implementation plan for Cambridgeshire and Peterborough is being delivered. This includes the award winning 'Stop Suicide' campaign, which raises awareness and offers training in suicide prevention and provides resources for self-help.
- A local 'Crisis Care Concordat implementation plan aims to prevent mental health crisis in community settings and reduce the use of section 136 of the Mental Health Act. A new crisis care telephone helpline and a community place of safety are proposed for the coming year.
- Implementation of the Joint Peterborough Mental Health Commissioning strategy includes redesign of the mental health accommodation pathway, increased choice of housing options, a placement model of employment support, stronger links between commissioners and clear focus on the right support, the first time, at the right place, by the right people.

FUTURE PLANS

- Bring together findings from the Peterborough Mental Health JSNA (2015) and refresh the Mental Health Commissioning strategy in 2016 to tailor implementation plans to address unmet mental health need.
- A new recovery coach service to support people after discharge from secondary care and during transitions by connecting between third sector, local authority and mental health services
- An enhanced Primary Care Mental Health Service is planned to support people with greater needs upon discharge from secondary care. This will operate through community based teams.

HOW WILL WE MEASURE SUCCESS?

We aim to achieve improvements in:

- Hospital admissions for self-harm.
- Rates of use of section 136 under the mental health act
- Suicide rate
- Hospital readmission rates for mental health problems
- Enablement of those with severe mental illness, with more people in employment and independent living

2.5 AGEING WELL

Ageing is not just about being older or living for longer - it's about ensuring that people have quality of life that adds value and purpose and through which they can continue to contribute to their families, communities and the wider economy as they grow older. Ageing can however bring challenges, such as frailty and dependence which need not be an inevitable part of ageing. There is much that individuals can do to maintain their own health and wellbeing as they age. Public services, the third sector, the commercial sector and local government can ensure Peterborough is a good place to grow older.

NEEDS IDENTIFIED IN THE JSNA:

- Numbers of people over the age of 65 within Peterborough are expected to grow substantially over the next few years, by about 28% between 2013 and 2023.
- More people over 65 years have multiple long-term health conditions (LTCs) requiring treatment, and about 50% of people with multiple LTCs experience limitation of their day to day activities
- Rates of hospital admission and need for social care packages of care increase with age
- There are currently approximately 1,660 people living with dementia in Peterborough – this is projected to rise to 2,660 by 2030.

KEY HEALTH INEQUALITIES

- There are a higher proportion of older people aged 65+ in rural areas of Peterborough.
- In more deprived areas, people develop multiple long-term health conditions at a younger age

CURRENT JOINT WORK

The health and wellbeing challenges facing older people have been prioritised locally across health and care systems. In response UnitingCare (an NHS partnership responsible for providing older people's healthcare and adult community services across Cambridgeshire and Peterborough) are working together with local NHS commissioners, local Councils and voluntary organisations to enable people to age well and to live the life they want to lead by:

- Providing high-quality, responsive care and support
- Integrated working across health, social care and third sector services in Peterborough to ensure that care is joined-up around the needs of individuals within local communities, and avoidable admissions to hospital and care can be prevented.

FUTURE PLANS

- The Health and Wellbeing Board has commissioned an "Older People: Primary Prevention of ill health" JSNA for Peterborough which is due for completion in July 2016
- Developing a joint "Healthy Ageing and Prevention Agenda" to ensure that preventative action is integrated and responsive to best support people to age well, live independently and contribute to their communities for as long as possible
- To understand the challenges faced by local older populations, a specific programme of work in collaboration with older residents, will explore the main health and care issues faced by this group to inform future commissioning of services across the system and how stronger communities can empower people to self manage with minimal support.

HOW WILL WE MEASURE SUCCESS?

We will aim to achieve improvements in the following outcomes:

- Increased access and uptake of preventative services to promote and ensure ageing well
- Reduced rates of admissions to hospital and social care due to conditions that could have been managed in the community.
- Customer survey to establish if Older people feel safer and supported in their communities
- UnitingCare Outcomes Framework – covering several key priority areas for older people in relation to their NHS care, and the Social Care outcomes framework .

2.6 PROTECTING HEALTH – COMMUNICABLE DISEASES

NEEDS IDENTIFIED THROUGH THE ANNUAL HEALTH PROTECTION REPORT

- Rates of Tuberculosis (TB) in Peterborough are well above the national average – there are implications from the new national strategy and the opportunity to offer screening for latent TB infection to new migrants from high prevalence communities
- There is relatively poor uptake of adult bowel and cervical cancer screening programmes
- There is relatively poor uptake of childhood immunisation programmes, particularly in the inner city and areas of higher socio-economic deprivation
- Chlamydia screening is focussed on young people aged 15 – 24, with a high diagnosis rate in Peterborough despite low screening uptake suggesting that some young people who are infected may be missing out on screening
- There is reported late diagnosis of HIV for some men leading to poorer outcomes.

KEY HEALTH INEQUALITIES

- TB is recognised as being associated with deprivation and overcrowding
- There is some evidence that screening uptake is lower among some more deprived and marginalised populations and some new migrant groups
- The picture around immunisation uptake is complex but there is evidence that certain populations have difficulty accessing services for immunisation

CURRENT JOINT WORK

- Cambridgeshire & Peterborough CCG has convened a joint TB commissioning group, to develop plan to commission accessible and responsive services. The first task has been to develop a plan for implementation of Latent TB Infection (LTBI) screening in line with the national TB strategy and a bid for funding has been submitted to PHE.
- The Health Protection Steering Group, which involves the City Council, local NHS and Public Health England, has oversight of immunisation and screening uptake. Task & Finish Groups to look to at uptake issues for both have reported and implementation groups are due to take forward their recommendations.
- A multi-agency sexual health strategy group is due to commence work shortly, convened by Peterborough City Council

FUTURE PLANS

- Develop a TB Commissioning plan for Cambridgeshire & Peterborough
- Develop a joint strategy to address poor uptake of screening
- Develop a joint strategy to address poor uptake of immunisation
- Develop a Peterborough Joint Sexual Health Strategy

HOW WILL WE MEASURE SUCCESS?

We aim to achieve improvements in:

- Percentage of eligible people screened for latent TB infection
- Percentage of eligible newborn babies given BCG vaccination (aim 90%+)
- Increase in rate of completion of TB treatment
- Evidence of increasing uptake of screening and immunisation
- Reduction in late diagnosis of HIV
- Increased uptake of chlamydia screening

3.1 GROWTH, HEALTH AND THE LOCAL PLAN

The Planning System for the built environment affects health in many ways - through securing good housing construction, transport infrastructure, improving air quality and noisy environments, remediating contaminated land, providing open space and play space, enhancing biodiversity, providing opportunities for local food growing, reducing flood risk, provision of local employment and many more. The adopted Core Strategy for Peterborough sets the requirement for an additional 25,500 new homes and 20,000 new jobs by 2026. The new Local Plan will extent the plan period to 2036.

There is a clear correlation between health and where we live. A number of published studies have provided evidence that our local environments can have a positive effect on individual health and wellbeing. On the other hand, many aspects of the built environment can deter people from being physically active, which is important for health. Consideration of 'social infrastructure', encouraging communities in new housing developments to develop supportive social networks, has a positive impact on wellbeing.

NEEDS IDENTIFIED IN THE JSNA:

In Peterborough:

- The percentage of physical active adults is not significantly different to the England average
- The Peterborough Open Space Study Update Final Report (October 2011) indicates which areas of Peterborough are better or less well served in terms of open space.

KEY HEALTH INEQUALITIES

- Lack of access to open and green spaces can be bad for people's physical and mental health. Residents in areas of deprivation which have access to green space have lower rates of premature death than residents of deprived areas with less access to green space. The Peterborough Open Space Study Update Final Report (October 2011) indicates which areas of Peterborough are better or less well served in terms of open space.

CURRENT JOINT WORK

- The Environment Capital Action Plan (dates of plan) describes the following actions:
    - Secure funding to increase the number of Green Flag awards to 6.
    - Nene Park Trust will continually raise the quality of its facilities and improve the participation and engagement of visitors.
    - Seek funding to carry out a feasibility study into local, sustainable food production.
    - Achieve Fairtrade city status.
    - Develop planning guidance to support local food.

FUTURE PLANS

- The health of residents will be specifically considered in development of the new Local Plan.
- Public Health outcomes and/or objectives will be added to the Plan

HOW WILL WE MEASURE SUCCESS?

We aim to achieve improvements in the following outcomes:

The Local Plan potentially affects a wide range of health outcomes. Some outcomes likely to be influenced by the built environment and land use planning are:

- The percentage of physically active and inactive adults
- Excess weight in 4-5 and 10-11 year olds, and Adults
- The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime
- Utilisation of outdoor space for exercise/health reasons

3.2 HEALTH AND TRANSPORT PLANNING

Transport is a complex system affected by infrastructure, individual characteristics and behaviours and can have a broad impact on health. Components that could be linked to health outcomes include issues such as air and noise pollution, road design, impact on physical activity, road injuries and deaths, and access to health services. This illustrates the diverse nature of the policy areas that are related to transport and may have a direct or indirect impact on health. Travel offers an important opportunity to help people become more physically active. Motor vehicle traffic accidents are a major cause of preventable deaths and morbidity, particularly in younger age groups.

NEEDS IDENTIFIED IN THE JSNA:

In Peterborough:
- The number of children killed or seriously injured in road traffic accidents is not significantly different to the England Average.
- The number of adults killed or seriously injured on road is not significantly different to the England Average.
- Travel offers an important opportunity to help people become more physically active. However, inactive modes of transport have increasingly dominated in recent years.
- Approximately 37% deaths from Coronary Heart Disease are related to physical inactivity.

KEY HEALTH INEQUALITIES
- The effects of road traffic disproportionately impact on socially excluded areas and individuals through pedestrian accidents, air pollution, noise and the effect on local communities of busy roads cutting through residential areas.
- Areas with higher levels of deprivation tend to have lower levels of general physical activity

Cycling proficiency is also linked to where people live, with those in more deprived neighbourhoods less likely to report being able to cycle.

CURRENT JOINT WORK

The City Council's Travelchoice initiative encourages people to walk, cycle, use public transport, car share as well as the uptake of low emission vehicles.

- Increasing the number of pupils receiving Bikeability training from 951 to 1300 annually.
- The Cambridgeshire and Peterborough Road Safety Partnership (CPRSP) works with a number of organisations to look at the causes of road accidents, understand current data and intelligence regarding the county's roads and develop multi-agency's solutions to help prevent future accidents and reduce collisions.
- Addenbrooke's Regional Trauma Network is a key partner in the CPRSP, and through various data sources allow the serious accident data to be broken down into more detail to gain a clear understanding of the impact of severe collisions to the NHS and longer term social care and other partners.

FUTURE PLANS

- The Fourth Local Transport Plan (2016-2020) will contain a strong emphasis on the role transport can play in health of Peterborough residents
- Collect further JSNA information on transport for Peterborough, using locally developed methodologies. .

HOW WILL WE MEASURE SUCCESS?

We aim to achieve improvements in the following outcomes
- The numbers of adults and children killed or seriously injured in road traffic accidents.
- The number of businesses with travel plans
- % of adults who meet the CMO guidelines on physical active (active people survey)
- To further develop a robust monitoring network to enable in depth transport modal data to be collected.
- Measures of air quality

3.3 HOUSING AND HEALTH

CREATING A HEALTHY ENVIRONMENT

The National Housing Federation states that poor housing conditions increase the risk of severe ill-health or disability by up to 25% during childhood and early adulthood. Housing conditions that adversely affect health, include; indoor dampness; pollutants associated with respiratory problems; features that lead to physical injury. Household overcrowding is associated with an increased risk in the spread of infection, and Indoor cold is associated with excess winter deaths and cardiovascular problems. The combination of factors associated with poor housing and economic stresses has been identified as having an adverse effect on mental health.

Homelessness is associated with adverse health, education and social outcomes, particularly for children. Statutory homeless households contain some of the most vulnerable and needy members of our communities. The Welfare Reform Act 2012 introduced a range of benefit changes which are likely to result in a loss of income for some claimants and could result in an increase in homelessness if people are unable to meet their housing costs. There are also national requirements to reduce social rented housing,

NEEDS IDENTIFIED IN THE JSNA AND KEY HEALTH INEQUALITIES:

In Peterborough:

- The rate of family homelessness is worse than the England average.
- The 3 year rate of excess winter deaths (which may be related to winter infections, cold homes, and becoming cold outside the home) remained similar to the England average in Peterborough in 2010 -2013.
- It is estimated that poor housing conditions are responsible for over 651 harmful events requiring medical treatment every year. The estimated cost to the NHS of treating these is £2.2M annually.

CURRENT JOINT WORK:

- Housing Related Support (formerly Supporting People) funds support to a variety of providers and settings to ensure their clients are supported into move on accommodation, can maintain tenancies, and therefore prevent them from becoming homeless.
- The Peterborough Older Persons Accommodation Strategy identified that over 90% of people wished to remain at home and be supported to do so through the provision of aids and adaptations, and a demand for Extra Care Accommodation. To date, 262 additional units of Extra Care accommodation have been provided in partnership with Registered Providers. A further scheme of 54 dwellings is under construction.
- Care and Repair provides a handyperson (HP) scheme to help aged and vulnerable people with small scale works. The minor aids and adaptations installations and the HP assist hospital discharge and enable health services to be delivered in people’s homes. The Agency provides advice and has a network of contacts for onward referral and works with other voluntary sector groups on winter warmth initiatives.

FUTURE PLANS

- Peterborough City Council is working in partnership with Registered Providers to provide new supported housing schemes including accommodation for people with learning disabilities and mental health disorder to enable them to live independently with a live in carer where necessary or floating support.
- The Peterborough Market Position Statement has identified a significant shortfall of nursing and residential care accommodation and it will be a priority to increase this provision for the aging population.
- A task and finish group including Housing managers and Hospital managers is reviewing complex cases causing hospital discharge delays, and how use of disabled facility grants could address this.
- There is currently (winter 2015) a public consultation on introducing selective licensing in 5 areas of the city covering 6205 privately rented properties. This would help raise the standard of private rented accommodation and therefore improve the health and well- being of those residents.

HOW WILL WE MEASURE SUCCESS?

- Decrease in the ratio of excess winter deaths to average non-winter deaths
- Reduction in unintentional injuries in the home in the under 15 year olds
- Reduction in delayed discharge related to housing issues.

4.1 GEOGRAPHICAL HEALTH INEQUALITIES

NEEDS IDENTIFIED IN THE JSNA:

- This link between more adverse socio-economic circumstances (deprivation) and poorer health is well known.
- The five most deprived electoral wards in Peterborough are Dogsthorpe, North, Paston, Central and Ravensthorpe. Within these wards, deaths rates from all causes under the age of 75 and rates of admission to hospital are significantly high.
- Other parts of Peterborough also have residents living in difficult socio-economic circumstances – for example Bretton North, Orton Longueville and Park wards are not included in the five 'most deprived' but have a higher percentage of children in poverty, lower achievement at GCSE and a higher percentage of the working age population claiming out of work benefit than the Peterborough average.

CURRENT JOINT WORK

- The City Council has a focus on economic development and regeneration in the City, together with improving educational attainment. In the long term these measures should improve both socio-economic circumstances and health.
- City Council commissioned Children's Centres work closely with health visitors, and are located to ensure focus on the areas of the City with the highest levels of need.
- The City Council has identified the 'Can Do' Area around Lincoln Road, which includes parts of Central Ward, Park ward and North ward. The 'Can Do' Board focusses on supporting environmental and service improvements for the area and includes senior staff from the City Council.

FUTURE PLANS

- The NHS Clinical Commissioning Group has a statutory duty to reduce health inequalities and to carry out health inequalities impact assessments of any significant services changes.
- City Council proposals for selective licensing of private sector housing in parts of the City (outlined in the previous section) could impact on geographical health inequalities in the longer term.
- There is potential to target preventive public health initiatives and services so that they focus more on areas of the City with the greatest health and wellbeing needs.

HOW WILL WE MEASURE SUCCESS?

We aim to achieve improvements in the following outcomes:

- Increase in levels of education and economic attainment in electoral wards with highest levels of deprivation.
- Increase in life expectancy in wards with highest levels of deprivation.
- Reduction in emergency hospital admissions from wards with the highest levels of deprivation.
- Smoking cessation rates in wards with highest levels of deprivation
- Health checks completion in wards with highest levels of deprivation

4.2 HEALTH AND WELLBEING OF DIVERSE COMMUNITIES

NEEDS IDENTIFIED IN THE JSNA:

DIVERSE COMMUNITIES

- Peterborough has an ethnically diverse population; 70.9% of residents self-identified as White English/Welsh/Scottish/Northern Irish/British compared to 86.0% in England as a whole. A higher proportion of our population than average are of South Asian and Eastern European descent.
- Black & Ethnic Minority populations are highest in the Central ward (58.2%), Park (35.8%) and Ravensthorpe (30.8%).
- World Health Organization research concludes that
    - the risk of cardiovascular disease and type 2 diabetes is higher in South Asian population groups
    - alcohol consumption is rising in many Eastern European countries, contributing to a significant decline in life expectancy among men of Eastern European descent
    - rates of tuberculosis are also known to be higher in some African, South Asian and Eastern European countries than in England.

CURRENT JOINT WORK

- The Health and Wellbeing Board has commissioned a Joint Strategic Needs Assessment (JSNA) on the health and wellbeing needs of Eastern European migrants.
- Eastern European 'community connectors' employed by the City Council are working closely with the local NHS on issues such as promotion of screening and immunisations

FUTURE PLANS

- The benefits of tailored preventive programmes, working with South Asian communities to prevent diabetes and cardiovascular disease, are increasingly recognised nationally. The CCG and City Council will work together to assess the feasibility of local schemes.

HOW WILL WE MEASURE SUCCESS?

Measuring success is more challenging for health and wellbeing issues in diverse communities, as recording of ethnicity by health services is not always complete. This makes it hard to rely on routinely collected data. Population mobility and change can also make measuring progress more challenging.

- Work with local health services to improve data collection on ethnicity, both generally and to assess the success of targetted interventions.
- Outcome measures for health and wellbeing of Eastern European migrants will be developed following completion of the JSNA.

4.3 HEALTH AND WELLBEING OF PEOPLE WITH DISABILITY AND/OR SENSORY IMPAIRMENT

NEEDS IDENTIFIED IN THE JSNA:

The population of Adults in Peterborough living with a learning disability is forecast to rise by 10% between 2014 and 2030 from 2865 people to 3152 (source Department of Health Information Centre). In particular:

- Growth in in number of residents with severe Learning Disabilities is from 174 to 193 (11%)
- Growth in number of residents with autistic spectrum disorders is from 1179 to 1320 = 12%

The number of people with moderate or serious physical disabilities is forecast to rise by 14% between 2014 and 2030 from 11,208 to 12,743

In particular

- Forecast growth in those requiring assistance with personal care is from 5155 to 5904 (15%)
- Forecast growth in residents with serious visual impairment is from 76 to 84 (11%)
- Forecast growth in residents with moderate to profound hearing impairment is from 4178 to 4895 (17%)

CURRENT JOINT WORK AND FUTURE PLANS:

The Council and Clinical Commissioning Group have agreed a strategy for supporting older people and adults with long term conditions within the Better Care Fund plan, working together to support people with disabilities through the following five key workstreams:

- Data Sharing – enabling effective sharing of care and support information between health and social care professionals with access controlled by the person with disabilities.
- 7 Day Working – expansion of health and social care service provision to be accessible and responsive at evenings and weekends.
- Person Centred System – multi-disciplinary teams linked to the communities in which people live.
- Information, Communication and Advice- enhanced information and advice to support people to access the support they might need.
- Ageing Healthily and Prevention – help for all to stay healthy and self-manage long term conditions wherever possible.

HOW WILL WE MEASURE SUCCESS?

We aim to achieve improvements in the following outcomes:

National measures: Adult social care outcomes framework (ASCOF)

- Percentage of adults known to ASC in employment - to increase
- ASCOF Percentage of adults known to ASC in settled accommodation – to increase
- ASCOF permanent residential admissions of adults to residential care – to decrease

Local measures

- Numbers of adults in receipt of assistive technology
- ASC Service user survey quality of life measure – improvement for clients aged under 65 with both learning disability and physical disability
- Numbers of adults with disabilities receiving short term services to increase independence.
- Number of adults with disabilities receiving information advice and guidance

5.1 PARTNERSHIP BOARDS

The Peterborough Health and Well Being Board is supported by a number of Boards and Groups that are key to delivering the outcomes of the Joint Health and Wellbeing Strategy.

The Boards are as follows:

- Housing Partnership
- Children and Families Joint Commissioning board
- Adult Joint Commissioning Board
- Mental Health Board
- Borderline and Peterborough Executive Partnership Board
- Public Health Board

These Boards define outcomes for delivery by focussed Task Groups, and these outcomes are core to delivery of the Joint Health and Wellbeing Strategy.

To avoid duplication and give opportunities to join up work when appropriate, the Health and Wellbeing Board agreed to the development of a Health and Wellbeing Partnership Delivery Board. This comprises the Chairs of all the above Boards and the joint chair of the City's Skills Board. It's role is to take an overview of the work going on and ensure it is co-ordinated. This Programme Board also has strong links with the Safer Peterborough Partnership Board and Adult and Children Safeguarding Boards.

5.2 COMMISSIONING PRINCIPLES

Commissioning is about supporting the development of a thriving, strong and diverse social and health care market that is flexible and responsive to everyone in Peterborough, not just those eligible for direct Council or Health support - We want to stimulate the development of new services, and promote competition so people have a varied care and support market to purchase from. To achieve this, we will work to ensure we commission services that are:

1. Affordable and sustainable;
2. Evidence based;
3. Locally shaped;
4. Improving quality and the patient experience;
5. Addresses Health Inequalities
6. Appropriate in scale; and
7. Reflects the user's voice.

The City Council have developed a set of design principles when commissioning services, shown in appendix A. The NHS is a national tax-funded organisation – so some of the principles around commercialism and revenue generation are less relevant to local NHS organisations – but many aspects of good commissioning practice are shared.

KEY PROGRAMMES

The following pages describe two key programmes to meet the future needs of growing populations, within a available resources:

- The Cambridgeshire and Peterborough 'Health System Transformation Programmes
- The Peterborough City Council Customer Experience Programme

5.3 CAMBRIDGESHIRE AND PETERBOROUGH HEALTH SYSTEM TRANSFORMATION PROGRAMME

Cambridgeshire and Peterborough Clinical Commissioning Group (CCG), which plans, organises and buys most NHS-funded healthcare, and the providers of local hospital and community healthcare are working together for the benefit of the whole local NHS healthcare system. They have joined together under the System Transformation Programme to look at shaping a sustainable health system fit for the future. Peterborough City Council and Cambridgeshire County Council are also part of the programme, as are local Healthwatch organisations. The work of the programme also fits in with NHS England's recently published (October 2014) Five Year Forward View. The Five Year Forward View recognises that the world has changed and health services need to evolve to meet the challenges NHS health services face.

SYSTEM STRATEGIC AIMS AND GOALS

The Cambridgeshire and Peterborough health system has agreed to a set of strategic aims for the next five years. These strategic aims are set out in the diagram below which shows how the strategic aims relate, with people at the centre of all we do.

The Cambridgeshire and Peterborough System Transformation Programme is looking at all hospital-based, GP and community healthcare services in Cambridgeshire and Peterborough. It is particularly focussing on the following areas of care:

- Children's and maternity services
- Mental health services
- Care delivered through GP surgeries
- Planned care (both in hospital and in the community)
- Emergency and urgent care.

It's also taking into account the improvements expected to take place in older people's (over 65s) healthcare under the innovative Integrated Older People's and Adult Community Services contract. Prevention is key to the programme with everyone having a role in helping to reduce demand on our health services.

If we do not plan to change our health system, we are likely to see:

- funding shortfalls, possibly leading to unplanned service changes over which we have little control
- decreased quality of care and poorer health outcomes for people
- a continued rise in the need for health care
- some General Practices going out of business
- hospitals continuing to experience a rise in emergency admissions
- hospitals finding it harder to undertake planned work (such as scheduled operations)
- a decrease in quality and access performance standards in hospitals, and an increase in financial deficits
- an increase in pressure on all parts of the health system and an already stretched workforce.

The Health System Transformation Programme has taken a wide range of opportunities to engage with the wider public and feedback will inform and be reflected within the development of ideas for change across the system

5.4 PETERBOROUGH CITY COUNCIL CUSTOMER EXPERIENCE PROGRAMME

The Customer Experience programme will develop and improve the ways in which customers access or are provided with public services, ensuring those that need help the most are able to reach the most appropriate services quickly and first time. This approach will enable services to meet the needs of those affected by health, social and economic inequalities across Peterborough, and will build resilience and capacity in communities to sustain improvements. The programme targets a reduction in costs, an increase in revenue and the management of current and future demand. The programme is divided into seven themes:

i. Front Door – redefining the method of accessing and contacting the council, ensuring those that can will be able help themselves and those with more complex needs reach the right services quickly
ii. Investment in Communities – ensuring we invest appropriately in community, voluntary or faith services and capacity as an alternative to public sector services
iii. Operating Models – designing new service delivery arrangements between council services and with partners
iv. New Ways of Working – enabling staff to work flexibly and in an agile way, making full use of digital technologies
v. Revenue – strengthening the council's commercially-minded approach, Increasing the amount of profitable revenue
vi. Building Optimisation – making the best use of public buildings and office space
vii. Digital Technology – investing in new technologies to improve ways of working and to enhance the offer to customers

The council wants its customers to:

- Ask once – we will only ask the customer for any information needed once
- Be self-directed – we will maximise any opportunity for the customer to self-serve
- Be in control – we will ensure services are customer-led and take account of the customer's views
- Be protected – we will identify and act upon any safeguarding concerns
- Be confident the information we hold about them is consistent across the organisation
- Be able to make full use of universal information and provision as the norm through interactive use of technology, blended with 'expert' assistance
- Have their queries resolved at the first point of contact wherever possible
- Be able to access council services or information in the most appropriate settings – there will be no wrong front door.

If we get these things right then it will be better for customers as they will receive a better and more accessible service, whilst at the same time enabling us to manage demand more effectively and sustainably.

CURRENT JOINT WORK

The Customer Experience programme is enabling a sharp focus on developing greater integration between the council and health partners. For example:

- the Operating Models theme is scoping an integrated health and social care operational delivery model which could see social workers co-located with health professionals
- the Operating Models theme is developing a new delivery model to bring together reablement and preventative health and social care services into a trading vehicle
- the Front Door theme is exploring a single, integrated front door model for council and health services
- the Investment in Communities theme is determining what health and social care preventative projects could be commissioned to help manage demand
- the Digital Technology strand is piloting new assistive technologies that could help reduce demand on the health and social care system

FUTURE PLANS

The Customer Experience programme is still at the early stages of delivery, but has well established principles including the desire to deliver integration across health and social care services wherever possible and appropriate. We will ensure that health colleagues across the system are fully engaged in the programme.

5.5 A VISION FOR HEALTH AND WELLBEING IN 2016/19

The context for the 2016/19 Joint Health and Wellbeing Strategy is:

- **Significant budget reductions**
- **Growing population and demand for services**

To meet these challenges, Health, Local Authority and other partners in the Health and Wellbeing Board will work in a new way - focusing on outcomes not organisations. We will get done what needs to be done by who is best to do it, and use evidence based sources and best practice to ensure what we deliver has the best chance of success. Success is now seen as collective.

PLACING PEOPLE AT THE HEART OF A SYSTEM WHICH MAKES SENSE TO THEM

The Health and Wellbeing Board will achieve its aims by:

A focus on **prevention**

- making Peterborough a healthy environment in which to live
- supporting people and communities to maintain their own health and independence.

Driving **delivery** of:

- The right services
- To the right people, families and communities
- By the right people
- At the right time
- In the right place
- At the right cost

Monitoring **outcomes** which matter to local residents, families and communities

7. PETERBOROUGH CITY COUNCIL COMMISSIONING DESIGN PRINCIPLES

Efficient and effective

- Ground-up approach based on lean principles
  - Non value add - ***Stop***
  - Non value add but necessary - ***Automate***
  - Value add -
- Internal self-serve
- Reducing supply chain
  - Reduced number of transactions / cost of transactions
- All resources will be organised around the Target Operating Model principles:- and Operational Plan
  - Self-serve/ Self Management wherever possible
  - most experienced staff at front door
  - in integrated teams

Role of the Commissioner

- Leadership – promoting, facilitating & place shaping
- Forecasting demand and need; Facilitating and coordinating solutions
- Regulator / Quality Assurer / Safeguarding
- Information provider and empowering local people

Statutory objectives

- Only providing services that are a statutory obligation or
- Where they evidently support statutory objectives or
- Generates profitable revenue where appropriate and lawful

Commercially viability

- Profitable revenue creation is a priority
- Retained 'business units' must be commercially viable

Demand management

- Prioritise the commissioning of services and solutions that will prevent or delay escalating support and service needs.
- Solve Customer problems as early in the journey as possible
- Build Community and Market Capability
  - To develop and extend the Community and Market capability, involvement and offer
- Target commissioning
  - Evidence based & Outcomes focused
  - Using best means of delivering outcomes
  - mixed economy of providers (public, vehicles, private and 3rd Sector)

Collaborate or partner whenever financially viable

- Commissioners will use Joint Funding mechanisms to procure services when appropriate and reduce transaction costs?

All infrastructure will be shared with partners

- Limit single organisation only occupancy and base on maximum occupancy Agile / mobile working the norm

Political

- Commissioning activity will take account of and be sensitive to the national and local political context. Engagement with elected members will be carried out throughout the commissioning process

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 10
10 DECEMBER 2015		PUBLIC REPORT
Contact Officer(s):	Catherine Mitchell, Local Chief Officer, Cambridgeshire and Peterborough CCG	Tel. 01733 758505

PETERBOROUGH SYSTEM WINTER PLAN

R E C O M M E N D A T I O N S	
FROM: Catherine Mitchell, Local Chief Officer, Cambridgeshire and Peterborough CCG	**Deadline date:** N/A
That the Health and Wellbeing Board note the update set out in the report.	

1. ORIGIN OF REPORT

1.1 This report is submitted to the Board from the Peterborough System Resilience Group (SRG).

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to inform the Peterborough Health and Wellbeing Board of the planning undertaken by the Peterborough SRG, based on partners' combined understanding of the demand and capacity requirements to ensure the system is able to operate and manage patient flow through the services over the winter period.

3. BACKGROUND

3.1 The Peterborough SRG is the multi-agency board responsible for the delivery of the 95% A&E, 18 week Referral to Treatment, and Cancer standards. The Board is made up of members from acute and community services, primary care, voluntary sector, commissioners, ambulance services, and social care from Peterborough, Cambridgeshire and Lincolnshire.

3.2 The attached Winter Plan is based upon a robust evidence base of expected demand across the system based on previous years' activity and any known events likely to impact the system. The key outcomes of the capacity modelling are:

- Attendances and admissions through A&E are consistent across the year, and previous seasonal peaks and troughs are no longer seen;
- Length of stay doesn't increase by more than 0.5 day during winter; and
- That events such as outbreaks of Norovirus will generally impact on a reduction of 20-40 beds.

3.3 The winter plan is a section of the SRG 10 Point Action Plan, implemented to deliver continuous improvement.

3.4 The system has a robust management system in place that measures delivery in real time, as well as daily, weekly, and monthly dashboards of all services.

3.5 Schemes included in the winter plan are those schemes that have been funded through operational resilience monies that have either been proven to have a positive impact on managing patient flow, or are testing new concepts to improve ways of working.

4. ANTICIPATED OUTCOMES

4.1 The SRG will continue to deliver the 95% A&E standard without a negative impact on the 1 8 week referral to treatment target.

6. APPENDICES

- Appendix A – Peterborough Borderline System Resilience Plan
- Appendix B – Winter Pressures

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

OPERATIONAL RESILIENCE AND CAPACITY PLAN

Financial Year 2015/16

Borderline and Peterborough -Peterborough and Stamford Hospital Foundation Trust

Version 12

Contents

1. The Peterborough Vision 2
2. Current Position 4
3.1 Urgent and Emergency Care 7
3.2 Elective Care 16
4. Governance and Risk Management 18
4.1 System Resilience Group Governance 18
4.2 Top Level Risks 20
Appendices 21

1. The Peterborough Vision

The Peterborough and Stamford Hospital Foundation Trust system covers five Local Authority and three CCG areas. The largest volume of activity comes from Cambridgeshire and Peterborough CCG.

Cambridgeshire and Peterborough CCG is one of the eleven challenged health economies, and there is a System Transformation Programme to close a financial gap of £250m.

The Cambridgeshire and Peterborough CCG system was awarded the Urgent and Emergency Care Vanguard in September 2015. Our vision for implementing the UEC Review is to create an overarching clinically led strategic super-SRG, as part of the East of England Urgent and Emergency Care Network (population of approx. 6m), and to accelerate the pace of improvement we have started to deliver. We aim to achieve a model of best practice in line with the NHS England vision focussed on delivering:

- **Optimum delivery of urgent care in communities** and neighbourhoods for all age groups developing consistent fast and effective services across our rural, semi urban and urban areas.
- **Centres of emergency care excellence.** We currently have three A&E departments, with CUHFT as the specialist emergency care centre and trauma centre; PSHFT as a trauma unit and general emergency care unit; and HHT as a general emergency care unit. We will undertake a clinical and financial sustainability review including minor injury and illness units, to ensure that the model of emergency and urgent care best meets the need for local urgent care and consistent high quality and specialist emergency care.
- **Adoption of best practice in hospital pathways** as recommended by ECIST to sustainably deliver the 95% A&E standard towards which are starting to make good progress.
- **Development of our progressive and integrated model of Older Peoples commissioning**, supporting the new accountable provider, Uniting Care, to deliver improved outcomes for older people. This is an innovative model of commissioning which is **outcome based through a capitated budget**. The whole system (primary care, community, and mental health in the community) is integrating at the level of neighbourhood teams to enable Older People to live well in their communities, to receive urgent care in these communities and to return to them, living independently or with support, in their own homes as quickly as possible following a hospital admission.
- **Integration of the minor injury units in our communities with out-of-hours primary care**, which can be accessed by ambulatory patients, ambulances and community rapid response services to keep care as close to home whenever clinically safe to do so.
- High rates of access to all urgent and emergency care by **telephone first** so patients are clinically directed to the service that best meets their needs. We are currently procuring an **integrated Out of Hours GP and 111 service with a multi-disciplinary clinical hub** – this is a formal procurement which has completed public consultation, and is now in the final stages. It builds on our successful model of 'GP in 111' reducing A&E dispositions by 70%.
- **An ambulance service that thinks community first** –working with the Joint Emergency Teams (JET) in the community and primary care in and out of hours. A current CQUIN scheme to pilot GP triage of green ambulance calls in the control room is about to commence – stitching the ambulance service into our community services is as vital as their ability to respond to emergency calls within national response time standards.
- **A coordinated and integrated response for patients of any age with mental health urgent and emergency care needs**. We currently have a patchwork of services including crisis home

treatment, Section 136 suite, hospital based psychiatric liaison of varied hours and workforce in each of the three A&E departments - with little provision for Young People where growth in demand is not being met. We want to redesign these services so all patients can access appropriate urgent and emergency mental healthcare quickly, regardless of age and as close to home as possible.

- **Development of urgent primary care at scale** transformation programme. The Borderline and Peterborough (B-P) GPs were successful in their Prime Ministers Challenge Fund (PMCF) bid in 2015 resulting in the creation of evening and weekend primary care urgent care hubs in B-P LCGs. This 12 month pilot will be the precursor of developing extended primary care access across the CCG in order to support keeping people well in their communities.Primary Care to operate at scale to cover 250,000 pop in B-P.
- Practices will group into hubs serving 50,000 to 80,000 patients.
- 8.00am to 8.00 pm access on week days; direct booking to appointments via 111.
- At weekends 8-8 Primary Care delivered at Front Door ED

Promote 24 hour access to primary care through 'WebGP' with a one hour response to clinician if required. . The anticipated benefits will be

- A simpler system and extended access
- Reducing pressure on ED
- Continuity within larger primary care hubs
- Creating additional capacity for direct care
- Enhancing professional morale (sense of control and clarity on workload). Better able to serve the expectations of new staff; resilience and consistency of service
- Integrating care for older people
- Integrating pharmacy within the new approach
- Making better use of IT and comms technology

- **Develop a plan to implement the revised standards from RCPCH (Facing the Future) which are clear on the need for 24hr community nursing services for children** and the positive impact this has for admission and length of stay. This would be linked to the transformation of paediatric services across the patch. Addressing the needs of parents using 111 services is vital and will form part of the multidisciplinary clinical hub.
- **Development of a social network of support to enable people to live independently** and supported through the transitions of care by the local authorities, and by the voluntary sector who are increasingly a vital part of the urgent and emergency care system – working with Uniting Care as a significant partner, and helping people home from hospital. Development of Voluntary Sector Prescribing.
- **Working with the County Council and housing partners to develop a range of older people's short and long term accommodation** to reduce the need for acute hospital admission and to promote timely discharge. A Project Board, with system wide sign up has been established to take this work forward. The work includes partnership with the private sector and with Sheffield Hallam University. The focus is on both immediate needs (0-5 years) and longer term needs(5-25 years).
- **Develop practical options for data sharing** between key organisations. The initial phase is building on work led by Uniting Care to provide a Single view of key data. This work includes the use of the NHS number as the single patient identifier as part of the Better Care Fund Plan.
- Exploring opportunities to develop intelligence lead healthcare. This will involve sharing high level data and also triangulating it with the intelligence picked up by health and social care staff to prevent deterioration in our most vulnerable patients.

2. Current Position

2.1 What are the current challenges we are facing?

2.1.1 Population and Demography

Peterborough has a young population with a higher than average number of children and young people. It is also one of the fastest growing cities in the UK, with predicted population growth of 34.9% between the 21 years spanning 2010-2031. The city is ethnically diverse, with 29.1% of residents not self-identifying as White English/Welsh/Scottish/Northern Irish/British. The next most common ethnicities declared in the 2011 census were Asian/Asian British: Pakistani or British Pakistani (6.6%), White Polish (3.1%) and Asian/Asian British: Indian or British Indian (2.5%).
In 2014, economic migration was most common from Poland (1,100 migrant national insurance registrations), Republic of Lithuania (974), Portugal (504), Romania (427) and Latvia (397). There are socio-economic inequalities within the local authority area, with areas of significant deprivation close to central Peterborough.

Life expectancy at birth for females has risen in England from 79.1 years in 1991/93 to 83.1 years in 2011/13, an increase of 4.0 years or 5.1%. In Peterborough, the increase in life expectancy in this period has been slower than that observed nationally, from 79.2 to 82.6 years, an increase of 3.4 years or 4.3%. Evidently, the life expectancy in Peterborough has fallen from slightly above the England average to slightly below over this 20 year period.
For males, life expectancy at birth has risen more substantially but also at a slower rate than observed in England. Male life expectancy nationally has increased from 73.7 years in the 1991/93 time period to 79.4 years in 2011/13; an increase of 5.7 years, or 7.7%. However, life expectancy in Peterborough has increase more slowly, from 73.8 years in 1991/93 to 78.1 years in 2011/13. This represents an increase of 4.3 years or 5.8%.

Children's health
Peterborough has a higher number of children than the national average living in poverty (27.2%) and a high level of diversity among the child population. The level of school readiness is at the national average and is better than average for children entitled to free school meals. However levels of educational attainment at GCSE vary significantly between electoral wards and poor attainment is closely associated with socio-economic deprivation. Childhood obesity is higher than the national average at 'reception' age, but lower than average amongst 10-11 year olds, although the proportion of underweight children is high at this age. The proportion of teenagers not in employment, education or training is higher than average, as are the numbers of teenage pregnancies. Hospital admissions for self-harm amongst children and young people, and admissions for injury amongst 15-24 year olds are also higher than average.

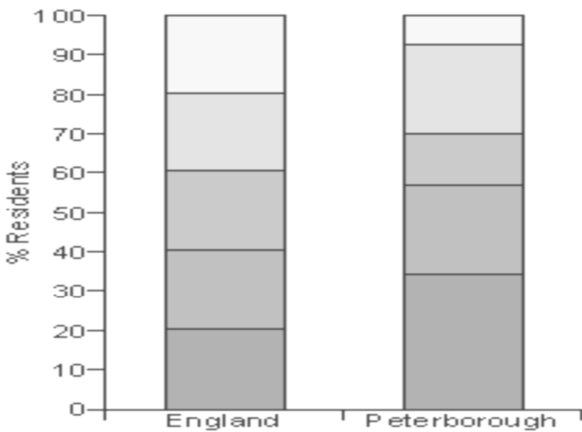
Adult health
A feature of adult health in Peterborough is a relatively high rate of premature death and disability, with life expectancy and healthy life expectancy being below national averages. Premature deaths from cardiovascular disease including in particular coronary heart disease, and from respiratory disease are higher than average – and these high rates of cardiovascular disease are focussed in electoral wards with the highest levels of socio-economic deprivation. Rates of premature death from cancer and liver disease are similar to the national average. Standardised hospital admission rates follow the pattern of premature mortality, with high admission rates for cardiovascular disease (and for all causes) from the more deprived wards.

There are lifestyle and health behaviour issues with longer term implications for public health – adult smoking rates are above the national average at 21%, hospital admissions specific to alcohol use are higher than average, and about two thirds of adults are overweight or obese (similar to the national average). It is known that smoking, excess alcohol and obesity all cause long term medical conditions which require treatment and that high prevalence of these behaviours will result in additional demand on health and social care services.
Suicide rates in Peterborough are currently similar to the national average, but admissions to hospital for mental health causes are higher than average. The predicted increase in the number of older people in the population means that the numbers of people with dementia in Peterborough, as well as older people suffering from depression is forecast to increase significantly over the next ten years, which will increase demand on health and social care services.

2.1.3 Deprivation

- The overall level of economic deprivation is higher for Peterborough Unitary Authority (UA) than for that of England overall, with a higher percentage of residents than of England overall within the most deprived economic quintile and a lower percentage in the most affluent quintile.

- **Figure 5 - Peterborough vs England deprivation quintiles5**



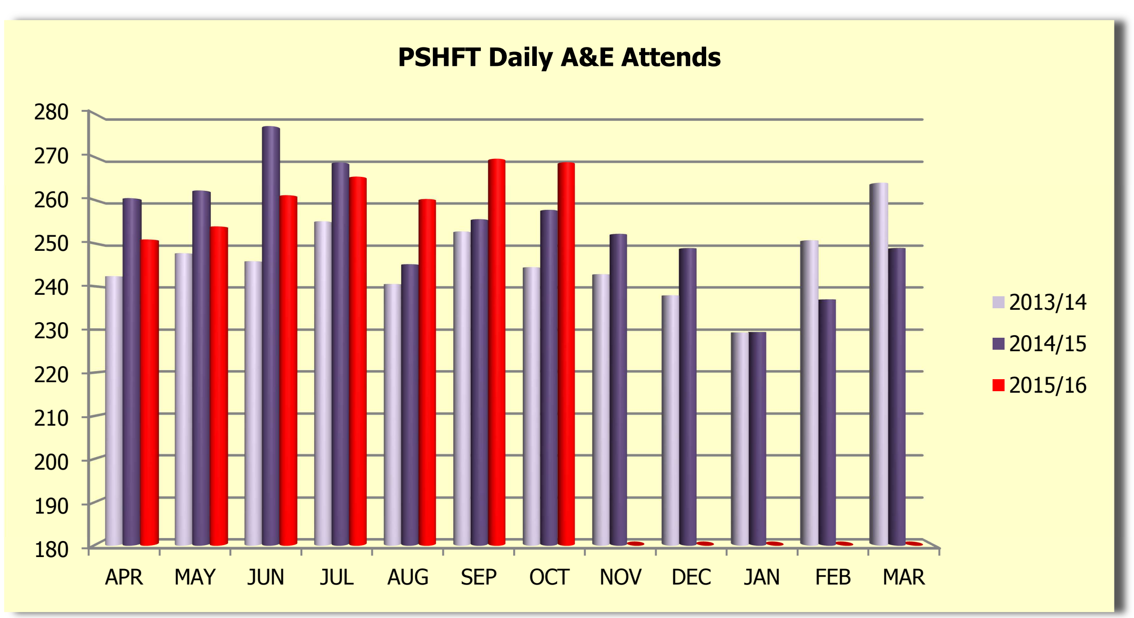
- Deprivation does, however, vary significantly throughout the UA – the below map illustrates that income deprivation prevalence is most apparent in wards near the centre of the UA, with the darkest shaded areas representing some of the most deprived wards in England. The percentage of residents living in income deprived households is highest in Dogsthorpe (28.0%), North (26.5%) and Central (25.5%).

