

SCRUTINY COMMISSION FOR HEALTH ISSUES

WEDNESDAY 10 SEPTEMBER 2014

7.00 PM

Bourges/Viersen Room - Town Hall

AGENDA

Page No

1. Apologies

2. Declarations of Interest and Whipping Declarations

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

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

3. Minutes of Meeting Held on 8 July 2014

3 - 12

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

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

5. Local Health Economy Five Year Strategic Plan

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6. Cardiovascular Disease

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7. Adult Social Care Update

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8. Forward Plan of Key Decisions

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9. Work Programme 2014/2015

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

10. Date of Next Meeting

Tuesday, 14 October 2014

Emergency Evacuation Procedure – Outside Normal Office Hours

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

Committee Members:

Councillors: B Rush (Chairman), J Stokes (Vice Chairman), S Allen, R Ferris, Sylvester, K Sharp and A Shaheed

Substitutes: Councillors: N Shabbir, D Fower, R Herdman and M Lee

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

**MINUTES OF A MEETING OF THE SCRUTINY COMMISSION FOR HEALTH ISSUES
HELD IN THE BOURGES / VIERSEN ROOMS, TOWN HALL
ON 8 JULY 2014**

Present: Councillors B Rush (Chairman), J Stokes, K Sharp, R Ferris, N Shabbir and A Shaheed

Also present

David Whiles	HealthWatch
Jessica Bawden	Director, Corporate Affairs – C&PCCG
Dr Neil Modha	Chief Clinical Officer – C&PCCG
Neil Winstone	Associate Director of Performance Delivery, Cambridge & Peterborough NHS Foundation Trust
Jane Pigg	Company Secretary, Peterborough & Stamford Hospitals NHS Foundation Trust
Caroline Walker	Acting Chief Executive, Peterborough & Stamford Hospitals NHS Foundation Trust

Officers Present:

Jana Burton	Executive Director of Adult Social Care and Health and Wellbeing
Wendi Ogle-Welbourn	Director of Communities
Paulina Ford	Senior Governance Officer

1. Apologies

Apologies were received from Councillor Sylvester and Councillor Allen. Councillor Shabbir was in attendance as substitute for Councillor Sylvester.

2. Declarations of Interest and Whipping Declarations

There were no declarations of interest or whipping declarations.

3. Minutes of Meeting Held on 25 March 2014

The minutes of the meeting held on 25 March 2014 were approved as an accurate record.

4. Call-in of any Cabinet, Cabinet Member or Key Officer Decisions

There were no requests for Call-in to consider.

5. CPFT Consultation: Personality Disorder Community Service/Complex Cases Service, including Lifeworks

The Associate Director of Performance Delivery, Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) introduced the report which provided the Commission with information on proposals for the provision of the Community Personality Disorder Service and the current position regarding the service. It further provided Members with the consultation paper and information regarding Borderline Personality Disorder, Complex Cases Services and Lifeworks.

Observations and questions were raised and discussed including:

- The representative from HealthWatch noted that Lifeworks would continue in Cambridge and wanted to know if this would draw money away from the county and Peterborough. *The Associate Director of Performance Delivery responded that there had been a choice whether or not to keep a specialist personality disorder service and there was a commitment to keep this going. The arrangement to continue Lifeworks in Cambridge would not affect the proposals.*
- Members referred to pages 20 to 34 of the report and the Impact of the Proposed Changes and asked for further context regarding the scale of the personality disorder issues in the City. *Members were informed that Borderline Personality Disorder affected roughly 1% of the population and was the one which was most common. There would be roughly 55 people in Peterborough accessing the service. Distribution of resources had been based on population figures. Community locality teams would continue to work with people.*
- Members noted that the timescales following outcomes of the consultation were to be confirmed and were concerned that there was no deadline. Members asked if there was further detail on the timescales. *Members were advised that the outcomes would be presented to the Clinical Commissioning Group (CCG) Board meeting on 30 September. Responses would be collated shortly and the formal decision would be made by the CCG in conjunction with CPFT on 30 September.*
- Members noted under Lifeworks that the redesign of Complex Case Services (CCS) aimed to increase the capacity from an approximate caseload of 70 service users to about 240. Members wanted to know if this was because there had been an increase in cases or if it was part of a developing plan to focus more on people who were of higher risk. *The Associate Director of Performance Delivery stated there was no increase in the prevalence, but it was about trying to provide a specialist service to a greater number of people. Previously there had been a small group of people receiving intensive long-term help. The new system represented a more expanded system based on a greater evidence base.*
- Members wanted to know if all partners were working closely in partnership with the CPFT to help develop and take this proposal forward. *Members were informed that the CCG and the GP mental health leads had been involved in developing the process. The consultation had gone out widely to many stakeholders such as A&E, Police, Probation and others who came into contact with service users. A project group was being established to develop proposals to further develop the service enhancing the support post-discharge in order to provide longer-term support. If adopted, these proposals would require additional funding.*
- Members referred to pages 32 and 33 of the report and the Peterborough tables, the section on Crisis Work. Members noted that the proposed service was that '55 clients would have access to two full-time advanced nurse practitioners running a team of up to four people county wide'. Did this refer to county-wide clients or Peterborough clients as it was listed under Peterborough? *The Associate Director of Performance Delivery stated that this was a typing error and the figures referred to Peterborough clients only.*
- Members were concerned that the Scrutiny Commission had not automatically been included in the consultation and that it had not been widely advertised. They therefore asked why there was not greater visibility of the proposals. *The Associate Director of Performance Delivery apologised for this but was not sure why this had not been referred to scrutiny beforehand. He stated that he would be happy to arrange a further meeting with himself and one of the clinical team for Members of the scrutiny commission to provide more information.*
- Members asked which service users had been contacted as part of the consultation. *The Associate Director of Performance Delivery stated that all current service users of the specialist service had been written to directly and the consultation had been put on the website. All the clinical teams within the CPFT had been informed so that they could raise awareness with any clients that they were working with.*

- Members asked if there was scope for increasing the scheme in Peterborough. *The Associate Director of Performance Delivery stated that this was a funding issue and the scheme could theoretically be increased if there was more funding available.*
- Members stated that the proposal did not seem to be integrated with other services such as social care. *Members were informed that the Trust was an integrated Trust and that there was a social worker working within the team and there was contact with social care and mental health leads in Peterborough.*
- Members stated that there was no identification of key outcomes for this group of service users and was presented as a crisis plan. Was this the intention? *Members were advised that the proposal used the payment by results care plan clusters for the outcomes which was very much an outcome-orientated model. The outcomes were about trying to avoid crisis by using occupational therapy and psycho-education, such as providing service users with information about their condition and utilising psychological interventions.*
- Members asked what the position was with regard to the end of the 'sit in' regarding the proposed closure of Lifeworks at Tenison Road, Cambridge. *Members were advised that an agreement had been reached that Lifeworks at Tenison Road would continue for a period of no longer than five years for two days a week to current and new service users. Part two of the agreement was to set up a joint working group across Cambridgeshire and Peterborough to develop an agreed model which would provide users with a long-term safety net. This would therefore not affect any other proposals unless further developments presented a better way to do things.*
- Members asked when there would be a review period of the proposals. *Members were informed that services were reviewed annually regardless but the recommendations which came out of the consultation would be those which were adopted and would be reviewed annually.*
- Members followed up responding that the program would need at least a few years to assess the impact. *The Associate Director of Performance Delivery responded that this was indeed true and individual outcomes would be taken into account.*

ACTION AGREED

The Commission noted the report and requested that the Associate Director of Performance Delivery report back to the Commission with the outcomes of the consultation and the proposals that would be presented to the CCG Board on 30 September.

6. End of Consultation on Proposals to Improve Older Peoples Healthcare and Adult Community Services

The report was introduced by the Director of Corporate Affairs. At the time of publication of the agenda the outcome of the consultation had not been published. A link to the End of Consultation Report which had recently been published on the Cambridgeshire and Peterborough Clinical Commissioning Groups website since the publication of the agenda had been sent to the Members of the Commission prior to the meeting. The Director of Corporate Affairs went through the highlights of the report which covered a thematic analysis of the views of the public and organisations responding to the consultation and the CCG's recommended responses to these themes.

Key Themes highlighted were:

- More joined up care: organising care around the patient.
- Better planning and Communication: delivering 'seamless' care.
- Bidders should be required to demonstrate how mental health would be integrated through the service.
- Security of data should be protected through a 'single electronic record system' adhering to statutory data protection standards.

- Proposals for joint working with voluntary sector organisations would need to be taken into consideration regarding bidders.
- There would need to be a focus on prevention in order to support older people to stay independent.
- Services should need to support people by working together to give effective co-ordination and continuity of care.
- Improved community services: reducing emergency hospital admissions, re-admissions and long stays in hospital.
- End of Life Care
- Local issues should be taken into account, including equality of access to services and resourcing.
- Bidders should demonstrate how they intend to work with and support primary care.
- There should be clarity in contracts with regards to scope of lead provider services.
- Outcomes Framework: The CCG should review its capacity and capability to ensure the new contract is managed effectively.
- The CCG would need to work with all partners in the local health and social care system.
- Evaluation criteria should be applied in order to analyse the credibility of financial aspects of proposals.
- Performance should be evaluated and made available to increase staff satisfaction.
- Standard NHS contract clauses relating to poor performance should be used effectively, and compensation clauses should be included in the event of termination.
- All steps should be taken to ensure a safe and efficient transition, including certainty for the transfer of staff.

Observations and questions were raised and discussed including:

- Members stated that the biggest issue for Peterborough was the Better Care Fund and asked if funding would still be available for this. *The Director of Corporate Affairs stated that the expectation was that this would continue but discussions were still ongoing.*

ACTION AGREED

1. The Commission noted the report and the End of Consultation report on the Proposals to improve older people's healthcare and adult community services and requested that the Director of Corporate Affairs and the preferred bidder when chosen report to the Commission at the November meeting.
2. The Commission agreed to the continuation of the Joint Working Group to comment on how bidders take on proposals and look at future scrutiny during mobilisation and transition.

7. Peterborough and Stamford Hospitals NHS Foundation Trust, CQC Report

The Acting Chief Executive presented the report which provided the Commission with an overview of the outcome of the Care Quality Commission Inspection of Peterborough and Stamford Hospitals NHS Foundation Trust that was undertaken in March 2014. The CQC had released its report on the Trust's inspection on 16 May 2014 which had highlighted that the Trust 'requires improvement' however many of the individual scores were higher and there were no immediate actions that needed to be taken. Members were informed that the inspection regime was a new regime and the inspection focused on five questions across a range of services:

- Are services safe?
- Are they effective?
- Are they caring?

- Are they well-led?
- Are they responsive to patients' needs?

The Acting Chief Executive also gave a presentation on actions being taken which is attached at Appendix 1.

Observations and questions were raised and discussed including:

- Members commented that they were pleased with the report overall.
- Members asked what the reduction in falls of 4% meant as the figure expressed as a percentage was unclear. *The Acting Chief Executive informed Members that 4% was a reduction in the falls since last year but was unsure of the absolute figure. A lot of hard work went into reducing the number of falls and there had been a noticeable reduction of falls with significant harm. There were many vulnerable patients in a hospital environment who fall and it was difficult to significantly reduce falls.*
- Members asked why recommendations were all “should do” rather than “must do” and expressed concern that phrasing the recommendations in this way would be less likely to restore public confidence. *The Acting Chief Executive stated that this was the wording used by the CQC because the findings of the inspection did not require immediate action and reflected time scales rather than priority.*
- Members asked if the new paediatric area would compromise the four-hour target in A&E. *Members were informed that the four-hour target was already difficult to meet. However it was hoped that the paediatric area would not affect waiting times and the dedicated space was necessary.*
- Members asked if plans were in place to address the issues highlighted in the inspection prior to the inspection. *The Acting Chief Executive stated that there were already plans in place to address all of the issues but the inspection had focused the need to get things done and timelines had therefore been re-evaluated.*
- Members asked if the report had had a detrimental effect on the morale of the staff. *The Acting Chief Executive stated that there had been some disappointment expressed however there had been extensive communication to all staff.*
- Members asked if it were possible to visit the hospital to see evidence of the actions being taken. *Members were advised that this would be possible and could be arranged.*
- Members asked what would happen if a patient were admitted to A & E and then needed to go onto a specific ward but there were no available beds. *The Acting Chief Executive stated that they would stay in the Emergency Department until an available bed was found but this might not be in the appropriate ward. A patient might have to be moved again when a bed was found in the appropriate ward.*
- Members asked if there was competition amongst salaries for nurses. *The Acting Chief Executive stated that there was a national pay scale so there would be no competition amongst hospitals setting salaries for nurses.*

ACTIONS AGREED

The Commission noted the report and requested that a visit be arranged to the Hospital for Members of the Commission to observe how the CQC Action Plan was being implemented. It was also requested that if possible Members of the Commission be invited to attend a Management meeting where the action plan was reported to.

8. Health and Wellbeing Board LGA Peer Review Letter and Action Plan

The Director for Communities who is also Chair of the Health and Wellbeing Programme Board introduced the report. The report provided the Commission with an opportunity to comment on the feedback letter received from the Peer Review of the Health and Wellbeing Board and the development of a draft action plan following the review. The Health and Wellbeing Board commissioned the Peer Review in March 2014 the purpose of which was to help identify where the Board was doing well and where it needed to improve. One of the

key areas identified was that there needed to be stronger involvement by scrutiny with the Health and Wellbeing Board to ensure the Board was carrying out its statutory functions.

Observations and questions were raised and discussed including:

- Members commented that the remit for the Commission was wide and various organisations and stakeholders requested to attend the Commission. There would need to be consideration as to how the Commission could effectively scrutinise the work of the Board within such a limited time frame at meetings and workload of the Commission. *The Director for Communities responded that the Peer Review required Scrutiny to ensure that the Board focused on the greatest needs in Peterborough which had been identified through the Joint Strategic Needs Analysis.*
- Members asked why all the RAG ratings were green. *The Director for Communities said that this was a draft action plan and the RAG ratings had not been completed and therefore should not be considered, what was relevant was the text.*
- Members noted that the actions listed in the action plan did not have deadline dates. *The Director for Communities advised that the Programme Board would be agreeing upon deadline dates and this would be submitted to the Commission.*

ACTION

The Commission noted the report.

9. Review of 2013-2014 and Work Programme for 2014-2015

The Senior Governance Officer introduced the report which provided the Committee with a review of the work undertaken by the Committee during 2013/14 and the opportunity to approve the draft work programme for 2014/15.

The Director of Corporate Affairs, CCG informed the Commission that the Preferred Bidder would not be selected until 30 September and requested that the Preferred Bidder attend Scrutiny in November. The Commission agreed to this request.

ACTIONS AGREED

The Committee noted the report and approved the draft Work Programme for 2014/15.

10. Forward Plan of Key Decisions

The Commission received the latest version of the Forward Plan of Key Decisions, containing key decisions that the Leader of the Council anticipated the Cabinet or individual Cabinet Members would make during the course of the following four months. Members were invited to comment on the Forward Plan of Key Decisions and, where appropriate, identify any relevant areas for inclusion in the Commission's work programme.

ACTION AGREED

The Commission noted the Forward Plan of Key Decisions.

The meeting began at 7.00pm and finished at 8.43pm

CHAIRMAN

Peterborough and Stamford Hospitals NHS Foundation Trust

CQC action plan Inspection undertaken in March 2014


May 2014



Peterborough and Stamford Hospitals NHS Foundation Trust

Action planning process


- Thorough review of the report
- Capture of all areas for improvement
- High level action plan
 - Trust wide issues
 - Alignment with existing work plans e.g. Urgent Care Board, HCAI
 - Areas requiring engagement with partners
 - Areas identified as 'should' improve
- Detailed clinical stream action plans
 - Review plans received to date
 - Avoid duplication through use of trust wide plan



Peterborough and Stamford Hospitals NHS Foundation Trust

Action plan


- The 5 key questions used for the inspection will be replicated as the framework for the action plan
- CQC action plan steering group
- Progress to be monitored by the Quality Assurance Committee




Peterborough and Stamford Hospitals NHS Foundation Trust

Are services safe?


- Review child safeguarding checks in the Emergency Department
- Provide a paediatric area within the emergency department
- Ensure timely replenishment of gel dispensers
- Review and monitor storage to ensure patient, staff and visitor safety from trip hazards
- Improve job planning for Consultant Physicians




Peterborough and Stamford Hospitals NHS Foundation Trust 

Are services safe? 2


- Additional investment in Consultant Physicians and Medical registrars
- Review of cleaning specification and investment in services (approximately £1.2 million)




Peterborough and Stamford Hospitals NHS Foundation Trust 

Are services effective?


- Review pain relief for patients being cared for at the end of their life
- Ensure appropriate participation in the national clinical audit programme
- Improve effectiveness for patients who have had a stroke including review of therapist staffing levels
- Continue recruitment and retention activities




Peterborough and Stamford Hospitals NHS Foundation Trust 

Are services caring?


- Roll out intentional rounding – include the Emergency Department
- Improve response times to call bells
- Investment in additional matron post to support Medical Ward services



Peterborough and Stamford Hospitals NHS Foundation Trust 

Are services responsive? 1

- Reduce the number of patients admitted to 'inappropriate' wards
- Increase joint working with the Mental Health Trust to improve services (PLS and CAMHS)
- Review accommodation and facilities for adolescents
- Continue Urgent Care pathway improvement programme



Are services responsive? 2

- Improve 18 weeks performance
- Reduce the number of cancelled operations
- Improve ward processes and discharge effectiveness
- Clear the backlog of complaints
- Review the use of face to face meetings with complainants
- Improve complaints handling – consider roll out of ED model



Are services well led?

- Complete the mandatory training database development and provide accurate records
- Reiterate the Raising Concerns Policy and ways in which staff can gain support when reporting issues
- Confirm the programme of events to promote Board level visibility across both sites



CQC action plan steering group

- Terms of reference
- Membership: as for preparatory taskforce
- Includes a Non-Executive Director
- One hour per month – after TMB (11:30-12:30)
- Executive Director sponsor for each stream
- Standing agenda items:
 - Action plan updates
 - Constraints for progress
 - Risk assessments



Any questions or comments?



SCRUTINY COMMISSION FOR HEALTH ISSUES	Agenda Item No. 5
10 SEPTEMBER 2014	Public Report

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

Contact Officer(s) – Jessica Bawden, Director of Corporate Affairs

Contact Details – Cambridgeshire and Peterborough Clinical Commissioning Group

LOCAL HEALTH ECONOMY FIVE YEAR STRATEGIC PLAN

1. PURPOSE

- 1.1 This report gives an update on the ongoing development of the Local Health Economy Five Year Strategic Plan. The purpose of the item is to provide information and to raise awareness to members of the Scrutiny Commission for Health Issues.

2. RECOMMENDATIONS

- 2.1 Members of the Scrutiny Commission for Health Issues are asked to discuss the ongoing work and to make comments.

4. BACKGROUND

- 4.1 The NHS has been asked to develop, in conjunction with providers, partners and patients, five year plans that will deliver sustainable health care now and in the future. This is the first time that plans have been developed for five years rather than one or two years. There are four phases of plan development as follows:

20th June 2014: Agree Framework and Baseline

- System stakeholder identification, identification of key local issues, produce baseline on improvement metrics, identify opportunities to introduce new interventions over the next five years, agree process for next phase

July 2014 to June 2015: Design and decide

- Full system engagement, decisions about what needs to change and how to do it, modelling of impacts on the outcomes that matter to people, preparation for public consultation

July 2015 to June 2016: Change and construct

- Consultation on key changes, implementation phase, evaluation of change with full public and patient engagement

July 2016 onwards: Implementation

- Ongoing key engagement meetings

We are currently in Phase two. Phase one, which concluded at the end of June, required Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) to submit draft plans to the NHS England for comment, and then a final plan, known as the 'System Blueprint' to NHS England on 20 June 2014. The System Blueprint sets out a five year plan for the whole of the local health system.

‘Challenged Health Economy’

The Cambridgeshire and Peterborough system has been identified as one of 11 ‘challenged health economies’ nationally. This reflects some of the challenges faced by both the CCG and the healthcare provider organisations in Cambridgeshire and Peterborough. As a result, external advisors PricewaterhouseCoopers (PwC) worked with the Cambridgeshire and Peterborough system from 3 April to 30 June 2014. Their objective was to support the local health system to develop a joint strategy across Cambridgeshire and Peterborough that would deliver clinically and financially sustainable healthcare. Their work was being sponsored and overseen by NHS England, Monitor and the Trust Development Authority (TDA).

PwC’s approach centred around using “Care Design Groups”. These were clinically focussed groups that functioned to:

- Develop agreement at a care professional level of the preferred affordable model of care for the area under consideration
- Reflect this model to commissioners and providers organisations so that an affordable system as a whole could be outlined
- Describe the capacity required to deliver the new models of care to ensure this could then be matched against available capacity.

The CCG has adopted this Care Design Group approach.

Cambridgeshire and Peterborough health system blueprint

The final version of the Cambridgeshire and Peterborough health system blueprint was submitted to NHS England on 20 June 2014. The plan was developed with feedback from stakeholder groups including the CCG’s Patient Reference Group. Further feedback will be sought from all stakeholders during phase two. The system blueprint includes the following information:

The formation of the System Blueprint including the reasons for selecting Cambridgeshire and Peterborough as a challenged health system

The Cambridgeshire and Peterborough health system faces significant challenges over the next five years. We have used the intelligence gained from Joint Strategic Needs Assessments (JSNAs) and other sources of evidence to learn more about the health needs of our population and in doing so we recognise the following key messages:

- The Cambridgeshire and Peterborough health system is not financially sustainable and if nothing is done, it will face an financial gap of at least £250m by 2018/19
- The population of Cambridgeshire and Peterborough is increasing and there will be a greater proportion of older people in five years’ time
- Demand for mental health services continues to increase
- There are significant levels of deprivation and inequality that need to be addressed
- People are living longer and health outcomes are generally good but there are significant differences in people’s health across our system
- Our health system has multiple stakeholders

In this context, and specifically as a result of the financial challenges faced by the system, fundamental changes are required to the organisation, provision, co-ordination

and delivery of services.

We have focused our work in the following key areas:

- Elective care
- Mental health
- Non-elective care
- Older people and vulnerable adults
- Prevention and self-care
- Women and children

NHS England, Monitor and NHS Trust Development Authority undertook an exercise to identify those health systems which were particularly challenged as a whole, and were most likely to benefit from intensive support in order to develop plans which would improve outcomes for the public and patients whilst developing a financially sustainable future across the health economy. These were the health systems that were at most risk of failing if the plans submitted did not identify future service configurations that were achievable and could resolve the major local challenges. In particular, the exercise focused on the level of financial challenge within the health system, and how aligned provider and commissioner plans were.

NHS England, Monitor and NHS Trust Development Authority then appointed teams to support commissioners and providers in these challenged health systems to consider options for the future sustainable provision of healthcare services. The objectives of this work were to provide support at a local level that:

- Enabled commissioners and providers in the local health system to submit strategic plans that were robust, deliverable and clearly set out how the anticipated challenges would be met
- Facilitated commissioners and providers to develop full implementation plans for the change that would prevent risk of failure
- Provided confidence that capacity was in place to deliver the plans, and outlined any areas of risk or where further support may be required

For further information see page four of the System Blueprint.

Information about Cambridgeshire and Peterborough's population and health context

Overall health is good across the local health economy. However there is a significant inequality. Life expectancy is a good summary measure of health experience and differs significantly across the CCG area:

- 77.7 for men in Peterborough (significantly below the national average)
- 80.6 for men in Cambridgeshire (significantly above the national average)
- 82.6 for women in Peterborough (statistically the same as the national average)
- 84.5 for women in Cambridgeshire (significantly above the national average)
- Circulatory disease and cancer are the main causes of death

The health of people in Cambridgeshire is generally better than the England average, although there are areas that are affluent and areas that are deprived within the county. Deprivation is lower than average, however about 14,400 children live in poverty. Life

expectancy for both men and women is higher than the England average. Life expectancy is 7.2 years lower for men and 5.3 years lower for women in the most deprived areas of Cambridgeshire than in the least deprived areas.

The health of people in Peterborough is generally worse than the England average although some areas are less deprived and some more deprived. Deprivation is higher than average and approximately 9,500 children live in poverty. Life expectancy for men is lower than the England average. Life expectancy is 9.4 years lower for men and 5.6 years lower for women in the most deprived areas of Peterborough than in the least deprived areas.

For further information see page 10 of the System Blueprint.

Information on where we need to get to as a health system (including the over-arching themes identified in the Joint Strategic Needs Assessments)

Several over-arching themes emerge from the available Joint Strategic Needs Assessments and health needs profiles.

Information from the Office of National Statistics shows that in Cambridgeshire the population is forecast to increase by 5.0% between 2014 and 2019 (32,000 people in total) with most of the increase in Cambridge City and South Cambridgeshire. In Peterborough, the population is forecast to increase by 6.1% between 2014 and 2019 (11,600 people in total). In Cambridgeshire and Peterborough the population aged 75 years and over is set to increase by 24% between 2014 and 2019 (16,000 people).

In Peterborough the city's deprived areas are those that are more densely populated and 26% of the population live in these areas. Some of the wards in Peterborough are rated amongst the highest areas for child poverty in England and 13 of the city's smaller neighbourhoods (lower super output areas) are amongst the most deprived 10% in the country. The most deprived areas in Cambridgeshire are concentrated in the north east of the County. Fenland, north-east Cambridge and parts of north Huntingdon have the highest levels of relative deprivation.

Our population varies both in levels of experience of unhealthy lifestyles and their consequences, as well as in the take up of preventive services such as smoking cessation.

Average life expectancy in Cambridgeshire is 80 years for males and 84 years for females. In Peterborough, average life expectancy is 78 years for males and 82 years for females (2008-2010 ONS Life Expectancy). Life expectancy in both areas is increasing over time and death rates for the major causes of death are generally declining locally, as they are nationally. Death rates for diseases like circulatory diseases are falling more quickly than death rates for cancers. However, important differences remain between the life expectancy and mortality of our populations between local authority districts and between areas in both Cambridgeshire and Peterborough, for example in Peterborough the rate of coronary heart disease (CHD) mortality is not falling as fast as in Cambridgeshire, some districts in Cambridgeshire have higher death rates than the county average, e.g. in Fenland and there are important differentials in premature deaths from CHD.

Local mental health services face many of the same trends as identified in the preceding paragraphs, in particular the increase in overall population growth, but especially of older people. The demand for services continues to increase, and

especially the number of people presenting with dementia. The modern focus on community-based “recovery” services places significant pressures on community services. Community Health Profiles also provide an overview of local mental health prevalence. The most significant risk-factors for poor mental health locally are deprivation, unemployment, limiting long-term illness, crime, substance misuse, physical health, and being part of a “marginalised” group (e.g. an ethnic minority, being homeless or having a learning disability). There are pockets of deprivation throughout the CCG, but for most mental health risk factors Fenland, Peterborough and Cambridge City are above national averages, whilst Huntingdonshire, South Cambridgeshire and East Cambridgeshire are below national averages.

For further information see page 17 of the System Blueprint and Appendix 3 of the Appendices document.

Our ambition to improve health in Cambridgeshire and Peterborough

The health system in Cambridgeshire and Peterborough exists to improve the health and wellbeing of its population. There are many indicators of health and wellbeing, and seven indicators that are relevant to monitoring improvement in outcomes over the five year time frame of this planning cycle have been selected.

A summary of the trajectories for improvement for these top level outcomes is as follows:

- To reduce the Potential Years of Life Lost from causes amenable to health care across Cambridgeshire and Peterborough by 6.2% reduction over the five year time period. This represents a significant gain in health
- To improve the health related quality of life of people with one or more long-term as measured by EQ 5D on the GP patient survey by achieving a score of 80 within five years
- To reduce emergency admissions from causes considered amenable to healthcare by achieving a 12% reduction in the composite emergency admission indicator
- To increase the number of people having a positive experience of care outside hospital, in general practice and in the community by achieving a score of 4.1 on the relevant domains of the GP patient survey
- To increasing the number of people having a positive experience of hospital care by achieving a score of 122 (current baseline is 127.6) over 5 years

To make significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

For further information see page 18 of the System Blueprint.

Our plans to improve financial sustainability in Cambridgeshire and Peterborough

The increasing demands on the Cambridgeshire and Peterborough health system are driven by a population that is increasing and a population that is aging.

There has been much work already across the health system to ensure that care for patients is provided in the most appropriate place. However if demand continues to increase at a greater rate than the achievement of system efficiency savings then costs will continue to rise even though the overall system is more efficient.

PwC have modelled three financial scenarios for the whole of the Cambridgeshire and Peterborough health system for 2014-2019.

- In scenario 1 no provider savings are achieved i.e. there are no savings from cost improvement plans or commissioning efficiencies. The financial gap across the health system widens to over £300m by 2018/19.
- In scenario 2 the providers in the health system achieve their cost improvement plans and commissioners make modest savings. This lessens the financial gap in 2018/19 but it still remains at £250 m.
- In scenario 3 each provider achieves a cumulative 4% efficiency savings year on year and the commissioners also make 4% efficiencies. This amounts to reducing costs by over 19% over the five year time period from the 2013/2014 baseline. In this scenario the health system overall will break even in 2017.

At present the financial plans across the system do not align with the forecasts of available funding. All providers geographically located in Cambridgeshire and Peterborough serve, to a lesser or greater degree, populations from other health systems. This means that there need not be complete alignment between the local commissioner plans and the plans of providers. However, with respect to Cambridgeshire and Peterborough residents, the whole system needs more alignment to remain sustainable. Achieving this alignment will involve a several approaches:

- Continuing to increase the efficiency of the health system i.e. doing the same things in a more efficient way
- Transforming areas of the health system i.e. delivering health services differently
- Reducing demand for healthcare i.e. reducing the amount of healthcare that is needed by people by increasing health and wellbeing across the population. Delivery of Local Authority Health and Wellbeing strategies will be central to this.

For further information see page 19 of the System Blueprint.

Challenges facing primary care

The Cambridgeshire and Peterborough health system incorporates 108 GP practices and 850 GPs (equating 350 full time posts). The CCG, as a GP member practice organisation, maintains a close relationship with each practice. Historically primary care has been a strong aspect of the healthcare system across Cambridgeshire and Peterborough. However NHS England has recognised at a national level that general practice and wider primary care services (pharmacy, optometry and dental services) face increasingly unsustainable pressures and that there is a need to transform the way primary care is provided to reflect these growing challenges.

The CCG has worked with GPs at Member Practice events, provider stakeholder events, through discussion at LCG Board meetings, discussions with the Area Team and through the elective and non-elective Care Design Groups to identify a set of critical success factors for primary care. These success factors are as follows:

- Generate a greater sense of individual responsibility to remain well and choose health lifestyle choices to avoid ill health
- Reduce unwarranted variation and address inequalities (evidence shows that primary care can reduce inequalities and improve health outcomes)
- Deliver quality improvement

- Improve access to GPs
- Develop capability and capacity to meet the demands of a rapidly increasing population, and a greater number of older people with associated frailty and long term conditions

To enable these changes to happen the following the following enables need to be considered:

- Closer working with Public Health England to promote self-care and healthy lifestyles
- Exploration of options to deliver primary care at scale through, for example, increased collaboration between GP practices
- Review of capacity within primary care including mapping against demand
- Better signposting of services
- Improved communication between GPs and secondary care clinicians

Primary care services have the potential to contribute significantly to the Cambridgeshire and Peterborough health system goal to produce a sustainable health system because primary care reduces demand on health services through its role in preventing illness.

Forward process for the Cambridgeshire and Peterborough System Blueprint

Going forward, the work will be overseen by a System National Partners Group made up of an NHS England Director, the Enforcement Director at Monitor, the Head of Delivery and Development from the NHS Trust Development Authority and the Chief Operating Officer from Cambridgeshire and Peterborough CCG.

A Health and Care System Transformation Board has been established, made up of Chief Executives from the health organisations in the local health system, Chief Executives or Directors of Adult Social Care from Cambridgeshire County Council and Peterborough City Council, and representatives from the System National Partners Group. This group has started to meet on a monthly basis and will drive forward the work.

In addition, a project team has been appointed, responsible for day to day delivery of the work. This includes a Programme Director, Programme Managers and Workstream Leads and individuals appointed are from health organisations from across the local health system.

The Transformation Board has decided on a final set of workstreams to be included in the programme as follows:

- Elective Care
- Mental health
- Non elective care
- Older People
- Primary Care
- Women and Children
- Acute Configuration Review

(Note that prevention, initially proposed as a workstream in its own right, has now been incorporated into all other workstreams).

A key element of the next phase of work is developing the workstreams above in more details. This includes further analytical work to provide a baseline for 'where we are now' as well as work to determine what changes need to take place and what the outcomes of making these changes will be.

5. KEY ISSUES

- 5.1 The commission is asked to consider the ongoing work and to make comments.

6. IMPLICATIONS

- 6.1 The implications of this work will be determined in Phase two.

7. CONSULTATION

- 7.1 Preparation for public consultation will take place prior to June 2015. Consultation will take place from July 2015 onwards. Timescales will be determined by each workstream during Phase 2.

8. NEXT STEPS

- 8.1 The commission is not required to make any decisions asked at this stage. Further updates will be presented at future meetings for consideration and comment.

9. BACKGROUND DOCUMENTS

- 9.1 System Blueprint: <http://www.cambridgeshireandpeterboroughccg.nhs.uk/five-year-plan.htm>

10. APPENDICES

- 10.1 Appendix 1 – Cambridgeshire and Peterborough Health System Blueprint
Appendix 2 - System Blueprint appendices



Cambridgeshire and Peterborough health system Blueprint

2014/15 to 2018/19



20th June 2014

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1. Document purpose

This document sets out a System Blueprint for the Cambridgeshire and Peterborough health system for the years 2014 to 2019. This health system exists to serve the people of Cambridgeshire and Peterborough and its overall aims are to empower people to stay healthy, improve the quality of care and improve outcomes and to continually develop a sustainable health and social care system.

Production of this document has been led by Cambridgeshire and Peterborough Clinical Commissioning Group (CCG). However sustainable system development is dependent on all health organisations working in partnership. Local Authorities are important commissioners of health and public health as well as commissioners of social care. We believe that by working together as a health and social care system we can achieve the best outcomes for patients, their carers and for the population we serve.

We recognise that forming a plan to deliver better health outcomes and a more sustainable health system is a complex process. This version of the System Blueprint is a working document which is being actively considered and discussed by the Boards of the partner organisations in the health system in June and July. A timeline showing the phases of work is set out in figure 29, section 10 (Forward process for the Cambridgeshire and Peterborough System Blueprint).

Whilst we have endeavoured to keep our plans realistic and grounded in what we think we can achieve, we also aspire to commission safe, high quality care and to achieve the best patient experience possible within the resources available to us.

2. Summary

The Cambridgeshire and Peterborough health system faces significant challenges over the next five years. We have used the intelligence gained from Joint Strategic Needs Assessments (JSNAs) and other sources of evidence to learn more about the health needs of our population and in doing so we recognise the following key messages:

- The Cambridgeshire and Peterborough health system is not financially sustainable and if nothing is done, it will face a financial gap of at least £250 m by 2018/19
- The population of Cambridgeshire and Peterborough is increasing and there will be a greater proportion of older people in 5 years' time
- Demand for mental health services continues to increase
- There are significant levels of deprivation and inequality that need to be addressed
- People are living longer and health outcomes are generally good but there are significant differences in people's health across our system
- Our health system has multiple stakeholders

In this context, and specifically as a result of the financial challenges faced by the system, fundamental changes are required to the organisation, provision, co-ordination and delivery of services.

We have focused our work in the following key areas:

- Elective care
- Mental health
- Non-elective care
- Older people and vulnerable adults
- Prevention and self-care
- Women and children

A number of transformation programmes are ongoing in these areas already. For example the Older People's Healthcare and Adult Community Services (OPACS) Procurement is an innovative way of commissioning for better outcomes and the Better Care Fund provides an opportunity to commission with Local Authority partners. A "Care Design Group" approach has been used for elective and non-elective care to identify schemes that have the potential to reduce our £250m gap by up to £80m. Further schemes and system changes need to be considered and worked up, and similar development work, led by our clinicians, will determine the way forward in each of these key areas. The System Blueprint also needs to align with developments in primary care. Going forwards, the planning process needs to enable individual organisations to align their plans to the System Blueprint.

Governance and resourcing requirements have been determined and will enable the blueprint process to move into phase 2 and beyond. This document describes these key areas, as well as the other enablers (IM&T, workforce) that are crucial to the successful delivery of the changes being developed.

Although the next few years will have many challenges, we know, too, that we have significant opportunities to innovate and transform services. We believe that we are well placed to make the most of the opportunities available and to effectively address the wide range of challenges set out in this plan.

3. Introduction

This plan takes as its starting point transformational interventions that were already ongoing in the Cambridgeshire and Peterborough health system. From April to June 2014 the planning process has been supported by a team from PwC who were funded by NHS England, Monitor and the NHS Trust Development Authority to provide additional support to the Cambridgeshire and Peterborough health system

3.1 The formation of this System Blueprint: the reasons for selecting Cambridgeshire and Peterborough health system as a challenged health system.

In 2013 NHS England, Monitor and the NHS Trust Development Authority issued coordinated planning guidance requesting commissioners and providers to develop 5 Year Plans for their systems by the end of June 2014.

NHS England, Monitor and NHS Trust Development Authority undertook an exercise to identify those health systems which were particularly challenged as a whole, and were most likely to benefit from intensive support in order to develop plans which would improve outcomes for the public and patients whilst developing a financially sustainable future across the health economy. These were the health systems that were at most risk of failing if the plans submitted did not identify future service configurations that were achievable and could resolve the major local challenges. In particular, the exercise focused on the level of financial challenge within the health system, and how aligned provider and commissioner plans were.

NHS England, Monitor and NHS Trust Development Authority then appointed teams to support commissioners and providers in these challenged health systems to consider options for the future sustainable provision of healthcare services. The objectives of this work were to provide support at a local level that:

- Enabled commissioners and providers in the local health system to submit strategic plans that were robust, deliverable and clearly set out how the anticipated challenges would be met
- Facilitated commissioners and providers to develop full implementation plans for the change that would prevent risk of failure
- Provided confidence that capacity was in place to deliver the plans, and outlined any areas of risk or where further support may be required

What factors make the Cambridgeshire and Peterborough health system unusual?

There are a number of factors that could make this health system more complex than many others. These include the following:

- Hinchingsbrooke Health Care NHS Trust: The first NHS trust to be operated by a private partner, Circle
- Peterborough and Stamford Hospitals NHS Foundation Trust: Currently supported by a contingency planning team to find a system-wide solution to the Trust's financial challenges

Cambridgeshire and Peterborough health system Blueprint

- Cambridge University Hospitals NHS Foundation Trust: A national centre for specialist treatment, and one of five Academic Health Science Centres in the UK
- Papworth NHS Foundation Trust: The UK's largest specialist cardiothoracic hospital, with a plan to proceed with building a new hospital in Cambridge

Additionally, whilst the health system as a whole has better than average health outcomes, including healthy life expectancy, there are significant health inequalities.

Method of joint working

The content of this plan has been informed by three distinct but related strands of cross-system joint working.

1. A Joint Strategic Planning Stakeholder Group has been meeting regularly from December 2013 to . This is chaired by the CCG Director of Commissioning and has on its membership Directors from across the Health and Social Care system and Healthwatch. In May 2014 the group held a “system summit” which considered the different plans from the organisations in the system. Outputs from this work include agreement on the demographic projections and the risk log. The system summit realised that there were differences in growth assumptions across the system and as a result the CCG commissioned further work to illustrate these differences. This is shown in section 5.3.
2. PwC were appointed by NHS England to work across Cambridgeshire and Peterborough. They commenced this role on 3rd April 2014 and their work has been overseen by a local steering group chaired by the Director of the NHS England Norfolk, Suffolk and Cambridgeshire Area Team. This process has produced an overview of healthcare, and a system-wide estimate of the financial challenge. PwC have facilitated two “Care Design Groups” that have taken a clinically focussed approach to identify changes that could improve outcomes and the financial sustainability of the health system. Their estimation of the financial impact of these changes is shown as figure 23.
3. The Cambridgeshire and Peterborough Chief Executives Group is working to agree the governance and delivery arrangements for this strategic planning work. A concordat on joint working is in the process of being signed off by the organisations in the system. Proposals on a delivery structure and resourcing for the next phase of this process will be considered by the Chief Executives Group on 27th June 2014.

