PETERBOROUGH CITY COUNCIL

HEALTH AND WELLBEING BOARD

THURSDAY 25 SEPTEMBER 2014
1.00 PM

Bourges/Viersen Room - Town Hall
Contact – Gemma.george@peterborough.gov.uk, 01733 452268

AGENDA

Page No

1. **Apologies for Absence**

2. **Declarations of Interest**

3. **Minutes of the Meeting held on 17 July 2014** **3 - 12**

4. **Health and Wellbeing Board Membership**

   For the Board to receive a verbal update.

5. **Programme Board Performance Report Update** **13 - 20**

   For the Board to note the update report.

6. **NHS England / Local Board**

   (a) **Challenged Health Economy Work**

   For the Board to receive a verbal update.

7. **Clinical / Local Commissioning Groups**

   (a) **Better Care Fund Submission** **21 - 130**

   For the Board to note the report and agree the recommendation as contained within the report.

8. **Public Health**

   (a) **Health Protection Exception Report** **131 - 140**

   For the Board to note the report and agree the recommendations as outlined within the report.

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 Gemma George on 01733 452268 as soon as possible.

(b) Update on the Cardiovascular Disease Priority Work Programme **141 - 156**

The Board is requested to note the report and agree the recommendations as outlined within the report.

OTHER ITEMS

9. Performance Report on Sexual Health Services **157 - 160**

The Board is requested to note the report and update.

10. Recruitment of GPs and Other Health Professionals **161 - 170**

The Board is requested to note the report and to suggest any additional activities.

11. Schedule of Future Meetings and Draft Agenda Programme **171 - 172**

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

Board Members:
Cllr Cereste (Chairman), Cllr Lamb (Vice Chairman), Cllr Fitzgerald, Cllr Holdich, Cllr Scott, Gillian Beasley, David Whiles (Healthwatch), Dr Caskey, Dr Van den Bent, Dr Gary Howsam, Dr Rigg, Jana Burton, Cathy Mitchell, Andrew Reed, Andy Vowles, Sue Westcott, Dr Henrietta Ewart, Wendi Ogle-Welbourn

Co-opted Members: Russell Wate and Claire Higgins

Substitutes: Dr Harshad Mistry
Further information about this meeting can be obtained from Gemma George on telephone (01733) 452268 or by email gemma.george@peterborough.gov.uk

PETERBOROUGH CITY COUNCIL

MINUTES OF A MEETING OF THE HEALTH AND WELLBEING BOARD HELD IN THE BOURGES / VIERSEN ROOMS, TOWN HALL ON 17 JULY 2014

Members Present:	Councillor Marco Cereste, Leader of the Council (Chairman) Councillor Diane Lamb, Cabinet Advisor for Health (Vice Chairman) Councillor Fitzgerald, Cabinet Member for Adult Social Care Councillor Scott, Cabinet Member for Children's Services Gillian Beasley, Chief Executive, PCC Jana Burton, Executive Director of Adult Social Care and Health and Wellbeing, PCC Sue Westcott, Executive Director of Children's Services, PCC Andy Vowles, Cambridgeshire & Peterborough Clinical Commissioning Group Cathy Mitchell, Cambridgeshire & Peterborough Clinical Commissioning Group Dr Richard Withers, Cambridgeshire & Peterborough Clinical Commissioning Group, Borderline LGC Dr Ken Rigg, South Lincolnshire CCG Andrew Reed, National Commissioning Board Local Area Team David Whiles, Peterborough Healthwatch
Co-opted Members Present:	Claire Higgins, Chairman of the Safer Peterborough Partnership
Also Present:	Wendi Ogle-Welbourn, Director for Communities Dr Henrietta Ewart, Interim Director of Public Health Tracey Cogan, Head of Public Health, NHS England, East Anglia Dr Shylaja Thomas, Screening and Immunisation Lead, NHS England, East Anglia and Public Health England Gemma George, Senior Governance Officer

1. Apologies for Absence

Apologies for absence were received from Councillor Holdich, Russell Waite, Dr Van den Bent and Dr Caskey.

2. Declarations of Interest

There were no declarations of interest.

3. Minutes of the Meeting Held on 27 March 2014

The minutes of the meeting held on 27 March 2014 were approved as an accurate record.

4. Health and Wellbeing Board Membership

The Board received a report following the Health and Wellbeing Peer Review which had been undertaken in March 2014. The Review had suggested that the membership of the Board was heavily weighted towards the local authority and that consideration should be given to a better balance, particularly in respect of Health.

Wendi Ogle-Welbourn, the Director of Communities, introduced the report and requested that Members consider the number of people they thought appropriate to sit on the Board, as

well as the makeup of the Board. It was suggested that consideration be given to the following:

- That the Board be made up of one third local authority, one third health and one third other, to be commissioners only (as the Health and Wellbeing Programme Board's membership included providers) if they could evidence their added value to the makeup of the Board;
- That it may be appropriate for the Vice Chairman of the Board to be someone from the Clinical Commissioning Group (CCG); and
- A request received from the Police to have a place on the Board and for all future requests to be in writing, detailing how the agency/organisation could add value to the Board.

Members debated the report and comments and responses to questions included:

- It was suggested that a formal written request be submitted to the CCG via the Chief Operating Officer and the Chairman, requesting a Council place on its Board. This could be undertaken jointly with Cambridge. Local authority membership would be advantageous and this process was becoming standard across the country;
- Closer working between the Local Authority and the CCG would be beneficial in the long term;
- Further clarification was sought as to what added value the Police would bring to the Board;
- There was a consensus between providers that they felt 'out of the loop', and therefore the right balance needed to be struck with regards to their involvement;
- It was suggested that the Chairmanship could be alternated between the local authority and Health to ensure greater health professional representation. In response to this point it was stated that it was important to have a consistent Chairman as well as a consistent Vice Chairman;
- It was further suggested that membership could extend to a representative from the hospital;
- A Chairman and Vice Chairman could be elected from nominations within the Board Members;
- Providers sat on the Health and Wellbeing Programme Board (HWPB) and they could also attend any meeting of the HWB in order to make a case, as long as it was of a strategic nature;
- The rationale behind the Police representation was due to their focus being very much around victims, including resourcing work around the drug and alcohol agenda and treatment of victims of domestic abuse. It was felt that they could bring to added value to the Board, forming part of a wider prevention and intervention strategy;
- Parties who wished to sit on the Board should be evaluated on their own merits;
- The focus of the Board was around Health and Wellbeing and commissioners. Therefore it was felt that providers would not be best placed to sit on the Board;
- The Vice Chairman should be a CCG Board Member;
- There needed to be a discussion around the local authorities involvement with the Local Commissioning Group (LCG), which would be discussing the local strategy and delivery of services around Peterborough;
- Providers needed to be on board in order to ensure progression and delivery;
- The HWB must not lose sight of its purpose and how it was influencing the delivery and provision of Health and Wellbeing for the population;
- Concern was expressed about expanding the membership to a degree that it could impact upon the decision making of the Board and make the Board less focussed;
- The Police argument was more operational in nature. They had many platforms and were represented on the Safer Peterborough Partnership (SPP), the Chairman of this Board being a co-opted Member on the HWB. It was therefore felt that any issues

could be channelled through the Chair of the SPP back to the HWB for consideration. This proposal would be relayed back to the Police and it was proposed that they be permitted to present in future, should they feel that they had a case to pursue for a seat on the HWB; and

- It was proposed that the thirds be made up of statutory members plus five others from each third and that nominated deputies be included within the membership list. The Chairman further requested that an initial membership list be drafted for circulation.

RESOLVED

The Board noted the report and agreed that:

1. The make-up of the Board should be in thirds, from the Local Authority, Health and Others, with statutory members and five others from each third and nominated deputies as appropriate;
2. That a CCG member should be the Vice Chairman of the Board;
3. That the Police would not be invited as a Member at the current time, instead for them to utilise the SPP as a platform for relaying issues to the Board. Future presentations to be accepted from the Police should they wish to put a written case forward for a seat on the Board.

It was further agreed that:

1. A formal written request would be submitted to the CCG, jointly with Cambridge, via the Chief Operating Officer and the Chairman, requesting a Council place on its Board; and
2. That an initial membership list, taking on board the agreed makeup, would be drafted for comment.

5. NHS England / Local Board

(a) East Anglia Screening and Immunisation Performance Report

Tracey Cogan, Head of Public Health, NHS England, East Anglia and Dr Shylaja Thomas, Screening and Immunisation Lead, NHS England, East Anglia and Public Health England introduced a report and gave a presentation to the Board which provided an update on screening and immunisation. Key points highlighted included:

- The presentation followed a recommendation from the Peer Review that the Board should be assured and informed of the performance around screening and immunisation in Peterborough;
- It was agreed that exception reporting would be undertaken going forward to each meeting of the Health and Wellbeing Board;
- The report was vital and it needed to outline the progress made in each area. Improvements needed to be made in screening rates;
- The presentation highlighted the commissioning arrangements, the delivery arrangements and the current picture for Peterborough;
- There were a number of programmes currently commissioned by NHS England East Anglia for the population of Peterborough;
- There were a number of delivery arrangements including GPs, the Cambridgeshire and Peterborough Foundation Trust and Cambridgeshire Community Services, amongst others;
- An overview of the Abdominal Aortic Aneurysm Screening Programme was provided. This screening programme was based on lowering mortality rates in men;
- Community Pharmacies had been commissioned for the first time in 2013 to support GPs for the delivery of flu immunisation programmes within at risk groups;

- Performance processes were outlined, including quarterly Screening Programme Boards and the inspection of the screening service on a three yearly basis amongst others;
- The Childhood Flu Programme had been rolled out in a pilot programme 2013, this being a nasal spray vaccine licensed for use of children between the ages of 2 and 16. The main benefit of giving the vaccine to children was to ensure the illness was not passed on to adults within the family. It was to be piloted in secondary schools in 2014;
- The Performance and Quality Monitoring Group met monthly, with a number of Boards feeding into it. Performance could be monitored and actions identified in order to bring performance back on track if required;
- The majority of immunisation and screening programs were doing well in Peterborough including breast screening uptake rates and diabetic eye screening uptake rates;
- Across the programme, 25% of those booked in for abdominal aortic aneurysm screening appointments failed to attend. Further work needed to be undertaken in order to highlight the importance of this screening;
- Improvements needed to be made in relation to uptake for some other screening programmes, such as bowel cancer and cervical screening in younger women, and improvements also needed to be made in relation to the uptake for some immunisation programmes, particularly flu immunisation programs; and
- A number of recommendations were highlighted within the presentation in order to progress the issues forward, these being:

    i. For the Board and individual member organisations to work collaboratively with NHS England and Public Health England to promote screening and immunisation in Peterborough;
    ii. For the Board and individual member organisations to work in partnership with NHS England and Public Health England to address the lower uptake by particular groups, including those from deprived and ethnic communities;
        - Cervical screening in younger women
        - Bowel screening
        - Childhood immunisations to achieve 95%
        - Flu vaccinations for 'at risk' groups and pregnant women to achieve 75%

    iii. To agree the setting up of a task and finish group with multi agency membership to implement recommendations 1 and 2 above

Members were invited to comment on the presentation and points raised and responses to questions included:

- Further work needed to be undertaken as to the reasons behind people not attending their screening sessions;
- Younger women were becoming increasingly less likely to undergo cervical screening, and this was a trend seen across the country, not just in Peterborough;
- Extended hours or evening clinics may be a solution to the problem of low uptake of cervical screening;
- The Cambridge and Peterborough bowel cancer screening programme had low uptake in comparison to other authorities;
- It needed to be identified where the health promotion budget sat;
- There appeared to be little in the way of clear strategy outlined within the presentation;
- A further presentation was needed with more locality-specific analysis to be able to analyse problems and present data in a way more suitable to the Health and Wellbeing Board's remit;

- The decisions around age limits for screenings were made by the National Screening Committee, a body of Public Health England, all decisions being backed by evidence before being implemented as policy;
- If at risk people were identified early, such as those at risk of flu, this would improve outcomes in the long term;
- There needed to be a more proactive approach to screening and immunisation in order to provide greater value for money and greater uptake. If evidence could be gathered as to the savings that proactive improvements would make, this could make obtaining future finances easier;
- It was suggested that in the first instance, further work be undertaken via the Health Enquiry Group, which was led by Cathy Mitchell, CCG, and Dr Henrietta Ewart, Interim Director of Public Health. This work would identify whether there were opportunities to work differently and how to achieve better engagement. It was further suggested that Healthwatch be involved in this initial work as they had recently won an award in engaging hard to reach groups;
- The implementation of a task and finish group could not be supported at the current time. The situation was extremely complex and the research needed to be clearer, as did the methodology, membership and terms of reference of any proposed group;
- The rationale behind the report being presented to the Board in the first instance had been to address the levels of screening, as there had been concerns aired. However, it was to be noted that screening levels were performing better than expected and no worse than the rest of England;
- The level of interest from the Board around the subject matter was to be commended and support for Peterborough being better than average going forward was important. An initial piece of work did need to be undertaken to scope issues;
- A small focus group consisting of experts, lay people and Healthwatch etc. should be convened and tasked with providing an overview of the issues and where the priorities lay. This would assist the commissioners of these services;
- The issues needed to be identified prior to the implementation of a task and finish group;
- There was an issue around the lack of analytical support, hence the lack of clear data for Peterborough. A solution to this issue would be would be explored;
- Providers were held to account for performance, however they could not be made to work outside of their remit; and
- It was positive that the Board was so engaged with the issue and suggestions of how to progress the task and finish group forward were welcomed.

RESOLVED

The Board noted the report and presentation and agreed for further work to be undertaken around the establishment of a fit for purpose task and finish group.

(b) Primary Care Strategy Update Report

The Board received a report, and accompanying strategy document, which provided an update on the work being progressed by NHS England to provide a strategic framework for primary care development in East Anglia.

Andrew Reed introduced the report and highlighted key points including update reports being more focussed going forward and addressing the more bespoke elements of Peterborough; the work being about addressing the challenges facing primary care nationally, but with an area focus over the forthcoming five years and beyond; a lot of the work being focused on general medical services and the associated services; the strategy covering the whole of the East Anglia area, which encompassed many different areas with different needs and profiles; the drivers for change as outlined in the report which included demographic issues, patient expectations, workforce and financial issues; workforce being a

major issue due to the inability to recruit GPs; more financial investment being required as the burden and expectation upon primary care was likely to increase going forward; the ambitions for the strategy including the 'opportunities, challenges and issues specific to the Cambridgeshire and Peterborough system' and a program of co-commissioning primary care being initiated, which was the responsibility of NHS England.

Members debated the report and comments and responses to questions included:

- A review of Personal Medical Services (PMS) was due to be undertaken. A consequence of this would be felt across Peterborough, it being a predominantly PMS city. It was advised that any money extracted would be reinvested in primary care;
- Peterborough was a rapidly growing authority and there had been issues faced around infrastructure etc.
- The local issues were not reflected within the report and needed to be further explored. Bespoke plans were required for specific areas. Work would be undertaken in this regard;
- Conversations had been held at the Joint Local Commissioning Boards in order to identify what work could be undertaken at a local level in order to address recruitment issues;
- The CCG sought support from the Area Team for the ability for practices to begin to 'cluster' and to trial alternative models. This request would be taken on board and the next step would be to sit down with the CCG in order to tailor particular aspects; and
- The amount of 'language line' use was not reflected within the strategy. The time spent on translation caused a number of issues.

RESOLVED

The Board noted the report.

(c) Update on PricewaterhouseCooper (PWC) 'Challenged Health Economy Work'

The Board received a report which provided an update on the Challenged Economy Programme and its planned further progress. The report was submitted to the Board following a meeting of local health and care chairs, elected members and chief officers on 30 April 2014.

Andrew Reed introduced the report and highlighted key points including the work being focussed on Cambridgeshire and Peterborough and that the report set out the work undertaken by PwC; the work being fundamentally about addressing major financial problems within the Cambridgeshire and Peterborough health economy in the context of improving services and outcomes; the CCG being the lead on the work and in the process of developing a 12 month programme; formal buy in being required from all key stakeholders within the health economy as the work progressed; work would have to be undertaken to identify exactly which providers could provide services; and that the PWC work had been at no cost to the Local CCG health economy or the Area Team;

Members debated the report and strategy and comments and responses to questions included:

- Progress on the agreed concordat could be expected and it would be revisited regularly in order to strengthen it.

RESOLVED:

The Board noted the report.

6. Clinical / Local Commissioning Groups

(a) Better Care Fund Highlight Report

The Board received a report which provided an update on the progress of the Better Care Fund since 27 March 2014.

There was no discussion on this item due to time constraints.

RESOLVED

The Board noted the report.

7. Public Health

(a) Report on Health Protection, Emergency Planning and Response to Emergencies

The Board received a report which informed of the arrangements that ensured the responsibilities of Peterborough City Council regarding Health Protection were discharged and reported, and that there was an appropriate process to address any incidents or concerns relating to health protection.

The Interim Director of Public Health introduced the report and provided a summary overview of the structures and governance arrangements in place for managing the entirety of the Health Protection, Emergency Planning and Emergency Response agenda. It was advised that it was a complicated scenario which was split in terms of commissioning, delivery and scrutiny across multiple partners. An overview of structures was provided and it was advised that it was a work in progress, however the Board was to be assured that the basic structures and governance arrangements were in place.

RESOLVED

The Board noted and agreed the proposed arrangements

(b) Memorandum of Understanding between Public Health and LCGs – Public Health Work Plan

The Board received a report which informed of the arrangements under which the healthcare public health advice service would be supplied to the LCGs/CCG, as per the Memorandum of Understanding (MoU), which had been signed off by Peterborough City Council and the LCGs/CCG, and to inform and invite comment on the draft work plan, particularly with respect to the extent to which it reflected the agreed priorities of the Board.

The Interim Director of Public Health introduced the report and advised that the Peterborough Public Health team had a statutory responsibility to provide the healthcare public health advice service to the CCG. The original arrangement had commenced in April 2013 however it was subsequently identified that this arrangement was not adequate as it did not pick up the particular needs of Peterborough, as the focus of the work was CCG centric. Therefore the MoU had been terminated and a new one had been drafted and was attached to the covering report submitted to the Board. It was further advised that further work was underway to create the first annual work plan which reflected the priorities of the HWB.

RESOLVED

The Board noted the Memorandum of Understanding (MoU) and the draft work plan.

(c) Update on Cardiovascular Disease Priority Work Programme

The Board received a report which followed the decision taken by the Health and Wellbeing Programme Board (HWPB) at its May meeting that Cardiovascular Disease (CVD) should be at the top priority focus area. The HWPB had tasked the Public Health Team with leading an exercise to scope CVD and to propose a work plan with key performance indicators and outcomes, to be considered and signed off by the HWPB and the HWB.

The Interim Director for Public Health introduced the report and advised that at its June meeting, the HWPB agreed that it would act as the steering group/programme board for CVD, given its priority on the health and wellbeing agenda. It would be important to identify work streams already established for CVD to ensure that these were included in the governance arrangements and to avoid duplication.

It was further advised that the best approach to embedding the CVD priority was to pull together all work currently taking place within the city across organisations which related to CVD and its treatment or causes, to ensure that CVD was given a higher profile in these work streams and that there were reporting streams with metrics and data collection aligned.

The HWPB had agreed that the CVD Programme should be split into three thematic work streams, these being:

- Prevention and Early Intervention;
- Healthcare and Rehabilitation/Reablement; and
- Continuing Support

The arrangements for progression of work were outlined, as proposed by the HWPB which included a half day stakeholder and work stream mapping event being led by the Public Health Team, to build upon the proposed work streams.

Members debated the report and comments and responses to questions included:

- The CCG had CVD as a priority and the work should remain connected with the new duties and responsibilities arising from the Care Act;
- The Area Team hosted a strategic clinical network for Cardio Vascular services and support would be readily available from them; and
- This was an extremely important issue for the city, and the way the situation was approached needed to be clarified going forward.

RESOLVED

The Board noted the proposals for progressing Cardiovascular Disease (CVD) as the Board's top priority.

8. Children's Services

(a) Development of the Joint Child Health Commissioning Unit

This was to be a verbal update to the Board and due to time constraints, the Board agreed to receive further an update in writing.

OTHER ITEMS

9. Peer Review of the Health and Wellbeing Board

The Board received a report which followed the feedback letter being received from the Peer Review and development of a draft action plan.

RESOLVED

The Board noted the report.

INFORMATION ITEMS

10. Concordat for Joint Working Between Peterborough City Council, Cambridgeshire County Council and Health Organisations Across Peterborough & Cambridge

The Board received the noted the report as presented to Cabinet on 30 June 2014.

11. Schedule of Future Meetings and Draft Agenda Programme

The Board noted the dates and agreed future agenda items for the Board.

3.30pm – 5.30pm
Chairman

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Health and Wellbeing Board
Action and Delivery Plan 2014/15
September 2014

Focus: Children and Young People **Lead: Wendi Ogle-Welbourn** **Objective: Improve the health and wellbeing of children and young people in the city**				
Num	**Recommendation**	**Action**	**By Whom / When**	**On Track**
1	Delivering the Healthy Child Programme	• Invite Janet Dullaghan (Head of Child Health & Wellbeing) to present progress to the Board *NB: all actions are captured in the Joint Childrens and Families Commissioning Board Action Plan and Performance Framework*	Wendi Ogle-Welbourn Ongoing *Action plan driven by CFJCB*	
2	Safe transfer of the health visiting service from NHS England to the local authority	• Partners to work together to ensure a smooth transfer of staff and the service	Wendi Ogle-Welbourn November 2014	
3	Securing emotional health and wellbeing for children and young people	• Invite Janet Dullaghan (Head of Child Health & Wellbeing) to present progress to the Board *NB: all actions are captured in the Joint Childrens and Families Commissioning Board Action Plan and Performance Framework*	Wendi Ogle-Welbourn Ongoing	Child and Mental Health Services capacity remains an area for concern. Waiting lists for Tier 3 high; however new behaviour services in schools will help
4	Develop the Healthy Schools Programme	• All schools to have access to health and wellbeing clinics that provide advice, information and guidance and onward referral if needed. To include; emotional health and wellbeing, sexual health, substance misuse, relationships, jobs, healthy eating, physical activity	Julian Base April 2015	

Focus: Cardio Vascular Disease
Lead: Dr Henrietta Ewart

Objectives: Reduce under 75 mortality rates from all cardiovascular diseases and reduce morbidity associated with all cardiovascular diseases and Increase healthy life expectancy

Num	Recommendation	Action	By Whom / When	On Track
1	Organise a CVD focussed workshop to develop local CVD prevention and intervention plans.	• Ensure partners from across the City are invited to partake in the workshop, are clear on the workshop objectives and outcomes are then fed into the House of Care application for funding	Julian Base August 2014	Completed. A workshop was held on 18 July
2	Implementation of the British Heart Foundation's House of Care model for CVD and the associated opportunity to bid for BHF monies to support this work locally	• Circulate a draft application for partner consultation • Submit the final application to the British Heart Foundation – House of Care for funding	Julian Base August 2014	Completed. The application was submitted on 12 August
3	Organise a stakeholder workshop to address the Healthcare and Rehabilitation / Reablement workstream	• Engage relevant partners / third party sectors to attend the workshop and report back to the Programme Board	Dr Ewart November 2014	
4	Implement the British Heart Foundation's House of Care model (regardless of success of the application)	• Engage partners in the creation of a model for Peterborough	Julian Base October 2014	

Focus: Health Protection
Lead: Jana Burton, Dr Henrietta Ewart, Cath Mitchell

Objective: The population's health is protected from communicable disease, environmental hazards and major incidents and other threats, while reducing health inequalities

Num	Recommendation	Action	By Whom / When	On Track
1	Build and improve relationships with the local PHE and NHS England representatives	• NHS England to present regular updates on progress on core priorities • Review of joint working opportunities	Jana Burton, Dr Ewart, Andrew Reed, Cath Mitchell (ongoing)	Ongoing. A briefing paper on the role of NHS England was presented to the Board and a reporting mechanism was agreed
2	Identify and agree health priorities / challenges	• Drive through agreed priorities and challenges, reporting regularly to the HWB on progress and outcomes	The Programme Board September 2014	Completed. Priorities have been agreed as CVD and Children and Young People
3	Review the current immunisation programme	• Invite the accountable consultant in screening and immunisation from the embedded PHE team to attend the health protection committee • Consultant to present an annual report to the HWB for debate and to feedback on ad hoc incidents that may arise • The HWB to review the commissioning arrangements for the current immunisation programme and the performance monitoring in place	Dr Ewart PHE The HWB November 2014	Completed. A focus group has been set up to consider improving immunisation rates
4	Robust JSNA in place	• Develop JSNA approach for Peterborough	Dr Ewart April 2015	Priorities have been presented to the Programme Board
5	DPH to present annual report to the Programme Board	• Draft report to be prepared and presented	Dr Ewart April 2015	

Focus: Campaigns and communications
Lead: Wendi Ogle-Welbourn

Objective: Develop a city wide, multi partnership communications plan to enable a joined up approach and shared resource and funding opportunities.

Num	Recommendation	Action	By Whom / When	On Track
1	Workshop to be organised with partners, including providers to ensure mutual understand all health challenges and actions required	• The programme board to be the lead on the organisation and delivery of the workshops and to report back to the HWB on progress and outcomes	Helen Gregg, Andy Carter, Julian Base November 2014	
2	Reinstate chief executive meetings	• Chief Executive to contact CEO's of partners and organise a programme of meetings/dinners	Gillian Beasley October 2014	
3	Develop a childhood obesity strategy	• Presentation to the HWB and scrutiny panel for consultation and approval • Organise consultation with schools, school nurses, primary care, health visiting services and dietetics services • HWB to provide clear leadership and guidance in the future direction of the strategy, evaluation and accountability • Re-establish the Change 4 Life Alliance to oversee implementation and report progress	Julian Base August 2014	Completed. The strategy was presented to the Board and agreed. This will now form part of the development of the Healthy Schools Programme
4	HWB Strategy to be updated and published	• The Programme Board to facilitate an LGA/peer led workshop with partners and providers to refresh the strategy and consider priorities (to be scheduled for early 2015)	Programme Board March 2015	
5	Undertake horizon scanning / research of best practice models	• Attendance at regional and national learning sets and contacting other LA's to identify best practice models	Dr Ewart Ongoing	

Focus: Health & Wellbeing Board Development and Scrutiny Lead: Jana Burton and Cath Mitchell Objective: Improved partnership delivery of the Health & Wellbeing Strategy				
Num	**Recommendation**	**Action**	**By Whom / When**	**On Track**
1	Commence a review of the Board membership	• Partners/providers to complete a form detailing why they wish to be added as a member for the HWB to review when agreeing the revised membership • Partners/providers to be formally invited as a member of the Board • Board meeting seating plan to be refreshed to encourage partnership working	Wendi Ogle-Welbourn September 2014	
2	Improve political engagement within the HWB	• Leader to hold a 'Leader's Summit' for politicians and agree a programme of regular meetings	Cllr Cereste, Cllr Lamb, Cllr Fitzgerald, Lead officer, Jana Burton November 2014	
3	Challenged Health Economy	• Organise a workshop and engage members and partners to include the acute trusts, mental health partners, other local authorities	Jana Burton November 2014	
4	Maintain quality, cost and resource effectiveness	• Develop joint services through the Better Care Fund	Jana Burton, Cath Mitchell Ongoing	
5	Strengthen the involvement of the CCG	• Consider CCG representative to be vice chair of the HWBB	HWBB Chair	Completed. Agreed
6	Presentation of statutory responsibilities to the HWB with regard to health protection including emergency planning and response	• Health protection and emergency planning report to be tabled at the HWB on regular basis • Kevin Dawson to be included as a member of the Health Protection Committee and provide progress reports	Dr Ewart Ongoing	

		• Feedback on actions agreed at future Health Protection Committee for HWB to debate if the arrangements in place are robust and effective • HWB to consult on current 'test exercise programme' to ensure staff are prepared		
7	Strengthen effectiveness of the health scrutiny commission in relation to the work of the HWB	• Create a robust challenge mechanism in line with the work programme • Training offered to the panel members on leadership and challenge • Chair of scrutiny to have a standard agenda item at future HWB meetings to report on progress of the action plan and recommendations	Cllr Brian Rush Jana Burton November 2014	

Focus: Other Lead: Wendi Ogle-Welbourn				
Num	**Recommendation**	**Action**	**By Whom / When**	**On Track**
1	Relocation of the adults commissioning service into the Communities Directorate	• Service is scheduled to move by December 2014	Wendi Ogle-Welbourn	Completed

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 7(a)
25 SEPTEMBER 2014		PUBLIC REPORT
Contact Officer(s):	Jana Burton, Executive Director of Adult Social Care and Health and Wellbeing	Tel. 452409

BETTER CARE FUND SUBMISSION

RECOMMENDATIONS	
FROM : *Jana Burton, Director* *Andrew Vowles, Chief Strategy Officer, Cambridgeshire and Peterborough CCG*	**Deadline date : n/a**
1. The Board is asked to confirm the decision of the Borderline and Peterborough Joint Commissioning Forum to sign off the BCF submission for Peterborough	

1. ORIGIN OF REPORT

1.1 This report is submitted to Board following endorsement from the Joint Commissioning Forum on Friday 19th September as the latest submission was required by noon on this date and the Health & Wellbeing Board is not due to meet until 25th September 2014

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to

(g) Formally sign off the Peterborough Better Care Fund submission.

The purpose of this paper is to update the Board on the Better Care Fund (BCF) submission in the light of the new guidance recently issued by Central Government, which requests that plans were resubmitted by 19th September 2014.

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

3. BACKGROUND

3.1 The Better Care Fund was announced by the Government in the June 2013 spending round, with the aim of supporting transformation in integrated health and social care. The BCF was announced as a single pooled budget to support health and social care services to work more closely together in local areas. The pooled budget is expected to be in place from April 2015.

3.2 In Peterborough, the amount allocated to the fund is £11.999m. This is not new money granted by Government, but rather a re-organisation of existing funding that is currently used to provide health and social care services in the county. Figure 1 below demonstrates the sources of funding for the BCF both nationally and locally. The ambition of Health and Wellbeing Board partners and the voluntary sector is to achieve a fundamental shift in emphasis in the health and care system, with a view to taking action which will prevent or reduce the need for costly specialist services and find effective ways to reduce reliance on

statutory support. This implies significant changes for services supporting the health and wellbeing of our residents.

3.3 Our original BCF plan was submitted in April 2014 following approval by the Health and Wellbeing Board. Since the last report to the Health and Wellbeing Board there have been significant changes to the national approach to the BCF as described below.

4 RECENT NATIONAL DEVELOPMENTS AND RESUBMISSION OF PLANS

4.1 On 25 July, Andrew Ridley, BCF Programme Director with the Department of Health, wrote to Health and Wellbeing Board Chairs to provide new guidance and templates for the Better Care Fund. The documents issued included revised BCF planning guidance, revised technical guidance and two revised planning templates to be completed. Plans were required to be resubmitted following approval by the Health and Wellbeing Board no later than midday on 19 September. Parts 1 and 2 of the Plan submitted is attached as Appendix A.

4.2 The main change included in the guidance is confirmation of a major shift in the performance-related element of the BCF. Of the £1.9bn additional NHS contribution to the BCF, £1bn will remain within the BCF but will be solely focused on reducing Accident and Emergency (A&E) admissions. A proportion (at least £600m nationally) will be reserved for commissioning by the NHS on out-of-hospital services in order to achieve that reduction; and the remainder will be held back as performance related funding. If the target for total emergency admissions in local areas is achieved this sum is intended be released to BCF pooled budgets; if not it will be used by commissioning groups to pay for the above target acute activity. The intention of this policy change is to ensure that the risk of failure for the NHS in reducing emergency admissions is mitigated, and CCGs retain the funding to pay for unplanned non-elective activity if planned reductions are not achieved.

4.3 The expected minimum target reduction in total emergency admissions set out in the guidance is 3.5% for all Health and Wellbeing Board areas. Money will be released quarterly from the CCG to a pooled budget depending on performance against the agreed target. Each area's plan must clarify how much funding from the £1.9bn NHS additional contribution to the BCF is to be used for the protection of social care, including the share of the £135m that has been identified nationally to support the implementation of the Care Act. Locally it has been agreed that this is not achievable so the local submission reflects the local ambition more accurately as referred to in paragraph 5.3.

4.4 The national metrics and conditions (residential and nursing home admissions; patient and service user experience; avoidable emergency admissions; reablement; and delayed transfers of care) will still apply but will have no performance mechanism attached.