2.2 What has changed?

In previous years there has been a distinction between winter and summer performance against the 95% standard. It has generally been accepted that there are seasonal fluctuations in activity and a recognised 'winter' pressure on the urgent care system. However, over the last couple of years there has been little differentiation or let up coming out of the winter months.

Cambridgeshire and Peterborough CCG have worked closely with South Lincolnshire CCG to build effective working relationships with providers to effectively manage patient flow. The two CCG's have worked collaboratively in aligning commissioning decisions and jointly commissioning services where it is in the best interest of patients.

Cambridgeshire and Peterborough CCG has led the development of an SRG that is collaborative in approach, with strong relationships that allows for robust challenge, and a collective understanding and agreement on the actions required to address continuous improvement.



2.2.1 Activity and performance at PSHFT level.

- The 4 hour standard has been met every month since May 2015, after a long period of not being met.
- Average monthly ED attendances have remained constant in 2015/16 compared with the same period in 2014/15. April-September 2014/15 7,973, 2015/16 7,933. Although there has been some variation in the peaks in activity compared with previous years
- EEAST ambulance conveyances have increased by 8% year to date in 2015/16 on 2014/15
- Ambulance handover standards are below target.
- Delayed Transfers of Care remain a system challenge

The system has made a number of significant improvements since winter 2014/15, these are set out in section 3.1

2.2.2 System Management and Escalation

The system has a robust system in place to manage delivery. There are real time updates throughout the day from the acute trust. In addition there are daily, weekly and monthly scorecards, and a community capacity scorecard has recently been added. Examples of these scorecards are in appendix 2.

The system develops a weekend plan each week, with a system wide call with on-call managers each day to review delivery and address capacity issues. A copy of a weekend plan is at appendix 2.

The system has developed an escalation policy with clear triggers and actions for each levels of escalation, this is attached at appendix 3.

3. Continuous Improvement and Sustainable Performance Plan

3.1 Urgent and Emergency Care

The system has developed a 10 point improvement plan that sets out the actions the system has, is, and will be taking to improve urgent and emergency care. The work-streams are based on external reviews, national best practice, and the UEC Vanguard. The 10 point plan can be found at Appendix 1 . **The 10 point plan is the system's winter plan.** The document is a **live** document and is reviewed fortnightly at the SRG. The plan has had ongoing review by the tripartite and ECIST as part of the Monitoring process of PSHFT's recovery plan.

The winter plan can be found on tab 10 of the 10 point plan and is also included at appendix 1a.. The schemes on this plan are schemes funded to provided resilience to the system through a mixture of; additional capacity to existing services, continuation of schemes found to be beneficial in winter 2014/15, and new/redesigned services that are being piloted.

The system has been working to deliver the 8 high impact changes required by November 2015. The position of our delivery is set out below

Intervention	Is this intervention in place? Please answer 'Yes', 'No', or 'Partially'	Brief overview on how this intervention is covered in operational plans	Commentary on investment to support the intervention
1. No patient should have to attend A&E as a walk in because they have been unable to secure an urgent appointment with a GP. This means having robust services from GP surgeries in hours, in conjunction with comprehensive out of hours services.	Yes	• In hours. Prime Ministers Challenge Fund bid that will extend opening times 8-8 weekdays, and provide Primary Care at the front of ED at weekends and bank holidays with a phased go live from August. • OOH contract in place and being re-commissioned CCG wide. For Borderline and Peterborough SRG system co-location on the acute site will provide GP presence at ED. • MIIU open 8-8 7 days a week. GP led service. • Data is available from piloting a GP in ED model during the winter, and from audit work undertaken. GP working in ED Friday, Saturday, Sunday funded by PSHFT most weekends. • Patients contacting GP surgeries out of hours are directed to 111, who make a disposition to OOH GP and MIIU. • Data requested from NHS England on availability of appointments commissioned from Primary Care. • Need to triangulate appointment availability with number of patients presenting. Patients saying they can't get an appointment hasn't correlated with appointment availability in previous audits. • Choose well literature in practices, websites, radio adverts through CCG communications teams. Further work tailored to community groups needs to be reviewed.	• Prime Ministers Challenge fund £2.6 Million • OOH Contract – CCG wide £3.4m • 111 Contract – CCG wide £7.98m

2. Calls categorised as Green calls to the ambulance 999 service and NHS 111 should have the opportunity to undergo clinical triage before an ambulance or A&E disposition is made. A common clinical advice hub between NHS111, ambulance services and out-of-hours GPs should be considered.	Yes	• 111- GP in control room evenings and weekends. Shifts 8.00-22.00. There is a need to recruit more GPs to fill these shifts. • Evidence is good on reducing ambulance call out and conveyances • SRG have considered one clinical hub and concluded at this time with the current providers this would not be feasible and would be clinically risky. • A CQUIN with the ambulance trust – EOE ambulance is being developed for 2015/16 to review green ambulance conveyances. Start date expected Q2. • NHS 111 - clinical triage of Green Ambulance Dispositions : In April 2015, we commissioned our NHS 111 provider to clinically triage green ambulance dispositions returned by NHS Pathways at the following times : Monday to Friday 18.30 -22.00 Saturday and Sunday 8.00 - 22.00 The provider is due to complete technical testing in respect of this by w/b 11 May 2015 and based on results to date does not foresee any issues arising from a technical perspective that would prevent this triage from going ahead. The clinical capacity for this triage is to be provided by the GP's employed by the service to review ED dispositions. It is likely based on initial assessment of demand for green ambulance review, that this capacity will need to be increased. On this basis remote working facilities have been set up to expand the potential source of GP's beyond Peterborough where the service is based, into Cambridge. and the surrounding area. • EEAST 999 Urgent & Emergency Transport Service - Regional contract :We have proposed a regional CQUIN for the review of G2 ambulance dispositions returned by the above service. The consortium lead, Suffolk CCG are currently exploring this proposal with EEAST. The biggest risk to this proposal being implemented is the shortage of GP's or Enhanced Nurse Practitioners to do triage . service went live in Q2 New -UnitingCare OneCall service commenced 6th May -providing 24/7 co-ordination of clinical services -provide an alternative disposition for both 999/111 .This will co-ordinate the community OOHs services including rapid response and the new Joint Emergency Team, which will ramp up over Q1 to provide a 24/7 service by Q2.	The clinical triage in NHS 111 of green ambulance dispositions is to be pump primed in year 1 and funded out of savings generated thereafter. The review of G2's within 999 service is to be funded out of Regional CQUIN funding . Costs to be confirmed end of May 2015 - available funds approx. £900k across CCGs in consortia.

3. The local Directory of Services supporting NHS 111 and ambulance services should be complete, accurate and continuously updated so that a wider range of agreed dispositions can be made.	Yes	• The DOS is reviewed on an ongoing basis in response to any reported issues in NHS 111 and/or as part of themed reviews to address service areas which could be improved (e.g. dental). • The DOS is a standing item on the monthly NHS 111 Clinical Governance Board agenda. • DOS changes as a result of the last version of pathways (version 9) were implemented in November 2014. • The services profiled on the DOS are primarily those taking referrals from NHS 111. The z code profiling exercise currently underway will expand this to include partner more services, especially in the area of mental health. • Reporting is in place to monitor journeys to A&E where alternatives are not available. UnitingCare OneCall service using the DoS and is an output for the DoS	

4. SRGs should ensure that the use of See and Treat in local ambulance services is maximised. This will require better access to clinical decision support and responsive community services.	Yes	• Ambulances have access to GP in 111, OOH doctors, Intermediate Care pathways, Ambulatory Care in PSHFT • Currently no ECPs within ambulance service • Ambulances can contact GP practices in hours • Halo service will be funded for 2015/16 1) Commissioners are monitoring Red and Green call non- conveyed rates to A&E by hospital site and are tracking trends and will require EEAST to produce remedial plans if rates increase. 2) Specific CQUIN will be in place for Q2 to support ambulance crews on the ground to help with conveying decisions - this follows successful Pilot run in Norfolk and also learning from similar support schemes in 111. 3) EEAST current position is an average of 42% non conveyed which is about 5% higher than national average. As 2014.15 saw significant acuity rises in red calls (which were up 17% on prior year) the commissioners have set a 'maintain' target for 2015/16 - longer term commissioners expect a stretch target on this as EEAST continues progress in recovering their core Red response standards. 4) Clinical capacity is being built up by EEAST as the core aim of the recent Transformation Programme and the increase in paramedic capacity towards a 70% skill mix ratio of qualified/non qualified front line staff will be monitored by commissioners. 5) Ambulance crews cannot directly refer to Out of Hours to book appointments at present, owing to the mix of providers running these services in the region however SRGs will be looking at how this barrier can be addressed. 6) Some hospitals run rapid access clinics and SRGs are reviewing their DoS entries to ensure these services are up to date and ambulance crews know how to refer into these services 7) Development work continues on regional DoS and this is work in partnership with EEAST and community providers locally to ensure that DoS is up to date. Through UnitingCare there is currently a care home educator within the Peterborough locality ,will review benefits and possibility of increasing service	Commissioners are targeting CQUIN funding of around £4.7m to make this happen for two schemes - first is to support EEAST in training the second year student paramedics to maximise capacity and skill mix of crews and second scheme is around enhancing clinical support for crews in Emergency Operations Centres to help with conveyancing decisions.

5. Around 20-30% of ambulance calls are due to falls in the elderly, many of which occur in care homes. Each care home should have arrangements with primary care, pharmacy and falls services for prevention and response training, to support management falls without conveyance to hospital where appropriate.	Yes	• Primary Care are aligned to each Care Home with a LES in place for undertaking ward rounds in the home and providing care to patients • Care Homes have access to GP in 111 • Pharmacy team working with care homes to undertake medicine reviews and training. Over 12 months the medicines of 1954 care home residents have been reviewed by the team. In the same period 2822 interventions were made, with 1964 being recorded as a quality or safety intervention. The associated cost saving was £252,259 • Care Home educator providing training to all care homes in Borderline and Peterborough. • Data capture of care home admissions monitored on a daily basis, and reported monthly • Ambulance can make referral to the community falls service • South Lincolnshire CCG have commissioned EMAS to deliver a falls car enabling patient triage once an ambulance is called. If the triage suggests that the patient could be seen by the falls car, the car will be sent. A full patient assessment is made and treatment offered on site if not life threatening. If the patient can be treated they will be and transported home or to an appropriate safe place (e.g. to a family member). Referrals to voluntary organisations are made by EMAS where appropriate. If the patient is assessed and needs urgent attention they are conveyed to hospital. The pilot is operational 7 days a week. The pilot started in November 2014 and so far has been successful with latest data evidencing a non conveyance rate (i.e. admission avoidance) of 37.5% from 24th November 2014 to 31st March 2015 . Monthly data is submitted to the CCG's performance team for analysis. The pilot will be evaluated and if successful a business case will be written to fund for the year ahead. • The CCG has also commissioned LCHS to provide a care home educator role to work with care homes across south Lincolnshire and educate staff on several key areas. Several topics will be focused on this year including pressure ulcers, end of life and UTI's. If a high proportion of falls are identified within one particular care home the care home educator will deliver training within the care home and educate staff on falls prevention and what action to take if a patient does fall. The care home educator is part of the Neighbourhood Team in Long Sutton and picks up any care homes with high admissions. This approach will be rolled out to the remaining Neighbourhood Teams across the south of Lincolnshire once implemented - anticipated by end September 2015.	Care home Pharmacy team costs £156k. The care Home Educator is funded by through Uniting Care.

		• South Lincolnshire CCG have asked PSHFT to identify care homes with high numbers of admissions. The CCG and Care Home Educator will address if analysis shows any admissions into hospital which could have been prevented.	
6. Rapid Assessment and Treatment should be in place, to support patients in A&E and Acute Medical Units to receive safer and more appropriate care as they are reviewed by senior doctors early on.	Partially	• Pilot commencing 7th May for a consultant to RAT patients coming into majors, wont be 24/7 or 7 days a week as there is currently not the consultant cover to ensure this can be rostered effectively. Consultant recruitment is taking place with new consultant to start in ACU in September. • Ambulatory Care Unit taking patients 8-6 Monday to Friday, 8-4 Saturday and Sunday. Medical Assessment Unit opens 7/5/15	

7. Daily review of in-patients through morning ward or board rounds, led by a consultant / senior doctor, should take place 7 days a week so that hospital discharges at the weekend are at least 80% of the weekday rate and at least 35% of discharges are achieved by midday throughout the week. This will support patient flow throughout the week and prevent A&E performance deteriorating on Monday as a result of insufficient discharges over the weekend.	Yes	• System has agreed a target of 40% of discharges by 1pm • Consultant led ward rounds 7 days per week – this will be happening on MAU from 7th May, but there will not be standard full ward rounds 7 days per week on the other wards. There are Board rounds happening every day on each ward and these are being rolled out to all wards at weekends • Weekend plans identify patients to be discharged. Plans don't currently reflect the post take discharges. • Discharge planning team is now in place 7 days a week. Staff consultation is in process to amalgamate the discharge planning teams to provide a full 7 day service. • The Transfer of Care Team (PCC) have implemented 6 day working for Adult Social Care to support weekend discharges including support in the E.D. and MAU. Access to the reablement service is 7 days per week. However, consistently low numbers of referrals. including completion of assessment and support planning Social care assessments are available for some areas 6 days a week and not yet robustly, but not for all LA areas. • Care home contracts are being amended to reflect the need for patients to be accepted 7 days a week. PCC have commissioned an additional 185 reablement hours to support discharge planning and avoidable admissions • Ongoing Review of all community beds to look at effective working across 7 days • SRG has responsibility for the BCF 7 day work stream	

8. Many hospital beds are occupied by patients who could be safely cared for in other settings or could be discharged. SRGs will need to ensure that sufficient discharge management and alternative capacity such as discharge-to-assess models are in place to reduce the DTOC rate to 2.5%. This will form a stretch target beyond the 3.5% standard set in the planning guidance.	Partially	• Integration of discharge teams into one service. Discharge team now present in the trust 7 days a week • D2A beds and interim beds are in place for Borderline and Peterborough patients. Issue of capacity for other areas • Metrics are in place for assessment times • Medically fit patients are identified on a daily basis for discharge • Task and finish group established to deliver stretch target – focus on training, implementing best practice else where, alternative capacity for some areas with limited bed availability • System management in place to escalate DTOCS – Daily calls and when needed twice daily calls to expedite discharges. • 'Red/Green days' introduced 15/7/15 to manage action is taken for every patient every day. • South Lincolnshire CCG have also continued to commission the AIR's team who focus on DTOC's and ensuring that these are kept to a minimum for South Lincolnshire Patients. The team also assist the Trusts discharge with CHC assessments when required to ease the pressure of the urgent care system. This service currently operates Monday to Friday 8.30am until 4.30pm. The CCG have recently approved additional funding to expand the team from 2 whole time equivalent nurses to 3 whole time equivalent nurses and 25 hours of administration support to move to a proactive planning for discharge from point of admission model of care which will: improve patient experience, prevent DTOC's and improve capacity and flow throughout the Trust. • Lincs: increased community capacity in place, further review of community capacity (homecare and beds under way). Work underway on agreed LoS reduction in community beds and agreed admission criteria and discharge plan. • Additional capacity for step up/step down reablement flats commissioned from operational resilience from July 2015. • Online training module developed for Wards staff in the acute trust. • Capacity and pathway review of community services to be completed by end of August. • Red Cross service has been recommissioned from operational resilience fund to commence 1st September	Interim beds are funded through the Uniting Care contract. Discharge to assess beds - the SRG has committed £552k for beds in 2015/16. Further work to undertake a procurement exercise is planned to ensure value for money

3.2 Elective Care

The sections below are based on the '12 principles of good practice' for elective pathways building on the key target areas set out in 2014/15:

For Elective Care, our aim is to continually improve access to services for patients and their carers both directly through meeting the NHS constitution operating standards and through the re-design of pathways and services. We continually monitor measure and report on our performance against local and national targets to ensure that the services we commission on behalf of patients meet their needs based on Clinical Threshold (CT) policies.

Our plan for elective care also has several components which are described in this section.

3.2.2 RTT Staff Training Programme	There is an ongoing process for ensuring Trust staff are compliant with RTT policies. Additional resource has been put into Administrative teams.
3.2.3 Annual Analysis of Capacity and Demand	RTT capacity was part of a major review in 2014. As part of the review areas where further capacity was required were identified and delivered through central RTT funding. The 2015/16 contract planning round included analysis of waiting times and demand and sufficient capacity to deliver aggregate RTT activity has been built into the Indicative Activity Plan. .
3.2.4 Making Capacity Mapping business as usual	This is embedded into the annual, 2 year and 5 year planning processes.
3.2.5 Elective Pathways for common Referral / Treatment Plans	. The 2015/16 QIPP planning process has identified the following elective areas for development: Community ENT service – commenced 01/04/15 Ophthalmology triage Integrated MSK rheumatology and pain service across community and acute providers.
3.2.7 Review of Local Application of RTT Rules	Local Application of RTT rules will continue to be reviewed. The Trust will undertake a rolling validation process of all pathways.

3.2.8 Data Validation and Quality Improvement	We will continue to work closely with our analysts across the system to ensure the accuracy of the data that we supply and that it is used to support the commissioning of services within the urgent care system.
3.2.9 Performance Management Framework	We will performance manage our providers using the mechanisms we have in place via the contracting teams within the Cambridgeshire and Peterborough Clinical Commissioning Group. The NHS Standard Contract contains specific measures in relation to Elective Care. These are set out in Schedule 4. Quality Requirements part A. Operational Standards. A Contract Query and Remedial Action Plan is in place
3.2.10 KPIs well established	Trust set of metrics are in place.
3.2.11 Promoting good Practice in Referral Management	The LCG's have an electronic referral management system in place:- Pathfinder. This will be further enhanced by the move to a new system from January 2016
3.2.12 Promoting Choice of Provider	We continue to promote Choose and Book and other mechanisms that facilitate choice for the patient. Choose and Book is a CCG requirements.
3.2.13 Board Assurance on Implementation	Governance arrangements for the Peterborough Resilience Group are set out in the current Terms of Reference. The System Resilience Group is not a decision making body, but is responsible for making recommendations to the Cambridgeshire and Peterborough CCG Senior Management Team and to the CCG Governing Body for approval and final decision making. Members of the System Resilience Group will also report to their individual Boards within their respective bodies.

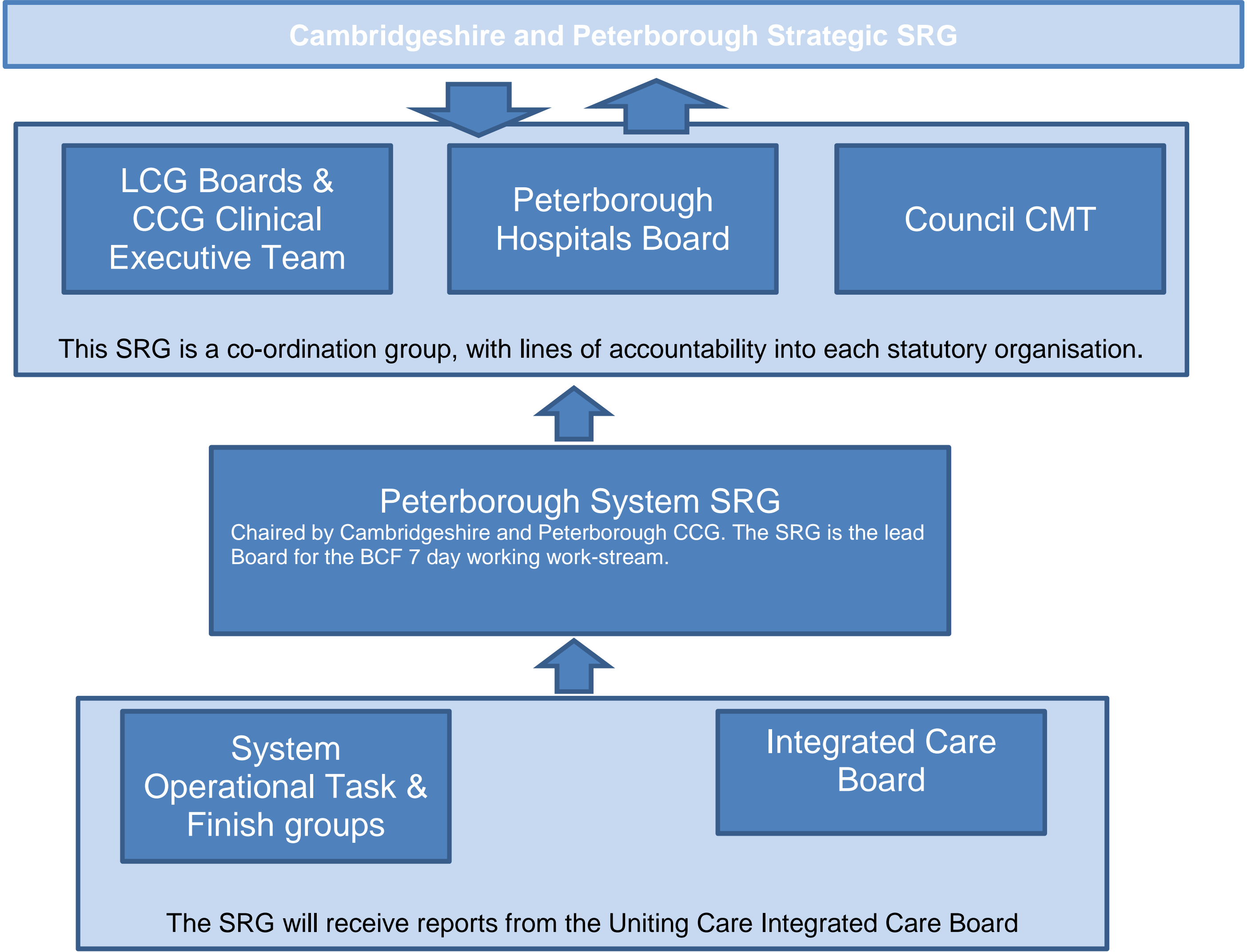
4. Governance and Risk Management

4.1 System Resilience Group Governance

The Peterborough System Resilience Group (SRG) is a multi-stakeholder group responsible for overseeing and driving the development of urgent and elective care services. There is a robust structure for the SRG to report into the CCG and system partners.

The Peterborough system structure is shown in the diagram below.
Each of local area SRG's may utilise elective and urgent care operational sub groups. The SRG's links into the UEC Vanguard, and LCG and CCG boards through to the CCG governing body

Peterborough SRG Governance:



4.2 Top Level Risks

Operational resilience risks are reported, reviewed, and actioned within the SRG as part of the continuous review of the system 10 point plan

We have identified several top level risks that are set out below.

Risk Register for "Top Level" Operational Resilience in Peterborough.

No	Risk	Mitigation	Risk Owner
1	Bed occupancy unable to be maintained between 90-93% due to surges of emergency activity.	Full implementation of 10 point plan, with 100% delivery supported by community and statutory partners; Roll out of System Resilience Operational Plan 2015/16; 75% uptake staff 'flu vaccinations	N.Doverty
2	Recruitment and retention of staff, and ongoing reliance on agency/locums. System-wide developments, including 7 day services all pulling from same pools of staff	Adoption of good practice in nursing recruitment to medical staff recruitment; monthly Recruitment & Retention Strategy Group refocused to identify key new actions	I.Crich
3	Appetite for significant organisational change over short timeframe and impact on staff	Staff engagement and robust communications across whole system. Continue with system-wide workshops to maintain face to face comms	I.Crich/C. Mitchell
4	Shortage of step up and step down facilities leading to longer length of stay	Additional beds already purchased, but now focus needs to be on non-bed based models	S. Myers/ C.Hall
5	Ability to reduce DTOCS to 2.5% OBD and maintain lower levels throughout winter period	system management and escalation in place. Understanding capacity demands, and during service reconfiguration having alternative pathways in place	SRG
6	Demand during winter is greater than expected across winter 15/16	Daily and weekly review of trends. Resilience funding has been reserved to purchase additional capacity of required	SRG
7	Inadequate discharges and times of discharges will impact the ability of MAU to operate successfully.	Increase discharges using discharge lounge, and promotion of PDDs when medically fit to ensure adequate discharges during day. Improved weekend discharges	N. Doverty
8	Consultations for neighbourhood teams and integrated teams having a negative impact on staff - potential for increased sickness +/- losing staff to other organisations	Neighbourhood teams have been implemented and staff inducted into new roles. Overall staff are positive about changes	S. Myers

Appendices

Document title	Supporting File
Appendix 1 Peterborough 10 Point plan	
Appendix 1a Operational schemes for winter 2015	Winter plan summary templateFINAL 3010.
Appendix 2system management scorecards	SRG Weekly Scorecard 20151018. SRG Monthly Scorecard 20150309. System Resilience Group Weekend Plan SRG Daily Dashboard 20151027.xlsx
Appendix 3 Escalation policy – A CCG wide policy is being finalised and will supersede this policy shortly	escalation policy August 15.docx

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APPENDIX B

Briefing Template					
WINTER 2015/16 ACTION PLAN SUMMARY					

SRG Name:	Borderline and Peterborough	SRG Chair name:	Catherine Mitchell	Main Provider:	PSHFT
Date completed:	01/10/15	SRG Chair e-mail:	catherine.mitchell1@nhs.net	Plan completed by:	Simon Pitts

Please select the key pressures approaching winter, from the dropdown lists provided below (each choice can be used more than once):	Specific details of key local pressures	SRG actions to address local pressures	Action owner within the SRG (CCG/Acute Provider/Other Provider/LA)	Current timeline for action to be delivered	Comments
Demand	Increased demand predicted for heart failure and respiratory specifically over the winter months. Also tend to have increased demand from diabetics - either as a co-morbidity or primary problem	SRG funding to increase specialist nurse presence in the hospital for 6-7 days per week. Will cover predominantly ACU, MAU and ED, but also work with discharge team to increase weekend discharges	PSHFT	Oct-15	All posts recruited to. Services commenced for 6-7 days in diabetes, respiratory and heart failure.
Demand	Predicted increased demand in respiratory patients	SRG winter funding to provide additional respiratory physio at weekends, supporting front door and non-critical care areas at weekends	PSHFT	End October 2015	
System Capacity	Increase in weekend discharges to reduce pressures on acute beds over weekend and bank holiday periods	Increased weekend discharge team - currently have one consultant who works on discharges in the morning and ACU thereafter. Needs support from junior doctor for TTOs, diagnostic requests, bloods etc.	PSHFT	Nov-15	Difficulties may be experienced for junior doctor recruitment into this post. Alternative support being investigated.
System Capacity	Lack of surge capacity and acute medical beds in PSHFT to cope with increased winter demand	Additional beds added to B core wards to increase overall capacity by 12	PSHFT	End Nov 2015	

Demand	Increased demand of patients requiring psychiatric assessment/support attending ED	Full psychiatric liaison service available in ED (08:00 - 01:00) 7 days per week from Nov 2nd	CPFT	2nd Nov 2015	Confirmation of full implementation from CPFT
System Capacity	Increased predicted demand through winter months. Need additional acute care capacity for peaks in demand	Provision of two gynae/women's health surgical assessment beds (additional to ward compliment)	PSHFT	Nov-15	Building work commenced to change two non-clinical rooms into clinical assessment rooms.
Throughput	Reduction in LOS required in order to manage	Phase 2 of MAU development to increase assessment function and provision of a	PSHFT	Nov-15	
Throughput	Increase in weekend discharges and reduction in	Implement nurse-led discharge on key wards in the Trust, including short stay unit.	PSHFT	Dec-15	
System Capacity	Pressures on step down/rehabilitation beds in the system to facilitate movement from acute beds	Provision of an additional 10 rehabilitation beds on JVG ward at Stamford to support Lincolnshire and north Peterborough patients	PSHFT	Dec-15	Internal refurbishment required.
Throughput	Increase in weekend discharges and reduction in length of stay to ensure enough capacity during winter months	Red Cross discharge service to support simple discharges for older people, service to be focussed on weekend discharges	Red Cross	Oct-15	staff recruited and service to commence
Throughput	Pressures on step down/rehabilitation capacity in the system	Provision of physio in the reablement service to enable a wider group of patients into the service, increase patient outcomes, reduce LOS in reablement	PCC	Sep-15	commenced
System Capacity	Pressures on patient flow	Provision of a coordinator for patients who would benefit from third sector support	PCC	Nov-15	On track
System Capacity	Pressures on patient flow	Provision of additonal discharge nurse and admin support to Single Point of Access	PCVS	Nov-15	On track
System Capacity	Pressures on step down/rehabilitation capacity in the system	Provision of 2 residential reablement flats in Peterborough. Increase provision of reablement for patient snot able to return home but not needing interim nursing	PCC	Sep-15	Commenced
System Capacity	Pressures on ED for people requiring Dementia	Support for patients and carers in the community of SH - lead CW	SL CCG	Oct-15	
System Capacity	reased pressures on Ambulance and ED. CAT Car sche	Car operated by EMAS to attend calls in an attempt to treat at scene or signpost to	SL CCG	Apr-15	commenced
Throughput	CHC Assessments	Scheme to increase the number of CHC/DST assessments completed to reduce	SL CCG	Apr-15	commenced
System Capacity	LCHS rapid response/admissions avoidance	Commissioned LCHS to provide urgent response teams supporting neighbourhood	SL CCG	Apr-15	commenced
Throughput	Intermediate Care Project	Intermediate step up and step down beds in Bourne commissioned via LCHS.	SL CCG	Apr-15	commenced
S:\Joint LCG\Joint LCG info\ Operational ughput	Expansion PSHFT AIRS	Expand Airs team in PSHFT to allow for discharge planning from point of admission.	SL CCG/CP CCG	Apr-15	commenced
ughput	Additional Nursing Beds	The CCG have agreed to fund an additional 2 ILT nursing beds at Barchester	SL CCG	Apr-15	commenced
ughput	Tallington Beds	Tallington ILT bed - Cost Increase. The CCG agreed to fund the increase for the	SLCCG	Apr-15	commenced
ughput	Pressures on ambulance handovers and conveyance	Ambulance HALO based in ED to support ambulance conveyance, handovers and	EEAST	Oct-15	commenced
Demand	Pressures of ambulance conveyances to PSHFT	GP in EEAST call centre to triage green ambulances	EEAST	Sep-15	commenced
System Capacity	GP hubs open 8-8 7 days per week	Increased system capacity for primary care with 3 hubs across the Peterborough regi	PMCF	Oct-15	Commenced
Demand	Pressure on social Care provision	Increase in Reablement capacity by 185 hours a week	PCC	Oct-15	commenced

Demand	Provision of JET to reduce demand	JET admission avoidance by supporting patients in the community.	Uniting Care	Sep-15	Commenced
Demand	Neighbourhood teams	Case management and co-ordination processes	Uniting Care	Oct-15	Commenced
System Capacity	Hospice at Home	Implementation of Hospice at Home and rapid response service for Peterborough	Uniting Care	Oct-15	commenced
Demand	Crisis team	Intensive dementia support at home	Uniting Care	Oct-15	commenced
Demand	additional Oncology support	Additional clinical staff to review oncology patients in ED to prevent admissions	PSHFT	Nov-15	commenced
Demand	Pharmacy	Additional hospital Pharmacy support to revised MAU and A3 ward rounds	PSHFT	Nov-15	commenced

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 11
10 DECEMBER 2015		PUBLIC REPORT
Contact Officer(s):	Jo Procter – Head of Service Adult & Children's Safeguarding Boards	Tel. 01733 863765

PETERBOROUGH SAFEGUARDING CHILDREN BOARD ANNUAL REPORT AND PETERBOROUGH SAFEGUARDING ADULT ANNUAL REPORT

R E C O M M E N D A T I O N S	
FROM: Chair of the Safeguarding Boards	**Deadline date:** N/A
1. These reports are for information purposes.	

1. ORIGIN OF REPORT

1.1 These reports are submitted to Board following a request from the Health and Wellbeing Board

2. PURPOSE AND REASON FOR REPORT

2.1 There is a statutory requirement that Safeguarding Boards produce an annual report and these are shared with the Health and Wellbeing Board.

2.2 The purpose of these reports being brought to the Health & Wellbeing Board is to ensure that members are fully aware of the work and progress of the Peterborough Safeguarding Children Board and Peterborough Safeguarding Adult Board. The Adult safeguarding Board annual report was published in July 2015 and the Children's Safeguarding Board report was published in September 2015. The reports are being brought to the Health and Wellbeing Board for information only purposes.

3. MAIN BODY OF REPORT

3.1 Due to the length of the two reports they are attached not inserted. Please see full reports.

4. CONSULTATION

4.1 Partner agencies, including Peterborough City Council and Health agencies contributed to the reports. The reports were approved by the two safeguarding boards in July and September 2015 and were then published.

5. ANTICIPATED OUTCOMES

5.1 The reports are produced on an annual basis and focus retrospectively on the work of the Boards for the previous financial year. Accordingly, the information is historical but does provide both agencies and the public with an overview of the work undertaken by the Boards to keep children and adults at risk safe.

6. REASONS FOR RECOMMENDATIONS

6.1 There are no recommendations, the reports are for information only.

7. IMPLICATIONS

7.1 The reports were published on the Safeguarding Boards websites and shared via social media:

- www.peterboroughlscb.org.uk
- www.peterborough.gov.uk/safeguardingadults

8. BACKGROUND DOCUMENTS

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

None.

9. APPENDICES

- Appendix A – Safeguarding Children Board 2014/15 Annual Report
- Appendix B – Safeguarding Adults Board Annual Report 2014/15

APPENDIX A

2014/15 ANNUAL REPORT

Keeping Children Safe Together

WWW.PETERBOROUGHLSCB.ORG.UK

Foreword and Introduction

BY RUSSELL WATE QPM, PSCB INDEPENDENT CHAIR

It gives me great pleasure to present to you Peterborough's Safeguarding Children Board annual report for the period April 2014 – March 2015. The report outlines both the activity and contribution of the board and its partners that has taken place during the last year. The year has been as always a very challenging one for all agencies. I would like to thank all of the board members (in particular the lay members) and their organisations, especially the frontline staff, for the hard work they have carried out to keep children and young people safe from harm in Peterborough.

Our overarching objectives through Working Together 2015 are still to *1) Co-ordinate what is being done by each person or body represented on the board to safeguard and promote the welfare of children in Peterborough* and *2) Ensure the effectiveness of what is done by each such person or body for those purposes.* However, you will see in the report that we have worked well through our priorities for the year, and as a result of these being correctly identified we are now continuing with them for another year. Some of these priorities we share with our partner boards, for example the priority of ensuring children and young people receive early help in Peterborough. This is achieved in conjunction with the Children and Families Joint Commissioning Board and evidences clear joint working arrangements in Peterborough.

The biggest challenge for the Board and its partners has been the continued investigations in the city into child sexual exploitation. This has been a very successful example of the commitment of agencies, in particular children's services and the police, to face the issue head on and to tackle it with vigour. As a result of effective multi-agency working a number of successful prosecutions have already taken place.

It was recognised by the Board that a slogan was needed that would be more reflective of young people across the city, so a competition was launched across primary and secondary schools. The winner came from a primary school who suggested the slogan 'Keeping children safe together' It was one of my best memories visiting the school at their assembly to present the award to the winner.

We, as a board, feel the next year is an exciting one for us with lots of opportunities for the partnership to continue our work and to move to be a very good, if not outstanding, safeguarding board.

Finally I would like to thank Jo Procter and all of her team for their unstinting commitment to the work of the board and keeping children in the City safe.

Dr Russell Wate QPM

Contents

ESSENTIAL INFORMATION 4
GUIDING PRINCIPLES OF OUR WORK 5
THE LOCAL CONTEXT 7
PETERBOROUGH HAS A FAST GROWING CHILD POPULATION: 7
CHILD AND FAMILY POVERTY IN PETERBOROUGH 9
THE STATUTORY AND LEGISLATIVE CONTEXT 11
WHAT ARE THE RESPONSIBILITIES OF PETERBOROUGH SAFEGUARDING CHILDREN BOARD? 11
GOVERNANCE AND ACCOUNTABILITY ARRANGEMENTS 12
WHO IS REPRESENTED ON THE PSCB? 12
LINKS WITH OTHER BOARDS 14
BUDGET 2013 - 14 15
PSCB SUB-GROUP STRUCTURE 16
Child Death Overview Panel (CDOP) 17
The Case Review Group 18
Quality and Effectiveness Group 19
Strategic Learning and Development Group (SLDG) 23
Joint Cambridgeshire and Peterborough Child Sexual Exploitation Group 24
E-Safety 25
Health Executive Board and Health Safeguarding Group 26
Child Protection Information Network (CPIN) 27
Task and Finish Groups 28
BUSINESS PRIORITIES 2014/15 29
"EARLY HELP AND PREVENTATIVE MEASURES ARE EFFECTIVE" 29
"CHILDREN AT RISK OF SIGNIFICANT HARM ARE EFFECTIVELY IDENTIFIED AND PROTECTED" 33
Child Protection Plans 34
Looked After Children 36
"EVERYONE MAKES A SIGNIFICANT AND MEANINGFUL CONTRIBUTION TO SAFEGUARDING CHILDREN" 38
"WORKFORCE HAS THE RIGHT SKILLS/KNOWLEDGE AND CAPACITY TO SAFEGUARD CHILDREN" 39
"UNDERSTAND THE NEEDS OF ALL SECTORS OF OUR COMMUNITY" 43
"CHILDREN ARE FULLY PROTECTED FROM THE EFFECTS OF DOMESTIC ABUSE (DOMESTIC VIOLENCE) AND NEGLECT" 44
Domestic Abuse 44
Neglect 45
"CHILDREN ARE FULLY PROTECTED FROM CHILD SEXUAL EXPLOITATION" 46
ADDITIONAL GROUPS OF CHILDREN 48
CHILDREN MISSING FROM HOME AND CARE 48
PRIVATE FOSTERING 51
ALLEGATIONS MANAGEMENT 52
THE VOICE OF CHILDREN, YOUNG PEOPLE AND FAMILIES 55
BUSINESS PRIORITIES AND BOARD DEVELOPMENT 2015-16 56
SCRUTINY AND CHALLENGE 56
CONCLUSIONS AND FUTURE DEVELOPMENTS 59

Essential Information

This report has been compiled on behalf of the Peterborough Safeguarding Children Board by the PSCB Business Unit. The format and content has been guided by the Association of LSCB Chairs suggested model for Annual Reports (2015). The content is drawn from the work of the PSCB and its subgroups including; reports presented to those groups; records of meetings; multi-agency audit findings and the findings from Serious Case Reviews.

The report will be published in October 2015 and will be a public document.

For further information about the content of this report or the work of the PSCB please contact the PSCB Office on 01733 863744 or by email pscb@peterborough.gov.uk or visit the website at www.peterboroughlscb.org.uk

For further information or queries about Peterborough Safeguarding Children Board (PSCB) visit our website or contact any of the members of the staff team listed below:

Russell Wate; PSCB Independent Chair	Russell.wate@peterborough.gov.uk
Jo Bramwell; PSCB Business Manager	Joanne.bramwell@peterborough.gov.uk
Hannah Campling; Sexual Exploitation Co-ordinator	Hannah.campling@peterborough.gov.uk
Jody Watts; Business Support Officer (Board)	Pscb.admin@peterborough.gov.uk
Isabel Pacheco; Business Support Officer (Training)	Pscb.training@peterborough.gov.uk

Guiding Principles of our Work

Peterborough Safeguarding Children Board (PSCB) is committed to safeguarding and promoting the welfare of children and young people and expects all staff and volunteers to share the same commitment.

Peterborough Safeguarding Children Board believes that:

- ✓ The welfare and safety of the child is paramount
- ✓ We will be more robust in safeguarding children if we all work together. This includes both statutory and voluntary agencies and also the wider communities
- ✓ Early help is a critical part of keeping children safe
- ✓ We will support families in bringing up their children safely, engaging with them in the wider agenda for safeguarding
- ✓ We will ensure agencies provide an equitable, quality service to all children and their families
- ✓ Services should be provided which are appropriate to race, religion, culture, language, gender, sexual orientation and disability
- ✓ We need to be accountable for our actions, open to challenge, and to learn from practice in order to achieve continuous improvement
- ✓ Procedures and processes must be open and transparent

These principles should underpin everyone's approach to safeguarding children and promoting their welfare, regardless of the extent of their involvement.

Peterborough Safeguarding Children Board will further ensure that:

- ✓ Personal information is held confidentially and only by those who need to know
- ✓ Information will be shared safely and effectively, so that agencies working with children, young people and families know the whole story, understand the risk, and the child only has to tell their story once
- ✓ Safeguarding children is viewed in the wider context of their needs and rights

PSCB Business Priorities 2014/15:

- “Early help and preventative measures are effective”
- “Children at risk of significant harm are effectively identified and protected”
- “Everyone makes a significant and meaningful contribution to safeguarding children”
- “Workforce has the right skills/knowledge and capacity to safeguard children”
- “Understand the needs of all sectors of our community”
- “Children are fully protected from the effects of domestic abuse (domestic violence) and neglect”
- “Children are fully protected from Child Sexual Exploitation”

It is the aim of the PSCB that these priorities will primarily be achieved and monitored by undertaking the following:

- Monitoring and evaluating the effectiveness of safeguarding activities by partner agencies individually and collectively and advising and supporting them to make improvements
- Undertaking reviews of serious cases and disseminating identified learning to partner agencies
- Collecting and analysing information about all child deaths across Cambridgeshire and Peterborough to increase the learning opportunity
- Developing and updating policies and procedures to ensure consistency and transparency between partner agencies
- Communicating the need to safeguard and promote the welfare of children amongst professionals, parents and carers and children and young people, raising awareness of how this can best be done and encouraging it to happen
- Publishing an Annual Report on the effectiveness of safeguarding arrangements for services for children in Peterborough.

A new slogan for 2014/15

One of the most exciting pieces of work the PSCB has undertaken in this year has been to invite children and young people to design a new slogan for the Board.

It was recognised by the Board that a slogan was needed that would be more reflective of young people across the city, so a competition was launched across primary and secondary schools. Entries came from children and young people from 5 and 16 years old and were reflective of the ethnicities in the city. The winner came from a primary school who suggested the slogan ‘Keeping children safe together’. The judges felt the slogan ideally summed up the focus on children and partnership working that the Board prides itself on.

As a result of the competition and the engagement of the children and young people in conversations with members of the Board about its work, the profile of the Board has been raised and the city’s youth population are better informed about practices and services which aim to keep them safe.