3.2 Approach

The starting point of this plan has been an understanding of the health needs of the Cambridgeshire and Peterborough population. Information about this is presented in appendix 1. The ambitions for improving health outcomes have been analysed and are presented in appendix 2.

The need to improve health outcomes whilst maintaining a financially sustainable system is not new to the Cambridgeshire and Peterborough health system. This plan outlines the transformational interventions that

Cambridgeshire and Peterborough health system Blueprint

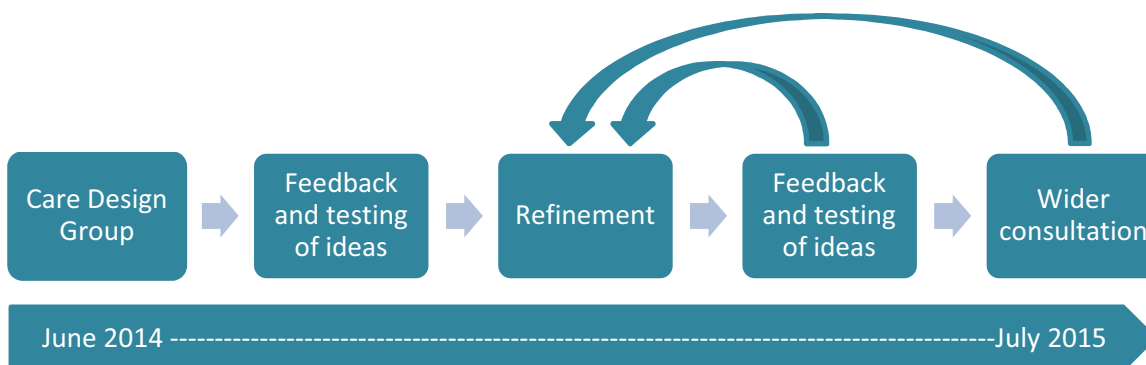
are ongoing already, notably the CCG's Older People's Healthcare and Adult Community Services (OPACS) Procurement, and how these are expected to impact on the system.

PwC has provided some of the system-wide financial analysis. The design of interventions for system change has centred on the use of "Care Design Groups" (CDGs). These are clinically focussed groups that function to:

- Develop agreement at a care professional level of the preferred affordable model of care for the area under consideration
- Reflect this model to commissioners and providers organisations so that an affordable system as a whole can be outlined
- Describe the capacity required to deliver the new models of care to ensure this can then be matched against available capacity.

The Care Design Group process is set out in figure 1 below:

Figure 1: Care Design Group process



The CDG process has, to date, identified potential savings of up to £80m. It is recognised, however, that £80m, is significantly short of the £250m shortfall and other approaches to identify options for change are likely to need to be considered.

3.3 Cambridgeshire and Peterborough: our population

Cambridgeshire and Peterborough CCG serves a diverse, ageing population with significant inequalities. The CCG population is currently 883,000 and is predicted to increase between 2014 and 2019 by 5.3%.

- The population in this local health system is increasing with a greater absolute increase in people who are aged over 65

Some areas of the CCG have a population that changes rapidly. For example, Cambridge City has a student population of nearly 30,000 equating to nearly 23% of the City's resident population. In addition, changes in the migrant population add to the complexity of commissioning services. International migrants in Cambridgeshire and Peterborough come from all over the world and from different socio-economic backgrounds. The most common countries of origin for migrant workers registering in Cambridgeshire and in Peterborough in both 2010 and 2011 were Lithuania, Latvia, and Poland.

Cambridgeshire and Peterborough health system Blueprint

Overall, Cambridgeshire is less deprived than Peterborough although there are significant areas of deprivation in Fenland, North East Cambridge and North Huntingdon. Peterborough is predominantly urban with 26% of the population in Peterborough living in the most deprived areas in the country (Dogsthorpe and East Wards).

Figure 2: Resident and registered population projections 2011 to 2019

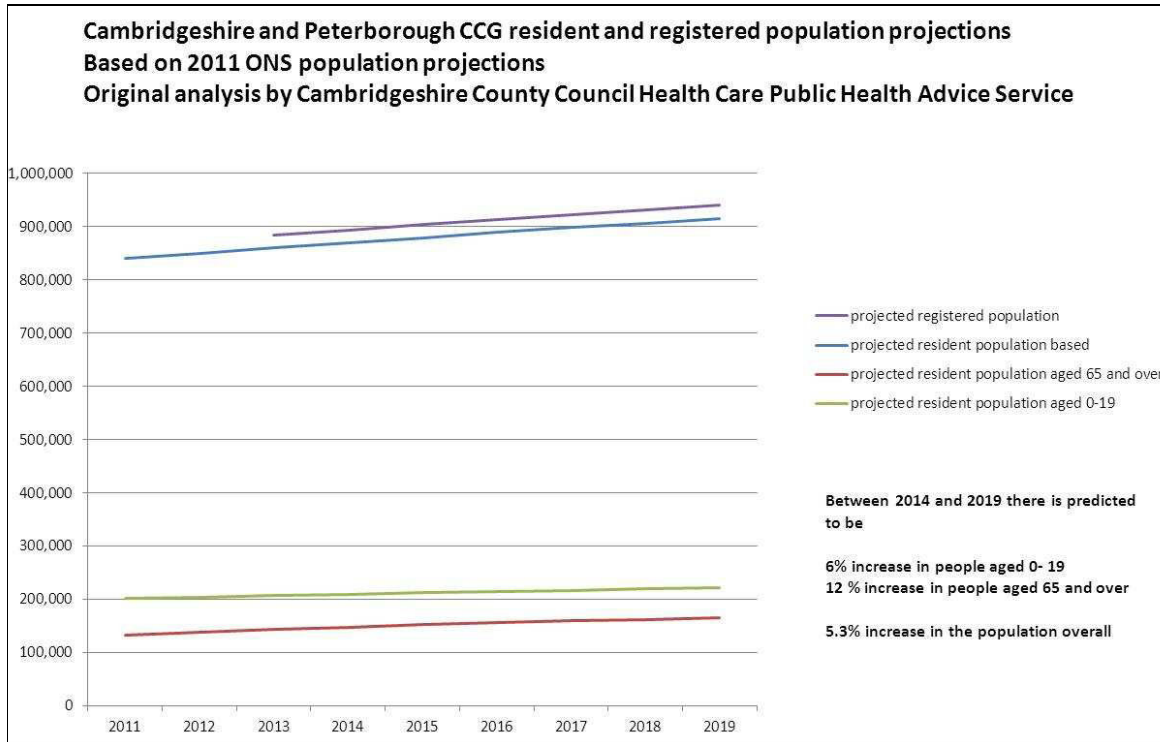


Figure 3: Cambridgeshire & Peterborough: Area and population overview

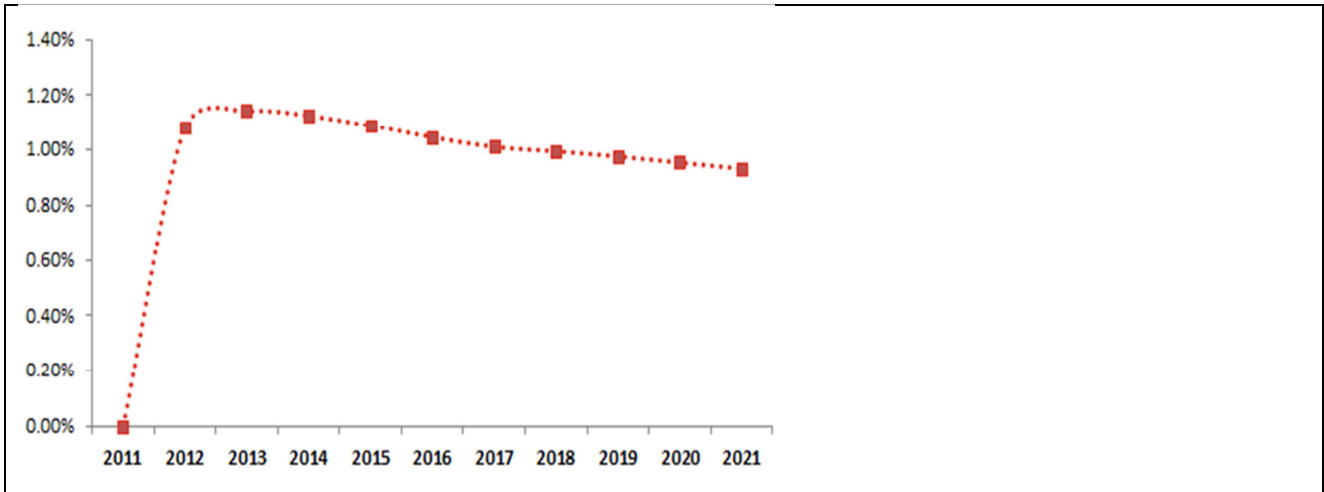
Population projections (2011 – 2021)

- Projected total population by 2021: 0.99m
- Projected population increase for Cambridgeshire: 11%
- Projected population increase for Peterborough: 13%

Source: PwC

Cambridgeshire and Peterborough health system Blueprint

Figure 4: Population growth, 2011 – 2021

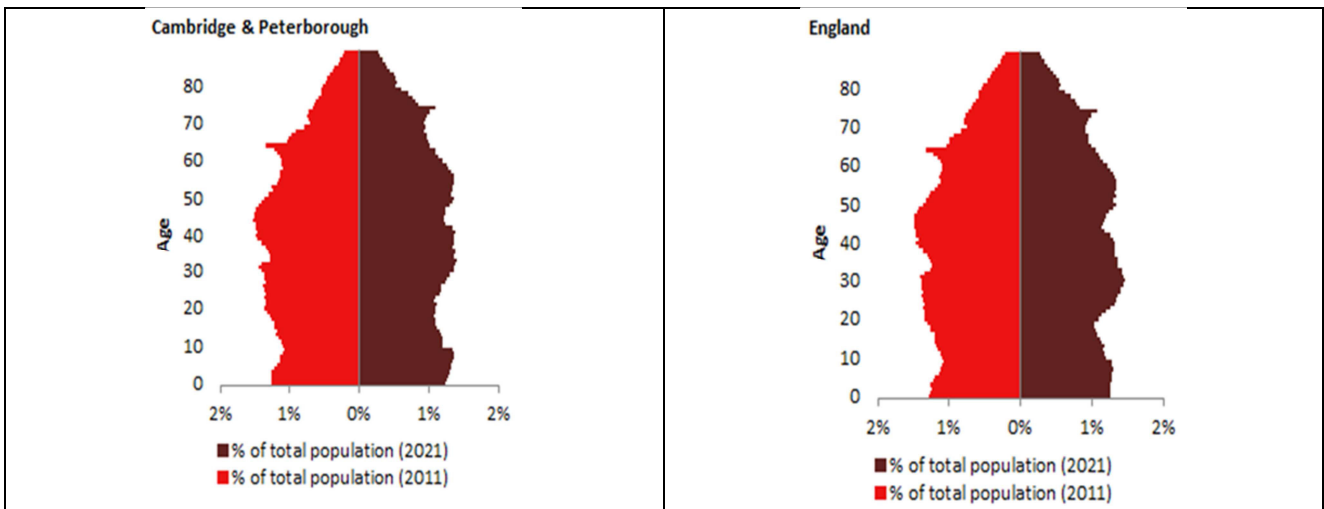


Source: PwC (information from Office of National Statistics (ONS) Sub-national population projections, Interim 2011-based)

Figure 5: Population age distribution (2011 – 2021)

- The population aged 75 and over is projected to increase by 33% in C&P.
- Source: PwC

Figure 6: Cambridgeshire and Peterborough and England age distribution, 2011 vs. 2021



Source: PwC (information from Office of National Statistics (ONS) Sub-national population projections, Interim 2011-based)

3.4 System strategic aims and goals

The Cambridgeshire and Peterborough health system has broadly agreed to a set of strategic aims for the next 5 years and strategic goals that will move us to them.

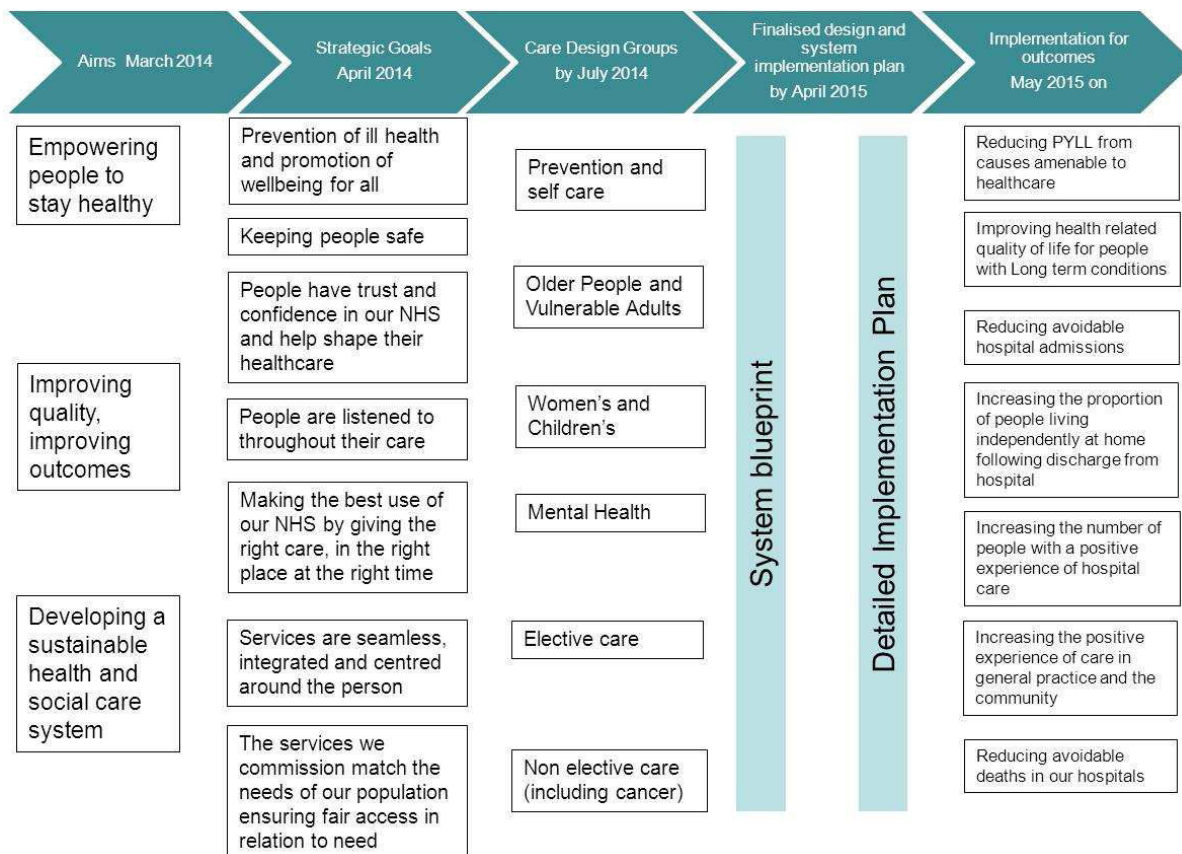
Figure 7 shows how the three strategic aims relate, with people at the centre of all that we do. Figure 8 shows how the strategic goals for the Cambridgeshire and Peterborough health system.

Cambridgeshire and Peterborough health system Blueprint

Figure 7: Strategic aims for the next 5 years: Cambridgeshire and Peterborough health system



Figure 8: Strategic aims and goals for the next 5 years: Cambridgeshire and Peterborough health system



We have identified that our biggest challenge is to ensure that we make the best use of our NHS by giving the right care, in the right place and at the right time. To do this we need to ensure clinical effectiveness, cost-effectiveness and health system efficiency.

4. Cambridgeshire and Peterborough health system Context

This section describes the current context in which the local health system operates and the expected changes in that context over the next 5 years.

4.1 Cambridgeshire and Peterborough: the health of our people

- Overall health is good across the local health economy
- However there is a significant inequality

Life expectancy is a good summary measure of health experience and differs significantly across the CCG area.

- 77.7 for men in Peterborough (significantly below the national average)
- 80.6 for men in Cambridgeshire (significantly above the national average)
- 82.6 for women in Peterborough (statistically the same as the national average)
- 84.5 for women in Cambridgeshire (significantly above the national average)
- Circulatory disease and cancer are the main causes of death

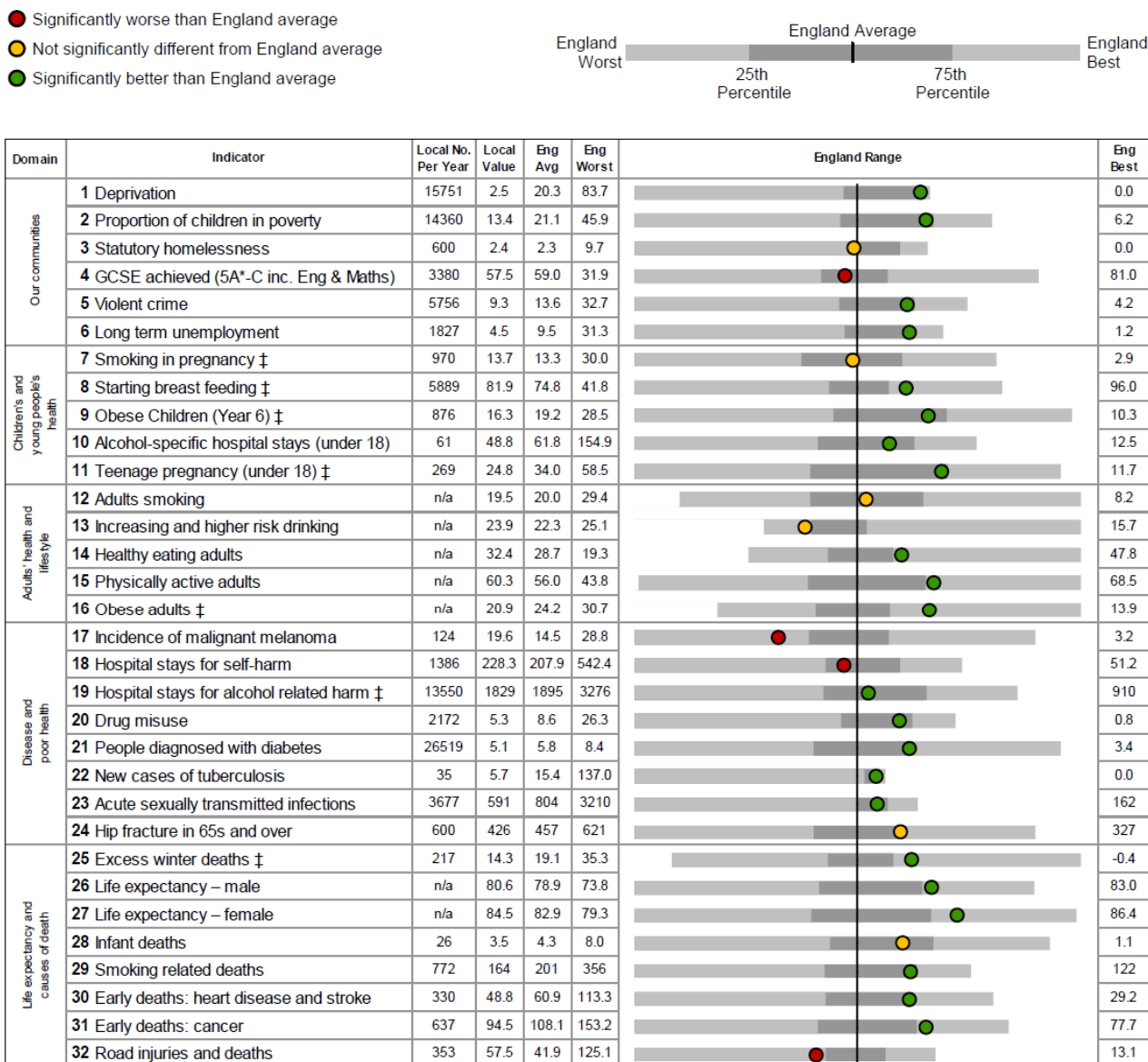
4.1.1 Cambridgeshire

The health of people in Cambridgeshire is generally better than the England average, although there are areas that are affluent and areas that are deprived within the county. Deprivation is lower than average, however about 14,400 children live in poverty. Life expectancy for both men and women is higher than the England average. Life expectancy is 7.2 years lower for men and 5.3 years lower for women in the most deprived areas of Cambridgeshire than in the least deprived areas.

- Over the last 10 years, all-cause mortality rates have fallen. Early death rates from cancer and from heart disease and stroke have fallen and are better than the England average
- In Year 6, 16.3% of children are classified as obese, better than the average for England.
- The level of GCSE attainment is worse than the England average
- Levels of teenage pregnancy, alcohol-specific hospital stays among those under 18 and breast feeding are better than the England average
- Estimated levels of adult 'healthy eating', physical activity and obesity are better than the England average
- The rate of road injuries and deaths is worse than the England average
- Rates of sexually transmitted infections and smoking related deaths are better than the England average
- Rates of incidence of malignant melanoma and hospital stays for self-harm are worse than average

Cambridgeshire and Peterborough health system Blueprint

Figure 9: Health profiles – Cambridgeshire



‡ For comparison with PHOF Indicators, please go to the following link: www.healthprofiles.info/PHOF

4.1.2 Peterborough

The health of people in Peterborough is generally worse than the England average although some areas are less deprived and some more deprived. Deprivation is higher than average and approximately 9,500 children live in poverty. Life expectancy for men is lower than the England average. Life expectancy is 9.4 years lower for men and 5.6 years lower for women in the most deprived areas of Peterborough than in the least deprived areas.

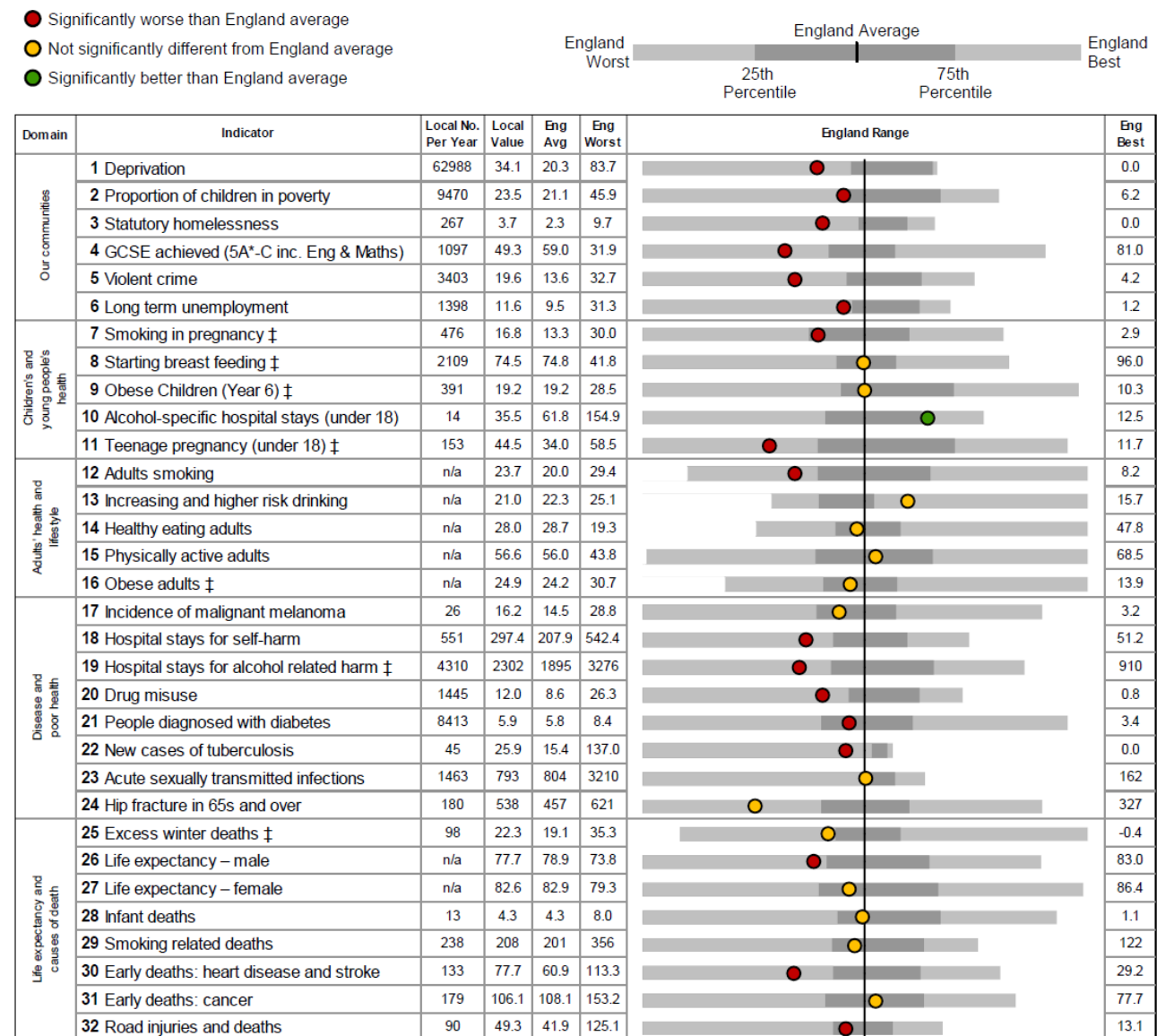
- Over the last 10 years, all-cause mortality rates have fallen. The early death rate from heart disease and stroke has fallen, but is worse than the England average.
- In Year 6, 19.2% of children are classified as obese.

Cambridgeshire and Peterborough health system Blueprint

- Levels of teenage pregnancy, GCSE attainment and smoking in pregnancy are worse than the England average.
- The level of alcohol-specific hospital stays among those under 18 is better than the England average.
- The estimated level of adult smoking is worse than the England average.
- Rates of road injuries and deaths and hospital stays for alcohol related harm are worse than the England average.

Priorities in Peterborough include reducing premature mortality, reducing inequalities in coronary heart disease and promoting healthy lifestyles.

Figure 10: Health profiles – Peterborough



‡ For comparison with PHOF Indicators, please go to the following link: www.healthprofiles.info/PHOF

Appendix 3 provides further context around the health needs of our population, the health outcomes we want to deliver, our current position, areas where we can improve, our ambitions for improvement and next steps.

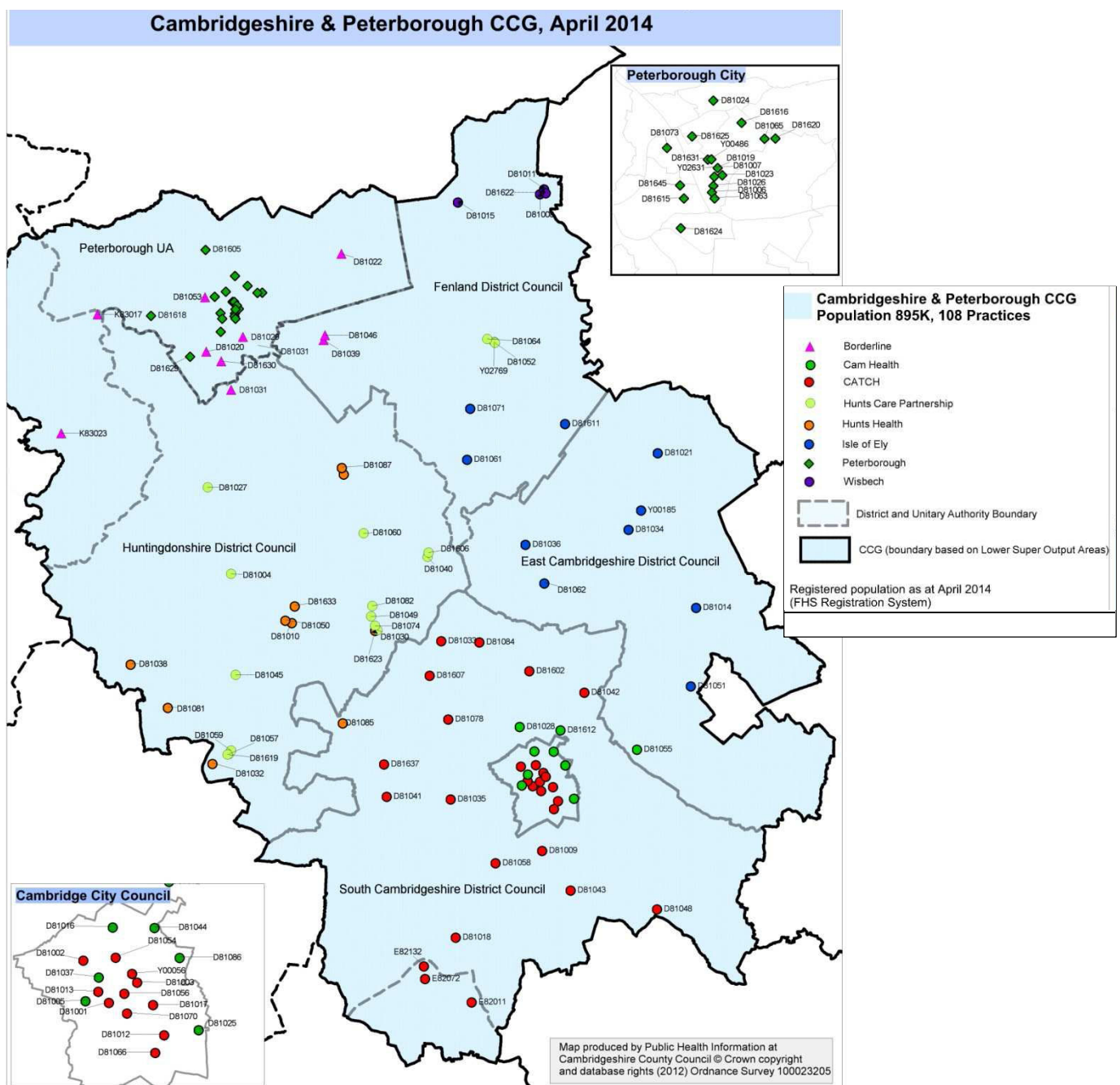
Cambridgeshire and Peterborough health system Blueprint

4.2 The health system across Cambridgeshire and Peterborough

The main health care commissioner in the health system is Cambridgeshire and Peterborough CCG. The CCG is the third largest in England covering a population of over 890,000 across 108 GP practices. The CCG is responsible for ensuring that high quality NHS services are provided to people living in the local area.

The following map shows where the CCG's practices are situated:

Figure 11: Cambridgeshire and Peterborough CCG



Cambridgeshire and Peterborough health system Blueprint

In Cambridgeshire and Peterborough, local GPs have formed Local Commissioning Groups (LCGs) which ensure a local focus when decisions about health services are made. This means that decision making is shifted closer to patients, enabling local change to happen quickly.

Every GP practice across Cambridgeshire and Peterborough, plus two practices in Northamptonshire and three practices in Hertfordshire, is a member of one of the following eight LCGs:

- Borderline
- CATCH
- Hunts Health
- Isle of Ely
- Peterborough
- Cam Health
- Hunts Care Partners
- Wisbech

The main healthcare providers in the Cambridgeshire and Peterborough system are as follows:

- Cambridge University Hospitals NHS Foundation Trust (CUHFT comprising both Addenbrooke's and the Rosie Hospitals)
- Peterborough and Stamford Hospitals NHS Foundation Trust (PSHFT)
- Hinchingsbrooke Health Care Trust (HHCT)
- Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) – provides mental health services
- Cambridgeshire Community Services (CCS)
- Papworth Hospital NHS Foundation Trust - a tertiary cardiothoracic hospital

In addition, the care across Cambridgeshire and Peterborough depends on primary care, out-of-hours services, care homes with nursing beds, local authorities and the work of our Health and Wellbeing Boards.

4.3 Summary of services by setting of care

Figure 12 below summarises the services available in the health system by setting of care.

The CCG has commissioned work to understand how the settings for delivery of care in Cambridgeshire and Peterborough compare to other health systems in England. This benchmarking exercise considers activity commissioned by the CCG and NHS England. The work is still in progress and initial findings are:

- Overall, the CCG and Area Team commissioned less acute care than the national average in 2013/14. The difference between the activity across Cambridgeshire and Peterborough and national comparators indicates that there were fewer elective spells, excess bed days, and first and follow-up attendances than the national average. This was partly balanced by more outpatient procedures than expected. This effect was also seen in general at LCG level.
- The CCG buys more episodes of care in hospital for patients 65 years and older than might be expected for the size of the population aged 65 and over. One possible explanation for this is that people aged 65 and over in the CCG may receive some services in acute care whereas, in other health systems, these services are delivered in another setting. Section 6.1.1 outlines the role of the Older People's and Adult Community Services Procurement in enabling care for the over 65 year old population to take place in the best possible health setting for them.

Cambridgeshire and Peterborough health system Blueprint

Figure 12: Summary of services by setting of care

Increasing distance from patient's home & increasing specialisation of service.

Patient's home	GP	Community	Ambulatory	Hospital	Tertiary
<p>Ambulance service see and treat.</p> <p>Early supported discharge.</p> <p>GP advice and care (phone and/or in person).</p> <p>Home rehabilitation/ recuperation.</p> <p>Hospital aftercare package.</p> <p>Integrated virtual ward.</p> <p>IV therapy.</p> <p>Palliative care.</p> <p>Primary care, mental health and community input into nursing homes.</p> <p>Rapid response team.</p> <p>Self care following advice.</p> <p>Telephone advice from case manager/ other specialist professional.</p>	<p>Advice and signposting from social care assessment team.</p> <p>Available for advice to hospital staff to support decision making.</p> <p>Early supported discharge.</p> <p>Enhanced unscheduled care access and provision by individual GP practices.</p> <p>Rapid access to advance from hospital specialist.</p> <p>Voluntary sector signposting.</p>	<p>Broader access to nursing homes to return patients where this is their home.</p> <p>Early supported discharge.</p> <p>Enhanced primary care service.</p> <p>Social care assessment providing advice and signposting.</p> <p>Intermediate care in a residential setting.</p> <p>IV therapy.</p> <p>Palliative care.</p> <p>Rapid access to social care assessment to facilitate discharge.</p> <p>Rapid response.</p> <p>Community rehabilitation/ recuperation.</p> <p>Step up/ down.</p>	<p>Certain procedures provided in an ambulatory centre or day surgery unit.</p> <p>Enhanced primary care service.</p>	<p>A&E.</p> <p>Drug, alcohol & mental health liaison. Early supported discharge.</p> <p>ICU/ HDU.</p> <p>MAU/ SAU.</p> <p>Medical and surgical inpatient care.</p> <p>Multi-disciplinary discharge planning from admission.</p> <p>Primary care led minor injury/ illness service.</p> <p>Theatres.</p>	<p>Specialist cardiothoracic services.</p> <p>Specialist trauma services.</p> <p>Specialist drug and alcohol interventions.</p> <p>Specialist input provided via telemedicine.</p> <p>Specialist medical& surgical input.</p> <p>Specialist psychiatric interventions.</p>

Virtual

999 including hear and treat, 111, online information, directory of services.

Source: PwC

4.4 Stakeholders in the Cambridgeshire and Peterborough health system

There are numerous stakeholders across our system and stakeholder management is integral to the successful development and delivery of the System Blueprint. A stakeholder management strategy has been developed. As part of this, stakeholders have been categorized in groups and methods of engagement have been determined for each group as follows:

Stakeholder Group A

Stakeholders for whom a significant proportion of business is to commission or deliver healthcare in the system

- *CCG Governing Body*
- *CCG Strategic Action Team*
- *Contracted NHS provider Trusts*
- *Directors of Social Care, Cambridgeshire and Peterborough*
- *Local Commissioning Group (LCG) Chairs and Local Chief Officers in Cambridgeshire and Peterborough*

Stakeholder Group B

Organisations who have a section of their business interested in commissioning or delivering healthcare in the system

- *CCG member practices: Cambridgeshire and Peterborough*
- *CCG Patient Reference Group*
- *CCG staff*
- *Cambridgeshire County Council*
- *Peterborough City Council*
- *Hertfordshire County Council*
- *Northamptonshire County Council*
- *Health and Wellbeing Boards: Cambridgeshire, Peterborough, Northamptonshire and Hertfordshire*
- *Health Education England*
- *Health Overview and Scrutiny Committees: Cambridgeshire, Peterborough, Northamptonshire and Hertfordshire*
- *Healthwatch organisations: Cambridgeshire, Peterborough, Northamptonshire and Hertfordshire*
- *Local Medical Committee (LMC)*

Stakeholder Group C

People who do not have a job to commission or deliver healthcare but are still a vital part of our local health system

- *Charitable organisations*
- *District Councils*
- *Independent and salaried contractors: GPs, dentists, pharmacists*
- *Interest groups*
- *Our residents in Cambridgeshire and Peterborough*
- *Optometrists*
- *Other Local Professional Committees*
- *People who use local health services and their carers*
- *Patient Forums and Patient participation groups (PPGs)*
- *Private and voluntary providers*
- *Media*
- *Voluntary, community and third sector organisations*

5. Where do we need to get to: Current state of the Cambridgeshire and Peterborough health system

This section considers the changes that the Cambridgeshire and Peterborough health system needs to make between 2014 and 2019 to build a sustainable health system in which health outcomes continue to improve.

5.1 Joint strategic needs assessments: Over-arching themes from our JSNAs

Several over-arching themes emerge from the available Joint Strategic Needs Assessments and health needs profiles. These are shown in the JSNA summary document in Appendix 3 and highlights are given below.

- The population of Cambridgeshire and Peterborough is increasing
- There will be a greater proportion of older people in 5 years' time

Information from the Office of National Statistics shows that in Cambridgeshire the population is forecast to increase by 5.0 % between 2014 and 2019 (32,000 people in total) with most of the increase in Cambridge City and South Cambridgeshire. In Peterborough, the population is forecast to increase by 6.1% between 2014 and 2019 (11,600 people in total). In Cambridgeshire and Peterborough the population aged 75 years and over is set to increase by 24% between 2014 and 2019 (16,000 people).

- There are significant levels of deprivation that need to be addressed

In Peterborough the city's deprived areas are those that are more densely populated and 26% of the population live in these areas. Some of the wards in Peterborough are rated amongst the highest areas for child poverty in England and 13 of the city's smaller neighbourhoods (lower super output areas) are amongst the most deprived 10% in the country. The most deprived areas in Cambridgeshire are concentrated in the north east of the County. Fenland, north-east Cambridge and parts of north Huntingdon have the highest levels of relative deprivation.

- Lifestyle has an important bearing on the prevention of ill-health and premature mortality

Our population varies both in levels of experience of unhealthy lifestyles and their consequences, as well as in the take up of preventive services such as smoking cessation.

- People are living longer but there are significant health inequalities

Average life expectancy in Cambridgeshire is 80 years for males and 84 years for females. In Peterborough, average life expectancy is 78 years for males and 82 years for females (2008-2010 ONS Life Expectancy). Life expectancy in both areas is increasing over time and death rates for the major causes of death are generally declining locally, as they are nationally. Death rates for diseases like circulatory diseases are falling more

quickly than death rates for cancers. However, important differences remain between the life expectancy and mortality of our populations between local authority districts and between areas in both Cambridgeshire and Peterborough, for example in Peterborough the rate of coronary heart disease (CHD) mortality is not falling as fast as in Cambridgeshire, some districts in Cambridgeshire have higher death rates than the county average, e.g. in Fenland and there are important differentials in premature deaths from CHD.