4.5 The aim of the new planning templates is to ensure that each area can better provide:

- **The case for change**: a clear analytically driven and risk stratified understanding of where care can be improved by integration
- **A plan of action**: A coherent and credible evidence-based articulation of the delivery chain that underpins the shift of activity away from emergency admissions developed with all local stakeholders and aligned with other initiatives and wider planning
- **Strong governance**: clear local management and accountability arrangements, and a credible way of tracking the impact of interventions and taking remedial action as necessary, as well as robust contingency plans and risk sharing arrangements across providers and commissioners locally
- **Protection of social care**: How and to what level social care is being protected, including confirmation that the local share of the £135m of revenue funding resulting from new duties within the Care Act is protected, and the level of resource dedicated for carers is spelled out.

- **Alignment with acute sector and wider planning**: including NHS two-year operational plans, five-year strategic plans, and plans for primary care as well as local government plans

5. CHALLENGES IN DEVELOPING THE BCF

5.1 Since receiving Andrew Ridley's letter in July, officers from the CCG and City Council have been working to understand the guidance and begin to complete the new templates for BCF plans.

5.2 The timetable for completion of the new templates was extremely ambitious and there were a number of areas which needed to be resolved prior to the completion of the revised templates. The main issue is that all of the resources that will make up the BCF are currently funding existing housing, health and social care services. The funding for the BCF is drawn primarily from NHS budgets, although it is made up of some ring-fenced resources (such as the Disabled Facilities Grant) and some resources that are already transferred to the local authority. The resources that form the existing transfer are currently allocated in CCC budgets for the provision of adult social care services.

5.3 Both the Council and CCG have significant concerns about the ability to reduce the pressures on A&E admissions on the scale now required by the updated guidance. Because of the current increasing trend in emergency admissions a stretching and achievable target of 1% has been proposed There is a mismatch between the BCF vision (which proposes reduced acute activity) and providers' 5-year plans (which plan for increased acute activity and staffing); and this must be addressed. The scale of the challenge ahead is acknowledged in the CCG's Five Year System Blueprint which includes re-designing non-elective care. The CCG has established a Strategic Transformation Group (at Chief Executive or equivalent level) to drive system service transformation.

5.4 Finally the local procurement of Older People and Community Services by the CCG means that it is challenging to achieve the flexibility required in budgets that are within scope of the procurement exercise, particularly before the provider has been appointed. Officers from the CCG and Council are continuing to work together to address this as far as possible before the appointment of the provider in Autumn 2014. Reducing A&E admissions will though be a key objective of the new provider, who will be incentivised to reduce bed days for the over 65s.

5.5 These issues were highlighted to central Government in the 'checkpoint' updates we are required to submit under the new timetable for the Better Care Fund.

6. NEXT STEPS

6.1 The submission was made on 19th September and will then under go an assurance process. Plans will be categorised as follows:

- Approved
- Approved with support
- Approved with conditions
- Not approved

6.2 The BCF steering group will continue to develop plans during this time assuming that the plan will be assured.

7. CONSULTATION

7.1 Consultation amongst partner organisations has been ongoing throughout this process. There has been some patient engagement in the process, but it is suggested that further engagement takes place as workstreams are developed in detail.

7.2 The JCF will carry out further scrutiny in order for the local clinicians and patients to have sufficient time to fully consider the content and implications of the plan. The JCF will provide further input and recommendations on how the joint working and transformation in the BCF can be delivered

8. ANTICIPATED OUTCOMES

8.1 The BCF seeks to make transformational change to how health and social care services are delivered.

9. REASONS FOR RECOMMENDATIONS

9.1 The Better Care Fund is a Government requirement for each Local Authority and CCG area.

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	Peterborough City Council
Clinical Commissioning Groups	NHS Cambridgeshire and Peterborough Clinical Commissioning Group
Boundary Differences	For NHS Cambridgeshire and Peterborough Clinical Commissioning Group, there are two differences to the boundary when compared with that of Cambridgeshire County Council and with Peterborough City Council. From 1st April 2012, several practices from North Hertfordshire and Northamptonshire became part of NHS Cambridgeshire and Peterborough Clinical Commissioning Group: *North Hertfordshire – Royston* Three Royston practices provide care for a patient population of 24,142 residents in the town of Royston itself and the surrounding villages and they comprise Royston Medical Centre, Roysia Surgery and Barley Surgery. *Northamptonshire* The Oundle and Wansford practices provide care for a patient population of 17,448 residents in the town of Oundle itself and the surrounding villages and they comprise Oundle Surgery, Wansford Surgery and Kings Cliffe (branch surgery).

Date agreed at Health and Well-Being Board:	The Peterborough Health and Wellbeing Board are next scheduled to meet on 25th September 2014. Agreement has been reached for the HwB board to review proposals for the BCF, and to virtually sign off the templates prior to this 19th September submission. Additionally the HwB have agreed to delegate ongoing oversight of implementation of the BCF during 2014/15 to the Joint Commissioning Forum.
Date submitted:	**Friday 19th September 2014**
Minimum required value of BCF pooled budget: 2014/15	£661,000
2015/16	£11, 999,000
Total agreed value of pooled budget: 2014/15	£661,000
2015/16	£11, 999,000

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	NHS Cambridgeshire and Peterborough Clinical Commissioning Group
By	Andy Vowles
Position	Chief Operating Officer
Date	Friday 19th September 2014

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Council	Peterborough City Council
By	Jana Burton
Position	Executive Director of Adult Social Care, Health and Wellbeing
Date	Friday 19th September 2014

Signed on behalf of the Health and Wellbeing Board	Peterborough Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor Marco Cereste
Date	Friday 19th September 2014

See attached letter

c) Related documentation
Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Better Care Fund Consultation and Engagement Plan	Sets out a suggested approach for consulting on Cambridgeshire and Peterborough's Better Care Fund plans and how engagement with key stakeholders will be managed.
Review of Evidence to support Better Care Fund (BCF) Spend	This review assesses and qualifies the evidence of the effectiveness of social care and health interventions that impact on the outcome measures required by the Better Care Fund. Both integrated health and social care and non-integrated interventions are considered. The review assesses interventions across a spectrum from primary prevention of social care to interventions aimed at reducing hospital admissions.
The King's Fund Evidence summary: Making best use of the Better Care Fund	This document provides a summary of the requirements of the BCF with supporting evidence and suggested approaches,
NHS Cambridgeshire and Peterborough CCG 2 Year Operational Plan	This document sets out our medium term financial plan for the period 2013/14 to 2016/17 which shows how we will deliver the financial metrics requested by NHS England by 2014/15 and gives an overview of plans for future years.
NHS Cambridgeshire and Peterborough CCG Older Peoples Pathway and Adult Community Services procurement information	A range of materials are available on the Older Peoples Programme pages of the CCG website relating to the scope, outcomes model, and proposed implementation for the CCG-wide procurement of community and older people's services.
Better Care Fund Performance Metrics (Peterborough)	Provides an overview of the national and local performance trends to support the targets associated with BCF metrics, and tracking progress towards the conditions attached to the Better Care Fund.
Health and Wellbeing Strategies: Cambridgeshire, Peterborough, Hertfordshire and Northamptonshire	These documents set out the key priorities on which the Health and Wellbeing Boards will focus on in the next five years. NHS and Local Authority plans need to be informed by the Health and Wellbeing Strategies.
Joint Strategic Needs Assessments for Cambridgeshire and Peterborough	JSNAs analyse the health needs of populations to inform and guide commissioning of health, well-being and social care services within local authority areas. The JSNAs underpin the health and well-being strategies of each local authority and the CCG commissioning plans
Peterborough City Council Medium Term Financial Plan	This plan sets out the Cabinet's proposals for meeting the challenges of the Government's

	Spending Review (October 2010) and following Government announcements that impact local government funding.
Appendix 1 - Programme Portfolio – Care Services	Peterborough City Council Transformation programme, including detailed description of schemes relating to the Better Care Fund.
Appendix 2 - Programme Portfolio – Commissioning	Peterborough City Council Transformation programme, including detailed description of schemes relating to the Better Care Fund.
Appendix 3 – Learning Disabilities and Autism Strategy	Peterborough Strategy for People with a Learning Disability or Autism diagnosis.

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

The overall vision for health and social care services in Peterborough brings together all of the public agencies that provide health and social care support, especially for older people, to co-ordinate services such as health, social care and housing, to maximise individuals' access to information, advice and support in their communities, helping them to live as independently as possible in the most appropriate setting'

From out Joint Strategic Needs Assessment it is clear that Peterborough need to plan for a rapidly ageing population, with very specific mental health challenges and a diverse ethnic population. Peterborough falls under the ONS classification of 'new and growing towns' and comparisons are made within that group. Peterborough City Councils comparators, include; Swindon, Bedford, Thurrock, Milton Keynes, Harlow, Stevenage and Ipswich.

Some of the highlights from the JSNA are:

Population Profile and Growth

- The Population of Peterborough is 185,000
- Peterborough population is predicted to grow by 11% by 2021
- The largest growth in population will be seen in:
    - 65-74 age group 26%
    - 75-84 age group 21%
    - 85+ age group 52%
- Peterborough has a higher percentage of children than England average
- Peterborough has a higher percentage of adults 25 – 44 than England average

Ethnicity

- Peterborough has a diverse ethnic population, and is ranked the 40th most diverse of 152 Primary Care Trust's (PCT's) PCT[1] nationally for ethnic diversity. Peterborough is considered to be the second most diverse of the 14 PCTs in the Eastern Region, behind only Luton.
- People of the Pakistani ethnic group make up 6.6% of total population.
- 80% of migrant workers are from Europe of which 40% are from Lithuania and Latvia.

(Source: ONS mid-census population figures 2008)

Deprivation

- Peterborough is described as the most deprived Local Authority in the New and Growing Towns ONS Cluster.
- Peterborough is ranked 90th in England out of 354 Local Authorities.
- The deprived areas are densely populated and 26% of the population are living in the most deprived areas in the country[2]

[1] PCT were replaced by Clinical Commissioning Groups in 2013
[2] The English Indices of Deprivation (2010)

- In 2010 there was an estimated 4,320 people unable to work
- The unemployment rate between July 2012 and June 2013 was 9.6% compared to the Great Britain average of 7.8%[3]
- It is predicted that over 14,000 people in Peterborough have a limiting long term illness
- Peterborough is significantly worse than the national average for 16-18 year olds not in education, employment, or training
- Peterborough is significantly worse than the national average for violent crime and first time entrants into youth justice system[4].

Despite the local challenges relating to population growth as outlined above Peterborough has reducing financial resources, and without change, our services will be unsustainable in the very near future. Consequently, the HWB Board, PCC and the CCG have already been planning to move resources to invest in joined-up services that are focused on preventing deterioration and which support people to be independent, healthy and well in all aspects of their lives, thereby reducing demand for higher cost, more intensive services.

The Health and Well-being board have identified the better are fund as an important opportunity to transform the overall local health and social care system for patients, service users and carers'

This vision is ambitious, given the specific challenges that the system is facing in Peterborough:

- Peterborough is one of 11 'challenged health economies' that face particular difficulties in developing sustainable quality health services over the next five years. This is mirrored by challenging financial circumstances that affect our ability to ensure sustainable social care services.
- A reduction in acute activity runs counter to the current trend in Peterborough. Existing CCG plans are based on a 1% reduction in A&E admissions, in the context of the current trend which is for an annual increase of around 2%. There is also a mismatch between the BCF vision of reduced acute activity and providers' 5-year plans which plan for increased acute activity and staffing. The scale of the challenge ahead is acknowledged in the CCG's Five Year System Blueprint which includes redesigning non-elective care.
- The local procurement of Older People and Community Services by the CCG means that Peterborough faces particular challenges in achieving the flexibility required in budgets that are within scope of the procurement exercise. This is particularly true at present because the provider has not yet been appointed.

Focusing on preventative community support where possible means a shift away from acute health services, typically provided in hospital, and from emergency social care services. This cannot be achieved immediately – such services are usually funded on a demand-led basis and provided as they are needed in order to avoid people being left untreated or unsupported when they have had a crisis. Therefore reducing spending is

[3] www.nomis.co.uk/reports/IMP/la/1946157202/report.aspx?town=peterborough#tabempunemp (downloaded 6 November 2013)
[4] Neighbourhood statistics 2010-2011

only possible if fewer people have crises: something which experience suggests has never happened before.

We recognise that the development of preventative community based services (as an alternative to reactive, crisis based services) requires significant changes to our thinking and arrangements about how best to support the health and wellbeing of Cambridgeshire and Peterborough residents. Over five years we are working towards a fundamental shift in emphasis in the system – instead of needing to support people when they are in crisis with hospital or long-term social care support, personalised services provided in the community will wherever possible prevent crisis in the first place. Our collective ambition is to achieve this big change.

The scale of this transformation opportunity is significant; it is much more than just reducing admissions to hospital. Rather, it is about changing the whole system so that it is focused on supporting people wherever possible with person-centred and professionally-led primary care / community / social care, guided by the goal of living as independently as possible, for as long as possible.

Nevertheless, collectively our organisations in Peterborough are committed to achieving this, because the alternative is unsustainable services. In addition, preventing people from going into crisis is better for them and their families. This approach will also be supported by a clear focus on improving access to timely information, advice and guidance.

The BCF is one part of our overall transformational activity but is not the solution in itself, other important work around the Care Act (part 4 integration) is closely aligned to the BCF.

Work is also underway locally improve our urgent care capabilities following the recent support provided by Emergency Care Intensive support Team (“ECIST”) work with Peterborough and Stamford Hospitals NHS Foundation Trust work is underway to implement a 26 point plan which will make a series of improvement to urgent care. This will see changes to non-medical support in A&E in terms of physiotherapy and occupational therapy being made available at the point of contact to prevent admission in areas such as when an elderly patient may have had a fall or trip at home which does not result in a fracture, placing the emphasis on adequate pain relief and physiotherapy assessment as opposed to admission. Social care packages of care can be increased/ arranged if these people are seen early in the process.

We recognise that BCF is not new money – all of the money allocated to the BCF is already spent on health and social care services in Peterborough. The Better Care Fund does however offer a unique opportunity to re-think how a significant amount of public money will be more efficiently and effectively spent.

We will focus our use of the BCF on initiatives that help to prepare the system for a bigger change in the medium term, by protecting existing social care services; supporting the development of 7 day working and data sharing; and supporting the development of closer working, including development of joint assessments with an accountable lead professional. We aim therefore to ease the pressure on the system more generally, enabling it to provide better services to the whole population.

New Model of Care

Peterborough City Council and Peterborough and Borderline Locality Commissioning Group have developed a model of care that focuses on prevention promotion and early intervention. As commissioners we wish to see the development of a primary and community care model, which reduces reliance on traditional secondary, care support and acute care services. This model will be based on Local Area Coordination, Asset Based Communities and further development of an integrated primary and community based service that seeks to build community resilience and minimise demand upon services.

The White Paper "Caring for our Futures; reforming care and support" (HM Govt 2012) and previous policy initiatives (A Vision for Adult Social Care, Think Local Act Personal, Putting People First etc.) have identified the need to move the balance of care and support from crisis and service driven to prevention, capacity building and stronger communities.

"Caring for our futures" now identifies Local Area Coordination and Asset Based Community Development (ABCD) as key approaches for strengthening communities and supporting vulnerable people to build non service solutions wherever possible.

The paper on building social capital by Think Local Act Personal (Volunteering: unlocking the real wealth of people and communities, Wilton, 2012) also cites Local Area Coordination as a key approach to supporting people to find local solutions, building capacity and strengthening communities (p.7). This concept is also central to the discussion paper, Policy Paper 15 - August 2013. ('Turning the Welfare state upside down?' Developing a new Adult Social Care Model) by the Health Services Management Centre and the importance of focusing on creative working with existing social capital and local community resources as the starting point for Adult Social Care.[5]

Table 1 below sets out Peterborough City Councils' Target Operating Model and Customer Journey. This identifies Local Area Coordination as the Foundation of this model of care which will make available relevant, timely and appropriate information at the start of the customer journey.

Table 1: PCC Target Operating Model - Customer Journey

[5] Health Services Management Centre (2013); 'Turning the welfare state upside down?' Developing a new adult social care offer http://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/HSMC/publications/PolicyPapers/policy-paper-fifteen.pdf Retrieved 6th November 2013

Our long-term shared vision is to bring together all of the public agencies that commission and provide health and social care support, especially for older people, to co-ordinate services such as health, social care and housing, to maximise individuals' access to information, advice and support in their communities, helping them to live as independently as possible in the most appropriate setting.

To be successful, this transformation will require the contribution of a range of health, housing, and social care commissioners and providers, along with the greater involvement of the community and voluntary sectors. Peterborough has a strong commitment to coproduction, and will using the existing coproduction groups to share and develop designs and when they are available at an early stage.

We want to ensure that Peterborough is an area with first class facilities and services for all its residents, local businesses, those who work in the area, and those who visit here. We see the Peterborough of the future as an area that will have a strong and well-defined positive image, confidence and sense of place.

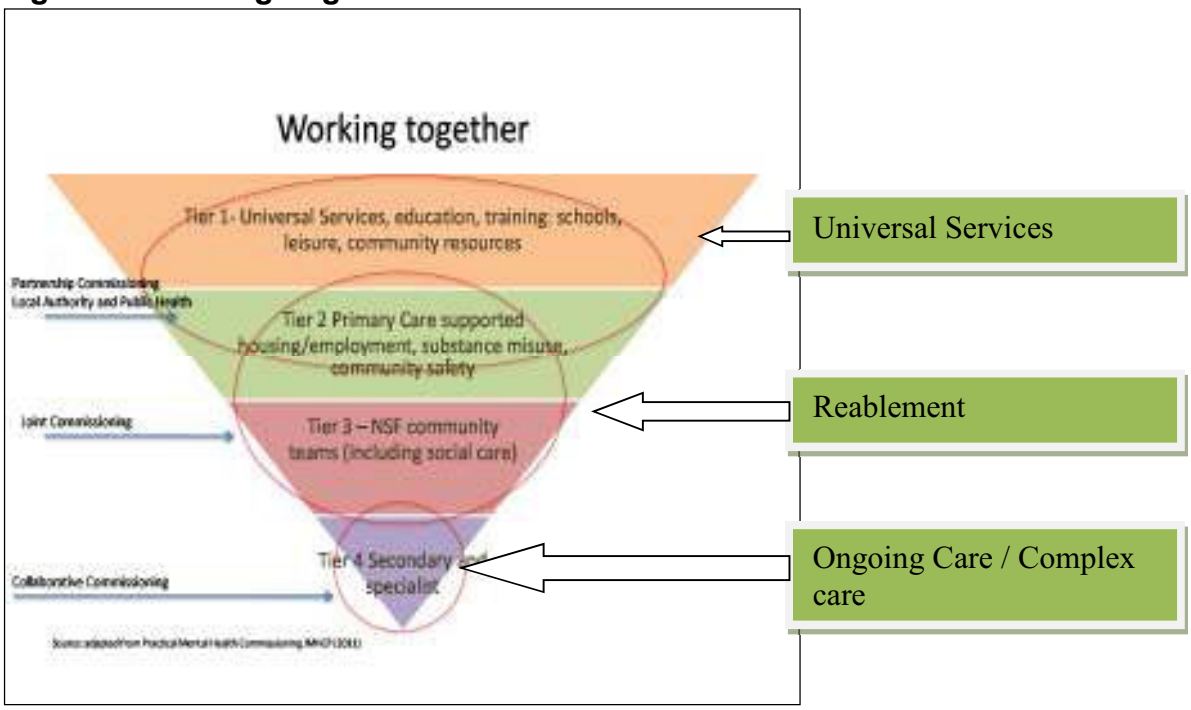
Our vision is also about creating a place that is known - locally, regionally,

nationally and internationally - as a 'modern city', a place offering the best balance of social, economic and environmental benefits - combining the best of urban and rural life.

Of course, communities are about people and our vision is of a 'safe, caring and healthy city' where local people will feel safe and secure in a strong community and have pride in the heritage, culture, environment, diversity, and achievements and success of the area.

Figure 1 below gives a pictorial view of how stakeholders will work together, understanding the key roles, responsibilities and accountabilities of the respective organisation. The figure also shows the key elements of Peterborough Customer Journey and how they fit with a 'whole systems commissioning strategy'

Figure 1: Working Together



Linked to the Better Care Fund programme in Peterborough are the many and various changes arising from the Care Act, and Peterborough's vision for Social Care and Health is in line with the general responsibilities in the Care Act with a focus on promoting wellbeing, developing community resilience and re-designing the whole system to deliver in ways which focus on early intervention, prevention, and proactive support. Specific examples include plans to enhance and align the offer to carers, enhance and integrate reablement and admission prevention services and to jointly develop tele health and tele care services.

This approach aligns with the principles set out by Government, NHS England and Local Government Association, is consistent with the priorities set out in Cambridgeshire's and Peterborough's Health and Wellbeing Strategy 2012-17. It is also well-supported by evidence that clinical and service integration delivers better

outcomes for people, particularly if groups of patients or service users are clearly identified and services for them are joined up around their needs.

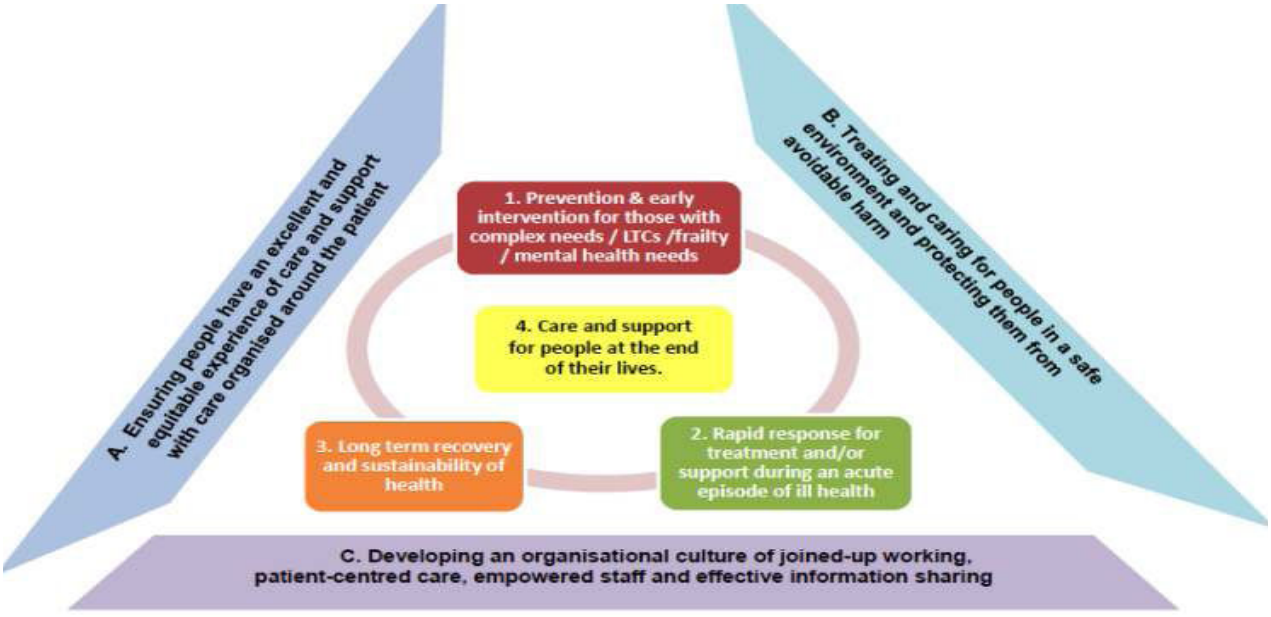
In Peterborough we are developing a 'Model of Care' that has at its heart 'building resilience' in the Community, with families and individuals. This has emphasis on the individual, family and communities emotional health alongside the care, support and interventions required. We recognise that mental health, wellbeing, and physical health are intrinsically linked and there is a need to accommodate a duality of approach. Closing the Gap priorities 13-15 focus on integrating physical and mental health care and a focus on wellbeing. To meet these priorities we will need to further define and develop how health and social care will work together.

b) What difference will this make to patient and service user outcomes?

We anticipate a range of positive outcomes for patients and service users including:

- Greater personalisation of service response to users' needs
- Enhanced support and guidance to carers
- Services which are responsive, timely and pro-active
- A greater emphasis on developing resilience and the emotional wellbeing of communities

Many of these are encapsulated within the Outcomes Framework being developed within the CCG OPPACS procurement (as summarised below), and it is hoped that this might form a good starting point for the development of a shared outcomes framework with providers, the public, stakeholders and the voluntary and community sector.



Supporting older people to stay independent

We would like to see care delivered to older patients, or for older patients to be able to access care, in ways that allow them to maintain their independence. Ways suggested for doing this are:
• offering support at an earlier stage to a larger number of people than is the case now
• focusing on prevention - making sure those aged 65 plus have access to information and services that will help keep them well, for example diet advice and exercise opportunities
• with patient consent, offer a health/care review to identify and address issues, for example housing problems
• increased working with local voluntary organisations to direct patients to services and provide more informal support
• establishing healthcare contact points venues other than GP practices
• using technology such as Skype/Telehealth to provide support for people with long term
conditions
• developing a record system that patients can access, so they can self-manage their care

Improved community services: reducing emergency hospital admissions, re-admissions and long stays in hospital.

Quite often during an episode of severe illness, hospital treatment is necessary. However a significant number of people are admitted to hospital who could have been safely treated at home, or discharged at an earlier point, if community services were organised in a different way.

We would like to see a healthcare system that reduces the number of older people being taken to hospital unnecessarily, or staying in hospital longer than needed.

Proposals received suggest this can be achieved by:

• improving information for, and engagement with patients, their relatives and carers to increase understanding of long term conditions, so they can better identify minor changes
or serious deterioration and request help accordingly and earlier
• emphasis on personal case management to identify patients at risk of being admitted or
re-admitted to hospital, managed through Multi-Disciplinary Teams (MDTs)
• having a 24/7 urgent care system that can send a community team to the patient to both
assess and treat at home, without the need to go to A&E unless necessary

• good access to urgent hospital specialist advice and assessment
• much stronger links between the community and the hospital, from the A&E department
to the wards, with teams based in the hospital supporting care and linking with community teams in-reaching into the hospital, supporting better arranged discharge

• better rehabilitation services to support people to recover from episodes of ill health. This could include the provision of 'step down' beds in community settings, or a hospital at home service giving help with personal hygiene such as bathing, shaving etc, as well as medical care.

End of Life Care

Alongside improving care for older people, the CCG has made improving End of Life Care across Cambridgeshire one of its priorities. The preferred provider(s) awarded the contract will be expected to work with the CCG on delivering improved End of Life Care.

Service users and carers will be directly involved in the commissioning, contracting and procurement of services, on a fully co-produced basis...

Service Users and Carers have confidence in the services they receive. Through the implementation of the new care model which is based on supporting natural communities regardless of client group we will build / develop the health and wellbeing of the community.

By developing our Asset Based Enterprise model alongside Local Area Coordination we will build on people's strengths and abilities. Developing innovative and bespoke responses to achieving an individual's 'good life'. Through the work on Local Area Coordination resilience will be built within Individuals, Families and Communities, and Statutory services are then seen as a last resort.

More people particularly those with Learning Disabilities, Mental Health challenges and autism will be in employment improving their self-esteem and general well-being. Through our initiatives relating to supported housing less people will be unnecessarily admitted to hospital or long term residential and nursing care.

Through our implementation of assistive technology more people particularly older people will be able to stay at home reducing the number of older people moving into residential care settings.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

Our plan is to move to a system which will support 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 through family and community support. This might be through all organisations understanding the first signs that someone may need more support, or be developing greater support needs, and highlighting this to other organisations who can arrange any necessary support. This support will focus on returning them to independence as far as possible; but more intensive and longer term support will be available to those that need it.

Our key areas for investment are as follows:

1. Older People and Community Services (OPACS) Procurement
2. 7 day services in health and social care
3. Joint assessments including accountable professional
4. Data Sharing

Through our transformation of services to Older People we will consider how we can monitor, understand and improve the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. Central to the pattern and configuration of services is the CCG led Older People and Adult Community Services (OPACS) Procurement which is summarised below:

OPACS Procurement

The CCG has embarked on an ambitious Older People and Adult Community Services (OPACS) procurement which is designed to achieve transformation across the health and social care system. This procurement was established prior to announcement of the BCF and will happen independently; however, the scope of the procurement means that some of the BCF investment will inevitably be used on the services in scope. The main components of the OPACS procurement are

- An innovative Framework for improving outcomes which goes beyond traditional organisational boundaries
- A new contracting approach which combines a capitated budget with Payment By Outcomes to enable a population approach to service delivery, align incentives in a better way than current funding mechanisms allow, in a way which is consistent with the CCG's long term financial plan
- A 5 + 2 year contract term to enable investment and transformation
- A Lead Provider responsible for the whole pathway, providing leadership and operational coordination

The underlying principle is to create an integrated care pathway between all of these services including the Services which are the subject matter of this Procurement. The core scope of services includes acute unplanned hospital care for older people (65 and

over), older people's mental health services and older people and adult community services. The entire range of services relevant to the care of older people is shown in Figure 1: Service range.
The core scope of services is acute unplanned hospital care for older people (65 and over), older people's mental health services and older people and adult community services. The entire range of services relevant to the care of older people is shown in Figure 1: Service range. The underlying principle is to create an integrated care pathway between all of these services including the Services which are the subject matter of this Procurement.

Whilst the full range of social care services and funding is not in the scope of the procurement, the CCG is working closely with Local Authority partners on the procurement and wider Older People Programme. Cambridgeshire County Council, Peterborough City Council and District Council representatives have been integrally involved in steering the programme and also in the detailed dialogue and evaluation associated with the procurement. There is a strong alignment and synergy between the OPACS work and the aims of the Better Care Fund which will enable and support it.

Services in scope of the procurement will become the responsibility of a 'Lead Provider' which will directly provide community services and hold the budget for the other services, so that the whole 'pathway' of care is more joined up and better o-ordinated. The Lead Provider may be a single organisation or a consortium made up of several partners. They will not just be responsible for providing and co-ordinating care, but also for supporting the health of the whole older population. This will include working with GPs and others to identify people who are at higher risk of becoming seriously ill and offering advice and support which reduce the risk of crises or hospital admissions. The Lead Provider will employ the community services staff and be responsible for ensuring that they are well supported.

The OPACS provider will be incentivised to work to reduce emergency admissions – one of the key aims of the Better Care Fund. BCF Partners will work closely alongside the provider to agree how these services will relate to other strands of Better Care Fund activity. As the provider is not yet appointed, it is not possible to outline in full what projects will be established; however, areas of interest include:

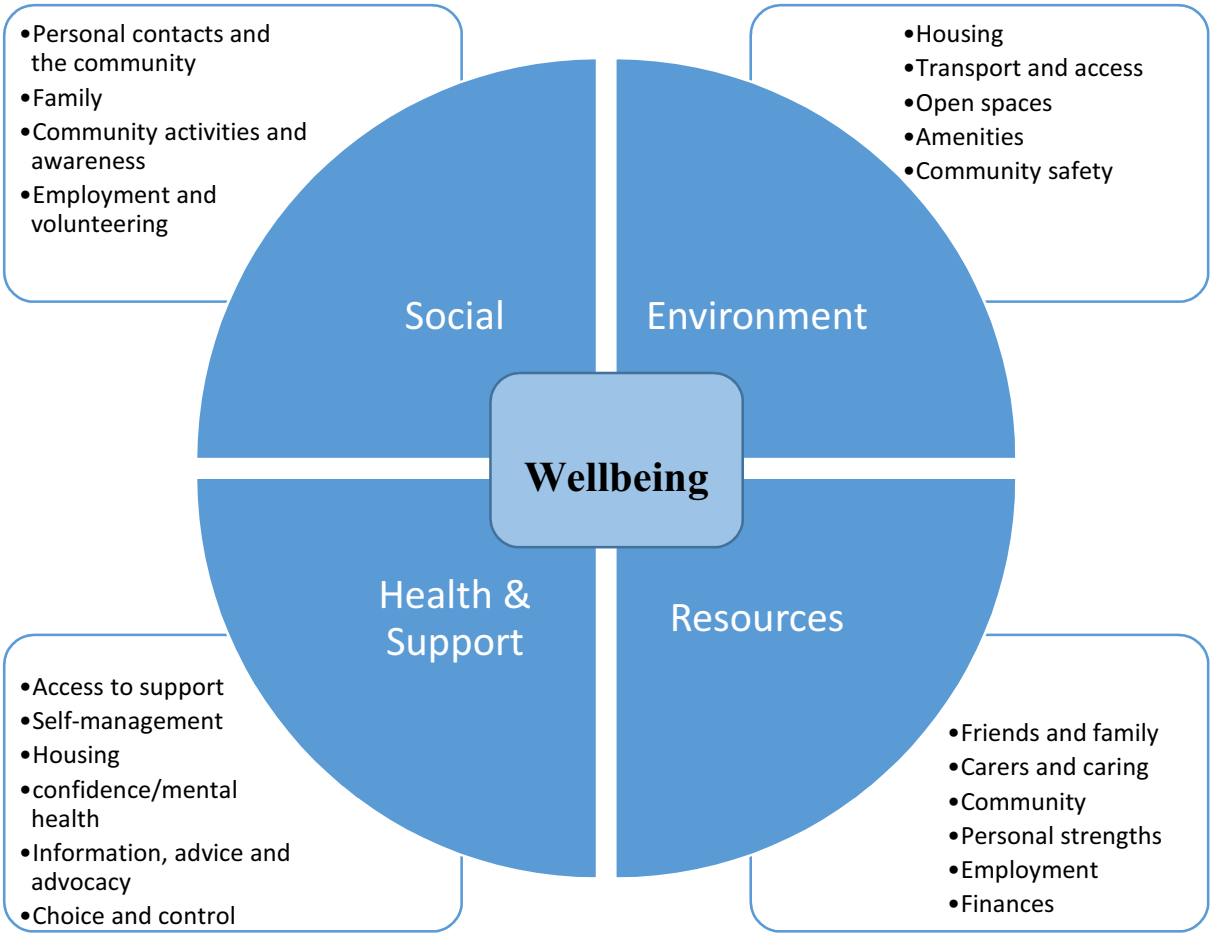
Vision

- People are able to manage the opportunities and challenges of life, to remain independent and to have the best health and wellbeing possible and People are able to make a positive and purposeful contribution and to maintain and develop connections with family, friends and their communities

We want to develop a model of wellbeing that focusses on removing or reducing the barriers that prevent people participating and that disable them and affect their quality of life. To do this we need to understand and support people's hopes and aspirations and enable, wherever possible, self-management of wellbeing. We need to move away from a default position of professionals providing support and care after a problem has arisen.