‘Keeping Children Safe Together’

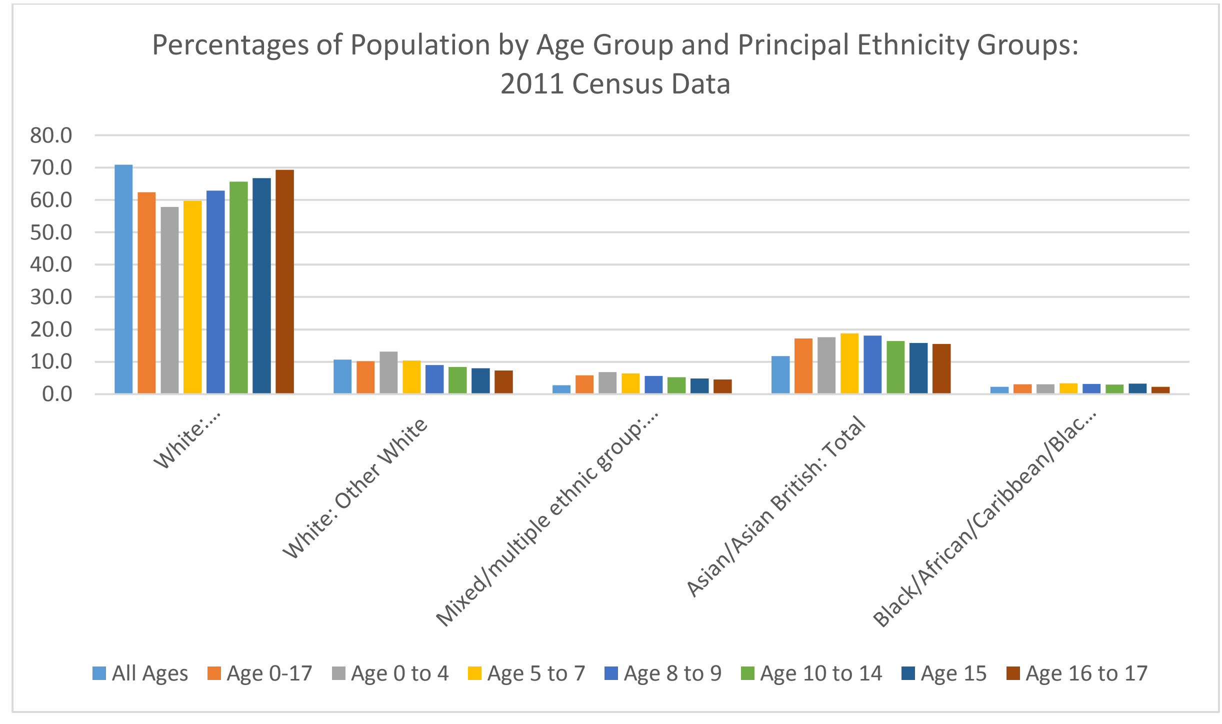
The Local Context

Peterborough has a fast growing child population:

Peterborough has a young population with a higher than average number of children and young people. It is also one of the fastest growing cities in the UK, with predicted population growth of 34.9% between the 21 years spanning 2010-2031. The city is ethnically diverse, with 29.1% of residents not self-identifying as White English/Welsh/Scottish/Northern Irish/British. The next most common ethnicities declared in the 2011 census were Asian/Asian British: Pakistani or British Pakistani (6.6%), White Polish (3.1%) and Asian/Asian British: Indian or British Indian (2.5%).

Peterborough is one of the UK's fastest growing cities

The graph below indicates how rapidly this increasing diversity of population is taking place across the age bands:



So, while the proportion of our 16 and 17 year olds who are from White British populations is broadly similar to the all age population at around 70%, among 0-4 year olds, the White British population is 58% of the total.

In 2014, economic migration was most common from Poland (1,100 migrant national insurance registrations), Republic of Lithuania (974), Portugal (504), Romania (427) and Latvia (397). There are

socio-economic inequalities within the local authority area, with areas of significant deprivation close to central Peterborough.[1]

The Peterborough Children and Young People's JSNA analyses data relating to children and young people in Peterborough and describes a very fast growing city with a young and ethnically diverse population, significant levels of deprivation and accompanying poor health and educational outcomes. There are wards in the centre of the City with long-standing problems: poverty, over-crowding, poor attainment, poor health, unemployment and poor housing stock. Alcohol, drugs, sexually transmitted infections, teen pregnancies, smoking, low birth weight and infant mortality are also issues for these areas of Peterborough as are high levels of injuries, asthma, dental problems and hospital attendances and admissions. The life-course approach to analysis of the data shows that outcomes are poor throughout life, with events in early life affecting children as they grow to adulthood.

Most of the needs identified are not new but the speed of population growth and the changing ethnic mix of the population together with shrinking public sector funding have intensified the challenges for Peterborough.

Age Group	2011	2013 [2]	2016	% change 2013-16	2021	% change 2013-21	2026	% change 2013-26	2031	% change 2013-31
0-4	14,300	14940	15,900	6%	17,500	17%	17,300	16%	17,100	14%
5-10	13,800	15320	17,600	15%	19,800	29%	21,000	37%	20,800	36%
11-15	10,800	11000	11,300	3%	14,500	32%	16,000	45%	17,000	55%
16-19	8,200	8320	8,500	2%	9,000	8%	11,400	37%	12,400	49%

While the growth rate of 0-4 year olds stabilises from 2021, the projection is that there will be 17% more children in this age range in 2021 than there were in 2013. It is projected that there will be an almost 30% increase in the number of children aged between 5 and 10 over this period and a 32% increase in the number of young people aged 11-15. The population of children and young people aged 0-18 is projected to increase by 21% between 2013 and 2021.

The most serious issues for the local authority is the rising birth-rate, the inward migration and the growth agenda; all of which have an impact on the number of school places required and the options for creating more.

The Local Authority has in place a School Organisation Plan which informs the process of school place planning and continues to seek any reasonable ideas to increase school places - extensions, bulge years etc., but the predictions are for a continuing shortage of school places for the foreseeable future. Whilst there are enough places, unfortunately they are not always in the right place. The vast majority

[1] Joint Strategic Needs Assessment Core Dataset Overview 2015
https://www.peterborough.gov.uk/upload/www.peterborough.gov.uk/healthcare/public-health/PeterboroughJSNACoreDataset-June2015.pdf?inline=true

[2] 2013 figures are estimated by assuming growth between 2011 and 2016 for each age band follows a linear progression between these years. Taken from the Children and Young People's Joint Strategic Needs Assessment June 2015

of in-year allocations are unable to find places at their local schools. This then has an impact on the school transport budget.[3]

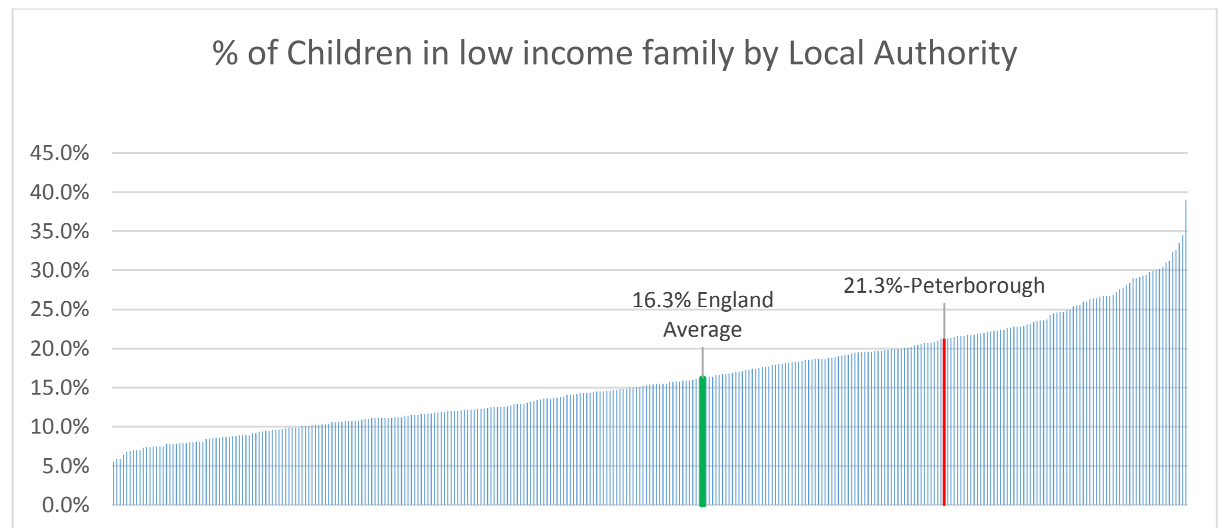
This rapidly increasing and changing population is likely to place additional pressures on services over the coming years. An increasing population of children implies that, all things being equal, there will be increasing numbers of children who are in need, including those who are in need of protection and/or looking after. The PSCB will need to ensure that it has an awareness of safeguarding issues in all sectors of Peterborough's communities. This in itself will be a challenge for the Board.

One of the main remits of the Communication and Engagement subgroup has been to establish links with Peterborough communities which will continue to be a priority for the Board in 2015/16.

Child and family poverty in Peterborough

- Peterborough has a high percentage (21.3%) of children in low income families when compared to national averages (16.3%).
- There are around 8,860 children in families which claim Income Support of JSA and a total of around 49,195 children in Child Benefit families within the city.
- Compared to statistical neighbours, Peterborough has a high proportion of children living in families in receipt of out of work benefits despite a reduction between 2012 and 2013.
- Those who are in employment in the city earn less than others in the East of England and the country as a whole.
- Peterborough has a higher percentage of children in workless households than both regional and national averages.
- Peterborough has the fourth highest rate of children in families in receipt of out of work benefits of all Local Authorities in the East of England.

The below chart shows the percentage of Children in low-income families which highlights those living in families in receipt of Child Tax Credits whose reported income is less than 60 per cent of the median income or in receipt of Income Support or JSA within each Local Authority. Peterborough has a relatively high percentage of children in low income families, 21.3%, when compared to all Local Authorities in England and this is reflective when compared to national averages.



[3] School Admissions Annual Report 2015 https://www.peterborough.gov.uk/upload/www.peterborough.gov.uk/residents/schools-and-education/SchoolAdmissionsAnnualReport-2015.pdf?inline=true

Children who grow up in homes of persistent poverty are more likely to suffer poorer health, have a lower life expectancy, perform less well at school and have lower self-aspirations and self-esteem.

In the Children and Young People's Joint Strategic Needs Assessment, it shows where babies are born it can be seen that the highest numbers of births are occurring in the areas where there are also the highest levels of deprivation affecting children. These children are likely to have greater needs and this increases the challenge for services in Peterborough.

The Statutory and Legislative Context

What are the responsibilities of Peterborough Safeguarding Children Board?

The PSCB was established in accordance with the Children Act 2004 and for the period covered by this report operated within the statutory guidance 'Working Together to Safeguard Children 2013'. The PSCB is independent and provides the key statutory mechanism for agreeing how organisations within Peterborough cooperate to safeguard and promote the welfare of children and for ensuring the effectiveness of what they do.

Core functions of the PSCB are:

- Developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:
    - The action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;
    - Training of persons who work with children or in services affecting the safety and welfare of children;
    - Recruitment and supervision of persons who work with children;
    - Investigation of allegations concerning persons who work with children;
    - Safety and welfare of children who are privately fostered;
    - Cooperation with neighbouring children's services authorities and their Board partners;
- Communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;
- Monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;
- Participating in the planning of services for children in the area of the authority;
- Undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.
- Putting in place procedures to respond to unexpected child deaths and collecting and analysing information about all child deaths in Cambridgeshire and Peterborough

The PSCB does not commission or deliver frontline services or have the power to direct other organisations but does have a role in making it clear where improvements is needed. Each Board partner retains their own lines of accountability for safeguarding. The PSCB continues to provide a full programme of multi-agency training.

Governance and Accountability Arrangements

Who is represented on the PSCB?

The PSCB has an independent chair, Russell Wate, who was appointed in February 2013 and is accountable to the Chief Executive of the Local Authority. The PSCB is composed of senior representatives nominated by each of its member agencies and professional groups. Statutory (the Board partners set out in Section 13(3) of the Children Act 2004) & Other Partners, of whom 100% attendance at meetings is expected by the representative or nominated substitute:

Name	Agency
Russell Wate	**Independent Chair**
Mark Hopkins	**Assistant Chief Constable Cambridgeshire Constabulary and PSCB Vice-chair**
Sue Westcott	**Executive Director Children's Services**
Sharon Hawkins	**Assistant Director Safeguarding Families & Communities**
Wendi Ogle-Welbourn	**Director for Communities**
Alison Bennett	**Head of Service, Quality Assurance and Safeguarding**
Mavis Spencer	**Patient Experience Manager, NHS England East Anglia Area Team**
Jill Houghton	**Director or Nursing and Quality, Cambridgeshire and Peterborough CCG**
Emilia Wawrzkowicz	**Designated Doctor Safeguarding Children**
Sarah Hamilton	**Designated Nurse Safeguarding Children**
Poppy Reynolds	**Head of Sexual Health, Cambridgeshire Community Services**
Matthew Ryder	**Assistant Director, National Probation Service**
Roz Morrison	**Director, BeNCH Community Rehabilitation Company**
Issy Atkinson	**Service Manager, CAFCASS**
Melanie Coombes	**Director of Nursing, Cambridgeshire & Peterborough Foundation Trust**
Chris Wilkinson	**Director of Nursing, Peterborough & Stamford Hospitals NHS Foundation Trust**
Nick Edwards	**Service Manager, NSPCC**
Tina Hornsby	**Assistant Director Quality, Information and Performance, Adult Social Care**
Iain Easton	**Head of Youth Offending Service**
Rick Hylton	**Cambridgeshire Fire and Rescue**
Ross Brand	**East of England Ambulance Service**
Dr Muhammed Nawaz	**Lay Member**
Sue Hartropp	**Lay Member**
Professional Representatives, who provide insights from and communication with their professional bodies but do not represent a single agency or organisation:	
Claire George	**Assistant Principal; Representing Secondary Schools**
Sarah Levy	**Headteacher; Representing Primary Schools**
Joanne Hather-Dennis	**Executive Director (students), Peterborough Regional College; representing Further Education establishments**
Catherine Shingler	**Little Miracles, Representing Voluntary Sector**

Partner agency representatives are of sufficient seniority to make decisions around their agency's resources. They are given delegated authority to make decisions to an agreed level on behalf of their agency and have access to those responsible for making the decisions for which they do not have delegated authority.

The PSCB is supported by ta full-time Business Manager, part-time Child sexual exploitation Coordinator and 2 Business Support Officers (1 Full-time, 1 Part-time).

Each representative on the PSCB is responsible for ensuring two way communication between their agency and the Board by disseminating information between the PSCB and their agency/professional body and identifying any necessary actions, as well as bring any issues with partners that their agencies have identified to be challenged by the Board.

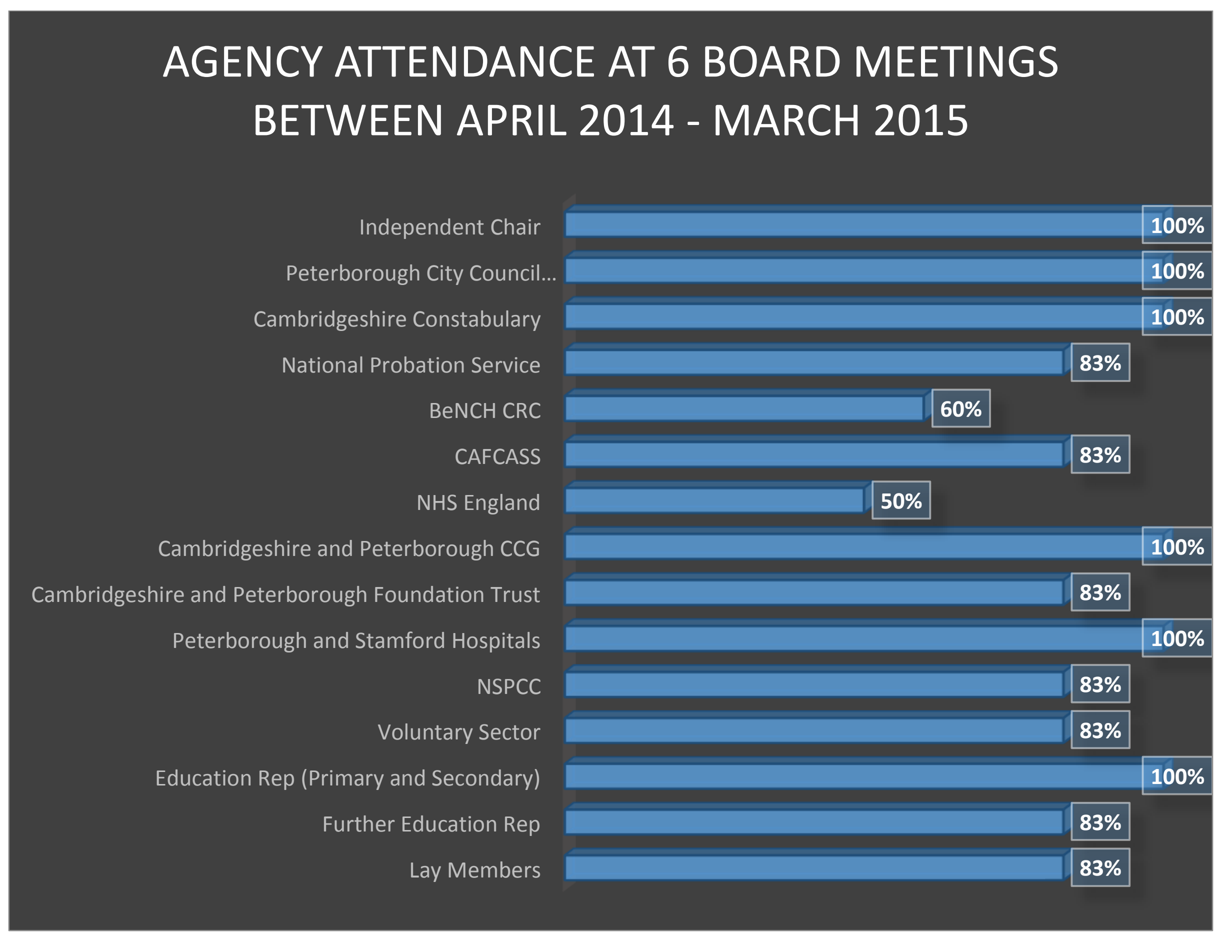
The Cabinet Member for Children's Services is a 'participating observer' of the PSCB, attending meetings as an observer, engaging in discussion but not being part of the decision making process. This enables the Cabinet Member to challenge, when necessary, from a well-informed position.

One Lay member have been part of the Board since September 2012 with a second lay member joining the board in September 2014. The remit of the lay member is to:

- Support public engagement in local safeguarding issues
- Contribute to an improved understanding of the PSCB's child protection work in the wider community
- Challenge the PSCB on the accessibility by the public and children and young people of its plans and procedures
- Help to make links between the PSCB and community groups.

Both lay members have considerable safeguarding experience and are able to provide constructive feedback and challenge to agencies. One lay member is an active member of several subgroups and chairs the new Learning and Engagement Group.

The PSCB met 6 times during the year and there were no extraordinary meetings held. As evidenced in the graph below, agency attendance for 2014-15 is, on the whole, good.



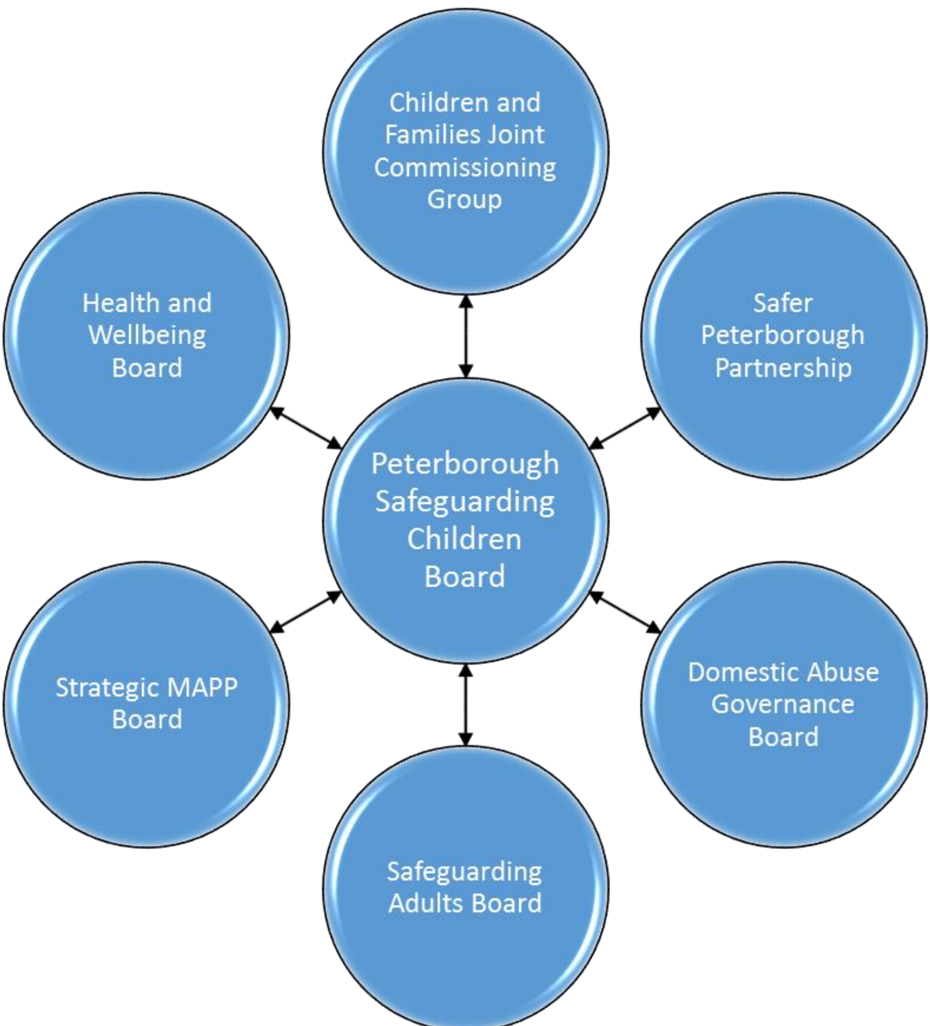
During 2014/15, the Board has undertaken several successful campaigns on relevant local safeguarding issues including:

- Child sexual exploitation (CSE)
- Safer Sleeping
- Safety around water
- Female genital mutilation (FGM)

All partner agencies actively contributed to the work of the campaigns and all of the above were delivered in partnership with Cambridgeshire Local Safeguarding Board (Cambs LSCB) to ensure lessons are learnt across the Local Authority border.

Links with other Boards

For the board to be influential in coordinating and ensuring the effectiveness of safeguarding arrangements it is important that it has strong links with other groups and boards who impact on child services. The board also has an integral role in being part of the planning and commissioning of services delivered to children in Peterborough.



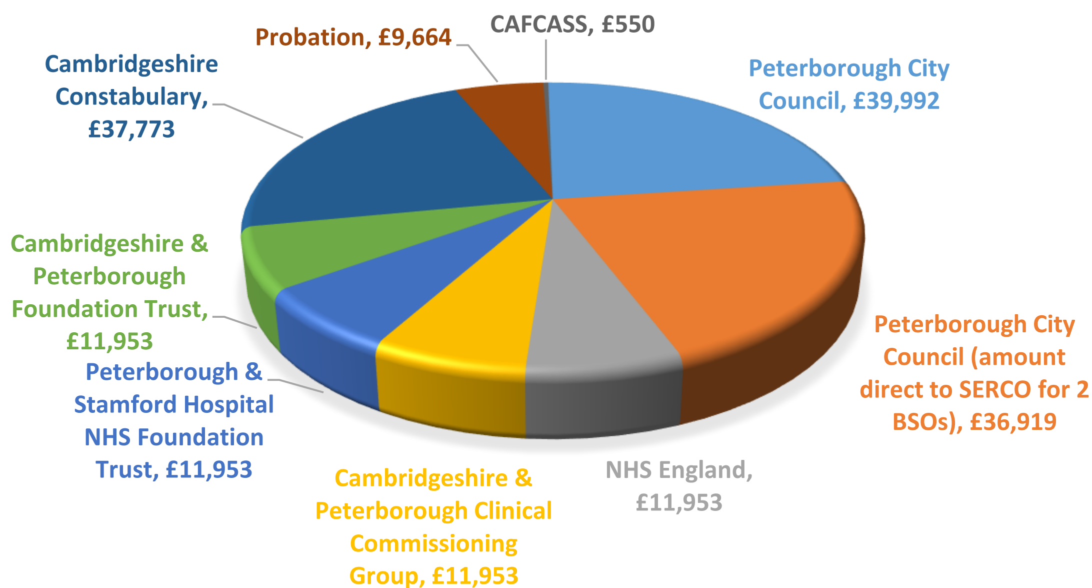
The Independent Chair of the Peterborough Safeguarding Children Board is a member of the Health and Wellbeing Board, the Children and Families Joint Commissioning Board, Safer Peterborough Partnership and the Strategic MAPP Board. This ensures that safeguarding children is a priority of the work of these groups. The Independent Chair is also the Chair of the Peterborough Safeguarding Adults Board, which provides consistency for services for children and adults across Peterborough.

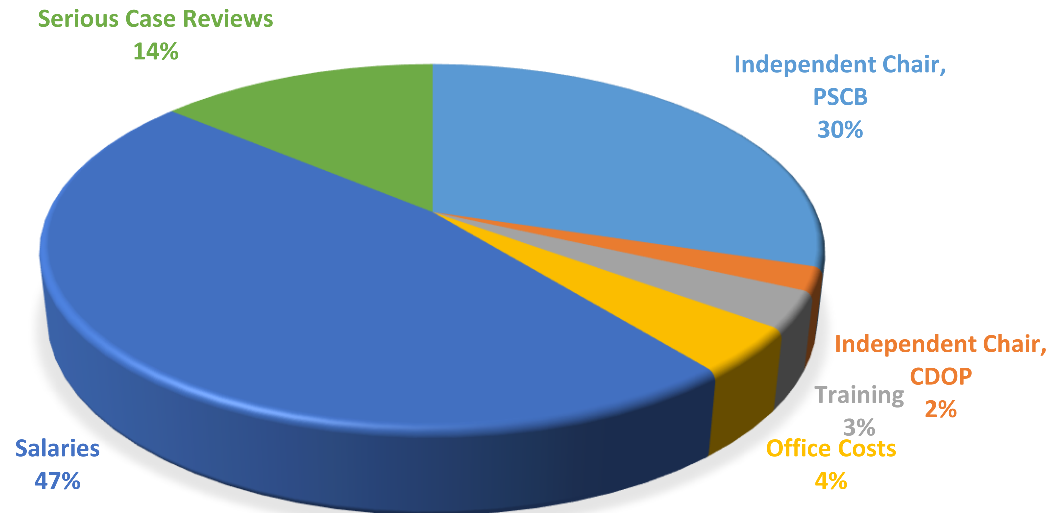
Members of the PSCB also sit on the Safer Peterborough Partnership, Domestic Abuse Governance Board, and Strategic Multi-agency Public Protection Board, in addition the Business Manager is a member of the Domestic Abuse Governance Board.

These links mean that safeguarding children remains on the agenda of these groups and is a continuing consideration for all members.

Budget 2013 - 14

The budget for the PSCB is made up of contributions from partner agencies.





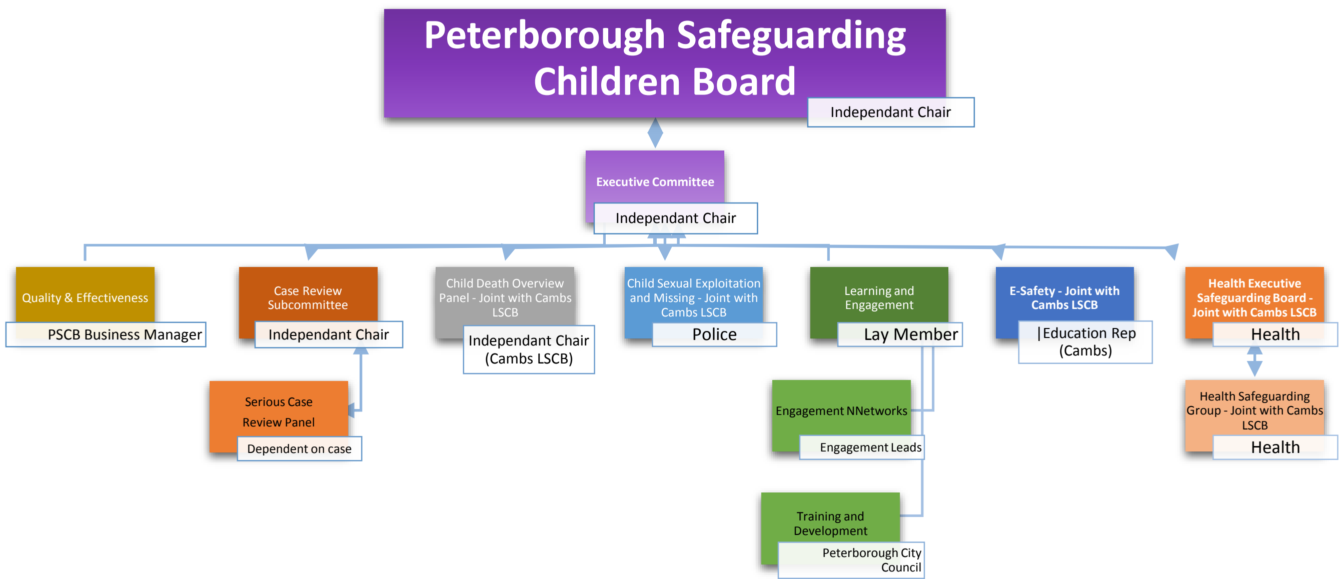
PSCB Sub-Group Structure

To enable it to fulfil its responsibilities effectively, Peterborough LSCB has the following subgroups:

- Case Review Group
- Learning & Engagement
- Strategic Learning and Development (Combined to form the Learning and Engagement Group)
- Quality & Effectiveness
- Education Child Protection Information Network (CPIN)
- E-Safety (joint with Cambridgeshire LSCB)
- Child Sexual Exploitation and Missing (joint with Cambridgeshire LSCB)
- Health Executive Safeguarding Board (joint with Cambridgeshire LSCB)
- Child Death Overview Panel (joint with Cambridgeshire LSCB)

Each subgroup has their own terms of reference and reporting expectations. They are chaired by an agency representative and supported by the PSCB Business Unit. To ensure that the subgroups are effective and progressing actions, an Executive Committee, which is a subgroup of the chairs, is held bi-monthly. This meeting is chaired by the Independent Chair of the PSCB and the work of the subgroups is challenged and scrutinised.

In addition to the sub-groups, task and finish groups are set up to consider particular issues and progress particular pieces of work. In the last year these have included groups looking at the child in need process and female genital mutilation. The work of both of these groups is covered within this report.



Child Death Overview Panel (CDOP)

Child Death Overview Panels (CDOP) were established in April 2008 as a new statutory requirement as set out in Chapter 7 of 'Working Together to Safeguard Children' 2006.[4] Their primary function (as required by the Local Safeguarding Boards Regulations 2006) is to undertake a comprehensive and multiagency review of all deaths of children normally resident in the area aged under 18 years of age, in order to understand better how and why they die and to use the findings to take action to prevent other deaths and to improve the health, wellbeing and safety of children and young people. The Local Safeguarding Boards of Cambridgeshire and Peterborough form a single Child Death Overview Panel.

Over the last year, the deaths of 43 children were reported to the CDOP across Cambridgeshire and Peterborough. This is the lowest number since 2008 when data was first collected and below the average of 55 deaths per year. 58% of these children were babies under one year old and 49% died due to a perinatal or neonatal event irrespective of their age. The majority died in the neonatal period however never having left hospital. 8 unexpected deaths were reported in Cambridgeshire this year (26% of child deaths) and none in Peterborough.

Safe Sleeping Campaign

The Safer Sleeping Campaign was developed and delivered by PSCB and Cambs LSCB, as a response to findings from CDOP. It was formally launched in April 2014 and a programme of six workshops and additional talks took place during 2014. The workshops were facilitated by the Designated Doctor for Death in Childhood, LSCB Training Managers, Health Visiting leads and DAAT.

A number of leaflets have been purchased and downloaded (different languages) from the lullaby trust. The Safer Sleeping leaflet and lessons learned briefing, from a Cambridgeshire Serious Case Review, has been distributed amongst the LSCB agencies, across Peterborough and Cambridgeshire, Local Practice Groups and the LSCB Committees. Safer sleeping and the 'lessons learned' regarding parental alcohol behaviours have been written into all relevant LSCB training courses.

Prior to the Christmas holidays, at a time when alcohol becomes a celebratory factor, all General Practitioners across both areas have been written to by the Chairs of the LSCB's, about the campaign and a number of leaflets for parents and professionals have been included for distribution within their surgeries. Additionally 'Night Time Economy' leads (Pubs / Clubs / Councils and supermarkets) have agreed to be part of the campaign and have distributed the leaflets within the public arena (i.e. in the bar, reception areas and public toilets (male and female).

It is positive to note that the target audience for which the workshops were aimed attended (these included nursery nurses, midwives, health visitors, children centre staff and family workers – those practitioners who would have the most contact with families and babies). However there were few social care staff present for whom the workshop would have been beneficial in terms of networking, sharing important information about safer sleeping for families and improving safeguarding practice. Overall all of the groups were well received and entailed much discussion from practitioners.

Safer Sleeping is contained within health visitor's breast feeding policy and clinical care packages. A small sample audit was undertaken and found that most health visitors recorded the discussion with parents around safer sleeping and that a leaflet had been put in the red book. It has been enlightening to see a number of children centre and family worker staff who attended the workshops and are displaying the leaflets within their establishments. Midwives also attended the event within the hospital along with specialist foster carers (working with babies of families who have alcohol / substance misuse issues) – both of which were eager to take the messages back to new mums and dads.

[4] 'Working Together to Safeguard Children' has been revised and was reissued in March 2015. The responsibilities of Child Death Overview Panels are set out in chapter 5 and remain unchanged.

The Safer Sleeping Campaign has been a success in terms of promoting awareness and the safeguarding messages to practitioners working with families about safer sleeping, combined with highlighting other impacting factors on infant death such as parental alcohol behaviours. Success should also be measured in terms of how many leaflets have been distributed and are visible and available to parents.

The safe sleeping campaign has been re-launched for 2015 and a further two workshops have been planned for early help workers, early years, locality teams and children's centres across the region. Further evaluation of the campaign (e.g. single agency audits of records of discussions with parents, discussions with professionals around how the campaign has influenced their practice) will be undertaken in 2015-16.

This information has been taken from the Child Death Overview Panel Annual Report 2014-15. This will be available on the PSCB website.

The Case Review Group

The overall purpose of the group is to consider cases and determine whether a serious case review/ case review should be undertaken and ensure that key learning is effectively disseminated.

The Case Review Sub Group is held bimonthly but in the last year only three meetings were held due to the large number of Serious Case Reviews being undertaken. It was necessary to cancel a number of Case Review Subgroup meetings in order to progress the individual case reviews.

Summary of Serious Case Reviews that were undertaken in 2014/15

Within the time period covered by this report, five Serious Case Reviews (SCRs) were in progress and one was published: Child A[5]

Child A was a nine week old baby who died of severe head injuries and had also sustained other non-accidental injuries. A number of recommendations arose as a result of the overview report including:

- A review of the Multi-Agency Protocol for the management of Unexpected Child Deaths
- And a Review of the Rapid Response Process

An Action Plan was formulated and monitored by the sub-group to ensure progress was made. The Action Plan is due for sign off in early 2015/16.

The remaining cases involved the Neglect of a baby, 2 cases of child sexual exploitation and sexual abuse and neglect. Whilst these SCRs are in progress, the learning is disseminated as it becomes evident, reinforced by learning events after the publication of the reports.

The approach to extracting lessons learnt from each case has been varied, this is considered to have been a good approach and will be utilised for future reviews.

At the conclusion of each SCR the PSCB Board Manager produces a PowerPoint presentation and practitioner leaflet detailing the lessons learnt from the SCR and the implications for practice. These are disseminated to all agencies for use within their own training and development programmes and Team Meetings. The PSCB has received positive feedback from a number of agencies about the impact of this approach and the fact that the lessons learnt are presented in such a way that practitioners can identify how it effects their practice. These resources are also shared with Cambridgeshire LSCB to cascade through their agencies.

[5] The Overview report is available to download from the PSCB website
http://www.peterboroughlscb.org.uk/serious-case-reviews/

As a direct consequence of a recent SCR, the PSCB in conjunction with Cambridgeshire and Norfolk LSCB's have submitted a bid to the Government Innovation Fund in relation to a project that looks at Eastern European migration and how we can obtain better information from host countries to assist in keeping children safe.

The PSCB has also carried out work in relation to significant national SCR's and actions are raised to ensure the PSCB's members are progressing in line with national benchmarks and the sub group has suggested that substantial progress has been made against all of the actions contained within these serious case reviews.

Quality and Effectiveness Group

The aims of the Quality and Effectiveness Group (QEG) are: to monitor the individual and collective effectiveness of the Peterborough Safeguarding Children Board members as they carry out their duties to safeguard and promote the welfare of children in Peterborough, and to advise and support the PSCB in achieving the highest standards in safeguarding and promoting the welfare of children in Peterborough by evaluation and continuous improvement. Five meetings of the group were held in the last year.

The PSCB has developed and implemented an annual themed audit programme which includes both single and multi-agency audits. All multi agency audits are linked to the PSCB Business Priorities.

In the past 12 months the PSCB has undertaken 4 multi- agency audits;

Multi-Agency Audit of Domestic Abuse Cases

In May 2014 the PSCB undertook a multi-agency audit of DA cases. A total of 20 Domestic Abuse cases were randomly identified. The cohort of cases selected included a range of Domestic Abuse incidents that differed in severity. It also included both male and female victims and perpetrators from a range of ethnic backgrounds. All of the cases involved families that included children, although the children were not present during all of the incidents that were reviewed.

The PSCB developed a bespoke multi-agency audit tool which sought evidence from the following areas:

- Was this a re-referral
- Source of notification
- Timescales for notification
- Action taken by agencies
- Effectiveness of multi-agency working
- MARAC process and outcome

Auditors were prompted to identify specific strengths and areas for development both within their own agency and in relation to inter agency working. Auditors had the opportunity to note any particular contextual issues that impacted upon practice and to identify potential learning in terms of both strategic and operational practice.

The audit was undertaken by a multi-agency panel. Individual agencies completed the audit using their own agencies records. Once completed the PSCB hosted a collaborative audit day at which all of the auditors came together to collate and analyse the findings. The structure of the day included an opportunity to consider learning in terms of developing a shared understanding of the case, identifying good practice, recognising where practice needed to improve and identifying what changes could be made in order to sustain improvement in practice. The results of the audit have been analysed and the audit found that on the whole DA notifications were received in a timely manner and DASH forms were completed on all of the cases. Schools were receiving DA notifications from CSC but there remained an inconsistency around notifications to Health. On the whole multi agency working was effective. In those cases where there were barriers to multi agency working it was concerning that the issues had

not been escalated. For this reason, from early 2015 the Board has asked agencies to keep details of all escalations that they raise and report them to the Board on a quarterly basis. This will allow the Board to have oversight of which agencies are raising escalations and identify any themes that arise from them.

Multi-Agency Audit of Core Groups

In October/ November 2014 the PSCB undertook a multi-agency audit of Core Groups. A total of 16 child protection cases were randomly identified. The cohort of cases selected included a range of child protection issues. It included both male and female victims, of differing ages from a range of ethnic backgrounds.

The PSCB developed a bespoke multi-agency audit tool which sought evidence from the following areas:

- Appropriate membership and attendance at Core Groups
- Timeliness of meetings
- Records of Core Groups including quality of minutes
- Risk management
- Progression of plans
- Professional challenge
- Effectiveness of the Core Group and Plan in safeguarding the child

Auditors were prompted to identify any specific strengths and areas for development both within their own agency and in relation to inter agency working. Auditors had the opportunity to note any particular contextual issues that impacted upon practice and to identify potential learning in terms of both strategic and operational practice.

The audit revealed that on the whole Core Groups are being held regularly and that with the exception of Probation, there is appropriate multi agency attendance at meetings.

It was a positive that parents and carers regularly attend Core Groups and are engaged with the child protection process. However, the voice of the child was not evident in all of the cases.

The audit concluded that in the majority of cases the Core Group members were monitoring the child protection plans, however there was evidence that not all plans were progressed in a timely manner. It is imperative that Core Groups are proactive and continue to risk assess cases and ensure that the child protection plans (and subsequent actions) reflect the current risks in the case. As a result of this audit all Independent Chairs have been reminded of the need to ensure that Child Protection Plans are checked against progress between reviews. In addition, the Team Manager for Conference and Review will dip sample 3 cases per month and report back quarterly to the PSCB through the Quality and Effectiveness Group. The first report is due to be reported to QEG in June 2015.

Multi-Agency Audit of Child Sexual Exploitation

A multi-agency audit of CSE cases commenced in February 2015. A total of 15 cases were identified to be part of the audit however it came to light that 4 of the cases were currently in legal proceedings and accordingly it was decided that these cases should not be discussed. Auditors were required to look at practice that had taken place on the case since 1st November 2013.

The audit tool sought evidence from the following areas:

- Whether the CSE Referral Risk Assessment had been used
- The quality of those CSE Referral Risk Assessments which had been completed
- The indicators of CSE recognised by referring agencies
- Planning and intervention of cases (including early help)
- The correlation between young people going missing from home, care and education and CSE
- The voice of the child
- Whether the child had been appropriately safeguarded

It was clear from the audit that the CSE Referral form is being completed but there were numerous discrepancies noted in the awareness of whether a form had been completed by the agencies involved with the young person. This should be rectified by the new process which will ensure CSE referral are treated in the same way as CP referrals. The dip samples of the form under taken quarterly will examine the information sharing process.

A range of indicators were recognised on completed forms, including substance misuse, frequent missing from home, care and school episodes and association with victims or perpetrators of CSE. The examination of common risk factors has been and will continue to be examined in the Quarterly Samples of the CSE Referral Risk Assessments.

In 10 out of the fifteen cases, it was identified that the voice of the child had been heard through their engagement in the process. Good practice was identified by Children's Social Care in two cases particularly where relationship building had been time consuming and difficult.

Thirteen out of fifteen cases agreed that parents had been engaged in the process. Good practice was identified in regular home visits being undertaken by Children's Social Care.

In thirteen out of the fifteen cases, agencies considered that the work on the case was adequate. In two cases there was an escalation due to the quality of working. A strategy meeting and a strategy discussion were held as a result of escalation and it was felt that these meetings addressed the concerns raised in the escalation.

Five out of the fifteen cases considered were involved in court proceedings. Comments regarding the support provided suggested that this was regarded positively by other professionals. Joint visits between Police and Children's Social Care to keep young people updated, purchasing appropriate clothing and supporting young people to attend pre-trial visits were offered as examples of good practice.

The impact of the quality assurance activity is that auditors can act as the "voice of the child" whilst regularly reviewing safeguarding practice to ensure that it is child centred. The PSCB can assure itself that safeguarding practice across the City is robust and fit for purpose.

Single Agency Quality Assurance Activity

The Quality and Effectiveness Group also requires the sharing of learning from single agency audits to allow the PSCB to be better informed of frontline practice and enable scrutiny and challenge as appropriate. It is recognised that this is currently an area of weakness and that the Board need to encourage agencies to be more proactive at their quality assurance role and more transparent in the sharing of learning to increase the effectiveness of partnership working.

Another area for development within the next year is the multi-agency dataset. The PSCB recognises that the dataset needs to be further developed and strengthened to include information from more partner agencies. This will provide a more holistic view of the safeguarding "picture" in Peterborough. It is the aim that a Task and Finish group will be established from the QEG to consider this work with the aim of gaining quantitative and qualitative data to enable the PSCB to better support and challenge agencies in their practice.

Section 11

Every two years the PSCB undertake a review of statutory partners S11 responsibilities. The last review was completed in March 2013. All agencies complied an overall s11 safeguarding responsibilities report was presented to the PSCB in May 2013.

An action plan was compiled from the responses received to the audit including all of the agencies who has responded. This plan is continuously monitored by the board and all actions were signed off within 2014/15. Examples of some of the actions included within the plan are as follows:

Issue	*What needs to happen*	*Lead*	*Timescale*	*Progress Against Actions*	*RAG*
Children's Social Care					
Standard 3. A clear line of accountability within the organisation for work on safeguarding and promoting the welfare of children					
3.2 Staff and volunteers are aware of their responsibilities if they are concerned about a child or young person and know the procedures to follow in such circumstances.	**Action:** Revise Induction programme to emphasise staff responsibility towards children and young people. Review e-safety messages to ensure fit for purpose **Outcome:** Clear staff responsibility	Practice Support Manager	30/06/13	The new induction programme and handbook has been completed and circulated to all managers	Green
Cambridgeshire Constabulary					
Standard 2. A clear statement of the agency's responsibility towards children is available to all staff					
2.3 There are arrangements in place to ensure that organisations commissioned to provide services on your behalf have regard to the requirements of section 11 of Children Act 2004.	**Action:** Review contract template for commissioned services to ensure they have regard to the requirements of Section 11 of the Children's Act 2004. **Outcome:** Robust contractual arrangements in place with explicit reference to safeguarding and promoting the welfare of children, monitored effectively on an annual basis.	Head of Contracts & Procurement	30th April 2013	Standard procurement documents have been checked and adapted. Reference to safeguarding included in the current templates with immediate effect.	Green

Amendments were made to the audit tool in March 2015 to include questions concerning child sexual exploitation and e-safety. The tool has been disseminated to all agencies and returns have been requested for June 2015. Results of this audit will therefore be included within the 2015/16 Annual Report. In addition to the statutory agencies, the PSCB also requests a response from the NSPCC to gain the widest possible picture of safeguarding practice in the city. As well as this, in 2015 the audit tool has been sent to all GP practices, as well as the British Transport Police. The PSCB are continually seeking ways to link with as many relevant agencies as possible and increase aware of safeguarding for the benefit of the children and young people in the city.