- Demand for mental health services continues to increase

Local mental health services face many of the same trends as identified in the preceding paragraphs, in particular the increase in overall population growth, but especially of older people. The demand for services continues to increase, and especially the number of people presenting with dementia. The modern focus on community-based “recovery” services places significant pressures on community services. Community Health Profiles also provide an overview of local mental health prevalence. The most significant risk-factors for poor mental health locally are deprivation, unemployment, limiting long-term illness, crime, substance misuse, physical health, and being part of a “marginalised” group (e.g. an ethnic minority, being homeless or having a learning disability). There are pockets of deprivation throughout the CCG, but for most mental health risk factors Fenland, Peterborough and Cambridge City are above national averages, whilst Huntingdonshire, South Cambridgeshire and East Cambridgeshire are below national averages.

5.2 Ambition to improve health in Cambridgeshire and Peterborough from 2014 to 2019

The health system in Cambridgeshire and Peterborough exists to improve the health and wellbeing of its population. There are many indicators of health and wellbeing, and 7 indicators that are relevant to monitoring improvement in outcomes over the 5 year time frame of this planning cycle have been selected.

An analysis of these for Cambridgeshire and Peterborough is shown as Appendix 2. This appendix also shows trajectories for improvement for these top level outcomes. In summary these are:

- To reduce the Potential Years of Life Lost from causes amenable to health care across Cambridgeshire and Peterborough by 6.2% reduction over the 5 year time period. This represents a significant gain in health
- To improve the health related quality of life of people with one or more long-term as measured by EQ 5D on the GP patient survey by achieving a score of 80 within 5 years
- To reduce emergency admissions from causes considered amenable to healthcare by achieving a 12 % reduction in the composite emergency admission indicator
- To increase the number of people having a positive experience of care outside hospital, in general practice and in the community by achieving a score of 4.1 on the relevant domains of the GP patient survey
- To increasing the number of people having a positive experience of hospital care by achieving a score of 122 (current baseline is 127.6) over 5 years
- To make significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

5.3 Improving financial sustainability in Cambridgeshire and Peterborough: the estimated financial gap

The increasing demands on the Cambridgeshire and Peterborough health system are driven by a population that is increasing and, as shown in Figure 5 above, a population that is aging.

There has been much work already across the health system to ensure that care for patients is provided in the most appropriate place. However if demand continues to increase at a greater rate than the achievement of system efficiency savings then costs will continue to rise even though the overall system is more efficient.

To illustrate this, figure 13 below considers emergency admissions between 2012/13 and 2013/14. It shows how the emergency bed days per weighted population have stayed the same but there has been an absolute increase in emergency bed day across the CCG. One possible reason for this is that the health system is working more efficiently but that the absolute level of demand has risen as a result of change in demographics.

Figure 13: Cambridgeshire and Peterborough CCG Emergency Bed Days 2012/13 and 2013/14

Locality group	Emergency bed days			Emergency bed days per 1000 weighted population		
	2012/13	2013/14	% change	2012/13	2013/14	% change
CATCH	75,946	77,886	3%	477.45	472.16	-1%
CamHealth	29,956	32,677	9%	456.54	480.33	5%
Health Care Partners	49,226	52,071	6%	462.17	470.57	2%
Hunts Health	26,362	26,333	0%	462.03	444.33	-4%
Isle of Ely	37,164	40,221	8%	470.96	487.70	4%
Wisbech	22,490	24,299	8%	452.74	475.63	5%
Borderline	39,706	42,499	7%	433.06	438.60	1%
Peterborough	50,591	53,197	5%	429.80	410.74	-4%
CCG overall	331,441	349,183	5%	455.74	457.93	0

Source: CCG Business Intelligence Team

Figure 14 considers this same issue and gives projections of how demographic changes might affect inpatient and outpatient activity between 2013 and 2021. The increase in activity is particularly marked in the age groups 60-75 and aged 75+.

Cambridgeshire and Peterborough health system Blueprint

Figure 14: Likely increase in activity within Cambridgeshire & Peterborough 2013 to 2021

Current inpatient activity				Current AE activity		Current outpatient activity		
Age group	Urgent Care	Elective Care	Maternity & Paediatrics	Age group	Urgent Care	Age group	Elective Care	Maternity & Paediatrics
0 - 4	4,181	1,507	1,683	0 - 4	9,119	0 - 4	22,224	-
5 - 19	3,456	3,816	408	5 - 19	25,214	5 - 19	70,879	852
20 - 39	6,702	10,088	7,643	20 - 39	38,297	20 - 39	155,776	12,323
40 - 59	8,221	22,874	323	40 - 59	29,084	40 - 59	182,680	636
60 - 74	8,227	27,722	-	60 - 74	19,227	60 - 74	183,015	-
75+	13,059	20,776	-	75+	17,971	75+	118,485	1

Future inpatient activity (2021)				Future AE activity (2021)		Future outpatient activity (2021)		
Age group	Urgent Care	Elective Care	Maternity & Paediatrics	Age group	Urgent Care	Age group	Elective Care	Maternity & Paediatrics
0 - 4	4,648	1,675	1,871	0 - 4	10,138	0 - 4	24,708	-
5 - 19	3,889	4,294	459	5 - 19	28,374	5 - 19	79,763	959
20 - 39	6,890	10,371	7,858	20 - 39	39,372	20 - 39	160,148	12,669
40 - 59	8,849	24,621	348	40 - 59	31,306	40 - 59	196,634	685
60 - 74	9,656	32,537	-	60 - 74	22,566	60 - 74	214,802	-
75+	17,448	27,759	-	75+	24,011	75+	158,308	1

Source: PwC. Information from Hospital Episode Statistics ("HES")

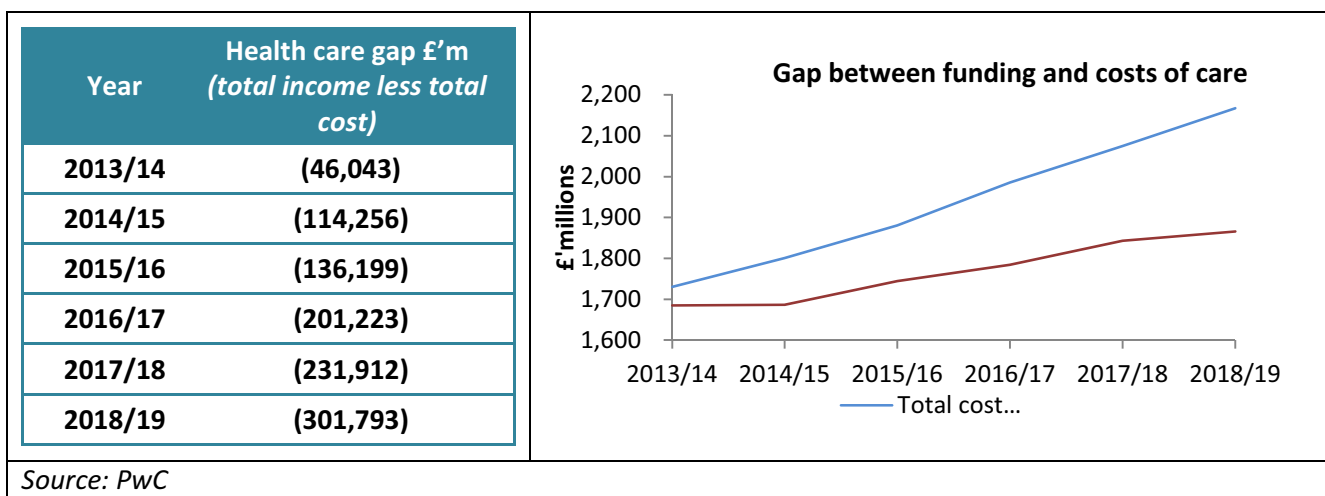
Cambridgeshire and Peterborough health system Blueprint

With these facts in mind PwC have modelled three financial scenarios for the whole of the Cambridgeshire and Peterborough health system for 2014-2019. The assumptions underlying this modelling are shown in appendix 4. All of these models include mental health and community care. They also include the Better Care Fund. The total for the health system includes funding for adult social care, children's social care and public health but these services are assumed in each case to be in neither deficit nor surplus. In other words the gap shown relates to gaps in funding of direct healthcare provision only.

Scenario 1: The "base case" scenario

In scenario 1 no provider savings are achieved i.e. there are no savings from cost improvement plans or commissioning efficiencies. The financial gap across the health system widens to over £300m by 2018/19.

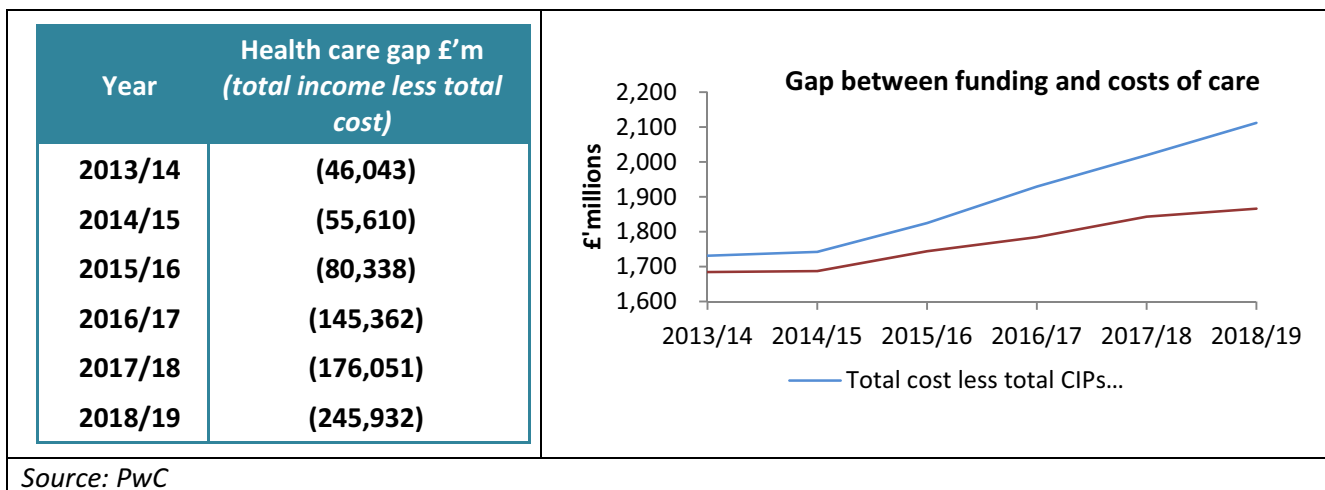
Figure 15: Scenario 1: gap between funding and the cost of care



Scenario 2: "Cost Improvement Plans achieved"

In scenario 2 the providers in the health system achieve their cost improvement plans and commissioners make modest savings. This lessens the financial gap in 2018/19 but it still remains at £250 m.

Figure 16: Scenario 2: gap between funding and costs of care

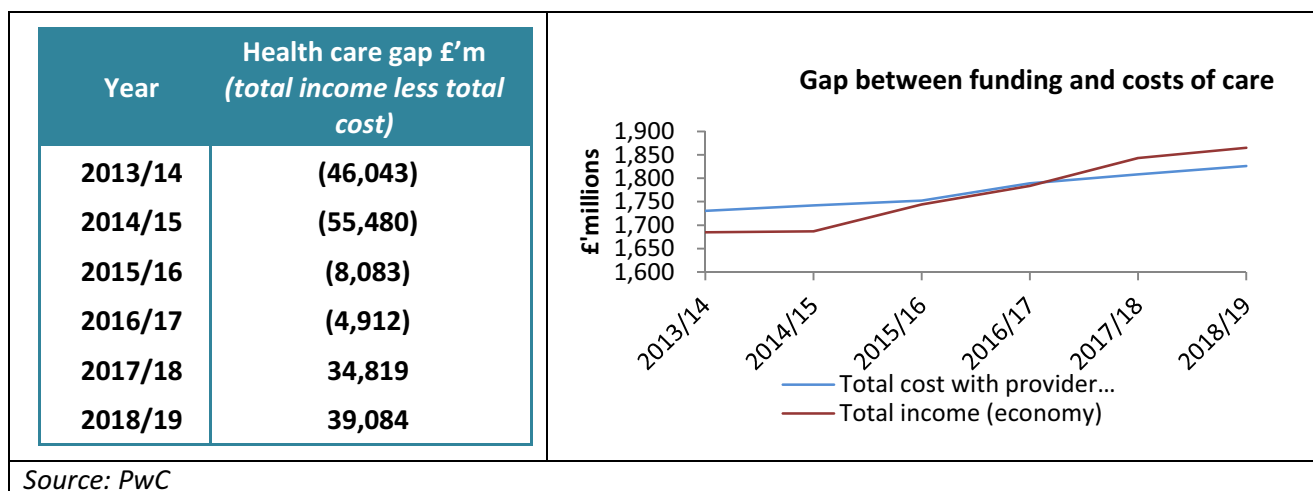


Cambridgeshire and Peterborough health system Blueprint

Scenario 3: “Year on year efficiency savings”

In this scenario each provider achieves a cumulative 4% efficiency savings year on year and the commissioners also make 4% efficiencies. This amounts to reducing costs by over 19% over the 5 year time period from the 2013/2014 baseline. In this scenario the health system overall will break even in 2017.

Figure 17: Scenario 3: gap between funding and costs of care assuming a 4% cumulative efficiency saving



Figures 18 and 19 below are tables commissioned by the CCG that show the current activity and financial growth projections from providers in the Cambridgeshire and Peterborough health system. They demonstrate that increasing activity and financial growth are planned across the system over this five year period. This observation is more important than the absolute numbers.

Figures 18 and 19 show that scenario 3, in which each provider reduces its cost base by 4% each year, is not likely. It is also unlikely that no savings will be made against cost improvement plans. Scenario 2 is therefore the most likely scenario for the Cambridgeshire and Peterborough health system.

- Across Cambridgeshire and Peterborough the health system will face an estimated deficit of at best £250m by 2019 unless there are changes to the activity and costs incurred by the system. The size of the gap is over 10% of the total health and social care spend.
- Even though there are some signs that the overall efficiency of the system is increasing demand is being driven by demographic changes.

At present the financial plans across the system do not align with the forecasts of available funding. All providers geographically located in Cambridgeshire and Peterborough serve, to a lesser or greater degree, populations from other health systems. This means that there need not be complete alignment between the local commissioner plans and the plans of providers. However, with respect to Cambridgeshire and Peterborough residents, the whole system needs more alignment to remain sustainable. Achieving this alignment will involve a several approaches:

Cambridgeshire and Peterborough health system Blueprint

- Continuing to increase the efficiency of the health system i.e. doing the same things in a more efficient way
- Transforming areas of the health system i.e. delivering health services differently
- Reducing demand for healthcare i.e. reducing the amount of healthcare that is needed by people by increasing health and wellbeing across the population. Delivery of Local Authority Health and Wellbeing strategies is outside the scope of this health system plan, but will be central to this.

Cambridgeshire and Peterborough health system Blueprint

*Figure 18: Activity growth projections by Provider across Cambridgeshire and Peterborough
(Work commissioned by the CCG)*

ACTIVITY	PROVIDER 1					PROVIDER 2					PROVIDER 3					PROVIDER 4				PROVIDER 5		
	Outpatients Total	Elective IP/DC Total	Non Elective total	A&E	Other	Outpatients Total	Elective IP/DC Total	Non Elective total	A&E	Other	Outpatients Total	Elective IP/DC Total	Non Elective total	A&E	Other	OP Total	IP Total	NE total	Other (MIU)	Outpatients Total	Elective IP/DC Total	Non Elective total
Average growth 2011/12-2013/14						4.7 %	4.4 %	2.4 %	3.4 %	4.0 %	5.9 %	5.8 %	5.1 %	1.7 %	5.1 %	mar ginal	mar ginal	mar ginal	2.9 %	24%	0%	8%
% Growth Assumptions Yr 1	-1%	1%	5.3 %	-4%		3.8 %	4.7 %	2.1 %	3.6 %	3.7 %	5.9 %	5.8 %	5.1 %	1.7 %	5.1 %	0.0 %	0.0 %	0.0 %	0.0 %	1%	2%	1%
% Growth Assumptions Yr 2	NA	NA	NA	NA	NA	4.0 %	4.6 %	2.5 %	4.0 %	3.9 %	4.5 %	4.5 %	4.5 %	4.5 %	4.5 %	0.9 %	0.5 %	0.8 %	1.0 %	4%	4%	5%
% Growth Assumptions Yr 3	NA	NA	NA	NA	NA	4.2 %	4.5 %	2.6 %	4.0 %	4.1 %	2.5 %	2.5 %	2.5 %	2.5 %	2.5 %	0.6 %	0.5 %	0.6 %	1.5 %			
% Growth Assumptions Yr 4	NA	NA	NA	NA	NA	4.1 %	4.4 %	2.6 %	4.0 %	4.0 %	2.5 %	2.5 %	2.5 %	2.5 %	2.5 %	0.5 %	0.5 %	0.6 %	1.5 %			
% Growth Assumptions Yr 5	NA	NA	NA	NA	NA	4.3 %	4.6 %	2.8 %	4.0 %	4.2 %	2.5 %	2.5 %	2.5 %	2.5 %	2.5 %	0.5 %	0.5 %	0.6 %	1.4 %			
Total Growth over Period						22%	25%	13%	21%	22%	19%	19%	18%	14%	18%	2.5 %	1.9 %	2.6 %	5.5 %			

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Cambridgeshire and Peterborough health system Blueprint

*Figure 19 : Financial Growth projections by Provider across Cambridgeshire and Peterborough
(Work commissioned by the CCG)*

	PR 1	PROVIDER 2					PROVIDER 3					PROVIDER 5		
FINANCIAL GROWTH	Total Financial Growth	Outpatients Total	Elective IP/DC Total	Non Elective total	A&E	Other	Outpatients Total	Elective IP/DC Total	Non Elective total	A&E	Other	Outpatients Total	Elective IP/DC Total	Non Elective total
Average growth 2011/12-2013/14		4.3%	4.3%	2.9%	3.4%	2.7%	5.9%	5.8%	5.1%	1.7%	5.1%	48.1%	9.0%	-6.6%
% Growth Assumptions Yr 1	-0.3%	5.7%	3.8%	2.7%	3.6%	3.0%	5.9%	5.8%	5.1%	1.7%	5.1%	0.6%	1.3%	3.9%
% Growth Assumptions Yr 2	0.8%	4.1%	5.5%	2.7%	4.0%	2.0%	4.5%	4.5%	4.5%	4.5%	4.5%	2.3%	3.4%	3.8%
% Growth Assumptions Yr 3		4.3%	4.5%	2.8%	4.0%	2.9%	2.5%	2.5%	2.5%	2.5%	2.5%			
% Growth Assumptions Yr 4		4.2%	4.5%	2.8%	4.0%	2.9%	2.5%	2.5%	2.5%	2.5%	2.5%			
% Growth Assumptions Yr 5		4.4%	4.6%	3.0%	4.0%	2.9%	2.5%	2.5%	2.5%	2.5%	2.5%			
Total Growth over Period	0.5%	25%	25%	15%	21%	15%	19%	19%	18%	14%	18%			

5.4 The challenges facing primary care across Cambridgeshire and Peterborough

Primary care services, which include General Practice, optometry, pharmacy and dentistry, are commissioned by NHS England. As well as having responsibility for primary care contracts, NHS England has a duty to commission primary care services in ways that improve quality, reduce inequalities, promote patient involvement and promote more integrated care. The Cambridgeshire and Peterborough health system incorporates 108 GP practices and 850 GPs (equating 350 full time posts). The CCG, as a GP member practice organization, maintains a close relationship with each practice.

Historically primary care has been a strong aspect of the healthcare system across Cambridgeshire and Peterborough. However NHS England has recognised at a national level that general practice and wider primary care services (pharmacy, optometry and dental services) face increasingly unsustainable pressures and that there is a need to transform the way primary care is provided to reflect these growing challenges.

Challenges facing General Practice nationally include:

- growing reports of workforce pressures including retirement, recruitment and retention problems particularly in general medical practice combined with significant pressures with rising workload demands
- increasing demand due to an aging population, growing co-morbidities and increasing patient expectations resulting in increased consultations
- increasing pressure on NHS financial resources, which will intensify further from 2015/16
- continued dissatisfaction with access to services – both in-hours and out-of-hours
- persistent inequalities in access and quality of primary care

These issues are intensified across Cambridgeshire and Peterborough by the effect of the removal of the minimum practice income guarantee over the next 7 years. This System Blueprint therefore needs to take account of the impact of these changes on our practices as both members of the CCG and also crucial providers in the local health economy.

The CCG has worked with GPs at Member Practice events, provider stakeholder events, through discussion at LCG Board meetings, discussions with the Area Team and through the elective and non-elective Care Design Groups to identify a set of critical success factors for primary care. These success factors are as follows:

1. Generate a greater sense of individual responsibility to remain well and choose health lifestyle choices to avoid ill health
2. Reduce unwarranted variation and address inequalities (evidence shows that primary care can reduce inequalities and improve health outcomes¹)
3. Deliver quality improvement
4. Improve access to GPs

¹ Contribution of Primary Care to health systems and Health, Barbara Starfield, Leiya Shi, and James Macinko, The Milbank Quarterly, Vol. 83, No. 3, 2005 (pp. 457–502)

5. Develop capability and capacity to meet the demands of a rapidly increasing population, and a greater number of older people with associated frailty and long term conditions

To enable these changes to happen the following the following enables need to be considered:

- Closer working with Public Health England to promote self-care and healthy lifestyles
- Exploration of options to deliver primary care at scale through, for example, increased collaboration between GP practices
- Review of capacity within primary care including mapping against demand
- Better signposting of services
- Improved communication between GPs and secondary care clinicians

Primary care services have the potential to contribute significantly to the Cambridgeshire and Peterborough health system goal to produce a sustainable health system because primary care reduces demand on health services through its role in preventing illness.

6. Transformational work already ongoing across the Cambridgeshire and Peterborough health system

6.1 The commissioner context: ongoing transformational programmes in the CCG

This section outlines in brief two areas of transformational change that are already ongoing in the Cambridgeshire and Peterborough health system: the Older People's and Adult Service Procurement and the Better Care Fund. Both of these programmes seek to increase efficiency, deliver health services differently and increasing health and wellbeing.

6.1.1 Older People's and Adult Community Services (OPACS) procurement

The CCG has embarked on an ambitious Older People's and Adult Community Services (OPACS) procurement which is designed to achieve exactly this type of transformation. 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

Taken together these elements are intended to deliver cultural, service and structural transformation.

In order to drive the process and leverage the best possible solutions, the CCG is using a two stage competitive dialogue procurement process. The total value of the contract over 5 years is in the order of £800m. Full solutions are due to be submitted at the end of July, with a decision on preferred bidder by the end of September 2014 and service commencement in early 2015.

The following sections briefly set out the case for change, the critical success criteria, service scope, and the outcomes framework.

Case for Change

In summary, significant transformation is needed to deliver the CCG's vision of integrated care focused around the patient in the context of the following issues:

- forecast demographic change
- minimal financial growth in the health sector, alongside likely reductions in funding for Local Authorities
- shortcomings in current service provision, which result in poor patient experience and clinical outcomes for patients. For example, there is evidence of a lack of joined up working between acute, community,

primary and social care organisations. The way in which services are organised is reactive to illness rather than proactive to prevent crises and maintain independence. This results in a number of current service issues including pressure on emergency departments, high occupancy in hospital beds, delayed transfers of care, extended lengths of stay in hospital and pressure on limited resources in community and primary care services. In addition, there are issues with information sharing, financial incentives not being aligned to support effective care and short term contracts.

Critical success factors

The CCG has developed the following critical success factors against which Bidders final solutions will be tested:

- 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
- provide a sustainable financial model (see Financial Principles below)

Financial principles

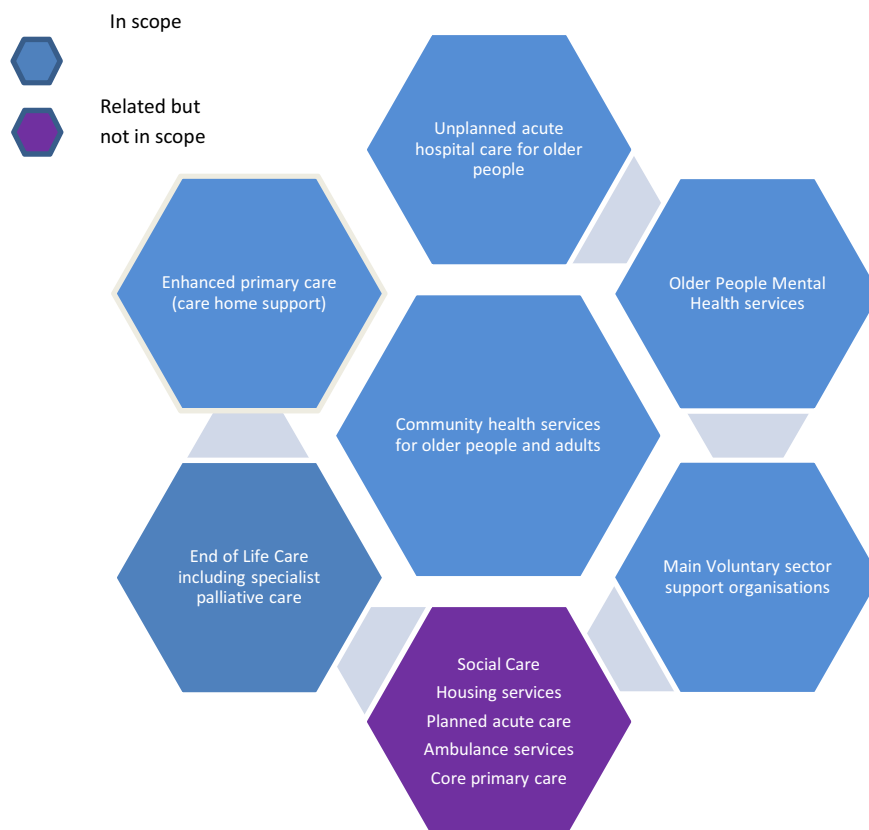
The CCG has agreed the following financial principles which have been used to develop the financial framework and to evaluate solutions:

- aligning improved patient outcomes with financial incentives
- delivering recurrent financial balance in a sustainable way
- sharing financial risk across the commissioner – provider system
- creating the conditions for investment and delivering a return on investment

Services to be provided

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 20: 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.

Figure 20: Service range



Note: Placements for NHS continuing care for patients aged 65 and over are not in scope at contract commencement, but will be for further dialogue with the Lead Provider(s) in Year 2/3 of the contract

Whilst the full range of social care 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.

Outcomes Framework

The CCG wishes to support transformation and investment in community services and is proposing a new funding and payment approach focused on outcomes. As a result the CCG has developed an Outcomes Framework based on seven domains and this will form the basis for service specifications to drive improvement in quality and outcomes. Bidders have considerable scope to innovate in how they achieve the outcomes.

Lead provider(s) will be expected to meet the Contract’s requirements including national and local quality standards, NHS Constitution principles and an outcome based payment mechanism. A set percentage of the

Cambridgeshire and Peterborough health system Blueprint

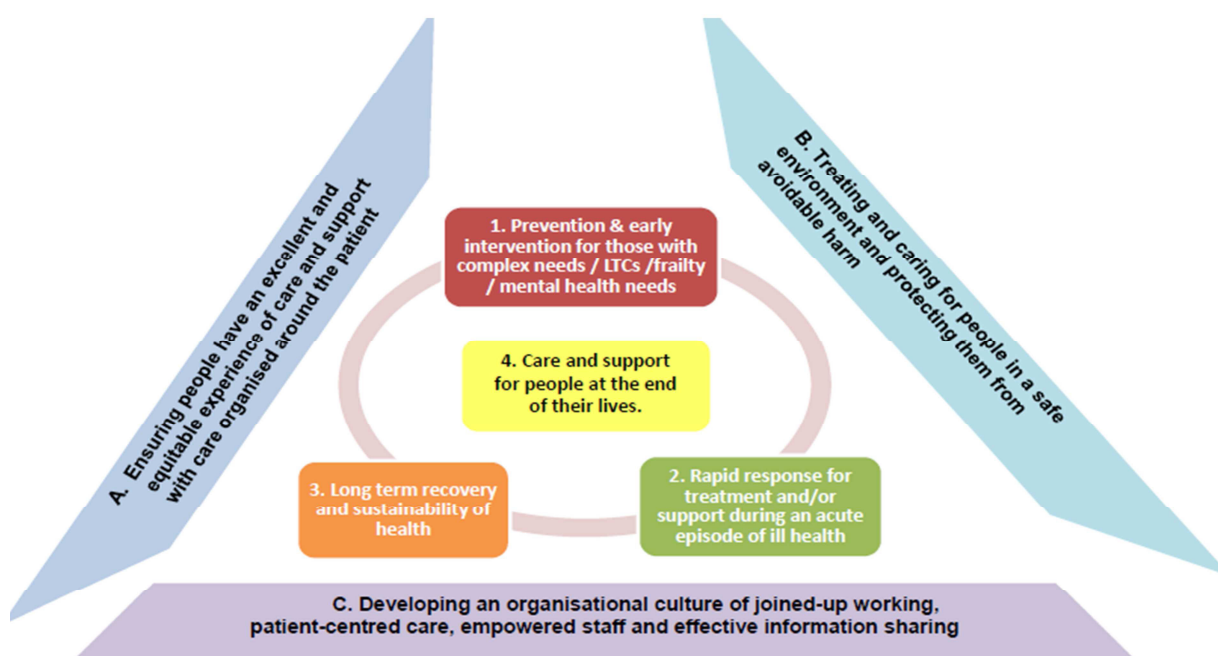
value of the Contract will be paid on achievement of the Outcomes Framework Indicators, which are designed as markers of a high quality, improved service which is financially sustainable.

The Outcomes Framework Indicators are derived nationally and from evidence based quality standards, local data sources, national guidance and research on patient experience and the expert perspective of Public Health, clinical leads and patients from the local population.

Outcomes Framework Structure

The Outcomes Framework covers seven outcome domains as shown below.

Figure 21: Outcomes Framework Domains



In each domain there are a number of specific outcomes with indicators underpinned by technical specifications.

Summary

The approach described above is designed to deliver fundamental change at scale across the whole system, whilst still delivering on local needs and engagement. In this sense it is a potential blueprint for further programmes covering broad areas where strategic change is necessary, and making maximum use of contracting and funding flexibilities to innovate. However, this does not mean that subsequent programmes will necessarily be delivered in exactly the same way.

6.1.2 Enhancing Integration and Joint Commissioning through the Better Care Fund

Cambridgeshire and Peterborough local health system believes the Better Care Fund is an opportunity to strengthen joint working across commissioners and providers to develop and deliver better patient experience and outcomes in line with agreed outcome targets. Fundamental to this ambition is the transformation of services which will be centred on the patient rather than constrained and fragmented by organisational boundaries. Our shared aim is to reallocate resources to early intervention and prevention which is critical to building a sustainable health and social care economy.

In Cambridgeshire and in Peterborough, there is an over-arching strategic framework in place which includes the respective Health and Wellbeing Strategies. This includes the Older People's and Adult Community Services (OPACS) Procurement Programme. The Better Care Fund has interdependencies with each of these strategic work streams.

In order to turn our shared ambitions and strategies into reality we will establish an integrated team which will shape future services and inform the joint commissioning of those services through our joint decision making structures. As services become less discrete to individual organisations the Better Care Fund will enable the design and joint commissioning of integrated services.

7. Possible interventions for change: the Care Design Group process to date

The Care Design Group process aims to identify options for change within the health system, confirm and challenge those options, determine which options could be taken forward and how this would be done and consider further options for development. It is a clinically driven process and works with representatives from across the whole health system.

In May 2014 PwC ran two Care Design Groups, on elective and non-elective care. Organisations were asked to nominate clinicians to be invited to the events. Clinicians and managers attended from the CCG, Hinchingbrooke Health Care NHS Trust, Cambridgeshire and Peterborough Foundation Trust, East of England Ambulance Service, Peterborough and Stamford Hospitals NHS Foundation Trust, Papworth Hospital NHS Foundation Trust, Cambridge University Hospital NHS Foundation Trust, Cambridgeshire County Council, Peterborough City Council, Urgent Care Cambridge and Herts Urgent Care. Patients representatives were also involved.

Design principles for the Care Design Group process

The following design principles were agreed as part of the Care Design Group process:

- Care is provided in the best setting (not necessarily the closest). Where patients must travel greater distances, issues with accessibility and transport are considered
- Care is patient centred, evidence based and does not compromise on quality
- Identify rules that are prohibiting efficient care, and flex them locally
- Set aside organisational boundaries, work for the benefit of the health system and the patients that we act for
- Be mindful of the impact we have on other health systems
- Manage patient expectations, work within financial limits (rights, entitlement, responsibility and education)
- The workloads of professional groups should be dictated by their skills, not their organisation
- Any future model of care should address the health inequalities across the health system
- Options for change must remain outcome focused
- Pathways must be designed to meet the needs of the most vulnerable

The result of the Care Design Group process was a set of proposals that could be used to improve outcomes and financial sustainability. These possible interventions are listed below and shown in more detail in appendix 5.

Elective CDG: possible interventions	
Elective 1	Primary Care Referral Protocols
Elective 2	Patient flow planning and aligned patient flows to relevant care environments to optimise efficiencies and post-operative care
Elective 3	Patients who should not be in an acute setting would not be there any longer
Elective 4	Single provider for specific elective services
Elective 5	Jointly owned, risk shared "cold site" for elective work

Non elective CDG : possible interventions	
Urgent 1	Single point of access (SPA) for patients
Urgent 2	Single Point of Access for Professionals
Urgent 3	Front end A&E model
Urgent 4	Discharge planning, including early supported discharge to ensure that patients do not stay in hospital for longer than they need to
Urgent 5	Regarding of an A&E unit following reconfiguration of services within the Local Health Economy to provide better quality of care, more cost effectively
Urgent 6	Closer links between GPs and the ambulance service

The CCG is leading an approach similar to Care Design Groups to develop models of care in other areas including the following:

- Older People and Vulnerable Adults
- Women’s and Children’s
- Mental health
- Prevention

7.1 Financial impact of possible changes generate by the elective and non- elective Care Design Group process.

The possible interventions that came out of the elective and non- elective Care Design Group process have been assessed by PwC.

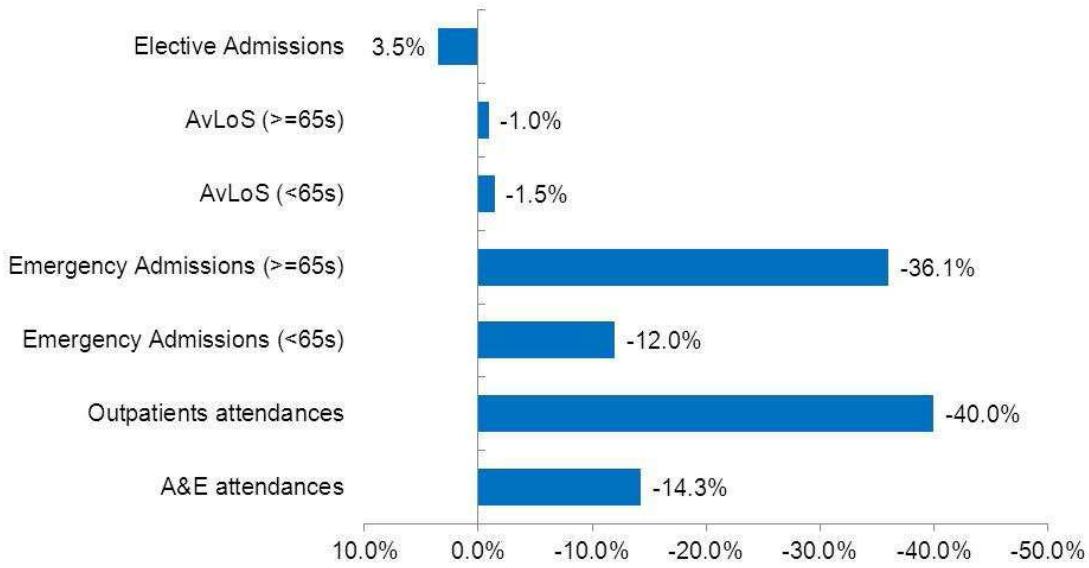
An indicative change in activity if they were all implemented is shown in figure 22, and the indicative financial savings that would result are shown in figure 23. The total that might be achieved is a saving of around £80m. This is substantially short of the estimated gap of £250m.

Many of these possible interventions identified in the non-elective and elective CDG process increase the efficiency of the current health system, rather than changes that will transform areas of health service delivery or reduce demand. To develop plans for a sustainable health system further consideration is needed of changes that will

- Deliver health services differently i.e. transform areas of the health system
- Reduce the demand for healthcare

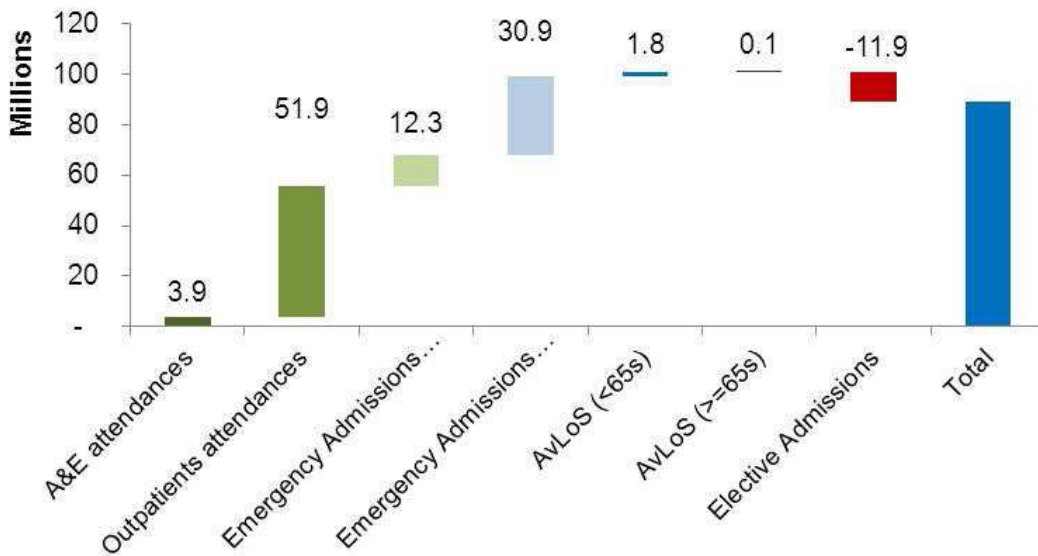
Cambridgeshire and Peterborough health system Blueprint

Figure 22: Impact on activity



Source: PwC

Figure 23: Indicative savings achieved if all elective and non-elective CDG proposals were implemented



Source: PwC

8. Conclusions from planning work to date

The Cambridgeshire and Peterborough health system faces a financial gap of at least £250m by 2018/19. A Care Design Group approach has been used to review elective and non-elective care and has identified schemes that have the potential to reduce this gap by up to £80m. The majority of change options identified will lead to more efficient delivery of current health services rather than wider transformational changes. A substantial gap remains and it is therefore necessary that other system changes are considered in detail.

Details of the governance and resourcing of the next phase of this work are under discussion. However it is recognised that the three regulatory organisations for our health system (NHS England, Monitor and the Trust Development Authority) have an important role in this work going forwards.

Existing ongoing transformational work programmes include the Older People's and Adult Community Services Procurement, led by Cambridgeshire and Peterborough CCG. This is an innovative way of commissioning for improving outcomes. Another example, the Better Care Fund, provides an opportunity to commission with local authority partners.

To create a sustainable health system where outcomes continue to improve, this planning process needs to consider transformational options and how the health system reduces demand by maximising health and wellbeing.