Central to wellbeing are the principles of safety and dignity: the Council will work with stakeholders to ensure that safety, dignity and human rights are paramount in all support, commissioning and development work.

The diagram below summarises the range of overlapping factors that can affect someone's wellbeing:



Key outcomes for these areas expressed as aspirational 'I statements' are:

- Social – I have a sense of purpose and good relationships; I live in my community and can play an active role
- Health, care and support – I am able to manage my health and wellbeing, get support when I need it and make choices about that support
- Environmental – I live in a place that is sensitive to my needs, healthy and enables active participation
- Personal resources – I can make of use my strengths and abilities; I can afford a good quality of life

How we will get there

The Council will work with other commissioners, providers and people using services to shape the range of support and opportunities that build on the strengths of people and their communities, to meet their needs and to benefit the wider community.

Central to the Council's approach to commissioning for older people are the principles of:

- Equality and diversity including tackling discrimination
- Understanding better when support is required, what support is required and how that support should be made available
- Prevention and early intervention, wherever possible tackling issues before they arise
- Focussing on outcomes, not on services
- Enabling and empowering people to make choices and take control of support that is tailored to the individual
- Working in partnership with people, their families and the communities they live in
- Mental health needs, physical health needs and social care needs are inter-related and equally important.

What this will mean in practice

There are some cross-cutting themes that the Council will be addressing including the development of clear care standards, training and support for workers across health and social care sectors and the promotion of safeguarding approaches and principles locally.

In terms of more specific areas for development:

Universal services

- High quality information, advice available directly from the Council's Customer Service Team and from voluntary sector organisations
- Advice and information on benefits and financial matters through the council's Financial Assessment Officers and independent organisations
- Commissioning a new integrated advocacy service so people can understand their rights and have a voice
- Advice and support related to maximising well-being such as access to fitness activities, emotional support, family and social networks, smoking cessation and falls prevention through the voluntary sector, Vivacity, the Council's Live Healthy Team, GP surgeries and community health services
- Increased opportunities to access volunteering, education and employment opportunities including working with the voluntary sector, Vivacity, local employers, education and training providers
- Ensure transport provision meets the needs of people and supports community engagement by developing new opportunities with local transport providers

Prevention and enablement

- Increase access to aids, adaptations, equipment and assistive technology including for people funding their own support through the Council's Service Directory, the Integrated Community Equipment Service, the Reablement Service and independent partners
- Commissioning Community Catalysts to work with social entrepreneurs and innovators to develop sustainable, community based micro-enterprises that offer direct support to people

- Work with voluntary sector partners to develop the right range voluntary sector and not-for-profit support locally
- Increase Reablement Service capacity and develop new approaches to interim support that minimise reliance on residential and nursing care including the piloting of specialist reablement accommodation with local hosing providers

Longer term support

- Increase uptake of Direct Payments promoting the benefits to people and professionals, expansion of services that support people to manage a Direct Payment and increasing the number of people working as Personal Assistants locally. The development of a Personal Assistant register will make it easier to employ a Personal Assistant and provide assurance and confidence to people wanting to employ someone directly to provide support
- Work with housing providers to develop a range of options that provide integrated accommodation and support including the development of extra care and more specialist dementia accommodation
- Develop the Council's Shared Lives service to include people over 65 to provide respite and longer term placements
- Develop a seven day specialist dementia day service at the Dementia Resource Centre and, longer term, in other community sites across Peterborough
- Develop a range of community based day opportunities that support inclusion
- All support to be developed and commissioned on a seven day and extended hours basis
- Develop approaches with health that take a whole family approach to assessing strengths and need and that consider the support needs of family carers
- Ensure that all health and care support works to maximise independence and self-management where possible
- The further development of the residential and nursing homes to ensure care is of the highest quality and opportunities for residential services to support people living nearby are developed with homes and communities
- Ensure a range of effective, coordinated and personalised support is available for people with multiple needs
- Establishment of quality improvement resources to support challenged providers to improve the quality of care and support they deliver.

From our Older Peoples strategy we intend to transform services to meet new outcomes as indicated in the table below.

	Issue	Activity	Who	When	Outputs and metrics
SOCIAL	Outcome **I have a sense of purpose and good relationships; I live in my community and can play an active role**				
	People are concerned about	Understand those groups most at risk of isolation to inform better	PCC LACs VCS	Apr 15	• Comprehensive directory of opportunities developed

	becoming isolated	targeting of resources. Map and develop social network opportunities locally and identify the range of support people need to access them. Complete a gap analysis to better inform commissioning plans. Raise awareness amongst communities and with professionals. Explore the development of a social prescribing model for Peterborough including identification of funding.	PCC LACs VCS PCC LACs PCC CCG Integrator PCC	Apr 15 Sep 15 Sep 15 Apr 16	• Numbers of people over 65 accessing • Opportunities are accessible (customer rating) • Number of opportunities available locally
	Older people want choices about how they take part in their communities	Work with PCVS, Community Catalysts and Local Area Coordinators to map and develop volunteering opportunities for older people. Support access to employment and training for older people.	PCVS PCC PCC Training providers Local employers PCC LACs VCS	Apr 15 Apr 16 Apr 15	• Number of people over 65 volunteering • Number of people over 65 supported as carers • Number of people over 65 in employment • Number of people over 65 accessing training and education opportunities

		Raise awareness within communities of the resources that older people offer and ensure that older people are supported to offer their resources if they choose. Support the set-up of community groups including the development of intergenerational opportunities.	PCC LACs VCS	Apr 16	
	Older people can lose confidence, this can be a barrier to getting involved in their communities and to getting the support they need.	Develop an awareness campaign using the Dementia Friendly cities model to raise awareness about the issues people over 65 face. Ensure community development, community safety planning and environmental planning considers the needs of people over 65 and is co-produced with them. Develop reablement approaches that include supporting people to develop	PCC CCG PCC PCC	Apr 15 Apr 16 and ongoing Apr 15	• Number of awareness activities delivered • % of plans and strategies specifically including issues for people over 65 • Reablement metrics • People over 65 accessing emotional support

		confidence and independence.			
		Ensure low-level psychological and emotional support is available locally including bereavement support.	PCC CCG	Apr 16	

In relation to mental health the key changes in delivery of care over the next five years are summarised below:

Area of Development	System Change	BCF
Public Health Communities	Local Area Coordination Delivering system change Formal care becomes a last resort Building resilience within Communities	Appointment of 6+ local Area coordinators Appointment of 3 CDW (BME) working as Local Area Coordinators (Peterborough)
	Suicide Prevention Clear Pathways across City Web based resource centre Training and awareness raising Peterborough Pledge	Sustainability funding Web maintenance and development Ongoing Training and awareness raising Anti –stigma national campaign Ongoing development and support for Peterborough Pledge
Area of Development	**System Change**	**BCF**
Public Health (cont.)	Bounce Project Delivering a programme of interactive workshops designed to promote well-being and resilience in general population. It explores individuals unique well-being and tailors individual solutions with the aim of increasing the ability to deal with life's challenges Building individual and community resilience	Sustainability funding

Primary Care	Development of Primary Care Mental Health	Appointment of 3 Mental Health SWs in Peterborough
		IAPT step one plus There is significant unmet need amongst people with assessed low level MH need but complex social context such as people who hoard or who are leaving care transitioning into adulthood, if addressed this would reduce the use of inappropriate services and individual distress. IAPT step one would include, assessment, supported sign posting and engagement, brief psychological interventions with preventative social care interventions
		Integrated health and social care personal budgets. True personalisation and integration of health and social care is significantly achieved by the integration of personal budgets. This initiative would develop the infrastructure and piloting of integrated health and social care budgets.
Area of Development	System Change	**BCF**
Crisis Concordat	Development of capacity AMHPs - stronger connection with Police Development of Alternatives to Hospital Adm. / crisis intervention Protocol developed to respond to frequent attenders to Custody Suite and representations via S136	Appointment of AMHPs (3 Peterborough) Police liaison Based in Police Control Centre Assessment and Custody Diversion AMHP based in Community Forensic Services (3 AMHPs Peterborough)

		Block contract for Alternatives to Hospital Admission
Integrated Health and Social Care	Enhancing S75 Agreements for the delivery of integrated care – • Health and Social care • Primary and Secondary Care • Physical and mental Health Care	Development of specialist reablement services to support Intermediate Care Services (alignment)Development of the Admissions Avoidance Team (health and Social Care) based in the Emergency Department Development of a single referral process for Health and Social Care for Transfer of Care from Secondary Care Development of a single assessment tool for Health and Social Care for the Admission Avoidance Team and Transfer of Care Development of the Discharge to Assess model from Secondary Care Development of the MDT model to support Secondary and Primary Care Development of Primary Care Mental Health Enhancing Acute Care Psychiatric Liaison
Care Act new responsibilities	Prisons; Assessment and Care Management;Carers;Self-Funders;Safeguarding;Health and Well Being, Personalisation; Preventing and Delaying through Self-Serve/Preventative Services	Capacity Building Developing Integrated Care

Priority 4 of the above plan is:
Supporting good mental health
The aim of this priority is to:
Enable good child and adult mental health through effective, accessible mental health promotion and early intervention and rapid response services to impact upon early signs of mental ill health or deterioration

The system changes as identified above support the overarching aim of this priority. The actions identified via the delivery plan are:

1. Review of operation of ARC single point-of-access
2. Re-establish local suicide prevention group
3. Universal settings support children and young people effectively and promote their resilience
4. Services are commissioned to support children and young people with developing additional mental or emotional health needs at tier 2, preventing need for accessing services at Tier 3
5. Tier 3 CAMH services are commissioned such that children and young people with more complex needs are able to access tier 3 services in a timely way with resultant improvements in their mental health and emotional wellbeing
6. Development of PCC/LCG MH Commissioning Strategy. This will include making links with:
    a. Suicide Strategy Development
    b. Public Health MH Strategy
    c. Police MH Strategy
    d. MH Employment Strategy
    e. Accommodation Strategy
    f. Joint CCG MH Strategy
7. Revising policy on parents and carers with mental health problems
8. Developing a specific and holistic re-ablement response within mental health services that incorporates BME and hard to reach communities. Services targets most deprived political wards

Progress has been made on the majority of actions identified above

Conclusion
A key priority for mental health services in the next few years is to address the underfunding issues that exist both within Health and Social Care and to rebalance the investment toward a prevention, promotion, early intervention and personalisation agenda.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

Over the next five years we aim to deliver changes to services that:

- A transformational shift from what has tended to be an acute hospital-centric system to one which provides timely and appropriate care and support along the whole care pathway, delivered through a variety of service providers and care givers
- Greater emphasis on multi-disciplinary working across health and social care leading to more effective care planning, early recognition of impending crisis and better co-ordination and targeting of resources tailored to the service user's needs
- A transition to 7 day working to enable all agencies to respond in a timely and effective manner
- A more holistic approach to commissioning health and social care recognising the importance of taking into account social, mental health and physical conditions

Specific strategies are in place designed to improve services over the next 5 years:

Adult Social Care Adult social care strategic commissioning plans

Good housing and accommodation options are a key contributor to peoples overall wellbeing and across Peterborough a series of strategic plans are underway for people across the whole Social Care and Health system in the form of an overall accommodation strategy based on three priorities which are to:

- promote and support people to maintain their independence
- Deliver a personalised approach to care and to
- empower people to engage with their communities and have fulfilled lives

Where ever possible services are being commissioned on a joint basis across health, social care and housing. Work is underway to focus on commissioning a range of preventative services, which together will support the aims of the better care fund. High priority is being is being attached to enhanced reablement services, and the implementation of assistive technologies as examples.

During the course of 2014-15 to 2019 (and beyond) we will be further developing our commissioning strategies and plans and creating a market position statement that sets out the local authority's ambitions for working with care providers to encourage the development of a diverse range of care options. It will include statements about local demand for different care and support options, the local authority's vision for care and support, and commissioning policies and practices.

We will focus on delivering the various Strategies such as the transformation of Day services across all sectors with the City, we are reviewing and re-commissioning

residential care and support service for people – including access to short breaks (respite), specialist services, support and personal assistants.

We will ensure that good quality information and advice is available for all people whether they fund social care themselves or it is funded by the council. We are now implementing new designs and technology in assistive technology which support people and carers to remain living and accessing community services.

From the Joint Strategic Needs Assessment we are reviewing the likely future demand for housing suitable for people in transitions, leaving residential care, people moving out from living with older carers including greater co-ordination between the planning authority and social and health care and housing providers, and working with the market and ensure that the needs of people can be met within general housing needs accommodation wherever possible.

An accommodation strategy for Adult Social Care services has recently been established and is in the process of consultation with housing partners to ensure a that there is clarity around the strategic needs of the Council and how these can best be met by partners and stakeholders within Peterborough across both Health and Social Care economies.

We are working with partners within the City Council and with RSLs to ensure effective use of existing housing and reviewing the use of Supporting People funding to ensure it is directed in the right places to maximise outcomes for older people. We are creating new investment in Specialist Housing following the Winterbourne enquiry

We are making a series of changes surrounding The Learning Disability Housing Strategy will be completed and we will commission long-term suitable housing that meets the needs of people with learning disabilities that are either living in the City already with family carers (transitions and adults) who will require accommodating and those people returning back to Peterborough from out of area placements. This work-stream is in partnership with Serco.

At Peterborough we understand that housing is a key enabler to independent living and that an effective and appropriate housing strategy can act as a preventative strategy enabling people to build worthwhile and sustainable lives.

A transformation of available Housing options for those people with a learning disability/autism diagnosis is in place so that people will have greater choice and control and greater flexibility in being part of a wider community. People and in particular young people transitioning from children into adult services as part of ‘mid-life transitions’ will be able to identify shared/group living options to support independent living. This will enable People and their families to choose where they live and who they live with wherever this is practicable and affordable.

Work is underway to improve the management and utilisation of the existing supported housing portfolio, particularly shared/group living, through the introduction a central void management system and compatibility assessments, to increase the capacity available across Peterborough.

We are improving the management of the adult social care CBL reserved allocations to ensure they are used efficiently and effectively. We will continue to improve the support offered to people with learning disability who bid for social housing through CBL where they have low needs or shared living is deemed not suitable.

At the same time Peterborough intend to maintain and improve partnerships and knowledge sharing with private sector and social landlords through the establishment of a landlord' forum. The forum will be particularly important in engaging landlords in the future planning and provision of housing.

We are developing our commissioning processes for transitions covering both Learning Disability (children to adult transitions) and older people (older people with older carers). We will develop an accommodation planning process which provides a pathway to source accommodation in a collective yet personalised manner.

We are also developing our long-term suitable housing that meets the needs of people with mental ill health that are living in the City already and those people returning back to Peterborough from out of area placements. We continue to review and refresh our Transport Strategy and commission transport services that meet the needs of our customers.

Stakeholders have identified accommodation for people with mental health care needs in Peterborough as a key concern. There is a lack of a clear pathway to access appropriate housing. This together with very limited resources results in people receiving their care outside of Peterborough boundaries.

Settled accommodation for those people in receipt of secondary care mental health services is a key performance management target for the Local Authority. Peterborough is recorded as having 33.6% of those in receipt of secondary mental health care in settled accommodation. This compares to 59.3% England average and 63.2% Comparator Authorities average.

Working continues to recognise the vital role that Carers play and Peterborough Carers Strategy, will commissioning a range of services to support carers in their role.

For people with a Learning Disability or Autism diagnosis:

Employment

We understand the importance of employment for people with a learning disability and aim to support people to fulfil their aspiration of obtaining work experience or paid work, including those with more complex needs. We are working to promote personal budgets for employment support, develop current micro-enterprises into social enterprises as a means to promote employment and self-employment for people with a learning disability, encourage more supported employment organisations to operate in Peterborough and to link employment support more closely with day services, both in-house and external,

We also aim to promote joint working and work experience/placements and paid work for people with a learning disability. We will encourage public sector organisations and

their contractors to offer work experience/placements and paid work to people with a learning disability.

Partnerships with large scale retail businesses in the city will be developed so that they can offer work experience/placements and paid work to people with a learning disability, and we will improve referral pathways into the supported employment service from care management teams for people with a learning disability.

We will promote joint working and co-ordination of supported employment opportunities with organisations in the city through the establishment of an employment co-ordination group.

Employment for those people in receipt of secondary care mental health services is a key performance management target for the Local Authority.
Peterborough is recorded as having 4.0% of those in receipt of secondary mental health care in employment. This compares to 7.7% England average and 7.0% Comparator Authorities average.[6]

Day Opportunities/Activity

All people with a learning disability should be able to access day services/opportunities that support them to have an independent and inclusive life of their own. This includes employment, study, leisure and social activities and a range of community based experiences.

We will promote the use of personal budgets within day opportunities to meet individuals needs and choices, and ensure all support provided within day services/activities is outcome focused and support is provided in a way to meet these outcomes for each individual. We also intend to maintain day services/activities wherever possible in community based settings to promote independence and choice.

Health

Access to good healthcare is really important to people with a learning disability and their families. People with a learning disability have the right to good quality healthcare that meets their needs. The local authority in partnership with its NHS partners will work to reduce the inequalities in health outcomes between people with a learning disability and the general population “adding life to years and years to life”.

We have a programme in place to ensure that we proactively monitor people’s health. Specifically the work will address Annual health checks, Summary Care Records, Hospital E-Track system, Health Events, Eye Care Campaign, Pharmacy awareness, Public Health Programmes, National Screening Programmes, Dental Access Centre

We also want to put in place more “Easy Read” health information

Preparing for Adulthood

[6] ASCOF Comparator Report 2012-13

The transition of young people with learning disabilities into adulthood requires lots of planning and preparation. All services need to ensure the young person and their family carers are fully engaged in the process and are informed of all the options available early so planning can take place. Adult Social Care should have good intelligence of the needs of young people from the age of 0/25 onwards therefore able to plan the services required when they reach 18 years of age which is a critical life milestone. Links with housing, employment and education services should also feed in to their development plans as well as the take up and deployment of personal budgets across the commissioned responsibilities of Health, Social Care and Education.

In Peterborough work is advanced to ensure that we operating to Department of Health's guidance on the transition from children's to adult services and the SEND Agenda, we are work closely together with children's services and other stakeholders to plan and develop a multi-agency Transitions Strategy. A robust database of all known young people from the age of 0/14 and 25 onwards is to be further developed.

We are also making available a transitions information pack for young people entering adult services.

We are improving our management information so that we are bettered prepared to provide intelligence to housing and other departments and agencies of the type of services required for the next 3 to 5 years which is fit for purpose and meets the needs of the individuals.

We also aim to put in place Person Centred Services that reflect the needs and aspirations of young people which can be met within the boundaries of Peterborough, avoiding unnecessary travel for people and reducing the cost and demand for statutory services.

Mental Health Services

In 2014 Peterborough City Council and Peterborough and Borderline LCG approved their Mental Health Commissioning Strategy. This describes their vision for mental health care and their priorities for the next 5 years. This strategy has been coproduced with the Peterborough Mental Health Stakeholder Group which is jointly Chaired by the LCG lead GP 3rd Sector CEO and supported by Local Authority officers.

The purpose of this Strategy is to support the Clinical Commissioning Group's Mental Health Strategy as part of its 5 year plan, and to articulate the needs of Peterborough and its priorities.

Our vision for Mental Health Services

Our vision in the Peterborough Strategic Partnership is to:

- Ensure a whole systems approach to the commissioning of mental health care.
- This is to include Promotion, Prevention Early Intervention Mental Wellbeing and where necessary ongoing care
- To facilitate an individual's recovery by making most use of their strengths and existing community resources.

- Where possible we will offer help and support early to ensure that individuals receive advice and support that will prevent the need for ongoing care

Mental health and an overall sense of wellbeing is a key requirement of how people define wellness. It is central to confidence, independence, self-esteem, and inclusion. It is central to how people and communities perceive their quality of life.

Our Mental Health Commissioning strategy is about repositioning services, so people can get access to services that help them more quickly and easily, without having to negotiate a system that seems to present obstacles to obtaining help, or that defines them by their mental health problem. It is also about getting high quality and effective help in the most appropriate place, within a system that empowers people and promotes recovery.

Peterborough City Council Adult Social Care and Peterborough Locality Commissioning Group has three priorities:

1. is to ensure there are effective local providers of mental health services that are responsive to the needs of local commissioners and actively engages local people

2. is to ensure a model of care that has a focus on promotion, prevention, early intervention and support. Personalisation must be a key feature of this model

3. a greater degree of plurality in the market is required. This plurality needs to be established within the community infrastructure. The motivation for plurality is that it will achieve higher quality services, greater efficiency and improve value for money and choice for the consumer in line with the personalization agenda

Our Approach to Commissioning
Mental health commissioning according to the Joint Commissioning Panel for Mental Health (JCPMH) (2011) will in the future be freed from the traditional, activity –focussed specialist service orientated model. The norm will become a multi-agency approach commissioning for mental health and wellbeing. It is expected that a much wider range of organisations will deliver a broad spectrum of services. Investment will be channelled into new areas of development beyond the boundaries of traditional 'mental illness' treatment and care, recognising that positive well-being is not simply the absence of mental ill health.

These new areas, according to JCPMH, will include:
- Social capital, building community networks and resources
- Citizen pathways – creating opportunities for people's active participation in local government
- Mechanisms to ensure people have a voice at strategic, community and individual levels.

Offender Mental Health Care
It is estimated that 40% of the most serious offending in the county is concentrated in the Peterborough area. Peterborough city is in the 'worst' third of local authority areas regarding crimes per head of population, only being exceeded by inner city boroughs in

London and other large conurbations. There are relatively high levels of acquisitive crime, underpinned by a group of offenders with high incidence of repeat offending. In Peterborough – as in many other inner cities – there are also significant levels of violent crime, some of which is drug and alcohol related and high levels of domestic violence.
The relatively high levels of criminal behaviour in Peterborough are reflected in the case mix of the existing mental health teams and there is substantial co-morbidity of mental illness and substance misuse problems.

Peterborough also has the only prison in the country that houses both male and female prisoners, with respective populations of approximately 600 males and 400 females. It houses both remand and sentenced prisoners, with an annual turnover of approximately 10,000 prisoners a year. The Government's improvement plan in January 2013 to update Britain's prisons identified HMP Peterborough to convert to a 'House block' status will increase the total prison population from 1000 to 1300. This will take effect in 2015. The majority of prisoners are resettled locally, including a significant proportion of women offenders and offenders from ethnic minority groups (increasingly from Eastern Europe).

Between April 2011 and March 2012, 54 adults with mental health needs and who were receiving treatment from the HMP Peterborough Mental Health In-Reach Team were released to the locality of Peterborough.

The community forensic mental health service aims to meet the needs of mental health services in Peterborough and Fenland with forensic histories or high risk behaviours. Taking account of high-risk mentally-disordered offenders not currently engaged with mental health services, it is estimated there are at least 80 individuals whose needs would appropriately be met by the specialist forensic community team.

Over the last year much work has been done to take forward mental health care across Cambridgeshire and Peterborough. The Strategic Partners of Peterborough City Council NHS Cambridgeshire and Peterborough Clinical Commissioning Group, Cambridge County Council and Cambridge and Peterborough Foundation Trust have worked together to address a series of challenges.

The integrated system planned for Cambridgeshire and Peterborough through deployment of the Better Care Fund joint commissioning will have the following over-arching aims and objectives:

Coordinated and intelligence-led whole systems integrated approach which focuses on promoting wellbeing, early identification of need, and early intervention to address this.

For example, this could include:

- professionals being proactive in identifying need rather than waiting for it to be presented as a formal referral
- ensuring that the workforce are able to feed back as much intelligence as possible as to the needs of the service users they are supporting and how service delivery and deployment of available resources can be improved

- further improving information sharing between the range of organisations in contact with older people about individuals at risk of requiring more support in future
- Social Workers having greater identification with a community and working with other agencies to identify those at risk and interventions available
- Frontline practitioners being mental health aware and understanding the impact of anxiety and depression on a person's physical health and social functioning. Change to workforce development activities will support these cultural changes

Investment in community capacity to enable people to meet their needs with support in their local community.

For example, this could include:

- further development and investment in community capacity and resilience - building to prevent some people from entering statutory services or a crisis
- improving access to a range of specialist services with the potential to reduce long-term care costs
- helping people to stay where they want to be, that is, at home, clearly this will incorporate changes included in our Carers Strategy.

Current work in these areas includes the development of our Dementia Resource Centre. This development sees the integration of health, and social care which includes third sector providers. More recently we have begun a review of our mental health single point of access. This review is seeking to improve the integration of health and social care and the aspiration to achieve a single assessment process.

An improved approach to crisis management and recovery.

For example, this could include:

- a process for rapid escalation and action when a crisis occurs in the life of an older person
- a coordinated response from all agencies working in or operating as multi-disciplinary teams to provide intensive support in the short term and encompassing services such as respite care
- ensuring that when the crisis is over, older people and their carers remain as independent as possible and avoid short term crises triggering a deterioration which inevitably leads to long term health or social care need

A united approach to advice and information on community and public sector services.

For example, this could include:

- developing robust and reliable sources of advice and support for older people before they become frail or need to access the statutory system
- providing universal information and advice about services from all partner agencies, which should be quick to access, clear, friendly and personalised
- develop information sharing and referral systems between respective organisations in the Statutory and non-statutory sector

How we will measure our Aims and Objectives

We will measure how well we achieve our aims and objectives through a variety of methods including:

- setting and monitoring performance against agreed outcomes and metrics
- continuing engagement with service users, patients, carers and other key stakeholders and service providers which will provide feedback on how successful the initiatives we have commissioned are 'on the ground' and where the key gaps in service are
- formal reviews and evidence-building as we make progress with implementing our integrated commissioning approach

Applying Measures of Health Gain

We wish to ensure that the Better Care Fund plan initiatives form an integral part of joint plans and are not viewed as something separate. We will monitor the health gains achieved via the Better Care Fund using the following measures of health gain:

- EQ5D as a marker of health related quality of life for people with long term conditions
- Emergency admissions from causes considered amenable to healthcare as a marker of the ability of integrated care to keep people out of hospital

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

In support of the Peterborough vision and our case for change above Peterborough have designed our BCF programme around the three broad themes of Protecting Social Care, 7 Day Working and Data Sharing. When viewed as part of Peterborough's overall transformation programme these themes, along with CCG's OPACS Procurement will deliver the BCF outcomes. In summary

Protecting Social Care

Will implement a revised information & advice strategy for ASC health, social care and wellbeing; make improvements to how health and social care is accessed, and how assessments are undertaken on a joint basis. This theme will also to ensure that services are compliant with the Care Act. Here we will also develop quality of care provision via the Care Sector Quality Improvement Team, improve asset Based Community Development to deliver health & social care support / community resilience, implement an enhanced offer for Carers (all age), implement Tele care/Tele health/ AT, and reshape the housing market, minor & major adaptations,

We will also re-shape the 24 hour bed-based care market - residential care, nursing care, reablement/rehab bed based, implement an enhanced offer for Dementia, develop a market position statement for health and social care in Peterborough, and put in place Employment First – which will develop Employment opportunities for our service users. We will also develop our 3rd sector VCS and advocacy arrangements.

Within Protecting Social Care we have identified (Early intervention, prevention, and proactive support as a sub theme which is includes:

Carers' services: to enhance the offer for carers, building on carers' prescription, respite and other carers support, and working to align strategies for adults and children's services. Building on the future aspiration of the Joint Carers' Strategy and we wish to join up monies from the Council and the CCG to improve outcomes for carers, including young carers, and those adults who care for disabled or vulnerable children. It is envisaged that this work would include roll-out and implementation of Carers' Prescription Service, support at crisis, carers' breaks, and better advice and upstream support for carers and communities. Ensuring the new responsibilities of the Care Act are met as carers will have the right to an assessment and services.

Early intervention and prevention: to develop the upstream offer, to avoid future demands on health and care sector. We wish to develop a universally accessible and joined up first point of contact, as detailed in the new target operating model with a view to avoiding escalation of demand (including admission to care or acute settings, which in mental health care will mean the development of 'alternatives to hospital admission' and further development of appropriate supported housing). Building on existing Third Sector provision, we will pro-actively develop community navigator schemes that improve access to advice and information (including for carers, and wider

communities) and promote social and community capital with a particular aim to combat isolation, and the social causes of ill health. We will also promote empowerment and self-management, building on the philosophy of self-directed support, whether through development of personal health budgets, or associated planning mechanisms for those with long-term conditions.

Dementia Resource Centre: By recognising that Older Adults and those with a physical health problems are more likely to experience anxiety and depression, and how this will impact on their overall quality of life, and by ensuring we treat emotional and physical health together, we will achieve better outcomes for the individual. We wish to develop great community resource, building on the development of the Dementia Resource Centre, with a particular view to early diagnosis, and "upstream" interventions (e.g. psycho-educational, and including support to carers and wider communities) which may maintain independence and reduce (or delay) admission to long-term care settings.

End of Life Care: support the development of community resources alongside the Lead Integrator for Community Services. This includes enhanced home care support at end of life through the new specialist third sector provision, as part of the County wide Older People's procurement with the aim of improved experience for patients and their families at the end of life as well as reduced unplanned care costs.

Within Protecting Social Care we have identified Enhanced reablement and admission prevention as a second sub-theme

This theme includes the following:

Enhanced reablement team: Building on the provision successfully provided by the City Council under present Section 256 transfer arrangements, with the proposed impact being reduced admissions, reduced length of stay, and reduced (or at least delayed) demand for long term care. This initiative includes closer alignment of community therapies to develop a structured and intensively supported discharge service (in particular for conditions such as stroke for which there is an evidence base as to the positive impact of e.g. Early Supported Discharge plus orthopaedic discharges following hip fracture).

In addition, it will include a focused and preventative approach to (repeat) fallers, including close work with other initiatives including medication review, etc. We wish to improve waiting times and capacity by working in partnership with housing providers, to provide timely and preventative adaptations, as well as to enhance reablement services following admission etc. In future, we will consider whether local ICES contracts might be aligned or more closely integrated with this work. . Enhanced reablement will have direct referral/access to The Firm and Intermediate Care to avoid unnecessary admissions or re admissions to Secondary Care.

Enhanced reablement within mental health care will aim to prevent individuals entering secondary care services and giving people the coping strategies to deal with future crisis and life events without the need to access statutory services

Home adaptations, tele health and tele care: the inclusion of Disabled Facilities Grant (DFG) funding within the BCF envelope offers a huge opportunity to develop integrated support for people in and through their own homes. Although this can be captured under the heading of home adaptations, it should essentially be seen as running in an integrated way throughout both of the overarching work programmes, as an enabler for early intervention and maintaining and reabling independence. In addition, the development and utilisation of emerging and existing technologies to support independence, and reduce demand on acute / long term care sectors. We will invest in areas for which assistive technologies are proven (e.g. for people with chronic heart-failure, COPD / asthma) with a view to maintaining independence, and reducing unnecessary hospital admissions.