Future work of the group

As well as those developments mentioned previously in this chapter, t is the aim of the PSCB to undertake some multi-agency audits across the county of Cambridgeshire in response to requests by agencies who work across the county.

In addition, it is intended that there will also be audits which include both Children and Adult's Safeguarding Services, to determine the existence of, and ways of addressing, practice gaps in the transition between services. Any lessons learnt through these exercises will be shared across services, which it is hoped will be to the benefit of those services which deliver services to children and adults.

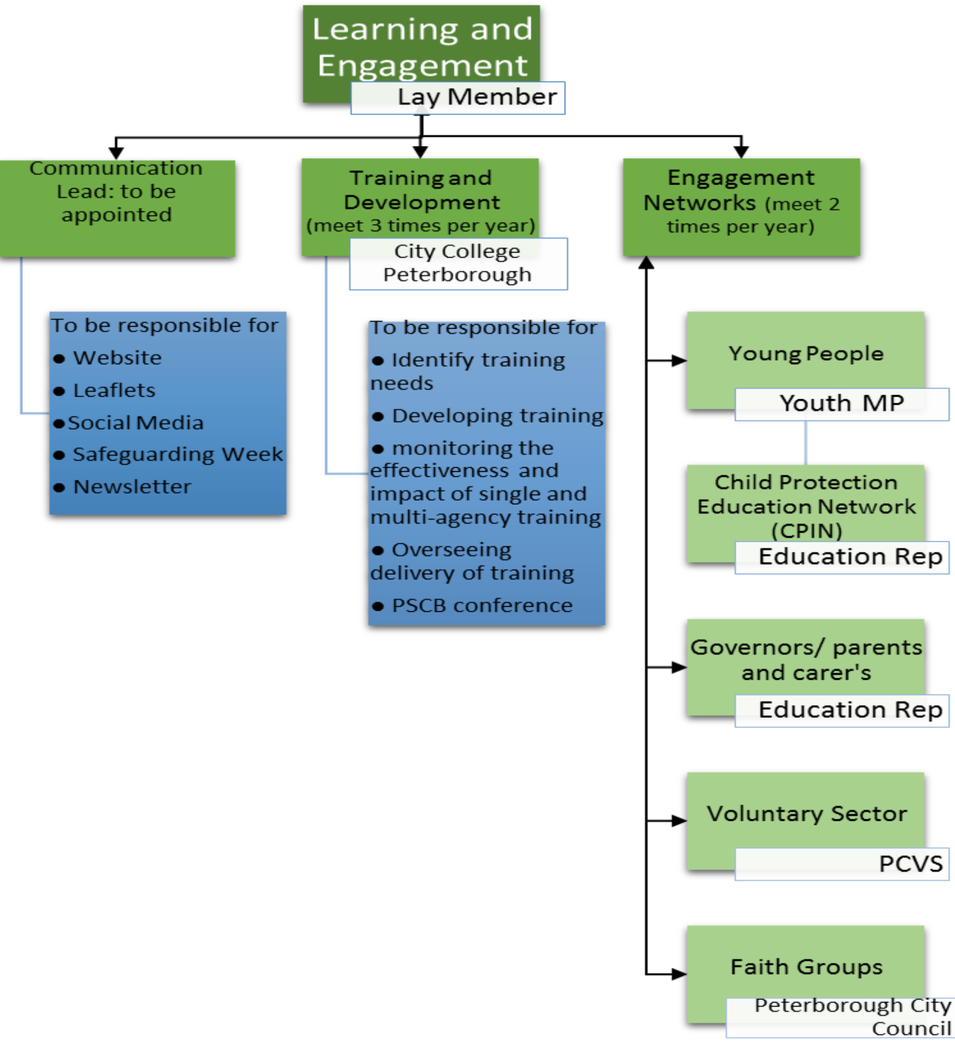
Strategic Learning and Development Group (SLDG)

Until early 2015 the PSCB had a Strategic Learning and Development Sub Group which was responsible for ensuring that the PSCB Training Strategy was implemented effectively across all partner agencies. The aim of the Strategy is for all workers in Peterborough in contact with children/young people and/or their parents and carers to receive appropriate and relevant training in safeguarding children.

The group was also responsible for agreeing effective quality assurance processes in order to ensure that the safeguarding children training provided by all member agencies meets agreed standards. It made changes in the light of any identified gaps in training or resulting from national and local findings of SCRs/CRs, research, new or revised legislation and guidance.

In January 2015 a decision was made to reconfigure the Strategic Learning and Development Group and the Communications Group into one Learning and Engagement Group (LEG) Training and Development will form one of this groups work streams. The first LEG meeting was held on 5th March 2015, where the structure of the group was agreed, as can be seen below.

At the initial LEG meeting, the structure, terms of reference, reporting arrangements and future meetings dates were all set. Further detail regarding the work and effectiveness of this group will be included within the 2015/16 Annual Report.



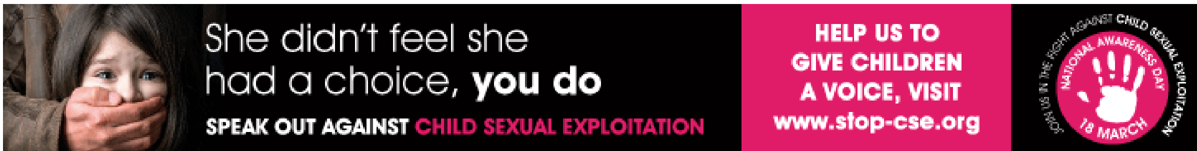
The revised structure will be supported by a new post within the reconfigured Business Unit. This post who will lead on the communications strand.

The work undertaken by the SLDG during 2014/15 included:

- Setting up a Task and Finish Group to put together a Training Resource Pack on child sexual exploitation. The aim of this resource is to aid agencies in delivering single agency briefings to ensure basic awareness raising is delivered in as many agencies as possible.
- Organising the ½ day conference on child sexual exploitation: arranging the venue, speakers and content. The impact of the conference is detailed under Chapter 3.4 of this report
- Exploration of the possibility of the PSCB supporting a multi-agency training pool. It was decided that there were insufficient resources to support this idea but that training continued to be well supported by professionals from a range of agencies.
- Considering the impact of training delivered by the PSCB: details can also be found in Chapter 3.4.
- Validation of single agency safeguarding training
- Preliminary discussion concerning a ½ day conference on Neglect. This conference is being organised for November 2015 and it is hoped that careful planning and consideration of the content will allow this conference to be as successful and well received as the conference on child sexual exploitation.

The overall purpose of the new Learning and Engagement Group is to ensure effective training, communication and engagement with professional, community groups and young people and their parents/ carers across Peterborough. The work of the group is informed by the PSCB business priorities and in response to learning arising from serious case reviews and other national and local concerns. The work of this group will be reported in the 2015/16 Annual Report

Joint Cambridgeshire and Peterborough Child Sexual Exploitation Group



Ensuring that children and young people are fully protected from CSE remains a business priority for the PSCB, and the positive reaction seen last year has continued.

During the last 12 months the Joint Cambridgeshire and Peterborough CSE Implementation group has completed the following:

- Reviewed the previous Action Plan and approved the new version which aims to incorporate responsibilities of all agencies and include learning from national reports such as the 'Independent Inquiry into Child Sexual Exploitation in Rotherham 1997 – 2013'. The action plan is closely monitored by the group to ensure recommendations are progressed.
- Reviewed and revised the referral pathway for CSE. In September 2014 the numerical scoring tool was removed from the referral form in response to learning from Operation Erle. Later in April 2015 the pathway was amended so that the CSE checklist was added to the Child Protection referral form which now means that CSE concerns are dealt with in exactly the same way as other child protection concerns. This has eliminated any confusion amongst partner agencies regarding thresholds for CSE.
- Across the county, an operational overview meeting to discuss themes, trends and live operations and share information across the county at a more tactical level has been formed.

- A Risk Management Tool has also been created and agreed which will be rolling out across the county following approval from this group. The aim is for this tool to be completed at the core assessment stage to comprehensively assess risk.

Additionally, although on the whole the members of the group have been proactive, at the end of 2014 it was necessary to review the membership of this group and a process was implemented to address non-attendance.

Future action for the group will be to oversee the updating of the CSE strategy, which will be re written to include national and local learning. It is intended that a multi-agency dataset can also be compiled to build a clearer picture of what CSE 'looks like' in the Peterborough and Cambridgeshire area.

More information can be found under the Board's priority "*Children are fully protected from Child Sexual Exploitation*" on page 46

E-Safety

This is a group shared with the Cambridgeshire Safeguarding Children Board. This area continues to be a focus for the Board. The group has a work plan which is structured under five priorities.

1. To support agencies in the safer use of Information Communication Technology
2. Develop procedures for dealing with e safety incidents which also identify trends.
3. Promote the awareness and understanding of E-safety issues.
4. Develop standards by which agencies can self-audit.
5. To support children and young people's participation in developing information for parents, carers and others.

The group changed its frequency of meetings from bi-monthly to quarterly but has kept its good attendance. The group aims to respond to ever-changing trends in the use of technologies and over the last year has included updating the guidance and information on the PSCB website for professionals, parents/carers and children and young people, in particular covering:

- Online Gaming
- and the Safe Use of Skype.

The group have also been reviewing the strategy and action plan in light of recommendations on policy made by EU Kids Online Network. E-safety audit tool has been revised and there was a session with the Internet Watch Foundation looking at their most recent research.

Lastly, an initiative to have E-safety Champions in each of the Cambridgeshire County Council Locality Teams has been launched and training has been started. The idea is that they will be able to run e-safety sessions with parents. Another means of trying to get the message across to parents. It is the plan for a similar project to be run in Peterborough, another example of good partnership working between the two local authority areas.

Health Executive Board and Health Safeguarding Group

The aim of the Health Executive Board is to strengthen and provide direction for the health community as well as agree the work plan for the Health Safeguarding Group. This group was established last year and through 2014/15 has provided two way communication between the Safeguarding Children and Adults Boards in Cambridgeshire and Peterborough: sharing the key messages from the boards to health partners and providing updates on relevant activity. For example the child sexual exploitation referral pathway, and providing operational feedback to the boards.

In addition the group has focused on the following:

- Health input into the establishment and development of the Multi-Agency Safeguarding Hubs for children's services and adult services
- Raising awareness and developing practice concerning Female Genital Mutilation
- Signing off updates to applicable policies and protocols, e.g. Bruising in Non-mobile Babies Protocol
- Workforce development: subject areas for training and barriers to accessing training
- Progress against the Safeguarding Work Plans for Childrens and Adults

The Health Safeguarding Group (HSG) continues to provide a forum for nurses and doctors to discuss such issues as CQC inspections, CSE and challenging and complex individual issues. The benefits of these meetings for peer support has been noted by the group.

Meetings of the HSG in 2014/15 were used to focus on specific areas of the work plan, as well as encouraging the sharing and good practice and discussion concerning specific issues. Areas covered by the group in the last year have included:

- A 'stock take' of local arrangements concerning child sexual exploitation
- Update to the Bruising in Non-mobile Babies Protocol
- Discussion regarding attendance of health representatives at multiagency meetings.
- Work streams concerning female genital mutilation
- Consideration of Policies concerning Chaperones

The work plan for 2015/16 has been agreed and will focus on the following areas:

- Domestic Abuse
- Serious Case Reviews: embedding learning
- Voice of the child
- PREVENT Agenda

It is believed to be good practice that these groups continue to operate as they provide the PSCB with a clear communication pathway with the many sectors of Health. This pathway ensures that information is received by the Board regarding safeguarding matters within the Health sector, as well as reassuring the board that messages and information are passed down to practitioner level.

Child Protection Information Network (CPIN)

The purpose of the subgroup is to facilitate effective two way communication between educational settings and the PSCB. It also provides a platform for the sharing of policy and protocols between settings, and the translation of DfE and other national and local guidance into every day practice.

The interpretation of, and implications for change as a result of Keeping Children Safe in Education 2014 formed a major part of the subject matter during the year. Ensuring all schools and settings are up to date with government expectations is crucial to compliance with their statutory duties.

Learning from Serious Case reviews was presented to the group, and supporting resources shared with all educational establishments.

Regular updates concerning issues around CSE were welcomed by schools and settings, who value the open and candid information sharing.

The group has representation from all educational sectors, from Early Years to Further Education. The result of this is greater consistency in the understanding of information shared, and clarity and a deeper understanding and appreciation of how each area operates when fulfilling their safeguarding role.

Whilst attendance is good, the main challenge of ensuring all settings receive the information is still apparent. Although circulated widely through electronic means, some of the context may be less clear than when face to face.

The release of Keeping Children Safe in Education 2015 and Working Together 2015 highlights the requirement for ongoing exploration of DfE expectations.

We continue to work closely with the PSCB to ensure their priorities are addressed and that schools and settings are meaningfully involved as much as possible.

CPIN is well supported by the PSCB and by the police. There are also regular opportunities for other partners, such as YOS and Health to share experience and expectations of their role and provide real life examples of how we can all work together.

Ofsted inspections assess the effectiveness a school's safeguarding practices. No setting has been identified as having serious weaknesses in this area, and a number have been seen as outstanding. Information and good practice sharing through opportunities such as those provided by CPIN underpin much of the evidence seen by Ofsted.

PSCB offer encouragement and challenge for all agencies involved in the safeguarding of our children. The 'hands-on' approach and the support provided, for example through production of support materials, is invaluable.

Task and Finish Groups

In addition to the work undertaken by the groups as outlined above, there has also been specific activity undertaken by Task and Finish Groups as standalone pieces of work for the Board.

Female Genital Mutilation (FGM)

This joint Peterborough and Cambridgeshire group was established in September 2014 to develop a pathway to manage cases of FGM and increase awareness of the issue.

Three meetings were held, attended by multi-agency colleagues including Heath, Education and Police, chaired by Dr Emilia Wawrzkowicz. Training and awareness raising, data collection and policies and procedures were discussed. The following were produced as a result of the activity by this group:

- FGM Resource Pack, which includes:
    - Practice Guidance for practitioners on Female Genital Mutilation
    - FGM Leaflet for professionals
    - Letter to nurses and early years practitioners
    - Flowchart 1 – If you suspect a child/young person has undergone FGM
    - Flowchart 2 – Pathway for management of pregnant woman – FGM
    - National FGM Poster
    - Leaflet and poster for girls and women, designed in consultation with a group of young people from Peterborough.

The resource pack was launched by both LSCBs in November 2014 and will be followed by multiagency workshops in Peterborough and Cambridgeshire.

Child in Need (CiN)

In response from the findings from a Serious Case Review, it was determined that a task and finish group should consider how the CiN process might be strengthened and how pressures on allocated workers might be reduced by increasing multi-agency responsibility for CiN cases. The outcomes of the work of this group fall outside of the timescale of this report so will be included next year.

Child Sexual Exploitation

As previously mentioned under the work of the SLDG, a group was established to look at the creation of a training resource pack on CSE. The pack was launched at the CSE conference in January 2015 and contains:

- Welcome letter
- Briefing presentation
- Leaflets for
    - Professionals
    - Children and young people (available in 8 languages)
    - Parents and carers (available in 8 languages)
- Poster
- Information on the MASH
- Warning signs and vulnerabilities checklist
- Joint Child Protection Referral Form
- Skype advice
- Brook Sexual Behaviours Traffic Light Tool
- Case studies

Business Priorities 2014/15

Partner agencies were in agreement that the business priorities from 2013/14 remained relevant and as they were based upon the views of agencies and children and young people, it was decided that they remain the same for 2014/15. Each priority forms its own chapter in this report, where the activity of the Board and partner agencies is detailed:

"Early help and preventative measures are effective"

Some families need help – this may be help in relation to housing, how to parent, behaviour/ anger management, how to budget and attendance at school. By helping these families it is hoped that the situation will improve and the family/ children will not need to have intervention by children's social care.

eCAF

Peterborough City Council moved to an eCAF solution with Liquidlogic which became live in January 2014, which mirrors the contents of the Peterborough Threshold Document. $00 delegates have been trained on eCAF and in excess of 120 Lead Professionals are initiating Early Help Assessments on the eCAF system.

Multi-Agency Support Groups (MASGs)

The panels are there to support referrals direct from partners through an Early Help Assessment and to support the de-escalation of Children's Social Care cases following a Child and Family Assessment where the outcome is that identified needs do not indicate a need for continuing involvement by Children's Social Care but where other multi-agency needs are identified.

Since the first MASG panel which took place on the 19th September 2012 there have been in excess of 600 families referred to the panel for support.

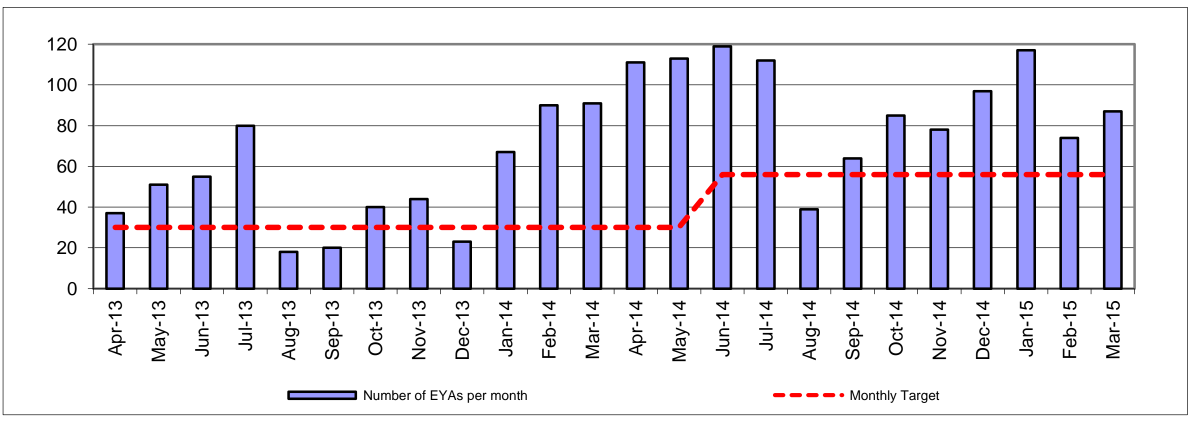
The external audit conducted in September 2014 included observation at one MASG panel. The report from this audit states:

- Attendance at the MASG panel was excellent. Moreover the effectiveness of attendees and the services they represented demonstrated inputs, outputs, outcomes and impacts for children, young people and families, which in some cases were good to outstanding.
- Professionals were knowledgeable in their own field and there was good evidence they acted as gateways and enablers to services.
- The panel has matured from a mechanical approach to a streamlined professional group with the child at the centre of attention.

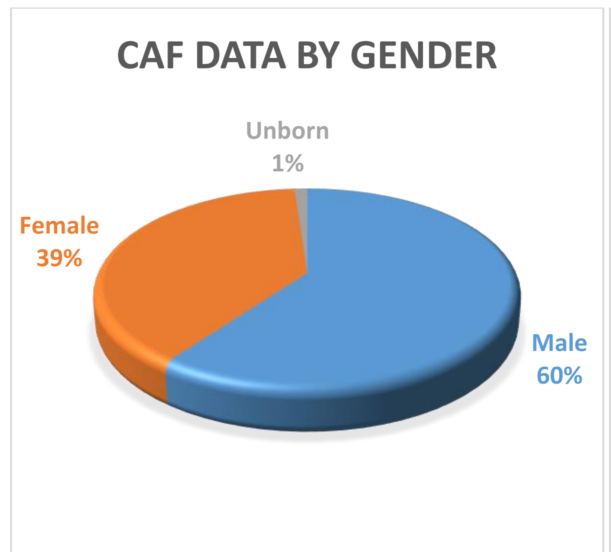
CAF Data 2014

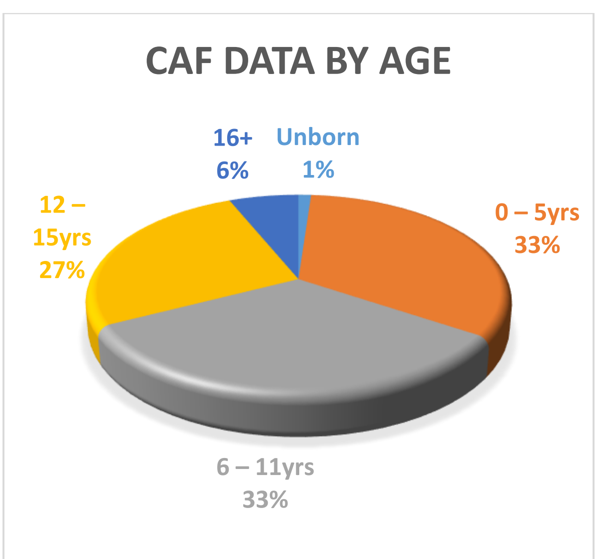
A summary of Early Help Assessment numbers is provided here for the year beginning Jan 2014:

By calendar month - 2014:

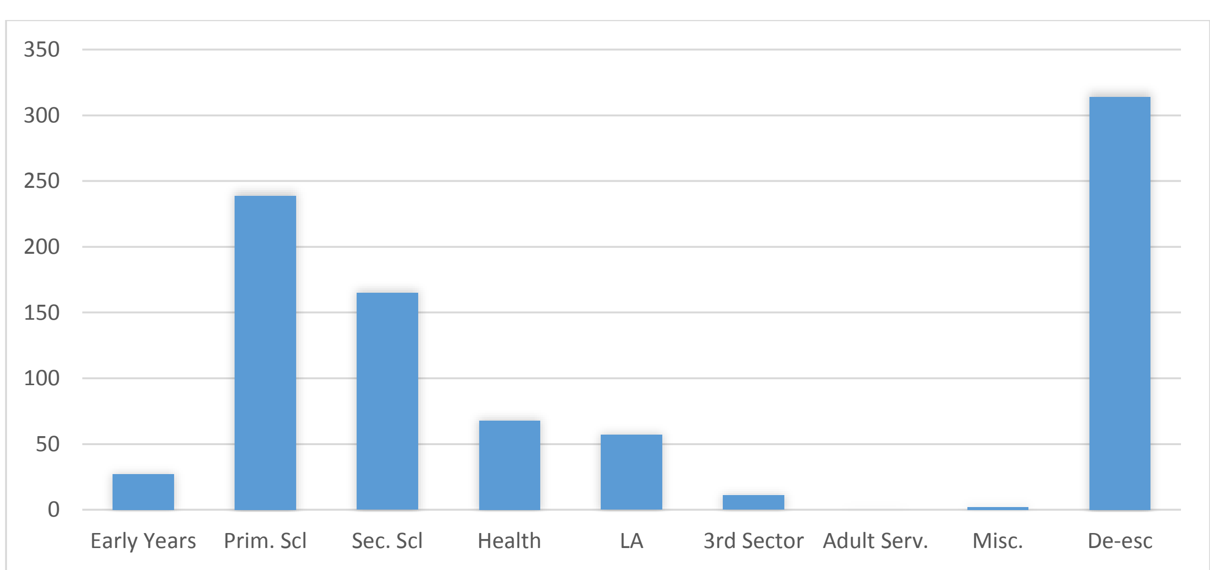


By Gender and Age:





Who Completed the Early Help Assessment?



In the January 2013 Ofsted inspection it was identified that some services were not engaging fully in CAF. Considerable effort has been put into engaging other services that have historically not engaged, including CAMHS.

Service User Feedback

A report examining responses from parents / carers on the Early Help Assessment process was produced in May 2014. This will now be produced as an annual report.

Early indications from Early Help Assessment parent / carer and child / young person comments received show:

- Commitments from parents to engage – putting this as a priority so that support for child / young person can be obtained.
- Parents consider the actions are a good step forward
- Young person accepted that they needed additional support

External CAF Audit

Findings of the external audit on CAF and Early Help Processes September 2014:

- MASG:
  - Heavily focused on the child
  - Areas in need of development are ensuring voice of the child evident on all cases and
  - Recognition and measurement of impact
- Case file audits:
  - CAF Co-ordinators (now called Early Help Co-ordinators) carry high numbers of Lead Professional roles
  - There was good evidence of CAF Co-ordinators chasing progress and safeguarding checks had been undertaken on all appropriate cases.
  - An area in need of development is ensuring the presence of Team Around the Child minutes on the system
  - The quality of CAFs was variable and CAF Co-ordinators are now quality assuring CAFs and sending back those that do not meet standards
  - There was good evidence of parental involvement in CAFs
  - Another area of development is consistently including the voice of the child
- Additionally:
  - There was evidence of a training and support programme for the implementation of eCAF
  - The volume of work for the CAF Team (now Early Help Team) continues to increase significantly
  - There is high continuity in the team and they offer a wealth of experience

An Action Plan has been developed as a result of the audit and is actively being worked upon.

Feedback to Practitioners

In January 2014 it was decided to trial for a period of 6 months providing direct feedback to Early Help Assessment initiators. The activity is considered to be so beneficial, that following the 6 month trial, this has now been built in as part of the standard quality assurance process.

Early Help Assessment QA results:

The Early Help Assessment QA is conducted 6 to 8 months after the Early Help Assessment was initiated. Therefore QA results recorded in October to December 2014 relate to Early Help Assessments completed in April 2014.

<u>Current results for 2014 indicate:</u>

Excellent grading - 6%

Good grading - 55%

Satisfactory grading -22%

Unsatisfactory grading – 17%

Early Help Delivery Group

An Early Help Delivery Group was set up summer 2014, with the following aims:

- The Aims of Early Help are to ensure that children and young people who need the support of more than one agency experience effective, coordinated early help assessments that lead to the delivery of services which enable improved outcomes.
- Children and young people accessing effective coordinated help through the Team around the Child approach should have their needs met and this should prevent needs from becoming more complex and reaching the point that intervention by specialist services is required.

Developments:

- The group have now approved the production and distribution of a range of material to encourage practitioners to seek out and record the voice of the child on assessments and as part of the TAC process.

- An Early help co-ordinator has now been supporting the Peterborough MASH (Multi-Agency Safeguarding Hub) since the beginning of January which is already having considerable impact, both in terms of sharing information and supporting contacts that come into Children's Social Care that are deemed not to need social care intervention but where the family would benefit from multi-agency support at a targeted level.

Proposed developments:

- The current Troubled Families programme ends in May 2015, however last year the Department for Communities and Local Government (DCLG) announced the programme would continue for a further five years, but that the criteria for qualification onto the programme would be wider to capture more families. The new programme will see Peterborough identify and work with 1,640 families over the five years of the programme. We have committed to identify and work with 82 families between 1st January and 31st March 2015. There is an obvious link between the programme and the Early Help (CAF) process and in Peterborough we are aligning the new programme to existing processes. This is to ensure the programme sits within the context of our wider early intervention work as a Council and a Partnership; in addition it ensures consistency and quality of our response to 'troubled families', and that the most appropriate multi-agency response is agreed. The Multi-Agency Support Group (MASG) panels will continue to be the gateway through which additional support for families can be accessed.

Information taken from 'Analysis and Impact of Early Help Assessments 2014-15' Karen Moody Jan 2015

Members of the Early Help Team sit on the Quality and Effectiveness Group and regularly participate in quality assurance activity. Early help quality assurance monitoring is now a standing agenda item on the QEG group to ensure that there is regular scrutiny. Members of the Early Help team have contributed to PSCB multi agency audits (CSE and Core Groups) and they also present regular updates on their internal quality assurance activity. Both the Core Group audit and CSE audit looked at thresholds as part of the audit process. The Business Manager for the PSCB and Head of Service for Early Help have regular update meetings and senior Managers with responsibility for Early help are active members of the PSCB.

It is clear from the external audit which took place in 2014 that the work of the Early help Team means that a significant number of families are supported under the eCAF and MASG process, a number which increases year on year. Feedback from families involved in the process is positive and demonstrates that they are engaged in the process from the start.

Work is underway to ensure the quality of assessments and support is offered to professionals completing assessments, providing a comprehensive training and support package around Early Help.

The data above concerns Quarter 3, data concerning Quarter 1 was presented to the Peterborough Safeguarding Children Board in July 2014 which painted an equally positive picture.

It is expected by the Board that work will continue within the Early Help Team on:

- The quality assurance of assessments and support for professionals
- Evaluation of the impact of Early Help via feedback from children, young people and their families and
- Monitoring of support provided under the Troubled Families Programme

During 2015/16 the Board will continue its scrutiny of Early Help to assure itself that the positive impact continues.

"Children at risk of significant harm are effectively identified and protected"

Significant harm within this priority means children who are the victims of child abuse. This could be emotional abuse, physical abuse, neglect or sexual abuse (including child sexual exploitation).

Actions undertaken against this priority have been as follows:

A review of the attendance of relevant agencies at child protection conferences along with the timelines of reports being available has been completed via a multi-agency audit through the Quality and Effectiveness Group. An action plan was formulated and has now been completed, and a reporting process is now in place from Children's Social Care on agency engagement that is shared with the PSCB on a six monthly basis. The first of these reports is due to be delivered at the May 2015 Board Meeting.

Links have been developed with the Strategic MAPP Board (SMB) via the Independent Chair and Business Manager who have become members of the SMB and a local procedure has been developed. The aim is to ensure that safeguarding is fully integrated into managing offenders who pose a risk to children.

The PSCB have retained a focus on Looked After Children in the last year by creating and maintaining links to the Corporate Parenting Panel and Independent Review Service, and Looked After Children placed out of the Local Authority. A reporting cycle is in place and the necessary information included within the dataset to ensure the PSCB remains informed of the quality of care and services for this group of children. The Chair and Business Manager also present annual updates to the Corporate Parenting Panel to ensure the flow of information between the Board and this group.

The Multi-agency Core Group Audit undertaken in November 2014, as detailed on p19-20 of this report, found that Core Groups are generally being held regularly and that almost all agencies are well engaged in this process. An Action Plan was compiled as a result of the audit with some actions which are now complete: e.g.

RECOMMENDATION	ACTION	RESPONSIBLE OFFICER (NAME AND JOB TITLE)	DATE DUE TO BE COMPLETED	PROGRESS	EVIDENCE OF COMPLETION	DATE OF AGENCY SIGN OFF
When membership of the Core Group is being decided the specific section of health should be identified (e.g. school nurse, health visiting, hospital)	Process to be agreed with health. This will form part of a wider discussion concerning health at Child Protection Conferences	Alison Bennett, Head of Service for Quality Assurance and Safeguarding, Children's Social Care	February 2015	Completed	New process in place.	February 2015

While some actions remain ongoing:

Where agencies have not completed actions that are attributed to them that should be challenged and held to account by Core Group members. This challenge must be recorded in the minutes.	A dip sample of plans to monitor effectiveness of Core Groups in progressing plans	Team Manager for Conference and Review Service	Commence May 2015 then ongoing			

Attendance at Child Protection Conference and parental feedback is presented by the Team Manager for the Conference and Review Service to the board for scrutiny on a quarterly basis.

Specific child protection issues have also been the focus of awareness raising activity in the last year: training has been targeted at General Practitioners, Early Years practitioners, schools and other health professionals on the subject of female genital mutilation. Wider awareness raising activity has also continued on the subject of child sexual exploitation.

Finally, progress is ongoing concerning the development of a robust auditing programme that includes a focus on the experience of the child, the impact and outcome of service provision and that leads to the identification of themes and plans for improvement which are robustly implemented and monitored. The auditing programme has been developed and is delivered through the Quality and Effectiveness Group. The programme includes single agency and multi-agency audits. Further developments are planned to ensure the voice of the child is captured.

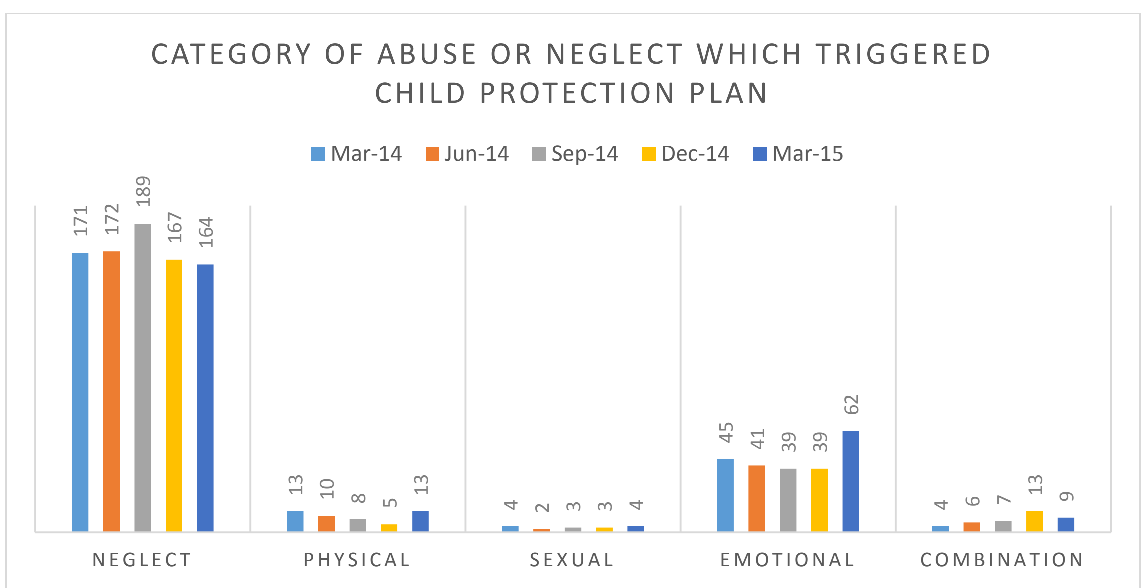
Child Protection Plans

All children at risk of significant harm or abuse will be the subject of a Child Protection Plan. A child protection plan is a working tool that should enable the family and professionals to understand what is expected of them and what they can expect of others. The aims of the plan are:

- To keep the child safe
- To promote their welfare
- To support their wider family to care for them, if it can be done safely

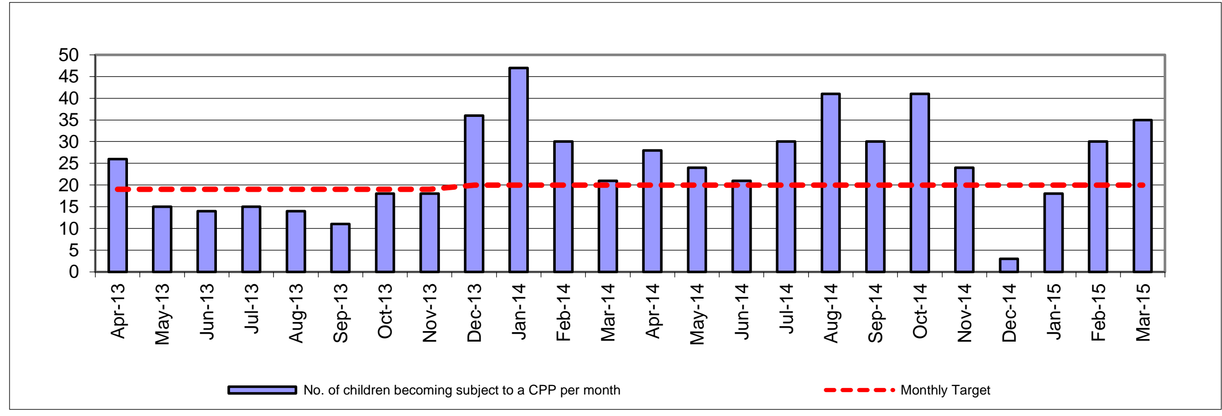
The table below and charts shows the number of Peterborough children on a Child Protection Plan

	Mar-14	Jun-14	Sep-14	Dec-14	Mar-15
Child protection	**237**	**231**	**246**	**227**	**252**



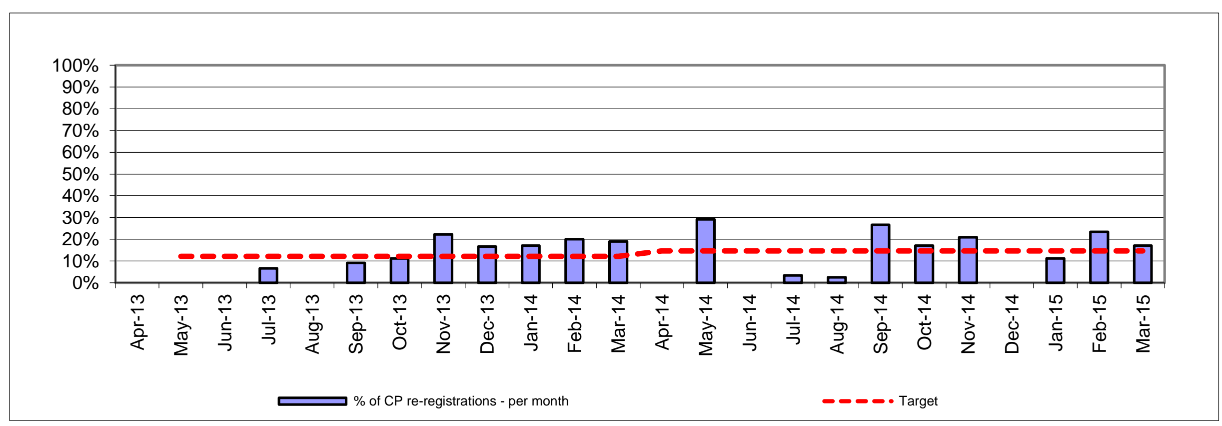
The majority of children and young people who are subject of Child Protection plans in Peterborough are registered under the category of Neglect. The PSCB has recognised this and accordingly, Neglect will remain as a business priority for the Board in 2015/16 and further work around the issues of neglect will take place.

The Number of children becoming the subject of a child protection plan per 10,000 of the local population (aged under 18)



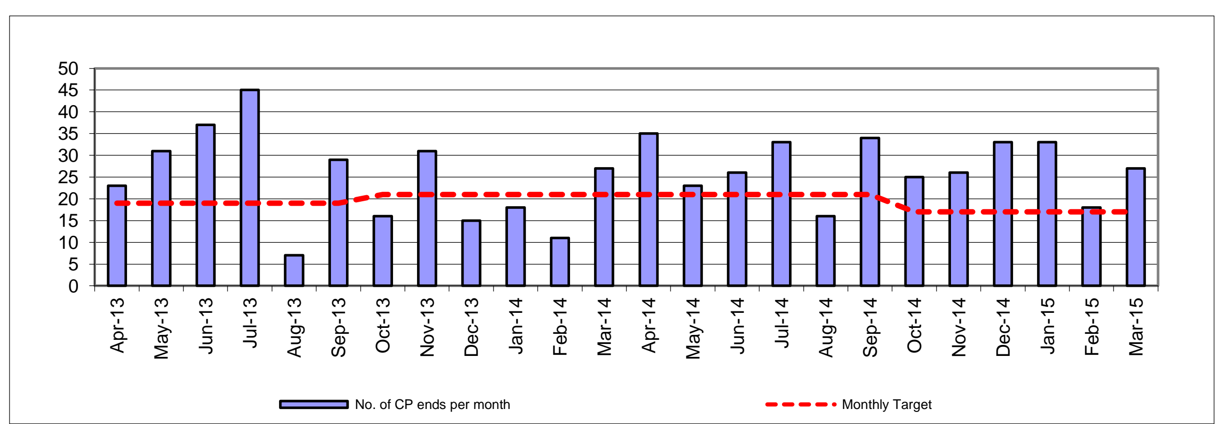
There were 264 children who became subject to a child protection plan during 2014/15. This equates to a rate per 10,000 of 58.7 which is 9.9% higher than the target rate of 53.4.

The number who became subject to a CP plan for second or subsequent time



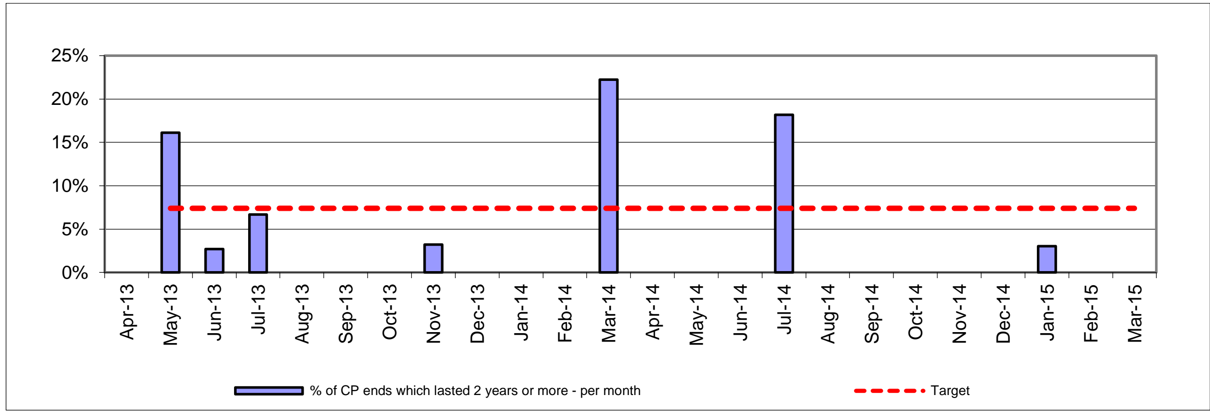
Of the 264 children who became subject to a child protection plan during 2013/14, 31 (11.7%) of them had previously had a child protection plan in Peterborough.

The number of discontinuations of a Child Protection (CP) Plan per 10,000 of the local population under 18



There were 290 children who ceased to be subject to a child protection plan during 2014/15. This equates to a rate per 10,000 of 64.4 which is 14.1% higher than the target rate of 56.5.

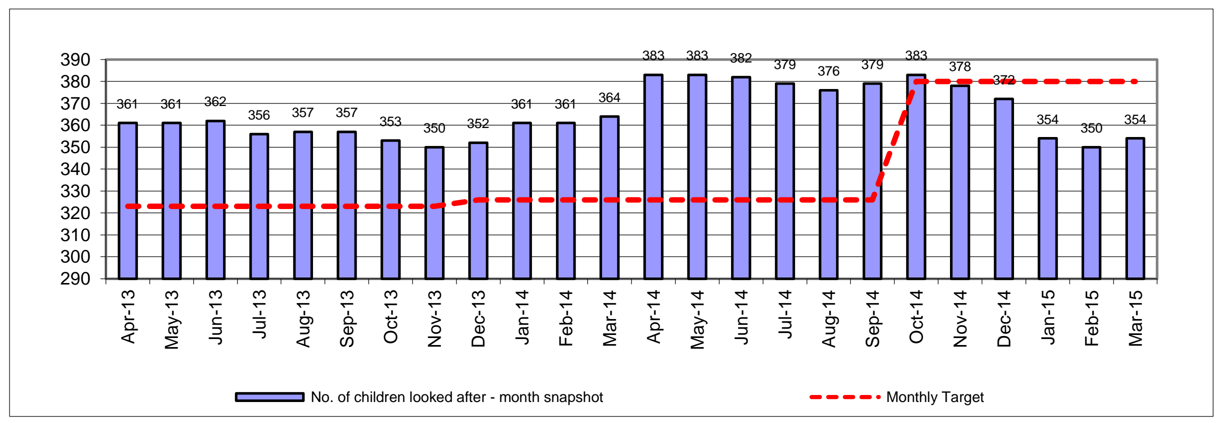
Child Protection Plans lasting 2 years or more



Of the 290 children who ceased to be subject to a child protection plan during 2014/15 16 (5.5%) of them had been subject to a child protection plan for more than two years. This is 1.9 percentage points better than the target of 7.4%.