9. Enablers for change

9.1 Quality Promise for Cambridgeshire and Peterborough

The Cambridgeshire and Peterborough System Blueprint articulates the imperative for fundamental change and service redesign across the Cambridgeshire and Peterborough system. Any period of change affords an opportunity to innovate and do things better and the Quality Promise will ensure that quality is the cornerstone of the future delivery of healthcare services across the whole system in Cambridgeshire and Peterborough. A quality perspective will be the backdrop against which all innovation and change will be considered, and all service changes will be planned, commissioned and evaluated. In essence the Quality Promise will be an explicit driver for change and continuous improvement in service delivery and will ensure that positive patient experiences are delivered.

The Quality Promise will provide reassurance to patients and other stakeholders that quality is the fundamental building block upon which all services are commissioned and will be developed as a series of high level statements which make explicit the requirements expected from current and future providers of healthcare in respect of quality, safety and patient experience.

The Quality Promise Statements

The Cambridgeshire and Peterborough System will:

- Place patients at the centre of everything, ensuring their voices and experiences as service users and carers are heard when services are being planned, commissioned and evaluated, and act as a driver for service improvement.
- Work in partnership with patients and other stakeholders to facilitate whole system seamless working which transcends organisational and professional boundaries to achieve improved patient outcomes
- Drive a culture of learning and continuous improvement, making best possible use of technology and data to improve patient safety and experience; and enhance the adoption and spread of evidence based practice.
- Oversee the implementation of recommendation from Francis, other national reports, and the Dignity and Compassionate Care requirements set out in the national nursing strategy to include improving communication, care, compassion, courage to challenge, competency and commitment to make this happen
- Support providers to develop a well-trained, appropriately resourced, responsive workforce to deliver the right care, in the right place, at the right time.

9.2 Cambridgeshire and Peterborough Workforce

Baseline

Health Education East of England (HEEoE) is working with the CCG to help improve the quality of health and healthcare by ensuring that the local workforce has the right numbers, with the right skills, values and behaviours when and wherever they are needed. Between 2000 and 2010 the local workforce in

Cambridgeshire and Peterborough health system Blueprint

Cambridgeshire and Peterborough grew by 60%. This is faster than the workforce growth across the other counties in the East of England (EoE).

- Medical workforce grew by 82%
- Registered nurses grew by 35%
- Support to clinical staff grew by 39%

All of above growth figures were higher than the respective average growth rates for EoE. After the 10-year growth staff numbers per population in the area were above EoE average and above the average for England.

Projections

Following a review of the 2013/14 workforce plans it is evident that the system is facing a significant efficiency savings gap. The workforce capacity gap is estimated at 5.6% p.a. over the next 5 years. The workforce plans demonstrate that overall establishment levels are forecast to reduce in the next 5 years by 4% with the most significant reductions in Community and Mental Health sectors (11%) and acute care (1.5%).

Figure 24: Establishment by profession 2013-2018

Staff group	Establishment 2013	Establishment 2018	% change 2013-2018
Medical and dental	2133	2228	4%
All registered nursing, midwifery and health visiting staff	6313	6192	-2%
All scientific, therapeutic and technical staff	2877	2816	-2%
NHS infrastructure support	2806	2594	-8%
Others	75	72	-4%
Support to clinical staff	5801	5272	-9%
TOTAL	20005	19163	-4%

Figure 25: Establishment plan by sector: 2013-2018

Sector	Organisation	Establishment FTE		FTE Change	% Change	EOE average
		March '13	March '18			
Acute	Org 1	8194	7895	-299	-4%	
	Org 2	1505	1452	-52	-3%	
	Org 3	1644	1802	158	10%	
	Org 4	3511	3531	20	1%	
Acute Total		14854	14680	-174	-1%	-2%
Community	Org 5	2664	2254	-411	-15%	
Community Total		2664	2254	-411	-15%	-11%
Mental Health	Org 6	2250	2004	-246	-11%	
Mental Health Total		2250	2004	-246	-11%	-11%

It is evident that a shift of workforce capacity to support the delivery of care closer to home is not happening. Over the last 3 years the number of registered nurses employed by acute trusts grew by 6% while numbers in the community reduced by 8%.

The average ratio of GPs per population in Cambridgeshire and Peterborough is higher than the EoE average; in Peterborough the number is below the national average. This presents an issue given that deprivation in Peterborough is significantly worse than the national level.

Skill Mix

The cost of non-medical skill mix is more expensive in Cambridgeshire and Peterborough area than in any other part of the EoE, where there are relatively more staff in higher pay bands in additional clinical services, estates and ancillary and healthcare scientists groups.

Whilst the local workforce has the richest non-medical skill mix in the region, assessment of consultant productivity in 2008/09 indicated significant variations across trusts and across individual consultants in the same specialties. In 2012/13 acute workforce productivity in EoE started to show small signs of improvement, with two Trusts in Cambridgeshire and Peterborough demonstrating significant improvements in estimated workforce productivity during this period.

National Workforce Priorities

HEEoE invests up to £67m each year into workforce in Cambridgeshire and Peterborough. A significant amount of this is aligned to contracts with Education Providers. As 70% of the healthcare workforce are currently employed in the NHS in the East of England, consideration should be given to the education and development needs of this workforce to enable them to continue to deliver high quality care and support the implementation of new models of care delivery.

Both national and local priorities inform investment priorities for Cambridgeshire and Peterborough. Key national workforce priorities include:

- Exploring the impact of National Quality Board Safe Staffing guidance on nursing and midwifery workforce planning requirements
- Maintaining midwifery training numbers at a sufficient level to meet service demand
- Continuing to deliver “Call to Action for Health Visiting” in order to achieve sufficient health visitor by April 2015, ensuring a smooth transition of health visitors to Local Government from April 2015
- Commissioning Improving Access to Psychological Therapies (IAPT) Training places at a sufficient levels and numbers to meet service demand and commissioning intentions across all aspects of the IAPT programme to 2015
- In collaboration with East Anglia Ambulance Trust, supporting the delivery of up to 550 paramedics through two strands; degree and technician training route
- Increasing mental health awareness across all front line staff
- Recruiting, retaining and developing staff based on the NHS Constitution Values

- Increasing GPs in training by 50% by 2016
- Widening participation for bands 1-4 (including doubling the number of apprenticeships, embedding care certification for health care assistants and providing enhanced career progression into professional training routes)

Local Workforce Priorities

There is recognition across the Cambridgeshire and Peterborough that to meet future workforce needs there will need to be considerable system wide workforce transformation with a focus on robust operational and strategic workforce planning across the system. NHS providers in the system have agreed to the following principles for the development of the local workforce:

- Integrated planning in order to provide the right care, in the right place with the right workforce
- Developing a skilled and safe workforce
- Creating a productive workforce
- Developing an engaged and values driven workforce

HEEoE is supporting four workforce projects to begin this transformation. These projects focus on developing an agreed values based recruitment framework for Bands 1-4 across all NHS providers in the area, reviewing and up skilling care homes staff in order to improve care of frail and elderly, supporting better discharge of frail and elderly; and modelling advanced practitioner roles within Emergency Departments.

Four strategic workforce priorities for 2014/15 have been endorsed local providers and include:

- Developing and agreeing a recruitment and retention programme to address the registered nursing gap across the Cambridgeshire and Peterborough health system
- Developing and agreeing a system wide approach to 'grow your own workforce' for registered nurses and other key shortage areas.
- Undertaking a workforce impact analysis to identify the consequences on specialist skills due to the increase in GP training
- In conjunction with other key partners reviewing and shaping the development of the primary care strategy for Cambridgeshire and Peterborough to ensure future investment into education and training is fit for purpose.

Primary Care

Health Education East of England has a remit to train and develop the whole workforce, commissioning both non-medical and medical training across primary and secondary care. For many years, as part of their workforce analysis, HEEoE have asked NHS providers in the secondary and community settings to take part in a workforce planning process to inform the significant investment (c£400m) spent each year in the East of England on education and training.

During 2014/15 HEEoE will be working with the Norfolk, Suffolk and Cambridgeshire Area Team and Health and Social Care Information Centre to better understand the demand and supply needs of the General Practice workforce. In time HEEoE will be looking to extend their planning processes to a wider primary care workforce as well. The aim is to better understand primary care workforce requirements, determine future workforce needs and assist in the commissioning of appropriate training and education.

9.3 Information management and technology

This section presents an outline of the system-wide improvements in information management and technology for 2014-15 which are being led by the CCG. This plan for 2014-2015 needs developing to enable delivery of the overarching health system blueprint for 2014-2019.

Strategic context for information management and technology

- The CCG has embarked on a major Older People's and Adult Community Services Procurement Programme. This changes the operational landscape and gives us an opportunity to redesign IT systems
- The Better Care Fund has challenged the CCGs and Health and Social Care to integrate services
- Increasing financial pressures mean we have to review ways of working to use new technologies to drive efficiencies in delivery of patient care
- The National Programme for IT contract ends in 2016

Current position:

The Cambridgeshire and Peterborough Health System currently has a mixture of IT systems and information flows. The GP Practices mainly use hosted clinical systems with existing and active sharing of information across care settings, including patient data. Acute Trusts are responsible for provision and development of their own information systems, and sometimes developments occur in isolation of one another. All Trusts in the system exchange information electronically but not comprehensively with a variable set of approaches in use across systems and pathways.

Areas where we can improve IT across the health system:

The following have been identified as areas for improvement:

- Data quality
- System integration across health and social care providers
- Technologies to make best use of information to support patient care, integrated services and robust service planning
- Putting information in the clinicians hands at the point of care
- Supporting patient access to their records and electronic interaction with Health and Social Care services

The CCG, together with NHS England, GP practices, acute and community providers have a number of active programmes to allow patients and carers to manage and share data on their own care. These include the

provision of Summary Care Records, Electronic Prescription Service, patient access to selected electronic services within GP practices (e.g., ordering repeat prescriptions, booking appointments, patient record access, etc). Completion statistics are reported to the respective national leads. The CCG is also working with providers to encourage them to enable their clinical systems to allow greater patient and carer involvement.

There is currently limited use of “telehealth” and telecare services within the CCG although there are some notable exceptions. HMP Litchfield use telehealth services to support prisoner health, CUHFT have an established stroke thrombolysis service across a network of acute hospitals, Cambridgeshire Community Services use telecare services in support of patients. CCS also has an assistive technology team and work is ongoing in the development of technology use. The CCG continues to encourage current and potential providers to examine telehealth and telecare services as a way of improving services for patients. This process of encouragement will continue during 2014/15.

The CCG, with the support of the Health Innovation and Education Cluster, have implemented a number of initiatives based on the Clinical Dashboards Digital Quality, Innovation, Productivity and Prevention (QIPP) agenda – namely an Urgent Care Dashboard which is currently in use across Cambridgeshire and Peterborough with all practices able to access this tool. The Urgent Care Dashboard provides information of unscheduled care attendances across our local Acute Hospitals (A&E), Out of Hours, Minor Injuries Unit and Walk in Centre settings current from within the previous 24 hour period. This is also supplemented by an Inpatient and Discharge Dashboard showing for each GP Practice their current inpatients (as of the previous 24 hours) and discharges as of the previous day. Views of these dashboards are also being developed to support Multidisciplinary Team Co-ordinators and Community Matrons in their case finding function.

Following standardisation of End of Life Care data recording and summaries, the CCG has also embarked on a project to develop a clinical dashboard using data extracted from GP Practice Systems and presented back to GP Practices with additional information, allowing review of end of life patients by the practice at a glance to ensure appropriate actions have been taken in the patients care and supporting multidisciplinary team work for people at the end of their lives. There is also the provision of customised views of the information to support retrospective review of a patient’s care after they have passed away.

Inherently this has also provided a central End of Life Care Register and also provides the LCGs and CCGs with the ability to interrogate the data from an aggregated perspective to better understand the End of Life Care provision across practices and localities.

Should this model prove successful, similar dashboards will be scoped to support multidisciplinary working for the management of frail elderly patients.

The CCG programme of work for 2014-15 has the following vision and aims

PROGRAMME VISION:

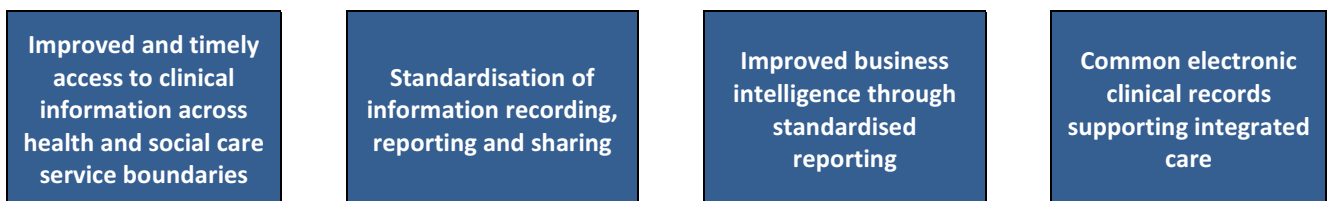
Integrated technologies supporting Integrated Care across Cambridgeshire and Peterborough

PROGRAMME AIM:

- To ensure safe and effective technologies are available for people to be proactively supported to maintain their health, wellbeing and independence for as long as possible, and support care in their home and local communities wherever possible
- For technologies to be used in an integrated way, with systems supporting services organised around the patient
- To ensure that introduction of systems meet local needs, adhere to national requirements and are implemented based on best practice
- To ensure systems provide value in support of good and efficient care with measurable outcomes
- To enable introduction of systems that support identification of the most appropriate services and clinical pathways for the patient
- To support availability of essential clinical information in unscheduled care settings to aid clinical decision making and inform patient care.
- To facilitate exploitation of joint procurement options for introduction of common technologies across service providers
- Supporting QIPP initiatives across all LCGs

The headline outcomes milestones and projects are shown below.

Figure 26: Headline Outcomes : Cambridgeshire and Peterborough system IT development 2014-2015



Cambridgeshire and Peterborough health system Blueprint

Figure 27: Key Projects - Milestones

Feb 14	Mar 14	Apr 14	May 14	June 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14
SystemOne Clinical Record Viewer Promotion/ Support										
End of Life Care Dashboard Development and Pilot		EOLC Dashboard Roll Out		EOLC Dashboard BAU						
	Frail Elderly Dashboard Scoping	Frail Elderly Dashboard Design		Frail Elderly Dashboard Pilot	Frail Elderly Dashboard Roll-out		Frail Elderly Dashboard BAU			
			Safeguarding Process Redesign (Clinical Systems)							
Referral Support Services - Clinical Decision Support Tool(s)										
Older People's Programme Dialogue		Older People's Programme Integration Planning			Older People's Programme ISFS Review		Older People's Programme Mobilisation Preparation			
eHospital – Local Health Economy integration										
Local Health Economy Integration/ Information Sharing Strategy and Programme Planning										
Health and Social Care Data Integration Programme										

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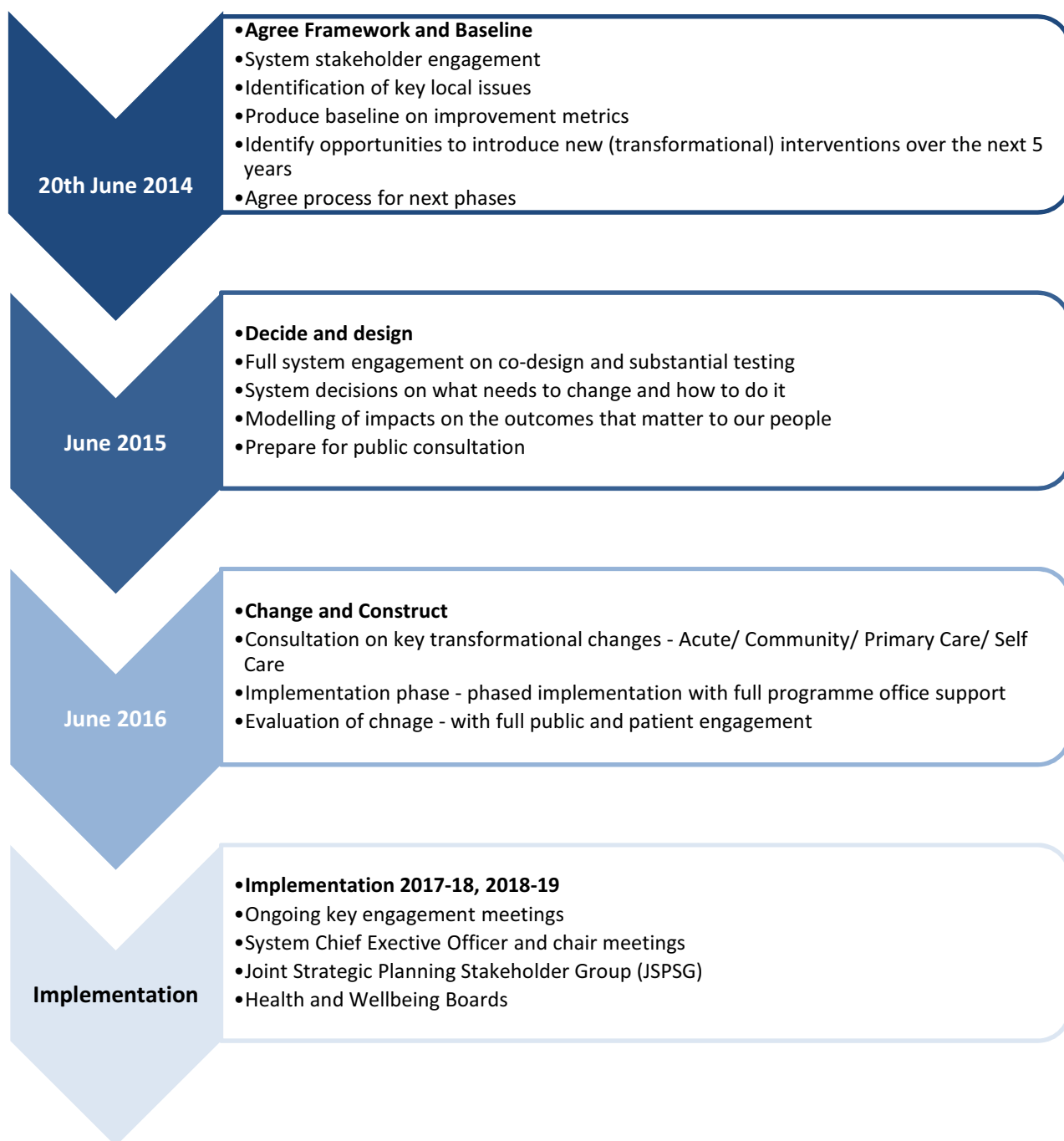
Figure 28: Projects descriptions

Project	Description	Start Date	End Date	Dependency
SystemOne Clinical Record Viewer Promotion/Support	Challenge acute providers, mental health and potentially social to make best use of access to the SystemOne clinical record	Feb-14	Apr-14	Executive level endorsement of the SystemOne clinical record viewer use in provider organisations
End of Life Care Dashboards	Dashboard supporting data quality, patient management. MDT and improved business intelligence related to End of Life Care	Dec-13	Aug-14	GP Practice Opt-in
Frail Elderly Care Dashboard	Dashboard supporting data quality, patient management. MDT and improved business intelligence related to frail elderly patients	Mar-14	Dec-14	GP Practice Opt-in
Safeguarding Process Re-design (Clinical Systems)	Standardisation of information recording and sharing with respect to Safeguarding Children	May-14	Sept-14	None
Referral Support Services	Introduction of technologies to support referrers in patient management and referral to the right service at the right time	Mar-14	April-15	LCG decision on preferred solution(s)
Older People's Programme (OPP)	Manage IM&T related element of the Older Peoples services procurement	Aug-13	April-15	None
Health and Social Care Data Integration Programme	Integration programme including e-hospital, local health economy information sharing and health social care data integration.	Sep-14	April-15	Provider Engagement

10. Forward process for the Cambridgeshire and Peterborough System Blueprint

Development and implementation of the System Blueprint is a complex process and will be carried out in four phases as follows:

Figure 29: Phases of work



The submission of this System Blueprint marks the end of Phase 1. The process for Phase 2 of the work is as follows:

GOVERNANCE

The work will be overseen by a System National Partners Group made up of an NHS England Director, the Enforcement Director at Monitor, the Head of Delivery and Development from the NHS Trust Development Authority and the Chief Operating Officer from Cambridgeshire and Peterborough CCG. The role of this group will be initially to oversee the transition of the Cambridgeshire and Peterborough Local Health Economy Steering Group to the Cambridgeshire and Peterborough System Strategic Transformation Group. The ongoing function of the group will be to ensure that the relevant health system regulators have understanding and oversight of the work undertaken, and to receive updates from the System Strategic Transformation Group, providing expert advice as required. Terms of Reference for this group will be agreed by the Chief Executives on 27th June 2014.

Reporting to the System National Partners Group will be a Strategic Transformation Steering Group made up of Chief Executives from the health organisations in the local health system, Chief Executives or Directors of Adult Social Care from Cambridgeshire County Council and Peterborough City Council, and representatives from the Area Team, Trust Development Agency and Monitor. The main purpose of this group is to set the programme of work, define the actions required, set milestones and monitor progress against these milestones. Terms of Reference for this group will be agreed by the Chief Executives on 27th June 2014. A Concordat has been signed off by members of this group and is included in Appendix 10.

On a day-to-day basis delivery of the work will be overseen by a Programme Director, and a team of Programme Managers and workstream leads. These positions will be filled by individuals working in the Cambridgeshire and Peterborough health system and to ensure buy-in from each of the health organisations it is anticipated that the team will be taken from across the health system rather than from just one organisation.

DELIVERY

Progress on this plan will continue in two main areas:

- detailed care pathway improvement work
- broader system-wide change

A set of areas have been established to look at the design and delivery of care within the current system for delivering healthcare. These are listed in the table below. They are developed to different stages, and work continues in each of these areas. The outputs of the care design work undertaken by PwC will be taken forwards by the relevant workstream area.

Care Design Group Area	Progress to date
Elective care	Programme established
Mental health	Programme in formation
Non-elective care	Three urgent care boards in place across CCG area
Older People and Vulnerable Adults	Programme established
Prevention programme	Health and wellbeing boards lead across the system. Further discussion on health system focus planned for July 2014
Women's and Children's	Programme being established

TIMELINES

Timelines for the initial months of Phase 2 are as follows:

Milestones	Timescale
Oversee the transition of the Cambridgeshire and Peterborough Local Health Economy Steering Group to the Cambridgeshire and Peterborough System Strategic Transformation Group	July to September 2014
Cross-system funding for transformation team agreed	By 10 th June 2014
Steering Group for transformation programme established from CEO group	By 27 th June 2014
Transformation team commences	1 st July 2014
Outline draft delivery plan for ongoing work	By 14 th July
First decision point: prioritisation of next phase of programme delivery	By 18 th July 2014
Milestones set for delivery across the six CDG areas	15 th August 2014
Validation of quantified information in plan (financial gap; impact of interventions on outcome and financial sustainability from commissioner and provider perspective)	16 th September
Refresh of system wide plan	30 th Sept 2014

11.Risks

We have drawn up a list of potential risks associated with the development and delivery of the System Blueprint and have presented them below in the tables below (figures 30 and 31). This list will continue to be refined as we develop our plan further.

Figure 30: Risks to Blueprint Production

Risk Area	Potential Risk	Mitigation	Level of risk
System Blueprint	Providers reluctant or unable to share their plans with the CCG	Discuss at Steering Group. Escalate through Chief Executive Officers Group if necessary.	High
System engagement	Local Commissioning Groups/ GPs/ patient representatives/ Health and Wellbeing Boards do not feel that they've had the opportunity to contribute to the plan	Communications and engagement plan.	Medium
	Lack of engagement - regulatory bodies (Monitor/ NHS England/ Trust Development Authority etc)	Consider at Steering Group	Low

Figure 31: Risks to Blueprint Delivery

Risk Area	Potential Risk	Mitigation	Level of risk
Data from the local health economy	Activity data cannot be aligned across the system to promote an overview of opportunities for service realignment	Minimum data sets to be agreed by Sept 2014 at the latest	Low
Capacity to deliver	Insufficient capacity identified to create safe and effective service redesign	System-wide summit to agree way forward	High (in some specialties)
	Lack of capacity in the system generally to cope with demographic growth and increased morbidity	System-wide summit to agree way forward	High
	Projected growth in population in Peterborough and further impact on capacity across all services	System-wide summit to agree way forward	High
	Insufficient resources across the system for phase 2	Consider at Chief Executive Officers meeting	Medium
Stakeholder engagement	Potential proposed changes destabilises other/ peripheral services and are not safe/ effective	Promote policy changes that will allow change to take place	High
	Board level concerns about proposed changes	Series of Board to Board discussions/summits planned across the system	High

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Risk Area	Potential Risk	Mitigation	Level of risk
	Governance concerns about proposed changes	Agreed and shared joint approach to clinical and organisational governance	High
	Elected Member concerns about proposed changes	All proposed changes subject to usual Overview and Scrutiny Committee arrangements(due process and consultation)	High
	Clinical concerns about proposed changes	Clinical input into joint summits from all providers	High
	Quality concerns about proposed changes	Clinical input into joint summits from all providers	High
	Patient/public concerns about proposed changes	Formal public consultation process and early engagement with patients on service designs	High
	Media concerns about proposed changes	Joint communication process to be agreed	High
	Other stakeholder concerns (e.g. Royal Colleges)	Clinical input into joint summits from all providers	Medium
Workforce	Skills/HR deficit mean that proposed changes is unsafe	Individual assessments of proposed designs	Medium
	HR/Staff negotiation issues lead to delay	Clear HR leadership arrangements to be agreed	Medium
Financial risk	Assumptions underlying financial projections are significantly inaccurate	Assumption verification via modelling	High
	Long-term financial viability of Trust/Organisation destabilised	Promote policy changes that will allow change to take place	Medium
	Potential proposed changes destabilise revenue funding	Promote policy changes that will allow change to take place	Medium
	Lack of capital(buildings)	Timescale adjusted to ensure safe service transfer	High
	Lack of capital (Age, quality and quantity of medical equipment)	Timescale adjusted to ensure safe service transfer	High
Regulation and Competition issues	Competition rules present challenge to proposed changes	Prepare evidence for Monitor's Cooperation and Competition Panel as appropriate	High
Phase 2 resources	Insufficient resources across the system for phase 2	Add to corporate risk register	

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Cambridgeshire and Peterborough health system Blueprint

2014/15 to 2018/19

Appendices

20th June 2014

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Appendix 1: Our strategic goals: where we are and where we need to get to?

This section describes our assessment of our position against each of our seven strategic goals. It concludes with an analysis that identifies our priorities for action against these goals.

Placeholder:

All goals to be mapped against CCG Outcomes Indicator Set, PHOF , to highlight most relevant outcomes for our CCG

A1.2 Strategic Goal (1) Prevention of ill health and promotion of wellbeing for all

Where are we now?

In 2004 the Wanless reviews¹ used various scenarios to examine future health trends and the factors that would influence the long term resource needs of the NHS. The review provides evidence of a “win- win”: if people have a high level of engagement in their health better health outcomes are associated with a less expensive health system.

Preventing ill health involves many actions, some of which are under the control of health services and some are not. The interaction of these factors can be complex, but estimates from studies on major disease states such as coronary heart disease show that approximately half the interventions that reduce ill health occur in the health system². So maximising the prevention of illness is a strategic goal for the CCG. To deliver this the CCG will work with partners in the local Health and Wellbeing Boards who have responsibility for health promotion and some of the wide determinants of health such as housing and transport. The CCG also recognises that through its contracts with providers it contributes significantly to the local employment opportunities, and that socio-economic conditions themselves are powerful wider determinants of health.

Two overarching indicators of “wellbeing for all” are potential years of life lost and life expectancy. Potential years of life lost vary across the CCG area and show an inequality gradient. This indicator is considered in more detail in Appendix 5. Healthy life expectancy is the number of years that a person would be expected to live in good health, with the definition of “good health” being based on the person’s own assessment.

¹ Wanless, D (2004) Securing Good Health for the whole population. HSMO: Norwich.

² http://www.nice.org.uk/niceMedia/documents/CHD_Briefing_nov_04.pdf

Figure A1-1

	Cambridgeshire	Peterborough
Healthy Life Expectancy at birth (male)	64.5	61.6
Healthy Life Expectancy at birth (female)	67.8	60.3
Life Expectancy at birth (male)	81.0	77.9
Life Expectancy at birth (female)	84.6	82.5
Gap in Life Expectancy from England as a whole (male)	1.79	-1.31
Gap in Life Expectancy from England as a whole (female)	1.59	-0.51
Statistically above Statistically below ----- Data taken from Public Health Outcomes available at http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000049/pat/6/ati/102/page/0/par/E12000006/are/E10000003		

These data can be used to calculate the proportion of their life that a person can expect to have in poor health. Women in Peterborough can expect to spend 27% of their lives in poor health as compared to women in Cambridge who can expect 20% and men in Cambridgeshire and Peterborough (20% and 21% respectively). Whilst these data are available for Cambridgeshire and Peterborough Local Authority Areas, they are likely to represent the general gap in health experience between more deprived and less deprived groups of people across the CCG (for example, between Wisbech and the rest of Cambridgeshire or between more and less affluent areas in Cambridge City).

The Public Health Outcomes Framework ³ shows the pattern of prevention in Cambridgeshire and Peterborough. Local Authorities have considered these issues in depth in the Joint Strategic Needs Assessments and the summary of local JSNAs in Appendix 4 shows the top level recommendations for improving prevention from these documents.

Where we would like to get to

Simply, we wish to continue to improve the health of our whole population whilst improving the health of those who are worst off fastest. This will mean not only working for those who currently experience worst health, but working proportionately across the whole inequality gradient.

As shown in the Appendix on Health Outcomes (Appendix 3) although the CCG benchmarks well, our inequality is wide and so to make improvements overall we need to focus in areas of highest deprivation.

Top level outcomes that we will use to measure change

Ambition 1: Improving outcomes for people: Securing additional years of life for our local population with treatable conditions as measured by potential years of life lost (PYLL) from causes amenable to healthcare.

There is a marked difference between PYLL in Cambridgeshire and Peterborough. The ambition is to reduce PYLL from causes amenable to health care preferentially in deprived areas which will reduce the inequality at the same time as improving health overall.

³ <http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000049/pat/6/ati/102/page/0/par/E12000006/are/E10000003>

Ambition 3: Improving outcomes for people - Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.

Key actions to get there

The CCG believes that cross-sector partnership that will prevent ill health and promote wellbeing. The CCG population is covered by four health and wellbeing strategies, each of which it fully supports.

There are also specific health system interventions that will contribute to preventing ill health. These have been considered in Appendix 5. Specifically this reports on interventions that can reduce potential years of life lost across the CCG area and recommends the following initial actions for the CCG:

- Extending “making every contact counts” approaches across the health system
- Increasing physical activity
- Increasing the detection and management of atrial fibrillation
- Increase proportion of Transient Ischaemic Attacks (TIA) treated within 24 hours to 100%
- Ensure provision of Early Supported Discharge schemes following stroke across the CCG
- Improve GP access for cancer diagnostics (e.g. colonoscopy)
- Support uptake of cancer decision support tools in routine consultations
- Support the scoping and development of a specialist smoking cessation midwife role in all Trusts (initial focus on Peterborough)

In addition to the above actions that have been recommended to decrease Potential Years of Life Lost and reduce the health inequality, the public health outcomes framework indicates that we should also pay attention to the following areas:

- Increasing the access to diabetic retinopathy screening across Cambridgeshire and Peterborough
- Reducing the admission rate in Peterborough for unintentional and deliberate injuries in young people aged 15-24
- Reducing the rate of hospital admissions due to falls in Peterborough

The CCG will continue to work in partnership with other agencies through the Health and Wellbeing Boards to maximise prevention and improve wellbeing.

A1.2 Strategic Goal (2) Keeping people safe

The CCG believes that keeping people safe and maximising harm-free care can be achieved as long as patients receive the right care at the right time from the right staff. The delivery of care in this way is integral to the way services are commissioned by the CCG and to achieve this there needs to be an appropriate level of professional clinical overview of services being commissioned.

Where we are now

There are several methods within the CCG for monitoring how providers are keeping people safe and maximising harm free care. These include a range of quality assurance mechanisms to ensure provider organisations are maintaining and improving quality of care and the use of early warning systems to identify

poor provision including Clinical Quality Review meetings (CQR), announced and unannounced visits, thematic reviews and deep-dives into specific areas of concern. Quality Dashboards containing quality metrics and thresholds are used to manage provider performance, and they are monitored on a regular basis via our CQR meetings with providers. Where thresholds are rated amber or red, an action plan is requested from the provider to address issues identified and formal process of a contract query can be followed. These include learning and sharing of best practice at specific events, quality networks and clinical summits.

Where we would like to get to

Clearly the systems already in place to monitor “keeping people safe” would need to continue. However, these need to be constantly reviewed to ensure they address any new developing national NHS and partner agency requirements. Some emerging areas include more detailed review of mortality, recognition of the deteriorating patient, improving seamless care between providers (timely transfer home from acute care with good discharge processes) and better analysis of medication incidents resulting in severe harm or death. In addition contracts need to be developed with Care Homes where patients with Continuing Health Care needs (CHC) or those requiring funded nursing care (FNC) which are financed by the CCG have the same monitoring systems in place as those as the major providers where services are commissioned.

Top level outcomes that we will use to measure change

- Ambition 3: Improving outcomes for people - Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital
- Ambition 7: Improving outcomes for people - Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

Key actions to get there

To achieve these outcomes the CCG will work with providers to agree quality metrics and thresholds for new areas identified and ensure that these are included in the quality schedules of their contract. We will also work with providers to undertake themed reviews of the emerging themes including mortality, recognition of the deteriorating patient and discharge processes and ensure that there is enough resource within the Quality Directorate to monitor services effectively.

A1.3 Strategic Goal (3) People have trust and confidence in our NHS and help shape their care

Where we are now

The CCG is committed to ensuring that there is a strong patient voice in helping us to design healthcare services for the future. By having a local commissioning group structure the CCG can ensure it is led locally by clinicians in partnership with their community to commission quality services that ensure value for money and the best possible outcomes for those who use them. This means that decision making has been shifted closer to the patient.

The CCG recognises that empowered clinical leadership must go hand in hand with strong patient and public engagement, with patients working with the organisation as 'critical friends' and this ethos is reflected across the CCG and the LCG system approach to public engagement.

The CCG's Patient Reference Group, which is a formal Sub-Committee of the Governing Body, currently provides constructive challenge on a broad range of work, policy development and changes to patient pathways. Other groups with whom we engage on a regular basis include Patient Participation Groups, Patient Forums, Healthwatch, Health Overview and Scrutiny Committees, Health and Wellbeing Boards. Taking into account the feedback we receive from these groups, we then decide on what the most appropriate means of public engagement will be at each stage of the commissioning process from planning to the consideration of specific proposals for change.

Examples of public engagement that we started last year were our summer roadshows where we talked to the general public about Cambridgeshire and Peterborough CCG as an organisation and its priorities. In March this year we reached a stage where we had enough information on proposals to improve older people's healthcare and adult community services to go out to public consultation. The public were asked for their feedback on the initial proposals a number of organisations have put forward on how services could be delivered differently to achieve the improvements we are looking for. We will be reviewing each consultation project individually to provide comprehensive consultation to maximum benefit.

Where we would like to get to

Over the next five years we are dedicated to making sure we effectively engage, consult and feedback how we have taken views into account in our decision-making and communicate clearly about how we are investing tax payers' money in services. As a health and social care system in Cambridgeshire and Peterborough, we aim to operate in an open, integrated and transparent way that will put people's best interests at the heart of all decision-making to achieve the best care outcomes for patients, their carers and the population. We aim to empower patients to make the right choices and to be able to take control of their own health; this can only be done if they have the right information when they need it through effective communication and engagement.

Each commissioning activity we undertake will be different and the means of public involvement at each stage in the process is likely to vary and targeted to give us the most feedback. For example, at some stages of the commissioning process public involvement may be achieved through the publication of information regarding our activities, whereas at others formal consultation may be more appropriate. Our decisions on the means by which we engage the public in each commissioning activity are likely to include consideration of the following relevant factors, among others:

- the range of services we are proposing to change
- the size of the geographical area
- the number of people affected by the proposed change
- the nature of the particular stages of the commissioning process

We will be reviewing each consultation project individually to provide comprehensive consultation to maximum benefit.

Top level outcomes that we will use to measure change

- Ambition 6: Improving outcomes for people: Increasing the number of people having a positive experience of care outside hospital, in general practice and in the community
- Ambition 6: Improving outcomes for people - Increasing the number of people having a positive experience of hospital care

Key actions to get there

Our Public Engagement Strategy (see appendix 6) sets out how we intend to deliver this goal.

A1.4 Strategic Goal (4) People are listened to throughout their care

Where we are now

In line with the NHS Constitution, the CCG engages with a wide range of patient groups throughout every stage their care. The CCG uses a range of mechanisms to measure patient opinions, and monitor provider responses.

The Patient Reference Group includes patient representatives from each of our eight Local Commissioning Groups, as well as Healthwatch Cambridgeshire and Healthwatch Peterborough. The focus of the Patient Reference Group is on providing an independent view of the work of the CCG. It ensures that in all aspects of the CCG's business the public voice of the local population is heard. Alongside the Patient Reference Group, we engage on a regular basis with Patient Participation Groups, Patient Forums, Healthwatch, Health Overview and Scrutiny Committees, Health and Wellbeing Boards.

There are always opportunities for our stakeholders and members of the public to engage and share their views with us. Our stakeholder newsletter, which is sent out to our stakeholder database and is posted on our website, has a facility for people to leave comments. Our Engagement Team email address is publicised on all our communications and we encourage members of the public to contact us. We respond to emails and telephone calls where we are given feedback or concerns are raised by our stakeholders or the public.

We employ a range of approaches as part of our strategy to learn from complaints and to improve the experience of making a complaint, for example:

- Patient experience team - provide assistance and support to enquirers wishing to make complaints about NHS services

- Service user questionnaire/ leaflets – advertise existence of team and allow service users to provide feedback or ask for assistance. Enquirers also have the option to share with the CCG, via Patient Stories, their experience (below)
- Risk management database - Details are logged on in-house risk management database to support provision of reports
- Reports provided to the Patient Safety & Quality (PSQ) Committee.
- Soft Intelligence Line - Complaints/concerns are also raised via healthcare professionals, GPs and Patient reference Groups via the Soft Intelligence Line; issues raised with providers via the CQRs.

Collaborative learning is also encouraged and we place emphasis on providers via CQRs of the importance of illustrating understanding of the issues raised and learning and sharing via action plans. We also promote the ethos of the “6 Cs” both in everyday business undertakings and via actions plans. We place great importance on Compassion in Practice and we listen and act on feedback from service users as a priority. We have been progressing our work on developing Personal Health Budgets and Continuing Health Care, for example:

Where we would like to get to

Patient experience information helps to inform us about our public’s perception of us as an NHS organisation and we must continue to learn from these experiences to help raise our performance.

Patient insight is crucial and we will continue to develop efficient and effective ways of harnessing public voices so that commissioning decisions are shaped by people’s expressed needs and wants.

Top level outcomes that we will use to measure change

- Ambition 4: Improving outcomes for people: Increasing the number of people having a positive experience of care outside hospital, in general practice and in the community
- Ambition 6: Improving outcomes for people - Increasing the number of people having a positive experience of hospital care

Key actions to get there

Our Public Engagement Strategy (see appendix 6) sets out how we intend to deliver this goal.

A1.5 Strategic Goal (5) Making the best use of our NHS by giving the right care, in the right place at the right time

This strategic goal considers how we maximise clinical effectiveness, cost-effectiveness and health system efficiency.

Clinical effectiveness ensures that health is improved at the level of the individual person and cost-effectiveness assesses the amount of health that we produce by using dedicated resources at the level of an intervention or pathway. To increase health system efficiency we need to achieve the best possible

outcomes at an individual and population level for total resources, financial, environmental and social, that we have available.