Care Sector Quality Improvement Team: Establishment of central team with virtual members across the health and social care economy To support medication reviews, quality improvement, and discharge from short-term care placements, market alignment, support, and development. We will develop enhanced services (alongside incoming Lead Integrator for Older Peoples Community Services, and with reference to the Primary Care Strategy, in partnership with Primary Care) to review the health and care needs of residents in the care sector (including those supported by Domiciliary Care Services, or in Extra Care or Sheltered Housing provision). We wish to review the quality of care and to support discharge (back to more independent living), increased independence (for those who require longer term care), and with a view to e.g. medication review.

7 Day working theme

We will build on the existing arrangements for 7 Day working to further improve transfer of care on a 7 Day basis integration with health to improve hospital admission / hospital avoidance

The Firm / MDT: move to 7 day working and enhanced level of service (including Adult Social Care input) to promote admission avoidance, and timely discharge from acute and intermediate care. We will increase investment in frontline care services targeted in areas of need which are presently under-provided by the health and care sector. This includes:

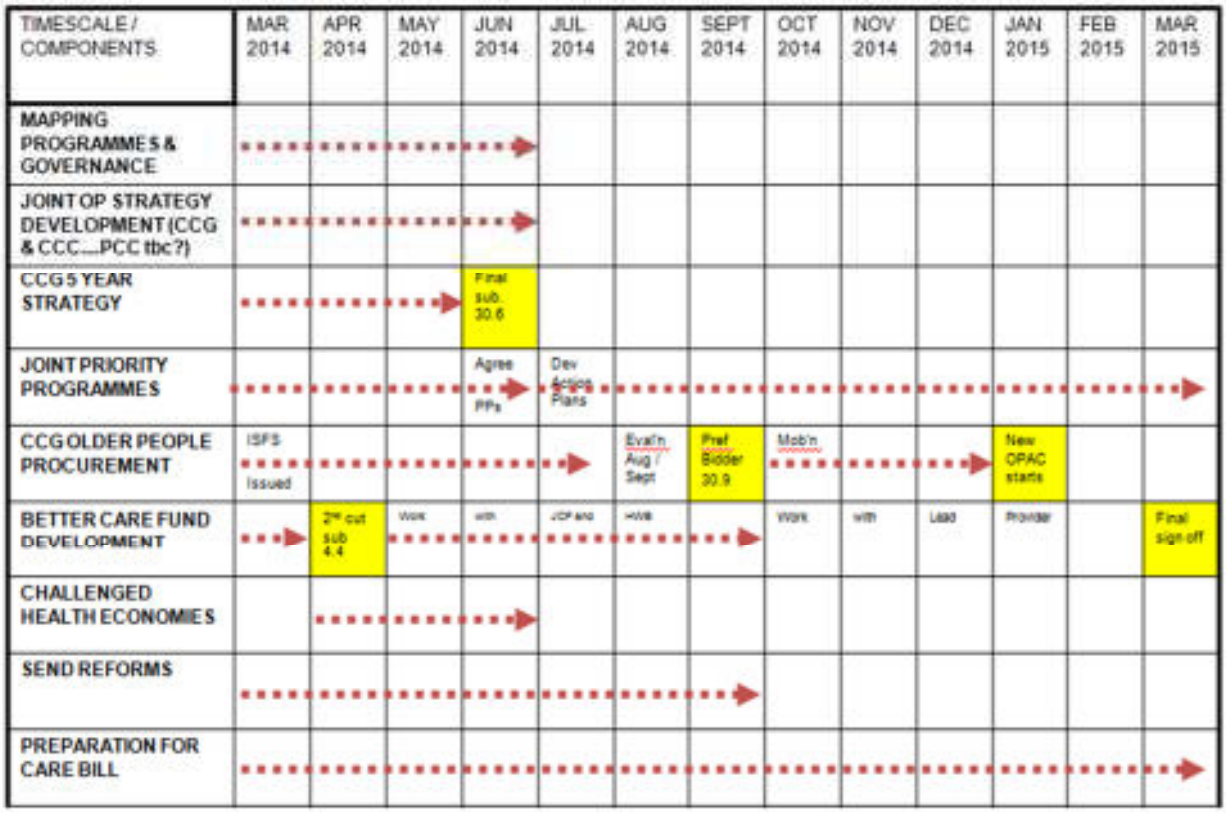
- building on existing intermediate care and admission avoidance schemes (including The Firm)
- Further developing the Admission Avoidance Team in the Emergency Department to continue to reduce the number of unnecessary admissions to the Acute Trust.
- Development of the Domiciliary Care and Care Home Market to respond to 7 day working
- further reducing the number of avoidable admissions and emergency bed days through enhanced MDT (including mental health, alcohol and substance misuse) working with adults as well as older adults (e.g. to reduce admissions for patients with concurrent learning disability and epilepsy, or improved routine review of medications)
- increased social care input to all MDT working

- 7-day working through MDT (or similar) teams and inclusion of 7-day working in acute contracts, including The Firm , Intermediate Care, Enhanced Reablement and Admission Avoidance Team
- improved psychiatric liaison services and mental health presence in MDTs (GP practices) to enhance discharge (and admission) planning, and develop timely care packages for discharge
- Increased patient flow through intermediate care sector to ensure access to "step-up" and "step down" as well as reablement beds.

Data Sharing

We will continue to work on the readiness of ICT systems, and processes to monitor and respond to the impact of the Care Act (including use of NHS number)

A detailed transformation programme for the Care Act, the BCF, and incorporating Peterborough's strategies for Mental Health, Older People, Learning Disability and Autism, along with the Peterborough system response to the ECIST review is under development and will be completed in November 2014. The overall transformation plan will ensure the delivery of the BCF outcomes commencing April 2015. This is indicated in the outline plan below:



Key BCF Milestones are therefore as follows:
<u>October</u>

- Map all change activity already underway including; existing governance arrangements, use of resources, identify interdependencies, expected delivery dates, expected benefits (financial and non-financial).

- Confirm priorities and re-align change activity accordingly (including streamlining governance, making best use of resources, re-planning delivery dates taking into account interdependencies).
- Complete and agree detailed BCF proposals and consult with stakeholders

November

- Establish the BCF Programme with phased projects to deliver changes (developing phased implementation plans, risks and issues, communications plans) and cross cutting delivery work streams (EG ICT, HR, Finance and benefits realisation, contracts and procurement, engagement and communication etc.).
- HWB sign off of detailed BCF proposals and planning

November - December

- Work with Providers, including OPPACS Lead Integrator when appointed to align / finalise implementation plans.

Jan-March

- Begin implementation in phased/controlled way January 2014 onwards

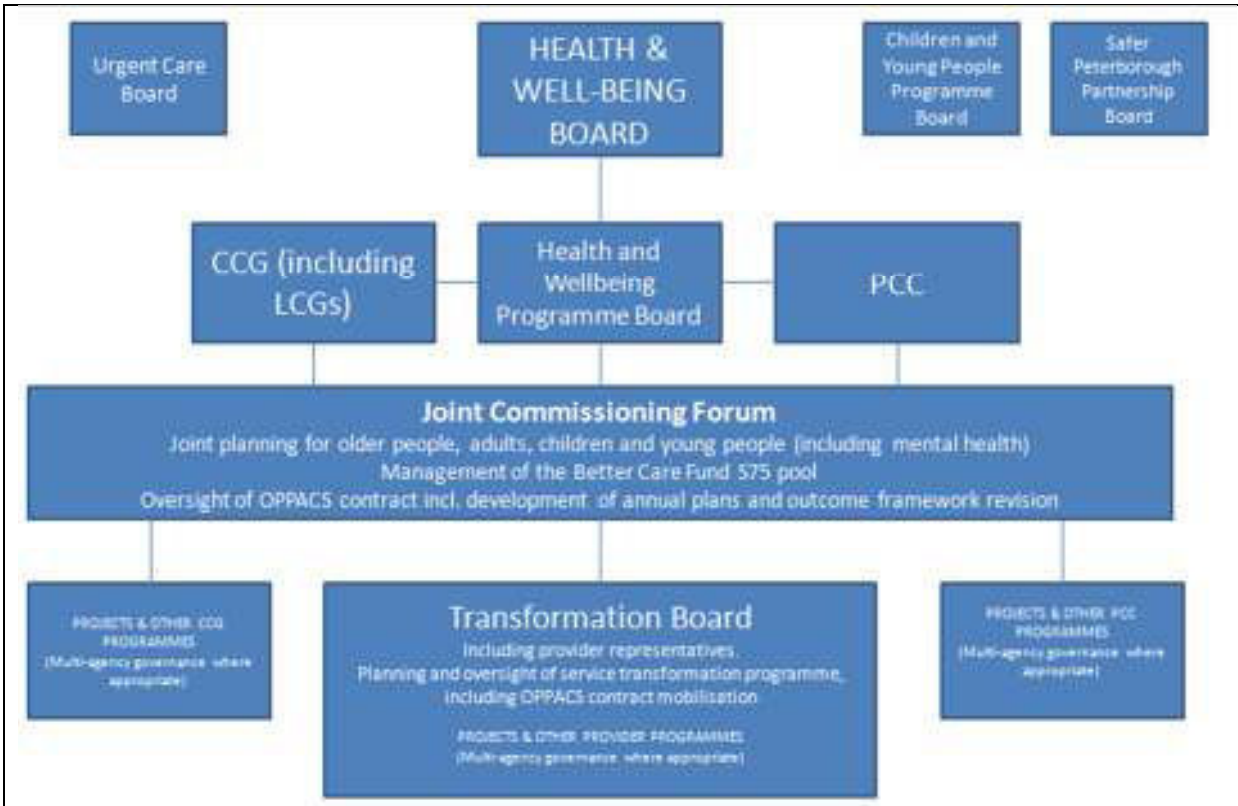
The detailed planning for the BCF has been severely constrained by an extremely onerous and demanding series of checkpoints by the BCF programme office/NHS England which have caused significant management time pressure through the main holiday period, which in turn has made it extremely difficult to complete the work to fully base-line the BCF programme, however following submission on the 19th September the programme will be prepared, and consultation will take place with key stakeholders.

b) Please articulate the overarching governance arrangements for integrated care locally

The move to greater integration is underway at various levels in the system. As examples there are integrated governance arrangements through the Joint Commissioning Forum. All partners have made a commitment to multi- disciplinary working and joint assessments and to a united way of providing information and advice.

Oversight and governance of the Better Care Fund proposals are provided by the Peterborough Health and Wellbeing Board who will sign off the plan. The development of plans for the Better Care Fund in the Borderline and Peterborough LCGs is undertaken jointly with Peterborough City Council (PCC), Cambridgeshire County Council, and Northamptonshire County Council. The majority of the agreement will relate to funding transfers (and subsequent pooled funding arrangements) with the former, PCC. With this in mind, the following arrangements have been developed:

- The PCC Health and Wellbeing Board has delegated a small working group (the BCF Working Group) to take forward the planning work. This group meets regularly to coordinate the work
- The BCF Working Group has reported monthly to the Joint Commissioning Forum from February to April. The Forum has been delegated responsibility for the sign-off of drafts of the plan (in advance of the next Health and Wellbeing Board meeting in April)
- the monthly Transformation Board has been used to engage stakeholders
- For 2014/15 the HWB have delegated the Borderline and Peterborough Joint Commissioning Forum to act as a formal sub-group of the Board for the purposes of further developing the BCF, with the Transformation Board used to monitor the implementation of the proposals with partners.
- Joint Governance arrangements for 2015/16 will be further developed and finalised as part of this ongoing work, however, the following model is in place.



- In the above model the JCF provides a forum in which to develop a joint strategic approach to service transformation and delivery of the Better Care Fund, alongside local oversight of the OPPACS contract once established.
- The objectives for the JCF in relation to the BCF are likely to include:
    - To provide effective leadership, management and governance of the Better Care Fund Section 75 pool
    - To provide a forum for multi-agency oversight of the OPPACS contract including development of annual plans and outcome framework revision
    - To develop and oversee a joint action plan to deliver the transformation programme, and guide the work of joint integration staff.
    - To ensure safeguarding is mainstreamed into commissioning and service delivery.

More detailed transformation planning, including management oversight of transformation and joint commissioning for each area of change, and interrelatedness with the mobilisation and subsequent transformation based on the OPPACS contract, would be undertaken by the Transformation Board. Along with commissioning leads, this group also includes provider representatives. It would be envisaged that a number of working groups would report into this Board on key areas of transformational work. Regular formal and informal reporting is undertaken to each organisation's board / governing body.

Within NHS Cambridgeshire and Peterborough CCG, leadership from the top is provided by the Chief Clinical Officer, supported by the Chief Operating Officer, who generate the drive, focus and performance management ethos within the organisation on behalf of the Governing Body. The Chief Clinical Officer works particularly closely with Local Commissioning Group Chairs to ensure that service transformation is shaped and steered through clinically-led commissioning. Local commissioning group

engagement is steered and overseen by Local Chief Officers who work closely with their respective Local Commissioning Group Boards.

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

Peterborough will manage the BCF programme using best practice Office For Governance Commerce “Managing Successful Programmes” methodology, in recognition of the very high complexity of the programme. Individual projects will be managed using the PRINCE2 method. The whole change will be managed through a dedicated programme office. These change methodologies coupled with the governance arrangements above will Through the robust governance arrangements outlined above we will escalate any and all project activity that may begin to go off track through the Programme Management office function.

d) ` **Planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
1	**Protecting Social Care**
a	Implementing the information & advice strategy for ASC health, social care and wellbeing
b	Accessing health and social care
c	Care Act compliant care management (including joint assessments)
d	Development of Care Sector Quality Improvement Team
e	Asset Based Community Development to deliver health & social care support / community resilience
f	Enhanced offer for Carers (all age)
G	Tele care/Tele health/ AT
H	Re-shaping the housing market, minor & major adaptations
I	Re-shaping the 24 hour bed-based care market - residential care, nursing care, reablement/rehab bed based
J	Enhanced offer for Dementia
K	Market position statement for health and social care in Peterborough
L	Employment First - developing Employment opportunities for our service users
M	Development of 3rd sector VCS and advocacy
2	**7 Day working**
A	Integration with health to improve hospital admission / hospital avoidance
3	**Data Sharing**
3a	Monitoring and responding to the impact of the Care Act (including use of NHS number and shared view of patient / user records)
4	**OPACs Procurement**

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
Loss of Strategic Perspective and Scale: The plan focuses on many small scale initiatives leading to lost opportunity to undertake strategic transformation of services	**3**	3	9	• Refer back as needed to the 5 year strategic plan context and over-arching priorities and other revenant strategic and commissioning plans • Consistently map the initiatives and proposals back to the agreed End State to check for right scale and scope • Agree a set of categories for strategic change and group ideas and proposals around these •

Failure to protect social care services: Demand for social care increases at a rate that outstrips the increased investment and transformation	3	5	15	• Closely monitor demand for social care arising from demographic change and the new statutory duties under the Care Bill
Failure to protect acute services: Investment in prevention fails to sufficiently reduce demand for acute services, creating financial challenges for the acute sector	**3**	3	9	• Closely monitor demand for acute services and ensure that contingency plans are in place for diversion of funding if necessary
Failure to meet performance targets:	**3**	3	9	• Effective negation of targets with government • Clear alignment of BCF investment and change areas to key performance targets • Robust performance management arrangements are put in place
Destabilising 'the system:' Making changes to the	**3**	3	9	• On-going review of strategy and vision • Robust arrangements

current patterns and models of service delivery in advance of implementing new ways of working de-stabilising current levels of demand and performance				for reviewing progresses across all change activities • Appropriate investment in communication to users and staff • Development appropriate workforce and OD plans
Clinical Commissioner engagement: Localities and member practices feel disenfranchised and alienated by the planning process	**3**	3	9	• Regular briefing and discussion at CCG Governing Body and at Clinical Management & Executive Team meetings • Local Chief Officers to keep their Local Commissioning Group (LCG) Boards fully informed and ensure they have the opportunity to contribute • Nominate clinical champions from LCGs / local health systems who would co-lead with SROs the priority change programmes • LCGs to engage regularly with their practices / localities and ensure that they are kept informed and

				aware of the wider context • CCG Members' Events to give opportunity for wider discussion and opportunity to address concerns raised by the membership
Provider engagement: Lack of engagement and support from Providers				• Use the Chief Executive Officer Group to identify and obtain consensus on the key strategic priorities • Invite providers to submit their ideas and proposals for transformation and use these to inform on-going discussions • Use selected provider clinical forums to keep clinicians aware and engaged • Incorporate specific change initiatives into the mainstream commissioning and contracting cycle to ensure that the BCF plans are part and parcel of everyday business
Staff engagement: Staff are not fully aware of and engaged	**3**	3	9	• Hold regular staff briefings • Post updates to organisations' websites

with the changes set out in the Better Care Fund plan				• Use the organisations' newsletters to promote better understanding and flag examples of excellent performance and innovation
Strategic Vision / End State: Lack of clarity around the 'end state' resulting in loss of delivery	**3**	3	9	• Link to the 5 year Strategic Plan – move to single OP's Plan for Cambridgeshire • Ensure all clients groups are reflected in the vision • Agree vision and principles and set them out clearly in the Better Care Fund plan (and reflect this in each organisation's core planning documents) • Set out in the plan each initiative and how it will contribute towards realisation of the bigger picture
Stakeholder Engagement: Key stakeholders do not have the opportunity to contribute to and shape the Better Care Fund plan	**1**	3	3	• Ensure that key stakeholders are identified • Build time into the Better Care Fund planning timetable to brief and discuss stakeholders • Maximise the opportunity to

				brief and debate through attending existing meetings • Organise bespoke events e.g. Health and Well-being Board development days etc. • Keep stakeholders up to date with progress in drafting the plan e.g. through regular written briefings, use of websites etc. • Reflect back to stakeholders the key outcomes of the engagement discussions •
Financial Information: Lack of clarity around the funding to be transferred from the CCG to the Better Care Fund joint commissioning pools	**1**	3	3	• CCG and Local Authority Finance leads agree the methodology for calculating the funding to be transferred and the process for transfer • Financial information to be set out explicitly in core planning documents e.g. CCG 5 Year Strategy
Planning Assumptions: Early planning assumptions	**1**	3	3	• Ensure that the BCF plan is updated regularly to reflect the

may prove to be incorrect.				emerging position and any agreements and/or changes made • Ensure effective co-ordination of the work of the different local authority project teams to allow timely update of assumptions
Governance: Insufficient project control, transparency and accountability.	**1**	3	3	• Appoint a Senior Responsible Officer in each organisation who will be accountable for progress with developing and implementing the plan • Appoint joint CCG/PCC project team(s) to implement the process and to meet the key milestones for delivery • Maintain the opportunity for scrutiny through regular formal reporting to boards responsible for decision-making • Through regular communication and briefing, ensure sufficient transparency and openness with regard to the Better Care Fund Plan • Maintain a detailed project

				timetable to ensure that key board meeting dates are identified and met
Sign-Off: Lack of agreement between partners and at the Health and Wellbeing Board means that an agreed plan cannot be signed off				• All partners to be involved in discussions and represented at the Executive Group • All partners signed up to Vision and Principles • Special meeting of the Health and Wellbeing Board to allow sufficient time for discussion
Government Approval: Delay in government signing off use of the Better Care Fund, leading to loss of the funding				• All partners working to ensure that proposals address the national criteria • It is likely that the Government will allow time to refine proposals rather than rejecting immediately

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

Discussions between Peterborough City Council and the CCG are ongoing and agreement is not yet reached in terms of BCF funding and therefore risk sharing is unclear.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

A detailed transformation programme for the Care Act, the BCF, and incorporating Peterborough's strategies for Mental Health, Older People, Learning Disability and Autism, along with the Peterborough and Borderline ECIST action plan is under development

- It would be sensible for providers to design transformation proposals jointly instead of each organisation putting forward its own set of ideas. There is a clear recognition of the need for alignment of resources and change management effort
- Closer alignment of community therapies to develop a structured and intensively supported discharge service (in particular for conditions such as stroke for which there is an evidence base as to the positive impact of e.g. Early Supported Discharge plus orthopaedic discharges following hip fracture). In addition, it will include a focused and preventative approach to (repeat) fallers, including close work with other initiatives including medication review, etc. We wish to improve waiting times and capacity by working in partnership with housing providers, to provide timely and preventative adaptations, as well as to enhance reablement services following admission etc. In future, we will consider whether local ICES contracts might be aligned or more closely integrated with this work.
- **Care Sector Quality Improvement Team:** To support quality improvement in care and support services in the City, including medication reviews, discharge from short-term care placements, market alignment, support, and development. We will develop enhanced services (alongside incoming Lead Integrator for Older Peoples Community Services, and with reference to the Primary Care Strategy, in partnership with Primary Care) to review the health and care needs of residents in the care sector (including those supported by Domiciliary Care Services, or in Extra Care or Sheltered Housing provision). We wish to review the quality of care and to support discharge (back to more independent living), increased independence (for those who require longer term care).
- The national planning guidance has signalled the closer alignment of NHS and local authority planning cycles and this is welcomed. Historically, we have worked closely together to ensure that our service plans are in direct alignment where appropriate and that we have a shared understanding of the strategic direction to meet the health and social care needs of our population. As an example, in terms of strategic direction and priorities for Older People, Cambridgeshire County Council and NHS Cambridgeshire and Peterborough CCG are working closely to agree a single, shared strategy for Older People this year.

Specific works is aligned to the BCF as follows:

Dementia Resource Centre – co-locating health and social care under one roof. Delivering pre and post diagnostic support using a hub and spoke model. Delaying/

reducing the need for ASC intervention and reducing preventable hospital admissions for people living with dementia.

Carers Hub – Commissioned a central resource to provide carers the support they need to sustain their caring role. Includes GP prescriptions for carer support – a CCG funded initiative to provide a one off break to the carer to avoid/ prevent the breakdown of the caring relationship.

Development of extra care and sheltered housing as an alternative to hospital- Working with RSL's to develop a number of units that can be used as intermediate / interim care as part of enablement package of support. Ensuring people do not stay in hospital longer than necessary and to support people back to independence, reducing risk of them being transferred in to a long term placement.

Advocacy- Designing an advocacy service that will serve adults with care and support needs, ensuring their rights are upheld and they are receiving the benefits and other available support they are entitled to. The intention being to signpost people to community based support services early on, preventing them from presenting in primary care / hospitals.

Residential Care Contracts – The City Council is transferring all residential homes to the regional ADASS standard contract. The specification for older people's care will include the condition that the home must take admissions 7 days a week to support the Hospitals to free up bed space and improving the discharge process.

British Red Cross Contract – The City Council has recently awarded a contract to British red Cross to provide volunteer led reablement support to citizens with support needs. The Manager of this service splits their time between being based with the hospital discharge team and the community social work team. The focus of the service is matching those individuals who require some practical and/or emotional support following a fall, life event or period of ill health with a volunteer who can help them regain their independence.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

The BCF aligns with the CCG's 5 year plan through an agreed set of principles by which we will work together over the next five years:

•Organise services around the patient's clinical needs and not around organisational and professional specialties
•Integrate care to maximise continuity and safety for patients across separate facilities and organisations
•Expand the geographic and population reach for specialties to ensure clinical and financial sustainability

•Measure costs and outcomes for each patient and, where possible, develop local pricing to reflect local costs
•Build enabling information flows and IT platforms to maximise efficiency and continuity of care
•Work together effectively, openly and transparently in best interests of patients and public
•Maximise focus on prevention and anticipatory care to avoid unnecessary admissions and costs
•Allocate resources across time, place and person in way that maximises sustainability and reduces inequalities

The programmes of work being developed within the five year plan encompass the BCF to deliver transformational, sustainable change.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

The CCG is developing its approach to primary care co-commissioning with the Area Team. The CCG is seeking to develop an approach in co-commissioning for additional services beyond the scope of the standard contracting of Primary Care. The CCG has the desire to increase the capacity of primary care to deliver a greater range of services that support the local populations health needs

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

The locally agreed definition of protecting social care services is maintaining the existing thresholds set under Fair Access to Care Services or, following the introduction of national eligibility criteria, ensuring that social care services are able to meet the new criteria. Adult Social Care is facing increasing demographic pressures due to increased numbers of older people longevity and medical advances which mean people with disabilities are living longer. Pressure on services will be increased as a result of the implementation of the Care Act and in particular the need to assess self-funders and to assess and meet the needs of carer's, prisons and the principles enshrined with the Act of Well-being and personalisation. The BCF working group have proposed that the funding and schemes behind the two s256 funding agreements which currently exist for the main DH funding allocation for Social Care and additional reablement funding, will form the basis of the amount of fund set aside for the protection of social care services. Funding for care act This funding is already embedded in agreed priorities and investment in social care and delivering benefits across the health and social care spectrum. The areas will be reviewed as part of the use of other BCF funding with a view to ensuring that maximum transformational change can be developed across the entire pool of funding and the services to which it relates.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

Funding will be used to support existing services or transformation programmes, where such services or programmes are of benefit to the wider health and care system, provide good outcomes for service users, and would be reduced due to budget pressures in local authorities without this investment. In addition we will also seek to establish whether existing support can be provided effectively by the third sector and/or commissioned social care rather than more expensive social workers or health care professionals, and whether the extended use of tele care/tele health can help us to change previous thinking regards roles and expectations. The Local Authority will expect to fund the implications of the 'Care Act' via the additional social care funds transferring from 1 April 2015 in respect of national

eligibility criteria and carer assessments. Planning for local care services will prioritise the development of services that:

- Provide universal services intended to prevent, reduce or delay needs and Information, advice and guidance.
- For those whose need cannot solely be met through universal services, carry out an individual assessment or carer assessment considering benefit from Universal or local services.
- Development of integrated care and support plans to reflect personal choice and set up personal budget for those that meet eligibility criteria for social care Services.
- The emergent work on Peterborough's digital strategy will further protect social care

The plans will be reviewed over the period of the BCF and amended as necessary to ensure that maximum transformational change can be developed across the entire pool of BCF funding and the services to which it relates, and that social care service are protected and in a position to deliver services which will give a whole system benefit across health and social care.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

£6.011 million has been allocated to protecting adult social care (including £3.522m existing s106 agreements) and £407K has been allocated to supporting the implementation of Care act duties. The Council is taking a transformational approach to the allocation for protecting social care, by investing it in programmes to deliver transformational change, quality improvements and system efficiencies.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

The BCF allocation will be used to fund early assessments for self-funders, assessment and support for carers, resourcing of the new national eligibility criteria, additional advocacy support and information and advice for prevention. These are all area where new duties will impact on Social Care and where protection is important. There are also some resources allocated to related ICT development and staff training

v) Please specify the level of resource that will be dedicated to carer-specific support

A specific allocation of £150K has been allocated to carer prescriptions. The remainder of carer specific funding is apportioned to schemes within the Care Act allocations (£407K) and the protecting adult social care allocations (£6,011K)

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

Funding agreement has been reached between the Council and its CCG partner as to the deployment of the BCF funding for 15/16. The agreement recognises the complexity of the CCG OPPACS initiative and its impact upon the attainment of BCF outcomes in seeking to develop and transform the commissioning of existing services to meet these.
The Council and the CCG have therefore looked at the BCF funding allocation as a whole and apportioned funds to the OPPACS programme where those funds will be employed to meet the outcomes specified within the BCF submission, and apportioned equal unallocated funds to be spent on the transformation of Social Care services.
The latter will be employed to improve local services and generate efficiencies to be re-invested into BCF initiatives and the protection of Adult Social Care.
Both partners will exploit joint commissioning opportunities contained within the funding allocations to maximise the attainment of BCF outcomes and achieve the best return on investment.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

There is a shared commitment to 7 day working which has been accepted by the Health and Wellbeing Board and the Joint Commissioning Forum and which underpins service delivery models supporting the BCF agenda.

Community based health and social care services such as The Firm, Intermediate Care Services, Reablement and Community Nursing already deliver 7 day working. Community based services (in particular homecare and residential services) will be engaged and working arrangements be established to be able to deliver services 7 days per week from the 1st April 2015, including the acceptance of referrals to support discharge from, and prevent admission to, hospital based services. A CQIN relating to 7 day discharge has been in place with PSHFT during 2013/14 and has been built into the contract for 2014/15

In addition

- The offer of Health and Social care Domiciliary Services that can be called into stay with patients overnight by OOH's GP's to prevent admissions, with the same team supporting A&E Patients to return home overnight to prevent being admitted for Social Reasons.
- Care Homes accept referrals on the same day as assessment 7 days per week, step up and down, and Domiciliary Care Agencies accepting and starting new care packages 7 days per week.
- 7 day assessments Health and Social Care in the Hospital to support 7 day discharging includes CHC needs
- 7 day support from Voluntary Sector Organisations to support people in the Community who don't meet Health and Social Care

The System will review its approach and expectations of the Market to deliver 7 day a week response to support people requiring care/ support services. Success will mean that people will be able to be discharged from hospital at the weekend, because staff are there to medically approve discharge, plan their discharge and link up with a suitable provider if they need ongoing care. This will mean service providers needing to change their staffing patterns to allow this, which might mean changes in terms and conditions or working hours for staff in hospitals, social services, housing and care providers.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

Within Peterborough social care services, the NHS Number is collected, but not currently used as the primary identifier for correspondence, care plans etc. The Council has commenced data completeness checks and currently holds NHS number for around 50% of client records. For referrals from Peterborough City Hospital the NHS Number is already routinely captured and used as the primary identifier for MDT discussions.

Peterborough City Council is developing a universal front door and e-referral portal, collection of NHS Number and consent to store and share will be embedded into our front door processes and assessment tools. We are also anticipating alignment with health front door once the new Countywide contract has been awarded. We will commence conversations on how this model might operate in earnest following the selection of the preferred bidder to act as the Integrator, scheduled for end September 2014.

As part of our wider transformation programme we will move towards use of the NHS number as the primary inter-agency identifier via the following means:

- Introduction of e-referral for all referrals for professionals, which capture NHS number and consent of patients to the referral and sharing of NHS number.
- Updating all forms within the social care system, including letters and care plans, to pull through NHS Number.
- Exploring options for bulk uploads of missing NHS numbers

These work streams will be overseen by the Adult Social Care Systems Project Board, feeding into the Transformation Programme Board.

We have also established a Health and Wellbeing Board Information Working Group where information leads from across the Council and Health system as looking to establish procedures for safe data sharing within the Caldecott guidelines, for the purpose of needs assessment, commissioning intelligence and risk stratification.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Peterborough City Council has a digital strategy which is designed around interfaces between core records and apps which support practice. We are committed to the principle of collecting data and once and sharing. Our preferred models of assessment are those which can be accessed on line as a self-assessment tool or be completed with service users in their own home, this model allows recording consent to share at the time of collection. This model allows for service user / patient owned shared records, delivered via an online portal and interfaced to clinical and social care systems as appropriate.

We are also currently in the process of moving from secure e-mail to cloud based file sharing systems to facilitate safe sharing of assessments and care plans across support networks, to limit use of e-mail transfer. This system in time could also allow for user set permissions to personal records, thus supporting in reality the concept of the person held assessment and care plan.

Plans will be built on in more detail following the appointment of the system wide health integrator, as their role involves support of shared care plans.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, and professional clinical practice and in particular requirements set out in Caldicott 2.

The CCG submitted IG Toolkit Version 11 (2013/14) for publication at the end of October 2013. 'Satisfactory' assurance was attained for this early submission as required to enable Stage 1 Safe Haven status and the NHS Standard Contract was used. Caldicott2 recommendations are known and will be implemented. The CCG has a well-established IG and IM&T Group in place to ensure compliance with all aspects of information governance.

Peterborough City Council currently has certified PSN accreditation and therefore we must complete the I.G. Toolkit self-assessment to demonstrate our compliance with national standards. All organisations completing the IGT are expected to score a minimum of level 2 in all requirements or submit a comprehensive action plan detailing how they will reach level 2 during the following period. Whilst we have achieved 20 compliance requirements at level 2 to comply with PSN accreditation, we have five requirements at level 0 and 3 at level 1. These eight requirements are our priorities for improvement over the current year.

We have drawn up an IG Management Framework setting out all the roles, responsibilities and essential policies within the organisation. We are currently reviewing a draft overarching Information Governance policy, an improved and more robust data protection policy. We are ensuring that each contract not only contains the relevant information governance clauses but also that third parties have the appropriate IT and IG policies, strategies and procedures in place. Each requirement of the IG Toolkit will form our work plan for the coming year.