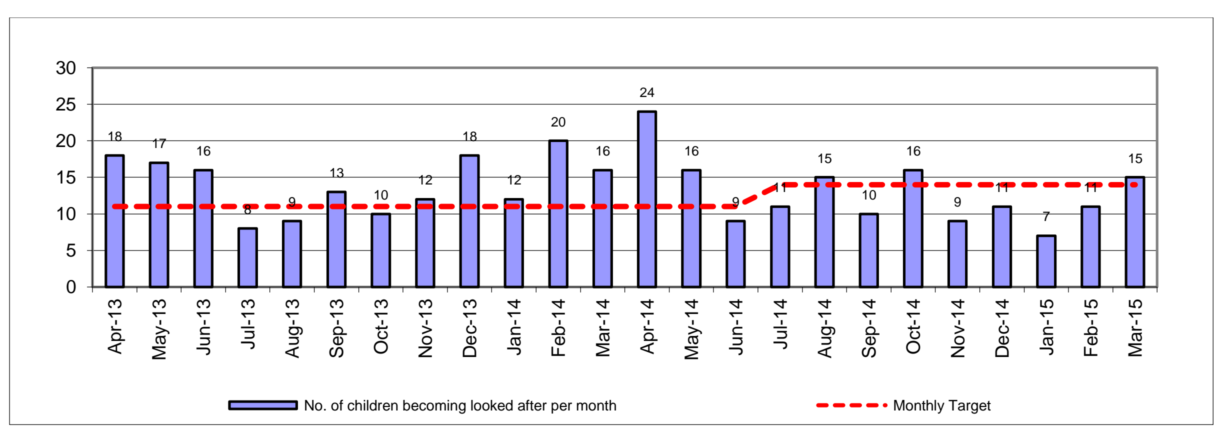
Looked After Children

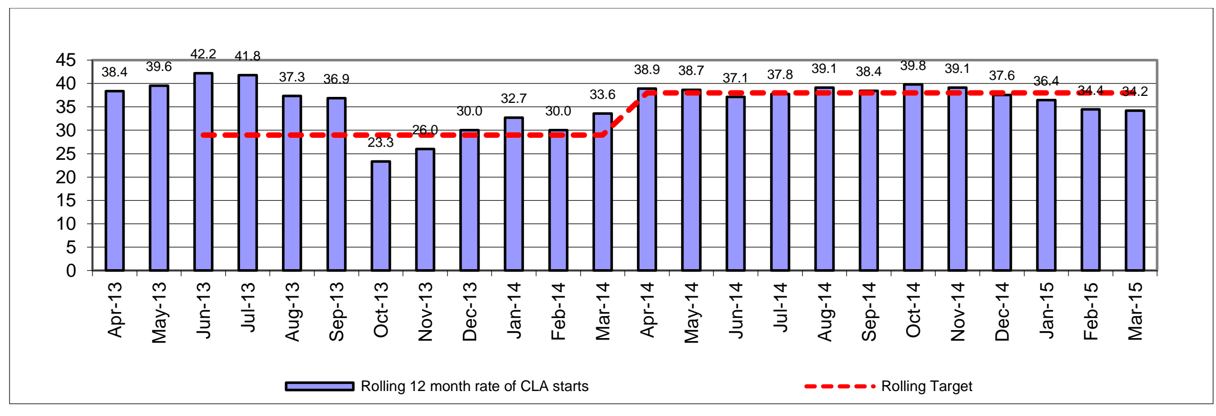
The number of children looked after at the end of March 2015 reached 354 which is an increase of 4 since the previous month but a decrease of 10 since March 2014. The rate per 10,000 is 78.7, 6.8% below the target (84.4).

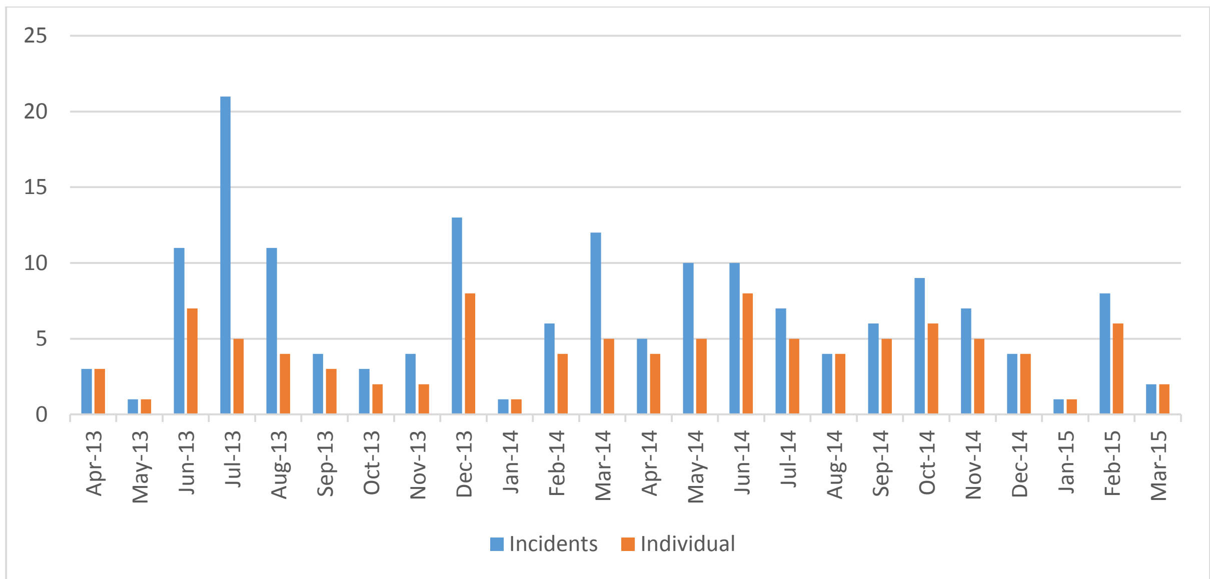


Admissions of Children Looked After per 10,000

15 children came into care during March 2015, above the target of 14 per month. The rolling 12-month rate per 10,000 at 34.2 is 9.9% below target.







Over the past year there have been 55 individual looked after children who went missing with a total of 73 incidents. Missing children are covered under Chapter 4: Additional Groups of Children in more detail.

All training delivered by PSCB covers thresholds and these are regularly monitored by the PSCB. This includes looking at thresholds at the point of CSC intervention and also the wider thresholds concerning S47 enquiries, Child Protection conferences and entrance to Care. This is also monitored through multi agency quality assurance activity and performance management information.

"Everyone makes a significant and meaningful contribution to safeguarding children"

Legislation states that everyone has a role to play in safeguarding children. Part of the role of the PSCB is to ensure that all agencies (including Police, Children's Social Care, Education, Probation, Youth Offending Service, Health and the Voluntary Sector) are properly completing their role in safeguarding. We do this through case reviews, audits, training and listening to children, young people, carers and professionals. Where we consider that an agency could improve their safeguarding activities the PSCB holds the agency to account.

This priority is primarily measured via the indicators within the dataset, which is in ongoing development. As detailed in the section in this report concerning Section 11 Audits, returns are undertaken by all agencies. The last s11 was completed in 2013 and requests have been sent to ensure the 2015 audit is completed on time. A discussion was held at the Chairs Group and it was decided that the s11 in 2015 would focus specifically on the voice of the child.

An Assessment Framework has been developed and is being delivered by Children's Services. The protocols within this framework aim to ensure:

- Assessments are timely, transparent and proportionate
- The needs of disabled children, young carers and children within youth justice are outlined and considered
- There is clarity on how agencies can make a contribution
- It is established how assessments can be linked to other specialist assessments

The multi-agency safeguarding recognition scheme which commenced in July 2013 has continued through 2014-15 with a total of 4 safeguarding awards having been distributed. All of these awards were given in recognition of the work undertaken to protect children from child sexual exploitation.

As previously mentioned, attendance at meetings of Peterborough Safeguarding Children Board by all of the wide range of agencies is good and all members have made contributions towards the campaigns run in the last year. In addition, those agencies who support the Learning and Development Programme by delivering multi-agency training include:

- Police
- Children's Social Care
- Health
- The voluntary sector

The board has sought input from young people in the city in the last year, detailed in Chapter 9. This ensures that the work completed by the Board and partners is relevant and appropriate for children and young people in the city, and allows them to contribute to work which may or may not directly affect them.

It is recognised that this is an area which should be expanded as good practice. In the next year the members of the Peterborough Safeguarding Children Board and the Business Unit in supporting of the members, will be considering how they can engage young people and parents/carers to a greater extent in their safeguarding practice.

"Workforce has the right skills/knowledge and capacity to safeguard children"

The PSCB has a duty to deliver multi-agency safeguarding training to agencies in Peterborough to ensure that all professionals know how to safeguard children and what signs to look for. We are also responsible for checking that any safeguarding training that is run by agencies in Peterborough is fit for purpose.

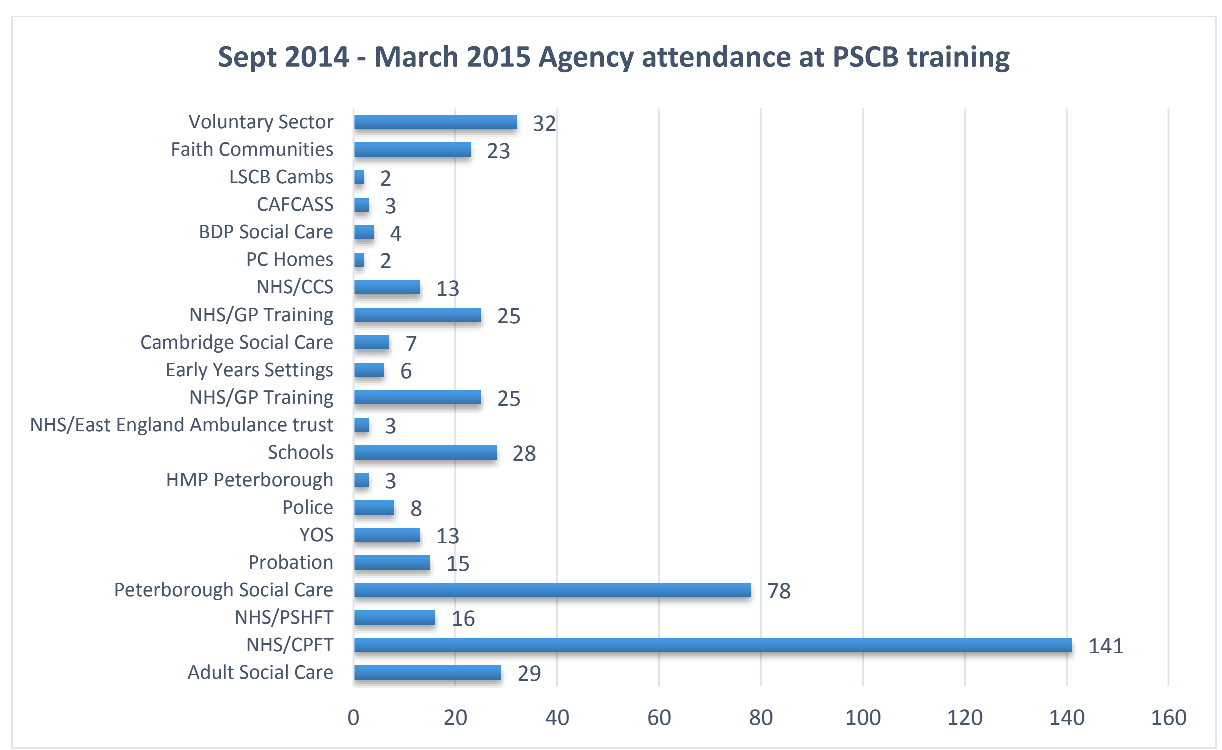
In March 2014 a decision was made that the PSCB training would revert to an academic year programme as oppose to a financial year. This resulted in the 2013/14 PSCB training programme concluding on the 31st March 2014 and the next full PSCB training programme commencing in September 2014.

During the period 1st September 2014- 31st March 2015 the PSCB delivered a total of 20 different safeguarding courses (13 of which form the core programme) with 27 individual training sessions offered (This does not include training that has been undertaken by the CSE Co-ordinator to groups of young people – e.g. Mini CSE "conference" at a secondary school – 150 young people attended) These varied in both subject area and course level but all of them were delivered to a multi-agency audience. The subjects discussed during the six months included;

- Child Development
- Child sexual Exploitation
- Neglect
- Domestic Abuse
- Parental Mental Health
- Safeguarding deaf & disabled children
- Safeguarding for Managers
- Messages from child death overview panel and serious case reviews
- GP Training

Attendance

During the six month period 476 people attended the training. Non-attendance rate was 4% the majority of reasons given for non-attendance was due to illness, bereavement, court attendances. Non-attendance continues to be followed up as to reasons why and a charge raised where appropriate.



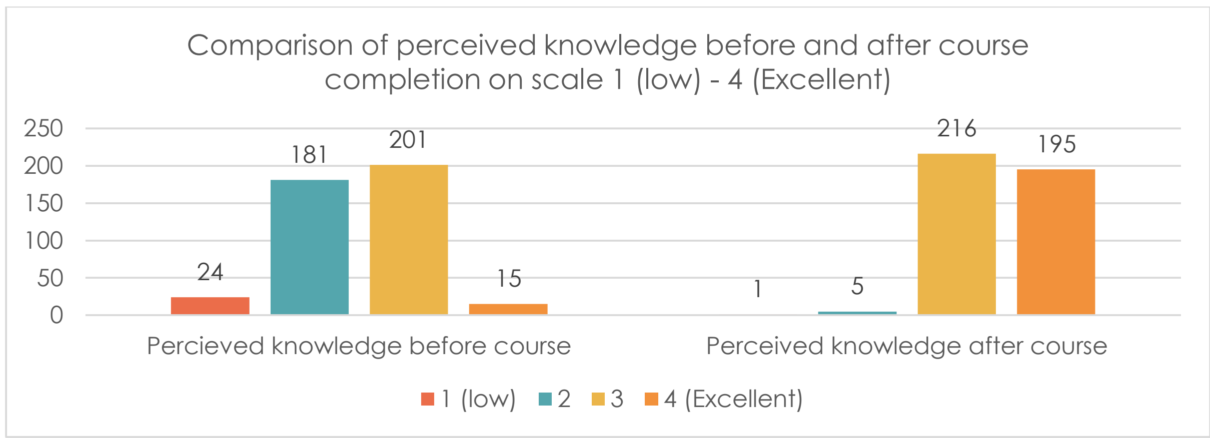
We have maintained our use of Northminster House as our primary training venue, which has in turn retained our increased participant space on courses. Delegates have commented that this training venue is easily accessible and is suitable for delegates who may have disabilities.

We have seen a good representation of agencies across the partnership, with health colleagues attending the most events with 30% of places, social care 16%, and the voluntary sector at 7%. Peterborough Safeguarding Children Board worked in partnership with Cambridgeshire Local Safeguarding Children Board and the Designated Doctor for Safeguarding Children and delivered 2 safeguarding sessions specifically aimed at General Practitioners. 25 general practitioners from Peterborough attended the sessions, there are a further two sessions scheduled for June 15 and September 15. In relation to the Faith Communities, in January 2015 the PSCB Business Manager and Education Safeguarding Lead from Peterborough City Council delivered specific safeguarding training to representatives from all of the Mosques in Peterborough and several Madrasah's. In excess of 20 people attended the two sessions and this will now form part of a rolling programme with a further session on Early Help planned for the summer 2015.

Impact of PSCB multi agency training September 2014- March 2015

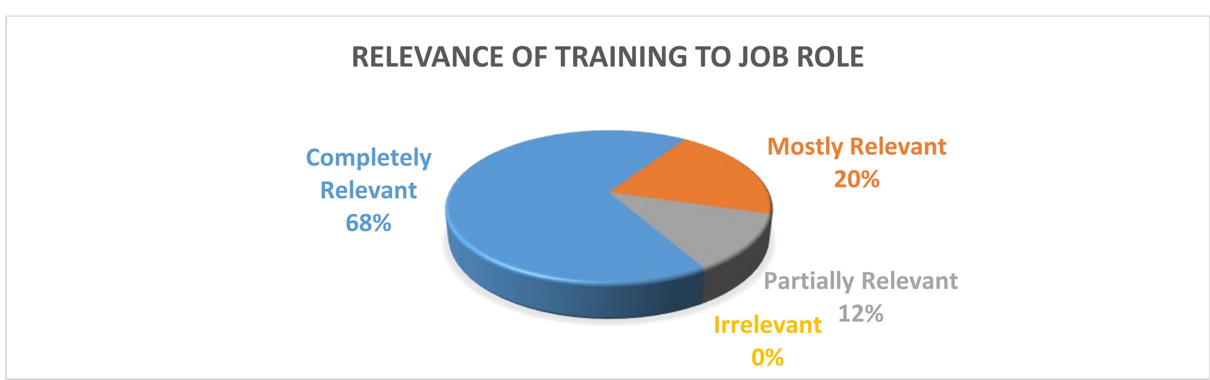
Perceived knowledge

The table below evidences that delegates considered that their knowledge had increased as a result of attending the training course. The graph clearly evidences that the training had a positive impact on the delegates who attended.



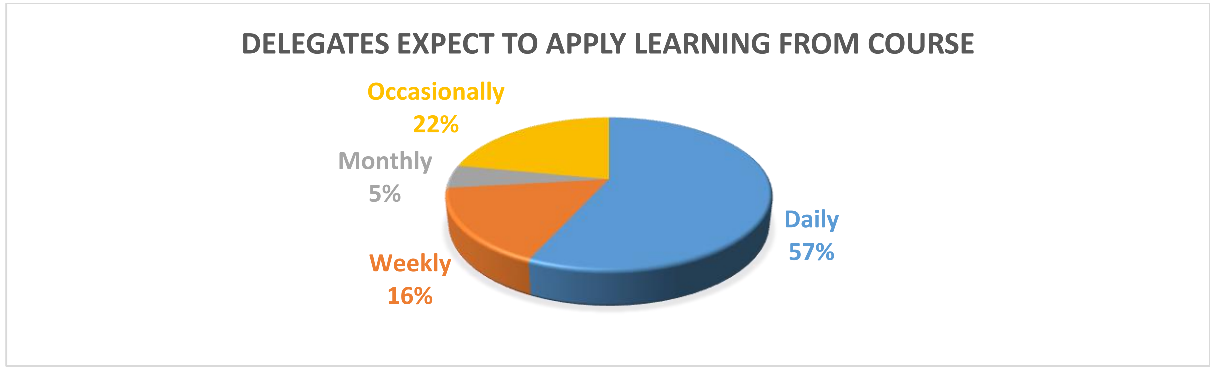
Relevance of training to job role

The graph below demonstrates that the vast majority of practitioners considered that the training was completely relevant to their job role. No delegates felt that the training was not relevant. Where delegates said the training was only partially relevant delegates said that this was because children were not their main client groups and so the information was only partially relevant.



Application of knowledge on practice

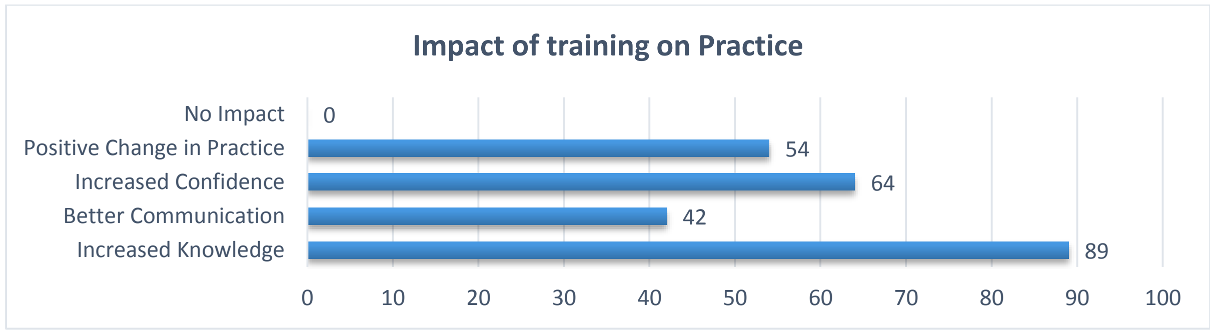
The graph below demonstrates how regularly delegates considered that they would use the information that they had learnt as a result of attending the training.



As can be seen above the vast majority of delegates (73%) considered that the information that they had learnt was important enough to use on a daily or weekly basis. We asked delegates to provide examples of how they would use the training.

Impact of training on practice

The graph below clearly demonstrates that all of the delegates who responded considered that the training had impacted on their practice. The most common impact was that delegates knowledge had increased – 89 delegates out of the 93 who responded (96%) considered that their knowledge had increased as a result of attending the training session.



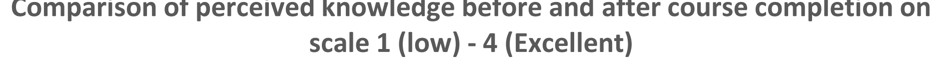
PSCB Conference

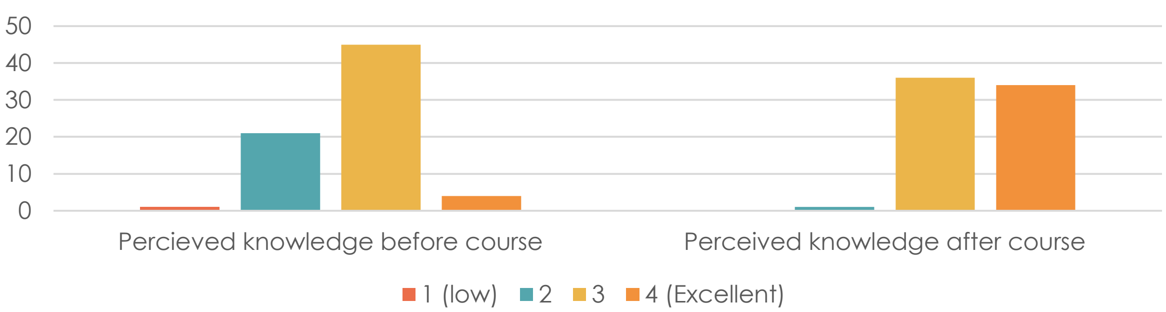
Peterborough Safeguarding Children Board (PSCB) held a half day conference on “Child sexual exploitation – continuing to learn” on the 21st January 2015 at the Fleet, Peterborough. Speakers represented services local to Peterborough and there were also two national speakers – Bina Parma from the National Working Group and Anna Banbury – CSE lead at the NSPCC.

The conference was also used as an opportunity to launch the CSE resource pack. This is a free pack that is available to all agencies across the City. The pack includes leaflets, posters, information on signs and symptoms and a 2 hour CSE briefing (including case studies) which can be used by agencies to deliver CSE awareness training. Following the conference 11 agencies (to date) have requested a copy of the CSE resource pack for use within their own agency

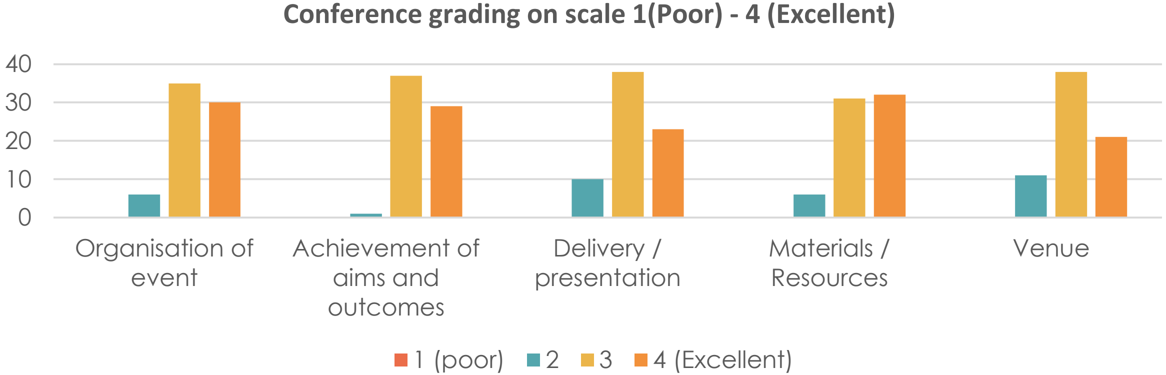
The conference was attended by 121 delegates, and 71 completed evaluation forms were returned at the end of the day. Feedback on the conference was generally very positive and delegates considered that they had learnt something from the session. A number of delegates felt that the half-day session was too short and that it would have been better to have had a full day conference which would have provided more time for discussion and networking.

Analysis of the evaluation





This graph demonstrates that the vast majority of delegates perceived knowledge of child sexual exploitation increased as a result of attending the training, with the most significant increase being in level 4 “excellent increase”. It is encouraging that no delegates felt that their knowledge had decreased as a result of attending the session.



The graph above demonstrates how delegates rated the organisation of the event, achievement of aims and outcomes, the delivery and presentation, CSE resource pack and the venue. It was unfortunate that the first speaker exceeded the time that she was allocated to deliver her presentation by approximately 30 minutes. This in turn had an impact on the remaining time that subsequent speakers had to deliver their presentations. This resulted in some of the presentations feeling rushed and only a limited amount of time available for questions. This is reflected in the delegates grading and comments about the organisation of the event and the delivery/ presentation.

When asked how the conference could be improved nearly half (48%) of the respondents felt that the conference should have been a full day session. This would have allowed for more time for each speaker to deliver their presentation and also time for workshops. There was also concern that the venue did not have enough car parking spaces for the number of people who attended.

The conference was a success, and had good attendance from a range of agencies across the City. The evaluation of the conference evidences that it had a positive impact on the delegate’s knowledge and understanding of CSE.

The PSCB should consider whether in future it holds conferences over a full day rather than a half day. This will need to be balanced against resource and financial implications.

Future Plans:

Activity in 2015/16 will include expanding the offer of training on safeguarding children to the adult’s workforce, as well as organising a multi-agency conference on the subject of Neglect. There will also be a focus on methods for monitoring single agency training.

"Understand the needs of all sectors of our community"

Peterborough is a multi-cultural City with lots of different communities. It is very important that the PSCB understands the cultural and religious beliefs of all sectors of its communities and how they may impact on safeguarding issues.

2014-15 has seen a new Lay member join the Board from the local Muslim community. Regular meetings and ongoing communication continues between the Business Manager and the Communities and Cohesion Manager to increase awareness of safeguarding within community groups and keep the board informed of local needs and issues.

A community work stream has been established through the new Learning and Engagement Structure which was implemented Mach 2015. The work stream will be led by the Community Cohesion Manager and will include focussed engagement from Eastern European communities.

The PSCB Business Manager and the Education Safeguarding Lead have worked with the Muslim council of Peterborough to produce a Booklet on "Safeguarding children and young people in mosques and Madrasah's in Peterborough". This was supported by the PSCB delivery of a train the trainer safeguarding course to representatives from all mosques in Peterborough and some Madrasah's in Peterborough. The PSCB will continue to work with the Muslim community and hold further development evenings.

There has also been work to develop a structure to capture the voice of children and young people on safeguarding issues in the city. This has included the formation of a youth ambassador's network in conjunction with Children's Social Care and Peterborough's Youth MP being appointed to the Board as a corresponding member.

Links have been developed with HMP Peterborough to ensure that safeguarding is integrated into the appropriate areas of work within the establishment. The Mother and Baby Unit completed the s11 audit for the first time last year so they have again been requested to complete this. There has been communication between the prison and the Board in support of this. The prison have expressed an interest to receive some training on child sexual exploitation so the CSE Co-ordinator has been in touch to arrange this. Staff from the prison have also attended multi-agency training delivered by the PSCB, allowing them to make links with community agencies.

One of the serious case reviews undertaken by the Board has highlighted the need to have important guidance for parents available in languages which reflect the diversity of Peterborough. In response to this the leaflets for parents and children and young people on child sexual exploitation were made available in 7 different languages: Latvian, Lithuanian, Polish, Russian, Portuguese, Slovak and Urdu. There are also plans to translate the leaflets on female genital mutilation into relevant languages. All of this work has been undertaken in partnership with Cambridgeshire LSCB to ensure a consistent message is delivered across the county. In addition, this particular SCR highlighted a need for communication between countries regarding previous criminal convictions to ensure risk assessments are completed with as much relevant information as possible. This matter is being explored and further information will be available in the 2015/16 Annual Report.

There has also been significant work this year to engage children and young people in the city, to ensure their voice is heard. This work is detailed in a later section of this report.

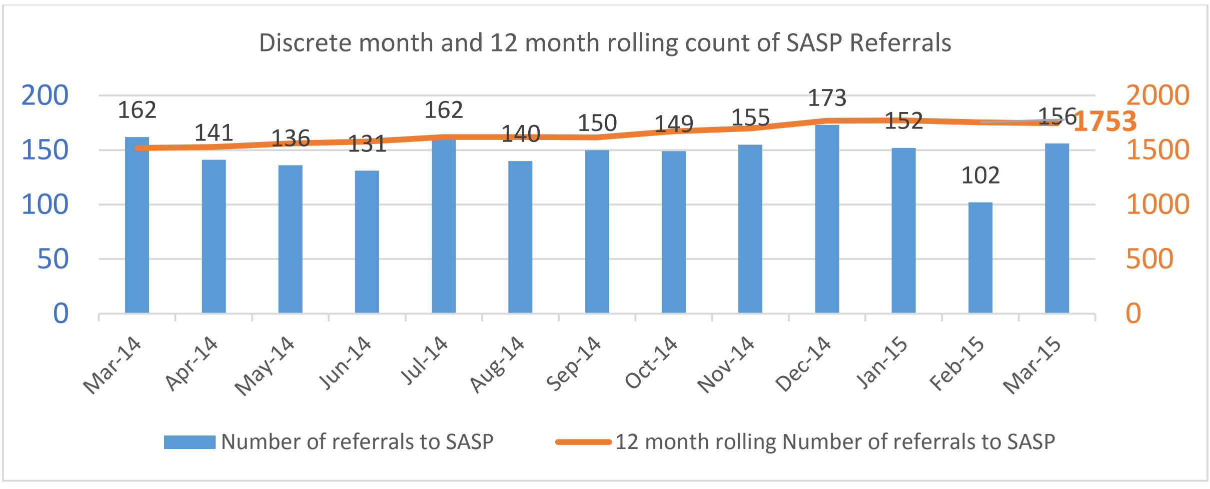
"Children are fully protected from the effects of domestic abuse (domestic violence) and neglect"

Peterborough has a high number of cases that involve domestic abuse and neglect. It is vital that professionals work together to ensure that children are fully protected from the effects. For this reason ensuring children are fully protected from the effects of Domestic Abuse is a business priority for the board. Peterborough agencies are engaged with working in a multi-agency capacity to offer services to those families effected by Domestic Abuse.

Domestic Abuse

Partial monthly data is now available from Specialist Abuse Services Peterborough (SASP) relevant to this section. The chart below shows both discrete month and 12 month rolling rates of all Peterborough Womans Aid (PWA) and Independent Domestic Violence Advisor (IDVA) referrals – March data showed a total of 156 referrals which is in line with the previous 12 month average (146). **The 12 month rolling rate is at 1747, which shows an effective increase from the baseline period (12 months up to the end of March 2014) of 15%.**

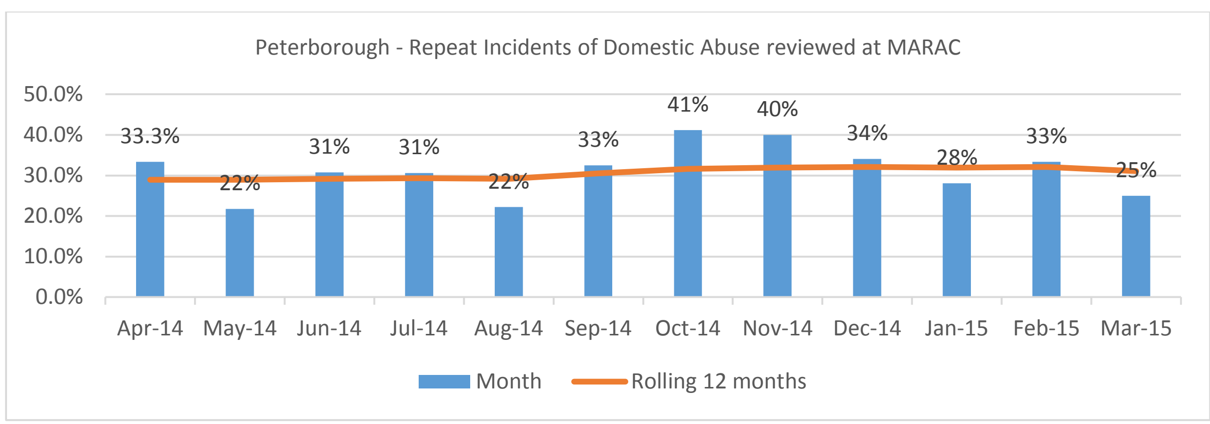
The following performance data must be considered in context of the significant changes made to the service following a retender exercise. In April 2014, traditional domestic abuse services for victims were integrated with sexual violence advocacy services to create SASP, an integrated service for adult victims of domestic abuse and sexual violence. In July 2014, SASP began its service for children and young people affected by domestic abuse or sexual violence. It is common for service activity to be affected during the initial period of transition into a new service.



There is currently no data provided with regards the number of re-referrals to SASP, however, this has been requested and a process is being implemented. This information is expected to be available in future reports.

MARAC data can however be used as a proxy, the most recent data available over the last 12 months is shown in the chart below where approximately one in three MARAC cases are repeats.

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Cases Reviewed	12	23	26	49	36	40	34	30	41	57	30	24
Repeat cases	4	5	8	15	8	13	14	12	14	16	10	6
Repeat rate												
Month	33.3%	22%	31%	31%	22%	33%	41%	40%	34%	28%	33%	25%
Rolling 12 months	28.9%	28.9%	29.2%	29.3%	29.2%	30.5%	31.6%	31.9%	32.1%	31.9%	32.1%	31.1%



A process has been put in place via SASP regarding the number of offenders brought to justice: this involves paper notes being made when a SASP worker is at the court. It is accepted that this is not a desirable way to collate this data and so a number of other avenues are being explored, namely whether the data can be received directly from the Specialist Domestic Violence Court, assuming Peterborough data can be disaggregated from the rest of the Cambridgeshire.

Rates of police recorded domestic incidents and crimes are not a measure in this report, however, do provide some useful context. **There were a total of 408 domestic incidents reported to the Police in June; the previous 12 month average was 392. The percentage of domestic Incidents raised that were classed as domestic crimes was 31% (n=128).**

Since the Victims Hubs began taking low and medium referrals, PWA have seen a decrease in the number of referrals from the Police, which has helped in reducing staff caseloads. The SASP still receive all medium and high referrals from the MASH.

PWA recruited two domestic abuse/sexual violence advocates in April and have been contracted to provide a full time advocate to sit within Peterborough's MASH to further enhance Peterborough's specialist multi-agency support offer.

SASP are now members of the Sex Workers Case management group, to ensure appropriate information sharing is in place for safety planning with high risk victims.

PWA continue to work with the Cambridgeshire Deaf Association, following a successful partnership project with DIAL Peterborough. This coming year PWA shall be piloting a Freedom programme for female victims who are deaf or have hearing difficulties.

The Children and Young People's Sexual Violence worker, funded by the Police and Crime Commissioner, is now fully embedded within the service and has supported 32 children and young people since December 2014. The worker is covering Fenland and Peterborough.

Since July 2014, SASP's specialist service for children and young people has received 152 referrals and has offered a service to all of these children and young people. Promotion of this service has increased awareness within schools across the city and many referrals have been received directly from them.

Neglect

Whilst neglect was identified as a priority 2014/15, the activity concerning child sexual exploitation which was already underway, increased significantly and the Board and its partner agencies responded proactively. This meant however that the focus on neglect was somewhat overshadowed. There were a suite of training sessions delivered on the subject to upskill staff in 2014/15 but it is recognised that the subject of neglect must take the forefront of activity in 2015/16 and there is already work underway to ensure this is the case, including the organisation of a multi-agency conference for November 2015.

"Children are fully protected from Child Sexual Exploitation"

The Board has continued with a proactive response to CSE throughout 2014-15 with the appointment of a part-time CSE, Trafficking and Missing Co-ordinator. This post commenced on 1st October 2014. One of the first tasks undertaken was a refresh of the CSE Action Plan. The new version includes recommendations from local and national reports on the subject of CSE.

This Action Plan is overseen by the CSE Implementation group and recommendations are considered in detail by the group. All agencies are expected to contribute updates towards the plan and are held to account for inaction where necessary. The CSE Strategy is under review and will be updated, with input from all members, following the successful conclusion of Operation Erle.

The work of the CSE Co-ordinator will continue with a focus on gathering and analysing data and reviewing the work completed by other agencies regarding CSE.

Raising Awareness of CSE:

Peterborough Safer Schools Officers have continued to support the delivery of the CEOP 'Exploited' programme within the secondary schools: it is the aim that teachers and staff within the schools will continue the delivery of this programme in the next academic year.

Alongside this, the Board has purchased the Barnardo's primary and secondary resources 'Real Love Rocks' which are designed to increase children and young people's awareness of healthy relationships, grooming and internet safety. The secondary resource has been introduced to the CSE Schools Forum with a view to increasing the amount and range of resources available to the schools to deliver work on sex and relationships. The CSE Co-ordinator will work alongside schools to monitor what is delivered and the impact of this on young people in the academic year 2015/16.

Leaflets and posters have been produced for young people to increase their awareness. Smart codes have been added to the leaflet and poster which is linked directly to the Peterborough Safeguarding Children Board website where there are videos, links and further information for young people to access, including where they can go to for support. Feedback from professionals has prompted consultation with young people to design material aimed at a slightly younger age group to ensure appropriate material is available to all young people.

A mini conference was delivered to a whole year group at one of the secondary schools in the city to inform students about what work has taken place to address CSE, following sessions delivered by Rape Crisis within their PHSE lessons focused on sexual exploitation and consent.

Consultation with young people is ongoing to determine their understanding of CSE and where they would go to gain information on the subject, this has included the 16-18 age group, who stated that they felt they were often 'missed out' by awareness raising campaigns.

Leaflets have also been designed for professionals and parents and carers. All are available on the PSCB website in 8 languages. A leaflet for businesses has also been designed ready for translation into appropriate languages and follows a week of action by Cambridgeshire Constabulary where local, targeted businesses were contacted to raise awareness of CSE and give them an appropriate avenue to report any concerns.

It is intended that further awareness raising activity will be targeted at appropriate local businesses, continuing the 'Say Something If You See Something' campaign locally by focusing on further groups of taxi drivers, hotels and fast food outlets.

Another important focus will be raising awareness with parents and carers and the CSE Co-ordinator is currently exploring with partners the best way or the variety of ways that this could be achieved.

Level 1 Awareness training continues to be delivered to multi-agency groups: 19 professionals attended the course in January 2014, gave good feedback and said they were interested in learning more about the subject and how to work with young people where CSE has been identified as a concern. In

response to this, Level 2 training will be designed to be part of the training brochure for 2015-2016, as well as workshops with a specific focus on CSE and boys and young men and CSE and disabilities.

To ensure that as wide an audience as possible is reached to increase the city's awareness of the issue of CSE, a Resource Pack was launched in January which contains all of the leaflets, a short presentation and information from guidance and reports on CSE. The pack has been designed to facilitate single agency briefings and discussions to enable those who cannot access multi-agency training to have an awareness and to ensure that consistent messages are delivered to all professionals. A similar pack has also been designed for female genital mutilation. Both packs have been well received by professionals locally and those outside of the local authority area.

A conference was held in January 2015 on Child sexual Exploitation to engage practitioners in an update on the subject and keep them informed about national research and findings.

Finally, a CSE forum has been established for secondary schools across the city with a view to ensuring the schools are aware of available resources and avenues of support for young people who are at risk or victims of CSE. The forum has been well received and this will continue on a termly basis into the new academic year.

Additional Groups of Children

Children Missing from Home and Care

Around 140,000 children go missing each year[6]. When a child goes missing, it is a clear sign of problems in their life. The reasons children go missing include domestic abuse, neglect, exploitation, mental health issues and substance misuse. Once away from home they are vulnerable to many risks including child sexual exploitation, gang exploitation, becoming involved in crime or becoming a victim of crime.[7] Failing to recognise missing as a serious safeguarding issue can lead to significant gaps in agencies' awareness and the effectiveness of their responses. In contrast, early intervention with a missing child can reduce the harm they experience, and help them change behaviour before it gets embedded: a sexually exploited 15 year old who frequently goes missing is likely to need significantly more safeguarding interventions and support than a child who goes missing once. The PSCB needs to assure itself that agencies are working together to identify and help those children and young people who go missing.

Children's services are alerted to missing incidents in the following ways:

- for children living in Peterborough who go missing (either from home or from a care placement), the contact centre receive a missing alert from the police
- for Peterborough children in care who are placed outside of the LA boundary, the social worker and contact centre are alerted by the care provider.

This has been in operation since November 2014 but has been made more robust following the appointment of a missing case worker located in MASH Hub since March 2015. In both of these cases, the incidents are recorded on Liquid Logic, the children's social care case management system.

The police changed their definition of missing in the spring of 2013 where it was split into "missing" and "absent".

The contact service only receive notifications of missing incidents meaning that any now classed as "absent" are no longer included in the data.

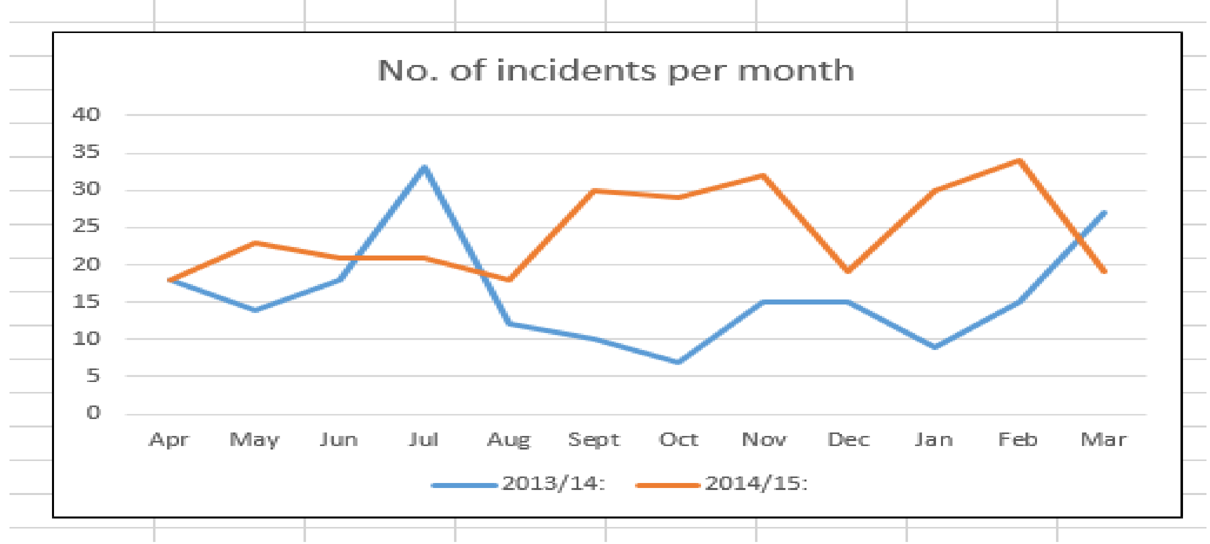
The table below shows the number of incidents each month from April 2014 to March 2015. The number of incidents have increased (294) compared with 2013/14 when 193 incidents were reported, this may in part be due to better reporting of missing and the improvement in recording created by streamlining front door processes and placing responsibility back with Children's Social Care

	Apr -14	May -14	Jun -14	Jul -14	Aug -14	Sep -14	Oct -14	Nov -14	Dec -14	Jan -15	Feb -15	Mar -15	2014 -15 YTD
Missing Incidents	18	23	21	21	18	30	29	32	19	30	34	19	**294**

An individual child or young person can have more than one missing incident over a month, quarter or year. The next table shows the number of individuals in each month with missing incidents. The total box is the number of individuals across the whole year, who may have incidents in more than one month.

[6] Report of the Missing Persons Taskforce, 2010, the Home Office

[7] Missing Children and Adults, A cross government strategy, 2011, the Home Office; Still Running 3, 2011, The Children's Society



During 2014/15 228 children have gone missing on 294 separate occasions. This is a considerable increase from 96 incidents involving 193 children in the previous year

	Apr -14	May -14	Jun -14	Jul -14	Aug -14	Sep -14	Oct -14	Nov -14	Dec -14	Jan -15	Feb -15	Mar -15	2014 -15 YTD
Incidents	16	16	19	16	13	23	23	24	16	21	27	14	**228**

There are some individuals who have had several missing incidents across several months. The next table shows how many incidents the 155 children and young people had during the year.