The quality work that the CCG undertakes with its providers is foundational to clinical effectiveness at an individual level. As an organisation we aspire to be evidence based and to monitor the impact of our commissioning actions so that we are continuously learning what works best to improve the health of our population for the available resources. This means working with local partners to create the evidence base, applying it in practice and evaluating the actions that we undertake as commissioner.

Where we are now

- Staff availability and capability underpin clinical and cost-effectiveness across the system. In response to the Francis report some of our providers are assessing whether the right nursing staff are in the right place with the right skills at the right time.⁴
- The CCG already has several processes in place to work at the level of clinical effectiveness and cost effectiveness for the individual patient. For example, the quality monitoring processes in the CCG are strong and regular action is taken on quality issues; Clinical Prioritisation and NICE implementation processes are in place.
- Working in partnership with the Healthcare Public Health Advice Service offered by our Local Authorities we continue to improve our ability to base our decisions on evidence and also learn, through evaluations, from our past actions.
- The outcomes based approach being used in the Older People's and Adult Community Service Procurement should aims to enable the health system to optimise right place right person right time. This is a new approach for our system and we plan to evaluate the impact going forwards.
- At the level of the whole system some of the current mechanisms , for example the method of funding our acute providers and the functional split between primary care and community care commissioning, make it challenging to assess the health system efficiently and do not maximise synergy in this area.

Where we would like to get to

We need to understand more about how the use of our financial, social and environmental resources as a health system can be best used to improve health outcomes for individuals and populations. In our draft sustainability strategy the CCG recognises that that sustainable development and carbon management are corporate responsibilities. Demonstrating high quality healthcare will not be possible without embedding sustainable development into NHS management and governance processes. however we recognise, in line with the "Sustainable Development Strategy for the NHS, Public Health and Social Care system"⁵ that there are social resources both within the health workforce, and beyond, that also are important in improving health outcomes and that optimising the use of environmental resources has co-benefits for health.

⁴ <http://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf>

⁵ http://www.sduhealth.org.uk/documents/publications/2014%20strategy%20and%20modulesNewFolder/Strategy_FIN_AL_Jan2014.pdf

We have strong financial metrics but do not routinely use social and environmental sustainability metrics to assess resource use. Alongside this the pressing need remains to maximise the efficiency of our use of financial resources.

Top level outcomes that we will use to measure change

- Ambition 4: Improving outcomes for people: Increasing the number of people having a positive experience of care outside hospital, in general practice and in the community
- Ambition 6: Improving outcomes for people - Increasing the number of people having a positive experience of hospital care

Key actions to get there

We will continue to work with our providers to extend the “right person right place” approach to other sections the health and social care workforces, starting with medical staff. We will continue to develop our use of the evidence, evaluation, our prioritisation and threshold processes and implementation of NICE guidance

However central to achieving progress against this strategic goal is more in depth analysis of our resource use at a system level against health outcome gain. Achieving a greater, practical understanding of this which we can apply to our business as commissioners is critical to further development of this CCG plan and its successful implementation to improve health outcomes

A1.6 Strategic Goal (6) Services are seamless, integrated and centred around the person

There is wide agreement that integrated, person centred care is important⁶. Achieving this goal keeps the people central to all that we do and also enables efficient design of the health system.

Where we are now

Currently a multidisciplinary approach to care in the community is being piloted across the CCG, and the CCG is realistic in our expectation about the time that this approach will take to show any changes. At present the CCG has no indicators that provide a system overview on integrated and seamless patient centred services. A methodology to measure this has been proposed by the Department of Health⁷. There is also anecdotal evidence from clinical colleagues on the impact of people in our system because of sub-optimal integration.

⁶ <http://www.kingsfund.org.uk/sites/files/kf/integrated-care-patients-populations-paper-nuffield-trust-kings-fund-january-2012.pdf>

⁷ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212896/Interim-Integration-Measures-for-Patient-Experience.pdf

The process of designing the Older People's and Adult Community Service Procurement has taken a person-centred approach and is designed to increase integration for this group of patients. This is reflected in the outcomes framework for this procurement.⁸

We recognise that developing community and primary care is fundamental to developing a more integrated health and social care system.

Where we would like to get to

We would like to be able to measure evidence of steadily improving seamless care for our patients are measured by the metrics above and verify this with systematic qualitative information from our health system.

Key actions to get there

We are plan to develop, in line with the suggestions above, methods for assessing system integration and use this to audit our system. We expect that this will need to be complemented by qualitative work following individual patient journeys to gain deeper insights in to the barriers to integrated working in our local system.

We need to systematically identify the levers available to the CCG to incentivise system working in particular pathway areas such as women's and children and mental health. We will evaluate the implementation of the Older People's and Adult Community Service Procurement which is designed to increase care integration. This is supported by our joint work with our Local Authority Partners on the Better Care Fund. (For further details on this please see the Two Year Plan).

Top level outcomes that we will use to measure change

- Ambition 3: Improving outcomes for people - Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital
- Ambition 2: Improving outcomes for people - Improving the health related quality of life of people with one or more long-term as measured by EQ 5D on the GP patient survey
- Ambition 4: Improving outcomes for people: Increasing the number of people having a positive experience of care outside hospital, in general practice and in the community
- Ambition 6: Improving outcomes for people - Increasing the number of people having a positive experience of hospital care

A1.7 Strategic Goal (7) The services we commission match the needs of our population ensuring fair access in relation to need

Progress towards this goal entails commissioning what the people in Cambridgeshire need, rather than what is wanted or supplied.

⁸ Draft version is available at:

<http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/CCG/Priority%20Older%20Peoples%20Programme/Older%20Peoples%20Programme%20-%20Outcomes%20Framework%20Mark%201%20-%20Jan%202014.pdf>

Where we are now

As a commissioner we make regular use of available JSNAs and advice available through the Local Authority Healthcare Public Health Advice Services. In the CCG the Improving Outcomes Team has a remit to ensure that the CCG fulfils its statutory duty to reduce health inequalities. Practical programmes of work to date have included the “Tackling Inequalities in Coronary Heart Disease Programme” and specific input into Older People’s and Adult Community Services procurement.

Our current best quantifiable overall needs assessment for health services across Cambridgeshire and Peterborough remains the activity data that is generated by our providers. These data measure use, not true need or supply. There is less detail in the data from community providers than from our acute providers and there is no general mechanism in place for linking data across the whole health system.

Where we would like to get to

As the CCG is one of several commissioners of health and social care across Cambridgeshire and Peterborough we would like to develop a proactive collaboration with partner commissioners and providers to ensure a shared understanding between commissioners of health and social care need.

This would enable co-ordinated commissioning with other commissioning bodies to ensure patient centred care. In particular it would support commissioning decisions that strengthen our role as investors in health and health outcomes as well as funders of care. We plan to do this by using an approach based on quality and outcomes and aligning contracting mechanisms and contract incentives to facilitate this.

To reach this we will need improved data collection and analysis systems across the whole system, especially in the areas of community care data and integrated data across providers. We need to develop mechanisms to collect and act on the information that this will provide. An ongoing programme of targeted need assessment work, such as the needs assessment that underpinned the Older Peoples and Adult Services procurement⁹, will help to separate demand from need and highlight areas for increased access to services.

Key actions to get there

The following actions will help us reach this goal:

- Contributing to the Joint Strategic Needs Assessment work undertaken by our Local Authority partners.
- Developing data linkage and health service activity surveillance solutions across the whole health system
- Building capacity for developing shared need and activity projections
- Commissioning regular health equity audits from the Public Health Healthcare Advice Service and act upon their recommendations
- Continuing to work with the Cambridgeshire and Peterborough workforce group

Top level outcomes that we will use to measure change

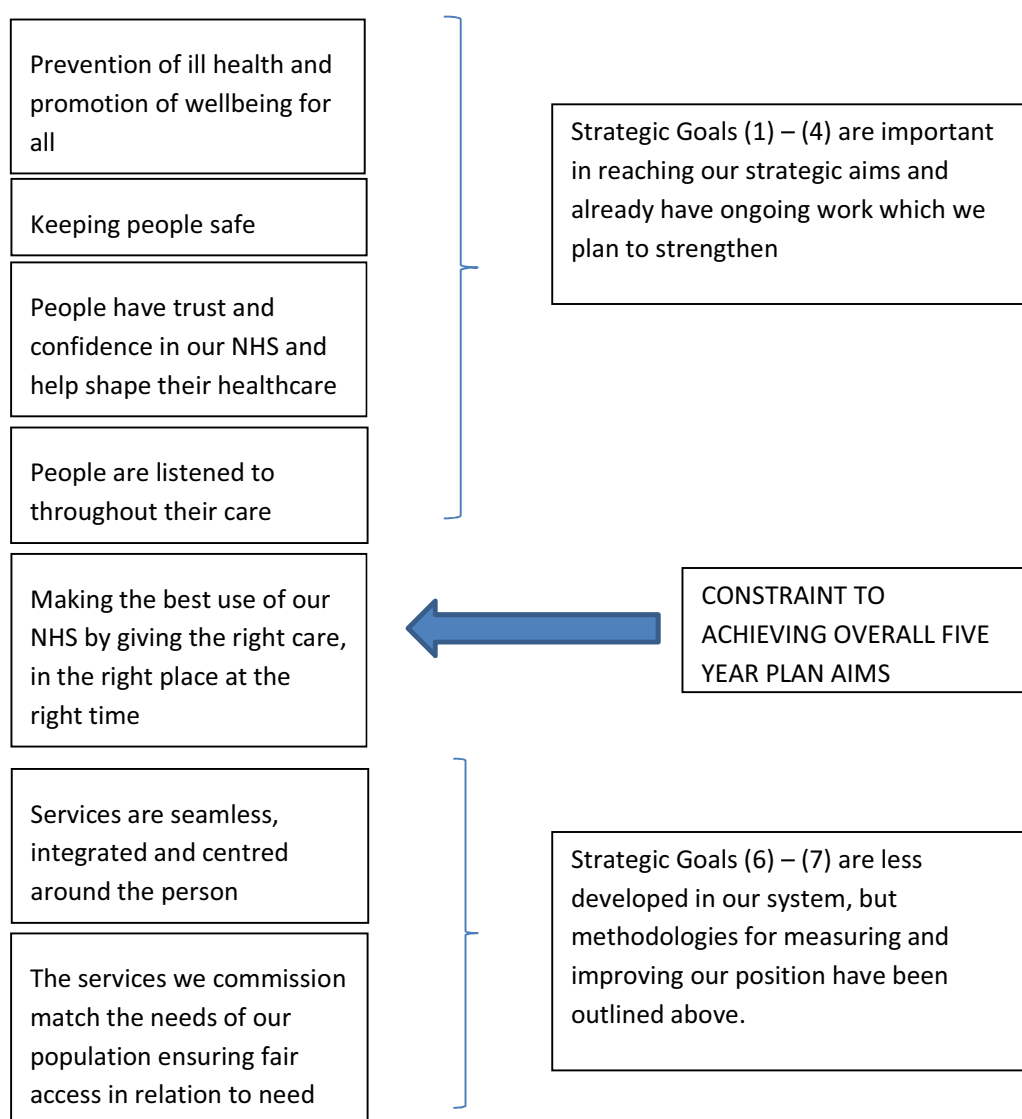
⁹ <http://www.cambridgeshireinsight.org.uk/currentreports/older-people-including-dementia>

- Ambition 1: Improving outcomes for people: Securing additional years of life for our local population with treatable conditions as measured by potential years of life lost (PYLL) from causes amenable to healthcare

A1.8 Our strategic goals: summary and overview

The above section has outlined our current position against our strategic goals, our key actions for change and how we will measure progress. Figure A1-2 shows that we need to prioritise strategic goal 5 “making the best use of NHS resources by giving the right care in the right place at the right time”.

Figure A1-2



Making the best use of our NHS by giving the right care in the right place at the right time stands out as the constraint to achieving our strategic aims because this is:

- The goal where our current position is least well understood
- The area where the current systems and implementation mechanisms make it hardest to action change
- The goal that most closely aligns to the well described current need to address the financial gap
- The goal that most closely addresses the need to build a financially, socially and environmentally sustainable health system for the future.

We therefore consider that our 5 Year Plan needs to focus on understanding how our use of our resources acts to improve health outcomes, how best to deploy them, and how to mitigate the current system levers that make this challenging to achieve. The next section describes our proposal for taking this forward.

Making the best use of our NHS by giving the right care, in the right place at the right time

Services are seamless, integrated and centred around the person

The services we commission match the needs of our population ensuring fair access in relation to need

Appendix 2: Health outcomes

Clinicians and staff in NHS England, CCGs and key stakeholder organisations have worked together to define seven key ambitions. This appendix sets out how the CCG's position against each ambition, areas where improvements can be made, ambition for delivery and next actions.

Ambition 1: Improving outcomes for people: Securing additional years of life for our local population with treatable conditions as measured by potential years of life lost (PYLL) from causes amenable to healthcare

Current position

- Potential years of life lost have fallen over the last 10 years in Cambridgeshire, (at an average rate of 3.4% per annum) but not in Peterborough
- Cambridgeshire is in the lowest Local Authority quintile for PYLL and Peterborough in the highest. Overall the CCG is in the lowest quintile for CCGs
- So an inequality exists and although these data are for Cambridgeshire and Peterborough this is likely to reflect inequalities in other geographical units across the CCG area.

Areas where we can improve

- Gains in PYLL are likely to be made by focussing on areas such as Peterborough where PYLL are currently above average. Further analysis is ongoing to understand which conditions are contributing to PYLL from causes amenable to healthcare in each of our LCGs and the CCG overall. A strategic programme to reduce the inequality in deaths from coronary heart disease is already in place.

Ambition for improvement

The trajectory has been chosen recognising the need to reduce inequalities. We do not yet know if the downwards trends in PYLL in Cambridgeshire has been maintained over the last two years. There is no significant downward trend for available CCG data. Further data may show that this is going up or staying flat.

The trajectory has been set at 3.2% for 2014 /15 then decreases at the same rate as the decrease seen across the CCG from 2010-2012. This would lead to a 6.2% reduction in PYLL over the 5 year time period, i.e. a significant gain in health.

Next actions:

- Benchmarking against NICE standards for the interventions, including those listed in "Our ambition to reduce premature mortality". This will include stroke standards and interventions to reduce cancer mortality.
- Impact analysis for the final list of interventions followed by feasibility assessment and prioritisation.
- The JSNAs for both Peterborough and Cambridgeshire make recommendations about reducing preventable ill health and these recommendations for action will be considered as part of the above process

Figure A2-1: Potential years of life lost from causes amenable to healthcare

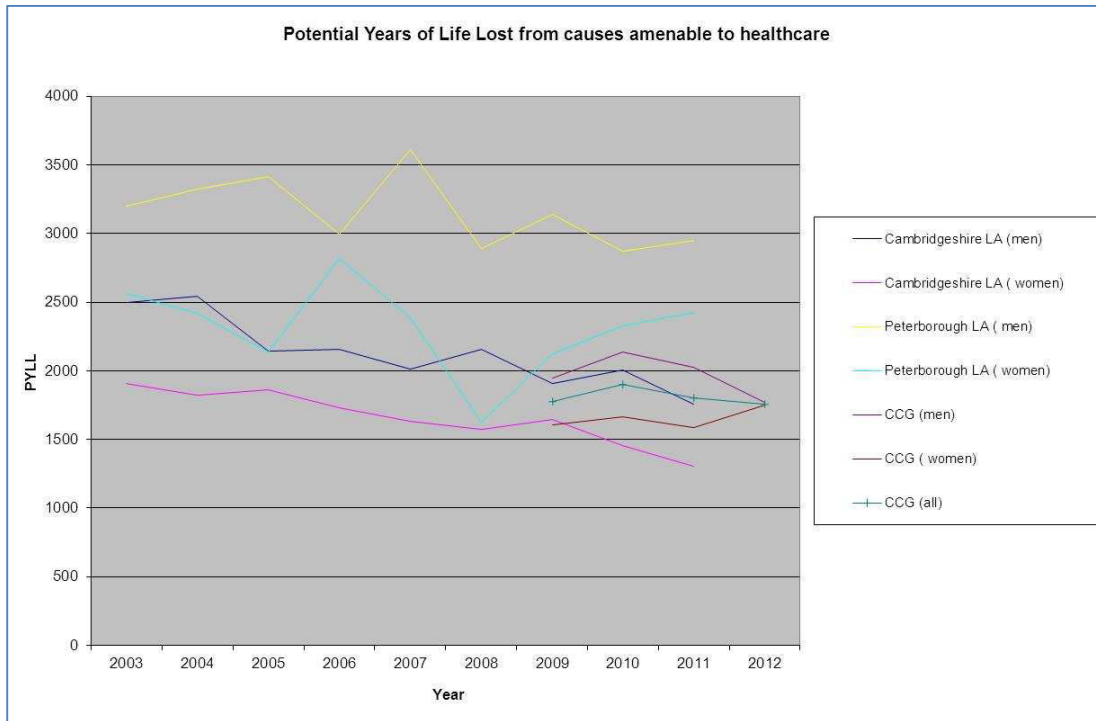
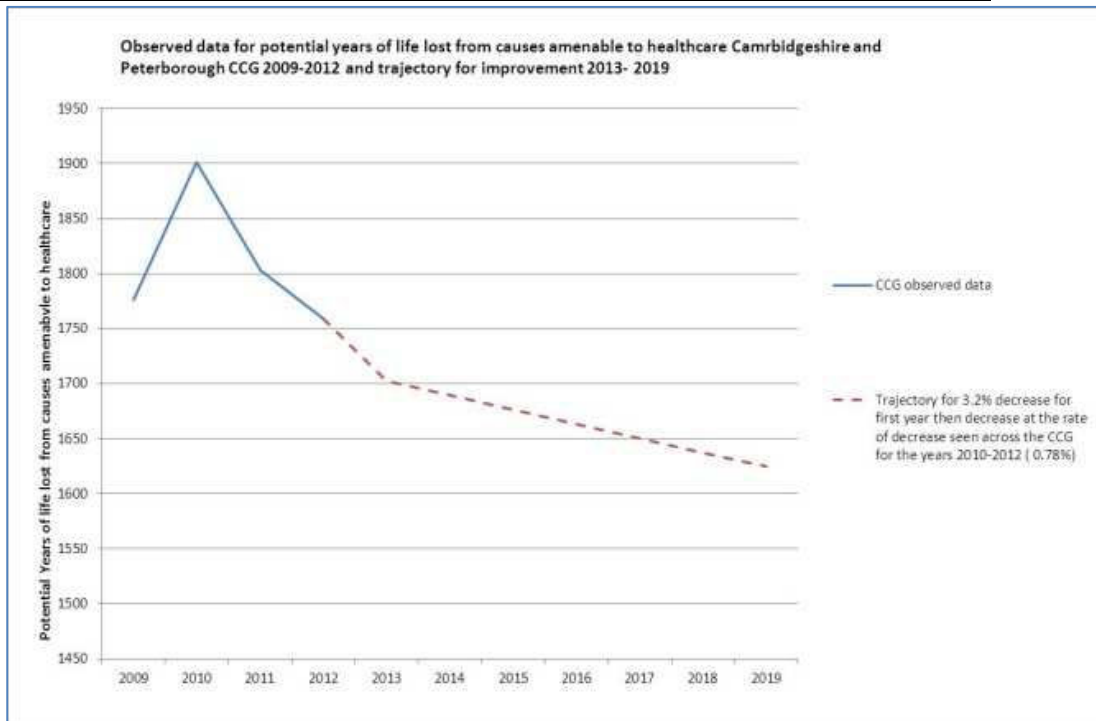
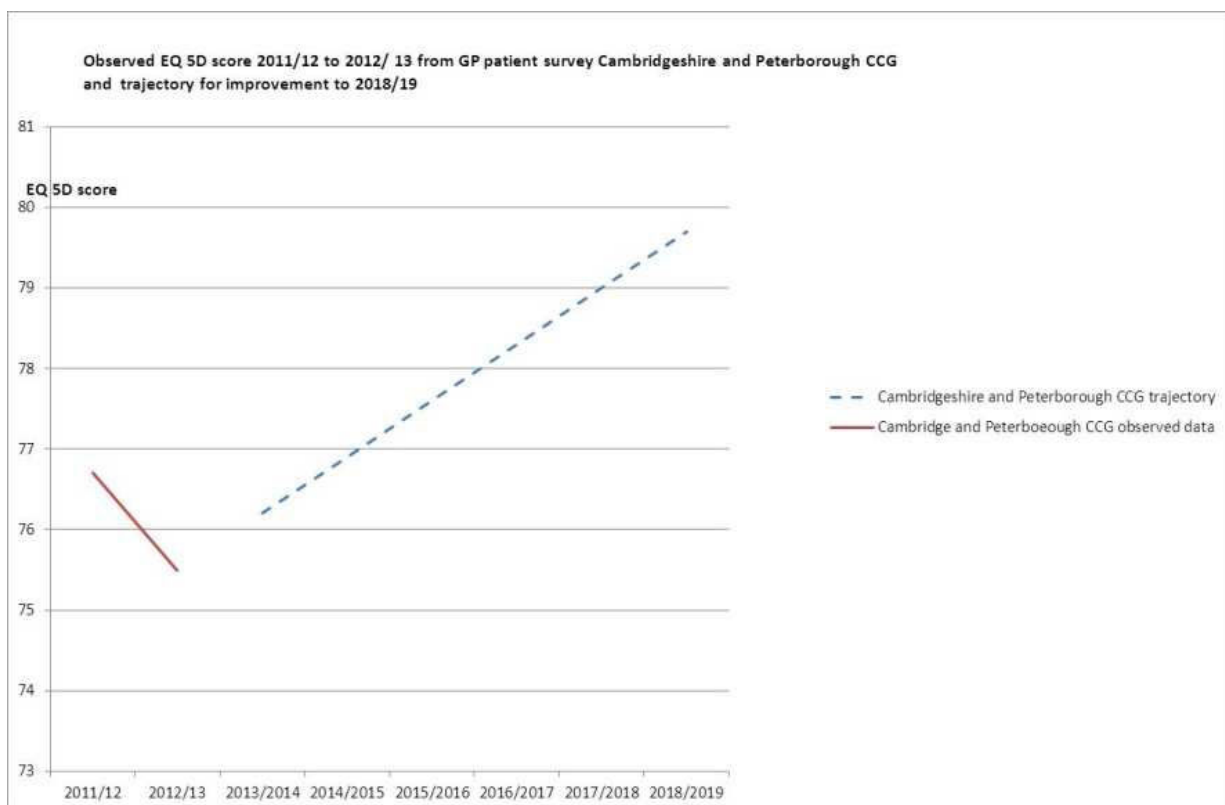


Figure A2-2: Observed data for potential years of life lost from causes amenable to healthcare





Ambition 3: Improving outcomes for people - Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital

Current position:

Emergency admissions in this category are approximately 25% of all emergency admissions. At CCG level this indicator has been flat from 2009/10 to 2012/13 with the CCG consistently in the second best quintile of CCGs. Sub indicator analysis is available by Local Authority area.

Sub- indicator	Cams relative position	Cams trend	Peterborough relative position	Peterborough trend
Unplanned hospital admission for chronic ambulatory care conditions	2 nd best quintile	Falling	2 nd worst quintile	Falling
Unplanned hospital for epilepsy, asthma, diabetes in under 19s	2 nd best quintile	Flat	Worst quintile	Flat
Emergency admissions for conditions that should not normally require hospital admission	2 nd best quintile	Up	Middle quintile	Up
Emergency admission for children with URTI	2 nd best quintile	Flat	2 nd best quintile	Flat

Areas where we can improve

Initial analysis (***NB this needs data verification***) suggests that's that major contributors to this are indicator

- Urinary tract infection
- Lobar pneumonia
- Gastroenteritis
- Acute URTI
- Cellulitis
- Acute tonsillitis

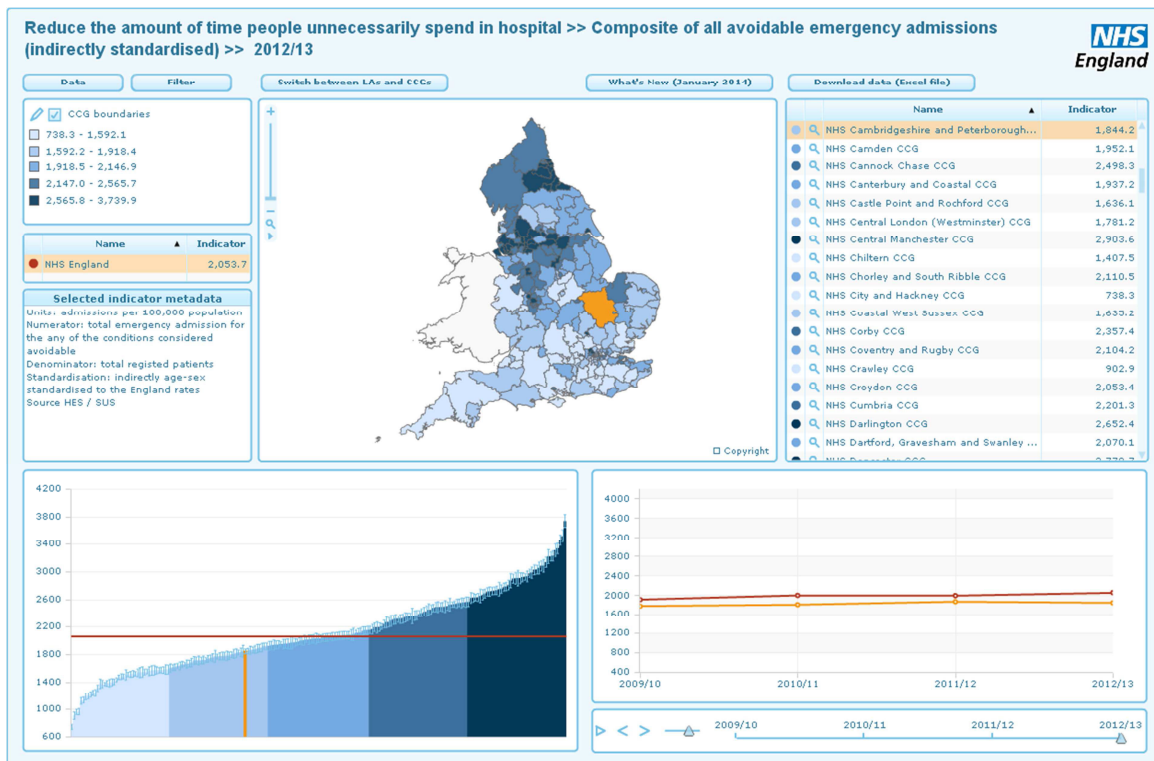
Together, these areas account for almost 80% of the 2013/14 admissions in this category to date.

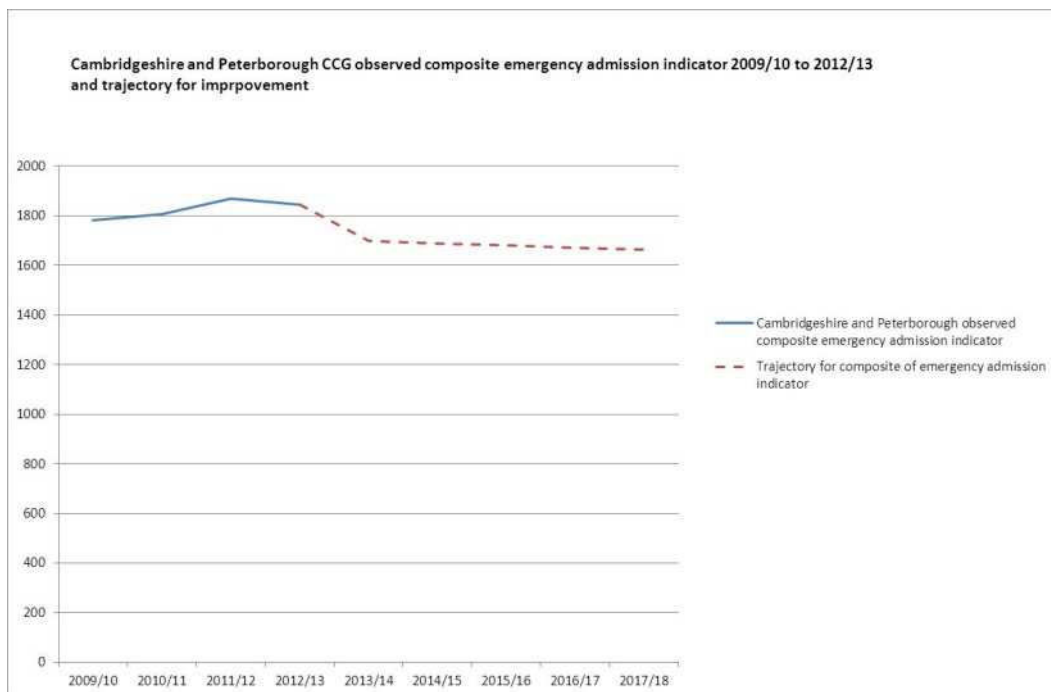
Ambition for improvement

The trajectory has been chosen taking into account the need for financial sustainability.

Next actions:

- Analysis of drivers to change this ongoing
- The programme approach outlined in the 2 year plan could be matched by clinically focussed service initiatives, for example on UTIs and Respiratory infections (adult and children)
- This area needs more descriptive epidemiology, but key threads are likely to be prevention, early self-management and care closer to home, including hydration; weather and its effects





Ambition 4: Improving outcomes for people: Increasing the proportion of older people living independently at home following discharge from hospital

Current position

There is no indicator available at CCG level to set a quantifiable level of ambition against. However, we are working with Local Authorities to plan and implement the Better Care Fund which is still at an early stage of planning. Initial plans have been drawn up and proposed initiatives have yet to be formally evaluated (planned for the April 2014 submission).

Areas where we can improve (using the Better Care Fund)

Thematic Area: Providing support for people who need help when they leave hospital

- Expand teams to provide 7 day discharge planning and discharge
- Develop a 'return home' package with voluntary sector to aid speedy discharge and post hospital discharge support
- Establish a joint team to oversee integration activity e.g. joint assessments, joined up packages of care
- In Peterborough, move to 7 day working for The Firm and multi-disciplinary teams and build on existing intermediate care capacity and support
- Improve psychiatric liaison support and mental health presence in MDTs
- Develop the potential of telehealth and telecare as well as assistive technologies
- Enhance dementia care support for patients and provide better support for carers

Ambition for improvement

- Greater avoidance of unnecessary admission to hospital
- Reduction in delayed transfers of care per 100,000 population
- Improved patient experience through optimising discharge pathways

Next actions

Joint evaluation with Local Authorities of the proposals; development of selection criteria; formulation of final list of proposals for implementation in 2015/16 – plans due April 2014

Ambition 5: Improving outcomes for people - Increasing the number of people having a positive experience of hospital care

Current position

Data is derived from the hospital inpatient survey and measures the rate of responses of poor experience of inpatient care per 100 episodes. There is a single data point for this indicator (2012). The CCG is in the best performing quintile.

Areas where we can improve

Scoping of the aspects of the hospital survey already undertaken and timely discharge seems to be an area where there could be improvement.

Ambition for improvement

If we were achieving 122 at the moment, we would be the second best performing CCG in the country our trajectory is to improve from 127.6 to 122 over 5 years

Next Actions

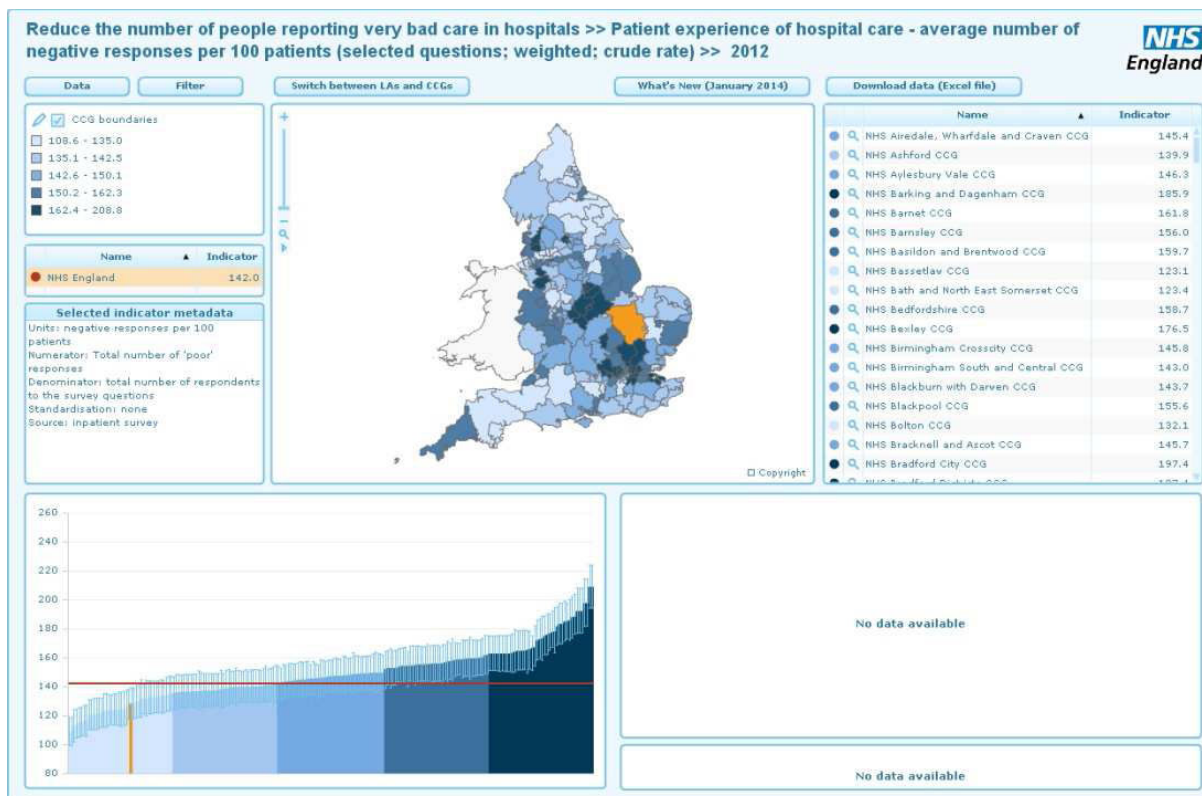
We will use Information and feedback from patients, families and carers, which details their experiences of local health services to design, develop and monitor services to ensure that services deliver what people need. We are committed to capturing this experience so that lessons can be learned and existing services can be improved or delivered in a more appropriate way. We consider patient feedback to be at the heart of its work.

With a view to increasing the amount of people reporting a positive experience of hospital care, we will work with its healthcare colleagues to demonstrate leadership and organisational commitment and assist them to understand patient experience with a view to improving services and co-designing improvements and will:

- dedicate resources to capture, understand and use patient experience, through storytelling and numerical data consistently frame patient experience as an integral part of the quality framework, alongside clinical effectiveness and safety focus on areas of poor performance and assist in developing actions for improvement.

- identify and acknowledge improvement in outcomes and quality of services as being as high priority alongside financial and clinical goals

- recognise the link between patient experience and staff well-being and develop plans for improving both (based on existing data collection on staff well-being within the 2011/12 quality dashboard)
- ensure patient experience forms an integral part of staff induction, development/training and appraisal
- raise awareness of and succeed in reaching all groups in the community, to understand and respond to their needs and reduce the differences, which exist in terms of access, experiences and outcome
- demonstrate that patients, families and carers' views make a difference to the commissioning of local health services



Ambition 6: Improving outcomes for people: Increasing the number of people having a positive experience of care outside hospital, in general practice and in the community

Current position

This indicator is made up of the total number of "poor" or "very poor" responses to the following questions from the GP Patient Survey:

- "Overall, how would you describe your experience of your GP surgery?"
- "Overall, how would you describe your experience of Out of Hours GP services?"

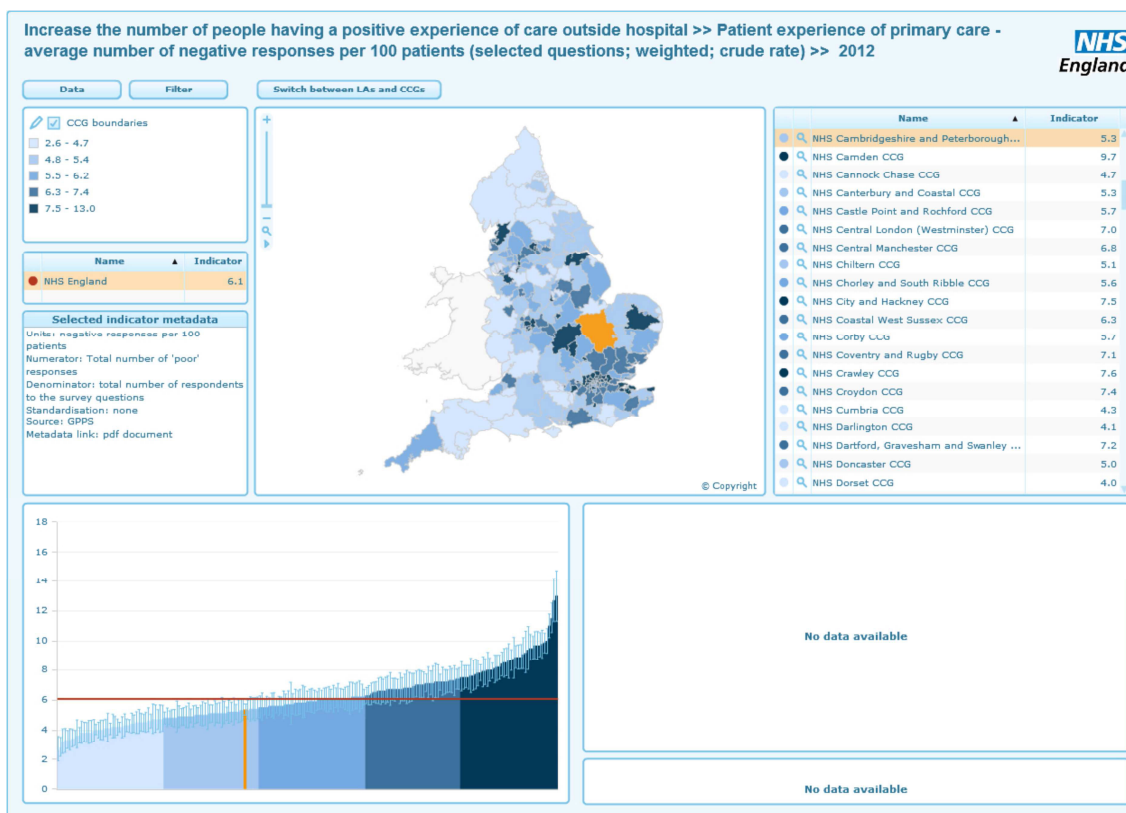
There is only one data point, for the year 2012. For our CCG this is 5.3 (5-5.7). This puts us in the second best, not the best quintile

Areas where we can improve and ambitions for improvement:

The middle range of the best quintile has a score of 4.1, so we will aim to achieve this over 5 years

Next actions:

More work is needed to understand where improvements can be made on this outcome, including analysis of out of hours data, data by practice and following discussion with NHS England about their ambition and contribution.



Ambition 7: Improving outcomes for people - Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

Current position

The baseline data for the outcome indicator underlying this ambition is not yet available. Below we show how we plan to improve outcomes in this area, on the journey towards eliminating avoidable deaths in our hospitals

Areas where we can improve/ ambition for improvement

Avoidable deaths in hospital are linked to many aspects of hospital life and low mortality rates do not necessarily mean that deaths were unavoidable and vice versa. Avoidable deaths were highlighted in the 'Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report Bruce Keogh July 2013 and the Francis Inquiries in to Mid-Staffordshire'. The 'Keogh' Mortality review highlighted 5 common areas in the 14 Trusts reviewed where mortality rates were high:

- Patient experience
- Safety
- Workforce
- Clinical and operational effectiveness
- Governance and leadership

It is essential therefore, that there is appropriate monitoring and scrutiny of these 5 areas in Provider organisations. The CCG Quality Directorate has developed a quality dashboard with a range of metrics and RAG rated thresholds. Providers are contractually required to provide evidence on a monthly or quarterly basis, which are reviewed by the Quality Directorate and areas of concern 1 red RAG rating or 3 Amber RAG ratings are escalated in an escalation report to the Patient Safety and Quality Committee and may result in a contract query with Providers and for them to produce an Remedial Action Plan to improve their performance.