We have noted the recommendations of Caldicott 2 and the revised principles from September 2013. These principles are embedded in approach to IG and we have also begun to map the 26 recommendations accepted by the government to the IG Toolkit where possible to ensure our compliance with both. We have also engaged with the Caldicott Implementation Monitoring Group to provide evidence and feedback on our compliance.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

Across Cambridgeshire and Peterborough CCG have introduced multi-disciplinary teams (MDTs) to provide better and more holistic support to frail elderly or other vulnerable people. MDT assessments will become the norm for people who fall into these categories. They bring together social, medical and community care plans involving GPs, hospital doctors, nurses, physiotherapy, social workers and voluntary or community groups. Learning from these pilots about the role of lead professionals and the application of risk stratification tools will be used in developing proposals to support people in need of help as described in Section 2c.

The Direct Enhanced Service for GPs will also require practices to risk stratify their service users, create personalised care plans for the most vulnerable, and ensure that this group has a named and accountable GP.

To support the development of multi-disciplinary working, a new assessment of need is being developed, which will cut across health and social care (GP services, District Nurse services, physiotherapist services, occupational therapy, social care), including acute and community-based care, and make the process of assessing service users with multiple needs more joined up and efficient.

The new assessment will be used in supporting everyone who is 80 or over- around 30,000 people, or 5% of the population, and the most important age group for the intensive institutional services that we are trying to reduce the need for. There will be a further development of this model through the CCG procurement exercise, where the successful bidder will be involved in developing further models of working both in relation to joint assessment and the notion of an 'accountable lead professional'.

Risk stratification will form a key component of the solutions being worked on by bidders as part of the CCG procurement for Integrated Older People Pathway and Adult Community Services. The illustration below emphasises the need to ensure that proactive care approaches extend beyond the most intensive service users, at the top of the pyramid, to cover those who are at moderate-to-high relative risk of admission to hospital.

The integrated model of delivery will be implemented across Peterborough on a phased basis targeting key clinical pathways, or groups of patients to ensure that inequalities are addressed, and impact in terms of health outcomes and financial savings are maximised. For the Living my Life programme to be effective we need to

identify those people most at risk of escalating care needs who would benefit from a more coordinated response to enable them to live more independently. This might include CVD, completion of reablement or rehabilitation programmes, diabetes, etc. and this focus will be further developed through the detailed implementation planning during 2014/15.

We are building up an understanding of the health and social care needs of Peterborough's population and will employ the outcomes to target those people who will benefit from early intervention within an integrated model of assessment and care. As the Peterborough City Council revised Target Operating Model becomes established, and alongside the expected transformation of services which will be undertaken by the incoming Lead Integrator for Older Peoples' and Community Services, commissioned activity arising will start to impact upon the key objectives identified within the BCF agenda.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

- It will also include: commitment to named lead professional for integrated packages of care, use of the NHS number as the primary identifier, and development of increased 7-day working.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

This data would be provided by the CCG as Primary Care hold joint care plans on S1?

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

Patient representatives are on the Joint Commissioning Forum, that has delegated responsibility for the BCF from the HWB. Patient forums have had presentations on the BCF process and high level plans. Post submission a more detailed programme of engagement is planned on the schemes included within the submission

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

Peterborough and Stamford Foundation Trust (PSHFT) have been involved with potential providers of the OPAC service in developing models of care to deliver the outcomes required. The ECIST review of the Peterborough health and social care system recommendations and subsequent action plans to deliver the recommendations are aligned and intrinsic to the workstreams set out within the BCF submission In addition the Cambridgeshire and Peterborough System have a collaborative programme with all partner organisations under the challenged health economy work to deliver a sustainable health and social care system for the future. Delivery of the BCF is embedded within this work.

ii) primary care providers

Primary care have been represented on the steering group of the BCF in Peterborough, and through the Joint Commissioning Forums, and Local Commissioning group boards of the CCG

iii) social care and providers from the voluntary and community sector

Peterborough commissioners meet regularly with provider networks in the independent and voluntary sectors. The BCF proposals have been discussed in with providers particularly where they are seen to be able to offer services which might meet BCF outcomes. More detailed work will take place through 2014/15 to offer clarity around particular delivery models where providers will be asked to submit proposals and engage in more formal procurement procedures for the identified initiatives, An example of this is the Day Opportunities for people with a Learning Disability exercise to re-shape services through the creation of community resilience models, reablement

and use of Assistive Technology solutions to create a whole systems approach to mitigating core service demand and addressing pressure points on the health and social care system. Strategic partners within the independent and voluntary sector as well as stakeholders have been involved in the design and co-production of the delivery model options and delivery vehicle. (Case for Change P.26)

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

Work is underway through the ECIST to improve the discharge processes and to "right size" Intermediate Care capacity.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.1a
Scheme name: Protecting Social Care (Implementing the information & advice strategy for ASC health, social care and wellbeing.)
What is the strategic objective of this scheme?
To create the environment whereby Peterborough residents are able to self-serve where-ever possible.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
To put in place an information and advice website and care directory. To put in place community specific content (care directory) designed to promote self-service To agree and implement a process/mechanism to keep content up to date, involving commissioners, contracts, procurement, 3rd sector, and providers To enable any Peterborough resident or carer to create their own support plan The introduction of capability that enables residents to find, order and pay for items to support the self-funder/self-service model To put in place a training programme targeted at social care operational staff
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
A detailed transformation programme for the Care Act, the BCF, and incorporating Peterborough's strategies for Mental Health, Older People, Learning Disability and Autism, along with the Peterborough and Borderline ECIST is under development at the time of this report which will be completed in October/November 2014. The detailed plan will provide details of the delivery chain for this scheme.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?
Reduction in demand for Statutory Services through the reduced volume of Health and Social Care contacts from residents.

Scheme ref no.1b
Scheme name: Accessing health and social care
What is the strategic objective of this scheme?
To ensure that conceptual plans for the creation of a new “front door” to health and social care are implemented in a way in which change is thoroughly embedded.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
To put in place a single point of initial contact, the new front door for social care - contact centre, telephony/IVR, electronic referrals, processing along with white mail / and fax referrals To create the single point of initial contact for health and social care including mental health To put in place triage/eligibility and initial demand management with reablement & assistive technology as the default To implement a new CRM system to support the new front door To create the ASC operating model to support the new front door
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
A detailed transformation programme for the Care Act, the BCF, and incorporating Peterborough’s strategies for Mental Health, Older People, Learning Disability and Autism, along with the Peterborough and Borderline ECIST is under development at the time of this report which will be completed in October/November 2014. The detailed plan will provide details of the delivery chain for this scheme.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

What are the key success factors for implementation of this scheme?
Reduction in demand for Statutory Services through the reduced volume of Health and Social Care contacts from residents.

Scheme ref no.1c
Scheme name: Protecting Social Care(Care Act compliant care management (including joint assessments)
What is the strategic objective of this scheme?
To make adjustments to business as usual operations so that services are compliant with the incoming care act in April 2015.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
To bring about changes to assessment & personalised support planning as a result of Care Act (e.g. eligibility, response to self-funders, carers) To implement a Care Act training programme changing care management culture To ensure that Case management system(framework) is compliant with the changes to the care act compliant Implementing changes to care management so that personalisation and direct payments are the default Making changes to care management processes so that Assistive technology is an intrinsic part of the assessment process.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
A detailed transformation programme for the Care Act, the BCF, and incorporating Peterborough's strategies for Mental Health, Older People, Learning Disability and Autism, along with the Peterborough and Borderline ECIST is under development at the time of this report which will be completed in October/November 2014. The detailed plan will provide details of the delivery chain for this scheme.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?
Service improvements made for Peterborough residents and new statutory duties implemented into "business as usual" operations

Scheme ref no. 1d
Scheme name Development of Care Sector Quality Improvement Team
What is the strategic objective of this scheme?
The creation of a multi-disciplinary team with a clear focus to support care providers to drive up standards, and improve the safeguarding of vulnerable people
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The Development of multi-agency quality improvement / trouble-shooting function with health and social care input; The provision of targeted/practical support to improve the quality of all commissioned care – e.g. care homes, day-care, home care, PA's etc. The design of "kite mark" quality standards and processes to support links with commissioning/contracts/procurement/contract monitoring. To be published on the website & care directory
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
A detailed transformation programme for the Care Act, the BCF, and incorporating Peterborough's strategies for Mental Health, Older People, Learning Disability and Autism, along with the Peterborough and Borderline ECIST is under development at the time of this report which will be completed in October/November 2014. The detailed plan will provide details of the delivery chain for this scheme.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?
Service quality improvements made for Peterborough residents and improvements to safeguarding arrangements across the Peterborough Care Sector.

Scheme ref no.1e
Scheme name Protecting Social Care - Asset Based Community Development to deliver health & social care support / community resilience
What is the strategic objective of this scheme?
To put in place community based systems that can function to provide support at a local neighbourhood level
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
To put in place arrangements for Local Area Coordinators To develop community assets into appropriate business models (e.g. groups, small enterprises, trading business etc.) To create a sustainable model of community development and resilience To put in place a culture change programme (training/engagement) on asset based community development for all staff and partners
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
A detailed transformation programme for the Care Act, the BCF, and incorporating Peterborough's strategies for Mental Health, Older People, Learning Disability and Autism, along with the Peterborough and Borderline ECIST is under development at the time of this report which will be completed in October/November 2014. The detailed plan will provide details of the delivery chain for this scheme.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?
Community based social enterprises formed and demand for statutory services is reduced.

Scheme ref no. 1f
Scheme name Protecting Social Care (Enhanced offer for Carers (all ages))
What is the strategic objective of this scheme?
To enhance the support that careers receive.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
carers integrated assessment & planning carers prescriptions respite for carers support for carers at crisis Improving info & advice for carers Developing the 3rd sector to support carers
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
A detailed transformation programme for the Care Act, the BCF, and incorporating Peterborough's strategies for Mental Health, Older People, Learning Disability and Autism, along with the Peterborough and Borderline ECIST is under development at the time of this report which will be completed in October/November 2014. The detailed plan will provide details of the delivery chain for this scheme.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?
New rights for Carers will be in place for April 2015 in line with the Care Act.

Scheme ref no.1g
Scheme name: Protecting Social Care (Tele care/Tele health/ AT)
What is the strategic objective of this scheme?
The AT project objective is to develop, implement and adopt an integrated approach, to achieve both Health and Social care outcomes, by the use of Assistive Technology, to improve the quality of care, enhance user lifestyle choice, promote independence and secure expedient benefits for the City of Peterborough and its citizens.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
To produce a clear tele care and tele health offer; To make changes to the integrated assessment and planning pathway with AT becoming the default To put in place systems that can order/monitor/track benefits To put in place a culture change programme (training/engagement) on the use of tele care/tele health/AT to reduce care package costs and time spent on assessment & support planning (initially focusing on self-management for long term conditions and falls prevention)
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
A detailed transformation programme for the Care Act, the BCF, and incorporating Peterborough's strategies for Mental Health, Older People, Learning Disability and Autism, along with the Peterborough and Borderline ECIST is under development at the time of this report which will be completed in October/November 2014. The detailed plan will provide details of the delivery chain for this scheme.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?

Reduced demand for statutory services, more people to stay at home for longer postphoning and preventing the need for residential care. Less hospital admissions through improved crisis response model.

Scheme ref no. 1h
Scheme name: Protecting Social Care (Re-shaping the housing market, minor & major adaptations)
What is the strategic objective of this scheme?
To put in place a better funded and much more responsive Equipment and adaptations offer making it easier for people to be discharged from hospital to home and for people to stay at home for longer.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Increase funding for Home adaptations Enhanced Care & repair / handyman service Improved provision and quality of sheltered accommodation
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
A detailed transformation programme for the Care Act, the BCF, and incorporating Peterborough's strategies for Mental Health, Older People, Learning Disability and Autism, along with the Peterborough and Borderline ECIST is under development at the time of this report which will be completed in October/November 2014. The detailed plan will provide details of the delivery chain for this scheme.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?

More of Peterborough's residents are able to live independently and safely reducing demand for hospital based services and expensive residential housing options

Scheme ref no. 1i
Scheme name: Protecting Social Care - Re-shaping the 24 hour bed-based care market - residential care, nursing care, reablement/rehab bed based
What is the strategic objective of this scheme?
To put in place better capacity to enable "step up" and "step down" options
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
To develop and implement a new service specification/contract to deliver improved provision and quality of residential and nursing care To develop and implement a new service specification/contract to deliver bed based reablement/rehabilitation at Friary Court"
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
A detailed transformation programme for the Care Act, the BCF, and incorporating Peterborough's strategies for Mental Health, Older People, Learning Disability and Autism, along with the Peterborough and Borderline ECIST is under development at the time of this report which will be completed in October/November 2014. The detailed plan will provide details of the delivery chain for this scheme.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?

Pressure on A&E and Acute beds reduced. More people are able to regain independence reducing demand for statutory services and improving overall Well-Being.

Scheme ref no.1j
Scheme name Protecting Social Care - Enhanced offer for Dementia
What is the strategic objective of this scheme?
To put in place specifically tailored additional capacity and specifically for people living with dementia, their carer's and families
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Establish a specialist Dementia Resource Centre Development of AT specifically for dementia. Support for carers of dementia Development of domiciliary care specifically for dementia Development of residential and nursing care homes specifically for care homes Development of extra care housing specifically for dementia"
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
A detailed transformation programme for the Care Act, the BCF, and incorporating Peterborough's strategies for Mental Health, Older People, Learning Disability and Autism, along with the Peterborough and Borderline ECIST is under development at the time of this report which will be completed in October/November 2014. The detailed plan will provide details of the delivery chain for this scheme.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?
Overall improvement to the capability and capacity of Dementia based services in Peterborough

Scheme ref no.1k
Scheme name: Protecting Social Care - Market position statement for health and social care in Peterborough
What is the strategic objective of this scheme?
To create a clear strategic view of where and what type of services are required in line with the Joint Strategic Needs Assessment.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
To map out all provision of health and social care against the JSNA needs assessment across Peterborough. Establish baseline. Analyse. Identify gaps. To develop commissioning intentions/strategies/refocus projects or initiate new ones to address these gaps
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
A detailed transformation programme for the Care Act, the BCF, and incorporating Peterborough's strategies for Mental Health, Older People, Learning Disability and Autism, along with the Peterborough and Borderline ECIST is under development at the time of this report which will be completed in October/November 2014. The detailed plan will provide details of the delivery chain for this scheme.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?
A clear market position statement which informs the detailed commissioning plans across Peterborough in-line with demographic growth forecasts.

Scheme ref no.1l
Scheme name Protecting Social Care - Employment First - developing Employment opportunities for our service users
What is the strategic objective of this scheme?
To review and open up employment pathways across Peterborough.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Develop and deliver programme of job skills development to support clients to access employment; Raise awareness with employers Set up as micro enterprise Develop pathway to employment (including volunteering) for each service user group
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
A detailed transformation programme for the Care Act, the BCF, and incorporating Peterborough's strategies for Mental Health, Older People, Learning Disability and Autism, along with the Peterborough and Borderline ECIST is under development at the time of this report which will be completed in October/November 2014. The detailed plan will provide details of the delivery chain for this scheme.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?
Increased volume of younger adults obtaining paid employment. Increased independence and reduced demand for statutory services

Scheme ref no.1M
Scheme name Protecting Social Care - Development of 3rd sector VCS and advocacy
What is the strategic objective of this scheme?
To develop capacity within the 3rd sector to improve advocacy.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
To design an integrated advocacy service To specifically review and redesign Older People's VCS day service To review and improve HIV support services To Develop Direct Payment and personalisation support in the 3rd sector To Develop support planning service in the 3rd sector To review and develop services that support Independent Mental Capacity Advocate (IMCA) services To review and put in place improvements to Community Support for stroke survivors To review Deaf, blind UK / about me Develop new focus for MIND (April 2015) Work with the voluntary sector to further develop reablement (e.g. British Red Cross)
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
A detailed transformation programme for the Care Act, the BCF, and incorporating Peterborough's strategies for Mental Health, Older People, Learning Disability and Autism, along with the Peterborough and Borderline ECIST is under development at the time of this report which will be completed in October/November 2014. The detailed plan will provide details of the delivery chain for this scheme.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

What are the key success factors for implementation of this scheme?
Development of Voluntary services at the community level. Reduced demand for statutory services.

Scheme ref no.2a
Scheme name 7 Day working - Integration with health to improve hospital admission / hospital avoidance
What is the strategic objective of this scheme?
To put in place improvements to the hospital discharge pathway, and to create an enhanced reablement offer
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Integrated hospital discharge pathway & team - 7 day working, strong alignment to MDT's Integrated reablement/rehab/intermediate care pathway & team - 7 day working, strong alignment to MDT's CHC pathway - funding without prejudice" " Development of reablement offer for both LD and MH Accountable professional named for any integrated packages of care"
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
A detailed transformation programme for the Care Act, the BCF, and incorporating Peterborough's strategies for Mental Health, Older People, Learning Disability and Autism, along with the Peterborough and Borderline ECIST is under development at the time of this report which will be completed in October/November 2014. The detailed plan will provide details of the delivery chain for this scheme.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?
Reduce demand for acute services. Improved patient/service user experience.

Scheme ref no. 3a
Scheme name: Data Sharing - Monitoring and responding to the impact of the Care Act (including use of NHS number)
What is the strategic objective of this scheme?
Implementation of the NHS number
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Set up appropriate systems to monitor impact (e.g. self-funders, carers, wellbeing eligibility, safeguarding etc.) on budget, waiting lists, time spent by operational staff - align reporting function to Care Act Set up system to forecast demand and model operational impact e.g. the ASC TOM effort model Use of NHS number as prime identifier Identifying/coordinating response to risks & issues related to the Care Bill (including engagement with other local authorities, national developments, legal support)
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
A detailed transformation programme for the Care Act, the BCF, and incorporating Peterborough's strategies for Mental Health, Older People, Learning Disability and Autism, along with the Peterborough and Borderline ECIST is under development at the time of this report which will be completed in October/November 2014. The detailed plan will provide details of the delivery chain for this scheme.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?

Patients/Service users can quickly be identified by Health or social Care professionals avoiding delays in establishing identity and medication history leading to an improved patient/service user experience.

Scheme ref no. 4

Scheme name: Older People and Adult Community Services Outcome Based Procurement

What is the strategic objective of this scheme?

In summary, the vision for Older People and Adult Community Services is:

for people to be proactively supported to maintain their health, well-being and independence for as long as possible, receiving care in their home and local community wherever possible;

for care to be provided in an integrated way with services organised around the patient;

to ensure that services are designed and implemented locally, building on best practice;

to provide the right contractual and financial incentives for good care and outcomes; and

to work with patients and representative groups to design how the CCG commissions services.

The strategic objective is for older people's healthcare and adult community services to be better organised around needs of the patient. We want to see:

• More joined-up care

We want to make sure that the health and care professionals involved in the care of an older patient or adult with a Long Term Condition, work together in joined-up teams. We are proposing to have a "lead" organisation responsible for delivering and co-ordinating this care, no matter where is it delivered, in the hospital or the community.

• Better planning and communication

We want to ensure that patients and their carers are involved in creating their health and care plans, and with consent, for these plans to be available at all times (24/7) to the appropriate professionals.

• More patients supported to remain independent

We would like older people to have access to care in ways that allow them to maintain their independence.

• Improved community and "out of hospital" services and fewer patients admitted to hospital as an emergency, where it can be safely avoided.

We want to stop people going into hospital unnecessarily (where it can safely be avoided) and we want make sure our older patients and adults with long term conditions can access the right support either at home or in their local community, in a timely manner. We want people to feel confident about the care they receive at home.

Overview of the scheme
Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The patient groups being targeted are those aged over 65 and adults who receive health commissioned community services.

The model of care will be developed in further detail from October 2014, when the provider is appointed and will include BCF objectives. At this stage proposals are:

- More joined up care: organising care around the patient

To improve both patients' and carers' experiences of the healthcare received by older people, along with the quality of services delivered, the CCG asked organisations taking part in the tendering process to put together proposals that showed care organised around a patient's need.

The proposals received suggest this can be achieved by:
• making sure that patients and carers are involved in making plans for their health and community care, so that services are delivered according to their need
• providing named care co-ordinators for patients
• the named care co-ordinators focussing on frail older patients, or those with complex problems, or those needing end of life care, will be supported by a team of doctors, nurses and therapists working together around the needs of each patient, and working better with voluntary organisations and social care
• if the patient is living with a long term condition such as dementia or diabetes or respiratory disease, the team would include a professional specialising in those fields
• providing specialist teams to provide support to the 'patient's team' when needed.

- Better planning & communication: delivering 'seamless' care

We want to see care delivered in ways the ensure people feel everyone is part of the same team and knows what each other is doing. We want both patients and their carers to feel that their care is 'seamless' not disjointed.
We want to see all staff involved in a patient's care to be communicating with one another and working in a co-ordinated way.

Proposals received suggest this can be achieved by:
• having a single point of access contact centre operating 24 hours a day, seven days a week - either nurse-led or staffed by professionals with links to expert advisors and all organisations involved in the care of older patients
• having a single electronic record system and shared protocols, so that all relevant health and social care professionals can access, with patient consent, information whenever necessary.
• the continuation and strengthening of the already established Multi-Disciplinary Team (MDT) models, with better links to hospital specialist advice
• ensuring all health and care professionals have an understanding of all the health and social care needs of people in their care, not just in the specific area that they are trained

to deliver care in
• bringing mental health professionals into the wider team, so that frail older people with
both physical and mental health problems receive better joined-up care
• solid partnership working with voluntary organisations providing everyday living support to older people for example with transport or providing respite for partners who are carers.

- Supporting older people to stay independent

We would like to see care delivered to older patients, or for older patients to be able to access care, in ways that allow them to maintain their independence. Ways suggested for doing this are:
• offering support at an earlier stage to a larger number of people than is the case now
• focusing on prevention - making sure those aged 65 plus have access to information and services that will help keep them well, for example diet advice and exercise opportunities
• with patient consent, offer a health/care review to identify and address issues, for example housing problems
• increased working with local voluntary organisations to direct patients to services and provide more informal support
• establishing healthcare contact points venues other than GP practices
• using technology such as Skype/Telehealth to provide support for people with long term
conditions
• developing a record system that patients can access, so they can self-manage their care

- Improved community services: reducing emergency hospital admissions, re-admissions and long stays in hospital.

Quite often during an episode of severe illness, hospital treatment is necessary. However a significant number of people are admitted to hospital who could have been safely treated at home, or discharged at an earlier point, if community services were organised in a different way.

We would like to see a healthcare system that reduces the number of older people being taken to hospital unnecessarily, or staying in hospital longer than needed.

Proposals received suggest this can be achieved by:

• improving information for, and engagement with patients, their relatives and carers to increase understanding of long term conditions, so they can better identify minor changes
or serious deterioration and request help accordingly and earlier
• emphasis on personal case management to identify patients at risk of being admitted or
re-admitted to hospital, managed through Multi-Disciplinary Teams (MDTs)
• having a 24/7 urgent care system that can send a community team to the patient to both

assess and treat at home, without the need to go to A&E unless necessary

• good access to urgent hospital specialist advice and assessment
• much stronger links between the community and the hospital, from the A&E department
to the wards, with teams based in the hospital supporting care and linking with community teams in-reaching into the hospital, supporting better arranged discharge
• better rehabilitation services to support people to recover from episodes of ill health. This could include the provision of 'step down' beds in community settings, or a hospital at home service giving help with personal hygiene such as bathing, shaving etc, as well as medical care.

- End of Life Care

Alongside improving care for older people, the CCG has made improving End of Life Care across Cambridgeshire one of its priorities. The preferred provider(s) awarded the contract will be expected to work with the CCG on delivering improved End of Life Care.

Proposals put forward include:
• providing:
− local specialist nurses
− 24-hour support for patients and carers if needed, at home or in community bed settings
− well co-ordinated MDT working around the needs of the patient, as described above
• with patient consent, making sure information on a patient's needs and wishes regarding resuscitation and the place where they wish to be cared for at the end of their life, is available to all healthcare services, including the ambulance service
• ensuring that community services are able to meet the needs and wishes of patients and their carers.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Service	Current Delivery Chain
Community services for older people and adults	Cambridgeshire Community Services NHS Trust
Unplanned acute hospital care for patients aged 65 and over (A&E, non-specialist services admissions)	• Cambridge University Hospitals NHS Foundation Trust • Hinchingbrooke Health Care NHS Trust • Peterborough & Stamford Hospitals NHS Foundation Trust • Queen Elizabeth Hospital Kings Lynn NHS Trust The main impact for this BCF plan will be for Peterborough and Stamford FT
Older People Mental Health Services	Cambridgeshire & Peterborough NHS Foundation Trust

Other services which support the care of older people	Specialist palliative care services providers; GP practices (local enhanced service for care homes/nursing homes); specific voluntary organisations; other acute Trusts (hospitals) providing unplanned acute care

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes
-

The CCG's programme is informed by a comprehensive assessment of the evidence available. This began with an assessment of need, and includes a detailed analysis of evidence on improving outcomes for patients. There is published evidence that better organised and joined-up care leads to better health outcomes. For example, in April 2013 the Kings Fund updated a report 'Transforming Our Health Care System: A Summary' where they published the evidence for the effectiveness for all aspects of care for older people. A separate summary of the clinical case for change can be found on our website

Specific JSNA s underpin the evidence base for our population. Bidders have been encouraged to use the local JSNAs to inform their commissioned services and development of integrated care pathways:

Primary Prevention for Older People JSNA

This JSNA provides important evidence and information to support the commissioning of preventative services and initiatives for Older People across health and social care and to encourage awareness and signposting of available public health improvement programmes and services available across Cambridgeshire. The successful lead provider will be expected to use this evidence and information to develop effective integrated pathways of prevention to support healthy behaviours in older people.

This JSNA focusses on modifiable lifestyle behaviours, for which there are clear associations with poor health outcomes and opportunities to take a preventative approach: active ageing and physical activity, maintaining a healthy diet (including preventing malnutrition), and stopping smoking. It provides evidence on health-related behaviours in older people, including local data where available and a description of local programmes or initiatives to support healthy behaviours or actions to reduce lifestyle risk

Carer's JSNA

The main question for the JSNA was 'What can we do to support carers to stay healthy and well?' In addition, to support the work around the Better Care Fund, the JSNA has

also looked at the evidence for whether supporting carers reduces health and social care service use. The scope of the JSNA is carers across the whole life course

Older People's Mental Health JSNA

The Cambridgeshire HWB highlighted older people's mental health as a priority area for JSNA work.

In consultation with partners the scope of an Older People's Mental Health JSNA was narrowed to focus primarily on dementia and depression. The JSNA makes an important distinction between mental wellbeing or mental health and mental illness or disorder

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The scheme is supported by outcome domains underpinned by metrics.

The CCG has agreed the following success criteria:

- improve patient experience and service quality for patients and their carers through care organised around the patient;
- deliver services which are sensitive to local health and service need, as defined in the Local Requirements;
- move beyond traditional organisational and professional boundaries, so front-line staff can work effectively and flexibly together to deliver seamless care;
- support older people to maintain their independence and reduce avoidable emergency admissions, re-admissions and extended stays in acute hospitals (including delayed transfers of care);
- deliver an organisational solution for older people's care which can demonstrate strong leadership, sound governance, resilience, and the confidence of commissioners and provider partners;
- demonstrate credible approach to engaging patients and representative groups in design and delivery of services; and
- Provide a sustainable financial model (see Financial Principles below).

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The Outcomes Framework for Older People and Adult Community Services to improve health, wellbeing and maintain independence includes seven domains.

Each domain is supported by performance metrics. Delivery against metrics will be managed by the CCG and partners through our joint governance arrangements
What are the key success factors for implementation of this scheme? This schemes is well advanced with the provider due to be appointed in October 2015 The procurement objectives are aligned with those for the Better Care Fund and this has featured in provider dialogue and the outcomes framework.

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	The Peterborough Health and Wellbeing Board
Name of Provider organisation	Peterborough and Stamford Hospitals NHS Foundation Trust
Name of Provider CEO	Stephen Graves
Signature (electronic or typed)	Stephen Graves

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	23,296
	2014/15 Plan	24,729
	2015/16 Plan	24,479
	14/15 Change compared to 13/14 outturn	6.15% increase
	15/16 Change compared to planned 14/15 outturn	1.01% decrease
	How many non-elective admissions is the BCF planned to prevent in 14-15?	170
	How many non-elective admissions is the BCF planned to prevent in 15-16?	1,694

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	No. We believe that to deliver a sustainable health and social care system, we together need to be challenging in the reduction in emergency admissions and hence believe that we should continue with at least the 3.5% reduction, which is the proposed level of 3.5% BCF guidance
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	Our basis for not agreeing to the proposed percentage reduction is that as a Trust we believe that with the continuing trend in the growing demand for non-elective services is not sustainable. Hence the percentage levels set in the BCF will not provide the significant benefits required to the patients, the local health and social care system, including this Trust. As a minimum we would seek to have 3.5% reduction.

3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Yes

Please see additional analysis doc from the CCG attached.

Health and Wellbeing Board Details

ROCR approval applied for

Please select Health and Wellbeing Board:

Peterborough

Please provide:

Tina Hornsby
tina.hornsby@peterborough.gov.uk

Health and Wellbeing Board Payment for Performance

There is no need to enter any data on this sheet. All values will be populated from entries elsewhere in the template

Peterborough

1. Reduction in non elective activity

Baseline of Non Elective Activity (Q4 13/14 - Q3 14/15)	16,752
Change in Non Elective Activity	-167
% Change in Non Elective Activity	-1.0%

2. Calculation of Performance and NHS Commissioned Ringfenced Funds

Figures in £

Financial Value of Non Elective Saving/ Performance Fund	249,000
Combined total of Performance and Ringfenced Funds	3,105,780
Ringfenced Fund	2,856,780
Value of NHS Commissioned Services	3,899,000
Shortfall of Contribution to NHS Commissioned Services	0

2015/16 Quarterly Breakdown of P4P

	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Cumulative Quarterly Baseline of Non Elective Activity	4,293	8,331	12,430	16,752
Cumulative Change in Non Elective Activity	-43	-83	-124	-167
Cumulative % Change in Non Elective Activity	-0.3%	-0.5%	-0.7%	-1.0%
Financial Value of Non Elective Saving/ Performance Fund (£)	64,114	59,641	61,132	64,114

Health and Wellbeing Funding Sources

Peterborough

Please complete white cells

	Gross Contribution (£000)	
	2014/15	2015/16
Local Authority Social Services		
<Please select Local Authority>		
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<Please select Local Authority>		
<Please select Local Authority>		
<Please select Local Authority>		
Total Local Authority Contribution	**-**	**-**
CCG Minimum Contribution		
NHS Cambridgeshire and Peterborough CCG		10,390
-		-
-		-
-		-
-		-
-		-
-		-
Total Minimum CCG Contribution	**-**	**10,390**
Additional CCG Contribution		
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Total Additional CCG Contribution	**-**	**-**
Total Contribution	**-**	**10,390**

Summary of Health and Wellbeing Board Schemes

Peterborough

Please complete white cells

Summary of Total BCF Expenditure

Figures in £000

	From 3. HWB Expenditure Plan		Please confirm the amount allocated for the protection of adult social care		If different to the figure in cell D18, please indicate the total amount from the BCF that has been allocated for the protection of adult social care services
	2014/15	2015/16	2014/15	2015/16	
Acute	-	-			
Mental Health	-	-			
Community Health	-	3,749			
Continuing Care	-	-			
Primary Care	-	-			
Social Care	-	6,997	661	6,011	
Other	-	-			
Total	**-**	**10,746**		**6,011**	

Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool

Figures in £000

	From 3. HWB Expenditure	
		2015/16
Mental Health		-
Community Health		3,749
Continuing Care		-
Primary Care		-
Social Care		150
Other		-
Total		**3,899**

Summary of Benefits

Figures in £000

	From 4. HWB Benefits		From 5.HWB P4P metric
	2014/15	2015/16	2015/16
Reduction in permanent residential admissions	227	227	
Increased effectiveness of reablement	2,600	572	
Reduction in delayed transfers of care	-	-	
Reduction in non-elective (general + acute only)	-	249	249
Other	-	-	
Total	**2,827**	**1,048**	**249**

Health and Wellbeing Board Expenditure Plan

Peterborough

Please complete white cells (for as many rows as required):

	Expenditure								
Scheme Name	**Area of Spend**	**Please specify if Other**	**Commissioner**	**if Joint % NHS**	**if Joint % LA**	**Provider**	**Source of Funding**	**2014/15 (£000)**	**2015/16 (£000)**
Older peoples and adult services procurement	Community Health		CCG				CCG Minimum Contribution		3,749
Care act implementation	Social Care		Local Authority			Local Authority	CCG Minimum Contribution		407
2014/15 section 256 agreement	Social Care		Local Authority			Local Authority	CCG Minimum Contribution		3,522
Protecting adult social care services	Social Care		Local Authority			Local Authority	CCG Minimum Contribution		2,489
Performance fund	Social Care		Local Authority			CCG	CCG Minimum Contribution		429
Carers prescription	Social Care		CCG			Charity/Voluntary Sector	CCG Minimum Contribution		150
Total								**-**	**10,746**

Health and Wellbeing Board Financial Benefits Plan

Peterborough

If you would prefer to provide aggregated figures for the savings (columns F-J), for a group of schemes related to one benefit type (e.g. delayed transfers of care), rather than filling in figures against each of your individual schemes, then you may do so.