	1 incident	2 incidents	3 incidents	4+ incidents	Individuals
2014/15:	100	25	13	17	**155**

100 children had 1 incident in the year, 25 young people had 2 incidents in the year, 13 had 3 incidents and 17 young people had more than 4 incidents during the year.

The next set of tables look at the characteristics of the 155 individuals. We can see that 68 of the young people were male (44%) and 87 female (56%). Previous years data suggests that missing incidents are higher amongst females. Data indicates that this has been the trend for several years.

	Male	Female	Individuals
2014/15:	68	87	**155**

The age split of the individuals below shows the majority of incidents occurring among those aged 14 and 17 with the most substantive increase happening in the 15 and 16 year old bracket.

	0-4	5-9	10	11	12	13	14	15	16	17	18
2014-15	2	3	2	1	6	11	19	34	44	23	10

93 of the individuals are white British (60%) and 32 are white European (21%) and 15 are of mixed ethnicity (10%). We have 6 individuals where their ethnicity is either blank, not known or is recorded as other these cases were not known to Childrens Services.

	W Brit	W Euro	Mixed	Asian	Black	Unknown	Individuals
2014/15:	93	32	16	3	5	6	**155**

Involvement with children's social care

Prior analysis has shown that children with missing incidents are likely to have links with children's social care. The following analysis looks at whether the child was known to social care at the time of their missing incident, prior to or subsequent to the incident. Where an individual has more than one missing incident over the year, the most recent one has been used in the analysis.

The first table looks at whether the child or young person had an open referral within social care at the time of the incident. For those that were not open to social care at the time, analysis shows whether they had either a prior or subsequent referral. The data shows that 77 individuals were open cases within social care at the time of the missing incident. 23 young people had a prior referral to the incident which had since been closed and 13 had a referral opened after the incident. 42 children did not have any children's social care involvement at the time of their missing episode.

Open Referral	**2014-15**	**2014-15 %**
CURRENT:	77	50%
PRIOR:	23	15%
SUBSEQUENT:	13	8%
NEVER:	42	27%
TOTAL:	155	100%

The 77 cases that were open to Social Care at the time of the missing episode can be broken down as follows.

Open to CSC	**2014-15**	**2014-15 %**
CURRENT CLA:	26	34%
CURRENT CP:	7	9%
CURRENT CIN:	44	57%
TOTAL:	77	100%

There are clear links between Child Sexual Exploitation and children who go missing. Barnardo's has documented that more than half of the children they worked with in 2010 following sexual exploitation had previously been missing from home or care on a regular basis. More than 100,000 young people under the age of 16 run away from home, their care placement or school each year. Within Peterborough there is a clear system in place that monitors those young people who are at risk of Child Sexual Exploitation and who go missing. There is a clear Hazard system in place that flags up the risk and this is reviewed in light of each missing episode through the normal safeguarding procedure.

How is the PSCB addressing this issue?

A multi-agency Missing Action Plan has been developed and is monitored and scrutinised by the Board via a quarterly update. Narrative information is also presented which covers themes from Return Interviews undertaken.

The Action Plan was created following both multi-agency and single agency audits in 2014 which highlighted areas for improvement and the Board has ensured it is well-informed on the issue and activity to allow for appropriate challenge.

A missing sub-group has been established, led by the Head of Service within Children's Social Care who is the lead for Missing. This group pulls together information from missing from home, care and education. The PSCB CSE Co-ordinator is member of this group and ensures that agencies are held to account around missing children and young people.

Private Fostering

A private fostering arrangement is one that is made privately (without the involvement of a local authority) for the care of a child under the age of 16 years (under 18 if disabled) by someone other than a parent or close relative of the child, in their own home, with the intention that it should last for 28 days or more. It should not be confused with fostering placements provided by Independent Fostering Agencies run by private companies.

A private foster carer may be a friend of the family or the child's friend's parents. However, a private foster carer is sometimes someone who is not previously known to the family, but who is willing to foster the child privately.

Examples of private fostering arrangements are:

- Children sent from abroad to stay with another family, usually to improve their English or for educational opportunities.
- Asylum seeking and refugee children.
- Teenagers who, having broken ties with their parents, are staying in short term arrangements with friends or other non-relatives.
- Children living with host families, arranged by language schools or other organisations.
- Children living with members of the extended family, e.g. Great aunt.

The Children Act 1989 requires parents and private foster carers to give the Local Authority advance notice of a private fostering arrangement. It also places specific duties on local authorities with responsibilities for children's services. The legislation made what was considered a private arrangement into a public matter by giving Local Authorities a role in ensuring that children are safeguarded.

The Board's role in Private Fostering is to have an overview of the numbers of cases being notified and that those cases are being dealt with within the guidance.

To ensure that the Board is fully aware of Private Fostering arrangements within the city, the Board receives regular updates reports from Children's Social Care as to numbers etc. In addition, the Board has played a role in ensuring that agencies are aware of Private Fostering and the implications for practice.

The low numbers of notified cases could be a concern and therefore the PSCB takes the role of ensuring that all partners are aware of what Private Fostering is and their responsibility to notify the Local Authority when they become aware of this sort of arrangement.

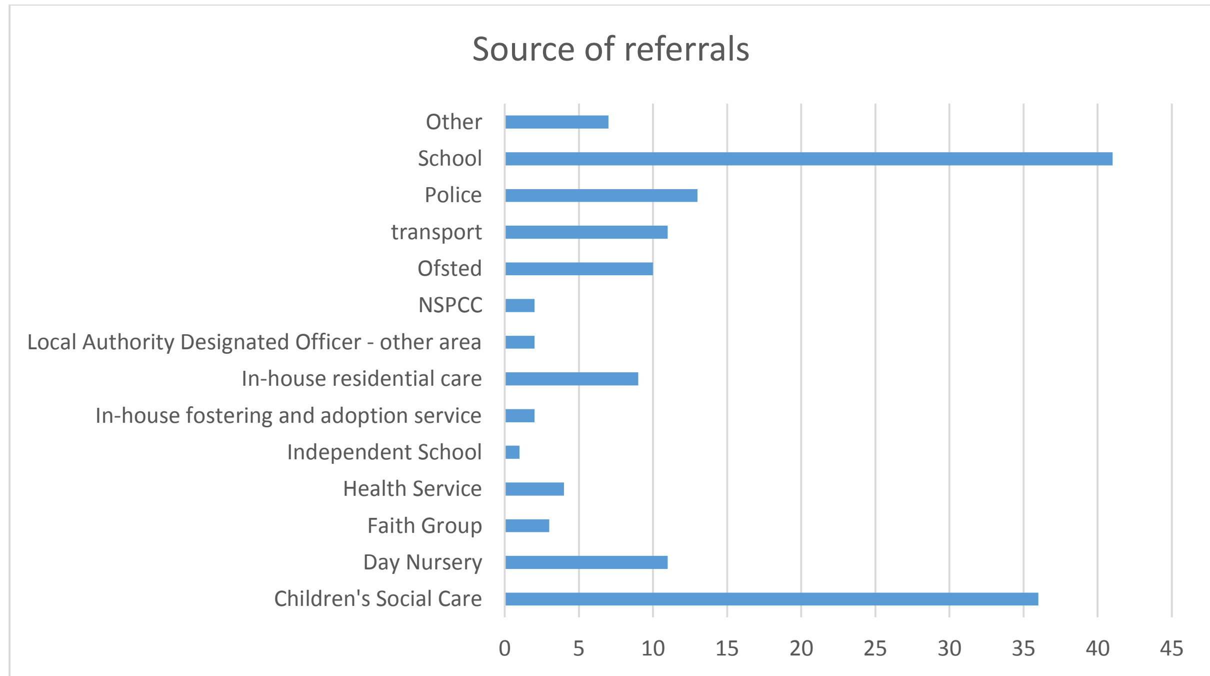
Allegations Management

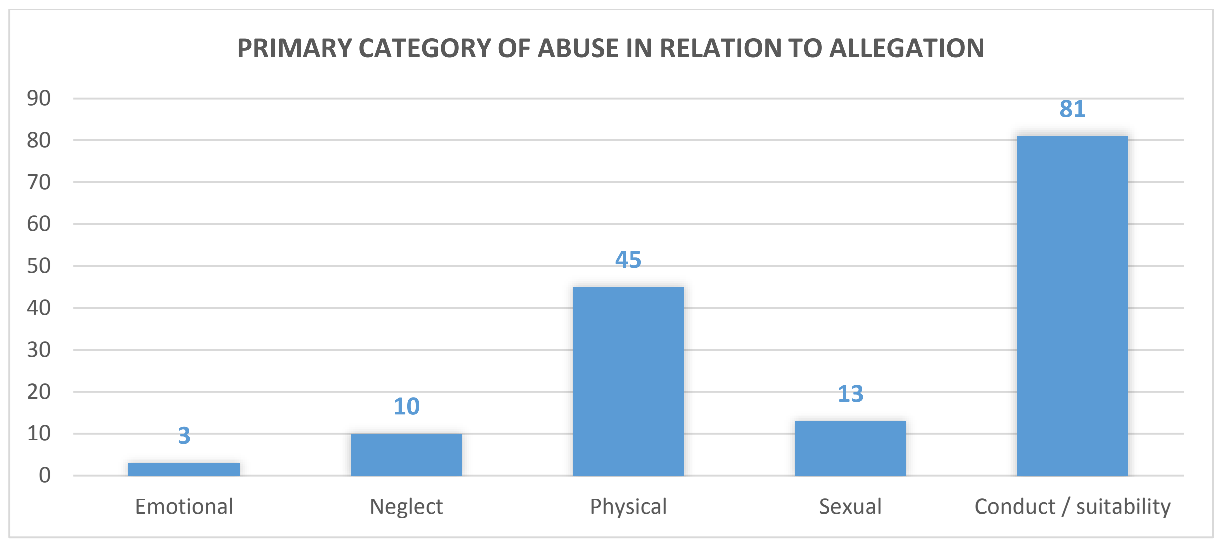
Working Together 2015 stipulates that local authorities must now have in place a 'Local Authority Designated Officer' (LADO) to handle all allegations against adults who work with children and young people. Although this practice must continue, the guidance no longer refers to them as LADOs only 'Designated Officers' or teams. People undertaking this role must now be qualified social workers (apart from people currently in post or moving between authorities).

The Designated Officer must also provide advice to employers, liaise with the police and other agencies, monitor the progress of cases, collect and report on relevant data. The PSCB has a responsibility within this guidance to ensure that there is effective inter-agency procedures in place for dealing with allegations against people who work with children, and for monitoring and evaluating the effectiveness of these procedures.

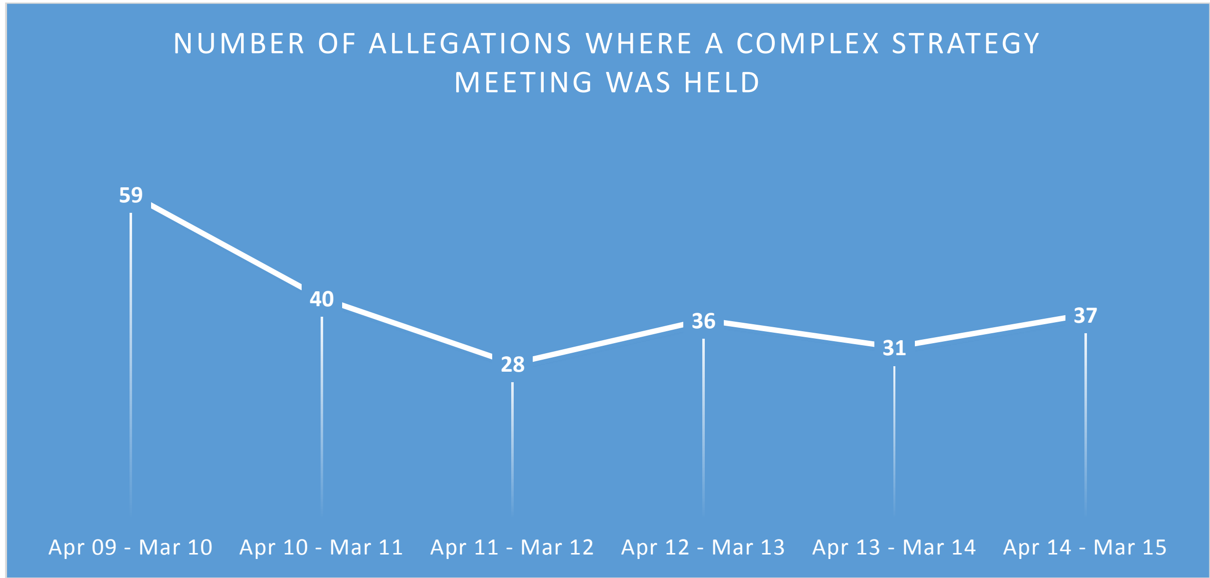
Once an allegation is received it will be assessed to see what action is required and if warranted it will progress to a Complex Strategy Meeting (CSM).

During the period of this report **152** concerns were discussed with the LADO where 115 did not meet the threshold for a CSM: these concerns have been raised by a range of organisations including social care, early years settings, education settings, secure accommodation, foster carers, youth work settings and the police which suggests that there is an increasing awareness of the process and the role of the LADO.

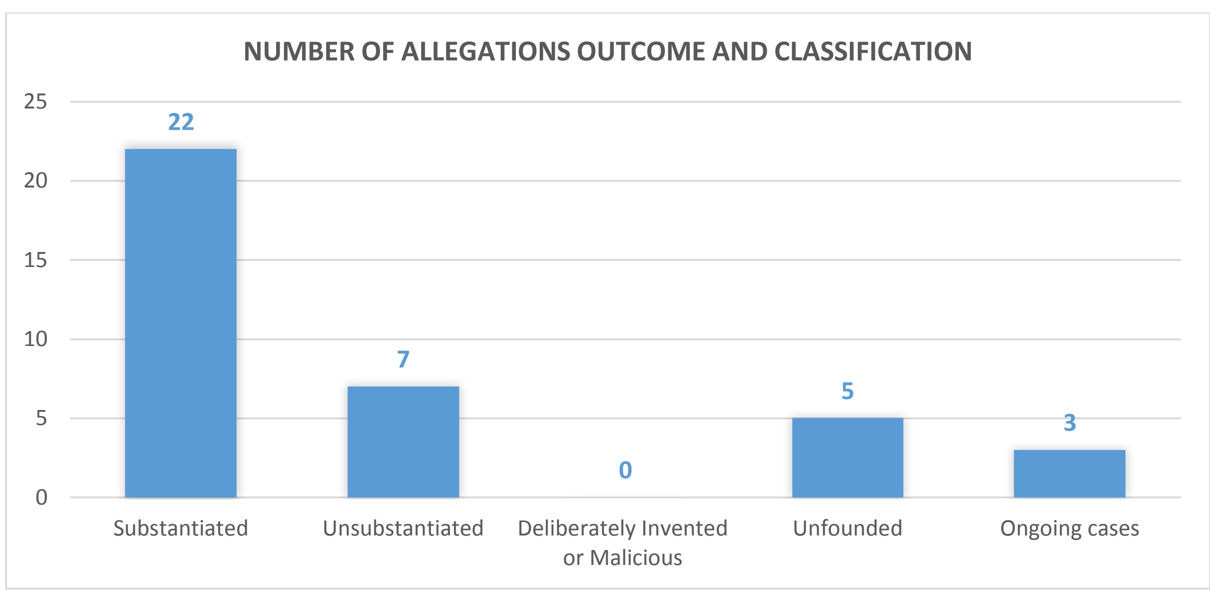




Out of the 152 referrals to the LADO, **37** referrals have resulted in CSMs being held, as compared to **31** referrals in the preceding 12 months.



The number of referrals that required a Complex Strategy Meeting (CSM) has remained reasonably consistent. The number of consultations that have not led to a CSM has increased significantly between April 2014 to March 2015 and have remained high within this reporting period.



Timeliness of referrals managed by LADO is generally consistent with previous years. LADO timescales continue to be affected by Criminal Investigations which can take up to and beyond 12 months if the case is subsequently prosecuted by the Crown Prosecution Service.

Engagement with the faith community has remained problematic during this year. The LADO devised and presented joint training with the Police and Passenger Transport for all staff employed by Children's Transport during 2013/14 and this will be rolled out again during 2015/16.

The increase in concerns being raised with the LADO that did not lead to a Complex Strategy Meeting has continued throughout 2014/15. This appears in part to be due to a lack of understanding of thresholds. Although training has been available to agencies in this area there is a clear need to continue with awareness raising.

As evidenced by the low number of referrals there is a significant need to engage all faith settings with safeguarding procedures and to raise awareness of safeguarding accordingly. The PSCB has worked closely with the Muslim Council of Peterborough in 2014/15 and established a safeguarding training and engagement network. The work of the LADO will be included in this programme of work in 2015/16.

The LADO will carry out an in depth analysis of referrals from schools, this will provide information about which schools refer, which schools do not refer. This work will inform whether there is any pattern and whether there is any work needed in order to be able to reassure the Board that all schools in the Peterborough area are fully aware of the Allegations Management procedure and when and how to use it.

The Voice Of Children, Young People and Families

The Board and their partners are very aware of the need to engage with families, children and young people in a meaningful way to understand and act on their views and concerns.

A questionnaire about child sexual exploitation (CSE) was sent to all secondary schools as a follow up to the delivery of Chelsea's Choice performances last year across the city. In excess of 515 responses were received. The majority of young people (72%) indicated that if they had a CSE concern they would speak to a teacher. As a result of this piece of work the PSCB requested that each secondary school in Peterborough had a designated CSE lead. Since January 2015 all Secondary Schools in Peterborough have appointed a CSE Lead.

To ensure that the PSCB fully understands the views and needs of young people in Peterborough about CSE, the PSCB have recently extended the CSE consultation to all further education and special schools. This has also been strengthened by the CSE Co-ordinator undertaking CSE focus groups with young people in secondary schools and further education colleges.

During the focus groups young people stated that on posters/ leaflets they wanted QR codes so that they can be scanned and then the young person can read the information at their leisure. As a result of this, CSE posters and leaflets have been revised to include QR codes which take people directly to the young people's CSE pages on the PSCB website. We are currently in the process of setting up the same process for female genital mutilation (FGM).

The PSCB CSE conference included videos of local young people who had been the victims of CSE commenting on CSE and their experience, including the service they had received.

Local young people have been involved in designing leaflets on CSE and FGM. The young people identified the information that they wanted to include on the leaflets including how they wanted them to appear.

In addition to the CSE work the PSCB is currently running a pilot with a local primary school to train a group of pupils as "Safeguarding Internet safety ambassadors". The pupils will be trained on internet safety and then be champions within the school setting by assisting and skilling other pupils on how to stay safe on line, including running assemblies and contributing to lessons on internet safety. The PSCB Business Manager has had initial meetings with the school and they have identified a group of "potential champions" that they would like to use. The training sessions with these children will commence in April 2015. It is anticipated that if the scheme is successful it will be rolled out across all primary schools in the City.

As well as this, other areas which the board has consulted with young on are, the Business Priorities and the Professional Development Programme. It was felt to be important that the Board ensured the work it aimed to focus on in the next year, detailed within the Board priorities, was considered to be relevant by the young people who may be affected by it. Schools across the city and the Children in Care Council were approached to gain feedback from young people about their opinions on each priority and the content of the training programmes run by the Board. This work allowed for not only the voice of those young people to be heard, but also to inform them about the work of the Board and partner agencies.

In July 2014 the PSCB ran a competition across all primary and secondary schools in Peterborough for a young person to design a new PSCB slogan. This work also promoted the PSCB to different young people.

Lastly, the quality assurance work of the Board is informed by the voice of local children and young people. It is always the aim for the Board that groups are consulted with following audit work to determine how pertinent the findings and results are.

Business Priorities and Board Development 2015-16

A Development Day held during a meeting of the PSCB in January 2015, gave board members and additional agencies representatives the opportunity to discuss the priorities for 2015/16. It was agreed by the group to retain the priorities in place in 2014/15 for an additional year. Those are:

- "Early help and preventative measures are effective"
- "Children at risk of significant harm are effectively identified and protected"
- "Everyone makes a significant and meaningful contribution to safeguarding children"
- "Workforce has the right skills/knowledge and capacity to safeguard children"
- "Understand the needs of all sectors of our community"
- "Children are fully protected from the effects of domestic abuse (domestic violence) and neglect"
- "Children are fully protected from Child Sexual Exploitation"

Scrutiny and Challenge

Section 14 of the Children Act 2004 *sets out the objectives of LSCBs, which are:*
(a) to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and

(b) to ensure the effectiveness of what is done by each such person or body for those purposes.

Scrutiny

In the last year the Board has provided scrutiny to agencies, through reports and discussion at, the bi-monthly Board meeting on the following issues:

Children's Social Care:

- Parental feedback on Child Protection Conferences
- Multi-agency attendance at Child Protection Conferences
- Update regarding the work of the Local Authority Designated Officer
- Private fostering
- Children and Families Single Assessments
- Child in need Cases: as detailed earlier in this report, the PSCB Board Manager set up and chaired a multi-agency task and finish group to look at how the child in need process could be made more robust.
- Missing from home and care: progress reports were required in November 2014 and March 2015. On both occasions the Board offered significant challenge and support on the issue.
- Looked After Children placement locations – including children and young people placed out of the city
- In addition frontline recruitment and practice is under continuing scrutiny from the Board.

Early Help

- Early Help and Prevention Strategy
- CAF assessments and Multi-Agency Support Groups
- Early Help and demand management
- Review of Early Help Audit and Action Plan

Health

- Review and sign off of the Bruising in Pre-Mobile Babies Protocol

- NHSE Primary Care Options
- Report on the Sexual Assault Referral Centre (SARC)
- Completion of LAC initial health assessments
- Waiting times following referrals to CAMHS

Police

- Domestic Abuse and Child Abuse Investigation Unit update
- Cambridgeshire Constabulary Management Information
- Review HMIC Inspection and the resulting Action Plan

Education

- Results of the CSE Consultation
- Safeguarding in Schools Annual Report
- Children Missing Education Audit

Multi-agency

- Update on development of the Multi-Agency Referral Unit (MARU)
- Update on Poverty in the Peterborough area
- Serious Case Review Action Plan
- Thresholds

In addition to the above, the PSCB Independent Chair and PSCB Board Manager offer scrutiny of policies and practice via the Boards linked to the PSCB, for example the Safer Peterborough Partnership, as detailed in Chapter 5 of this report.

Challenge

As well as evaluating and analysing operational issue within Board meetings, the PSCB has also been active in the last year, in challenging practice through individual case escalation. This can result in the PSCB facilitating meetings around practice or speaking directly to senior managers about the issue. The PSCB does not keep a record of every concern or challenge that it has participated in but it does keep a 'Challenge Log' of examples of concerns or challenges it has been involved in.

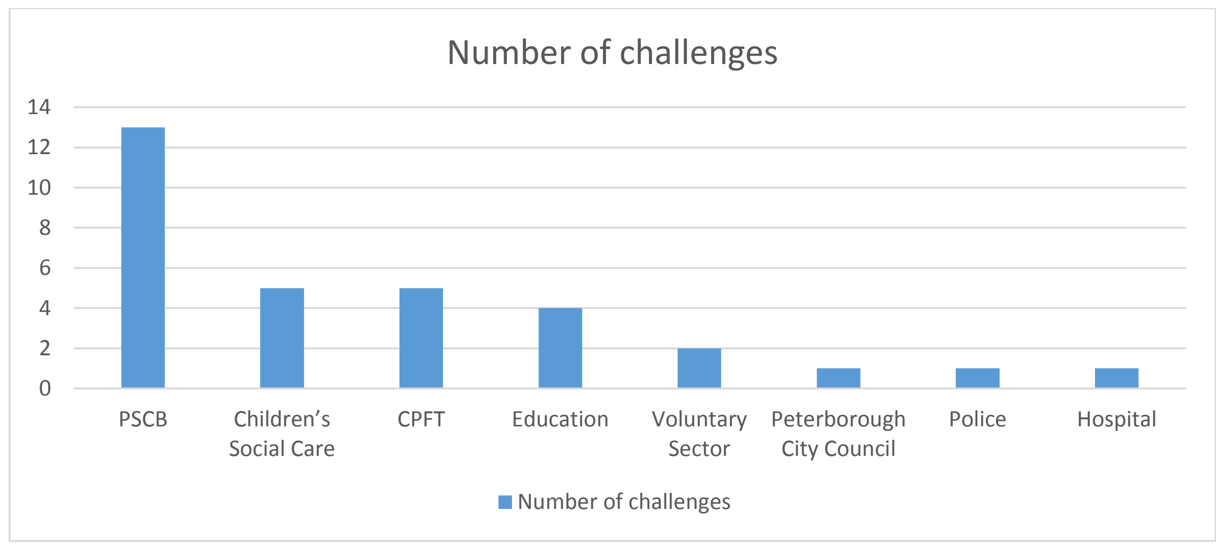
The log evidences that within the last 16 months the PSCB (through either the Chair or Board Manager) have facilitated 10 different inter agency meetings involving challenges to practice. In addition there have also been at least 7 cases where the PSCB Board Manager has raised escalation concerns directly with the appropriate Board Member regarding frontline practice.

Below is an extract from the log for illustration purposes:

Date	Source	Challenge	Outcome and Impact
Priority 1 - Ensure that that early help and preventative measures are effective			
July 2014	PSCB	PSCB requested an update to the Board on the effectiveness of CAF and the launch of the ECAF	Paper presented to the Board at the July meeting. Partners assured that Early help is embedded and effective.

Priority 2 - Ensure that children at risk of significant harm are being effectively identified and protected			
February 2015	Education	School raised concerns about a case. PSCB Business Manager raised concerns with Assistant Director of CSC.	Case resolved and Education satisfied with response.

The challenge log demonstrates that, since December 2013, 32 challenges have been recorded. Agency breakdown is as follows:



The response to each challenge is detailed as follows:

PSCB facilitated discussion on issue	12 occasions
A Report on the issue was presented to the Board	8
Further discussion has been necessary/the issue is ongoing	5
PSCB Raised concerns directly with the Director of Children's Services	4
A report was presented to a PSCB sub-group	1
PSCB developed a protocol/procedure to clarify the issue	1
Training was delivered by PSCB covering the issue	1

As can be seen from this table, in the majority of cases, the PSCB was able to make improvements to multi-agency working by facilitating discussion between agencies: reflective of the co-ordination function of the role of an LSCB. It if felt that this indicates the effectiveness of the Peterborough Safeguarding Children Board, in that agencies feel able to approach the Board with their concerns, and in that, as shown above in Table 1, over a third of the challenges logged were initially raised by the board itself. This demonstrates that the board has a good oversight of practice across agencies.

Conclusions and Future Developments

Conclusion

The Peterborough Safeguarding Children Board continues to be a strong partnership which has worked well together to coordinate activity and hold partner agencies to account for their activity to provide the best outcomes for children and young people in the city. The good work the Board has completed in the last year can be seen in the strengthening of its engagement with young people. The aim has been to gain their wishes, feelings and opinions, ensuring that the work of the Board is relevant and informed by the voices of local children. This work has been greatly supported by better relationships with the schools, secondary and primary, via the Education Safeguarding Lead who has contributed directly to ensuring the profile of the Board has been raised amongst children and young people in the city.

The Board offered a very good, proactive response to child sexual exploitation, including some excellent community engagement work. This work is ongoing and it is the aim that community engagement work with a range of safeguarding activities and awareness raising more generally, will benefit from the lessons learnt and good practice demonstrated in the Board's response to CSE.

Work with the faith communities in Peterborough has been a particular area of good practice in the last year. The Muslim Council of Peterborough, via the Communities and Cohesion Manager for Peterborough City Council and again the Education Safeguarding Lead have supported some excellent awareness raising and engagement work.

Lastly, there has been some excellent partnership work across the county of Cambridgeshire this year through joint work with Cambridgeshire Local Safeguarding Board and it is the aim that this work will not only continue but develop further to strengthen this partnership through 2015/16.

Future developments for Peterborough Safeguarding Children Board

As has been mentioned throughout this report, the future work for PSCB can be summarised as follows:

- Encouraging increased transparency by agencies through single agency audits
- Strengthening the multi-agency dataset to reflect safeguarding activity across the city and to provide the PSCB with a clear picture of agencies' performance
- Development of audit activity across the county, as well as across the children's and adult's safeguarding workforce
- Implementation and evaluation of the new Learning and Engagement sub-group structure
- Continued activity to ensure child sexual exploitation continues to be a priority for safeguarding agencies
- Increased engagement with children, young people, parents and carers
- Expansion of the Professional Development Programme to provide additional training opportunities for the adult's safeguarding workforce
- Development of processes to monitor single agency training on safeguarding
- And finally, increasing the focus of awareness raising and agencies response to neglect, including a multi-agency conference in November 2015.

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The Peterborough Safeguarding Adults Board Annual Report 2014/15

Safety, Enablement, Empowerment and Prevention, at the centre of everything we do

Contents

Introduction 3
Background 4
Who is represented 5
Attendance at meetings 6
How the Board operates 7

Priority Area 1 – Effective Safeguarding Policies, Procedures and Governance

Preparing for the Care Act 2014 8
Board Sub-Groups 9
Deprivation of Liberty Safeguards 12
Progress of actions identified in the 2013/14 annual report 13

Priority Area 2 – Improve response to safeguarding concerns

Safeguarding Adults Activity 2014/15 14
Safeguarding Adults Board Performance Dashboard 18
Safeguarding Adults Training Report 2014/15 21
Quality Monitoring and Audit 24
Notifications of Concern 26
Developing a Quality Framework for Adult Safeguarding 27
Progress of actions identified in the 2013/14 annual report 27

Priority Area 3 – Increased access and involvement.

Improving Accessibility of Information 29
Making Safeguarding Personal 30
Findings from the 2015 Adult Social Care User Experience Survey 31
Expansion of advocacy services 32
Case Study 32
Progress of actions identified in the 2013/14 annual report 33

Partners Reports **........ 34**

Introduction

It is my pleasure to introduce the Peterborough Safeguarding Adults Board's Annual report.

The aim of the report is to capture the difference we made in 2014/15, set against the priorities we had identified in the previous annual report, and set out our priorities for 2015/16.

The biggest challenge the board has had to face is preparing itself for the commencement on the 1st of April 2015 of the Care Act 2014.

As well as this once again, our work over the year took place in an environment of organisational change and resource constraint across the whole partnership, in particular with the continuing reconfiguring of the health system and probation system.
Nevertheless, I think that we have made some considerable progress again this year, particularly around our monitoring and oversight of the quality of care within Peterborough.

I realise there is much more to be done, and we must strive to work with all of the organisations and providers of adult care in Peterborough to make this a safe City to be a resident of in particular when you are vulnerable and in need of care and protection.

We have maintained close links with both the Peterborough Safeguarding Children Board and the Cambridgeshire Safeguarding Adults Board in recognition of those organisations that deliver services to both children and adults and across the council boundaries.

We have also kept close links with the Health and Wellbeing board in Peterborough. In the forthcoming year we will need to ensure we as a Board have fulfilled the expectations of the Care Act 2014.

I should also like to thank all of those colleagues who have worked so hard to promote and improve our approach to safeguarding over the last year.

Dr Russell Wate QPM – Independent
Independent Chair

Background

Throughout 2014-15 the Safeguarding Adults Board was governed by the No Secrets statutory guidance 2000. The Role of the Peterborough Safeguarding Adults Board under this guidance is summarised as follows:

- To ensure the safeguarding of adults at risk in Peterborough, to prevent abuse and neglect happening within the community and in service settings.
- To provide independent governance and audit of safeguarding practices and to promote the safeguarding interests of vulnerable adults to enable their wellbeing and safety.
- To promote, inform and support the work to safeguard adults in Peterborough across all the partnership agencies.
- To develop Peterborough's strategic safeguarding policies, and ensure the inclusion of these polices in all agencies strategy documents and plans.

In March 2015 the Board adopted a new Terms Of Reference and statement of purpose to reflect the requirements of the Care Act 2014.

The role of The Board is to work as a multi-agency group:

1. To ensure the safeguarding of adults at risk of abuse in Peterborough and to prevent abuse and neglect happening within the community and in service settings by providing effective strategic governance at senior management level across partner organisations.
2. To provide independent governance and audit of safeguarding practices and to promote the safeguarding interests of adults at risk to enable their wellbeing and safety.
3. To promote, inform and support the work to safeguard adults in Peterborough, across all the partnership agencies, and to inform and support cross boundary safeguarding arrangements.
4. To develop Peterborough's strategic safeguarding policies, and ensure the inclusion of these polices in all agencies strategy documents and plans.
5. To address poor practice and robustly act to ensure the principles are maintained.
6. To seek independent legal advice as appropriate.

Who is represented on the Peterborough Safeguarding Adults Board?

The Board is made up of senior representatives nominated by each of its member agencies. Those members representing providers were selected following an interview process which included the Independent Chair on the interview panel.

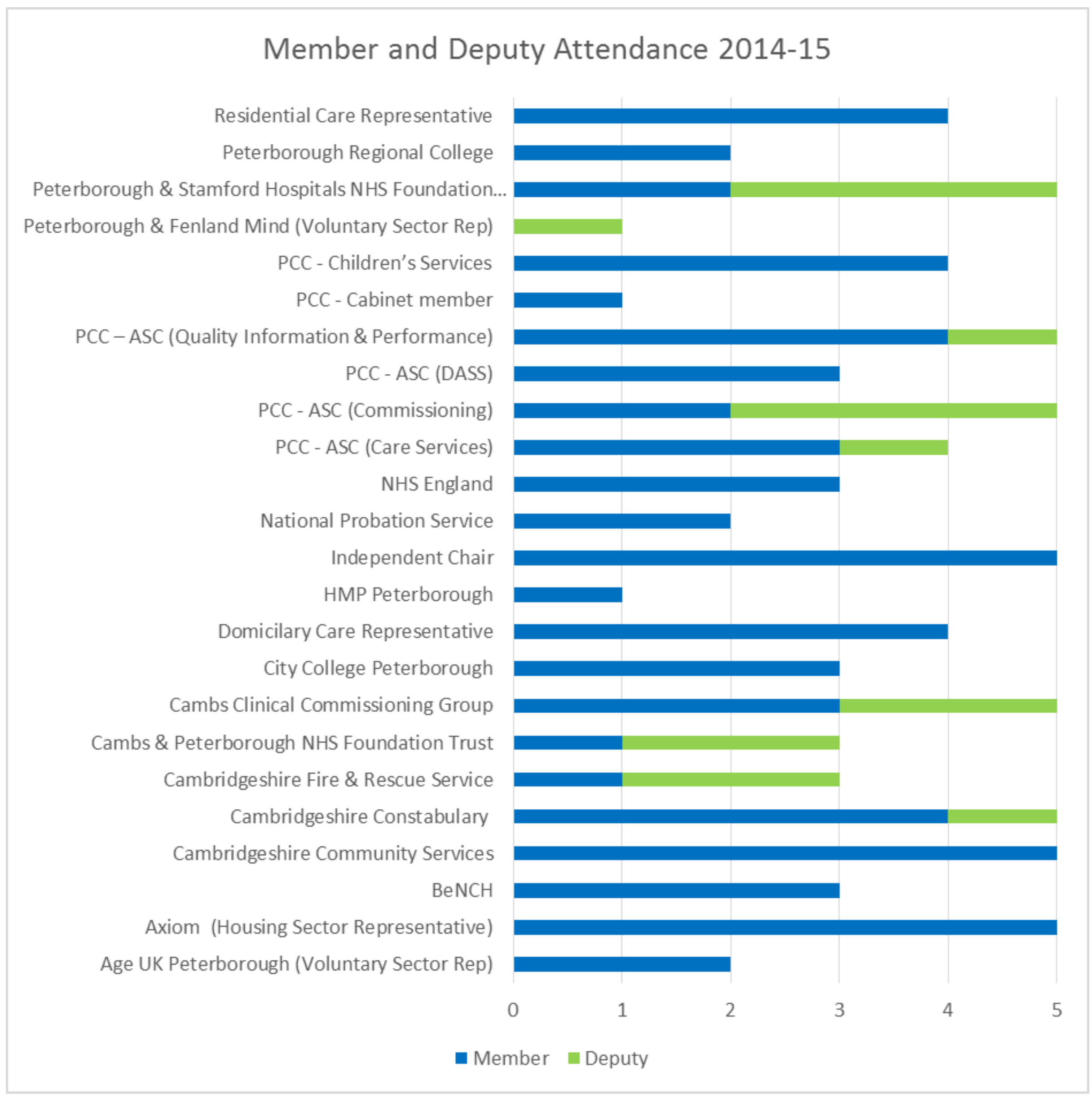
Name	Agency
David Bache	Age UK Peterborough (Voluntary Sector Rep)
Stuart Fort	Axiom Housing (Housing Sector Rep)
Esther Bolton	Cambridgeshire Community Services
Gary Ridgway (D. Supt)	Cambridgeshire Constabulary
Wendy Coleman	Cambridgeshire Fire & Rescue Service
Becki Morphus	BeNCH
Melanie Coombes	Cambs & Peterborough NHS Foundation Trust
Paula South	Cambs Clinical Commissioning Group
Tanya Meadows	City College Peterborough
Mat Hadman	Domiciliary Care Representative
Martin Marsh	HMP Peterborough
Russell Wate	Independent Chair
Matthew Ryder	National Probation Service (member from January 2015)
Mavis Spencer	NHS England
Debbie McQuade	PCC - ASC (Care Services)
Will Patten	PCC - ASC (Commissioning)
Jana Burton	PCC - ASC (DASS)
Tina Hornsby	PCC – ASC (Quality Information & Performance)
Wayne Fitzgerald (Cllr)	PCC - Cabinet member
Alison Bennett	PCC - Children’s Services
Emily Gray	Peterborough & Fenland Mind (Voluntary Sector Rep)
Lesley Crosby	Peterborough & Stamford Hospitals NHS Foundation Trust
Joanne Hather-Dennis	Peterborough Regional College
Kerry Elliot	Residential Care Representative

Partner agency representatives should be of sufficient seniority to make decisions to an agreed level on behalf of their agency.
Each representative is responsible for disseminating information between the PSAB and their agency and for identifying any necessary actions.

The Cabinet Member for Adults Services attends as a participating observer, this allows the member to challenge as necessary.

Members Attendance at Board Meetings

The Board met 5 times during the year, one of these meetings, in February 2015, was an extraordinary meeting to discuss the preparations for, and the implementation of, the Care Act. The chart below includes the attendance at this extra meeting. Members are expected to attend each meeting, or send an appropriate deputy if they are unable to attend.



How the Board Operates

The Peterborough Safeguarding Adults Board provides the strategic leadership for safeguarding adults work locally. The statutory guidance enshrines the six principles of safeguarding:

1. **Empowerment** - presumption of person led decisions and informed consent
2. **Prevention** - it is better to take action before harm occurs
3. **Proportionality** - proportionate and least intrusive response appropriate to the risk presented
4. **Protection** - support and representation for those in greatest need
5. **Partnerships** - local solutions through services working with their communities
6. **Accountability** - accountability and transparency in delivering safeguarding.

The Board has a duty to ensure that these principles are upheld and take action where these rights are infringed.

The Board is positively committed to opposing discrimination against people on the grounds of race, religion, gender, age, disability, marital status or sexual orientation.

The Board is supported by four sub-groups:

- Quality and Performance Sub-Group
- Training Sub-Group
- Safeguarding Adults Reviews Sub-Group
- Health Executive Safeguarding Board

The Board monitored its progress for 2014/15 against the three priorities identified in its business plan:

- Priority Area 1 - Effective safeguarding policies procedures and governance
- Priority Area 2 – Improved response to safeguarding concerns
- Priority Area 3 – Increased access and involvement.

This report reflects the work undertaken which we feel has delivered an impact across the system during 2014/15, and sets out some further work programmes for 2015/16 in line with our three year strategy.

Priority Area 1 – Effective Safeguarding Policies, Procedures and Governance

Preparing for the Care Act 2014

The Care Act sets out three statutory duties for Safeguarding Adults Boards from 1 April 2015.

- It must publish a strategic plan for each financial year that sets how it will met its main objective and what the members will do to achieve these objectives. The plan must be developed with local community involvement, and the SAB must consult the Local Healthwatch organisation.
- It must publish an annual report detailing what the SAB has done during the year to achieve its main objective and implement its strategic plan, and what each member has done to implement the strategy as well as detailing the findings of any Safeguarding Adults Reviews or any on-going reviews.
- It must conduct any safeguarding Adults Reviews in accordance with Section 44 of the act

There was recognition within the CCG that the implications of the Care act required additional staffing and the posts of Named nurse and nurse for safeguarding adults were established. *(CCG)*

The Board held an extraordinary meeting In February 2015 to ensure that it was prepared to deliver its duties under the Care Act. By the first of April the Board had ensured the following arrangements were in place:

- Reviewed membership and terms of reference for the Board
- Revised interim guidance for professionals around the process for undertaking safeguarding enquiries.
- A procedure for carrying out Safeguarding Adults Reviews, alongside revised membership and terms of referenced for the Safeguarding Adults Reviews Sub-Group.
- Designated Adult Safeguarding Managers (DASM) identified by all core members

A Local Government Association Peer Review of Safeguarding Adults in Peterborough scheduled for October 2014, had to be delayed due to sickness of the lead Peer. The City Council therefore asked for an external organisation to carry out a Health Check on Care Act compliance to support the Board in auditing compliance. The Local Government Association Peer Review is now scheduled for February 2016.

The Board also acknowledged the need to ensure alignment to other key partnership boards including Safer Peterborough Partnership and Domestic Abuse Strategy Board.

PSAB Sub-Groups

Quality and Performance Sub Group

The Quality and Performance Sub Group draws membership from organisations who are represented on the Peterborough Safeguarding Adults Board. The purpose of The Quality and Performance Sub-group can be categorised as:

- To assure adult safeguarding processes in Peterborough are safe, effective and provide a positive customer experience.
- To commission specific quality and performance analysis work and to report findings and make recommendations to the SAB

Highlight achievements

Maintained a quarterly overview of the Safeguarding Adults Dashboard which includes the following system performance indicators.
- Timelines for investigations
- Outcomes of investigations
- Use of Protection Plans
- Re-referral rates
- Number of DOLS requests made and granted
- Numbers in secure provision as per Winterbourne Review definition.

Completed a self-assessment in preparation for the LGA Peer Review which was later postponed at short notice due to the sickness of the lead peer.
Reviewed benchmarking information on the national Safeguarding Adults Return.

Took an overview of quality audit work programmes including:
- Making Safeguarding Personal pilot
- Safeguarding Outcomes Measure Project
- Advocacy Audit
- Notifications of concerns for care provision in Peterborough
- Case audits
- Social Care User Survey Analysis

Detail around performance and quality relating to Safeguarding is covered under priority 2, see page 12 onwards.

Training Sub Group

The purpose of the Training Sub Group is to oversee and commission training which further strengthens the awareness of safeguarding. To ensure that those who respond to and investigate safeguarding concerns have the necessary skills to do so effectively. The 2014/15 multi-agency training programme delivered training to 866 people.

Highlight Achievements

- Developed a Training Strategy and training programme for 2015/16
- Undertook a Training Needs Analysis event around Care Act with social care providers.

- Reviewed assessment of learning feedback
- Invested NHS England funding into a shared strategy for MCA and DOLS training for GPs and health professionals

Care Act Provider Event – Training Needs Analysis.

In March 2015 the Training Sub Group organised a training needs analysis session for health and social care providers. Key feedback from the event was that providers felt the need for more support to understand how multi-agency policies and procedures linked into provider's own policy and procedures. The majority of providers have an identified safeguarding lead, who would benefit from multi-agency best practice updates.

Many Providers have almost 'overhauled' their training programmes to ensure the training now meets the newly required 15 standards of the Care Certificate *(Domiciliary Care Rep)*

As all providers have a requirement to update their procedures in line with the Care Act this is a good opportunity for the Board to co-ordinate the sharing of exemplar and best practice materials.

Following on from this the Training Sub Group propose to put the following three key delivery elements in place:

- A session to support provider managers in the updating of their policies and procedures once the amended multi-agency policy and procedures are agreed.
- Quarterly best practice update sessions for health and social care provider managers
- Free access to learning pool (e-learning) and computer / internet facilities at libraries for health and social care workers.