These metrics are reviewed at least annually on publication of national reports such as the Planning guidance, outcomes framework and updated to meet emerging national requirements. In addition to the quality dashboard for 2014/2015, the Quality directorate are planning a themed review with each Provider of their of mortality systems to assess their robustness of identifying cases for review, e.g. mortality review tools - GTT

Mortality rates, for example HSMR and SHMI and crude deaths rates, are not sensitive enough to indicate whether deaths were avoidable. A low mortality rate does not necessarily mean low avoidable death rates

Appendix 3 : JSNA summary

JSNA Summaries: Cambridgeshire and Peterborough CCG
February 2014

This document is a working draft and it is important to note that the JSNAs for Hertfordshire and Northamptonshire have not yet been reviewed for these areas. However given the similarity of the areas in the CCG which are in these Local Authorities with the adjacent areas in Peterborough and Cambridgeshire this review is unlikely to add any substantial key issues.

JSNAs are written from different perspectives. They have been produced over the last few years and so the data in them is of differing ages. This summary first considers children and older people, then determinants of health and finally special groups in the population

For each area the table lists the key issues, JSNA recommendations and gaps identified. Links are given for further details.

Area	Key issues	Recommendations	Gaps	Links and other notes
Children and Young People	<p>A good start to life has a positive impact throughout the life course</p> <p>Need is to identify and focus on vulnerable children</p>	<p>Work in a targeted way with more vulnerable families to:</p> <ul style="list-style-type: none"> • promote parental mental and physical health • support good parenting skills • develop social and emotional skills • prevent violence and abuse 		<p>Cambridgeshire Children's and Young People's JSNA 2010 http://www.cambridgeshireinsight.org.uk/currentreports/children-and-young-people</p>
	<p>Peterborough has high rate of children 'in need' per 10,000 head of population of 0-17 year olds. In 2010 this was 547 per 10,000 population (in the highest 10% of LAs in England)</p> <p>Approximately 2.9% of the child population of Cambridgeshire were referred to social care in 2008/9</p> <p>Referrals are highest in Wisbech, Huntingdon and Cambridge South and lowest in Sawston and Linton and Bassingbourn, and St Ives Localities.</p> <p>Most Cambs referrals for abuse/neglect</p>	<ul style="list-style-type: none"> • Address some of the current challenges for safeguarding services • Recruitment, retention and work force stability • • Delivery of safeguarding training • • Engaging children and young people in effective consultation on service delivery• • Developing services for the families • Reducing accidents and intentional injuries to children and young people 	<p>The gap between the high rate of children in need in Peterborough and the low rate of children subject to a child protection plan warrants further investigation.</p>	<p>http://www.peterborough.gov.uk/health_and_social_care/joint_strategic_needs_assesmen/keeping_people_safe.aspx</p> <p>Children and Young People Safeguarding JSNA - Peterborough http://www.peterborough.gov.uk/pdf/HealthAndSocialCare-JSNA-ChildrenAndYoungPeopleSafeguarding.pdf</p> <p>Cambridgeshire Children's and Young Peoples JSNA http://www.cambridgeshireinsight.org.uk/currentreports/children-and-young-people</p>

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Area	Key issues	Recommendations	Gaps	Links and other notes
Children in poverty	Core priority for Peterborough.	<p>Consider the following areas:</p> <ul style="list-style-type: none"> • Information advice and guidance • Accommodation • New arrival families • Access • Employment opportunities • Services: staff skills • Education and training 		<p>Peterborough JSNA on Children and Young Peoples' outcomes: Child Poverty http://www.peterborough.gov.uk/pdf/HealthAndSocialCare-JSNA-ChildrenAndYoungPeopleChildPoverty.pdf</p>
Older People	Significant growth in numbers over the next 20 years	<ul style="list-style-type: none"> • Prevent ill health and promotion of good health amongst older people. • Promote the message that stopping smoking, sensible alcohol consumption, healthy eating and physical activity have health benefits even at older ages. 	Primary prevention needs consideration as well	
		<ul style="list-style-type: none"> • Reconfigure services to support older people to live in a community setting as long as possible, avoid admission to hospital/care homes, and return to a community setting after discharge from hospital. • Preventing hospital admissions and developing integrated care models • Case management by multi-disciplinary teams for "frail" elderly people • Falls prevention • Increase awareness of mental health problems amongst those caring for older people; developing integrated services for mental health which facilitate early intervention and support older people and their carers in the community. 	<p>The evidence base as to what works in preventive services and admission avoidance to hospital or care homes for older people is still developing, so it is essential to evaluate initiatives and measure how well they are working.</p> <p>In future needs assessments, explicitly consider the needs of older people as in specific</p>	

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Area	Key issues	Recommendations	Gaps	Links and other notes
		<ul style="list-style-type: none"> • Improve advice and support for carers of older people with mental health problems including cognitive impairment; • Improve commissioning processes to promote joint working across health, social care and voluntary organisations • Re-ablement services are now widely available and proven to be effective in helping older people regain their independence through assisting with re-learning everyday tasks. [2] 	<p>groups e.g. among prisoners, Travellers.</p> <p>The development of reablement needs to continue, to benefit more people</p>	
	<p>The recent JSNA work for both older people and people with disabilities has identified that there is a requirement to further assess the needs of carers and how their caring role impacts on their own health and wellbeing, and how a multi-agency approach can be developed to best support them.</p>	<ul style="list-style-type: none"> • Comply with the requirements of the national Carers' Strategy as identified by the Joint Carers' strategy for Cambridgeshire. 		<p>Cambridgeshire JSNA on Older people including dementia http://www.cambridgeshireinsight.org.uk/currentreports/older-people-including-dementia</p>
<p>Physical activity</p>	<p>Participation in physical activity decreases with age Overall downward trend in rates of participation in sport locally, with the exception of Huntingdonshire and South Cambridgeshire. Sports participation in all age groups is relatively low in Fenland and is generally lowest in the more deprived areas in each district, with the exception of East Cambridgeshire. In Peterborough local data indicates that low levels of take-up correlate strongly with wards with high levels of deprivation. These areas also correlate to higher levels of childhood obesity as identified through the National Child Measurement Programme</p>	<ul style="list-style-type: none"> • Incorporate into the Healthy City Plan, and delivered through the • Joint commissioning across partners to ensure best use of available resources. • Extend Carnegie Weight Management Clubs for year 2 		<p>Cambridgeshire JSNA on preventing ill health in adults of working age http://www.cambridgeshireinsight.org.uk/currentreports/jsna-prevention-ill-health-adults-working-age-2</p> <p>Peterborough Obesity JSNA http://www.peterborough.gov.uk/pdf/HealthAndSocialCare-JSNA-Obesity.pdf</p>

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Area	Key issues	Recommendations	Gaps	Links and other notes
Obesity	<p>Levels of adult obesity in Peterborough are higher than the East of England (EoE) average, but very close to the England average rate. Peterborough continues to have a higher level of childhood obesity than most other areas within the EoE.</p> <p>Nationally the prevalence of obesity among adults has increased over recent years. The estimated levels of obesity in Cambridgeshire (22.1%) are significantly lower than in England (24.2%). Fenland, with estimated obesity at 25.8%, is significantly higher than the county level (22.1%) but is not in comparison to the national levels (24.2%).</p>	As above for physical activity	Interventions that focus on diet	<p>Peterborough JSNA on Obesity http://www.peterborough.gov.uk/pdf/HealthAndSocialCare-JSNA-Obesity.pdf</p> <p>Cambridgeshire JSNA on preventing ill health in adults of working age http://www.cambridgeshireinsight.org.uk/currentreports/jsna-prevention-ill-health-adults-working-age-2</p>
Alcohol	<p>Increased risk drinking in Peterborough estimated to be lower than the regional average amongst some of the lowest in the country, with Peterborough ranked the 34th lowest local authority area for levels of hazardous drinking.</p> <p>The prevalence of binge drinking in Peterborough (19.7%) is similar to the national level (20.1%).</p> <p>Data from 2009 found that about 30% of men drank more than the recommended limit. Overall, Cambridgeshire as a county compares well to the national average on statistics for alcohol misuse and harm, but Cambridge City is above the national average for a number of indicators including hospital admissions specifically caused by alcohol, aspects of alcohol related crime, and binge drinking.</p>	<p>The priorities for action, include</p> <ul style="list-style-type: none"> • Ensure effective performance monitoring of all services commissioned, and evaluated to • Assess quality and outcomes, in particular their impact in reducing alcohol-related hospital admissions. • Establish effective data collection • Review the capacity at each tier within the treatment • Develop work within hospital to support alcohol-specific interventions for individuals • Undertake work to establish a greater understanding of who and what contributes to admission to hospital under the category 'mental and behavioural disorders'. • Target particular geographical areas of need or high risk groups, including proactive screening 	Alcohol actions in Cambridgeshire?	http://www.peterborough.gov.uk/pdf/HealthAndSocialCare-JSNA-Alcohol.pdf

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Area	Key issues	Recommendations	Gaps	Links and other notes
		<p>within primary care</p> <ul style="list-style-type: none"> • Systematic Tier 1 provision of Identification on and Brief Advice (IBA) within a range • Consider how issues related to emerging trends of increased drinking at home could be best identified and addressed, instigate specific interventions for older men (and specific ethnic groups) to address their increased representation in hospital admissions. • Improve safety within the city centre and the night-time economy, planning the • Development of a more balanced night time economy. • • Address street drinking and its related anti-social behaviour through consistent use of the • Designed Public Places Order (DPPO) etc • Continue the robust management of licensees 		
Diet	<p>Less than half of all older people in Cambridgeshire are thought to consume a healthy diet and 20% of older people are thought to be obese. Significant numbers of the latter group are heavy drinkers.</p> <p>Peterborough:30% of adults consume five or more portions of fruit or vegetables every day (comparable to the national average</p> <p>There are no significant differences consumption of fruit and vegetables by adults across MSOAs in Peterborough.</p>		Dietary habits in Cambs and recommendations for this	<p>http://www.cambridgeshireinsight.org.uk/older-people-including-dementia/facts-figures-and-trends</p> <p>http://www.peterborough.gov.uk/health_and_social_care/joint_strategic_needs_assesmen/how_we_live_affects_our_health.aspx</p>
Smoking	Peterborough:			Peterborough Health and Social Care JSNA

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Area	Key issues	Recommendations	Gaps	Links and other notes
	<p>calculated prevalence of current cigarette is 27% which is significantly higher than England (22.2%)</p> <p>In 3 MSOAs nearly 40% of adults smoke (Orton Longueville (38.9%), Paston (42.3%) and North Bretton (42.4%).)</p> <p>Cambridgeshire: Smoking prevalence estimated at 11.5 % * (less than the English average in) but 26.1 % in people in routine and manual occupations</p>			http://www.peterborough.gov.uk/pdf/HealthAndSocialCare-JSNA-Smoking.pdf
				http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/101/page/0/par/E12000006/are/E07000008
Different population Groups		<p>To consider the needs and outcomes for particularly vulnerable or marginalised populations in Cambridgeshire – including Gypsies and Travellers, homeless people, migrant workers, people with learning disabilities, people with mental health needs, people with physical/sensory impairments, when developing or changing services</p>		<p>Cambridgeshire summary JSNA http://www.cambridgeshireinsight.org.uk/cambridgeshire-joint-strategic-needs-assessment-jsna/jsnasummaryreport2013</p>
Gypsies and Travellers	<p>Gypsies and Travellers make up almost 1% of the population in Cambridgeshire representing the largest ethnic minority in the county.</p> <p>Gypsies and Travellers have</p> <ul style="list-style-type: none"> • significantly poorer health status (in Peterborough only 55% reported no health problems) • more self-reported symptoms of ill-health than the rest of the population • reported health problems being between two 	<ul style="list-style-type: none"> • better data collection and ethnic monitoring. • promotion of immunisations and screening. • Mental health specialist support services. • Male health specialist support services. • More support around complex health needs. 	<p>Investigation into infant and maternal mortality and prevalence of disabilities</p>	<p>Cambridgeshire JSNA on travellers 2010 http://www.cambridgeshireinsight.org.uk/currentreports/travellers</p> <p>Peterborough JSNA _ We are not all the same http://www.peterborough.gov.uk/health_and_social_care/joint_strategic_needs_assesmen/we_are_not_all_the_same.aspx</p> <p>More information on Peterborough travellers in</p>

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Area	Key issues	Recommendations	Gaps	Links and other notes
	<p>and five times more prevalent.</p> <ul style="list-style-type: none"> • Poor mental health is a particular concern Access issues • Low uptake of early intervention and prevention measures such as screening and immunisation • Adverse rates of lifestyle risk factors such as rates of smoking and obesity. 	<ul style="list-style-type: none"> • Raising awareness of the Gypsy and Traveller community with professionals. • Training health champions from the Gypsy and Traveller community. 		<p>Facts and Figures JSNA http://www.peterborough.gov.uk/pdf/HealthAndSocialCare-JSNA-DemographicPopulation-FactsFiguresAndTrendsSection.pdf</p>
<p>Homeless people</p>	<p>Cambridge In 2010 the population of single homeless people and rough sleepers was estimated to be approximately 500. This group of people are approximately 7 to 8 times more likely to be admitted to hospital and have a mean age at death of 44 years. Mental health issues and substance misuse are common. In addition around 600 families are classified as "statutory homeless" each year and there are a number of "hidden homeless people" who are unrecognised by services.</p>	<p>Multiagency working</p> <p>Service user involvement in service design</p> <p>Information sharing to enable integrated client records</p> <p>Develop services enabling prevention of homelessness and early intervention for the newly homeless to improve individual lives and to reduce overall homelessness.</p> <p>Support is particularly required at transition points such as leaving care, prison release and A&E/hospital discharge. In addition services should be co-ordinated, accessible and responsive to the needs of the homeless population.</p> <p>Develop a strategy to address the health needs of the homeless population in Cambridgeshire as part of a joint commissioning strategy</p> <p>Recognise that the issues identified in this JSNA are ongoing</p>	<p>Quantification of homelessness and its effects in Peterborough</p>	<p>Peterborough JSNA on social and environmental context contains information on employment, housing etc http://www.peterborough.gov.uk/pdf/HealthAndSocialCare-JSNA-SocialAndEnvironmentalContext.pdf</p> <p>Cambridgeshire JSNA on people who are homeless or at risk of homelessness http://www.cambridgeshireinsight.org.uk/currentreports/people-who-are-homeless-or-risk-homelessness</p>

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Area	Key issues	Recommendations	Gaps	Links and other notes
Different ethnic backgrounds and Migrant workers	<p>Peterborough:</p> <ul style="list-style-type: none"> • Proportionally more Pakistani people aged 0 – 15 years and more white British people aged 65+. • There has been a steady rise in the numbers of pupils with English as an Additional Language (EAL) from 14.7% (2003) to 19.4% (2007). • The ten most common languages are English, Punjabi, Urdu, Polish, Portuguese, Slovakian, Lithuanian, Gujarati, Czech and Chinese. • 83 different languages were recorded are spoken as first languages by students in Peterborough schools 	<p>Recommendations (Cambridgeshire JSNA)</p> <ul style="list-style-type: none"> • Increase access to primary care health services with emphasis on health promotion and disease prevention. • Engage with employers and other stakeholders to establish networks for sharing information and good practice with the aim of promoting healthy work conditions • Improve access to language provision in terms of initial access to short term translation and interpretation facilities. • Improve the access and condition of appropriate housing in order to reduce migrant worker dependence on poor quality tied accommodation and Houses in Multiple Occupation (HMOs). • Improve organisations' adaptive capacity; ensuring that service providers are flexible enough to respond to the changing needs of the migrant population, a population that can be highly mobile and transient in nature. • Improve data collection to ensure more robust, timely and comprehensive data • Ownership needs to be multiagency. 	<p>Examine the needs of those who have no recourse to public funds or who are destitute in order to ascertain how these individuals and families may be best supported.</p>	<p>Peterborough demographic facts and figures page 17http://www.peterborough.gov.uk/pdf/HealthAndSocialCare-JSNA-DemographicPopulation-FactsFiguresAndTrendsSection.pdf</p> <p>Cambridgeshire Migrant workers JSNA http://www.cambridgeshireinsight.org.uk/currentreports/migrant-workers</p>
People with learning disabilities	<p>Cambridgeshire:</p> <p>As the population grows and ages, the number of people with disabilities is also expected to rise.</p>	<ul style="list-style-type: none"> • Health checks for adults with learning disability are important to reduce inequalities in accessing healthcare. 75% of 		<p>Cambridgeshire JSNA on adults and children with physical and learning disabilities through the life course http://www.cambridgeshireinsight.org.uk/j</p>

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Area	Key issues	Recommendations	Gaps	Links and other notes
	<p>Leading to an increased proportion of people with a learning disability aged over 55 so that parents caring for them are likely to have died or become frail.</p> <p>Social care requirements for people with learning disability in England are expected to increase by 14%, up to 2030.</p> <p>The number of children with disabilities is predicted to increase. The number of children with statements of special educational needs has increased in Cambridgeshire.</p> <p>People with learning disability in England are more likely to go into hospital for conditions that could have been treated in the community.</p> <p>People with learning disabilities in Cambridgeshire reported certain shortcomings in the provision of health care services, in 2007. This included:</p> <ul style="list-style-type: none"> a lack of easy read information; poor attitudes from some health staff towards people with learning disabilities and their carers; insufficient care available whilst person with learning disability is in hospital; inadequate hospital facilities, including access and delays in referrals. <p>Local surveys identified that people with autism have unmet needs, such as difficulties with identification and diagnosis, and lack of training amongst staff concerning people with autism with whom they came into contact</p> <p>In 2011-12, most cases of alleged abuse were for adults with learning disability, with most abuse occurring in the adults' own homes. There was an increase in safeguarding referrals for adults with learning disability, compared with the previous year, which is thought to reflect good practice in</p>	<p>eligible adults received a health check, in Cambridgeshire, in 2012</p> <ul style="list-style-type: none"> • Identifying adults with a learning disability on information recorded during a hospital admission is important to ensure reasonable adjustments are made. This is happening less often in Cambridgeshire, than the England average for psychiatric admissions. • Better sharing of information on people with a learning disability across agencies would allow us to assess the best place for care 		<p>oint-strategic-needs-assessment/current-jsna-reports/physical-disabilities-and-learning</p>

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Area	Key issues	Recommendations	Gaps	Links and other notes
	the community.			
People with mental health needs	<p>The prevalence of mental ill health among the working age population is high in Cambridge City because of the demography, new growth, higher levels of crime, alcohol related harm and suicide.</p> <p>Fenland also has a high prevalence of mental ill health due to the association between mental ill health and its determinants with deprivation. Suicide rates are high in Fenland.</p> <p>Homeless, Travellers and prison populations have high levels of mental ill health. Migrant workers and black and minority ethnic communities are also vulnerable and may have barriers to accessing mental health services.</p>	<ul style="list-style-type: none"> • Apply the comprehensive evidence base of what works to promote mental health and wellbeing in communities • Strengthen and extend partnership working to promote mental health and wellbeing, and provide responsive services by: Obtaining views of local stakeholders on all changes to mental health services to ensure they are patient-centred and socially inclusive. • Working with GP Commissioning Clusters to ensure equitable provision and targeting of mental health services based on needs assessments that identify the areas and populations at greatest need. • Review availability of counselling services for groups where evidence shows greatest benefit to include: • Applying learning and experience from the 14-19s IAPT pilot to implement a 'transition' service for primary care mental health • Ensure seamless service for those who do not meet criteria for the IAPT or secondary care services but can benefit from provision of 'talking therapies 	<p>There is a perceived need for more counselling services especially for those whose needs fell between the criteria for IAPT and secondary care. People making the transitioning into or out of adult mental health services need to be catered for. Young adults (17-22 years old) may find current local service models unattractive and people with young onset dementia often have very different needs to older people with dementia.</p> <p>There is robust evidence for interventions that have the largest impact on improving mental health and wellbeing for the general</p>	<p>Cambridgeshire JSNA mental health in adults of working age http://www.cambridgeshireinsight.org.uk/currentreports/mental-health-adults-working-age</p>

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Area	Key issues	Recommendations	Gaps	Links and other notes
			population. Current service provision is more focused on mental illness and further opportunities exist to invest in 'preventive' interventions in a range of settings e.g. workplace health and through different providers.	

Other links:

Peterborough JSNA front page: http://www.peterborough.gov.uk/health_and_social_care/joint_strategic_needs_assesmen.aspx

Cambridgeshire JSNA front page: <http://www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/what-jsna>

<http://atlas.hertslis.org/IAS/hwb/priorities/dementia.html>

Appendix 4: Assumptions underlying the PwC financial projections

Source: PwC

The following key assumptions were used in the financial projections shown in section 5.

Population growth rates: (percentages)

	2015	2016	2017	2018	2019
<i>Under 65</i>	0.73%	0.75%	0.74%	0.74%	0.71%
<i>65 to 85</i>	2.60%	2.18%	2.07%	1.99%	1.98%
<i>85+</i>	3.10%	3.19%	3.55%	2.22%	2.28%

Source: <http://www.ons.gov.uk/ons/rel/snpp/sub-national-population-projections/Interim-2011-based/rft-syoo-persons.zip>

Population growth rates: (absolute numbers, in thousands)

	2015	2016	2017	2018	2019
<i>Under 65</i>	807	813	819	825	831
<i>65 to 85</i>	141	144	147	150	153
<i>85+</i>	19	20	21	21	22

Cost inflation rates:

	2015	2016	2017	2018	2019
<i>Cost inflation</i>	2.60%	2.90%	4.40%	3.40%	3.30%

Source: <http://www.monitor.gov.uk/sites/default/files/publications/GuidanceAnnualPlanningReview2014-15Revised.pdf>

Inflation rates:

	2015	2016	2017	2018	2019
<i>Inflation</i>	2.1%	2.00%	2.00%	2.00%	2.00%

Source: <http://cdn.budgetresponsibility.independent.gov.uk/Economic-and-fiscal-outlook-December-2013.pdf>

Provider efficiency rates (assuming leakage does not fall):

	2015	2016	2017	2018	2019
<i>Provider efficiency</i>	4%	4.5%	4%	4%	4%

Source: <http://www.monitor.gov.uk/sites/default/files/publications/GuidanceAnnualPlanningReview2014-15Revised.pdf>

Appendix 5: Care Design Group Outputs

Elective 1: Primary Care Referral Protocols

Summary of the idea / option	There should be consistent thresholds for referral to elective care across the whole LHE to ensure consistent and cost effective patient navigation and gatekeeping. Regular review of deviations from these protocols would inform pathway refinement.
Issues addressed	Lack of consistency in referral processes leading to confusion for both referrers and providers. A perceived high rate of unnecessary referrals. Better awareness and usage of currently underused services across the LHE.
Clinical outcomes	Pathways would be clearly defined, and constantly improved through a robust feedback loop. Referral protocols would empower GPs, who would be able to make more informed decisions on where to send their patients.
Financial outcomes	Reduction in the number and cost of unnecessary referrals.
Challenges and risks	Time will be required to develop protocols that are agreed upon by all parties. GPs would need to be incentivised to use the referral protocols. IT systems may not currently be fit for purpose.
Additional information or analysis required	What will the referral protocols look like? What information will they consider? What will the process for defining the referral protocols look like? How will they be continually refined? What enablers will be required beyond a shared IT system? Referral protocols into C&P from other LHE will need consideration as these will differ.
Interdependencies	Local examples already in place (for example, the MSK pathway in Peterborough). Elective 2: Patient flow planning and aligned patient flows to relevant care environments to optimise efficiencies and post-operative care Enabler: single IT system.
Delivery requirements	Improved, shared IT systems. A shared approach to developing referral protocols, involving all major stakeholders. A defined rollout programme to gain support and test the quality and financial benefits and risks. Consistent referral protocols for all major elective pathways, supported by a map of services. A robust process for identifying deviations from protocols and learning from them.

Elective 2: Patient flow planning and aligned patient flows to relevant care environments to optimise efficiencies and post-operative care

Summary of the idea / option	<p>Earlier and better forward planning for discharge and community care following a secondary care admission is needed to ensure that care is delivered in the most clinically and financially viable location, with the emphasis on greater provision in the community and on patient self-care.</p> <p>Post-operative care planning to occur at the same time as pre-operative planning. That would also ensure that post discharge support arrangements (physiotherapy, medical equipment, care support packages etc.) are available in time for medically defined discharge.</p>
Issues addressed	<p>The perception that discharge from acute settings is delayed due to a lack of early planning.</p> <p>Poor patient experience and other issues caused by organisational boundaries.</p>
Clinical outcomes	<p>Greater coordination between acute, community and primary care resulting in a more seamless experience for the patient.</p>
Financial outcomes	<p>Reduced delayed transfers of care; costs saved by reducing unnecessary stays in acute beds.</p>
Challenges and risks	<p>Significant changes to IT systems would be required to support a delivery model of this nature.</p> <p>Organisational boundaries and payment mechanisms do not currently incentivise this approach to care.</p> <p>Agreement over defined pathways required from all stakeholders.</p>
Additional information or analysis required	<p>Should there be a single responsible clinician or organisation for a full pathway?</p> <p>What else will be required to make this happen?</p> <p>Dependencies between organisations and between pathways will need to be understood.</p>
Interdependencies	<p>Local examples already in place (for example, the MSK pathway in Peterborough).</p> <p>Elective 1: Primary Care Referral Protocols</p> <p>Enabler: single IT system.</p>
Delivery requirements	<p>Single patient record and shared IT systems.</p> <p>Further detail to be explored in additional phases of work.</p>

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Elective 3: Patients who should not be in an acute setting would not be there any longer

Summary of the idea / option	Ensure patients are treated in the most appropriate setting, i.e., ensure patients that are being cared for in an acute setting that don't need to be there are cared for in the most clinically appropriate setting as close to home as possible.
Issues addressed	The perception that many activities currently carried out in an acute environment could be carried out at a community based site by different health care professionals. A lack of integration in the provision of care between community and acute settings.
Clinical outcomes	Improved coordination between care providers (primary, social, community and acute care). Improved patient experience by providing care in a more appropriate setting.
Financial outcomes	Providing services in a community setting is often better value for money. Reducing services that are currently duplicated in both acute and community settings.
Challenges and risks	There may not currently be the capacity to provide these services in a community setting (estate, workforce and other enablers will be required). Organisational boundaries may create challenges. Incentives (e.g. PbR) do not currently encourage the provision of care in the community. Efforts to date have had limited success in many areas (e.g. the Better Care Fund).
Additional information or analysis required	What is the most appropriate setting for all major pathways? What are the detailed requirements in terms of infrastructure, workforce, funding and IT? Which organisation would be responsible for care and how would it be governed?
Interdependencies	Elective 1: Primary Care Referral Protocols Elective 2: Patient flow planning and aligned patient flows to relevant care environments to optimise efficiencies and post-operative care Urgent 4: Discharge planning, including early supported discharge to ensure that patients do not stay in hospital for longer than they need to
Delivery requirements	Further modelling on patient need will be required to understand how care can be delivered in the community. This will be explored further in later phases of work.

Elective 4: Single provider for specific elective services

Summary of the idea / option	Use of a single provider or a single, shared protected site for elective work – shared by all organisations, including profit sharing arrangements. It was noted that patients would be happy to travel if in return cancellations were reduced and outcomes improved.
Issues addressed	Services are delivered by multiple providers in many different settings; in some cases there may not be the critical mass for safe delivery. There is a high rate of cancelled operations due to non-clinical reasons across the LHE.
Clinical outcomes	Complex procedures will be centralised to create a critical mass, leading to safer delivery of services and better outcomes for patients. Separating elective activity and urgent activity will reduce the risk of cancelled operations and will create a better patient experience.
Financial outcomes	Reduction in the duplication of service provision, and more straightforward care pathways. Better economies of scale. Centres of excellence may attract staff, addressing some recruitment challenges.
Challenges and risks	Maintenance of patient choice. How will services with lower activity levels be delivered safely?
Additional information or analysis required	Where should services be delivered? Which provider will be responsible for which service? How will current enablers (estate, workforce etc.) be used to deliver this new model?
Interdependencies	Elective 1: Primary Care Referral Protocols Elective 5: Jointly owned, risk shared "cold site" for elective work
Delivery requirements	To be considered further in later phases of work.

Elective 5: Jointly owned, risk shared "cold site" for elective work

Summary of the idea / option	Consideration as to whether a cold site could be jointly owned (using a risk sharing approach) by various provider trusts in order to deliver higher standard of care, cost efficiencies, better service to patients and to try to avoid planned treatments being cancelled due to the need to carry out emergency treatments.
Issues addressed	Services are delivered by multiple providers in many different settings; in some cases there may not be the critical mass for safe delivery. There is a high rate of cancelled operations due to non-clinical reasons across the LHE.
Clinical outcomes	Complex procedures will be centralised to create a critical mass, leading to safer delivery of services and better outcomes for patients. Separating elective activity and urgent activity will reduce the risk of cancelled operations and will create a better patient experience.
Financial outcomes	Reduction in the duplication of service provision, and more straightforward care pathways. Better economies of scale. Centres of excellence may attract staff, addressing some recruitment challenges.
Challenges and risks	How will the joint ownership and risk sharing arrangement work? How will the shared site be governed? If an existing site is used as a "cold site", how will urgent care be delivered safely across the remainder of the sites?
Additional information or analysis required	Where should services be delivered? How will current enablers (estate, workforce etc.) be used to deliver this new model?
Interdependencies	Elective 1: Primary Care Referral Protocols Elective 4: Single provider for specific elective services
Delivery requirements	To be considered further in later phases of work.

Cambridgeshire and Peterborough health system Blueprint 2014-2019

Urgent 1: Single point of access (SPA) for patients

Summary of the idea / option	There should be a single point of access for patients (initially by phone). This might be different for patients previously unknown to the systems, compared to those who have been admitted before. For those known to the system, records should be easily accessible, and the appropriate care coordinators should be notified.
Issues addressed	There are multiple points of access for patients, leading to inconsistencies in the way that patients are cared for. There is no single directory of services for all providers and referrers.
Clinical outcomes	Greater coordination between all services and organisations. Patients will be treated in the service and location that best suits their diagnosis and need; this will improve quality. Resources across the LHE will be utilised more appropriately.
Financial outcomes	Economies of scale. The cost of running various points of access will be reduced.
Challenges and risks	A number of points of access already exist (GPs, 111, 999); a single point of access must not simply add another point of access. Reliant on robust IT services and highly qualified staff manning the service; there is a risk that delays are caused if this does not function appropriately.
Additional information or analysis required	Which services will the SPA address; will this include acute hospital care, or only community and mental health? How will the existing points of access (GPs, 111, 999) be included in this new configuration? What additional resources are required (infrastructure, IT, workforce etc.)? How will this work across organisational boundaries?
Interdependencies	Urgent 2: Single point of access for professionals Urgent 3: Front end A&E model
Delivery requirements	Assess the need for infrastructure, IT and workforce further? Study LHEs where this model has been successfully implemented.

Cambridgeshire and Peterborough health system Blueprint 2014-2019

Urgent 2: Single Point of Access for Professionals

Summary of the idea / option	There should be a single point of access for professionals to access (for example, RADAR, crisis support, social care etc.)
Issues addressed	There are multiple points of access for patients, leading to inconsistencies in the way that patients are cared for. There is no single directory of services for all providers and referrers.
Clinical outcomes	Faster decision making, in particular for complex patients. Greater coordination between all services and organisations. Patients will be treated in the service and location that best suits their diagnosis and need; this will improve quality. Resources across the LHE will be utilised more appropriately.
Financial outcomes	Economies of scale. The cost of running various points of access will be reduced.
Challenges and risks	Reliant on robust IT services and highly qualified staff manning the service; there is a risk that delays are caused if this does not function appropriately.
Additional information or analysis required	What form will this service take; will it be a directory of services, or will it include qualified staff who can refer patients? Which services will the SPA address; will this include acute hospital care, or only community and mental health? How will the existing points of access (GPs, 111, 999) be included in this new configuration? What additional resources are required (infrastructure, IT, workforce etc.)? How will this work across organisational boundaries?
Interdependencies	Urgent 1: Single point of access for patients Urgent 3: Front end A&E model
Delivery requirements	Assess the need for infrastructure, IT and workforce further? Study LHEs where this model has been successfully implemented.

Urgent 3: Front end A&E model

Summary of the idea / option	Adopt a consistent front end A&E model that enhances the “see and immediately treat” service to ensure that only those that need to be cared for in the acute setting are admitted to hospital and patients are seen at the right place, right time by the right professional.
Issues addressed	<p>Increasing rates of A&E attendances, coupled with increased acuity, is placing pressure on existing urgent care services and increasing the cost of provision.</p> <p>There are a number of schemes to improve the efficiency and quality of care provided in A&Es, but these are not consistent across the LHE.</p>
Clinical outcomes	<p>Improved quality of care for patients attending A&E.</p> <p>Alternatives to A&E better signposted to absorb growth in demand.</p> <p>Patients will access the right service, rather than the one that they first arrive at.</p>
Financial outcomes	<p>Reduction in the number of A&E admissions and urgent bed days.</p> <p>Potentially may reduce demand for other urgent services.</p>
Challenges and risks	<p>Inconsistency in provisions across the LHE may present challenges in adopting a single model of provision in A&E.</p> <p>National shortages in staff for A&E.</p> <p>Historic attempts at patient education to reduce the demand on urgent care services have had limited impact.</p>
Additional information or analysis required	<p>What are the current schemes and provisions in place for the urgent care pathway across the LHE?</p> <p>Do we understand the details of patient flows, including variation by time, day and seasons? How does this affect demand, and can we predict it more accurately?</p> <p>What approaches have been taken elsewhere to improve patient awareness of A&E alternatives?</p>
Interdependencies	<p>Local examples already in place, for example, the use of the RAT model at PSHFT.</p> <p>Urgent 1: Single point of access for patients</p> <p>Urgent 2: Single point of access for professionals</p> <p>Urgent 5: Regrading of an A&E unit following reconfiguration of services within the Local Health Economy to provide better quality of care, more cost effectively</p>

Delivery requirements	<p>More effective “gatekeeping” to prevent inappropriate A&E attendances.</p> <p>Consideration of the long term model of urgent care provision, including reconfiguration of the current services, for example, the co-location of GP and minor injury units at the same site as A&E departments.</p>
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Urgent 4: Discharge planning, including early supported discharge to ensure that patients do not stay in hospital for longer than they need to.

Summary of the idea / option	Enhanced Discharge planning by ensuring practice is consistent across the LHE and is consistent with best practice, using, as appropriate, early supported discharge and discharge to assess. This option will overlap with proactive care interventions and dependent on accessibility and effectiveness of whole system working.
Issues addressed	<p>The perception that many activities currently carried out in an acute environment could be carried out at a community based site by different health care professionals.</p> <p>A lack of integration in the provision of care between community and acute settings.</p>
Clinical outcomes	<p>Improved coordination between care providers (primary, social, community and acute care).</p> <p>Improved patient experience by providing care in a more appropriate setting.</p>
Financial outcomes	<p>Providing services in a community setting is often better value for money.</p> <p>Reducing services that are currently duplicated in both acute and community settings.</p>
Challenges and risks	<p>There may not currently be the capacity to provide these services in a community setting (estate, workforce and other enablers will be required).</p> <p>Organisational boundaries may create challenges.</p> <p>Incentives (e.g. PbR) do not currently encourage the provision of care in the community.</p> <p>Efforts to date have had limited success in many areas (e.g. the Better Care Fund).</p>
Additional information or analysis required	<p>What is the most appropriate setting for all major pathways?</p> <p>What are the detailed requirements in terms of infrastructure, workforce, funding and IT?</p> <p>Which organisation would be responsible for care and how would it be governed?</p>
Interdependencies	Elective 3: Patients who should not be in an acute setting would not be there any longer

Delivery requirements

Further modelling on patient need will be required to understand how care can be delivered in the community. This will be explored further in later phases of work.

Urgent 5: Regrading of an A&E unit following reconfiguration of services within the Local Health Economy to provide better quality of care more cost effectively.

Summary of the idea / option

The closure of an A&E with the Local Health Economy may be possible following reconfiguration of services and investment in certain areas to support the new model. Efficiencies could be achieved from the closure of any A&E through improved economies and also utilising “out of hospital” urgent care facilities.

This would likely entail:

- Usage of 24/7 rotas;
- Required consultants to be available 24/7; and

Efficiencies would arise through savings on middle grade doctors, nursing staff, diagnostics and facility costs through economies of scale.

Issues addressed

A perceived view that urgent care services are dispersed over too many sites in the LHE.
Low activity at some urgent care sites.

Clinical outcomes

Emergency services will be concentrated on a smaller number of sites, allowing for greater specialism and experience.
May address challenges in recruiting emergency care clinicians.

Financial outcomes

Economies of scale will reduce the cost of delivering urgent care.
Patients will be seen at an appropriate site (better use of urgent care centres).

Challenges and risks

Increased pressure on other sites (including A&E and other urgent care services) which may worsen quality of care and increase financial pressure.
Public and political acceptance of a proposal of this nature.

Additional information or analysis required

Detailed modelling of the impact of the regrading of various sites across the LHE, to understand the impact it may have both within and outside the LHE.

Interdependencies

Urgent 3: Front end A&E model.

Delivery requirements	<p>Significant consultation process would be required if this is determined to be a viable option.</p> <p>Detailed modelling to understand the impact on other services, sites and LHEs.</p> <p>Improved “gatekeepers” to A&E will be required to minimise pressure on other sites, accompanied by strong patient education.</p>
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Urgent 6: Closer links between GPs and the ambulance service

Summary of the idea / option	A scheme in South Warwickshire has GPs undertaking shifts with the ambulance service. GPs attend emergencies instead of ambulance crews, reducing the number of ambulance call outs and also the number of conveyances to hospital.
Issues addressed	<p>The number of ambulance attendances where conveyance to hospital is not required.</p> <p>The number of attendances at A&E where primary care would be appropriate.</p>
Clinical outcomes	Appropriate treatment for patients who require medical attention, whilst avoiding hospital admissions.
Financial outcomes	<p>Reduction in the number of ambulance attendances where conveyance to hospital is not required.</p> <p>Reduction in the number of attendances at A&E.</p>
Challenges and risks	<p>Availability of GPs; staff shortages are already a risk without additional roles.</p> <p>GPs faced with more acute clinical presentations that may be rare in a traditional primary care environment; additional training may be required.</p>
Additional information or analysis required	Further information on the South Warwickshire scheme, including the cost of implementation and resource requirements.
Interdependencies	Urgent 3: Front end A&E model.
Delivery requirements	Further detail to be explored with South Warwickshire.