If so, please do this as a separate row entitled "Aggregated benefit of schemes for X", completing columns D, F, G, I and J for that row. But please make sure you do not enter values against both the individual schemes you have listed, and the "aggregated benefit" line. This is to avoid double counting the benefits.

However, if the aggregated benefits fall to different organisations (e.g. some to the CCG and some to the local authority) then you will need to provide one row for the aggregated benefits to each type of organisation (identifying the type of organisation in column D) with values entered in columns F-J.

2014/15

Please complete white cells (for as many rows as required):

			2014/15					
Benefit achieved from	**If other please specifiy**	**Scheme Name**	**Organisation to Benefit**	**Change in activity measure**	**Unit Price (£)**	**Total (Saving) (£)**	**How was the saving value calculated?**	**How will the savings against plan be monitored?**
Reduction in permanent residential admissions		Telecare/Telehealth/AT and reshaping the housing market, minor and major adaptations, Enhanced offer for carers, accessing health and social care, Market Position Statement	Local Authority	8	28,340	226,720	reduction in number of admissions x unit weekly price x 52 weeks	
Reduction in non-elective (general + acute only)		Older people and adults services procurement	NHS Commissioner			-		
Reduction in non-elective (general + acute only)		7 Day working, Telecare/Telehealth/AT, Development of Care Sector Quality Improvement Team, Reshaping the 24 hour bed-based care market, information and advice strategy for ASC, health, Social Care and Well-benig, Care Act compliant care management (including joint assessments), development of 3rd sector VCS and advocacy, Market Position Statement, Integration and data Sharing	Local Authority			-		
Increased effectiveness of reablement		Telecare/Telehealth/AT and reshaping the housing market, minor and major adaptations, 7 day working, Reshaping the 24 hour bed-based care market, Market Position Statement, Asset Based Community Development, Employment First Integration and Data Sharing	Local Authority	500	5,200	2,600,000	Historic modelling of previous reablement outcomes	
Reduction in delayed transfers of care		7 day working, reshaping the 24 hour care market, telecare/telehealth/AT, development of the care sector Quality Improvement Team, reshaping the housing market, minor and major adaptions, Market Position Statement, Integration and Data Sharing	NHS Provider	-		-	turnround the current trned in growth in numbers. With a view to reductions from 2015/16	
Other	Reduction in injuries due to falls	Telecare/Telehealth/AT, Development of Care Sector Quality Improvement Team, Enhanced offer for Dementia, Market Position Statement	NHS Commissioner	59		-	Predictive Modelling - fewer numbers of falls	
						-		
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Total			-	567	33,540	2,826,720	-	-

2015/16

			2015/16					
Benefit achieved from	**If other please specifiy**	**Scheme Name**	**Organisation to Benefit**	**Change in activity measure**	**Unit Price (£)**	**Total (Saving) (£)**	**How was the saving value calculated?**	**How will the savings against plan be monitored?**
Reduction in permanent residential admissions		Telecare/Telehealth/AT and reshaping the housing market, minor and major adaptations, Enhanced offer for carers, accessing health and social care, Market Position Statement	Local Authority	8	28,340	226,720	reduction in number of admissions x unit weekly price x 52 weeks	6,425,244,800
Reduction in non-elective (general + acute only)		Older people and adults services procurement	NHS Commissioner	167	1,490	248,830		370,756,700
Reduction in non-elective (general + acute only)		7 Day working, Telecare/Telehealth/AT, Development of Care Sector Quality Improvement Team, Reshaping the 24 hour bed-based care market, information and advice strategy for ASC, health, Social Care and Well-benig, Care Act compliant care management (including joint assessments), development of 3rd sector VCS and advocacy, Market Position Statement, Integration and data Sharing	Local Authority			-		-
Increased effectiveness of reablement		Telecare/Telehealth/AT and reshaping the housing market, minor and major adaptations, 7 day working, Reshaping the 24 hour bed-based care market, Market Position Statement, Asset Based Community Development, Employment First Integration and Data Sharing	Local Authority	110	5,200	572,000	Historic modelling of previous reablement outcomes	2,974,400,000
Reduction in delayed transfers of care		7 day working, reshaping the 24 hour care market, telecare/telehealth/AT, development of the care sector Quality Improvement Team, reshaping the housing market, minor and major adaptions, Market Position Statement, Integration and Data Sharing	NHS Provider	500		-	Reduction of 500 bed days	-
Other	Reduction in injuries due to falls	Telecare/Telehealth/AT, Development of Care Sector Quality Improvement Team, Enhanced offer for Dementia, Market Position Statement	NHS Commissioner	113		-	Predictive Modelling - fewer numbers of falls	-
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Total			-	898	35,030	1,047,550	-	9,770,401,500

Peterborough

Red triangles indicate comments

Planned deterioration on baseline (or validity issue)
Planned improvement on baseline of less than 3.5%
Planned improvement on baseline of 3.5% or more

Please complete the five white cells in the Non-Elective admissions table. Other white cells can be completed/revised as appropriate.

Non - Elective admissions (general and acute)

Metric		Baseline (14-15 figures are CCG plans)				Pay for performance period				
		Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	*Quarterly rate*	**2,251**	**2,117**	**2,149**	**2,266**	**2,203**	**2,072**	**2,103**	**2,218**	**2,155**
	Numerator	4,293	4,038	4,099	4,322	4,250	3,998	4,058	4,279	4,208
	Denominator	190,754	190,754	190,754	190,754	192,953	192,953	192,953	192,953	195,251

Rationale for red/amber ratings

P4P annual change in admissions	*-167*
P4P annual change in admissions (%)	*-1.0%*
P4P annual saving	*£249,000*

£1,490 National average cost of non-elective admission[1]

The figures above are mapped from the following CCG operational plans. If any CCG plans are updated then the white cells can be revised:

Contributing CCGs	CCG baseline activity (14-15 figures are CCG plans)				% CCG registered population that has resident population in Peterborough	% Peterborough resident population that is in CCG registered population	Contributing CCG activity			
	Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)			Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)
NHS Cambridgeshire and Peterborough CCG	18,315	17,237	17,554	18,496	22.4%	96.0%	4,101	3,860	3,931	4,142
NHS South Lincolnshire CCG	3,699	3,434	3,239	3,468	5.2%	4.0%	192	178	168	180
Total						**100%**	**4,293**	**4,038**	**4,099**	**4,322**

References

1. Based on 12-13 Reference Costs: average cost of a non-elective inpatient short and long stay combined excluding excess bed days. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/261154/nhs_reference_costs_2012-13_acc.pdf

Peterborough

Red triangles indicate comments

Planned deterioration on baseline (or validity issue)

Planned improvement on baseline

Please complete all white cells in tables. Other white cells should be completed/revised as appropriate.

Residential admissions

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Annual rate*	**592.8**	**539.9**	**527.3**
	Numerator	155	147	147
	Denominator	25,980	27,226	27,879
	Annual change		*-8*	*0*
	Annual change (%)		*-5.2%*	*0.0%*

Rationale for red rating

Reablement

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Annual %*	**73.8**	**80.0**	**83.3**
	Numerator	50	640	750
	Denominator	65	800	900
	Annual change		*590*	*110*
	Annual change (%)		*1180.0%*	*17.2%*

Rationale for red rating

Delayed transfers of care

Metric		13-14 Baseline				14/15 plans				15-16 plans			
		Q1 (Apr 13 - Jun 13)	Q2 (Jul 13 - Sep 13)	Q3 (Oct 13 - Dec 13)	Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	**1,269.0**	**1,259.2**	**1,087.3**	**1,147.2**	**1,177.6**	**1,177.6**	**1,177.6**	**1,165.0**	**1,033.3**	**916.6**	**813.0**	**711.7**
	Numerator	1,809	1,795	1,550	1,659	1,703	1,703	1,703	1,703	1,511	1,340	1,188	1,052
	Denominator	142,556	142,556	142,556	144,612	144,612	144,612	144,612	146,185	146,185	146,185	146,185	147,793
								Annual change	*-1*			*Annual change*	*-1721*
								Annual change (%)	*0.0%*			*Annual change (%)*	*-25.3%*

Rationale for red ratings

Patient / Service User Experience Metric

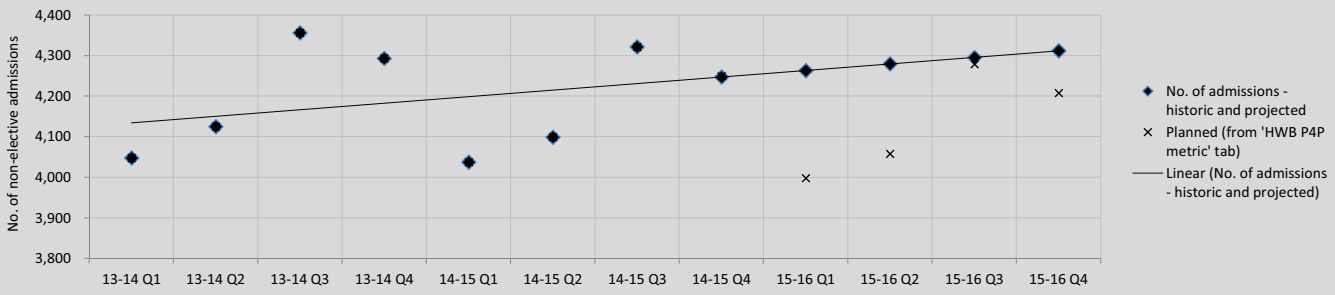
Peterborough

To support finalisation of plans, we have provided *estimates* of future performance, based on a simple 'straight line' projection of historic data for each metric. We recognise that these are crude methodologies, but it may be useful to consider when setting your plans for each of the national metrics in 2014/15 and 2015/16. As part of the assurance process centrally we will be looking at plans compared to the counterfactual (what the performance might have been if there was no BCF).

No cells need to be completed in this tab. However, 2014-15 and 2015-16 projected counts for each metric can be overwritten (white cells) if areas wish to set their own projections.

Non-elective admissions (general and acute)

Metric		Historic			Baseline				Projection				
		13-14 Q1	13-14 Q2	13-14 Q3	13-14 Q4	14-15 Q1	14-15 Q2	14-15 Q3	14-15 Q4	15-16 Q1	15-16 Q2	15-16 Q3	15-16 Q4
Total non-elective admissions (general & acute), all-age	*No. of admissions - historic and projected*	4,048	4,125	4,357	4,293	4,038	4,099	4,322	4,248	4,264	4,280	4,296	4,312

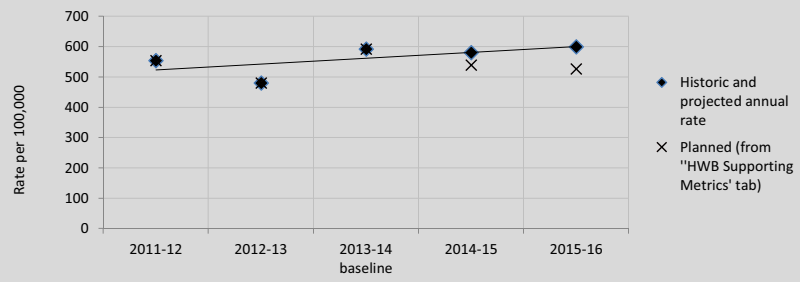


Metric		Projected				
		2014 -2015 Q4	2015-16 Q1	2015-16 Q2	2015-16 Q3	2015-16 Q4
Total non-elective admissions (general & acute), all-age	*Quarterly rate*	*2,226.8*	*2,209.7*	*2,218.1*	*2,226.4*	*2,208.5*
	Numerator	*4,248*	*4,264*	*4,280*	*4,296*	*4,312*
	Denominator	*190,754*	*192,953*	*192,953*	*192,953*	*195,251*

* The projected rates are based on annual population projections and therefore will not change linearly

Residential admissions

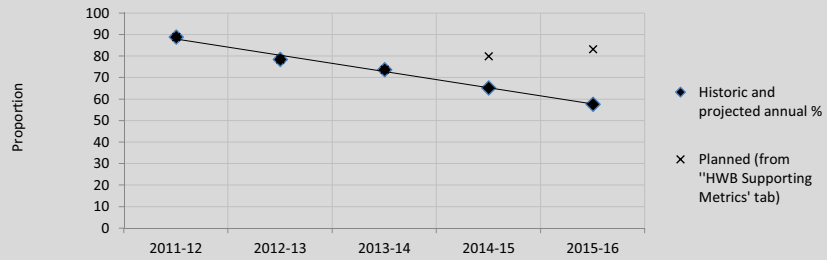
Metric		2011-12 Historic	2012-13 historic	2013-14 baseline	2014-15 Projected	2015-16 Projected
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Historic and projected annual rate*	554	481	593	*581*	*601*
	Numerator	140	125	155	*158*	*167*
	Denominator	25,075	25,980	25,980	*27,226*	*27,879*



This is based on a simple projection of the metric proportion.

Reablement

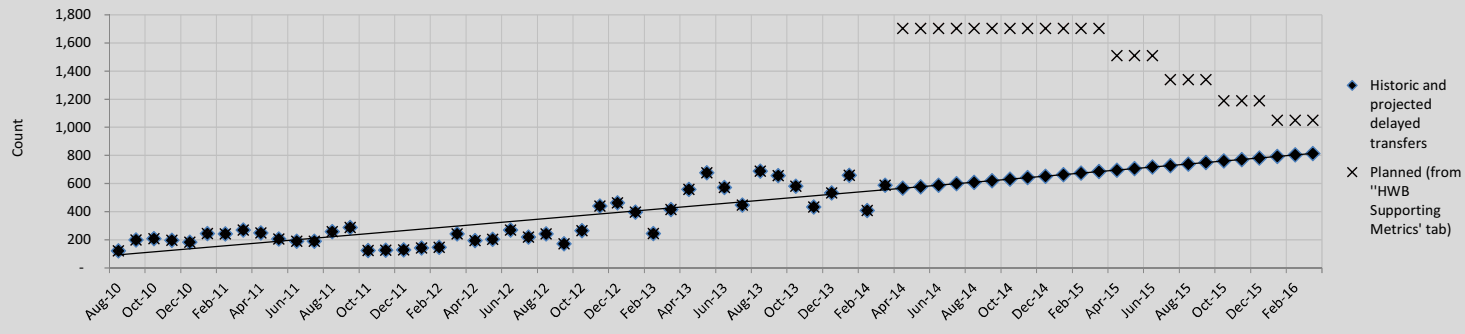
Metric		2011-12 Historic	2012-13 Historic	2013-14 Baseline	2014-15 Projected	2015-16 Projected
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Historic and projected annual %*	88.9	78.6	73.8	*65.3*	*57.8*
	Numerator	110	160	50	*42*	*38*
	Denominator	125	200	65	*65*	*65*



This is based on a simple projection of the metric proportion, and an unchanging denominator (number of people offered reablement)

Delayed transfers

Metric		Historic											
		Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11
Delayed transfers of care (delayed days) from hospital	*Historic and projected delayed transfers*	123	200	208	198	184	245	242	270	250	207	190	191



Metric		Projected rates*							
		2014-15 Q1	Q2	Q3	Q4	2015-16 Q1	Q2	Q3	Q4
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	*1,199.2*	*1,266.2*	*1,333.1*	*1,385.0*	*1,451.2*	*1,517.4*	*1,583.6*	*1,631.8*
	Numerator	*1,734*	*1,831*	*1,928*	*2,025*	*2,121*	*2,218*	*2,315*	*2,412*
	Denominator	*144,612*	*144,612*	*144,612*	*146,185*	*146,185*	*146,185*	*146,185*	*147,793*

* The projected rates are based on annual population projections and therefore will not change linearly

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 8(a)
25 SEPTEMBER 2014		PUBLIC REPORT
Contact Officer(s):	Dr Henrietta Ewart, Interim Director of Public Health	Tel. 01733 204175

HEALTH PROTECTION EXCEPTION REPORT

RECOMMENDATIONS	
FROM : Dr Henrietta Ewart, Interim Director of Public Health	**Deadline date :** seasonal flu and business continuity- at this meeting

The Health and Wellbeing Board is asked to:

1. note the updates on Tuberculosis, gonorrhoea and Ebola.
2. consider how to engage and communicate with members of the new migrant populations about health issues in the context of wider PCC engagement eg housing, benefits advice.
3. to consider asking CMT to make arrangements to encourage and enable frontline social care staff and other essential staff (directly employed or commissioned) to access seasonal flu immunisation to support business continuity and winter planning.

1. ORIGIN OF REPORT

1.1 This report is submitted to the Board as an 'exception report' to provide an update on current issues of interest in health protection.

1.2 The purpose of this report is to provide an update on:

A. The tuberculosis (TB) screening in Chatteris;
B. The apparent rise in notifications of gonorrhoea (gc) in Peterborough;
C. Ebola in West Africa;
D. Planning for seasonal influenza and business continuity for the winter; and invites the Board to consider the implications and actions recommended in relation to items A and D summarised in points 2 and 3, above.

1.3 This report is for Board to consider under its Terms of Reference:

'to keep under review the delivery of the designated public health functions and their contribution to improving health and tackling inequalities in health'.

The discharge of the Health Protection responsibilities of the PCC links with the following priorities of the Health & Wellbeing Strategy 2012-15:

- Ensure that children and young people have the best opportunities in life to enable them to become healthy adults and make the best of their life chances.
- Narrow the gap between those neighbourhoods and communities with the best and worst health outcomes.
- Enable older people to stay independent and safe and to enjoy the best possible quality of life.

2. UPDATE REPORT ON TUBERCULOSIS SCREENING AT A FRUIT-PACKING FACTORY IN CHATTERIS, IN APRIL 2014.

The report below was provided for the HWB by the lead investigator, Public Health England, on 27th August, 2014.

2.1 Context:

From January 2012 some cases of TB diagnosed among workers at a fruit packing business in Chatteris were noted to have the same VNTR (variable number tandem repeat – a form of modified genetic sequencing used routinely in the UK to identify cases of TB that could be linked). Many of the people diagnosed with this strain of TB were from Eastern Europe, giving rise to the hypothesis that the cases were a result of infection acquired in countries of origin with higher rates of infection than the UK.

However, there was also evidence of infection passing to colleagues in the workplace. Routine contact-tracing was not succeeding in preventing transmission of infection. Although many of the cases shared transport to work and had often shared accommodation, meaning that transmission could have taken place outside of work, the workplace was the most convenient place to intervene. Therefore a mass screening event was organised for April 10th and 11th 2014 using a mobile chest x-ray facility and blood tests.

2.2 Results:

A total of 523 people were screened. 173 people were identified as needing further assessment as either the chest x-ray showed evidence of lung disease needing investigation or the blood test indicated that they had latent TB. Latent TB is a dormant and non-infectious phase of TB disease that can progress in approximately 10% of people to active disease. By identifying people at this stage of infection and offering treatment it is possible to reduce the chance of them developing active TB by two thirds. Peterborough City Hospital and Addenbrooke's Hospital have been investigating and treating these people. The clinical teams will soon be in a position to report on the numbers entering and completing treatment.

2.3 Discussion:

The WHO estimates that one third of the world's population has evidence of TB infection. It is impossible to interpret the figures we obtained in the context of the UK population as large-scale screening exercises using the sensitive immunological blood tests have not been carried out. Migrant workers from Eastern Europe come from countries with higher rates of TB infection than the UK and may develop symptoms while working locally.

2.4 Issues for Peterborough:

The TB service has developed a good understanding of how Peterborough residents with family links to the Indian sub-Continent react to a diagnosis of TB, but the links have not yet been established with communities from Eastern Europe. This population may be suspicious of "state medicine" and reluctant to co-operate with contact-tracing. They may also experience barriers to accessing a range of health and social services.

2.5 Recommendation:

The need to engage, and communicate with, members of the new migrant populations about health issues has been identified in a number of forums and there is a plan to include an 'eastern European JSNA' in this year's JSNA refresh/ extension.

The HWB may wish to consider how the need to provide health advise and tackle the perceived stigma of TB can be addresses in the context of wider PCC engagement e.g. with housing and benefits advice.

3. UPDATE ON THE RISE IN NOTIFICATIONS OF GONORRHOEA

3.1 Background

The Peterborough Health Protection Committee received a verbal update of an increase in gonorrhoea notifications in 2013 from the Peterborough gentio-urinary medicine service.

Public Health England have provided the following data:

Year	Notifications of gonorrhoea
2008	47
2009	52
2010	32
2011	42
2012	64
2013	106
2014 (Jan-March)	19

The April –June 2014 data will be available at the end of September.

3.2 Action and response

PHE have raised the increase with the provider, Peterborough and Stanford Hospital Foundation Trust. PSHFT believe that the increase reflects a change in practice with regard to partner notification rather than a rise in index cases on gonorrhoea.

'Previously patients who opted to inform sexual partners of an infection were assumed to have done so. There has been a change in practice where a nurse/ health advisor would actively check that the index patient has informed sexual partners and take on the responsibility of contacting sexual partners where the index case had failed to do so. This has resulted in more partners being screened, diagnosed and treated'

3.3 Cambridgeshire Community Services won the tender to provide this service from July 2014. PHE has a meeting with the new provider early in September.

3.4 Recommendation

The HWWB is asked to note the explanation for the rise in gonorrhoea notifications due to a change in practice to active contact tracing, giving rise to an improvement in the identification, diagnosis and treatment of sexual partners of index cases.

4. EBOLA IN WEST AFRICA

4.1 Background

An outbreak of Ebola Virus Disease (EVD) was first reported in West Africa in March. Guinea, Sierra Leone and Liberia are all affected. This is the largest known outbreak of EVD and the World Health Organisation has warned that it is likely to 'continue for some time'. The death toll from the disease was reported by WHO as 1522 on the 28th August, which the United Nation's health agency considers an underestimate.

Ebola causes a viral haemorrhagic fever. It is a zoonosis –that is, its usual host in an animal rather than man. It is thought that hunting and eating bush meat is a factor in transmission to local populations. Ebola is spread through contact with the body fluids and secretions of someone with the illness and through local burial practices. The incubation period is 2-21 days and presentation is usually with a high fever, muscle pains and diarrhoea.

There have been six cases (PHE 3rd September) of infection in humanitarian aid workers who have been repatriated to their home countries for treatment. A British nurse who caught Ebola in Sierra Leone has been repatriated, treated at the high level isolation facility at the Royal Free and discharged home.

Public Health England advises that the risk for UK tourists, visitors and expatriates is very low. The likelihood of imported cases is low; healthcare providers have been reminded to remain vigilant for those who have visited an area affected by ANY viral haemorrhagic fever and who develop unexplained illness. Advice has been issued for travellers and for aid workers; to airlines, the UK Boarder Agency, the NHS and primary care, and the ambulance service. Both PHE and NHS England provide regular briefing notes and updates.

4.2 Local response

The Public Health Department receives regular updates and briefing notes from Public Health England and NHS England and disseminates information appropriately, working with the Peterborough and county wide health protection committees.

Peterborough City Council provided advice to front line staff in early August. The briefing note is attached at Appendix A for information.

4.3 Recommendation

The Health and Wellbeing Board is asked to note:

- that the likelihood of an imported case in Peterborough, as in the rest of the UK, is low based on the PHE assessment of risk;
- that the Public Health Department reviews and disseminates information from updates and briefings as appropriate;
- that Peterborough City Council has provided advice to front line staff through its Public Health Department and Internal Communications service;
- that NHS England has provided advice and briefings to acute trusts and primary care;
- that services are identified for the safe and secure transport of suspected / cases by the ambulance service and for treatment in high level isolation facilities.

5. SEASONAL INFLUENZA

5.1 Background

The Department of Health, Public Health England and the NHS Commissioning Board published a joint winter flu plan in April 2014 clarifying the responsibilities for delivery following the Health and Social Care Act 2013.

Local authorities, through their Director of Public Health, have responsibility for:

- providing appropriate challenge to local arrangements and advocacy with key stakeholders to ensure access to flu vaccination and to improve its uptake by eligible populations
- providing independent scrutiny and challenge to the arrangements of NHS England,PHE and local authority employers of frontline social care staff and other providers of health and social care
- providing leadership, together with local resilience partners to respond appropriately to local incidents and outbreaks of flu infection.

In addition, all employers of individuals working as providers of NHS services are responsible for:

- management and oversight of the flu vaccination campaign for their frontline staff
- support to providers to ensure access to flu vaccination and to maximise uptake amongst those eligible to receive it.

The impact of flu on the population varies from year to year and is influenced by changes in the virus that, in turn, influence the proportion of the population that may be susceptible to infection and the severity of the illness.

5.2 Eligible groups

Eligible groups for seasonal flu immunisation are listed in Appendix B. The focus is on vulnerable groups such as older people (over 65), people of all ages with a serious medical condition, carers, and pregnant women. In addition, in order to disrupt transmission of the virus to susceptible individuals, seasonal flu immunisation is being rolled out to children aged 2, 3 and 4 years and, as a pilot, to older children. Peterborough is a pilot site for immunisation of year 7 and 8 children in schools.

Public Health England is the lead organisation, commissioning vaccine and delivery programmes for target groups, working through CCGs, pharmacies, midwives and schools. The programme is coordinated by the Cambridgeshire and Peterborough Immunisation and Vaccination Committee and reports via the Peterborough Health Protection Committee.

5.3 Communications and recommendation to raise awareness

There will be a national flu marketing media campaign starting on 4th October targeting specific groups (people under 65 with long term health conditions; pregnant women and healthy children aged 2-4 years) to make them aware that they need the vaccine.

This provides an opportunity for Peterborough to provide additional local information to raise awareness and signpost services e.g. pharmacies in Peterborough contracted by Public Health England to provide immunisation to pregnant women.

In addition, Peterborough City Council may wish to consider providing information to support immunisation to vulnerable groups e.g. with any 'winter warmth' or similar communications.

5.4 Business continuity and recommendation to promote immunisation with front line staff

The City Council may wish to consider promoting the uptake of seasonal flu immunisation to employed front line staff caring for vulnerable groups e.g. by providing information and reimbursing staff in the identified groups for immunisations they purchase at a pharmacy as part of business continuity and winter planning. (Cambridgeshire County Council will reimburse identified front line staff through the expenses system on production of a receipt for the flu immunisation).

Peterborough City Council may wish to review contracts with providers of front line services with regard to business continuity and the promotion of seasonal flu immunisation.

6. IMPLICATIONS

Recommendation 5.6, if supported, will entail some additional costs for the reimbursement of front line staff (who are not in a group eligible for free NHS immunisation based on their own health) who take up the offer of flu immunisation. However, this may be offset by the reduction in sickness absence and the need to provide overtime or additional staff to cover essential care and services.

National pharmacy chains are quoting charges of £10-£13 per immunisation; some providers of occupational health services to businesses quote costs of ~£6 per vaccine for a corporate contract.

7. BACKGROUND DOCUMENTS.

2014-15 Flu Plan
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/306638/FluPlan2014_accessible.pdf

Ebola Operational Update, 4th September 2014, issue O6, NHS England

Ebola virus disease (EVD) outbreak – an update, serial number 2014/070; 3rd September 2014, Public Health England

Author:
Dr Anne McConville, MRCGP, FFPH
Interim Consultant in Public Health
08/09/14

APPENDIX A

Ebola outbreak in West Africa

You may have heard in the news recently about an outbreak of Ebola virus disease in West Africa centred in three countries: Guinea, Liberia and Sierra Leone.

Outbreaks of Ebola are nothing new and there is currently no direct threat to people in the UK from the Ebola virus, but health professionals are concerned about the size of the outbreak in West Africa.

Front line health and care staff to be extra vigilant

It is important that front line health and care staff are aware and vigilant if they come into contact with anyone who has visited areas affected by the outbreak within the last 21 days and they develop a sudden unexplained illness. More information about the Ebola virus and what to do in the event of suspecting a possible case are explained below.

What is Ebola?

Ebola is a virus (viral haemorrhagic fever) that can be spread through blood, bodily fluids and secretions of infected patients. The virus originated in the West African rainforest and is thought to have spread to humans by handling or butchering infected animals (bush meat). Once the virus enters the body it can replicate very quickly, causing a range of increasingly harmful symptoms, including internal bleeding.

How is Ebola spread?

Ebola virus is generally not spread through routine social contact such as shaking hands. The virus is not airborne, so it's not as infectious as diseases like the flu. The virus is spread in body fluids or secretions of infected patients, particularly in hospitals; as a result of unsafe burial practices; and through the use of contaminated needles, syringes and other medical devices. It is unlikely, but not impossible, that someone incubating the disease could arrive in the UK and then develop symptoms. Guidance has been issued to ports and airports. Although Public Health England assess the risk/ likelihood of imported cases as/is low, health and care staff should be vigilant.

What are the symptoms of Ebola virus?

An infected person will typically develop a sudden onset of fever (38 degrees), headache, joint and muscle pain, sore throat, and intense muscle weakness. Diarrhoea, vomiting, a rash, stomach pain and impaired kidney and liver function follow. The infected person may then bleed internally, as well as from the ears, eyes and mouth. In situations in which haemorrhagic fever is suspected, alternative diagnoses such as malaria should be considered.

What should I do if I suspect a case of Ebola?

Where ever you work, the person should be isolated and kept where they are whilst clinical advice is sought. The ambulance service will make special arrangements to transport them safely to a unit where they can be investigated and treated.

Ensuring good hygiene practices (hand washing, gloves, plastic apron and safe containment of any waste) are important immediate actions to take whilst waiting for advice.

If you visit or meet someone who has possible symptoms, the local Public Health England health protection team will provide advice on 03442253546.

Find out more

You can find out more about the Ebola virus by visiting www.nhs.uk/news

Publication of message

Email to Children's Social Care staff
Email to Adult Social Care & Health and Wellbeing staff
Email to Public Health staff
Publish message on insite (intranet) for all staff

EXTRACT FROM THE 2014-15 FLU PLAN

Groups eligible for the flu vaccination

Flu vaccinations are currently offered free of charge to the following groups:

- people aged 65 years or over (including those becoming age 65 years by 31 March 2015)
- all pregnant women (including those women who become pregnant during the flu season)
- all those aged two, three, and four years old (but not five years or older) on 1 September 2014
- all school-aged children who are part of the pilot childhood programme
- people with a serious medical condition such as:
- chronic (long-term) respiratory disease, such as severe asthma, chronic obstructive pulmonary disease (COPD) or bronchitis
- chronic heart disease, such as heart failure
- chronic kidney disease at stage three, four or 5
- chronic liver disease
- chronic neurological disease, such as Parkinson's disease or motor neurone disease
- diabetes
- splenic dysfunction
- a weakened immune system due to disease (such as HIV/AIDS) or treatment (such as cancer treatment)
- people living in long-stay residential care homes or other long-stay care facilities where rapid spread is likely to follow introduction of infection and cause high morbidity and mortality. This does not include, for instance, prisons, young offender institutions, or university halls of residence
- people who are in receipt of a carer's allowance, or those who are the main carer of an older or disabled person whose welfare may be at risk if the carer falls ill

The list above is not exhaustive and decisions should be based on a practitioner's clinical judgement. Consideration should also be given to the vaccination of household contacts of immunocompromised individuals, specifically individuals who expect to share living accommodation on most days over the winter and therefore for whom continuing close contact is unavoidable.