A similar training needs analysis session is being arranged with voluntary sector organisations for early in 2015/16.

Safeguarding Adults Review Sub Group

Serious Case Reviews
Within the timescales of this report the SCR sub-group has commenced, but not completed, 4 SCR's. It is expected that these will be completed during 2015-16 and any identified learning will be shared.

Referring Agency	Referral Date	SAR Criteria	No of adult cases being reviewed	Age of Service user at death or date of referral
CCG	April 2014 (Q1)	Death - neglect	1	78
PCC	April 2014 (Q1)	Abuse - Multiple victims	6	78,76, 88 82, 93, 86
PCC	Dec 2014 (Q3)	Death - neglect	1	81
PCC	March 2015	Death - neglect	1	92

Health Executive Safeguarding Board

The Health Executive Safeguarding Board is a subgroup of the SAB and takes a strategic view of health issues within safeguarding adults across the health economy working collaboratively with members of Cambridgeshire and Peterborough Local Authority Safeguarding adults teams

Safeguarding Adults Health Subgroup

The Safeguarding Adults Health Subgroup is a multiagency forum, including representation from both Cambridgeshire and Peterborough safeguarding adults teams, reviewing operational issues which reports to the Health Executive Safeguarding Board and had a collective work plan of

- Raising awareness of MCA/DOLs
- Monitoring of quality of care in care homes
- Developing a risk framework for referrals
- Sharing of information

Deprivation of Liberty Safeguards

A case law judgment on the application of the Deprivation of Liberty Safeguards regulations delivered in March 2014, has led to a surge in applications nationally. For Peterborough this has meant an increase from 24 applications in 2013-14 to 386 in 2014-15.

The Board has taken an overview of the response to this demand, receiving regular updates on progress. During 2014/15 414 applications were made to the Council for judgments as to whether a restrictions were being placed in a person's best interests. The Council has responded by establishing an MCA and DOLs team and utilizing the ADASS documentation. Although initially there was a backlog all applications relating to 2014/15 had been dealt with by June 2015.

The number of DoLS applications has increased substantially and amended guidance has been produced to reflect the changes *(CPFT)*

There are still some providers making bulk applications and annual reviews are now becoming due meaning there is ongoing pressure within the system. The Law Society are currently reviewing this legislation in light of the pressures felt across the country.

Figure 1 below shows the numbers of DOLs applications received in 2014/15 by source:

Figure 1 DOLs applications by source.

	Q1	Q2	Q3	Q4
Acute hospital	2	4	0	1
Psychiatric hospital	1	4	3	2
Learning Disability	16	24	7	7
Other Care Homes	121	63	95	64

Progress of actions identified in the 2013/14 Annual Report

Effective Safeguarding Policies, Procedures and Governance - Our priorities for 2014/15

- Review Safeguarding Procedures and develop a framework for Serious Case and other Multi-Agency Reviews in light of the Care Act, in partnership with Cambridgeshire and the regional ADASS safeguarding network.
  Interim process produced. Countywide multi-agency policy and procedures to be developed in light of national guidance now received, and following learning from first three months of MASH

- Develop a MCA and DOLS service that is able to provide a quality and timely response to the increased demand for use of DOLS within care settings.
  Team established and 441 applications received in 2014/15. All had been processed by end June 2015.

- Review SAB membership and funding in light of the Care Act 2014 guidance
  Review undertaken and new Terms of Reference in place. New joint board governance arrangements with Local Safeguarding Childrens Board to be put in place for 2015/16.

- Undergo an LGA Peer review of Adult Safeguarding arrangement in Peterborough
  Postponed until February 2016. External health check to be completed and outcomes shared by July 2015

We worked in partnership to transform the Multi Agency Referral Unit (MARU) into a Multi-Agency Safeguarding Hub (MASH) with adult safeguarding one of the priority thematic areas of the MASH.
(Cambs Constabulary)

Priority Area 2 – Improve response to safeguarding concerns

Safeguarding Adults Activity 2014 / 15

In order to ensure responsiveness to safeguarding concerns we need to ensure that there is awareness amongst all agencies and that appropriate alerts are raised.

Too many referrals can be evidence of a lack of understanding of what constitutes a safeguarding concern, too few can be evidence of a lack of awareness of adults at risk.

Learning is shared in team meetings regarding safeguarding and cases are discussed in clinical, team and daily meetings in order to ensure a multidisciplinary approach is used when making decisions regarding safeguarding and how best to manage cases. *(Aspire)*

In 2014/15 we saw a slight dip in the number of safeguarding concerns progressing to investigation, which has brought us more into line with national averages per head of the population, Figure 2 below.

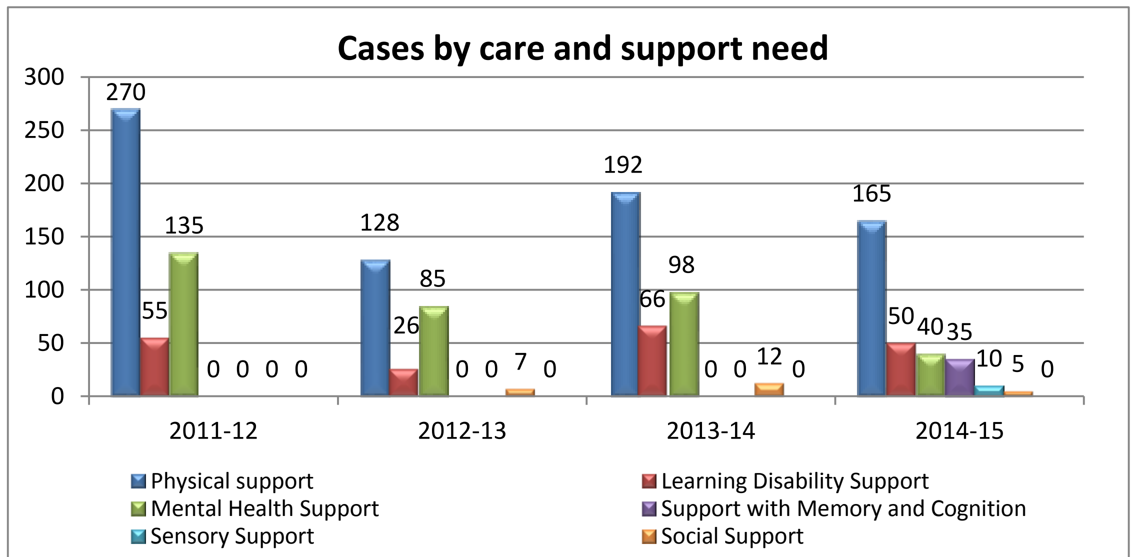
Figure 2 – Number of cases progressing to investigation per 100,000 of the population

	Total investigations	Total adult population	Investigations per 100,000
Peterborough (2014/15)	**364**	**143,854**	**253**
Peterborough (2013/14)	368	115,400	260
England (2013/14)	105560	33,013,910	251

There was also a change in the way we categorise adults at risk for the purpose of national data capture. Investigations regarding adults with cognitive memory and cognitive impairments are now separated from the mental health category.

Figure 3 below shows the historical trends for different categories of adults at risk, broken down by primary care and support need.

Figure 3: Cases by primary care and support need of the adult at risk



NOTE: The data shown above represents the number of individuals subject to a safeguarding investigation in the period, an individual might have more than one investigation, hence the difference in figures from the table in figure 2.

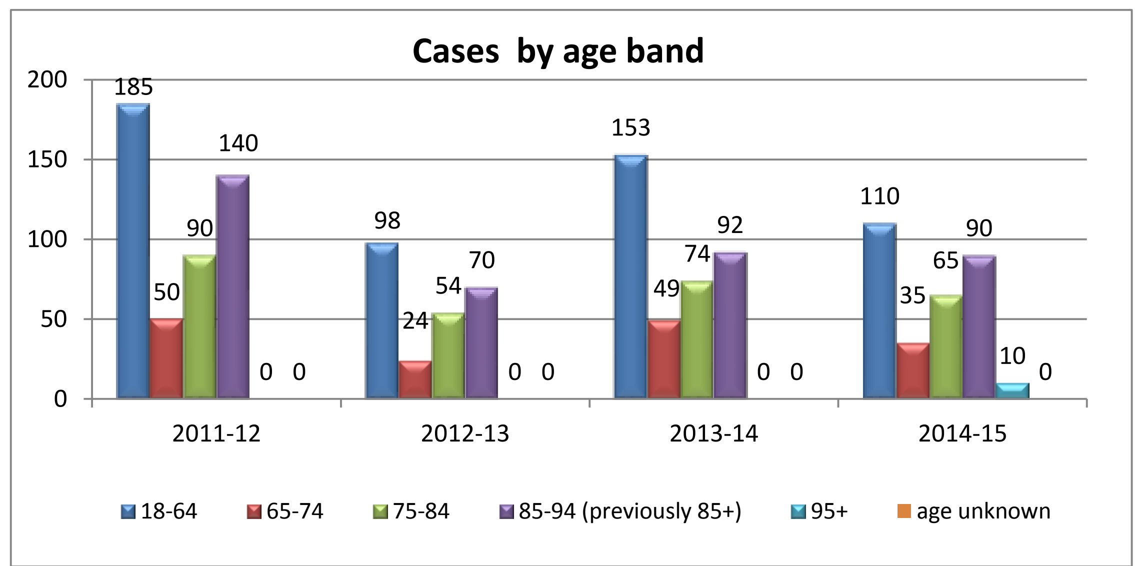
The clear primary care and support need for adults at risk for whom we progressed investigations was physical support (53%) and this has been the pattern for previous years also. The reduction in mental health numbers is likely to be due to those with memory and cognition support needs being separated out. Learning disability, mental health and memory and cognition have similar levels of referrals.

Of the investigations conducted 258 (84%) were for people with White British ethnicity, this is exactly in line with the previous year. As with the previous year referrals for other ethnic groups were spread, with the next largest percentage (4.6%) being Asian / Asian British.

Of the adults at risk 27% were not previously known to the Council, down 1% on the previous year. It was more common for men to have been unknown to the Council, 35% of the 108 investigations regarding men were for those not previously known. For women the percentage was noticeably lower at 22%. Adults at risk with mental health support needs were most likely not to have been previously known to the Council (49%).

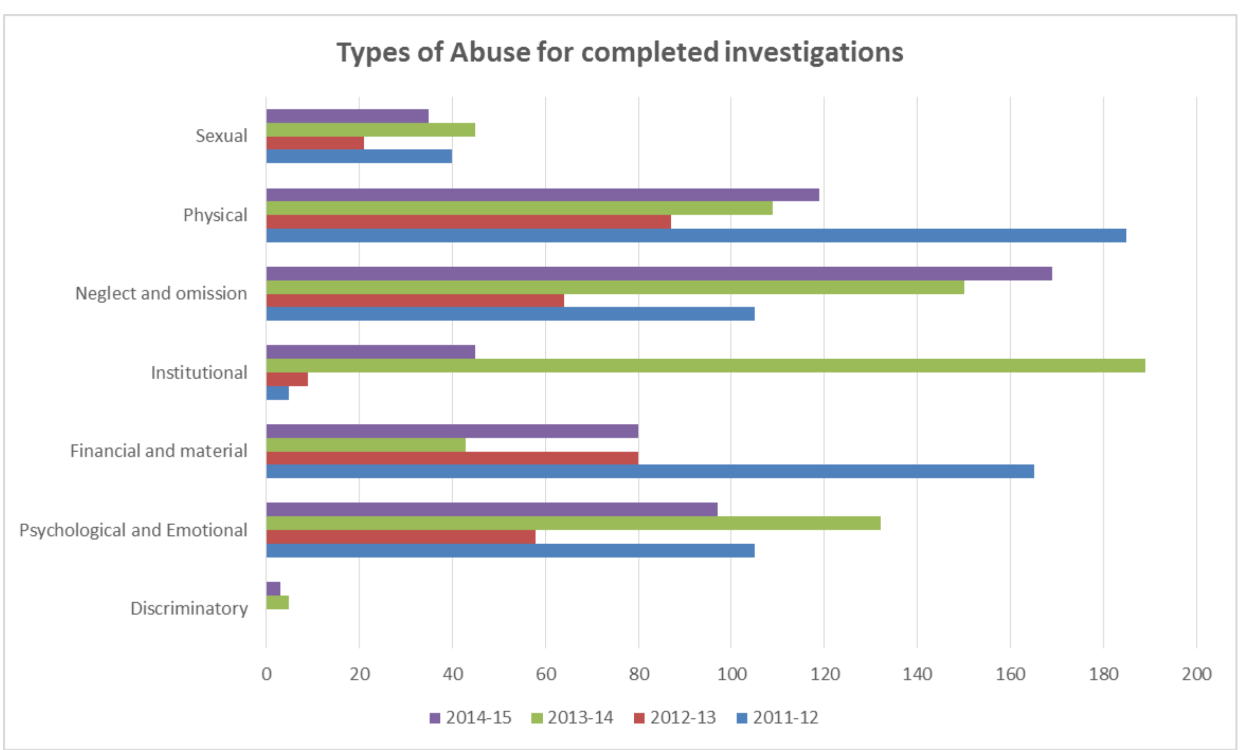
Over time we have seen an increasing proportion of investigations relating to those aged 85 and over. Figure 4 provides a breakdown by age over time. The number of investigations relating to those aged 85 and over at 101, almost equalled the numbers relating to those aged 18-64,(106).

Figure 4: Cases by age band



Of the investigations that were concluded within the year the majority related to neglect and omission, 30.5%, with physical abuse (22%) and psychological and emotional abuse (18%) being the next most common.

Figure 5 - types of abuse for completed investigations



The split between source of abuse remains comparable to the previous year. Most commonly alleged perpetrators are known to the adult at risk, although an increasing percentage are individuals who are not known, 11% in 2011/15 compared to 8% in 2013/14.

Figure 6: Source and type of alleged abuse

Type of abuse	Social Care / Support service 13/14	Social Care / Support service 14/15	Individual known to the person 13/14	Individual known to the person 14/15	Individual unknown to the person 13/14	Individual unknown to the person 14/15
Physical	**57**	**34**	**85**	**68**	**8**	**15**
Sexual	**8**	**4**	**33**	**27**	**4**	**5**
Psychological/ Emotional	**26**	**27**	**77**	**63**	**6**	**5**
Financial / Material	**17**	**10**	**102**	**61**	**13**	**10**
Neglect or omission	**125**	**92**	**42**	**57**	**22**	**20**
Discriminatory	**1**	**0**	**42**	**3**	**22**	**0**
Institutional	**40**	**27**	**3**	**16**	**0**	**0**
Total	**274**	**194**	**345**	**295**	**54**	**55**

Note: each investigation can have more than one allegation of abuse, hence numbers will not total to match the number of completed investigations.

The most commonly investigated form of alleged abuse was neglect or acts of omission, with 165 investigations. The majority of these allegations of neglect, 55%, related to social care providers or support services. Physical abuse overtook financial abuse as the most common form of abuse alleged to be perpetrated by someone known to the adult at risk.

During the year there were 3 large scale investigations concerning care homes in the City and these might have led to an increased number of investigations being captured which related to neglect or acts of omission. The Board will be reviewing its processes for dealing with investigations concerning providers during 2015/16 to ensure proportionate and effective responses which build on mutual learning.

Outcomes of investigations

Of the investigations completed in the year 135 (38%) found an allegation of abuse to be substantiated. A slightly decreased percentage were found to not substantiated (32%), whilst the % of cases where the outcome was inconclusive remained roughly the same (18%).

Figure 7 shows a breakdown of the case conclusions for all completed investigations.

Figure 7: Case conclusion

Case conclusions for completed investigations

	2011-12	2012-13	2013-14	2014-15
Substantiated	36%	28%	33%	38%
Partially substantiated	6%	6%	9%	8%
Not Substantiated	36%	44%	35%	32%
Inconclusive	22%	22%	19%	18%
Ceased at SU's request	0%	0%	0%	3%

At the completion of investigations a judgment is made as to whether there was risk found and if so whether this risk has been reduced or removed. For investigations completed in 2014/15 the following judgements were made in respect of risk.

No action taken, no risk remains = 38%
Risk remains = 7%
Risk reduced = 32%
Risk removed = 24%

Mental Capacity

Of the investigations completed in 2014/15 approximately 50% of adults at risk lacked mental capacity to identify outcomes. Of these 105 (60%) were supported through the process by an advocate or representative. This is an area in which we wish to improve in future years, as the adult at risk's wishes should be central to the safeguarding process.

Safeguarding Adults Board Performance Dashboard

Alongside collecting activity data for the national safeguarding returns the Board continues to monitor metrics around the quality and inclusiveness of safeguarding in the City. Measures on which the Board seeks assurance are summarised below:

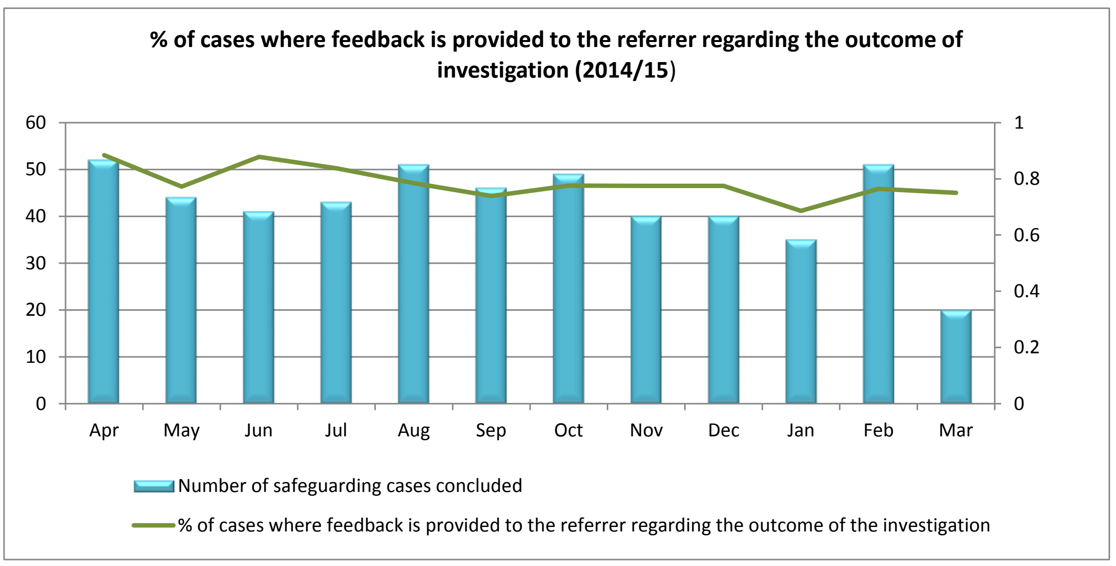
Strengthen response to referrers of safeguarding concerns.
Referrers had expressed concerns around a lack of feedback at key points of the safeguarding investigation process, at the point at which it is decided to treat a concern as a referral and at the conclusion of an investigation. Two measures are monitored within the dashboard.

1. ***Feedback to referrers***. Recorded feedback to referrers was consistently better than the 49% for the previous year, with performance ranging from 83% in

Quarter 1 to 67% in Quarter 4. However partner agencies and care providers continue to raise concerns about the frequency and usefulness of feedback, and spot audits have revealed that feedback is not always comprehensive of channelled to the appropriate person within an organisation. Further guidance on feedback was included in the new process guidance for professionals which came into place on 1 April 2015.

2. ***Feedback not given to referrers after the outcome of the investigation.*** Likewise recorded feedback of the outcome of investigations was consistently improved on 2014/15 in all quarters. However at just under 80% the frequency of feedback for outcomes is still not as good as it can be. The interim guidance makes it clear that referrers should be involved throughout the process where appropriate rather than just receiving feedback on completion.

Figure 8: Percentage of cases where feedback was given to the referrer regarding the outcome of the investigation

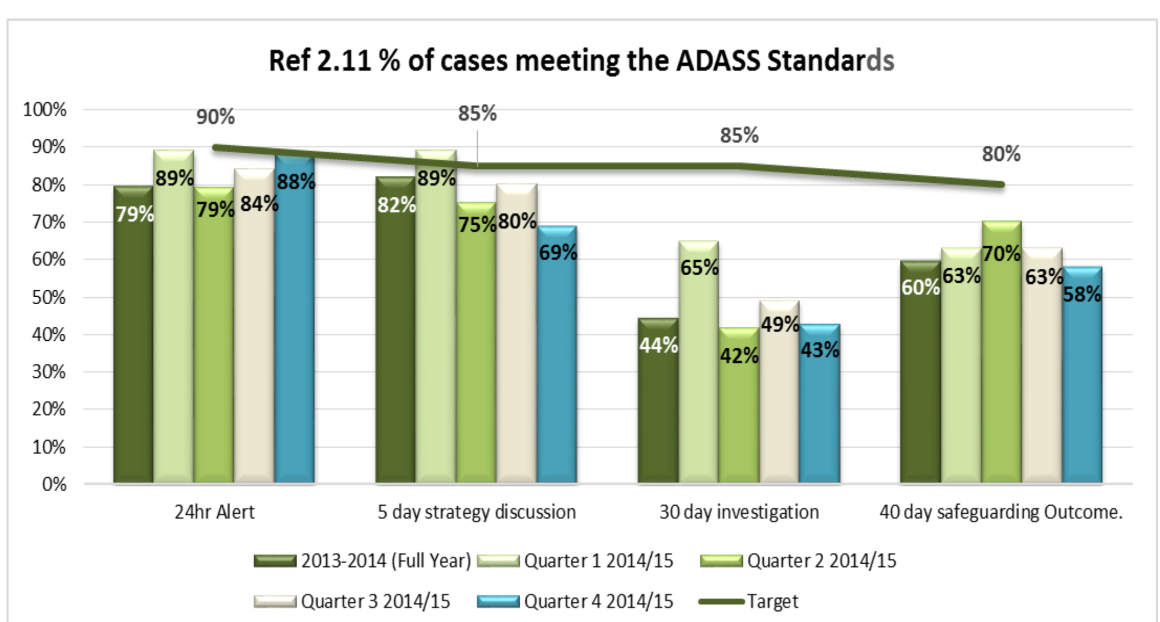


Improve timeliness of investigations

Although there are no nationally set timeframes for conducting and completing adult safeguarding investigations, the Board has continued to monitor timelines against the benchmarks, suggested by the Association of Directors of Adult Social Services (ADASS)

- 24 hour to decide to treat concern as a referral
- Strategy meeting or discussion to be held within 5 working days
- Investigations completed within 20 working days / 30 working days
- Outcome of the investigation to be known within 40 working days

Figure 9: Timeline indicators



Timelines have continued to be challenging and although the initial time lines targets were achieved in some quarters the investigation and outcome targets have not. Although it is important to monitor timelines, the improvement in percentages of substantiated cases might be evidence that timelines are not adversely affecting outcomes. Under the Care Act time lines have not been suggested in recognition of the need to set the pace of enquiries around the level of risk and what the outcome the adult at risk wishes to achieve. The Multi-Agency-Safeguarding-Hub where responsibility for triaging referrals is placed from 1 April 2015 have identified target timelines for 24 hours for high risk and 72 hours for all other referrals.

Prevention of further abuse

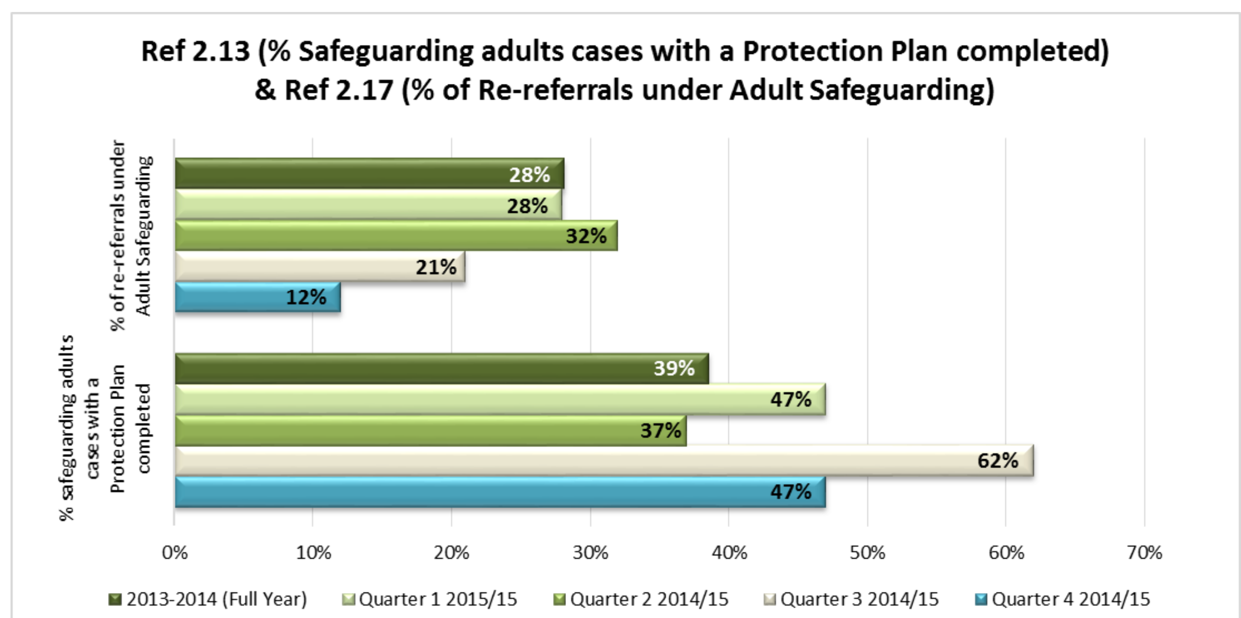
The Board dashboard has historically contained two measures which seek to track the impact of investigations in preventing further abuse:

- % of safeguarding adults cases where a protection plan was put in place
- % of safeguarding referrals that were re-referrals

For 20-14/15 the Quality and Performance Sub-Group also monitored the percentage of cases where risk was reduced or removed as summarised on page 13 above.

> There has been a great deal of activity to ensure compliancy with the new Prevent Duty to include further Business continuity training from NaCTSO for senior staff and WRAP training for all staff. The College now has representation on the Peterborough Prevent Strategic Board and Cambs Channel Panel. *(Regional College)*

Figure 10: Prevention indicators



In response the high level of re-referrals in the previous year and the first two quarters of 2014/15 a regular re-referral report was created. This report allows case audits where an adult at risk has had multiple referrals in a 12 month period. The rate of re-referrals reduced in Quarter 3 and Quarter 4 and this might be due to learning from the audits, or from an increased focus on delivering the outcomes identified by the adult at risk.

The use of protection plans having increased in the previous years continued to rise overall, despite a small dip in the second quarter. It is hoped that the focus on identifying the adult at risks outcomes will lead to further increases in the use of protection plans to document longer term actions to safeguard from harm.

Safeguarding Adults Training Report 2014/15

Identification and response to safeguarding concerns are dependent upon knowledge, understanding and awareness of all agencies. The Safeguarding Adults Board has an agreed training plan to enhance this. During 2014/15 63 courses took place and were accessed by a total of 866 health and social care workers or volunteers.

262 people attended bespoke training provided on request by their employer.

759 people booked training through the Board's training brochure, although 202 subsequently failed to attend. Attendance rates were better for the courses specifically aimed at managers of health and care services.

The table in figure 11 below provides a breakdown of courses offered via the training brochure with the booking, attendance and DNA rates.

Figure 11: Training programme 2014/15

Course Title	Number of Courses	Places Available	Total Booked	Total Attended
Case Conferences and Protection Planning	1	18	7	4
Deprivation of Liberty Awareness	4	72	77	48
Deprivation of Liberty Level 2	2	36	31	22
Large Scale Investigations	1	18	9	8
Leading Safeguarding Investigations (2 Days)	1	18	13	12
MCA & DOLs refresher	6	108	111	77
Mental Capacity Act Awareness	6	108	133	91
Mental Capacity Act Level 2	2	36	29	26
Roles and Responsibilities of Provider	2	36	40	31
Safeguarding Awareness	10	180	204	165
Safeguarding Awareness Refresher	4	72	75	33
The Care Act & Safeguarding Adults Workshop	2	30	30	31
TOTALS:		**732**	**759**	**548**
			76%	

Overall attendance rates were similar across sectors, although as expected the largest volumes of attendees were from the private and voluntary (PVI) sector. 72% of those who booked from PVI sector attended on the day, compared to 77% from the Council and Health organisations and 79% from the Mental Health Trust.

Figure 12: Attendance by sector

Attendance				
PCC	**PVI**	**Health**	**CPFT**	**Police**
131	**369**	**33**	**15**	**0**
77%	**72%**	**77%**	**79%**	**n/a**

The training courses were positively received by attendees with 100% rating them as either good or excellent. Some specific examples of learning recorded by attendees are recorded here:

Safeguarding Refresher
I will ensure safeguarding concerns are reported correctly
It reminded me of the correct procedures to follow
I will make observations during contact with the client

The Care Act & Safeguarding Adults Workshop
Really useful being able to discuss the Care Act and Safeguarding workshop with the other providers particularly those with a lot more experience and with varied backgrounds

Mental Capacity Act
It re-enforced that we should be acting in the best interest of patients
Overlaps between the Mental Capacity Act and other legislation were useful
I have a better understanding of my role in assessing capacity
What having capacity or lacking capacity means
I have learnt a lot about Mental Capacity issues, how to apply it in my daily work and how I may need to change certain things

Deprivation of Liberty Awareness
I am aware of who is responsible for making applications
I have a better understanding of what is meant by deprivation of liberty
The implication of DOL's
I have an awareness of the Supreme Court judgement
It was thought provoking

Safeguarding Case Conference and Protection plans
The course enabled reflective thinking
It increased my knowledge and skills
Don't ignore gut feeling – triangulation of evidence
It made me think outside the box
The whole process is much clearer now and the trainer instilled confidence
Good information about the things you need to consider in an investigation

Deprivation of Liberty Level 2
Better understanding of the impact of recent legislation
I felt the case study used was very thought provoking
I now have a clearer understanding of when to make a DOLs application

Roles and Responsibilities of Provider Managers
I feel more empowered in the management of a safeguarding concern
I gained an insight into how other providers feel about their role in safeguarding
Understand the role of advocacy in safeguarding
Connectivity between my behaviour/impact on staff
The whole process is much clearer now and the trainer instilled confidence

Quality Monitoring and Audit

During 2014/15 a range of audits of safeguarding investigations continued during which managers and frontline staff evaluated safeguarding cases.

24 case evaluation meetings took place in 2014/15. During these meetings, 52 safeguarding cases were evaluated in total:

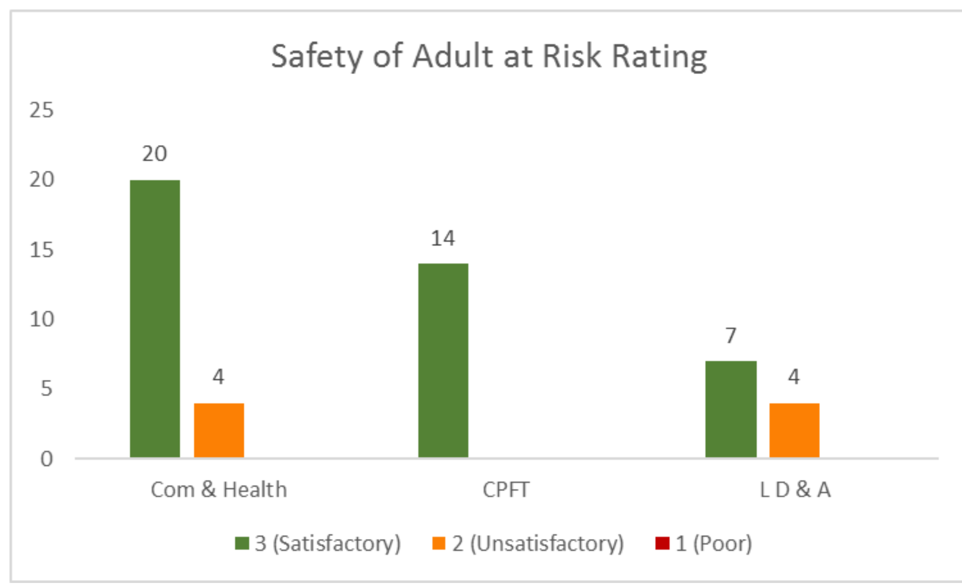
- 24 Community and Health cases
- 11 Learning Disability and Autism cases
- 14 Cambridgeshire and Peterborough Foundation Trust (Mental Health) cases

The safeguarding cases audited in the period were rated in terms of the **Safety of Adult at Risk** as follows:

Rating	Descriptor	Detail
3	*Satisfactory*	Cases where the risks to the Adult at Risk have been identified and addressed and there are no concerns about the safety of the Adult at Risk
2	*Unsatisfactory*	Cases where there are some concerns about the safety of the Adult at Risk and further non-urgent action is required to ensure their safety
1	*Poor*	Cases where there are serious concerns and the safety of the Adult at Risk has been compromised by an inadequate or flawed investigation

No cases were found to have continuing serious concerns in relation to the adults' safety. However, 8 in total had some continuing concerns and were referred back to safeguarding teams for further action. See figure 13 below.

Figure 13: Audit of Safety of Adult at risk



General Improvement and Awareness of Audit:

- Members of DMT attending the RTB case file audits/evaluations have commented that they are seeing improvements on the quality of work since the initiative was launched in July 2013.

- Through their own attendance at RTB case file audits/evaluations, workers are now aware that cases are being audited and what we are looking for in the audits which can in itself lead to an improvement in quality.

Guidance to Staff:

- Worker specific guidance on matters arising from the case evaluations has been communicated to staff through the audit forms and cascading from team managers to specific workers.

Safeguarding Investigation Training:

- As a result of issues identified in the case evaluation meetings training for workers entitled "An Outcome Based Investigation Method" was conducted.

Deep Dive and Focussed Audits

Alongside the regular audits of safeguarding investigations a number of other deep dive audits were conducted, to focus on areas where it was felt a closer understanding was needed. These audits included:

Unable to Ascertain Audit

In April and May 2014, there were **22** safeguarding investigations closed where the answer to 'Do you feel safer as a result of the investigation?' had been recorded as 'Unable to ascertain'. Each of these cases was looked at on Frameworki to ascertain the reason for this answer being selected. Of the **22** Adults at Risk involved, **11** did not have capacity. All of these had support from family and/or friends. **11** of the Adults at Risk did have capacity, the reasons for their not being able to respond included a lack of memory of the incident, ongoing police investigation and poor health. The new safeguarding processes focus on the views of the adult of risk throughout, rather than at the end of the process and should improve data capture around perceptions of risk and safety.

Advocacy Audit

An audit was undertaken on use of Advocacy within the safeguarding process. A total of **478** investigations were reviewed and of these **270** people were recorded to have capacity to participate in the investigation. **107** people were recorded as not having the capacity to participate. **101** people had this field completed as 'Don't know'.

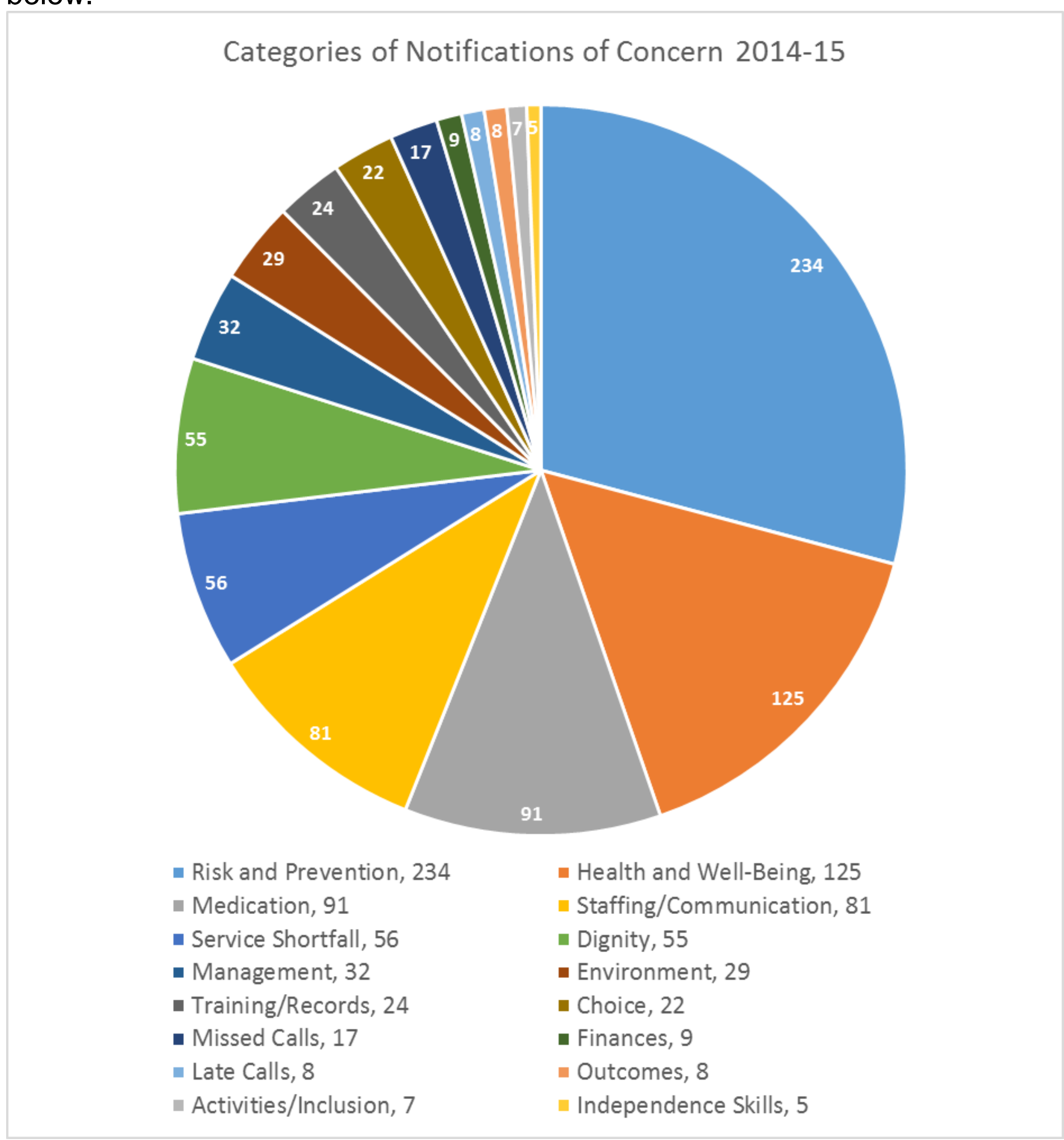
Of the **107** who lacked capacity, two died, leaving a population of **105** to be considered for this audit. A relevant Mental Capacity Act Assessment was found on file for **20%** of service users (**21/105**). Of the **105** people, **63** of them

were supported by an advocate, family member or friend and **42** were not (as far as the auditors could tell from the files). The new safeguarding procedures from 1 April 2015 include much clearer guidance on the need to involve advocates.

Notifications of Concern

The Adult Social Care department closely monitor the quality of services provided by independent social care providers. Intelligence is collected and scrutinised at monthly meetings, which are attended by partner agencies such as health and Healthwatch as well as internal council staff. The Police have requested to join the group for 2015/16.

In 2014/15 a total of 562 concerns were recorded covering the categories as shown below.



The largest category was ‘Risk and Prevention’ which included all issues handled as safeguarding, followed by ‘Health and Wellbeing’ and ‘Medication’.

Developing a Quality Framework for Adult Safeguarding

The Quality and Performance Sub Group of the Safeguarding Adults Board is developing a Quality Framework structured around the Key Objectives. The Quality Framework provides the following mechanisms for quality assuring safeguarding decision making, safeguarding process and risk management, Adult at Risk engagement and experience:

- Making Safeguarding Personal
- Service User and Carer Experience of the Safeguarding Process
- Quality Assurance Monitoring Processes and Audits
- Procedures and Staff Training
- Information for the Public
- Quality Improvement and Support for Providers of Health, Care and Support Services
- Performance metrics
- Peer Review

The Quality Framework, once completed, will be aligned to the Board's strategic priorities and reflect the six principles of Adult Safeguarding as set out in the Care Act 2014. The Framework will set out a menu of the mechanisms listed above against each of the strategic priorities in order for the Board to be able to identify and monitor success in delivering its duties and commitments.

Progress of actions identified in the 2013/14 Annual Report

Improve Response to Safeguarding Concerns – Our Priorities for 2014/15

- Work with the County project group and Children's Services to establish a MASH
  The MASH hub went live for Safeguarding Adults in Peterborough on 1 April 2015. Process and paperwork was agreed and implemented for that date
- Continue with national outcome pilots
  Safeguarding Adults Pilot and Making Safeguarding Personal pilots continued
- Training for GPs, in MCA and DOLs
  Agreement to a joint strategy across Cambridgeshire and Peterborough. Joint strategy and training programme under development covering GPs, Dentists and community health workers
- Enhance monitoring of quality around MCA and DOLs
  An interim Mental Capacity Act and DOLs Team Manager has been in post since December and there is now an established team of Best Interest Assessors. Most care homes have now submitted some DOLs applications.
- Continue to build on quality and audit processes
  Quality and Audit processes have been enhanced and a Quality Framework has been drafted for Board approval
- Establish a quality improvement team to support providers within the City
  Although a team has not been established there is much improved information sharing and co-ordination. Monthly Quality Improvement Meetings take place where soft intelligence is shared across health and social care professionals and actions to support providers in problem areas are agreed.

Priority Area 3 – Increased access and involvement

Improving accessibility of information

During 2014/15 we have continued to look at ways to better increase awareness of adult safeguarding and to improve the involvement of adults at risk in the process of investigations and in quality overview of social care provision and of our work as a Board.

The Council has redesigned the web site on which the Safeguarding Adults Web Pages are hosted to make it more accessible.

We have produced a safeguarding leaflet specifically for carers of adults with Care and Support needs.

We have added a "Keeping People Safe" section to the Care and Support Service Directory. This directory was available in printed version, with 5,000 copies being distributed to key points around the City and online at http://www.carechoices.co.uk/wp-content/uploads/2014/07/Peterborough-Care-Services-Directory-2014-15.pdf

This section covers identification of adults at risk of abuse / experiencing abuse and how to make a referral if you have concerns. The Directory will republished in July to cover amendments introduced by the Care Act 2014.

Making Safeguarding Personal

Adult Social Care continued to participate in the 'Making Safeguarding Personal' initiative, monitoring whether the adult at risk is placed in the centre of the process. Results from the most recent audit of cases demonstrated that practice has been improving.

↑	In 12 out of the 25 cases (48%) the adult at risk was aware of the safeguarding referral, compared with 36% last audit
↑	12 of the 25 Adults at Risk (48%) agreed to participate in the safeguarding process, significantly more than the 14% last time
↑	At referral stage it was considered that 10 of the 25 Adults at Risk (40%) had capacity to make informed decisions about their own safety, an increase on the 14% when last audited
↓	In 64% of cases (16 out of 25) there was evidence of an attempt to contact the adult at risk or their representative by strategy stage, a decrease on the 80% finding of the previous audit
↓	There were a number of unanswered questions about capacity and advocacy which had not been left unanswered last audit: 1 case did not specify how the adult at risk would be supported during the process, 3 did not say whether a Mental Capacity Assessment was required in relation to decisions about own safety, 1 did not answer whether an IMCA was required and 2 did not specify whether an advocate would be required
↑	76% cases included service user defined outcomes compared with 64% of cases last audit
↑	16 of the 25 service users (64%) felt that their views and wishes had been fully considered and the remaining 9 were unable to ascertain. The last audit had found just 10% of service users had felt that their views and wishes had been fully considered
↑	10 out of the 25 cases (40%) found a positive impact had been made as a result of the safeguarding investigation, as opposed to 30% of the investigations last audit
↑	3 of the 25 cases (12%) went to case conference compared with 7% last time the audit took place, and the service users in each case were invited to attend and declined to do so
↑	In 19 of the 25 cases (76%) the service user was offered a Protection Plan, compared with 70% from the previous audit
↑	In 17 out of 25 cases (68%) the service user was able to participate in the safeguarding adults process, a significant improvement on the 40% found last time the MSP audit took place

The audits show that we have a good foundation to build upon in ensuring our model of safeguarding puts the person at its heart.