Appendix 6: Summaries of proposed further CDG areas

OLDER PEOPLE PROGRAMME	
Summary of the idea / option	<p>The CCG wants to achieve the overall ambitions of improving outcomes and improving patients’ experiences of older people services. Our vision is for older people’s services to be organised around the needs of the patient, not around organisational structures. The objective is to make sure older patients have the right support to stay healthy, to maintain their independence and to receive care in their home or local community whenever possible with hospitalisation as a last resort. To do this, our aim is to improve the way services are organised and the way they work together to provide a seamless pathway for older people.</p> <p>To achieve our vision, we are tendering a contract for Integrated Older People’s services and Adult Community Services using a 5 year outcomes-based contract.</p> <p>http://www.cambridgeshireandpeterboroughccg.nhs.uk/older-peoples-programme.htm</p>
Issues addressed by this idea / option	<p>The case for change includes:</p> <ul style="list-style-type: none"> • Substantial growth in the numbers and proportion of older people • minimal financial growth in the health sector, alongside reductions in funding for Local Authorities • shortcomings in current service provision, which result in poor patient experience and clinical outcomes for patients. <p>The critical success factors for the programme are:</p> <ol style="list-style-type: none"> a. Improve patient experience and service quality for older people and their carers through care organised around the patient b. Deliver services which are sensitive to local health and service need, as defined in local outcome specifications c. Move beyond traditional organisational and professional boundaries, so front-line staff can work effectively and flexibly together to deliver seamless care d. Supporting older people to maintain their independence, and reducing avoidable emergency admissions, re-admissions and extended stays in acute hospitals (including delayed transfers of care) e. Deliver an organisational solution for the older people’s care which can demonstrate strong leadership, sound governance, resilience, and the confidence of commissioners and provider partners f. Demonstrate credible approach to engaging patients and representative groups in design and delivery of services g. Provide a sustainable financial model (see financial principles below)

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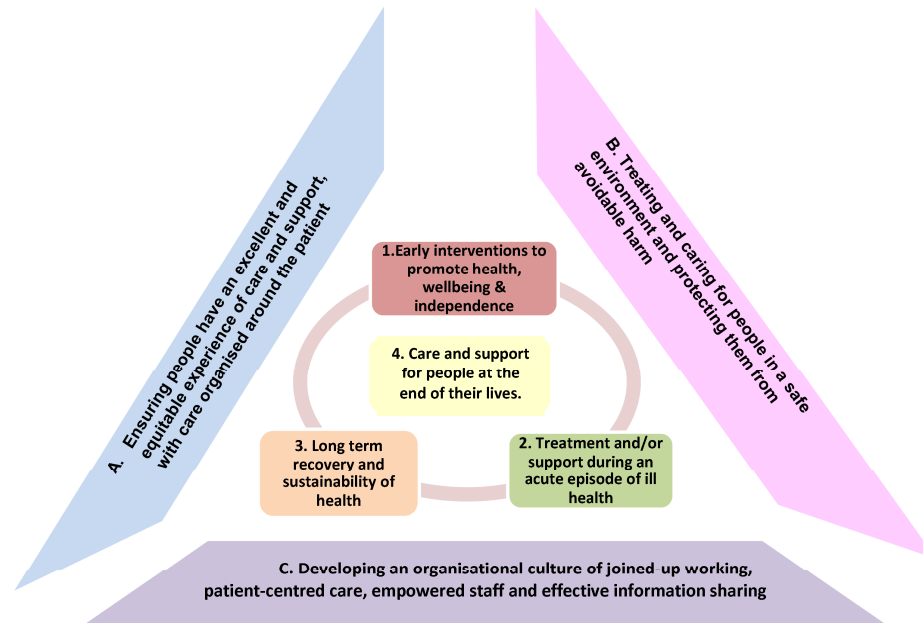
OLDER PEOPLE PROGRAMME

Clinical outcomes

Our approach is based on improving outcomes for patients (both clinical outcomes and patient experience outcomes). For this purpose we have developed an Older Peoples Outcomes Framework. The Framework is composed of outcomes built around the patient pathway (domains 1-4 in the diagram):

1. Prevention and early intervention
2. Rapid response
3. Long term recovery
4. Care and support for people at the end of their lives

There are an additional three overarching domains (A-C) which include patient experience, patient safety, and organisational culture.



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In each domain there are specific outcomes with indicators underpinned by technical specifications. See diagram below
 The Outcomes Framework will be built into the contract with the Older People's and Adult Community Services provider against which they will be performance managed and part of their remuneration will be based on the achievement of outcomes.

Figure 3: Draft Outcomes Framework for Older People and Adult Community services to improve

health, wellbeing and maintain independence

Overarching domain A: Ensure people have an excellent and equitable experience of care and support with care organised around the patient and their carers/family

- A.1 Patients and their carers, have an overall excellent experience of care and support.
- A.2 Patients and carers experience effective, joined-up working and co-ordinated care.
- A.3 Patients and carers are aware of, and involved in, the

Overarching domain B: Treat and care for people in a safe environment and protect them from avoidable harm

- B.1 There is a reduction in premature mortality from major causes of death.
- B.2 There is a reduction in the number of adverse experiences for patients and carers

Overarching domain C: Develop an organisational culture of joined-up working, patient centred care, empowering staff and effective information sharing

- C.1 Staff, and whole organisations, are committed to working in a joined up and integrated way and integrated working is evident across and within organisational boundaries...
- C.2 There is evidence of progress towards transformational

Pathway domain 1: Support older people and people with long term conditions (LTCs) through early interventions and evidence-based care to improve their health, wellbeing and maintain their independence

- 1.1 Individuals with long term conditions experience improved control and reduced complications.
- 1.2 All individuals with a long term condition (under the care of community services), and their carers, feel supported to manage their condition and maintain their independence.
- 1.3 The health and independence of frail older people is maintained or improved through proactive identification, assessment and care planning.
- 1.4 There is a reduction in the number of older people who suffer injury and/or fractures from a fall.
- 1.5 Individuals experience improved mental health and wellbeing and quality of life through early support and diagnosis.
- 1.6 Evidence-based advice and interventions are made available to all people in contact with community services to promote healthy lifestyles and behaviours

Pathway domain 2: Support older people and those with a LTC with an acute deterioration or inability to cope at home, to prevent avoidable admissions and reduce unnecessary hospital stays

- 2.1 There is a reduction in the number of days spent in hospital (from emergency admissions) by those aged 65 and over.
- 2.2 The impact of the programme on planned care is assessed and not adversely impacted.
- 2.3 The community team effectively manages acute health episodes, minimising unnecessary hospital admissions where medically appropriate.
- 2.4 When referred to hospital or presenting to A&E frail older people are pro-actively managed along an integrated frailty pathway.
- 2.5 Patients aged 65 and over and those with LTCs experience a timely and supported discharge from acute or community settings.

Pathway domain 3: Promote recovery, rehabilitation and sustainability of health and functional status after a period of ill health or injury, with supported discharge and reduced readmissions

- 3.1 Patients make a sustainable recovery after admission to acute or intermediate care, with no avoidable deterioration in health.
- 3.2 Patients feel supported in the community following discharge and during their recovery period.

Pathway domain 4: Optimise the experience of care of people approaching the end of their lives (and their carers) in all settings and at all times of the day and night

- 4.1 The quality of care experienced by the person who died, and their families, as reported by carers, was excellent.
- 4.2 Community staff are trained and enabled to look after those who are dying in an appropriate and compassionate way.
- 4.3 Those who are dying can access high quality care which is co-ordinated across different agencies and staff.

<http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/CCG/Have%20your%20say/Outcomes%20Framework%20Mark%202%20-%20final.pdf>

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OLDER PEOPLE PROGRAMME

Financial outcomes -	<p>The financial outcome will be to provide a sustainable financial model with the following financial principles:</p> <ul style="list-style-type: none"> • Aligning improved patient outcomes with financial incentives • Sharing financial gain and risk across the commissioner – provider system • Delivering recurrent financial balance in a sustainable way • Creating the conditions for investment and delivering a return on investment
Challenges and risks	<p>The challenge is achieve the overall ambitions of improving outcomes and improving patients’ experiences of older people services whilst also meeting the programme’s critical success factors.</p> <p>The overall risk is that we do not achieve our vision and our critical success factors. The programme has a comprehensive risk register including risks around:</p> <ul style="list-style-type: none"> • Clinical ownership • Communications and engagement generally • Contracting and legal risks • Finance and achieving the financial outcomes above • High dependency areas including the future of PSHFT and older people’s mental health • Social service integration, funding and use of the better care fund • The procurement • The timeline • Mobilisation including estates, IM&T and workforce
Interdependencies with other proposed or existing programmes	<p>The future of providers in the Cambridgeshire and Peterborough CCG footprint</p> <p>Developments around the Better Care Fund and other functional / contractual integration with Local Government services</p>
Delivery requirements -	<p>The programme will bring about many changes in our way of working and delivery including the use of a capitated budget, an outcomes based longer-term contract, workforce changes, estates changes and information technology changes</p>

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OLDER PEOPLE PROGRAMME

Impact on health inequalities

We are carrying out an 'Equalities Impact Assessment' (EIA). The EIA contains an outline of the means by which the CCG has gathered evidence in relation to groups with protected characteristics and patients who may face inequalities. The inequalities could be in regard to either access to, or outcomes from the proposals. The EIA also contains a description of the positive and negative impacts in respect of those groups and patients arising from the proposals. It will include consideration of how the CCG's proposals, in relation to the reconfiguration of services for older people, could be amended to improve the experience of people with protected characteristics or those patients who may face inequalities.

Using the EIA as a tool, we need to ensure the new services offer equitable access and outcomes to all, hence decreasing health inequalities. The EIA can be found at:

<http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/CCG/Have%20your%20say/Equality%20Impact%20Assessment%20-%20final.pdf>

Mental Health

MENTAL HEALTH	
Summary of the idea / option	<ol style="list-style-type: none"> 1. A further programme of mental health service transformation to reflect the latest evidence base and thinking on the “recovery” model for mental health. 2. Greater partnership working with local authority commissioners, housing providers, the voluntary sector, community services and primary care 3. Greater use of the potential of technology such as apps to support patients in the community. 4. Improved information provision/ information sharing processes with appropriate governance in place 5. Integrated physical/mental health approach to patient care
Issues addressed by this idea / option	<ol style="list-style-type: none"> 1. Consensus amongst service users and carers that community based care is usually the preferred option over acute ward admission, provided risks can be managed and sufficient community support is available. 2. More patients could be supported in the community if “non-medical” issues such as housing and employment were addressed. 4. The requirement to continue to deliver annual cost improvements and also the level of QIPP savings from mental health set out in the CCG’s five year plan. 5. Greater coordination between health and local authority commissioners (both social care and housing) will be critical to the success of any transformed service model designed to support more patients to remain in the community. This is a particular challenge for the CCG because we will need to work closely with a range of local authorities across Cambridgeshire and Peterborough. 6. Delivery of key national guidance such as Closing the Gap and Crisis Care Concordat. 7. Duplication of services will be reduced by integrated physical/mental health care
Clinical outcomes	<ol style="list-style-type: none"> 1. We routinely measure both clinical and non-clinical outcomes for people with mental health problems, reflecting the importance of non-clinical measures in terms of most patients’ overall quality of life and recovery. 2. The clinical outcomes we anticipate include measurable improvements in patient reported levels of health and wellbeing, both in terms of mental and physical health. 3. The non-clinical outcomes we anticipate include a range of social inclusion measures around work, employment, social contact etc. 4. Patients receive integrated care.

MENTAL HEALTH

Financial outcomes -	<p>Delivery of 4% annual cost improvement plus the QIPP savings requirements attached to mental health in the 5 year plan. Therefore it is essential that the CCG's 5 year plan is clear as to:-</p> <ul style="list-style-type: none"> • the level of financial savings required from mental health services; • any additional investment planned to meet population and acuity growth; • the investment plan for IAPT services in order to meet national access targets;
Challenges and risks	<p>Our main challenges arise from:-</p> <ol style="list-style-type: none"> 1. Our relatively low investment in mental health, making further savings extremely challenging; 2. The rapid growth in the local population, especially of older people; 3. Meeting the national requirement for IAPT access targets from the current MH budget will necessitate redeployment of resources away from areas of greatest clinical priority e.g. services for patients with severe/complex MH needs; 4. The reliance on local authority commissioners for community support services and suitable housing solutions; 5. Resources will need to be redeployed from secondary to primary care to enable primary care to manage an increasing number of patients, 6. The level of innovation and redesign has been very good and there is lack of clarity as to what else can be done to deliver savings, other than by decommissioning essential core services for vulnerable patients with significant mental health needs. 7. The recent focus of "parity of esteem" between physical and mental health has highlighted the strong link – i.e. good mental health improves physical health outcomes. This focus has highlighted the fact that under investment in mental health may actually increase costs across the local system. 8. National guidance sets service requirements and minimum standards which are not all deliverable within the existing mental health services budget e.g. Crisis Care Concordat
Additional information or analysis required	<ol style="list-style-type: none"> 1. We still lack robust information on the cost of each of the pathways that we commission and the patient outcomes that they deliver. Preparation for "care pathways and pricing" (formerly PBR) will help address this but progress is slow and hampered by poor data quality. This is a longstanding problem for mental health services nationally. A number of initiatives to improve information provision and financial transparency are ongoing. 2. Evidence of innovative cost effective service models elsewhere which could be implemented locally.

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<p>Interdependencies with other proposed or existing programmes</p>	<ol style="list-style-type: none"> 1. Enhanced mental health input into physical health services - both hospital and community based - would improve patient experience, clinical and quality of life outcomes, and lead to significant savings (as evidenced by liaison psychiatry and IAPT for people with long term conditions). 2. OPAC-the integrator and their approach after the 18 month subcontract could vastly alter the delivery of all mental health services 3. Children’s services redesign-a decision to commission an integrated model could impact on the proposed redesign 4. Better Care Fund –the bids proposed form part of the proposed service model, if these are not successful this will result in reduced service delivery.
<p>Delivery requirements -</p>	<p>Our redesign/transformation plans will require further radical changes in workforce, skills and methods of working, information technology use, and support for primary care, etc. We are currently developing a service redesign process with the following key stages:-</p> <ul style="list-style-type: none"> • A programme of service user engagement during the next 2-3 months - to gather key messages about priorities and what they seek most from the mental health services that they access; • Meetings with each Local Commissioning Group to gather local GP feedback on the main priorities for their patients and how services might be designed differently; • Parallel meetings with the local voluntary sector to gather views on the current challenges and their potential role in future solutions; • Ongoing meetings between GP commissioners, local authority colleagues and senior CPFT clinicians - to explore potential new service models that reflect the feedback received from service users and other key stakeholders; • An extensive programme of stakeholder engagement, likely to include a formal public consultation to gather feedback about the redesign proposals that will have been developed by that time; • Local commissioner review of the feedback received from this engagement, consideration of recommended changes to the original proposals and presentation of revised proposals to the CCG Governing Body and appropriate local authority decision making meetings for approval; • Regular briefings for local Health Committees (formerly Scrutiny Committees); <p>Additional commissioning time may be required.</p>

MENTAL HEALTH

Impact on health inequalities

1. There remain significant inequalities in access to specialist mental health services across different areas of the CCG. The size of these inequalities is difficult to quantify because of poor quality data on service delivery, but it does reflect:-
 - Different levels of investment and disinvestment in mental health services by predecessor PCTs;
 - Significant additional resources in the Cambridge area arise from academic links;
 - There is a greater volume of voluntary organisation activity in the Cambridge area, much of this is not funded by statutory bodies such as the CCG;
2. The poorest access is in the areas of greatest deprivation – itself an accurate predictor of poor mental health. Peterborough, Fenland and Cambridge City, have greater deprivation although there are “pockets” of deprivation and poor mental health in all areas of the CCG.
3. There is continued underinvestment in mental health services compared to other areas of the health economy within the CCG

Women and Children

WOMEN AND CHILDREN	
Summary of the idea / option	<p>The Children Programme Board is taking forward a number of projects in order to address locally identified issues. A major part of this work will focus around the comprehensive review of maternity, children and young peoples health services which is due to start in June 2014. It is likely that the result of this review will be a comprehensive redesign of these services which will be aligned with the Principles of the East of England Strategic Clinical Network which are:</p> <ol style="list-style-type: none"> 1. Child and Family Focused- we will ensure the voices of children, young people and their families are heard throughout the health care systems and their needs drive planning and delivery in collaborative with clinical expertise 2. Health Promotion – we will prioritise investment ad resources to improve the health and wellbeing of our children and young people 3. Transformation – we will invite children, young people and families to be active participants in the review and future design of services 4. Settings- we will offer children, young people and families services in settings where they feel welcome, comfortable, safe and cause as little disruption to family life as possible 5. Information and Communication – we will share the best information and intelligence between professionals and with children, young people and their families to allow the best possible healthcare 6. Evidence based and Sustainable – we will commission and deliver services to consistent standards, informed by best practice and available evidence. All children and young people will have equitable access to services to meet their needs
Issues addressed by this idea / option	<p>The following emerging priorities have been identified by both Cambridgeshire and Peterborough JSNA’s and the East of England Strategic Clinical Network</p> <ol style="list-style-type: none"> 1. Promote good health- reducing risks (smoking, obesity) 2. Identify high risk pregnancies/women with complex conditions 3. Promote good holistic health (Healthy Child Programme) 4. Early recognition of ill health 5. Safeguarding children and young people 6. Prevention and early detection of illness in Primary care, effective, safe, efficient and appropriate emergency and urgent care 7. Effective, efficient and best practice management of Long Term Conditions 8. Early engagement integral to service design and pathway delivery 9. Integrated pathways of complex care include transitional elements LTC – asthma, diabetes, epilepsy and cancer, CAMHS, SEND and Palliative Care

WOMEN AND CHILDREN

	<p>10. Maternal mental health assessments included in Maternity Pathway 11. Services are seamless integrated and centred around the patient Services offered by providers match population health need and ensure enough provision where there is increased deprivation</p>
Clinical outcomes	<p>1. Reduction in the incidence of infant mortality including still births 2. Reduction in the incidence of child and young person mortality 3. Reduction in Child and Young Person unplanned hospital attendance 4. To improve engagement of women, children and young people – experience of maternity and children’s services 5. To promote an effective transition for children into adulthood 6. To improve the mental health and wellbeing of women and children</p>
Financial outcomes -	<p>There will be some medium term savings to be gained from admissions avoidance for common conditions such as Asthma, Diabetes and Epilepsy which will be better managed in the community. Longer term savings will be gained from reductions in unplanned hospital admissions for children and young people, reductions in health conditions relating to smoking and obesity, a reduction in accidents and injuries in children and young people and improvements in maternal health and wellbeing.</p>
Challenges and risks	<p>Challenges:</p> <ol style="list-style-type: none"> 1. Development of sustainable and high quality services 2. Ensuring services maintain Child, Young person and family focus 3. Addressing Inequalities in provision 4. 23.7% estimated local population growth in 0-19 year olds over next 5 years 5. Poor Outcomes <p>Risks:</p> <ol style="list-style-type: none"> 6. Workforce- difficulties in recruitment , increases in costs, reductions in establishment across all areas of expertise 7. Training 8. Finances
Additional information or analysis required	<p>Further information needs will be identified as part of the overall programme development. Population data and other information is being collated to support the re-design of services across the whole area. Following the launch event for the Women and Children’s Programme held on June 6th and 7th Three very clearly defined work streams have been identified</p> <ol style="list-style-type: none"> 1. Children and Young People with Acute Care Needs 2. Children and Young People with Long Term Care Needs 3. Maternity and Newborn

WOMEN AND CHILDREN

	<p>These workstreams will be led by individual Service Design Groups who will feed into the whole service redesign workplan. Membership of the groups will be influenced by the expressions of interest that were collected during the launch event. Following on from the work achieved at the event a clear strategy has began to emerge and detailed project plans will be developed. A full time Programme Manager has been appointed and, when in post, will be responsible for putting together a detailed project plan.</p>
Interdependencies with other proposed or existing programmes	<p>Healthy Child Programme SEND agenda Child and Adolescent Mental health Perinatal Mental Health Maternity pathway Long Term Conditions Pathways</p>
Delivery requirements -	<p>Delivery requirements will be identified as part of the overall programme development and will evolve as part of the service re-design</p>

Prevention

Primary prevention strands of the existing CHD programme	
Summary of the idea / option	Reduce avoidable cardiac admissions through prevention of disease and commissioning effective, equitable cardiac rehabilitation services that are evidence-based Work with primary care and public health colleagues to equip the public to make lifestyle choices that reduce their cardiac risk, especially in those areas where the risk is highest
Issues addressed by this idea / option	Primary, secondary and tertiary prevention of coronary heart disease Inequalities Equity of service provision across the patch - reduce inequality in health outcomes Reduction in PYLL
Clinical outcomes	Reduction in cardiac mortality (concentrating on the most deprived 40% of the population) Reduction in cardiac morbidity Improvements in related disease areas through risk factor reduction (e.g. smoking reduction will also influence rates of cancers and lung disease)
Financial outcomes -	Reducing emergency cardiac admissions Reducing coronary heart disease management costs through preventative work
Challenges and risks	Engaging primary care and public in preventative work Adopting healthy lifestyle choices is a whole society responsibility and cannot be achieved only through the health service
Additional information or analysis required	Social marketing / segmenting insight to improve communications channels with the target population
Interdependencies with other proposed or existing programmes	Primary prevention work underway in other organisations e.g. LA PH team H&WB Boards Strategy CHD Programme - CCG Commissioning priority (work stream 1,2,3 & 4)
Delivery requirements -	The work has been designed to sit within current activity and budgets although financial incentives would be likely to improve effectiveness of some elements
Impact on health inequalities	Specific focus on reducing health inequalities through addressing CHD risk factors in the most deprived 40%

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MECC - Scope existing provision and options for extending provision

Summary of the idea / option	Make Every Contact Count training for front line NHS staff is available through Cambridgeshire LA. This training could be made available to all staff across the CCG in NHS Trusts and primary care facilities to increase the potential for the whole NHS to influence health behaviours.
Issues addressed by this idea / option	Engaging the public in making healthier choices Engaging the NHS workforce in supporting positive change Re-focusing the healthcare system from treatment to prevention
Clinical outcomes	Improvements in lifestyle modifications such as smoking cessation and physical activity Reduction in cardiovascular morbidity and mortality Improvement in mental wellbeing
Financial outcomes -	Reductions in healthcare costs through improving disease prevention strategy uptake and awareness
Challenges and risks	Bridging the gap between being trained and implementing training Cost of training staff (staff time and training cost) Measuring benefit
Additional information or analysis required	Frameworks for implementing the MECC concept in different NHS environments Staff opinions on training and implementation in "real life"
Interdependencies with other proposed or existing programmes	CHD Programme - CCG Commissioning priority (1 & 3) Health & Well being Boards LA public health teams
Delivery requirements -	Finance to fund training and backfill costs Systems to monitor training uptake and refresher scheduling Coordination and promotion staff to maintain momentum?
Impact on health inequalities	Through using NHS staff, vulnerable unhealthy populations more likely to be reached but may be biased by staff approaching those assessed as more likely to respond positively (likely to be people similar to themselves in age, ethnicity, social background etc)

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Increasing physical activity	
Summary of the idea / option	Link with public health colleagues in Cambridgeshire and Peterborough LA to identify action plans to scope options for increasing physical activity – possibly building on Walking for Health delivered through some GP practices in Cambridgeshire
Issues addressed by this idea / option	Reduction in population risk has potential to have large impact on PYLL across whole population Known issues of inequality in risk factors Low physical activity identified as most important risk factor in C&PCCG
Clinical outcomes	Low physical activity estimated responsible for around 113 deaths (approx. 1.9% of deaths) per year in C&PCCG*
Financial outcomes -	Prevention of developing established disease which impact on PYLL and require costly and/or long term clinical interventions
Challenges and risks	Developing effective partnerships with key stakeholders to invest in longer term interventions. Outcomes will not be realised within short timeframes – will need to review metrics to develop tangible shorter term quality based measurements as evidence of success
Additional information or analysis required	Intervention strategies for hard to reach communities, to reduce inequality gap
Interdependencies with other proposed or existing programmes	CHD Programme - CCG Commissioning priority (work stream 1) H&WB Boards – Strategic plans (Northants and Herts to be included)
Delivery requirements -	Initial start-up costs may need to be provided, to establish a range of options and interventions Should be low technical requirements
Impact on health inequalities	Interventions will need to describe how they will engage with vulnerable groups within the population – different approaches will be established to ensure maximum engagement

Atrial Fibrillation - detecting, and effective management of	
Summary of the idea / option	<p>Reduce the prevalence of undetected atrial fibrillation (AF) in the population and increase the proportion of those with AF who are effectively anticoagulated. Untreated AF confers a high risk of stroke which can be significantly reduced through anticoagulation</p> <ol style="list-style-type: none"> 1. Support GPs in detecting and treating AF, e.g. through the use of GRASP-AF audit 2. Work with public health colleagues to improve public understanding of AF and anticoagulation
Issues addressed by this idea / option	<p>Highest cause of PYLL and known driver of local inequalities Particular potential impact on men and more deprived groups Increasing contribution of stroke to CVD morbidity and mortality and morbidity through stroke</p>
Clinical outcomes	<p>PYLL reduction of 28.22 per 100,000 if all AF detected and treated appropriately (estimated 8423 patients in CCG not anticoagulated and at risk) Reduced incidence of stroke in the C&P population Reduction in deaths from stroke Reduction in long term morbidity in stroke survivors</p>
Financial outcomes -	<p>Reduced admissions rates for stroke Reduced spend on rehabilitation</p>
Challenges and risks	<p>Anticoagulation seen as difficult, inconvenient and risky Potential for increase in pathological bleeding Identifying unknown AF cases Effective engagement with primary care</p>
Additional information or analysis required	<p>Current use of GRASP-AF Prescribing advice re novel oral anticoagulants (NovACs) Service availability and constraints re INR monitoring throughput</p>
Interdependencies with other proposed or existing programmes	<p>Older People's Programme CHD Programme - CCG Commissioning priority (workstream 3) Health & Wellbeing Boards Academic work programmes ongoing re this issue locally and nationally (EAHSN)</p>
Delivery requirements -	<p>Engagement work needed to promote GRASP_AF and communicate benefits IT pathways for data flows for monitoring GRASP-AF / other metrics Investment in INR monitoring and / or prescribing budgets</p>
Impact on health inequalities	<p>Potential to increase health inequalities as mobile more able to access monitoring for warfarin unless services carefully designed</p>

Transient Ischaemic Attack (TIA) and Stroke - prevention and effective management of	
Summary of the idea / option	<p>Increase proportion of Transient Ischaemic Attacks (TIA) treated within 24 hours to 100% and Extend provision of Early Supported Discharge schemes following a stroke by</p> <p>3. Increase proportion of Transient Ischaemic Attacks (TIA) treated within 24 hours to 100%</p> <p>4. Extend provision of Early Supported Discharge schemes following a stroke to 40% (current performance indicate 4.5% achievement)</p>
Issues addressed by this idea / option	<p>Highest cause of PYLL and known driver of local inequalities</p> <p>Particular potential impact on men and more deprived groups</p> <p>Increasing contribution of stroke to CVD morbidity and mortality</p>
Clinical outcomes	<p>1. 2.57 per 100,000. CCG achievement (2013) 76.8% (target 100%)</p> <p>2. 2.57 per 100,000. CCG achievement (2013) 4.5% (target 40%)</p>
Financial outcomes -	Prevention of developing established disease which impact on PYLL and require costly and/or long term clinical interventions
Challenges and risks	Developing effective partnerships with key stakeholders. Securing engagement to assess the current situation and develop plan with Providers and primary care to move towards 100% and increase service provision where evidenced
Additional information or analysis required	<p>Service mapping to identify any barriers to current TIA pathway and– focus on reducing inequalities of outcome</p> <p>Service mapping early discharge scheme to identify any gaps in current service provision – focus on reducing inequalities of outcome</p>
Interdependencies with other proposed or existing programmes	<p>Older people Programme</p> <p>CHD Programme – work stream 3</p> <p>H&WB Boards – Strategic plans (Northants and Herts to be included)</p>
Delivery requirements -	Potential investment to support increased primary care prevention / therapies and early discharge schemes where evidenced
Impact on health inequalities	Focus on areas of high deprivation and high mortality CVD rates – will need to identify specific interventions to engage with hard to reach communities to ensure prevention work is targeted

Cancer pathways	
Summary of the idea / option	<p>Important cause of local PYLL</p> <ol style="list-style-type: none"> 1. Develop alternative pathways for investigation of symptoms not meeting 2WW criteria 2. Improve GP access for cancer diagnostics (e.g. colonoscopy) 3. Support uptake of cancer decision support tools in routine consultations
Issues addressed by this idea / option	<p>Improving early diagnosis of cancer Improving pick-up rates of cancers that present in non-classical ways Better gatekeeping for secondary care services</p>
Clinical outcomes	<p>These are difficult to quantify individually due to lack of PYLL data related to these interventions. As a bundle of measures, improving early detection and treatment of cancer is estimated to prevent 28.9 PYLL per 100,000</p>
Financial outcomes -	<p>Potential for reduction in emergency diagnoses of cancers; early diagnosis may reduce treatment costs</p>
Challenges and risks	<p>Overloading diagnostic services Poor value for money in new pathways (potential for high numbers of non-cancer referrals)</p>
Additional information or analysis required	<p>Current GP pathways for possible cancer outside 2WW Local service availability and capacity for direct GP referrals</p>
Interdependencies with other proposed or existing programmes	<p>Older People's Programme End of Life Care programme RSS programme</p>
Delivery requirements -	<p>May require significant expansion of diagnostic service capacity IT systems supporting decision tools</p>
Impact on health inequalities	<p>Potential to increase health inequalities if worried well are most able to access new services. Mitigate this by ensuring that new access pathways are available through non traditional routes to maximise access for all, including the most disadvantaged</p>

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Maternal and neonatal - smoking cessation

Summary of the idea / option	Support the scoping and development of a specialist smoking cessation midwife role in all Trusts (initial focus on Peterborough)
Issues addressed by this idea / option	High potential yield in averted PYLL from small numbers of very early deaths prevented Known local issues with maternal smoking and inequalities
Clinical outcomes	Prenatal smoking estimated to be responsible for 5% of infant mortality (from US studies) Not including stillbirths (figs not available), 5% of deaths under 1 year = approx. 2 deaths per year in C&P, each losing 75 potential years of life Also impacts on maternal and family health (CHD, cancers, respiratory)
Financial outcomes -	Prevention of developing established disease which impact on PYLL and require costly and/or long term clinical interventions
Challenges and risks	Link with Smoking Cessation Lead for Peterborough, determine support needed and develop plan for further actions, specifically how this post would be sustainably funded Appropriate and effective engagement strategies with pregnant women
Additional information or analysis required	Effective intervention strategies
Interdependencies with other proposed or existing programmes	CHD programme H&WB Board Strategies
Delivery requirements -	Funding to support specialised interventions including training and additional workforce requirements
Impact on health inequalities	Improve health of the women and longer term health benefits for the child

Appendix 7: Reducing potential years of life lost

Background

Fulfilling our commitment to reducing Potential Years of Life Lost (PYLL), (sometimes referred to as Years of Potential Lives Lost (YPLL)) requires analysis of the current CCG position and the potential for interventions to improve this position. In December 2013 NHS England published 'Our Ambition to Reduce Premature Mortality'¹⁰ This document lists a series of interventions with data regarding costs, mortality and PYLL, and combined with local data we have been able to recommend interventions with the potential to reduce PYLL in the population.

Metrics

The CCG Indicator 1.1 "Potential Years of Life Lost from causes amendable to healthcare" records, for each person who dies aged less than 75, the number of years of life lost and standardises this so that comparisons can be made across populations with different age structures¹¹.

Current situation

PYLL Data for Cambridgeshire and Peterborough CCG

Local PYLL data were analysed for by condition and by LCG by Public Health Intelligence (Tables 1 to 2 and Figure A7-1 below)¹²

LCG	Year				
	2008	2009	2010	2011	2012
Borderline	1,700.4	1,472.6	2,084.2	1,956.8	1,615.6
CamHealth Integrated Care	1,269.5	1,325.7	1,134.5	1,119.6	1,093.3
CATCH	2,940.1	2,965.9	2,454.0	2,225.2	2,707.3
Hunts Care Partners	2,434.8	2,115.8	2,175.0	2,111.1	1,608.4
Hunts Health	1,205.6	1,357.5	1,332.7	1,003.1	1,129.5
Isle of Ely	1,664.3	1,481.9	1,761.9	1,779.8	1,395.6
Peterborough	2,526.9	3,199.5	2,875.6	3,035.3	2,785.1
Wisbech	832.2	1,066.4	1,080.6	1,002.5	1,187.1
CCG	14,573.8	14,985.2	14,898.6	14,233.4	13,522.0

Table 1: Potential Years of Life Lost (PYLL), number, by LCG, 2008 - 2012

¹⁰ NHS England (2013). Our Ambition to Reduce Premature Mortality: A resource to support commissioners in setting a level of ambition. Available at: <http://www.england.nhs.uk/wp-content/uploads/2014/03/mort-res-22-5.pdf>, accessed 13.05.2014

¹¹ Specification: CCG Indicator 1.1 (NHS OF 1a). Available at: <http://www.hscic.gov.uk/catalogue/PUB11398/ccg-indi-aug-13.pdf>, accessed 19.05.2014

¹² Public Health Intelligence (2014). Potential Years of Life Lost from causes amenable to healthcare, Cambridgeshire and Peterborough CCG.

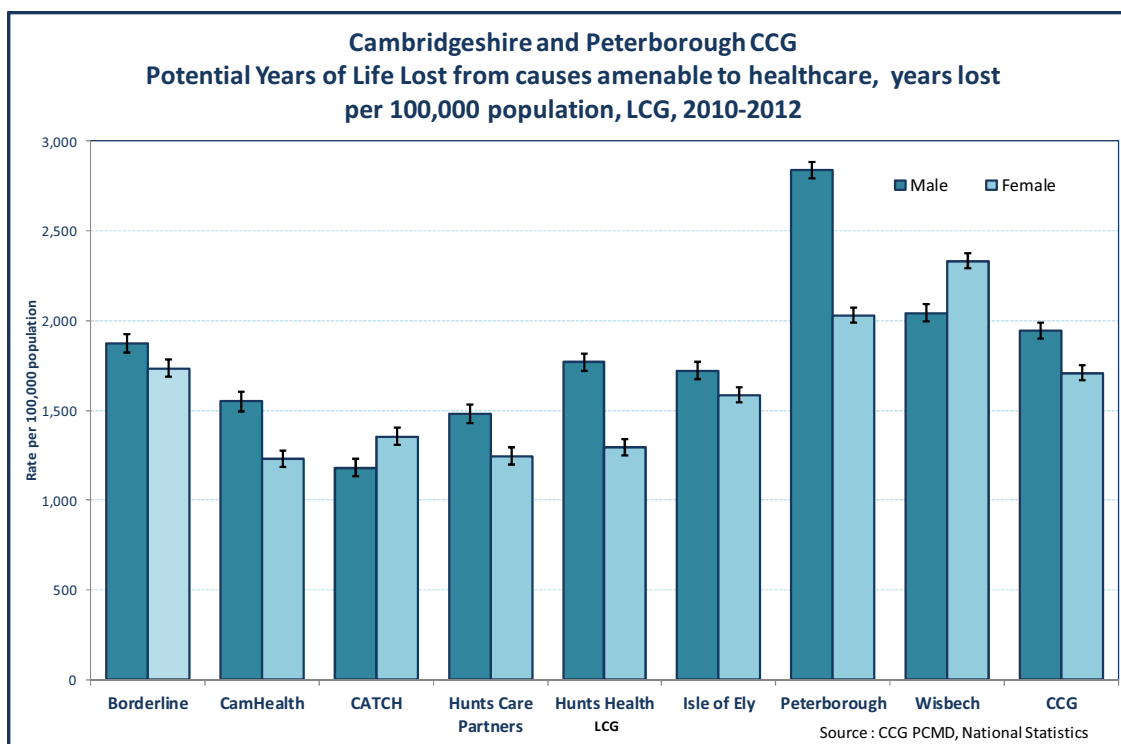


Figure A7-1: Potential Years of Life Lost (PYLL), rate per 100,000 population, by sex and LCG, 2010 - 2012

Main Cause	Year				
	2008	2009	2010	2011	2012
Cardiovascular disease	7,061.4	7,094.6	7,142.3	6,811.6	6,249.6
Digestive disorders	310.1	394.5	334.0	569.8	424.7
Genitourinary disorders	132.1	129.1	189.4	59.0	215.2
Infections	637.1	460.7	242.1	451.9	675.3
Injuries	18.6	89.3	44.5	56.5	91.5
Maternal & infant	776.7	278.3	470.3	379.7	611.2
Neoplasms	4,160.8	4,779.5	4,710.7	4,237.9	4,028.6
Neurological disorders	563.8	353.2	684.5	391.9	293.8
Nutritional, endocrine and metabolic	105.6	132.2	95.7	278.0	37.3
Respiratory diseases	807.6	1,273.8	985.1	997.1	894.7
CCG	14,573.8	14,985.2	14,898.6	14,233.4	13,522.0

Table 2: Potential Years of Life Lost (PYLL), number, by cause, 2008 - 2012

Compared with national data the CCG benchmarks well overall for PYLL (lowest quintile)¹³, but there is evidence of inequality by geography and by gender¹⁴.

¹³ NHS England Levels of Ambition Tool, available at: <http://ccgtools.england.nhs.uk/loa/flash/atlas.html>, accessed 19/05/2014

¹⁴ Public Health Intelligence (2014). Potential Years of Life Lost from causes amenable to healthcare, Cambridgeshire and Peterborough CCG.

In 2012, PYLL for the Cambridgeshire Local Authority was in the lowest quintile (and similar to the England average), whereas Peterborough LA was in the central quintile for PYLL¹⁵. Analysis by gender at CCG level shows that for 2009 to 2011, PYLL for men were significantly greater than for women in the same period. This difference was not seen in 2012. The main causes of premature (age under 75) deaths for the CCG for 2009-2012 were cancers and cardiovascular disease.

In Peterborough over 30% of the gap between the area and national life expectancy is caused by Coronary Heart Disease (CHD)¹⁶. This means that CHD alone reduces life expectancy by 0.36 years in the Peterborough area. In Cambridgeshire life expectancy is above national average but CHD and cancer are the main drivers of the life expectancy gap between the most deprived and least deprived areas.

The CCG's Coronary Heart Disease (CHD) programme, which is currently underway, aims to reduce premature deaths and unnecessary emergency admissions arising from CHD in people aged under 75 years, with a focus on reducing premature death rates fastest in areas of poorest outcome. This will address PYLL effectively by targeting both the highest impact condition and the associated health inequalities.

Risk factors that contribute the most to PYLL in C&PCCG

Data from the Public Health Intelligence team¹⁷ and published literature^{18,19} has been used to calculate the total number of deaths in Cambridgeshire and Peterborough in people aged under 75 that are caused by each risk factor using a measure called the 'population attributable risk' (PAR).

The data suggest that low physical activity and hypercholesterolemia (defined as serum cholesterol greater than 6.5mmol/l) were responsible for the highest number of deaths from Coronary Heart Disease, stroke and cancer in the CCG area (113 and 96 deaths respectively) in 2012. Obesity (defined as a Body Mass Index greater than 30) was responsible for 59 deaths, smoking was responsible for 56 deaths and hypertension (systolic blood pressure greater than 145mmHg) was responsible for 46 deaths.

In summary the results suggest that to reduce PYLL, the CCG should focus on measures to increase physical activity and reduce cholesterol levels, obesity, smoking and blood pressure.

As the population attributable risk estimates do not take into account PYLL or the age at which people died, Table 3 was produced to describe the mean age of death from breast/colorectal cancer, cerebrovascular disease and ischaemic heart disease in people aged under 75:

¹⁵ NHS England Levels of Ambition Tool, available at: <http://ccgtools.england.nhs.uk/loa/flash/atlas.html>, accessed 19/05/2014

¹⁶ Segment tool, Public Health England 2014, available at: http://www.lho.org.uk/LHO_Topics/Analytic_Tools/Segment/TheSegmentTool.aspx (accessed 1/5/14)

¹⁷ Public Health Intelligence (2014). Potential Years of Life Lost from causes amenable to healthcare, Cambridgeshire and Peterborough CCG.

¹⁸ Syed, A. M. et al. (2012). The use of epidemiological measures to estimate the impact of primary prevention interventions on CHD, stroke and cancer outcomes: experiences from Herefordshire, UK. *J Epidemiol Glob Health* 2(3), pp. 111-124.