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 8(b)
25 SEPTEMBER 2014		PUBLIC REPORT
Contact Officer(s):	Dr Henrietta Ewart, interim Director of Public Health	Tel. 01733 207175

UPDATE ON THE CARDIOVASCULAR DISEASE PRIORITY WORK PROGRAMME

R E C O M M E N D A T I O N S	
FROM : Dr Henrietta Ewart, Interim Director Public Health	**Deadline date : n/a**

The Health and Wellbeing Board is invited to:

a) note the progress report and recommendations made to the Health and Wellbeing Programme Board on 19th September;

b) comment on the proposed elements the cardiovascular disease strategy identified in the mapping of the coronary heart disease and cardiovascular disease programmes;

c) support the proposal that Public Health lead the establishment of a clinically focussed group to develop the Healthcare and Rehabilitation/Reablement workstream;

d) note the proposal to use PHOF, NHSOF and ASCOF indicators to monitor the outcomes of the three thematic workstreams.

1. THE ORIGIN OF THE REPORT

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

1.2 A progress report was provided to the Health and Wellbeing Programme Board on 19th September (full report attached – Appendix A for information)

1.3 The development of a cardiovascular disease strategy links with the following priorities of the Health & Wellbeing Strategy 2012-15:

- Narrow the gap between those neighbourhoods and communities with the best and worst health outcomes.
- Enable older people to stay independent and safe and to enjoy the best possible quality of life.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide the Health and Wellbeing Board with information on early thinking in mapping the relationship between the existing programme to reduce inequalities in coronary heart disease (CHD) and a wider strategy to reduce cardiovascular disease (CVD). It identifies synergies and opportunities for further development of a clinically focussed programme to address the Healthcare and Rehabilitation/Reablement workstream previously agreed as one on the three thematic work streams by the Health and Wellbeing Programme Board.

It proposes scoping the establishment of a healthcare and rehabilitation/reablement workstream group with the membership of relevant stakeholders to achieve clinical engagement and ownership of this theme of the cardiovascular programme.

2.2 In relation to the other workstreams identified and agreed by the Health and Wellbeing Programme Board in July (prevention and early intervention, continuing support) it maps selected indicators from national data sets to propose key metrics for each thematic group.

2.3 This report is for the Board to consider under its terms of reference no. 2.2 'to actively promote partnership working across health and social care in order to further improve health and well being of residents'.

3. THE CHD and CVD PROGRAMMES

3.1 The Peterborough, Boarderline and Wisbech Local Commissioning Groups of the Cambridgeshire and Peterborough Clinic Commissioning Group have established a clinically led group to tackle reducing inequalities in coronary heart disease outcomes (CHD), one of three strategic priorities identified by the CCG.

This programme has four workstreams:

1. **Health Check programme**
   Working in partnership with Local Authorities and primary care providers and public health to successfully implement the Health Check programme.

2. **Cardiac Rehabilitation**
   Effective use of the current Cardiac Rehabilitation pathways and recommending to both commissioners and providers areas for improvement based on local and national best practice.

3. **Primary care Interventions**
   Improving the management of prevention of coronary heart disease in primary care so that inequalities in CHD are decreased at both a GP practice level and across the LCG population.

4. **Smoking Cessation**
   Working in partnership to increase the effectiveness of specific interventions based on the available evidence.

3.2 There is significant overlap in the elements of the CHD programme and the proposed evidence –based healthcare and rehabilitation CVD workstream.

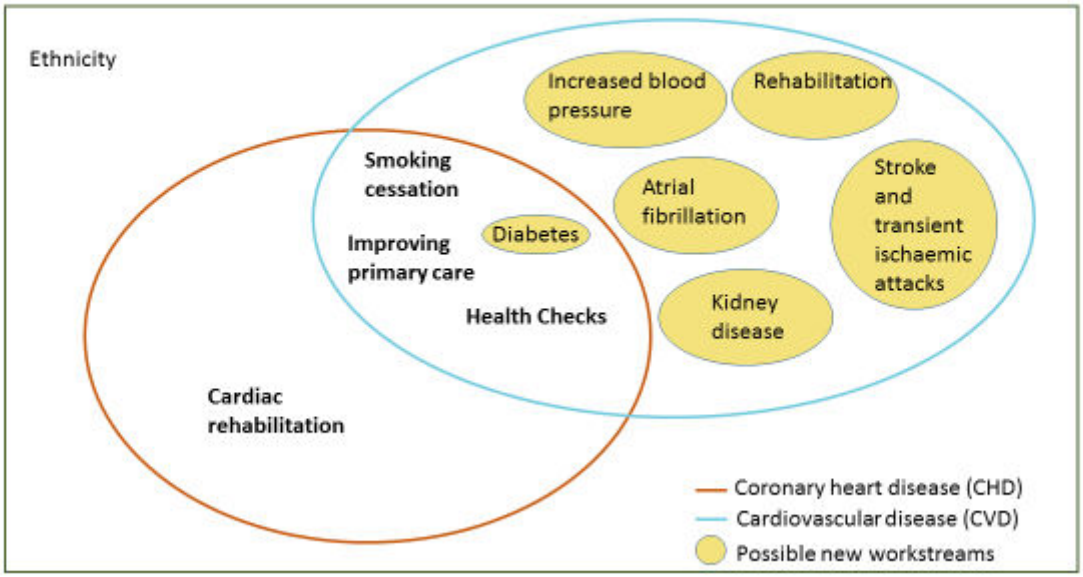
3.3 In response to an opportunity to bid to the British Heart Foundation, the CHD programme board and Public Health developed and submitted a proposal for a project to address inequalities in coronary heart disease in August.

3.4 The bid is based on a person centred model of care with four key elements:

a) Engaged, informed individuals and carers
b) Commissioning (including 'more than medicine' – ie whole pathway from prevention through to re-ablement/re-empowerment)
c) Commitment to partnership working
d) Organisational and supporting processes

3.5 It is proposed this model is explored for application to the wider cardiovascular disease programme.

Building on established interventions to reduce inequalities in coronary heart disease to address cardiovascular disease.



3.6 Ethnicity is a key factor in cardiovascular and diabetes risk and should be considered in relation to all aspects of the programme -risk thresholds, interventions, communications and access/barriers to services - so that inequalities in outcome are addressed for the population of Peterborough.

3.7 The additional areas for the CVD programme have been identified, for further consideration by the thematic group, based on the known risk factors for cardiovascular disease and the information on local indicators. See appendix B for Peterborough and Appendix C for the Cambridgeshire and Peterborough CCG.

3.8 The Public Health Intelligence Team have mapped selected indicators from the Public Health Outcomes Framework (PHOF), the NHS Outcomes Framework (NHSOF) and the Adult Social Care Outcomes Framework (ASCOF) against the three thematic workstreams for consideration by the HWPB and the thematic groups when established.

3.9 Inevitably, there is some overlap of indicators between workstreams and this may need to be worked through as the thematic action plans are developed by the theme groups to ensure appropriate accountability. This routinely collected data provides the means to ensure oversight of key outcomes of the CVD programme and track improvements over time although additional information may be required for operational management due to the timeliness of national reporting systems.

4. CONSULTATION

4.1 The half day stakeholder and workshop mapping in July focussed on the development of the British Heart Foundation 'House of Care' bid for a coordinated approach to the management and support of people with coronary heart disease. The bid was submitted on 11th August and the outcome will be known in November (shortlisted locations will have site visits in October/November).

4.2 In order to progress the Healthcare and Rehabilitation workstream, it is proposed that, following a stakeholder mapping, a second stakeholder workshop is convened with a focus on ensuring clinical engagement and that of relevant third sector and other groups e.g. the Stroke Association.

4.3 Consideration will need to be given to the potential overlap in membership between this and the Continuing Support workstream by the identified leads.

4.4 Further consultations will be required as the CVD programme as a whole is developed and the thematic work streams refined before the mature CVD strategy is approved by the Heath and Wellbeing Board and other key stakeholders.

5. RECOMMENDATIONS

The Health and Wellbeing Board is invited to:

5.1 note the progress report and recommendations made to the Health and Wellbeing Programme Board on 19th September;

5.2 comment on the proposed elements of the cardiovascular disease strategy identified in the mapping of the coronary heart disease and cardiovascular disease programme illustrated in the diagram;

5.3 support the proposal that Public Health lead the establishment of the clinically focussed group to develop the Healthcare and Rehabilitation/Reablement work stream;

5.4 note the proposal to use the PHOF, NHSOF and ASCOF indicators to monitor the outcomes of the three thematic work streams.

6. IMPLICATIONS

6.1 Proposals resulting from the adoption of cardiovascular disease as a key priority by the HWB/HWPB and from the subsequent work plans may have implications including: financial; legal; human resources; ICT; environmental; human rights; property; procurement; LAA targets; public health outcomes framework targets etc. These will be identified and addressed as they arise.

6.2 Tackling cardiovascular disease will require city-wide activity and strong partnerships. However, in order to address the inequalities which exist in outcomes from CVD, targeted approaches (which may focus on specific geographical areas or specific groups in the population) will also be required.

7. BACKGROUND DOCUMENTS

a) Living well for longer-a call to reduce avoidable premature mortality; Dept. of Health March 2013
b) Commissioning for value focus pack NHS Cambridgeshire and Peterborough CCG focus area cardiovascular disease (CVD) pathway, Public Health England, June 2014
c) PHOF, NHSOF and ASCOF data sets.

Dr Anne McConville, MRCGP, FFPH
Interim Consultant in Public Health - 11/09/14

APPENDIX A

HEALTH AND WELLBEING PROGRAMME BOARD		AGENDA ITEM No.
		PUBLIC REPORT
Contact Officer(s):	Dr Henrietta Ewart, interim Director of Public Health	Tel. 01733 207175

UPDATE ON THE CARDIOVASCULAR DISEASE PRORITY WORK PROGRAMME

R E C O M M E N D A T I O N S	
FROM : Dr Henrietta Ewart, Interim Director of Public Health	**Deadline date : n/a**

The Health and Wellbeing Programme Board is invited to:

a) support the proposal that Public Health lead the establishment of a clinically focussed group to address the Healthcare and Rehabilitation/Reablement workstream;

b) are invited to consider and identify the lead officer for each of the other thematic workstreams;

c) to consider how the development of the Communications Strategy needs to respond to the emergent cardiovascular disease strategy and workstreams;

d) support testing The 'House of Care' model for its application to the CVD thematic workstreams;

d) comment on the proposed elements the CVD strategy identified in the mapping of the CHD and CVD programmes (venn diagram);

e) consider and comment on the proposal to use PHOF, NHSOF and ASCOF indicators to monitor the outcomes of the three thematic workstreams.

1. ORIGIN OF REPORT

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

An update was provided in July and this report provides a further progress report.

1.2 The development of a cardiovascular disease strategy links with the following priorities of the Health & Wellbeing Strategy 2012-15:

- Narrow the gap between those neighbourhoods and communities with the best and worst health outcomes.
- Enable older people to stay independent and safe and to enjoy the best possible quality of life.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide information on early thinking in mapping the relationship between the existing programme to reduce inequalities in coronary heart disease (CHD) and a wider strategy to reduce cardiovascular disease. It identifies synergies and opportunities for further development of a clinically focussed programme to address the Healthcare and Rehabilitation/Reablement workstream previously agreed by the Health and Wellbeing Programme Board.

It proposes scoping the establishment of a healthcare and rehabilitation workstream group with the membership of relevant stakeholders to achieve clinical engagement and ownership of this theme of the cardiovascular programme.

2.2 In relation to the other workstreams identified in the previous paper, (prevention and early intervention; continuing support) it invites the HWPB to identify the lead officer for each programme. A similar mapping exercise, taking into account existing programmes of work, could be undertaken to inform the development of the specific thematic action plans.

2.3 The HWPB is requested to consider the establishment of these CVD programme thematic workstream groups and in relation to the requirements of the Communications Strategy which is in development.

2.4 Appendix A provides maps selected indicators from national data sets to propose key metrics for each thematic group.

3. THE CHD AND CVD PROGRAMMES PURPOSE AND REASON FOR REPORT

3.1 The Peterborough, Borderline and Wisbech Local Commissioning Groups of the Cambridgeshire and Peterborough Clinic Commissioning Group have established a clinically led group to tackle reducing inequality in coronary heart disease outcomes (CHD), one of three strategic priorities identified by the CCG.

This programme has four workstreams:

1. **Health Check programme**
   Working in partnership with Local Authorities and primary care providers/public health to successfully implement the Health Check programme.

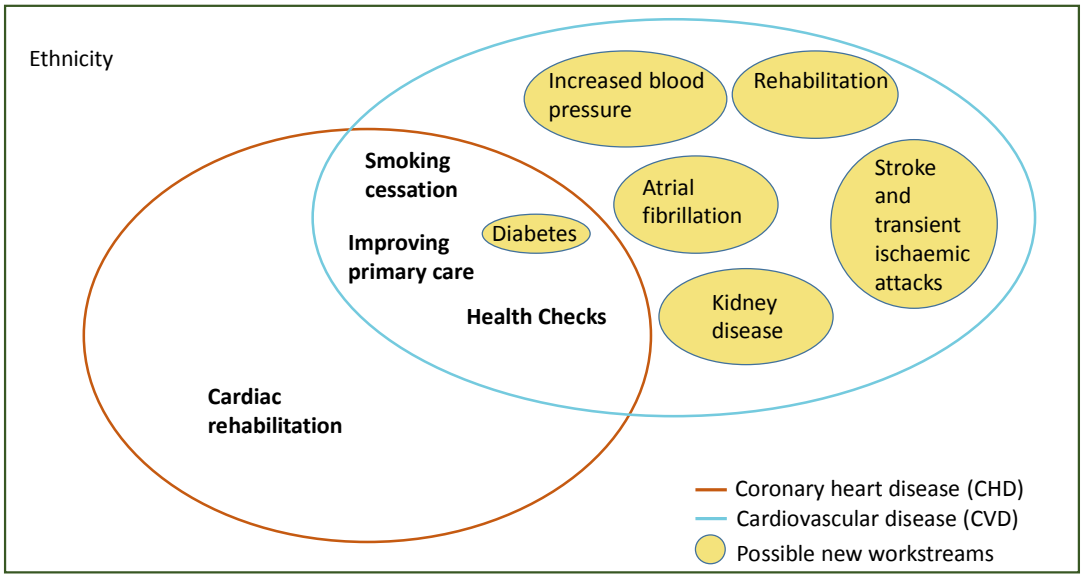
2. **Cardiac Rehabilitation**
   Effective use of current Cardiac Rehabilitation pathways and recommending to both commissioners and providers, areas for improvement based on local and national best practice

3. **Primary care Interventions**
   Improving management of prevention of coronary heart disease in primary care so that inequalities in CHD are decreased at both a GP practice level and across the LCG population

4. **Smoking Cessation**
   Working in partnership to increase the effectiveness of specific interventions, in response evidence based interventions.

3.2 There is significant overlap in the elements of the CHD programme and the proposed evidence –based healthcare and rehabilitation CVD workstream:

Building on established interventions to reduce inequalities in coronary heart disease to address cardiovascular disease.



3.3 Ethnicity is a key factor in cardiovascular and diabetes risk and should be considered in relation to all aspects of the programme - risk thresholds, interventions, communications and access/barriers to services - so that inequalities in outcome are addressed for the population of Peterborough.

3.4 The Public Health Intelligence Team have mapped selected indicators from the Public Health Outcomes Framework (PHOF), the NHS Outcomes Framework (NHSOF) and the Adult Social Care Outcomes Framework (ASCOF) against the three thematic workstreams in Appendix A for consideration by the HWPB.

3.5 There are 230 indicators available covering inputs, processes and outcomes so Appendix A provides a 'first cut' or 'straw man' for consideration by the thematic workstreams.

3.6 Inevitably, there is some overlap of indicators between workstreams and this may need to be worked through as the thematic action plans are developed by the theme groups to ensure appropriate accountability. This routinely collected data provides the means to ensure oversight of key outcomes of the CVD programme and track improvements over time although additional information may be required for operational management due to the timeliness of national reporting systems.

4. CONSULTATION

4.1 The half day stakeholder and workshop mapping in July focussed on the development of the British Heart Foundation 'House of Care' bid for a coordinated approach to the management and support of people with coronary heart disease. The bid was submitted on 11th August and the outcome will be known in November (shortlisted locations will have site visits in October/November).

4.2 In order to progress the Healthcare and Rehabilitation workstream, it is proposed that, following a stakeholder mapping, a second stakeholder workshop is convened with a focus on ensuring clinical engagement and that of relevant third sector and other groups e.g. the Stroke Association.

Consideration will need to be given to the potential overlap in membership between this and the Continuing Support workstream by the identified leads.

4.3 Appendix B sets out the discussion points at the original stakeholder workshop, many of which relate to social and environmental factors influencing cardio vascular disease risk. This will be of relevance to the Prevention and Early Intervention thematic workstream and relevant to the developing work on Healthy Schools and Healthy Places.

4.4 The CCG and Public Health England Centre have expressed interest in the development of the strategy and are keen to share promising practice.

5. RECOMMENDATIONS AND NEXT STEPS

5.1 In order to progress the development of the CVD strategy, the Health and Wellbeing Programme Board, as the steering group for the strategy, is requested to:

a) support the proposal that Public Health lead the establishment of a clinically focussed group to address the Healthcare and Rehabilitation/ Reablement workstream;

b) are invited to consider and identify the lead officer for each of the other thematic workstreams;

c) to consider how the development of the Communications Strategy needs to respond to the emergent cardiovascular disease strategy and workstreams;

d) support testing The 'House of Care' model for its application to the CVD thematic workstreams;

e) comment on the proposed elements the CVD strategy identified in the mapping of the CHD and CVD programmes (venn diagram);

f) consider and comment on the proposal to use PHOF, NHSOF and ASCOF indicators to monitor the outcomes of the three thematic workstreams.

6. BACKGROUND DOCUMENTS

1. Living well for longer-a call to reduce avoidable premature mortality; Department of Health March 2013
2. Commissioning for value focus pack NHS Cambridgeshire and Peterborough CCG-focus area cardiovascular disease (CVD) pathway, Public Health England, June 2014
3. Ryan's reference to data sets ?

(*Appendix A to HWPB report*)
PHOF = Public Health Outcomes Framework
NHSOF = National Health Service Outcomes Framework
ASCOF = Adult Social Care Outcomes Framework
Other = Healthcare related metrics sourced from the Health & Social Care Information Centre
Table 1: Prevention & Early Intervention Work Stream Metrics

#	Framework	Indicator
1	PHOF	1.16- Utilisation of outdoor space for exercise/health reasons
2	PHOF	2.12 - Excess weight in adults
3	PHOF	2.13i - Percentage of physically active and inactive adults - active adults
4	PHOF	2.13ii - Percentage of active and inactive adults - inactive adults
5	PHOF	2.14 - Smoking prevalence
6	PHOF	2.14 - Smoking prevalence - routine and manual
7	PHOF	2.17 - Recorded diabetes
8	PHOF	2.22iii - Cumulative % of the eligible population aged 40-74 offered an NHS Health Check
9	PHOF	2.22iv - Cumulative % of the eligible population aged 40-74 offered an NHS health check who received an NHS health check
10	PHOF	2.22v - Cumulative % of the eligible population aged 40-74 who received an NHS health check
11	PHOF	4.04i-Under 75 mortality rate from all cardiovascular diseases (Persons)
12	PHOF	4.04i-Under 75 mortality rate from all cardiovascular diseases (Male)
13	PHOF	4.04i-Under 75 mortality rate from all cardiovascular diseases (Female)
14	PHOF	4.04ii-Under 75 mortality rate from cardiovascular diseases considered preventable (Persons)
15	PHOF	4.04ii-Under 75 mortality rate from cardiovascular diseases considered preventable (Male)
16	PHOF	4.04ii-Under 75 mortality rate from cardiovascular diseases considered preventable (Female)
17	NHSOF	1.1 Under 75 mortality rate from cardiovascular disease
18	NHSOF	2.4 Enhancing quality of life for carers
19	Other	Directly age-standardised rate per 100,000 population of deaths attributable to smoking for all persons aged 35+ in the years 2003-05, 2004-06 and 2005-07
20	Other	Mortality from all circulatory diseases, directly age-standardised rate, persons, under 75 years, 2004-08 (pooled) per 100,000 European Standard population by local authority by local deprivation quintile.

Table 2: Healthcare, Rehabilitation and Reablement Work Stream Metrics

#	Framework	Indicator
1	PHOF	2.17 - Recorded diabetes
2	PHOF	2.22iii - Cumulative % of the eligible population aged 40-74 offered an NHS Health Check
3	PHOF	2.22iv - Cumulative % of the eligible population aged 40-74 offered an NHS health check who received an NHS health check
4	PHOF	2.22v - Cumulative % of the eligible population aged 40-74 who received an NHS health check
5	PHOF	4.04i-Under 75 mortality rate from all cardiovascular diseases (Persons)
6	PHOF	4.04i-Under 75 mortality rate from all cardiovascular diseases (Male)
7	PHOF	4.04i-Under 75 mortality rate from all cardiovascular diseases (Female)
8	PHOF	4.04ii-Under 75 mortality rate from cardiovascular diseases considered preventable (Persons)
9	PHOF	4.04ii-Under 75 mortality rate from cardiovascular diseases considered preventable (Male)
10	PHOF	4.04ii-Under 75 mortality rate from cardiovascular diseases considered preventable (Female)
11	ASCOF	2B(1)- Older people at home 91 days after leaving hospital into reablement
12	NHSOF	1.1 Under 75 mortality rate from cardiovascular disease
13	NHSOF	3.4 Proportion of stroke patients reporting an improvement in activity/lifestyle on the modified Rankin scale at 6 months
14	Other	Emergency hospital admissions for stroke
15	Other	Emergency hospital admissions for diabetes
16	Other	Proportion of patients of all ages discharged back to usual place of residence within 56 days of emergency admission to hospital with a stroke.
17	Other	Deaths within 30 days of a hospital procedure: stroke: indirectly standardised rate, all ages, 3 year average trend
18	Other	Mortality from all circulatory diseases, directly age-standardised rate, persons, under 75 years, 2004-08 (pooled) per 100,000 European Standard population by local authority by local deprivation quintile.
19	Other	Emergency hospital admissions for stroke
20	Other	Emergency hospital admission for diabetes
21	Other	Deaths within 30 days of a hospital procedure: stroke: indirectly standardised rate, all ages, 3 year average trend
22	Other	Mortality from all circulatory diseases, directly age-standardised rate, persons, under 75 years, 2004-08 (pooled) per 100,000 European Standard population by local authority by local deprivation quintile.

Table 3: Continuing Support Work Stream Metrics

#	Framework	Indicator
1	ASCOF	1.a -Social care related quality of life
2	ASCOF	1.b - Service users with control over their daily life
3	ASCOF	1.c(1)- People receiving self-directed support
4	ASCOF	1.c(2) - People receiving direct payments
5	ASCOF	2A(1)- Permanent admissions to care homes: people aged 18 to 64
6	ASCOF	2A(2)- Permanent admissions to care homes: people aged 65 and over
7	ASCOF	2B(1)- Older people at home 91 days after leaving hospital into reablement
8	ASCOF	2B(2)- Older people receiving reablement services after leaving hospital
9	ASCOF	3D(1)- Service users who find it easy to get information
10	ASCOF	3D(2)-Carers who find it easy to get information
11	ASCOF	4A- People who use services and feel safe
12	ASCOF	4B- People who say the services the use make them feel safe and secure
13	NHSOF	2.0 Health related quality of life for people with long term conditions
14	NHSOF	2.1 Ensuring people feel supported to manage their condition (proportion of people feeling supported to manage their condition)
15	NHSOF	3.4 Proportion of stroke patients reporting an improvement in activity/lifestyle on the modified Rankin scale at 6 months
16	NHSOF	3.6 Helping older people to recover their independence after illness or injury (i. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation service, ii. Proportion offered rehabilitation following discharge from acute or community hospital)
17	Other	Proportion of patients of all ages discharged back to usual place of residence within 56 days of emergency admission to hospital with a stroke.

Mortality rates/life expectancy

Type	Indicator/Report	Peterborough	East	England	England Range	1 Year Trend	3 Year Trend	Time Period
Local Indicator	Life expectancy at birth (males) in years	77.9	80.1	79.2		–	◄	2010-2012
Local Indicator	Life expectancy at birth (females) in years	82.5	83.0	83.7		◄	◄	2010-2012
Local Indicator	Gap in life expectancy (males) in years	-1.3	0.9	-		–	◄	2010-2012
Local Indicator	Gap in life expectancy (females) in years	-0.5	-0.7	-		◄	◄	2010-2012
Local Indicator	Healthy life expectancy at birth (males) in years	61.6	64.8	63.2		no data	no data	2009-2011
Local Indicator	Healthy life expectancy at birth (females) in years	60.3	66.2	64.2		no data	no data	2009-2011
Local Indicator	Mortality rate from causes considered preventable	210.9	165.7	187.8		–	◄	2010-2012
Local Indicator	Under 75 mortality rate from cardiovascular diseases considered preventable	71.5	48.1	53.5		◄	–	2010-2012
Local Indicator	Under 75 mortality rate from cardiovascular diseases	111.8	72.6	81.1		◄	◄	2010-2012

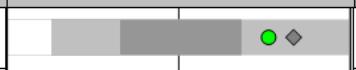
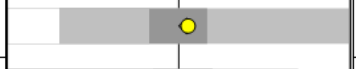
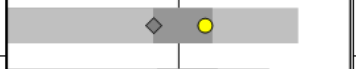
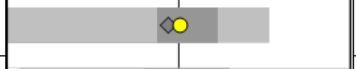
Diabetes

Type	Indicator/Report	Peterborough	East	England	England Range	1 Year Trend	3 Year Trend	Time Period
Local Indicator	Access to non-cancer screening programmes - diabetic retinopathy	72.7%	80.9%	80.9%		◄	no data	2011-2012
Local Indicator	Sight loss due to diabetic eye disease (rate per 100,000 population)	5.2	4.8	3.6		no data	no data	2010/2011
Local Indicator	Spend per head on endocrine, nutritional and metabolic problems	£53.76	£53.84	£54.33		►	►	2010/2011
Local Indicator	GP recorded diabetes prevalence (% of adults aged over 17)	6.1%	5.6%	5.8%		◄	–	2011/2012
Local Indicator	Blood sugar control (% of patients with diabetes with HbA1c < 7.5)	61.4%	60.3%	62.9%		no data	no data	2011/2012
Local Indicator	Access to diabetic retinopathy screening (attended screening as % of those offered screening)	77.3%	74.0%	79.2%		no data	no data	2010/2011
Local Indicator	Emergency admissions for diabetes (rate per 100,000 population)	38.7	25.5	27.4		–	◄	2010/2011
Local Indicator	Deaths from diabetes (rate per 100,000 population)	5.7	5.8	5.7		◄	–	2008-2010

Cardiovascular disease

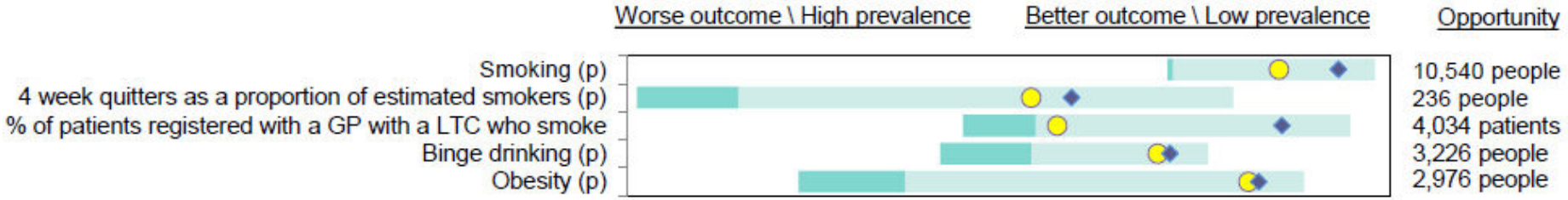
Type	Indicator/Report	Peterborough	East	England	England Range	1 Year Trend	3 Year Trend	Time Period
Local Indicator	Spend per head on cardiovascular diseases	£137	£132	£132		►	►	2010/2011
Local Indicator	Early deaths from cardiovascular diseases (rate per 100,000 population aged under 75)	65.5	65.3	62.0		◄	◄	2009-2011
Local Indicator	Early deaths from cardiovascular diseases considered preventable (rate per 100,000 population < 75)	39.7	40.2	40.6		no data	no data	2009-2011
Local Indicator	GP recorded coronary heart disease prevalence (% of adults aged over 16)	2.3%	2.2%	3.4%		–	–	2011/2012
Local Indicator	Deaths from coronary heart disease (rate per 100,000 population)	73.2	76.0	78.7		◄	◄	2008-2010

Stroke

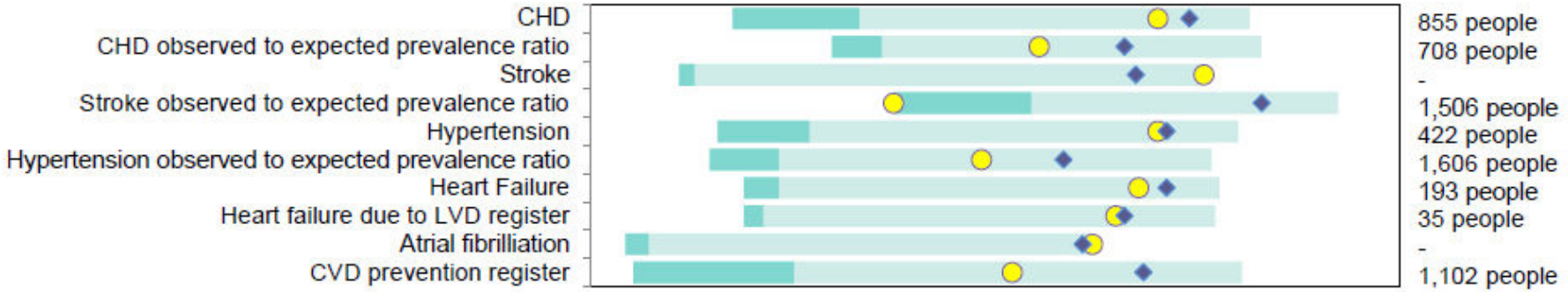
Type	Indicator/Report	Peterborough	East	England	England Range	1 Year Trend	3 Year Trend	Time Period
Local Indicator	GP recorded stroke/TIA prevalence (% of adults aged over 16)	1.22%	1.08%	1.74%		▶	◀	2011/2012
Local Indicator	Emergency admissions for stroke (rate per 100,000 population)	117	118	121		–	◀	2010/2011
Local Indicator	Emergency readmissions within 28 days of discharge for stroke (%)	9.4	13.7	11.7		▶	▶	2009/2010
Local Indicator	Early deaths from stroke (rate per 100,000 population aged under 75)	12.1	12.9	12.2		▶	–	2008-2010
Local Indicator	Deaths from stroke (all ages) (rate per 100,000 population)	36.1	37.8	42.7		▶	▶	2008-2010