Findings from the 2014 Adult Social Care User Experience Survey

The annual Adult Social Care User Experience Survey was conducted in February 2014. Key messages are summarised below.

The increase seen in 2013/14 for the percentage of service users who said care and support services help them in feeling safe continued.
2013/14 = 83.6%
2014/15 = 89.1%

However overall feelings of safety had continued to be poorer with only 64.5% of respondents stating that they felt as safe as they wanted.

The proportion of respondents who felt they had control over their daily life had improved from 76% in 2013/14 to 78.4% in 2014/15.

Measure	P'boro 2013/14	P'boro 2014/15	Difference	England 2014/15
1A - Social care-related quality of life score	**18.9**	**19.0**	**0.1**	**19.1**
1B - Proportion of people who use services who have control over their daily life (%)	**76.0**	**78.4**	**2.4**	**77.4**
1I Proportion of people who use services who reported that they have as much social contact as they would like (%)	**42.4**	**42.0**	**-0.4**	**44.7**
3A Percentage of adults using services who are satisfied with the care and support they receive (%)	**65.0**	**59.2**	**-5.8**	**64.7**
3D Proportion of people who use services who find it easy to find information about services (%)	**74.9**	**74.2**	**-0.7**	**74.5**
4A - Proportion of people who use services who feel safe (%)	**63.9**	**64.5**	**0.6**	**68.5**
4B - Proportion of people who use services who say that those services have made them feel safe and secure (%)	**83.6**	**89.1**	**5.5**	**84.5**

Expansion of advocacy services

In preparation for the implementation of the Care Act in April 2015 the Council has increased the range and availability of advocacy services. Identification of the need for advocacy support is now a key part of the initial triaging of safeguarding concerns within the MASH Hub and should ensure that going forward advocacy needs are identified and responded to early in the safeguarding process.

Case Study

Supporting an adult at risk of financial abuse.

A referral was made to the Council in respect of a vulnerable disabled individual in need of care who lacked mental capacity to manage her own finances. Her relationship had irretrievably broken down, and she presented to the Council with significant financial concerns, including debt, mortgage arrears and threats of legal action for monies owed. It became apparent that she had been financially abused. Her home was in a state of disrepair, and her wellbeing was seriously affected by these issues. The client income service quickly applied to the Court of Protection to become her deputy, allowing the Council to act on her behalf in managing her property and (financial) affairs. The Court approved the Council's application, and the Council set about dealing with the considerable financial problems she had faced. Creditors were contacted, repayment plans were arranged, and in some cases the debts were written off.

As a result of these actions, her home was secured, the disconnection of her utility supplies was prevented, and her debts were addressed. Urgent and remedial property repairs were also arranged and funded via accessing available grant funds and using the client's own funds including: fitting a new central heating and hot water boiler, installation of UPVC windows, re-decorating and re-carpeting her home, and landscaping and re-fencing her garden. The customer was supported to be involved in all decisions about these matters.

Her finances are now well-managed, monthly mortgage payments are routinely being repaid, additional welfare benefits have been successfully claimed, and a mobility vehicle has been applied for. Apart from her ongoing housing costs, the client should be debt-free by the end of 2015, and she is now happy, secure and settled.

Progress of actions identified in the 2013/14 Annual Report

Increased Access and Involvement – Our Priorities for 2014 /15

Continue to build on the Notification of Concerns process and system wide intelligence sharing
The process is now well embedded for concerns relating to care providers. The intelligence is shared with partner agencies and actions are co-ordinated.

Implement a quality improvement team with health and social care specialist inputs
Although actions are better co-ordinated between agencies where quality concerns are identified. A model for a quality improvement team is still being considered.

Improve service user perception of safety within the community
2014/15 survey results evidence that this is still an area for focus

Partner Reports

Aspire Recovery Service

Aspire Drug Treatment Service is a community recovery resource which supports people who misuse drugs. We work with individuals to develop life skills to help people enter education, training and employment so that each individual can build their personal recovery and reintegrate into the community. The name Aspire was chosen by service users and stands for A Service Providing Inspirational Recovery Empowerment.

We work closely with GP surgeries, mental health team, police, probation, HMP, courts and Drinksense. All of these agencies refer to us and we refer to them and share information regarding safeguarding as necessary.

- All staff receive safeguarding adult training on indication (CRI training)
- Staff receive refresher training every 2 years.
- Staff briefed on care act and summary guidance provided through morning team meetings and email advice and guidance.
- All staff are competent at referring cases to adult social care and do so on a regular basis
- Staff indicate those with safeguarding issues on an internal database and review these cases every 6 weeks
- CRI Aspire has a safeguarding lead, lead sits on the training sub group for the Safeguarding Adults Board.
- Safeguarding lead attends all relevant local safeguarding adults training and events
- Audit and governance lead at Aspire undertakes regular safeguarding audits and findings are used nationally within CRI
- Learning is shared in team meetings regarding safeguarding and cases are discussed in clinical, team and daily meetings in order to ensure a multidisciplinary approach is used when making decisions regarding safeguarding and how best to manage cases.
- All clients are risk assessed during the initial referral and registration process within the service. Any safeguarding issues identified at this point are then incorporated into the clients care plan and risk management plan. A notification/alert is also raised on the CRI internal database. Any safeguarding concerns identified are then highlighted to social care through the appropriate referral pathway, this is normally done via telephone.

Aimee Elener - Quality, Governance and Assurance Coordinator (Training Sub-Group member)

Axiom Housing Association

Axiom Housing Association was established in 1967. Our primary mission is to make a **positive difference to people's lives and our communities**.

Our supported services provide support for vulnerable people, those leaving care, people with learning difficulties and with mental and physical health needs.

We work across a number of county boundaries and deliver services to a large number of vulnerable people both in our accommodation and in the community.
In this year we have:

- introduced a “Health Check” approach within our services to check the quality of care and support being provided. This involves a random visit to a service by one of our staff to look at the service being provided and look out for any concerns about the way our services are being delivered. This approach is in its early stages of implementation.
- added a new role to our staffing structure – a Safeguarding Officer. The role will take the lead on all safeguarding issues across the organisation and our wide range of diverse priorities. The role will also have a strong remit on quality assurance. This role reflects our commitment to keeping our services safe and secure.

Stuart Fort – Operations Director

The Bedfordshire, Northamptonshire, Cambridgeshire and Hertfordshire Community Rehabilitation Company Limited (BeNCH)

Our principle task is to reduce reoffending and make our communities safer. We do this by working with the Service Users as they progress through their Sentence Plan which means they do everything required by the Court or their Prison Licence. Bench Probation Services have particularly focussed on collaboration and co-location with the County Multi-Agency Safeguarding Hub (MASH) and we now have a link offender manager based in the MASH who is the Probation Single Point of Contact for all Domestic Violence and Safeguarding notifications.

Becki Morphous – Team Manager

Cambridgeshire Constabulary

Cambridgeshire Constabulary remains committed to working with partners to safeguard vulnerable adults and has a specialist Adult Abuse Investigation and Safeguarding Unit (AAISU) within the Public Protection Department. The unit works closely with the Multi-Agency Referral Unit with an established referral pathway, referring on to the AAISU where necessary.

A criminal investigation is but one outcome of effective safeguarding activity and the Constabulary is committed to delivering safeguarding primarily through a countywide Multi-Agency Safeguarding Hub which increases the opportunity for agencies to share information quickly and speedily. This enhances the opportunities for partnerships to ensure risk is identified and responded to in the most effective manner, leading to better outcomes for vulnerable people. A safeguarding approach is now embedded across the organisation from the moment of first call, with resources being prioritised based on an assessment of threat, risk and harm.

In 2014-2015 we have:

- Worked in partnership to transform the Multi Agency Referral Unit (MARU) into a Multi-Agency Safeguarding Hub (MASH) with adult safeguarding one of the priority thematic areas of the MASH.
- Worked in partnership with adult safeguarding leads from Peterborough and Cambridgeshire to develop and implement new referral protocols that are Care Act compliant. Having embedded such protocols we remain focused, along with partners within the MASH, to review such protocols and ensure they are effective. In partnership we will use meetings such as the MASH project Board or the Operation Leads meeting in order to do so.
- Used the Constabulary “Get Closer” media campaign to encourage people to report concerns of abuse of vulnerable adults. This was a month long media campaign. Internally this campaign raised the awareness and profile of the Care Act within the Constabulary.
- Carried out investigations into allegations of Adult Abuse, including working closely with Adult Social Care to investigate allegations made within the care home environment.

Detective Superintendent Chris Mead - Head of Public Protection

Cambridgeshire Fire and Rescue Service

In 2014/15 we have looked into the following risk areas:

Hoarding

In the last year we visited 80+ residents that display hoarding behaviours across Cambridgeshire and Peterborough and responded to emergency calls that resulted in 4 deaths and a growing number of near misses.

Following each domestic fatal fire, the service conducts a multi-agency Fatal Fire Review to establish any similarities or learning from these deaths. It was recognised that hoarding was a significant factor in some of these fires and due to these findings the service has instigated an awareness raising campaign for its frontline staff. This standard operating procedure guides staff on how to engage with residents, how to help them make small steps to reduce their hoarding and who to refer for assistance. An e-learning package has also been made available as additional learning.

Staff will also be using health’s Clutter Image Rating (CIR) to enable a robust and uniformed understanding of the level of clutter.

Advanced smoke alarms, carbon monoxide alarms and fire retardant bedding are just some of the tools being implemented with residents to further reduce their risk of dying should a fire occur

Overcrowded properties

A significant risk has been identified for those communities living in overcrowded properties if a fire should occur.

Again due to these findings, research and partnership working is being undertaken to establish where these properties are within local communities.

CFRS has been working with NHS England in anticipation of receiving Exeter data to enable real time risk profiling of local communities.

We are currently working on:

Creating a multi-agency (starting with Cambridge) protocol for dealing with individuals that display hoarding behaviour. This is as a direct result of the fire deaths and injuries and the Care Act which actually notes hoarding as a marker of self-neglect.

We have instigated e-learning packages for both adult and children's safeguarding for our front line staff.

Project ICARUS was instigated in Peterborough prison. Nominated staff from CFRS and the prison have been trained by a clinical psychologist to deliver a therapeutic treatment programme for female clients that have an index offence of arson. This is the first of its kind in the county, and to date the results are extremely encouraging with participants securing homes and employment when they are released. We are expanding the ICARUS programme to work with the probation service.

We have identified from our S11 return that front line staff need additional training regarding CSE, human trafficking and FGM

Wendy Coleman –Community Prevention & Safeguarding Manager
Community Fire Safety Group

Cambridgeshire and Peterborough Clinical Commissioning Group

The CCG is a commissioning organisation commissioning health services for the people for Cambridgeshire and Peterborough and is committed to safeguarding adults

Partnership working

CCG staff attend multiagency meetings in order to achieve partnership working. There has been regular attendance at the Cambridgeshire Safeguarding Adult Board meeting and its subgroups

- **Health Executive Safeguarding Board**
  The Health Executive Safeguarding Board is a subgroup of the SAB and takes a strategic view of health issues within safeguarding adults across the health economy working collaboratively with members of Cambridgeshire and Peterborough Local Authority Safeguarding adults teams

- **Safeguarding Adults Health Subgroup**
  The Safeguarding Adults Health Subgroup is a multiagency forum, including representation from both Cambridgeshire and Peterborough safeguarding adults teams, reviewing operational issues which reports to the Health Executive Safeguarding Board and had a collective work plan of

- Raising awareness of MCA/DOLs
- Monitoring of quality of care in care homes
- Developing a risk framework for referrals
- Sharing of information

.

Achievements in relation to Peterborough SAB priorities

Priority Area 1 - Effective safeguarding policies procedures and governance

- The publication of the Care Act 2014 and the supporting guidance in October 2014 resulted in a review of compliance within the CCG and an action plan developed in order to achieve full compliance. A review of procedures and training across agencies which is still ongoing.
- The monitoring of commissioned providers compliance with the Safeguarding adults requirements in the quality schedule of the NHS contract was undertaken by the CCG on a quarterly basis as part of the Clinical Quality Review meetings (CQRs) held with providers using the quality dashboard with metrics and RAG rated thresholds.
- There were issues with compliance with the training requirements particularly in relation to MCA/DOLS. Additional funding has been received from NHS England to facilitate this

Priority Area 2 - Improved response to safeguarding concerns

There was recognition within the CCG that the implications of the Care act required additional staffing and the posts of Named nurse and nurse for safeguarding adults were established.
The Designated Adult Safeguarding Manager was identified as being the Designated Nurse for Safeguarding Adults
Attendance at the local authority information sharing meetings

Priority Area 3 - Increased access and involvement.

There have been a number of large scale safeguarding investigations and Serious Case Reviews undertaken by Peterborough SAB and the CCG was involved in these by attending meetings, and writing Individual Management Review reports. Final Serious Case Review reports have yet to be published and recommendations implemented

Priorities and challenges for 2015 -2016

- Revise the CCG safeguarding adults policy and procedures
- Revise CCG PREVENT policy
- Agree the training needs analysis for types and levels of training for CCG staff and provide basic awareness training in safeguarding adults and PREVENT for all CCG staff
- Revisit the commissioned Providers and review their safeguarding adults arrangements in light of the new Care Act requirements and the changing landscape within the NHS
- Develop a plan for utilisation of NHS England monies for MCA/DOLS training for 2015/16
- Monitor compliance with the quality standards in the NHS Care Home contracts
- Review the recommendations from the SCRs to be published and ensure these are implemented within CCG commissioned services

Doreen Simpson - Designated Nurse for Safeguarding Adults and Serious Incidents

Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)

We provide mental health services, statutory social care services, children's community services and learning disability care. We support people to achieve the very best they can for their health and well being

Statement of purpose

Cambridgeshire and Peterborough NHS Foundation Trust is committed to the working with partner agencies to ensure the safeguarding of adults at risk of abuse.

Governance and Accountability

Safeguarding matters are reported to the Board via the Quality Safety and Governance committee. The Director of Nursing is the Executive Director with Board responsibility for Safeguarding Adults, The Head of Adult Safeguarding is the lead officer for adult safeguarding with responsibility for developing processes and procedures within the Trust.

2014-15 Achievements

- **Training -** CPFT has trained 97% of its staff in adult safeguarding as April 2015.
- **Staff supervision -** SOVA investigators are supported by the programme of monthly peer supervision meetings of the 'Peterborough CPFT Safeguarding Adults Group'.
- **Healthcare services -** Following the successful tender for provision of integrated services for older people, CPFT has from 1st April 2015 taken on responsibilities relating to community health care services.
- **CQC registration -** In 2014-15, CPFT declared compliance with CQC Outcome 7, safeguarding. A further CQC inspection was carried out during May 2015, and the report is due in August
- **Activity -** Safeguarding activity was consistent with the previous year with only a slight increase in referrals over 2013-14.
- **Training -** Training in adult safeguarding reached 97% compliance at March 2015
- **Partnership working -** Work has proceeded to develop a Multi-agency safeguarding hub (MASH) as a single point for referrals and triage of all adult safeguarding matters. It is anticipated that CPFT will be fully integrated into this partnership by autumn 2015.
- **Care Act 2014 -** CPFT has worked closely with partner agencies to implement the requirements of the Care Act 2014 and Making Safeguarding Personal.
- **Deprivation of Liberty Safeguards -** The number of DoLS applications has increased substantially following the Supreme Court ruling in the Cheshire West case[1]. Amended guidance has been produced to reflect the changes.

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[1] [1] "P v Cheshire West and Chester Council and another" and "P and Q v Surrey County Council" Supreme Court Judgment 19 March 2014

- **Policy and Procedures -** The CPFT adult safeguarding policy has been updated to reflect Care Act changes
- **Serious Case reviews & prosecutions -**There were no serious case reviews held under Peterborough procedures during 2014-15 involving people receiving a service from CPFT. However the Head of Adult Safeguarding contributed to the work of the Peterborough Serious Case Review Panel.

Priorities for 2014-15

- Ensure all staff receive appropriate training and are able to identify and respond to safeguarding issues, and that the target of 95% for staff training continues to be met
- Ensure compliance with attendance at Mandatory PREVENT training
- Develop a model for adult safeguarding appropriate to the Older Peoples Integrated Care and Neighbourhood teams.
- Ensure that each ward and community team in the adult services has a sufficient number of trained SOVA leads
- Work with partners (including Local authorities & Police to implement the Multi-agency Safeguarding Hub (MASH)

Paul Collin - Head of Adult Safeguarding

Domiciliary Care Provider Representative

As the Domiciliary Care Member for the board I am responsible for representing a significant number of providers supplying community care & support in Peterborough. Staff for the care and support services will supply support with personal care; support with meeting nutritional needs and support with medicines, as well as other domestic and social activities to allow people to remain living in their own homes as independently as possible.

Over the past year Health & Social Care has seen significant changes with the implementation of the Care Act 2014, the Fundamental Standards and the Care Certificate for training standards. Many providers have worked hard to ensure their organisations have made the relevant updates and changes to support the implementation of new legislation. Providers have almost ‘overhauled’ their training programmes to ensure the training now meets the newly required 15 standards of the Care Certificate. This has included having to update training staff to be able to further develop the workforce. Many providers have also held updates/refresher courses early to ensure existing staff are aware, and familiar, with the updated legislation and policies and procedures of their organisations.

The challenges faced by providers over the coming year are likely to be in relation to the Care Certificate – some providers have already sought my advice on how to compile adequate evidence to support meeting the standards of the care certificate for their newly recruited staff and I believe this will be an ongoing learning process for some time. The further challenge will be to help providers understand how they may be required to lead a safeguarding enquiry. This is a large responsibility to be accepted by a provider so we must ensure providers have a good, sound understanding of the process and expectations of the Local Authority.

Providers are likely to face a period of un-certainty during the re-tender of domiciliary care by Peterborough City Council later in the year.

From the providers who make regular contact with me, I have found lots of good work to be taking place in relation to ensuring service users are happy with the quality of their service provision. Providers complete regular audits and quality monitoring visits to people using their services to ensure they are happy and where issues are found, take action quickly. It's very positive to see that there is such a lot of good work taking place, often un-noticed, within the Peterborough provider Market.

Progress against priorities:

Priority Area 1 - Effective safeguarding policies procedures and governance

All providers have completed reviews of their safeguarding policies and procedures to ensure they are updated to reflect the Care Act 2014. Providers have also updated their training programmes including Safeguarding Adults to meet requirements of the Care Act 2014 and the meet the standards of the Care Certificate.

Priority Area 2 - Improved response to safeguarding concerns

The MASH has now been set up, county wide and is functioning. Which is great to see. This will dramatically improve partnership working and ensure the correct professionals are involved in the Safeguarding process. However, I think it is important providers are made more aware of the MASH and its function.
I think is also important to ensure providers understand how to raise Safeguarding concerns appropriately and by the correct route.

Priority Area 3 - Increased access and involvement.

Many providers now have their own way of monitoring concerns raised with their organisation that are not formal complaints. These concerns help to identify trends and to address the training and development needs of the organisations workforce. Providers have also ensured that the people using their services have access to information relating to Safeguarding including telephone numbers for the Local authority and the organisations safeguarding policy.
With the introduction of the Fundamental Standards and the Care Act 2014 which both express a clear need for increased service user involvement I believe providers will continue to work on ways in which to ensure service user's voices are heard and their involvement is recognised.

Matt Cedar-Hadman – Atlas Branch Manager

National Probation Service (NPS)

The National Probation Service (NPS) was formed in June 2014 as part of Her Majesty's Government Transforming Rehabilitation plans. The NPS's role is to protect the public, support victims of serious sexual or violent crime and reduce re-offending. We do this by:-

- Assessing risk and advising Her Majesty's Court Service and the Parole Board to enable the effective sentencing and rehabilitation of all offenders;
- Working in partnership with Community Rehabilitation Companies, the police, prisons and others to deliver effective offender management;
- Directly managing those offenders in the community, and before their release from prisons, who pose the highest risk of harm to others and who have committed the most serious offences.

Much of our work relates to assessing and managing offenders who are registered sexual offenders and offenders with a pattern of serious violent offending. Some of this work involves NPS working with other agencies under multi-agency public protection arrangements (MAPPA) and in multi-agency risk assessment conferences (MARAC). There are also NPS staff working in the local multi-agency safeguarding hubs (MASHs) to help protect some of the more vulnerable members of our community.

In terms of adult safeguarding, NPS contributes to multi-agency work to protect and support victims of abuse and neglect and adults at risk of abuse and neglect. This includes victims of domestic abuse.

Matthew Ryder - Head of Cambridgeshire Local Delivery Unit (LDU)
National Probation Service

Peterborough and Stamford Hospital Foundation Trust (PSHFT)

PSHFT is an acute foundation trust covering two sites, Peterborough City Hospital and Stamford Hospital. We provide acute healthcare services to the public for 5 local authorities. We discharge our safeguarding arrangements to the local authorities who are the Lead Agents for Safeguarding Adults at risk of abuse.

PSHFT are active partners in the multiagency safeguarding meetings and contribute relevant health information to individual cases and provides general information to the boards and the CCG.

Priority Area 1 - Effective safeguarding policies procedures and governance

- PSHFT have a bi-monthly joint Adults and Children's safeguarding committee where current information is discussed with action plan in place.
- PSHFT have a local policy and procedure for staff to follow and this has been reviewed and amended in light of the Care Act 2014 and local interim guidance.

- PSHFT have employed a Safeguarding Adults Lead Nurse who has been in post since June 2014.
- Training presentations have been updated to reflect the new legislation.
- MCA and DOLS applications for authorisation are completed and sent to the local authority for approval. We have experienced an increase in demand but continue to provide timely response although the approval for authorisation were not received from the local authority in 2014/15

Priority Area 2 - Improved response to safeguarding concerns

- The appointment of the Safeguarding Adult lead nurse has improved our response and feedback to staff raising a concern.
- Training mandatory compliance has increased significantly with increased opportunities including e-learning during Q3 & Q4 which met the CCG commissioning requirement.
- Training for clinical staff in MCA and DOLs is 91%
- Training for all staff in Safeguarding is at 97%
- Enhanced recording and monitoring of MCA and DOLs applications and authorisations and informing the CQC on discharge has seen an improvement however local authority DOLS teams are still slow to give approval due to the Cheshire & West high court ruling.
- Audit processes have been built into the yearly plan for PSHFT
- Safeguarding Adults Handbooks have been given to every member of staff, developed by Midland and East Strategic Health Authority in 2012 and updated in 2015.

Priority Area 3 - Increased access and involvement.

- Continue to educate staff on the Notification of Concerns via the e-referral system on e-track and ensure consent gained and work in partnership with the local authority safeguarding leads.
- The Safeguarding Adults Lead Nurse has been in attendance at the large scale investigations and serious case reviews. She has provided comprehensive Individual Management Review reports for patients attending PSHFT. Any lessons learnt from the cases fed back to Trust Management via the Safeguarding Committee.
- Safeguarding and the prevention of significant harm is discussed weekly at the Chief Nurse Rapid review meetings and any concerns are documented and actions taken. We are actively reporting safeguarding concerns which occur within PSHFT and work in partnership with the Risk manager ensuring that we are open and honest and demonstrate duty of candour.

Priorities for 2015/16

- Finalise the local policy and procedures once final guidance received from the local authority
- Work within the MASH in an efficient way
- Work closer with the security team at PSHFT around the Prevent Agenda
- Lessons learnt and feedback to individual staff who raise concerns
- Local authority feedback required to give closure to staff
- Audit of safeguarding policies and procedure by internal audit team

Donna Phipps – Named Nurse for Safeguarding

Regional College – Peterborough

We are a further education college based in the heart of Peterborough, offering full and part-time courses, apprenticeships and higher education courses.

10% of our learners have learning difficulties ranging from mild to severe and multiple difficulties (2% moderate to severe). 14% of our learners have disabilities including visual and hearing impairment, physical and medical health difficulties. Additional learning support is provided for over 1750 learners. These learners are studying in both our main stream provision and our Inclusive Learning department. There are currently 70 learners in our Inclusive Learning Department studying a range of programmes from awards in personal and social development, skills for working life, skills for independent living and skills to enable progression.

New initiatives

We have updated our policies to reflect the new Keeping Children Safe in Education 2015, Working Together to Safeguard Children 2015, The Care Act 2014 and the Prevent Duty 2015.

There have been ongoing developments with our inclusive learning students to increase their inclusivity within the college. Additional qualifications have been developed with an emphasis on progression. We have an extensive range of part-time programmes to provide greater access/participation in college life for young adults who are preparing for independent living and study.

The Inclusive Learning Department are setting up House with Assistive Technology so that both learners and Adult Social Care can use the facility to train young people in using assistive technology as part of their normal daily lives. We are liaising with the LA to get some assistive technology installed over the summer to ensure a full and useful timetable for the house both internally and by some of our external colleagues.

There has been a great deal of collaborative working to implement the SEND reforms to include ‘Working together to help young people with special educational needs and disabilities achieve good futures’ in association with Preparing for Adulthood, DfE, and AoC and a ‘Planning Live’ event in association with Preparing for Adulthood and Peterborough Local Authority.

The Principles of Person Centred Planning Training was delivered in December 2014 to across college staff.

There has been a great deal of activity to ensure compliancy with the new Prevent Duty to include further Business continuity training from NaCTSO for senior staff and WRAP training for all staff. Two members of staff have done Train the Trainer training. An action plan/risk assessment has been developed to address all requirements of the new duty. The College now has representation on the Peterborough Prevent Strategic Board and Cambs Channel Panel. The safeguarding

policy, IT policies and Whistleblowing policy have been updated and specific reference included to training materials.

We have developed mental health awareness training for tutors and those with pastoral support responsibilities as we are having increasing numbers of students with mental health problems. This will be delivered in July.

Impact

- Students say that they feel safe in College.
- Staff and students are aware of College Safeguarding procedures and who to approach with concerns.
- All concerns and referrals are dealt with in a timely and appropriate manner.
- Excellent retention, success and destinations of supported learners
- Through our Learner Involvement Strategy we have developed a supportive and secure environment that helps young people feel valued and confident that they will be listened to.
- Retention of LAC/Care leavers has increased by 1% to 89%

Priorities for 15/16

- Continued staff training to include Mental Health/EBD.
- Implementation and monitoring of the Prevent Duty
- We are putting a bid together for funding to support the training of systematic instruction and train the trainer roles to be submitted to Peterborough Local Authority. Both of these training requirements will support the College's development of programmes in Supported Employment and Job Coaches
- There is still a need for cross college staff to be aware of the impact of the reforms and person centred planning. Section E and F of EHC plans detail learner's specific outcomes and objectives for teaching and support staff, which will need to be planned and measured. The contribution and measurement of these will impact on learners funding and the continuation of plans.
- The retention of our looked after/care leavers continues to be a priority which means that their attendance and retention will be closely monitored and there will be targeted interventions to ensure that they are retained.
- We need to consider and plan for the following to accommodate future learners and grow the supported learning provision:
- Training for teaching and support staff:
  - Intensive instruction/interaction
  - Total communication
  - Makaton
  - PECS (picture exchange communication)
  - Augmentative communication
  - Specialist VI/HI/Sensory/EBD for PMLD
- Curriculum development:
  - Courses need to be delivered using the above elements
  - Dual placements with Sense
  - Partnership with Phoenix to demonstrate route to PRC

Joanne Hather-Dennis - Executive Director – Students

Safer Peterborough Partnership (SPP)

The SPP involves a number of statutory and voluntary organisations who work together to deliver the priorities of the Safer Peterborough partnership. They work in partnership with a wide range of other services across the public and voluntary sector and community groups that contribute significantly to community safety.

Achievements:

Operation Launch

A multi-agency response to people trafficking in Peterborough and country wide. A Police led operation which SPP was involved in and in particular the setting up of a rescue centre. This involved ensuring their physical and mental health then assessing the rescued individuals for residency in the UK or support in returning to their own countries if they wanted or had no right to work and remain in this country.

Daily Management Meeting (DMM)

As its name suggests this happens daily. It takes place at 10:00 at Bayard Place and is chaired by a range of different people from across the SPP such as the police, Cross Keys Homes, Fire Service, HMP Peterborough and the city council.

The DMM process is supported by documentation which is a record of:

- what priorities have been set for a 24 hour period
- updates on the previous 24 hour priorities
- updates by exception from SPP partners and other relevant parties and areas of the city council which are deemed to require attention or partnership working solutions applied
- quarterly priorities from the 9 x Safer Stronger Neighbourhood Panel meetings
- ongoing problem solving activities
- upcoming events which will allow partners and beyond to engage with the citizens of Peterborough to further objectives

What partners provide:

- update your organisations section on the supporting documentation before 0930 each day with issues of exception which you deem to require attention or partnership working solutions to help resolve
- attend the DMM if your organisation has highlighted an issue of exception. Attendance for those not based at Bayard Place means being on the end of a telephone if you are unable to attend the meeting at Bayard Place
- update your organisations section on the supporting documentation with ‘nothing to add’ should your organisation have no issues of exception to bring to the DMM
- update your organisations section on the supporting documentation with the latest position on any issues of exception which have been brought to the DMM
- appoint a deputy so that should you be unavailable the DMM process can continue
- to act as the single point of contact (SPOC) for your organisation and nominate a deputy should you be unavailable

Streetlife meeting:

Following an increase in anti- social behaviour issues, primarily caused by those with street-based lifestyles, a multi-agency group was formed to identify offenders and to adopt a 3 strand problem solving approach of:

Education: in the main this is to the general public, specifically around supporting begging in the City
Engagement: with the offender in terms of support services
Enforcement: action taken against those who persistently commit ASB and refuse services

The partners involved include; PCC Housing Needs (Rough Sleeper Outreach worker), Peterborough & Fenland MIND, Drinksense, Aspire, PCC City Centre Services, City Centre Policing team, Police licencing team, PCC ASB Lead, Community Recovery Manager. The group meets every 4-6 weeks (depending on shift patterns) and some partners are involved in group early morning dawn patrols to identify those rough sleeping and provide support and advice.

The offenders are case managed via the use of ECINS to which most partners have access and information sharing is greatly improved.
The current caseload contains a cohort of 25 people.

MARAC

MARAC is a multi-agency conference that is well established in Peterborough with key agencies attending bi-weekly, to share information and complete safeguarding and target hardening for the protection of victims and their family's from domestic abuse. During 2015 we have heard 220 cases over 13 meetings, this is an average of 16.9 cases each conference.

We have partners that attend to represent the victim the children and the perpetrator to enable a full picture is shared of the situation.

The partners that attend MARAC regularly are as follows:

Police, W/aid, Probation, A&E, children's services, education, drug services, drink services, mental health, adult social care, Cross Keys and housing options, updates are received from children's health, the prison and the fire service, and they will attend if required to. This allows for wrap around provision and support with high level information exchange to ensure all partners are aware of the stages that others maybe at when working on cases which allows for greater ease and efficiency when supporting change within family or partnership groups.

New Initiatives:

Street Sex Working

We chair a multi-agency case management meeting which is held once every six weeks. The case management of the sex workers is recorded on ECINS and each profile is RAG rated to aid the multi-agency team in directing their efforts to those most vulnerable, at risk and in need of safeguarding and support.

There are currently 14 on-street sex workers on the case management system. All existing and new profiles are now routinely cross-referenced by the MARAC Co-ordinator to identify if they have an association with any known perpetrators of domestic abuse.

The Community Safety team is now also registered to the National Ugly Mugs Scheme so that reports of attacks on known workers or those suspected of sex working can be uploaded whilst at the same time monitoring reports of incidents in Peterborough and close surrounding cities.

Several workers had reported to the Police and the Pathway 8&9 Lead at Outside Links that they would benefit from outreach from the various support agencies. As such a request was put to the SPP Delivery Board and granted for a small budget to run a pilot evening outreach project held at Outside Links aimed at safeguarding sex workers and those thinking of entering or returning to this trade, as well as improving their engagement with support services. This will be delivered through:

- Promotion of the 'Ugly Mugs' scheme (a national database of 'customers' who present a high safety risk to those in the sex industry)
- The opportunity for the sex workers to share information with agencies and one another about 'customers' who present a significant high risk
- Sexual health checks and free contraception
- Gathering of intel in relation to the safeguarding of the known street workers and those that are not currently known to services
- The opportunity to speak with support services outside of standard office hours (which can seem inaccessible to some).
- Information on support services available in Peterborough
- Referrals to other support services relevant to their needs

In the interim, monthly evening outreach has been conducted with the Police Op Can Do team and two partner agency representatives, one evening per month. In addition, Aspire runs women only Wednesdays at Outside Links which is open to all women, but is often attended by the sex workers. The Community Safety Officer often attends these sessions to offer support and build relationships with the sex workers.

Seven street workers are currently in receipt of 3 month warnings for loitering within the known red light area. Six women have been prosecuted over the last 12 months and four Engagement and Support Orders issued.

One female has been served a Criminal Behaviour Order (CBO) under the Anti-social Behaviour, Crime & Policing Act 2014. In addition to placing specific prohibitions, the order also imposes positive requirements on her.

There has been a reduction in the number of active sex workers operating within the Burghley Road, Park Road and Church Walk area (19 sex workers reported in June 2014 to currently 14).

Andy Barringer - Community Recovery Manager (sub-group member)

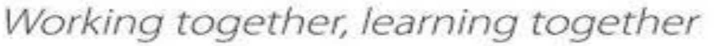
APPENDIX B

Peterborough and Stamford Hospitals
NHS Foundation Trust

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

For further information about the Peterborough Safeguarding Adults Board, please contact:
Jo Procter, Head of Service, Adults and Children's Safeguarding Boards

Telephone: 01733 863765
Email: joanne.procter@peterborough.gov.uk
Website: www.peterborough.gov.uk/safeguardingadults



Bedfordshire
Northamptonshire
Cambridgeshire
& Hertfordshire
Community Rehabilitation Company

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 12
10 DECEMBER 2015		PUBLIC REPORT
Contact Officer(s):	Matthew Smith, Assistant Director of Improving Outcomes	Tel. 01223 725389

PRIMARY CARE PROGRAMME UPDATE

R E C O M M E N D A T I O N S	
FROM: Matthew Smith, Assistant Director, Improving Outcomes	**Deadline date:** N/A
That the Health and Wellbeing Board note this report.	

1. ORIGIN OF REPORT

1.1 This report is submitted following a request from the Health and Wellbeing Board.

2. PURPOSE AND REASON FOR REPORT

1.2 The purpose of this report is to provide additional or background information requested by the Health and Wellbeing Board regarding Cambridgeshire and Peterborough CCG's Delegated Commissioning application.

3. BACKGROUND AND OVERVIEW

3.1 Under the Health and Social Care Act (2012) responsibility for commissioning and contracting most hospital, community and primary care services are as follows:

- NHS England hold the main GMS / PMS contract with GP practices, including the Quality and Outcomes Framework (QoF) and nationally directed enhanced services. NHS England also contract with dentists, optometrists and community pharmacies.
- Cambridgeshire & Peterborough CCG commission and contract for most hospital and community services, and also local enhanced services which are usually provided by GP practices.

3.2 Since April 2015, the CCG and NHS England formed a Joint Committee to 'co-commission' GP practice services (but not dental, optometry or pharmacy). The intention is to ensure decisions make sense locally for Cambridgeshire and Peterborough and complement decisions we make about hospital and community services. However, funding and ultimate responsibility for GP contract decisions remains with NHS England.

Delegated commissioning – Pros and Cons

3.3 In November 2014 NHS England wrote to CCGs to invite them to apply for 3 levels of greater involvement in commissioning primary care services (greater involvement; joint commissioning; and delegated commissioning). As described above, the CCG entered a joint commissioning arrangement with NHS England in April 2015. The CCG has been considering for several months whether or not to apply for full delegated commissioning (and has been engaging with local stakeholders throughout the process), which would be effective 1 April 2016.

3.4 In brief, the advantages of taking on delegated commissioning are:

- Strengthening and developing primary care is key to the CCG's wider service strategy. At the same time local practices are facing many financial and capacity challenges. Greater local control over decisions affecting the future of primary care is likely to help us deliver better, more sustainable services for patients and support primary care providers.
- One of our aims is to secure more joined up provision of primary, community and hospital services. Delegated commissioning of primary care would help the CCG to do this by bringing together decisions across the whole patient pathway
- The CCG has a good level of local clinical and management knowledge about local services, and our sole focus is on improving care for Cambridgeshire and Peterborough patients within the funds available. In contrast, the NHS England 'sub regional team' has to cover a very wide geographical area and prioritise the most pressing primary care issues which are not necessarily in our patch. NHS England has had to make significant reductions in its staffing budgets which further reduces their capacity to focus on Cambridgeshire and Peterborough matters.

3.5 However, the decision is not straight forward – there are a number of issues and risks to be aware of:

- Taking on responsibility for delegated commissioning of GP practice services increases the risk of real or perceived conflicts of interest. We would manage this risk by adhering to national guidance on how decisions were made to ensure that they were transparent. This would include a lay and executive majority committee meeting in public with representatives from our local Healthwatch organisations and our Health and Wellbeing Board, a register of interests developed in line with the NHS England Statutory Guidance, and an enhanced declaration of interests and register of procurement decisions. It is worth noting that 63 CCGs have already taken on delegated commissioning, and that we already have processes to manage decisions on Local Enhanced Services.
- Delegated commissioning would change the functions and Constitution of the CCG. This means that Member practices would need to support the decision to apply for it. For this reason, the CCG Governing Body has taken into account GP views, including those gathered from an LMC survey of individual GPs and Practice Managers, and a ballot of member practices in September.
- The CCG would need to be assured that there was sufficient funding for the services it would be commissioning. We have begun a 'due diligence' process of checking NHS England's budgets for primary care and our application would be subject to the outcome of this process.
- The CCG would also need to be confident that there were enough staff with the right skills and experience to do the work associated with delegated commissioning. We are in discussion with NHS England about how staff transfer might work. The CCG has a number of staff who have experience of working with primary care, managing contracts and pathway re-design.

3.6 The CCG's Governing Body has considered the potential risks and is confident that mitigating actions can be put in place. A 'due diligence' exercise is being carried out to assure the Governing Body that the CCG has the required budgets and resources to take on delegated commissioning.

Application to NHS England

3.7 The application to take on delegated commissioning was submitted to NHS England on 6 November 2015. The application is still subject to final CCG Governing Body sign off in the New Year (including due diligence, staffing, and associated governance documentation). It is anticipated that NHS England would make a decision on the application by early 2016. Delegated commissioning would then commence from 1 April 2016

3.8 Based on a working assumption that the application will be approved, the next steps for the CCG are:

- to fully work through the functional and structural requirements to clarify responsibility and required levels of resource,
- to add detail to the committee structures and governance arrangements,
- to continue to work with NHS England to ensure the required data sharing arrangements can be facilitated, and
- to continue to pursue financial due diligence on the budget assumptions and apportionment methodologies.

3.9 The Governing Body will need to assure itself on financial and resource implications in early 2016 before giving the final go ahead for 1 April 2016. The CCG would seek to work closely with NHS England, the Local Medical Committee, members and other stakeholders throughout this process.

4. ENGAGEMENT

Member Practice ballot

4.1 As the move to delegated commissioning would be a significant change to the responsibilities of the CCG and would require a change to the CCG's Constitution, it was necessary to seek member support for making the application. A survey of GPs and Practice Managers was undertaken in July 2015, which received 212 responses. The survey showed that the 'large majority see both potential risks and benefits, and think the decision is a difficult one,' but that completing due diligence on budgets and resources was key'.

4.2 In September 2015, GP practices in Cambridgeshire and Peterborough CCG's area were sent a letter asking them to endorse (or not) the following recommendation:

- That the CCG submits an application on 6th November 2015 to take on delegated commissioning of primary medical services from April 2016, subject to final assurance on the budgets and resources.

4.3 The vote returned a majority of 62.7% of practices (based on a turnout of 77.6%) in favour of submitting an application for delegated commissioning of primary medical services. This represents 52 'yes' votes and 31 'no' votes from the 83 practices that voted.

4.4 The results indicate that the majority of practices endorsed the Governing Body recommendation and gives the CCG a mandate to apply for delegated commissioning, subject to the conditions laid out above.

5. REASONS FOR RECOMMENDATIONS

5.1 This report is for information and noting.

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HEALTH AND WELLBEING PARTNERSHIP DELIVERY BOARD

Terms of Reference
November 2015

Purpose of Board

1. To be accountable to the Health and Wellbeing Board and drive through the Board's key priorities through the associated partnership boards

2. To inform and develop the Joint Strategic Needs Assessment and Health and Wellbeing Strategy

3. To delegate tasks to existing boards that sit below the Health and Wellbeing Board and set up task and finish groups as needed to deliver the Health and Wellbeing Strategy

4. To monitor the performance of the boards that sit below the Health and Wellbeing Board and task and finish groups set up to deliver the Health and Wellbeing Strategy

5. To support the boards that sit below the Health and Wellbeing Board and task and finish groups in facilitating performance against the Health and Wellbeing Strategy, challenging performance where necessary

6. To report performance against the Health and Wellbeing Strategy to the Health and Wellbeing Board, seeking assistance in addressing blockages to delivery where necessary

7. To report to the Health and Wellbeing Board on a regular basis, identifying issues, challenges and barriers and seeking their guidance and direction in addressing these issues

8. Delivery Board members are expected to work together outside of meetings to ensure that problem solving and sharing resources is embedded into the work to deliver against the Health and Wellbeing Strategy and to co-opt of activities when required

9. To support the development of the Health and Wellbeing Board and the setting of the agenda

10. To review the Terms of Reference and membership on an annual basis

Organisation of meetings

1 The Board will meet on a bi - monthly basis

2 The Board will be serviced by the Corporate Director of People and Communities office Manager with agendas and papers circulated in advance of the meetings.

Membership

Chair
Corporate Director People and Communities

Vice Chair
Service Director Adults and Communities

Members
Children and Families Joint Commissioning Board – Claire Higgins and Lou Williams
Public Health Board – Dr Liz Robin
Joint Commissioning Forum Cathy Mitchel/ Alan Sadler
Housing Partnership – Simon Machen
Mental Health – Janet Dullaghan
Education & Skills – Pat Carrington
CPFT, Uniting Care – Deborah Cohen

Advisers
Senior Analyst Public Health
Performance Officer – Helen Gregg
Business Management and Commercial Operations – Oliver Hayward
Other advisors identified as necessary

Any meeting with less than 4 members present (regardless of the number of advisers) will be deemed to be inquorate.

UPDATED: 19 NOVEMBER 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**

MEETING DATE	ITEM	CONTACT OFFICER
10 December 2015	Amended Health and Wellbeing Board Membership and Terms of Reference	**Wendi Ogle-Welbourn**
	Cambridgeshire and Peterborough Health and Care System Transformation Programme	**Andy Vowles/Fiona Head**
	Prevention Work for the Health System Transformation Programme	**Emma de Zoete/Tess Campbell**
	Substance Misuse Whole Treatment Service Retender	**Andy Barringer**
	Adult Social Care, Better Care Fund Update	**Will Patten**
	Draft Peterborough Joint Health and Wellbeing Strategy 2016-19	**Liz Robin**
	Peterborough System Winter Plan	**Cathy Mitchell**
	For Information:	
	Annual Reports - Adult Safeguarding Board and Local Safeguarding Childrens Board	**Russell Wate**
	Primary Care Programme Update	**Cathy Mitchell**
	Amended Health and Wellbeing Partnership Delivery Board – Terms of Reference	**Wendi Ogle-Welbourn**
24 March 2016	System Transformation Programme	**Andy Vowles**
	CCG Operational Planning 2016/17	**Cathy Mitchell**
	LA Operational Planning 2016/17	**Wendi Ogle-Welbourn**
	Migrant workers JSNA	**Liz Robin**
	Health protection Annual Report	**Liz Robin**
	Better Care Fund update	**Will Patten**
	Joint Child Health Commissioning Unit Review	**Wendi Ogle-Welbourn**
	Health and Wellbeing Strategy 2016-19 Final Sign off	**Liz Robin**
	Healthwatch Update	**David Whiles**
	Health and Wellbeing Partnership Delivery Board – Performance Report	**Wendi Ogle-Welbourn**
	Joint Procurement - Integrated Lifestyle and Weight Management Services	**Liz Robin**
	Adult Mental Health Joint Strategic Needs Assessment	**Liz Robin**
	For Information:	