Cambridgeshire & Peterborough CCG CVD Indicator Spine Charts

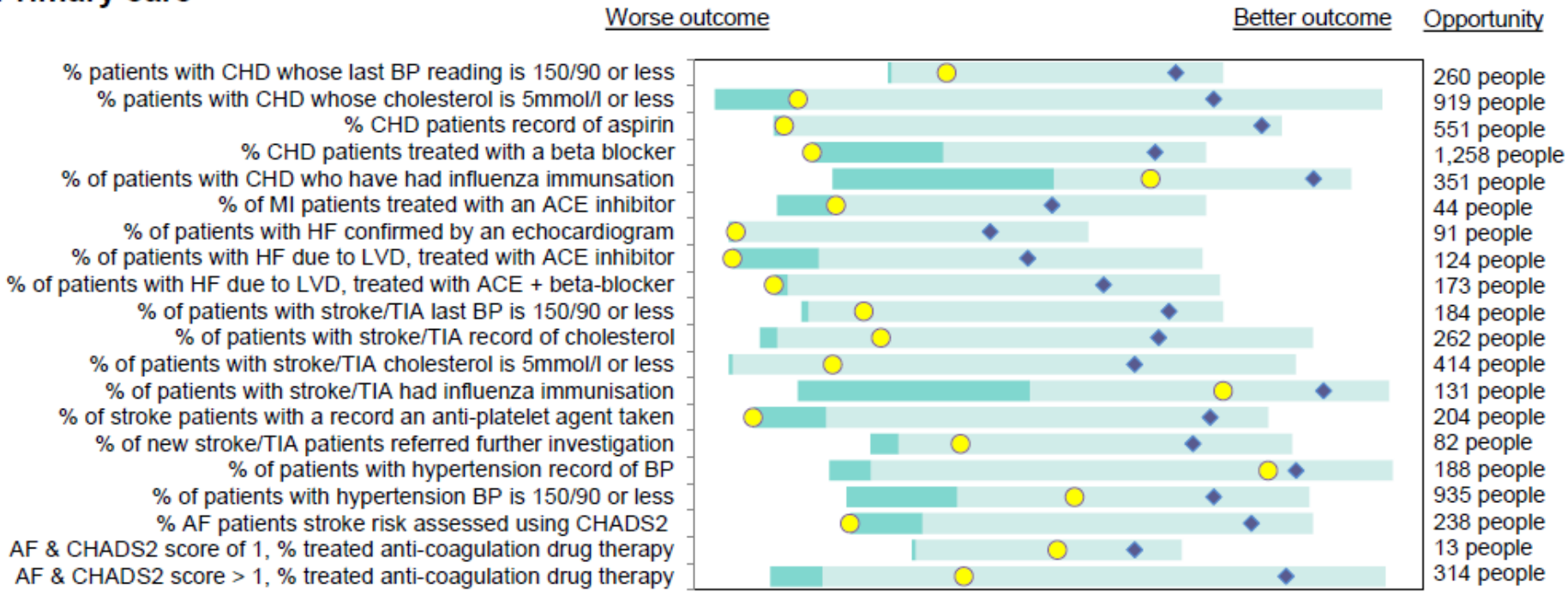
Prevention



Prevalence



Primary care



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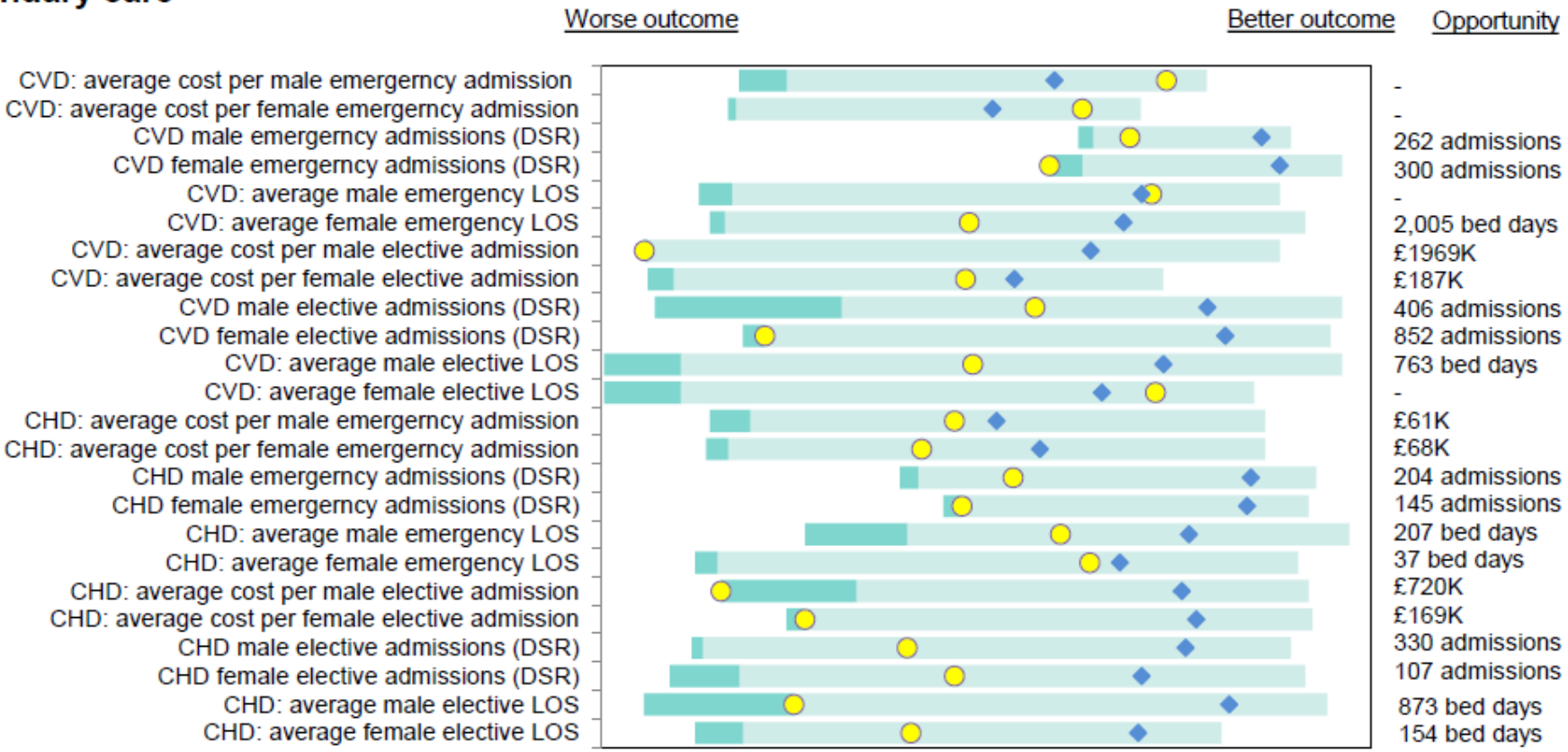

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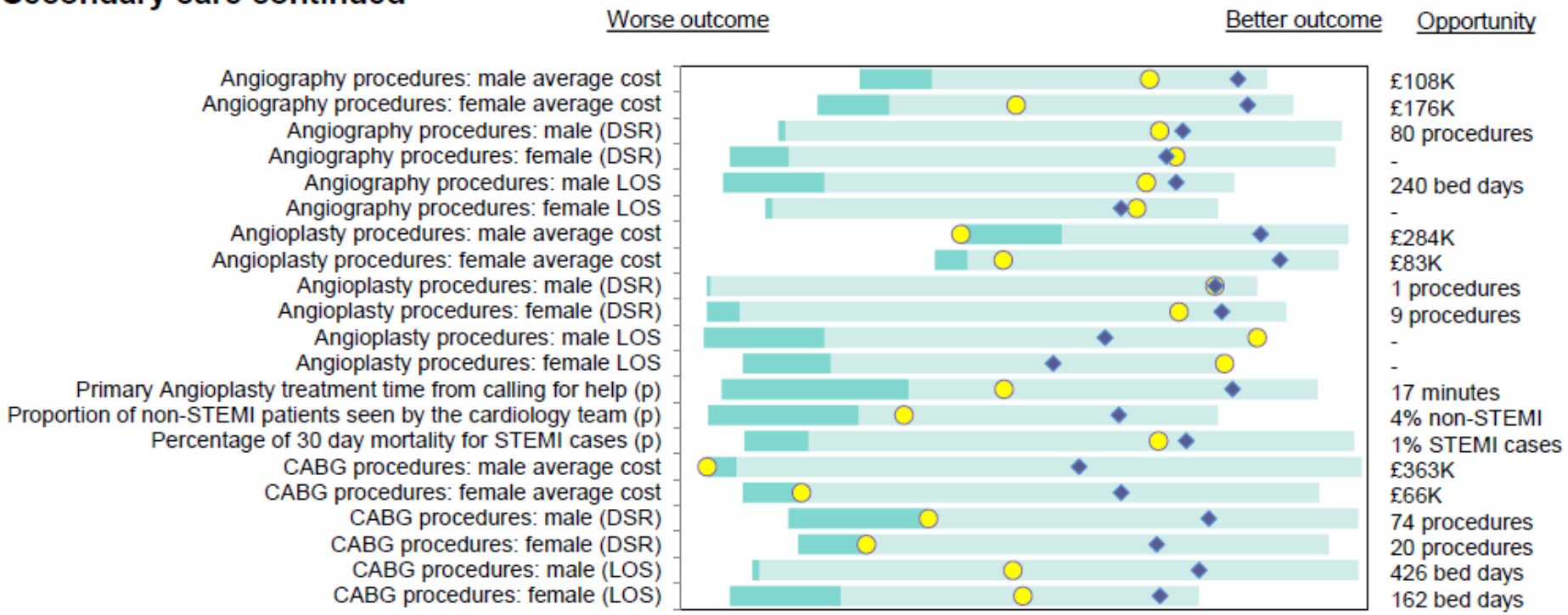

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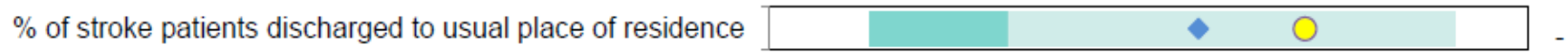

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 9
25 SEPTEMBER 2014		PUBLIC REPORT
Contact Officer(s):	Wendi Ogle-Welbourn, Director of Communities	Tel. 863749

Performance Report on Sexual Health Services

RECOMENDATIONS	
FROM : *Jo Melvin, Commissioner – Public Health*	**Deadline date :**
For the Board to note: 1. For information - update on successful retender to provide a fully integrated community based contraceptive and sexual health service 2. *For information – overview of performance against key sexual health indicators* 3. *For information - priorities for action.*	

1. ORIGIN OF REPORT

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

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide an performance update to the Board on Sexual Health Services.

2.2 This report is for Board to consider under its Terms of Reference No. 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. MAIN BODY OF REPORT

3.1 **Update on retender exercise**

Following the retender exercise undertaken by Peterborough City Council during 2013/14, the local contraceptive and sexual health service based at Rivergate and the genitourinary medicine department based at Peterborough City Hospital were merged to create a fully integrated contraceptive and sexual health service in the community. The new 'ICASH' service which opened on 1st July 2014 offers local residents a one stop shop for all contraceptive and sexual health issues, including HIV treatment. By offering all services in one place we hope to normalise and encourage STI testing and treatment alongside contraceptive provision. The ICASH service also delivers outreach services to engage those most at risk of sexual ill health or unintended pregnancy and undertakes health promotion and prevention activities across the city.

The ICASH service will establish a sexual health network for the city to share good practice, improve links between agencies and contribute to setting strategic direction for sexual and reproductive health issues in the city.

3.2 **Overview of performance**

The number of newly diagnosed STIs in the city is increasing and Peterborough's national ranking for STIs has deteriorated to 89th out of 326 local authorities (with 1 having the highest rate of STIs).

Rates of Gonorrhoea have been increasing year on year and are at their highest at present. We are working with Public Health England to ascertain if this is an outbreak or due to improved testing and partner notification.

Whilst teenage pregnancy rates have reduced in recent years they remain above the national average. Young people account for nearly 60% of new STI diagnoses and are a key target group for sexual health education and prevention. The most commonly diagnosed STI amongst under 25s is Chlamydia and Peterborough's high diagnosis rate indicates we are doing well at reaching the right young people. However, we need to increase the number of screens amongst the under 25s even further.

Rates of late diagnosed HIV are above the regional and national averages which suggests we need to improve our HIV prevention work and the uptake of HIV testing, particularly amongst men who have sex with men (MSM) and people of Black African origin.

Emotional wellbeing issues, drug and alcohol misuse and sexual risk taking behaviour are often linked. Health promotion and treatment needs to work holistically to identify and address these issues, particularly amongst young people and those MSM who engage in 'Chemsex' (sexual sessions under the influence of drugs).

Positively, GP prescribing of long acting reversible contraception (LARC) is above the regional and national averages.

3.3 **Priorities to improve current performance**

In order to improve performance the following priorities have been identified:-

1. Reduction in under 18 conceptions
2. Increase in Chlamydia screening amongst under 25s
3. Improve preventative health education and increase STI and HIV screening

3.4 **Proposed actions include:-**

a.) Review and improve HIV prevention activity to ensure it is targeted to at risk groups and reflective of HIV diagnoses locally - t*his has been set as an action for the ICASH service*

b.) Increase the number of under 25s screened for Chlamydia - t*his is an action for the ICASH service and has been raised as an action for the CCG/GPs via the Health and Wellbeing Programme Board*

c.) Review and improve sex and relationship education - a*ction is underway to develop a PSHE programme linked to Healthy Schools Programme which includes sexual health, child sexual exploitation and domestic abuse*

d.) Ensure young people have easy access to sexual health services (including school based provision) - *work is already underway to grow the number of secondary school based HYPA clinics which offer young people information and advice on a range of public health issues including sexual health, alcohol and drugs*

4. CONSULTATION

4.1 N/A

5. ANTICIPATED OUTCOMES

- To secure partner contribution to increasing the number of 15-24 year olds screened for Chlamydia
- To drive improvement in quality and scope of sex and relationship education in local schools

6. REASONS FOR RECOMMENDATIONS

Local authorities have responsibility for commissioning comprehensive sexual health services which includes contraception, STI testing and treatment and specialist sexual health services such as outreach, HIV prevention, sexual health promotion and school based services

7. ALTERNATIVE OPTIONS CONSIDERED

Do not implement actions as recommended. This rejected as the need for these actions has been clearly identified.

8. IMPLICATIONS

9. BACKGROUND DOCUMENTS

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

Sexual and Reproductive Health Profiles, Public Health England
http://fingertips.phe.org.uk/profile/sexualhealth

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 10
25 SEPTEMBER 2014		PUBLIC REPORT
Contact Officer(s):	Alan Sadler, Business Manager, Borderline and Peterborough LCGs	Tel. 776363

RECRUITMENT OF GPS AND OTHER HEALTH PROFESSIONALS

RECOMMENDATIONS	
FROM: Joint Borderline and Peterborough Local (LCG) Commissioning Group Board	**Deadline date:** 10 Oct 14

1. The Board is requested to note contents of report and suggest any additional activities that should be considered to improve the recruitment and retention of GPs and other healthcare professionals.
2. It is requested suggestions are forwarded by 10 Oct 14 and the author presents a follow up report in the New Year.

1. ORIGIN OF REPORT

1.1 Peterborough LCG practices recently raised concerns about recruitment issues in Peterborough. Furthermore, failure to resolve the recruitment and retention of GPs and other healthcare professionals may result in a potential threat to effective Primary Care. As a result a Task and Finnish group was set up look at how the LCG can attract more clinical staff to come and work in Peterborough GP practices. The group has gathered the following information in order to help identify the barriers and look at how we can recruit and retain our Clinical workforce.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to highlight the need to identify actions to improve recruitment and retention of GPs. These actions may also be applicable to other health sector skill shortages.

2.2 This report is for the Board to consider under its terms of reference no. 2.2 'to actively promote partnership working across health and social care in order to further improve the health and wellbeing of residents'.

3. GP SURVEY AND RESULTS

3.1 As a result of concerns raised GP Practices were asked to complete a questionnaire to determine the gaps in recruitment, the barriers affecting recruitment, any experiences, what can be done to improve the situation and how it is affecting their organisations.

3.2 The results of the survey included at Appendices 1 and 2 indicate a current shortfall of 8 GPs which is covered by 5 locums and an overstaffing of Practice Nurses. More worryingly the 2 – 5 year projection suggests a further shortage of 16 GPs due to retirement.

3.3 The results also considered the main barriers as: financial uncertainty of the current General Practice 'working model' alongside finance, pay and lack of training. It also highlighted inability to succession plan and cover clinics which hindered practices ability to run their businesses successfully.

3.4 Suggestions to help improve recruitment include 'selling' Peterborough, clear vision on the financial impacts of the PMS review, need for mentor support for newly qualified GP's,

advertising throughout the EU to expand area of search offer security to potential candidates and increase collaboration between practices.

4. Potential Future Actions

4.1 Some actions are within the influence of the GPs and the LCG. Early ideas include increased collaborative activity to ameliorate the effects of increasing workload and collaboration on recruitment. The established Task and Finish Group will continue to consider potential options and will also liaise with the LMC and NHS England on how to develop a Primary Care system for Peterborough which is attractive to GPs.

4.2 However it is considered there may be additional actions that can be promoted or endorsed by the HWB Board to promote Peterborough as an attractive working environment, identify medically skilled people within our current population and offer up-skilling, training or qualification opportunities.

5. CONSULTATION

Consultation to date has been with the LCG Boards and the task and Finish Group represented by GPs, LCG staff and PCC staff.

6. ANTICIPATED OUTCOMES

As a result of Board awareness additional actions to improve recruitment and retention of GPs and healthcare professionals may be identified.

7. REASONS FOR RECOMMENDATIONS

Recommendation is intended to highlight the need to resolve the potential threat to effective Primary Care by resolving the recruitment and retention of GPs and other healthcare professionals.

8. BACKGROUND DOCUMENTS

1. Survey Results – Appendix A
2. Survey Results – Graphic representation – Appendix B

Results of GP Recruitment Questionnaire

Ailsworth
Botolph – table 1 only
Parnwell
Orton Bushfield
Millfield – didn't fully complete a section
Thistlemoor
Minster
Welland
Paston
Westwood
Westgate – didn't fully complete first section e.g. ideal number of posts for practice
TWMC
Dogthorpe
The Grange
63 Lincoln Road – table 1 only
North Street - table 1 only
Park – table 1 only
Thorpe Road – table 1 only

Post	Ideal Number of Posts for practice (as per list size)	Current number of staff	Number of likely retirements in next 2-5 years
GP Partner	44.5	39.5	14
Salaried GP	17	20	1
Locum GP		5.1	1
Nurse Practitioner/Matrons	15	15	4
Practice Nurse	33.8	37.6	1
HCA & other Health Professionals	21	19	1
Phlebotomist	10.5	10.5	

What do you think are the barriers affecting the recruitment of Clinical Staff in Peterborough? Please score: 0 = no barrier 5 = high barrier

Barriers	0	1	2	3	4	5
Quality of premises	2	2		4	1	1
Comments	• Adequate • Need more space to develop services					

	• Premises, facilities could always do with updating and improving – so will never be 'perfect'.					
Peterborough as a place to live	1	2	3	2	2	
Comments	• Average housing • Reputation as influx of too many immigrants. Suffers from small city syndrome where there are too few events and attractions. • Schools very good – also Cathedral					
Peterborough as a place to work	1	4	1	3	1	
Comments	• Has all social facilities • Good links to villages • Pockets of high deprivation and hard to engage patients (language and cultural barriers) do9n't make life easy, could potentially put some off.					
Finance/Pay		1	1	2	3	3
Comments	• Slightly below national average • Due to the uncertainty of financial income coupled with reduction in income over the past few years. May be need to look at the golden hello payments once again? • Financial constraints mean its almost impossible to offer above average or significantly attractive salary package to draw potential recruits from other areas. •					
Training	3	2		4	1	
Comments	• Seem to have most training facilities in the area • Clinical Governance events, PLCG training packages for nurses – all supports practice in enabling them to in turn support CPD among their clinical staff.					
More flexible working	1	2	3	4		
Comments	• Dictated to by NHSE – have to work within their parameters. • CQC manpower expectations, patients expectations (extended hours of service delivery) and need to distribute workload equally between all clinical staff, mean that flexible working is sometimes hard to achieve.					
Confidence in the profession and career progression	1	2	2	1	1	3
Comments	• Young doctors put off GP work. Constant dumbing down of profession by the media. • Low morale. • High and unrealistic work load especially for partners. • Excessive demands for data collection. • Financial concerns and reducing income mean that some don't want historic patterns of career progression i.e. salaried GP being interested in becoming a partner. •					

Financial uncertainty of the 'working model' that is current general practice	2	1		2	1	4
Comments	• No confidence in the financial programme for the future. • National problem • This has a big impact on GP recruitment, GPs no longer willing to commit to partnerships • DH and NHSE 'visions' of the future of primary care, how and when that will change service delivery at the coal face and on a daily basis makes it hard to enthuse the team as we cannot envisage the changes and where we all might fit in within that structure.					
Other – please specify	• CQC intimidation • Old GP teams in Peterborough • Negative approach to new initiatives by senior/lead GPs – pervades through the team • Pointless collection of date • Locums – currently GP practices are very dependent on locums to keep services going in their practices, which are very costly. They know they have the monopoly and can attract an income around £650 - £750 a day which is more than a salaried GP or Partner can attract unless you are at a large practice which participates in nearly everything. It is time that all GP Practices Nationally put a cap on what they pay locums this then might attract GPs into Practices for security of income. • Sadly we rarely bring in new clinicians to the area, instead some clinical staff are simply moving from one C&P CCG surgery to another C&PCCG surgery, robbing 'Peter' to pay 'Paul' effect.					

Please share any recent experiences which highlight the difficulty you have had recruiting staff.

- Recently we have offered partnership deals to 3 candidates following interview despite positive reactions all have turned down the position to remain as locums due to the uncertainty of our new premises and the current PMS review as not enough information has been shared by the area team
- What can be done to help improve the recruitment of clinical staff in Peterborough?
- Reduce bureaucracy, paperwork and extra projects with little proven value.
-

What can be done to help improve the recruitment of clinical staff in Peterborough?

- "Selling" Peterborough. In a sense the impending retirement of a number of GPs can be both a bad and a good thing. Once a younger workforce is established then there could be more dynamism; getting to this stage is the problem and younger practitioners may be apprehensive about coming straight into a leading role in a practice. Emphasis on a good working relationship with LCG/CCG will be key; LMC can also play an important role. Cost of housing is significantly lower than in the south of the county. Increasing co-operation/federation, even merging of smaller practices could help. These are of course not unique to Peterborough but rather generic in Primary Care as a whole, as shown by the fall in applications for training posts.

- We need clearer visions on the financial impacts of the PMS review
- Reduce the bureaucracy for new premises
- Offer mentor support for newly qualified GP's
- Maybe advertise through EU to expand area of search
- Find a way to offer security to potential candidates
- Maybe we need to look at Salaried Partners to guarantee an income until we know the direction of Primary Care
- There seem to be a large number of locums (often newly qualified) who do not want to join practices because they can charge large fees for doing locum work – this is not helped by the fact that the 'privately run' GP practices seem to be able to pay excessive sums of money for locum cover.

- The current concerns over financing, and the future of General Practice, is not an attractive proposition for GPs

- Unsure that we can do much until practices fully understand their financial future, whether they will continue to be a viable business.

How is the recruitment issue affecting the running of your organisation?
Please score: 0 = no barrier 5 = high barrier

MILLFIELD DID NOT fully COMPLETE THIS SECTION

	0	**1**	**2**	**3**	**4**	**5**
Clinical	2		2	1	4	
Comments	• Increased difficulty getting locums • Likely retirement of partner within next 2 years makes things very difficult. Merging practices seems to be the way forward for us. • We have managed and are managing, but stretching everyone's day and pushing existing staff to the limit (and beyond) is not a long term option.					
Financial	1			1	4	3
Comments	• Smaller practices have a relatively greater financial squeeze on them. • Due to reduction in partners will have to use locums who will not do the extras that attract income; they just see patients and leave at end of their session. This leaves the remaining GP and staff trying to do everything which is impossible. •					
Ability to plan		1	2	1	4	2
Comments	• Uncertainty of local developments and potential medical centre rebuilds near by. • Plan part of on-going strategy • If a replacement cannot be found we are dependent on booking locums who can cancel at the drop of a hat, especially when they get a better offer.					

	• Uncertainty regarding succession planning • Problems covering clinics for general work, especially when ckinical staff need leave. Lack of locums available for cover and some of those available are very specific about what they will do and hours they will work, which doesn't necessarily fit in with surgery needs. •					
Wellbeing of Team	1		1	3	3	1
Comments	• Hard work, but family team • Stress levels increased • Part of organisational management • Aging workforce • Lack of permanent GPs - This puts considerable stress on the remaining members of the team and could lead to melt down • Working to full capacity on daily basis					

Sue Stephenson
Project Support officer
Borderline & Peterborough CCG
August 2014

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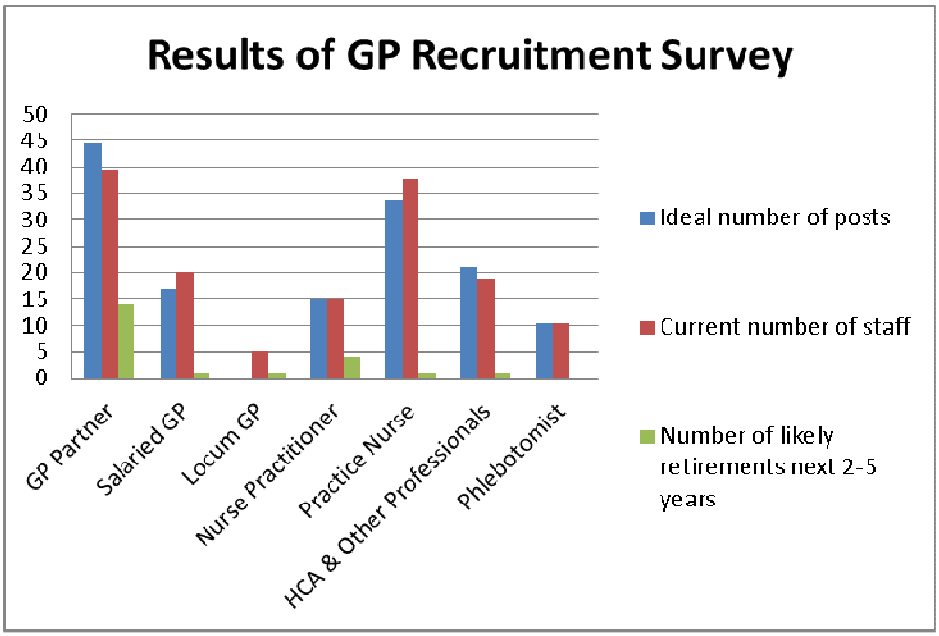
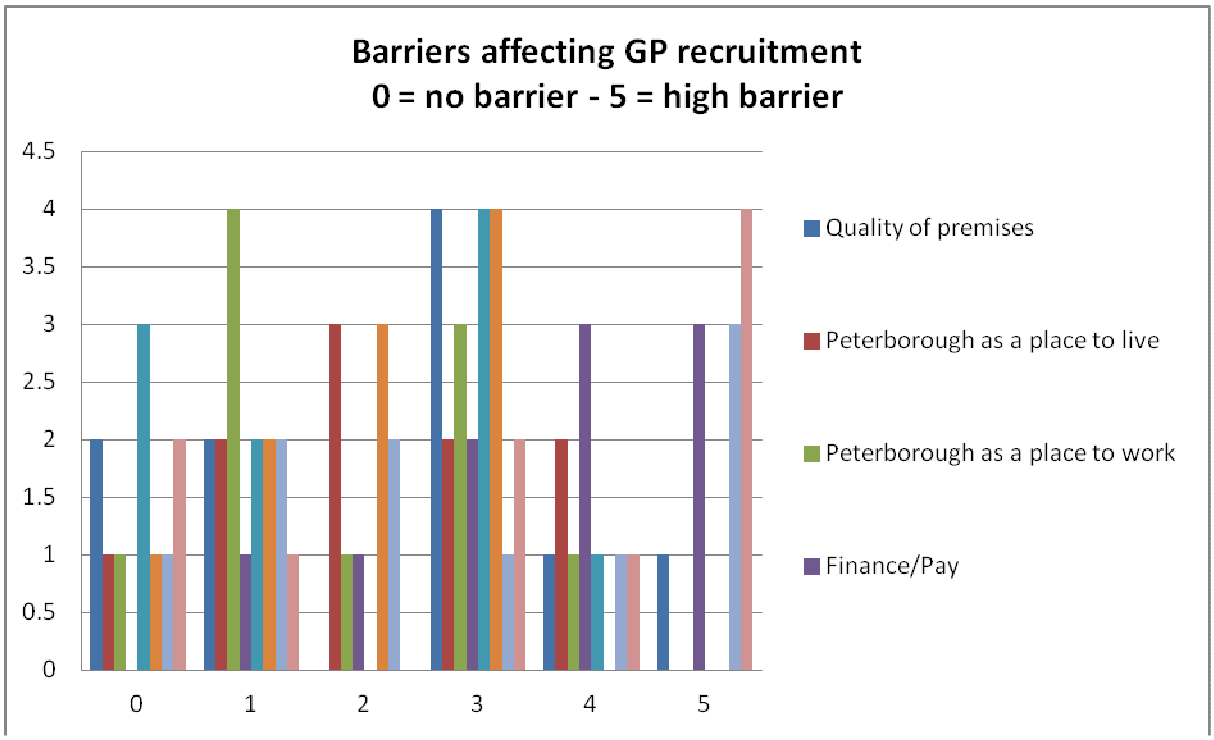
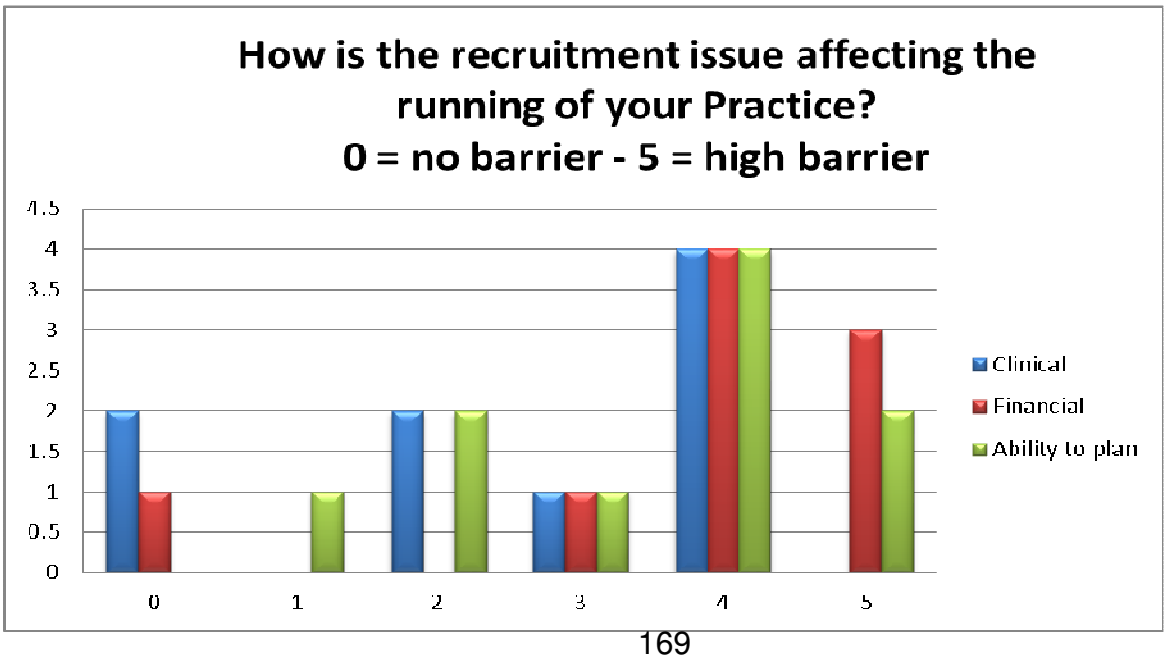
Appendix B - GP Recruitment Survey Results - Graphs







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UPDATED: 17 SEPTEMBER 2014

HEALTH AND WELLBEING BOARD
PROPOSED AGENDA PLAN 2014/15

MEETING DATE	ITEM	CONTACT OFFICER
11 December 2014	Update on SARC Review Programme Board Performance report on activity focused on identified priorities and activities in the refreshed Health and Wellbeing Strategy Report from NHS England on Screening and Immunisations performance Report from NHS England on development of Primary Care Strategy Report from Director of Public Health on health protection - emergency planning and response to emergencies that present a risk to the public's health arrangements Report on development of the Better Care Fund Action Plan Report on DV Report on substance misuse services Report on CSE Work Where appropriate tabled reports from CCG/LA/Healthwatch/NHS England and others.	**Tracey Cogan / Mark Hopkins Cambs Constabulary** **Wendi Ogle-Welbourn** **PHE/NHSE** **PHE/NHSE** **Dr Henrietta Ewart** **Cathy Mitchell** **Wendi Ogle-Welbourn** **Andy Barringer/Wendi Ogle-Welbourn** **Russell Wate / Gary Ridgeway**
26 March 2015	Annual DPH report on health of the local population Standard agenda items will always be: Programme Board Performance report on activity focused on identified priorities and activities in the refreshed Health and Wellbeing Strategy Report from NHS England on Screening and Immunisations performance Report from NHS England on development of Primary Care Strategy Report from Director of Public Health on health protection - emergency planning and response to emergencies that present a risk to the public's health arrangements Report on development of the Better Care Fund Action Plan	**Jana Burton** **Wendi Ogle-Welbourn** **PHE/NHSE** **PHE/NHSE** **Dr Henrietta Ewart** **Cathy Mitchell**

UPDATED: 17 SEPTEMBER 2014

MEETING DATE	ITEM	CONTACT OFFICER
For Consideration at Future Meetings	Tobacco Control Healthy Child Programme (including breastfeeding, 2.5 health checks) Public protection and regulatory activity to support reduction in health inequalities (including takeaways/fast food/alcohol, air pollution and fire safety) Healthy schools and pupils Warm and safe homes Helping people find good jobs and stay in work Active and safe travel Access to green and open spaces and the role of leisure activities Strong communities, wellbeing and resilience Health and spacial planning	**Julian Base**