¹⁹ World Cancer Research Fund (2009). Preventability of cancer by food, nutrition, and physical activity [Online]. Available at: http://www.dietandcancerreport.org/cancer_resource_center/downloads/chapters/pr/Appendix%20A%20and%20B.pdf [Accessed: 11.03.2014]

Table 3: Number and mean age of death related to the four diseases with the highest number of deaths relevant for the PYLL indicator

Cause of death	Number of deaths in people aged 0-74 in Cambs and Peterborough in 2012	Mean age of death in people aged 0-74 in Cambs and Peterborough in 2012 (years of age)
Breast cancer	60	61.9
Colorectal cancer	75	64.2
Cerebrovascular diseases	69	62.9
Ischaemic heart disease	193	63.9

Areas for intervention

*Our Ambition to Reduce Premature Mortality*²⁰ provides data on nine areas for possible interventions:

- Prevention and health promotion
- Cardiovascular disease
- Cancer
- Liver disease
- Respiratory disease
- Reducing mortality for people with a serious mental illness
- Maternal and neo-natal
- Reducing premature mortality in people with a learning disability
- Other interventions

Within these nine areas, the impact of a number of interventions on PYLL has been quantified by NHS England. However this has not been provided for all the interventions suggested in the document as in some cases there is not sufficient evidence to quantify the potential benefit, or benefits have been seen following the implementation of bundles of interventions and it has therefore not been possible to quantify the impact of individual interventions.

For the interventions with estimated impact on PYLL, we have attempted to establish baseline data for the CCG. One of the most striking observations locally is the low provision of Early Supported Discharge following a stroke. Data extracted from local hospitals showed that the rate for 2013 was 4.5%. The assumed baseline for this metric is 20% with aspiration to 40%.

Having reviewed the local data together with the suggested interventions, we decided to focus on the following four areas (table 4):

²⁰ NHS England (2013). *Our Ambition to Reduce Premature Mortality: A resource to support commissioners in setting a level of ambition*. Available at: <http://www.england.nhs.uk/wp-content/uploads/2014/03/mort-res-22-5.pdf> [Accessed 13.05.2014]

Area for intervention	Reasoning
1. Prevention and health promotion	Reduction in population risk has potential to have large impact on PYLL across whole population Known issues of inequality in risk factors
2. Cardiovascular disease	Highest cause of PYLL and known driver of local inequalities Particular potential impact on men and more deprived groups
3. Cancer	Important cause of local PYLL
4. Maternal and neonatal	High potential yield in PYLL prevented from small numbers of deaths prevented Known local issues with maternal smoking and inequalities

Table 4: areas selected for PYLL intervention analysis

Analyses from *Our Ambition to Reduce Premature Mortality* were combined with local data, guidance in the CCG-specific DH *Commissioning for Value Pack* and guidance from local experts in assessing the potential impact of identified interventions within the four areas.

Evidence-based interventions: brief overview

Area 1: Prevention and health promotion

General

- Making Every Contact Count (MECC) – Cambridgeshire Local Authority offers MECC training at present. Extension of this training across the CCG could empower all front-line staff within the NHS to deliver very brief interventions to promote behaviour change
 - o Smoking cessation brief interventions conducted by GPs/nurses, in all settings, to all age groups can gain QALYs (Quality Adjusted Life Years) at low cost (NICE guidance PH1)
 - o Interventions targeting the general population are more likely to be cost-effective (with better cost-utility results) than those aimed at vulnerable populations (NICE guidance PH49)

Health checks

- Interventions to reduce variation in take-up of health checks through targeting populations known to be high risk and / or outreach to access populations
- Interventions to improve referral to, and uptake of lifestyle services

Smoking cessation

- Consider commissioning a centralised (national) electronic referrals system that uses a proven model to identify smokers and maximise referrals into NHS Stop Smoking services and offers a programme management approach to ensure that the service is fully implemented and adopted by staff within acute trusts
 - o Local impact modelling will require further investigation into current situation and local feasibility

Areas for intervention not identified within *Our Ambition to Reduce Premature Mortality*

Alcohol

- Screening plus brief intervention at new GP registration and next GP consultation, or an A&E consultation (NICE guidance PH24)
 - Ensure staff have enough training, time and resources
 - Audit C and FAST are the recommended screening tools
 - Evidence for brief interventions is strongest in primary care, more limited in A&E and inconclusive for inpatient and outpatient depts.

Local situation:

- The Alcohol Identification and Brief Advice Training (no cost) is provided throughout Cambridgeshire – limited take-up amongst primary care staff.
- AuditC tool will be introduced into Health Check Programme from April 2014
- A&E in Cambridge University Hospitals will have nurse specialist who will do brief and extended interventions from April 2014

Physical activity

Cost-effective interventions:

- Exercise prescription (both more effective and more costly than usual care)
- Brief advice (both more expensive and more effective than usual care)
- Walking and cycling (NICE 2012: Walking and Cycling)

Local situation:

- Walking groups based on the Walking for Health model are being delivered in some GP practices in Cambridge and South Cambridgeshire
- This area overlaps with the remit on Coronary Heart Disease inequalities

Area 2: Cardiovascular disease

There is significant overlap with the preventative interventions considered above. Although ischaemic heart disease accounts for the largest proportion of PYLL locally, the recent significant reductions in CHD mortality and steady stroke mortality over the same period mean that stroke is becoming a more important element of cardiovascular disease prevention.

Stroke prevention

- Increase prescription of anti-thrombotics (warfarin) by supporting GPs to identify patients with atrial fibrillation (increase proportion of patients clinically indicated as being eligible from 54% to 100%)
 - Potential reduction in PYLL by 28.22 per 100,000
 - Approximately 2,721 patients with undiagnosed Atrial Fibrillation (AF) in the CCG
 - An estimated 8000 people with AF (diagnosed and undiagnosed) who should be on warfarin but are not (assuming 100% treatment rate as in NHSE Ambitions document) and are therefore at increased risk of stroke
 - £1778 prescribing / monitoring cost to CCG per PYLL prevented
 - Local work in Peterborough and Borderline LCG cluster to include GRASP-AF (Guidance for Risk Assessment and Stroke Prevention in AF) audit tool in the Practice Delivery Management Agreement (PDMA). This can facilitate AF case finding and increase anticoagulant prescribing

through stroke risk assessment (such as the 'CHADS-VASC' score) and risk of bleeding score (such as the 'HAS-BLED')

- Consider implementation of GRASP-AF across whole CCG to enable quality monitoring of AF management and reduce stroke risk at population level – the CCG currently has no data on AF anticoagulation prescribing rates

Improving management of stroke and transient ischemic attack (TIA)

- Proportion of TIA patients treated within 24 hours identified as an opportunity for quality improvement for CPCCG by the *Commissioning for Value Pack*
 - 5% of TIAs lead to stroke within a week
 - Up to 80% of TIA-associated strokes could be avoided if TIAs are treated according to the NICE commissioning guide
 - Potential reduction in PYLL: 2.57 per 100,000
 - Local figures indicate for 2013 the high risk TIA treatment within 24 hours was 76.8%; this merits further investigation against the NICE standards to clarify that definitions used are the same but gains may therefore be limited

Reducing mortality from CHD

- Local work ongoing within Tackling Inequalities in CHD programme includes increasing primary care preventative activity, encouraging accurate CVD risk assessment and improving statin prescribing practices as well as work on health checks, smoking and cardiac rehabilitation
- Cardiac rehabilitation: identified in *Our Ambition to Reduce Premature Mortality*
 - Potential reduction in PYLL by 10.45 per 100,000 if Cardiac Rehab uptake increased to 65% of patients post-MI and acute heart failure
 - Potential associated reduction in cardiac re-admissions of 30% (cost of readmission £3637 vs cost of cardiac rehab of £422 per patient)
- Increasing bystander cardiopulmonary resuscitation and automatic external defibrillator use
 - Reduction in PYLL 5.5 per 100,000
 - Contract in training of all front line acute trust staff in CPR, including HCAs and therapy assistants
 - Evidence supports training in CPR but limited evidence in favour of AED installation and training unless targeted to very high footfall areas with many available, trained users

Area 3 – Cancers

Cancer is the second most important driver of PYLL locally; the majority of this is contributed by deaths from breast cancer in women. This is mostly seen in Cambridgeshire Local Commissioning Groups. However since PYLL values for females and Cambridgeshire areas are generally better than those for men, especially in deprived areas, two potential areas for intervention for reducing gender and geographical inequalities have been identified:

- Improving uptake of bowel cancer screening in men in Peterborough
- Improving GP access to diagnostic colonoscopy / flexible sigmoidoscopy
- Improving screening uptake in men for bowel cancer
 - Further local data are needed to establish the potential for improvement
- Improving GP access to diagnostics
 - This has been identified nationally by the NAEDI initiative and locally by GPs as requiring improvement
 - Further work is needed to establish potential reduction in PYLL

Consultation with researchers in early cancer diagnosis has suggested prioritising support for GPs to appropriately manage patients with symptoms that could indicate cancer through:

- Developing alternative referral pathways such as rapid access for GPs to an assessment/diagnostic centre for people with symptoms less 'alarming' than those sent up the current two week wait (2WW) pathways;
- Reducing threshold for accessing diagnostic tests in primary care, such as via open access to tests such as CT scan, MRI, colonoscopy etc.;
- Supporting operationalization of computerised decision support tools such as Q Cancer & CAPER tools for GPs to use routinely and systematically in consultations.

Area 4 – Maternal and neonatal

High smoking in pregnancy rates in Peterborough exceed national targets. For England as a whole, the most recent figures²¹ indicate that 12.9% of mothers are current smokers at the time of delivery compared to 18% of new mothers in Peterborough. Infant mortality in smokers is known to be up to twice the rate of that in non-smokers and ex-smokers. Avoidance of infant deaths has potential for large impact on PYLL as well as the PYLL benefits from the mother's health gains.

Possible intervention:

- Maternity Smokefree champion midwife in Peterborough acute maternity system
 - o Relevant quality improvement opportunities identified in *Commissioning for Value pack*
 - Low birthweight and stillbirths
 - Quits at 4 weeks
 - o Impact on PYLL requires further modelling but likely to be significant

²¹ Public Health Outcomes Framework, available at <http://www.phoutcomes.info>. Accessed 1/5/14

Recommendations

Based on the above analyses we have attempted to group interventions into three categories: those which we would recommend as potentially high local impact (Category 1 - green), those for which further information is needed before they could be recommended locally (Category 2 - amber) and those which are not recommended as likely to impact local PYLL at this time (Category 3 - red).

Category	Interventions	Area of impact	PYLL prevented (per 100,000)	Notes
1	Maternal smoking cessation via SmokeFree Champion midwife in Peterborough hospital	<ul style="list-style-type: none"> • CHD • Cancers • Infant mortality • Stillbirths and low birth weight • Inequalities 	Not yet established	Infant mortality in smokers around twice that of non-smokers
1	The CCG CHD Programme: <ul style="list-style-type: none"> • Increasing uptake of cardiac rehabilitation • Improving detection and management of high cardiovascular risk • Smoking cessation • Health checks 	<ul style="list-style-type: none"> • CHD 	Difficult to estimate as bundle of interventions addressing known priority areas for PYLL 10.45 for cardiac rehab (MI and heart failure)	Include PYLL as a metric within this Programme
1	Increase prescription of anti-thrombotics by supporting GPs to identify patients with AF and increase anticoagulation prescribing rates through use of GRASP-AF audit tool	<ul style="list-style-type: none"> • Mortality from stroke 	28.22	Estimated total of 8423 patients in CCG with diagnosed and undiagnosed AF not on warfarin.
1	Extend provision of Early Supported Discharge schemes following a stroke (from 20 to 40%)	<ul style="list-style-type: none"> • Mortality from stroke 	2.57	CCG data for 2013 gives a ESD rate of 4.5%, far below the 20% indicative threshold given in the NHS England data
1	Increase proportion of patients with TIA treated within 24 hours (from 71 to 100%)	<ul style="list-style-type: none"> • Mortality from stroke 	2.57	CCG data for 2013 shows 76.8% treated within 24 hours. This is estimated to be a cost-saving measure

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2	Improving Bowel Cancer screening uptake in men in Peterborough	<ul style="list-style-type: none"> • Cancers • Inequality (gender and geography) 	Unknown	28.9 per 100,000 estimated PYLL benefit from combined cancer strategy interventions
2	Improving GP access to colonoscopy	<ul style="list-style-type: none"> • Cancers • Inequality (gender and geography) 	Unknown	
2	Other early diagnosis of cancer initiatives – alternative referral pathways, reduced thresholds for accessing diagnostic tests in primary care, computerised decision support tools	<ul style="list-style-type: none"> • Cancers • Inequality (gender and geography) 	Unknown	
2	Ensure that all patients transferred to a cardiac centre within 72 hours following nSTEMI (assumes increase from 92 to 100%)	<ul style="list-style-type: none"> • CHD 	0.92	Local data need clarification
2	Optimise/reconfigure acute stroke services to ensure 24/7 access to specialist care (incl. thrombolysis) and acute stroke units along the lines of the London model of centralised hyper-acute stroke services	<ul style="list-style-type: none"> • Mortality from stroke • Potentially inequality 	TBC	Local data need clarification
2	Bystander CPR – increase proportion of NHS staff trained in CPR	<ul style="list-style-type: none"> • Acute CHD mortality 	5.5 (for whole population training, not just NHS staff)	Local training levels unknown; PYLL benefit not clear if training restricted; training whole population may not be feasible
2	Implementation of NICE guidelines on Acute Kidney Injury		Unclear – NHSE revised estimates	
3	Greater provision of angioplasty following STEMI and reduced door to balloon times (increase rate of reperfusion from 70% to 100%)	<ul style="list-style-type: none"> • Acute CHD mortality 		Papworth's door to balloon time is 5 minutes lower than the national average and performs very well in other statistics to national averages. Unlikely that PYLL gains would provide a good return on investment.

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Recommended actions

The following are recommended as being the interventions likely to be of highest impact for the areas identified above as priorities for the CCG:

Area for intervention	Reasoning	Recommended actions	Likely impact on PYLL
A - Prevention and health promotion	Reduction in population risk has potential to have large impact on PYLL across whole population Known issues of inequality in risk factors Low physical activity identified as most important risk factor in C&PCCG	1. Include PYLL as a metric within the CCG CHD Programme	1. Process for measuring PYLL changes
		2. Extend Making Every Contact Count training availability beyond Cambridgeshire	2. Evidence that brief interventions for alcohol change drinking behaviour in 1 in 8 people resulting in reduced acute and chronic alcohol related illness and a ROI of £2.60 for every £1
		3. Scope options for increasing physical activity – possibly building on Walking for Health delivered through some GP practices in Cambridgeshire	3. Low physical activity estimated responsible for around 113 deaths (approx. 1.9% of deaths) per year in C&PCCG*
B - Cardiovascular disease	Highest cause of PYLL and known driver of local inequalities Particular potential impact on men and more deprived groups Increasing contribution of stroke to CVD morbidity and mortality	5. Support GPs in detecting and treating AF, e.g. through the use of GRASP-AF audit	3. 28.22 per 100,000 if all AF detected and treated appropriately (estimated 8423 patients in CCG not anticoagulated and at risk)
		6. Work with public health colleagues to improve public understanding of AF and anticoagulation	4. Relates to achievement of 1 above
		7. Increase proportion of Transient Ischaemic Attacks (TIA) treated within 24 hours to 100%	5. 2.57 per 100,000. CCG achievement (2013) 76.8%
		8. Extend provision of Early Supported Discharge schemes following a stroke	6. 2.57 per 100,000. CCG achievement (2013) 4.5% (target 40%)
C - Cancer	Important cause of local PYLL	3. Develop alternative pathways for investigation of symptoms not meeting 2WW criteria	These are difficult to quantify individually due to lack of PYLL data related to these interventions. As a bundle of measures,

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Area for intervention	Reasoning	Recommended actions	Likely impact on PYLL
		4. Improve GP access for cancer diagnostics (e.g. colonoscopy)	improving early detection and treatment of cancer is estimated to prevent 28.9 PYLL per 100,000
		5. Support uptake of cancer decision support tools in routine consultations	
D - Maternal and neonatal	<p>High potential yield in averted PYLL from small numbers of very early deaths prevented</p> <p>Known local issues with maternal smoking and inequalities</p>	1. Support the scoping and development of a specialist smoking cessation midwife role in all Trusts	<p>Prenatal smoking estimated to be responsible for 5% of infant mortality (from US studies)</p> <p>Not including stillbirths (figs not available), 5% of deaths under 1 year = approx. 2 deaths per year in C&P, each losing 75 potential years of life</p> <p>Also impacts on maternal and family health (CHD, cancers, respiratory)</p>

*Using calculations in Appendix 1

Action Plan – to implement the above recommendations, suggested next actions, leads and timescales are given below.

Area for intervention	Intervention goal	Next actions	Implement through
A - Prevention and health promotion	A1 - Include PYLL as a metric within the CCG CHD Programme	CHD programme leads to incorporate PYLL into programme metrics	CHD Programme
	A2 - Extend Making Every Contact Count training availability beyond Cambridgeshire	Scope existing provision and options for extending provision – options paper to CHD Board	CHD Programme
	A3 - Scope options for increasing physical activity – possibly building on Walking for Health delivered through some GP practices in Cambridgeshire	Link with public health colleagues in Cambridgeshire and Peterborough LA to identify action plan	CHD Programme
B – Cardiovascular disease	B1 - Support GPs in detecting and treating AF, e.g. through the use of GRASP-AF audit	Current draft proposal from Eastern Academic Health Science Network to extend pilot work on GRASP-AF to C&P – link with this work	CHD Programme
	B2 - Work with public health colleagues to improve public understanding of AF and anticoagulation	To be informed by above actions	CHD Programme
	B3 - Increase proportion of Transient Ischaemic Attacks (TIA) treated within 24 hours to 100%	Assess current situation and develop plan with Providers and primary care to move towards 100%	Older Peoples' Programme
	B4 - Extend provision of Early Supported Discharge schemes following a stroke	Link with clinicians to understand reasons for apparent low provision in C&P; appraise case for change and develop action plan	Older Peoples' Programme
C. Cancer	C1 - Develop alternative pathways for investigation of symptoms not meeting 2WW criteria	Link with national work on early diagnosis (NAEDI** and CR-UK) to identify models for change used elsewhere	Cancer commissioning lead

Area for intervention	Intervention goal	Next actions	Implement through
	C2 - Improve GP access for cancer diagnostics (e.g. colonoscopy)	Understand current local provision and undertake healthcare needs assessment	Improving Outcomes Team
	C3 - Support uptake of cancer decision support tools in routine consultations	Scope evidence and options and link with LCGs to identify opportunities and barriers to implementation	Improving Outcomes Team
D. Maternal and neonatal	D1 - Support the scoping and development of a specialist smoking cessation midwife role in all Trusts (initial focus on Peterborough)	Link with Smoking Cessation Lead for Peterborough, determine support needed and develop plan for further actions	CHD Programme

**NAEDI: National Awareness and Early Diagnosis Initiative. Joint venture Cancer Research UK and DH

Appendix 8: Feasibility and relevance assessment of projections of health need over the next 5 years across our health system

This appendix consists of two sections. The first considers activity projections that can be translated into bottom-up financial projections. The second considers projections of health need and how to assess whether there will be significant shifts in health need over this 5 year planning period that need to be taken into account in the activity projections. These reports are presented here as work in progress.

SECTION 1

The first section presents the beginning of work to build a projection of activity across our whole health economy over the next five years.

At this stage the model is simple and based on a cross section of 2013/14 activity, but it has potential for further development.

Methodology

The Month 10 2013/14 position was taken from provider monitoring reports for CUHFT, Hinchingsbrooke, PSHFT, QEHKL, Papworth and CCS. All other acute activity was taken from the admitted Patient Care CDS, Outpatient CDS and A&E CDS for months 1-10 2013/14.

The 1314 financial outturn position was taken by multiplying the month 10 actual by a factor of 1.2

This was then taken as the baseline for an annual price deflator of 1.2%

All growth percentages were applied uniformly to each line of each contract.

The population growth assumptions for each Trust were done on a Local Authority using Local Authority population projections from the County Council Research group as follows:

- CUHFT: Cambridge City, South Cambridgeshire and East Cambridgeshire
- Hinchingsbrooke: Huntingdonshire
- PSHFT: Peterborough
- QEHKL: Fenland
- Papworth: Cambridgeshire
- CCS: Cambridgeshire
- Others: Cambridgeshire

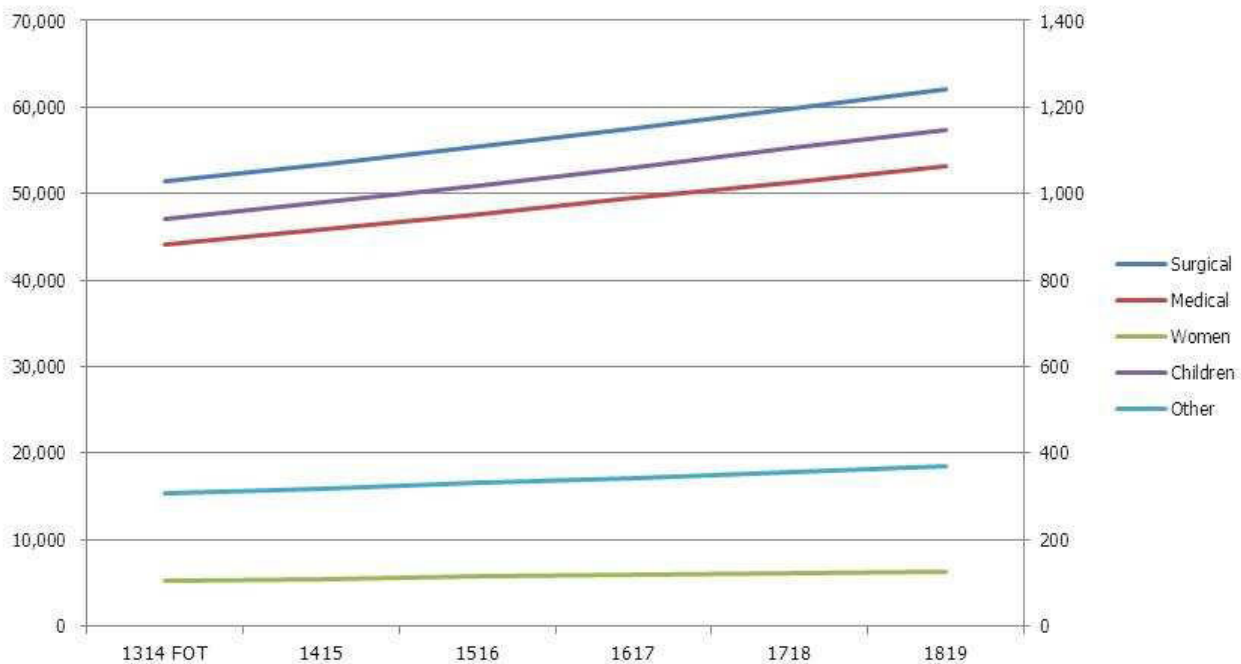
Older People's projections were based on age band projections from the Cambridgeshire CC Research Group

Information from CCS and CPFT has not been included because of data availability.

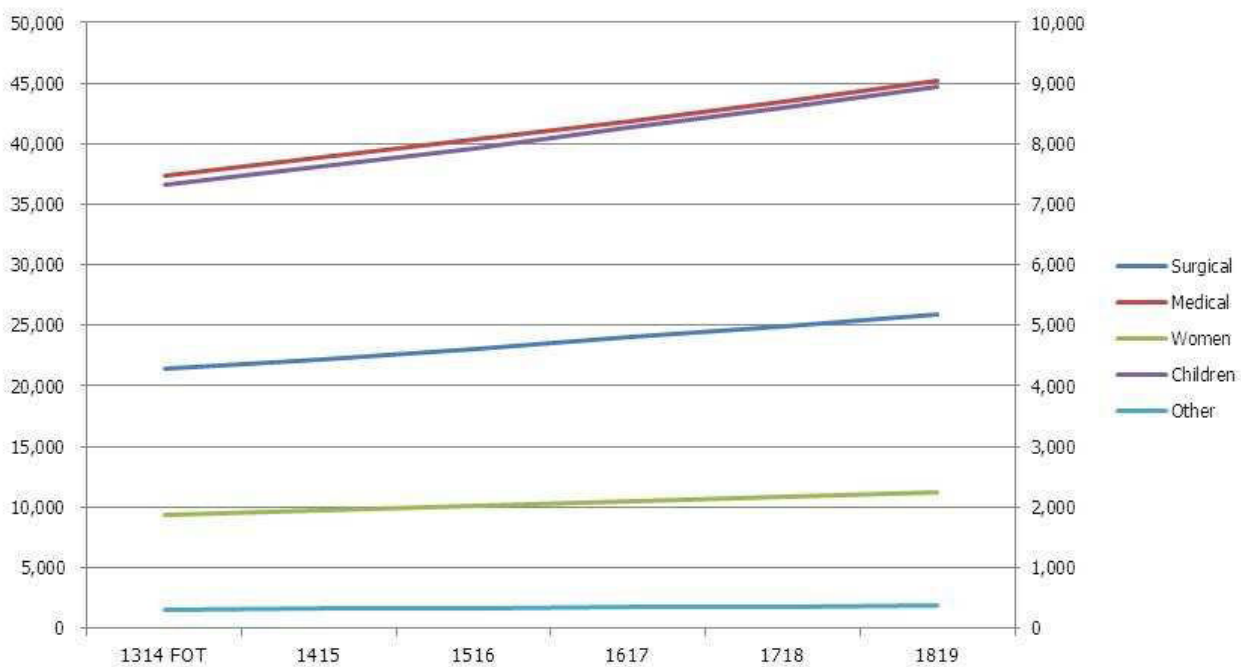
Results of the current model

These are presented graphically below:

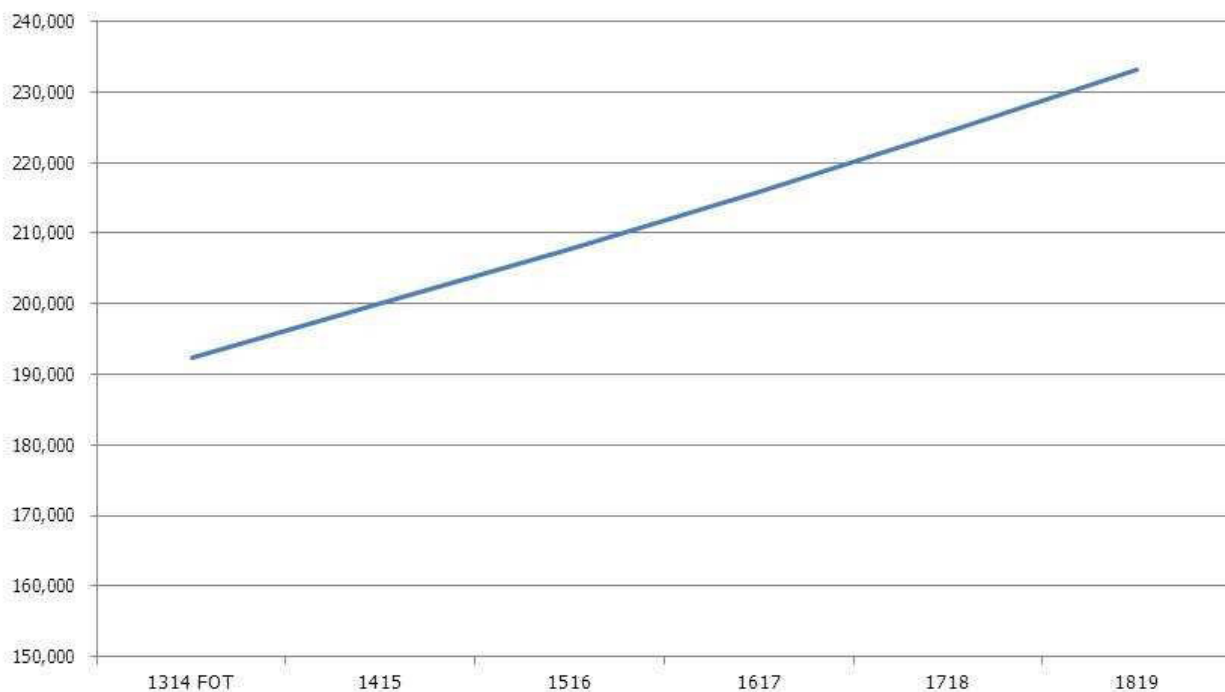
**Elective Activity Projections All Providers excl CCS
(Children and Other Plotted on RH Axis)**



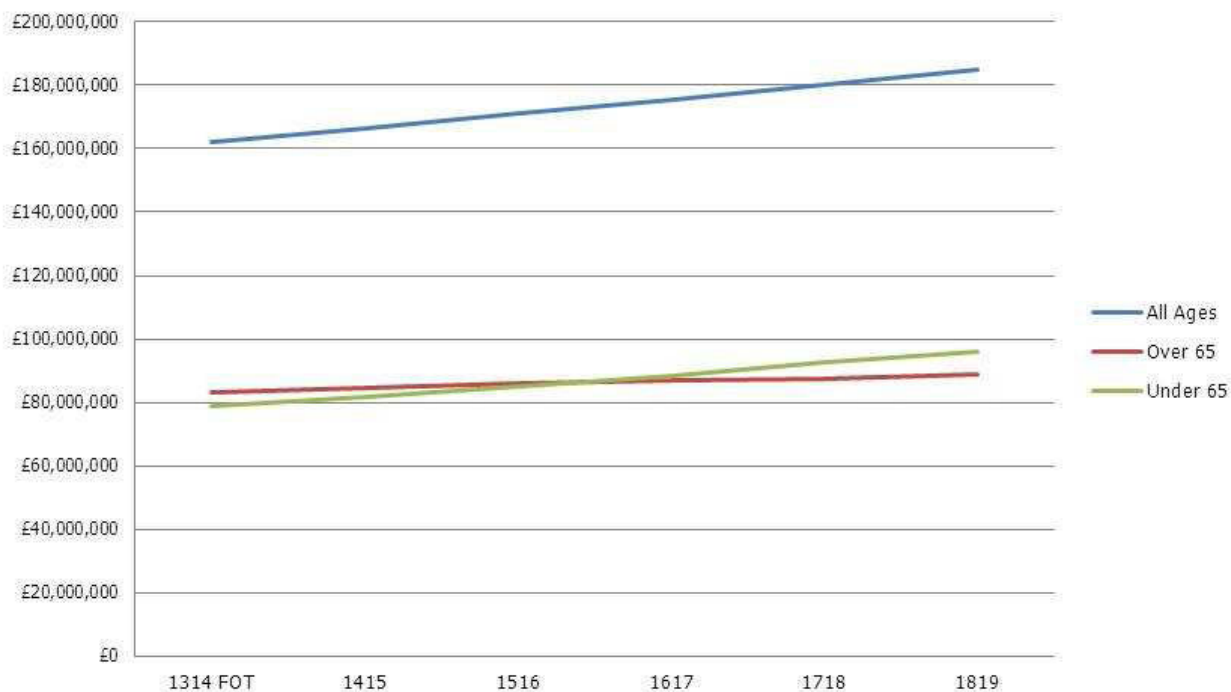
**Non-Elective Activity Projections All Providers excl CCS
(Children and Other Plotted on RH Axis)**



A&E Activity Projections All Providers excl CCS



A&E and Non Elective Spend Projections All Providers excl CCS



Comments on the model outputs so far:

This model needs more refinement to be of use in projecting health service demand over the next 5 years. Possible next steps are:

- 1) Estimation of activity in the various sections of the CCS and CPFT contract and adding this into the appropriate categories in the model
- 2) Exploring the assumptions used and sensitivity analysis
- 3) Retrospective analysis of PCT data to better understand the trends in areas of activity

SECTION 2

ESTIMATING CHANGES IN HEALTH NEED IN CAMBRIDGESHIRE AND PETERBOROUGH BETWEEN 2014-2019

This section of the report considers projections of health need and how to assess whether there will be significant shifts in health need over this 5 year planning period that need to be taken into account in activity projections.

Question 1: What will the prevalence of risk factors for cancer, CHD and ischaemic heart disease be in Cambridgeshire and Peterborough in 5 years' time?

The main risk factors (RFs) for cancer, CHD and ischaemic heart disease highlighted in Appendix 5 are hypercholesterolemia, physical activity, obesity, smoking, and hypertension. The prevalence of these risk factors in the local area is described below. Physical activity has not been included in the discussion below as its impact on health is difficult to model, but this may be included in future modelling work. Alcohol consumption has been added as an additional risk factor of interest.

1. Smoking

1.1 Previous smoking prevalence – national data

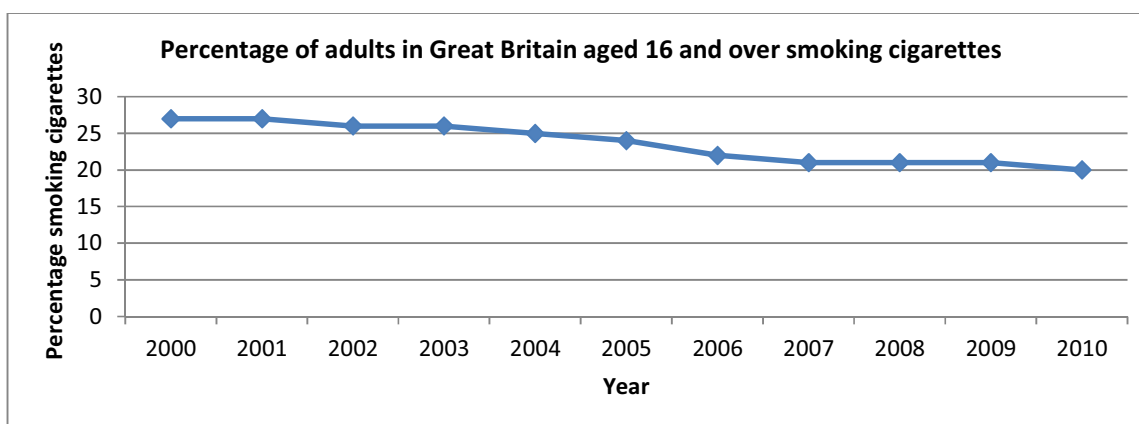


Figure 1: Smoking prevalence data from the General Lifestyle Survey, Office of National Statistics
<http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcM%3A77-226919>

Figure 1 shows that the prevalence of smoking in Great Britain reduced from 27% in 2000 to 20% in 2010.

1.1.1 Previous smoking prevalence – local data

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The data in figure 2 show the proportion of people aged 18+ who are self-reported smokers in Cambridgeshire and Peterborough between 2010 and 2012²². The proportion of adults who smoke appeared to decrease between 2010 and 2012 (Cambridgeshire: 19.0% in 2010, 17.9% in 2012. Peterborough: 25.2% in 2010, 21.1% in 2012), however this was not statistically significant.

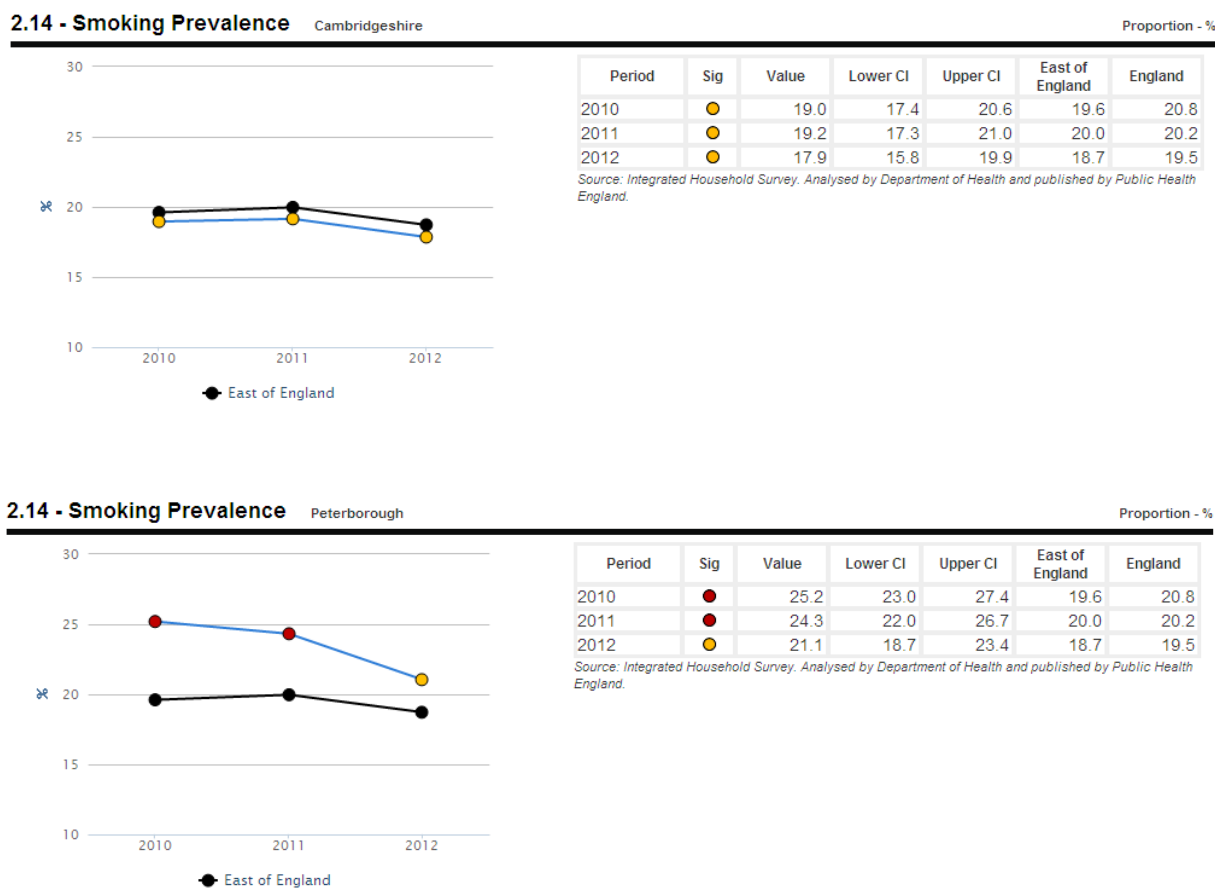


Figure 2: Smoking prevalence data from the Integrated Household Survey, taken from the Public Health Outcomes website: <http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000049/par/E12000004>

The first cross-sectional smoking prevalence survey in the CCG was undertaken in 2013. This revealed an overall smoking prevalence of 22% (ranging from 16.5% in CATCH LCG to 29.7% in Peterborough LCG)²³. This method is expected to provide a more accurate estimate of smoking prevalence across the CCG and will provide trend data over time.

1.2 Future smoking prevalence

²² The number of respondents was weighted in order to improve representativeness of the sample. The weights take into account survey design and non-response. This number is divided by the total number of respondents (with valid recorded smoking status) aged 18+.

²³ Registered patients age 15+ reported as current smokers within the previous 24 months. Data from CCG CVD Profiles. (managed through the CHD Programme)

It is difficult to predict the future behaviour of smokers given new innovations such as e-cigarettes and their unknown effect on smoking behaviours. The current trend nationally is a reduction in smoking prevalence; however the pace of this reduction is likely to slow as the smoking population contracts to include mostly determined smokers. Using the data in Figures 1 and 2, we estimate an ongoing fall in smoking prevalence over the next five years, giving a prevalence of 15-17% in Cambridgeshire and 18-20% in Peterborough in 2019 so an overall prevalence reduction of around 5-6% of baseline across the whole CCG.

2. Cholesterol

2.1 Current/previous cholesterol levels

The mean blood cholesterol level for men aged 16 and over in England in 2008 was 5.2mmol/l and for women 5.4mmol/l²⁴. Table 1 shows that the prevalence of high cholesterol levels (>5mmol/l total cholesterol) in England decreased from 66% in 2003 to 61% in 2008.

Prevalence of high cholesterol levels, by sex and age, England 1994 to 2008

	All ages	16-24	25-34	35-44	45-54	55-64	65-74	75+
	%	%	%	%	%	%	%	%
Men								
1994	75	32	61	82	88	90	87	79
1998	66	23	50	70	78	81	76	72
2003 unweighted	70	28	60	77	82	81	69	63
2003 weighted	66	26	60	77	81	80	67	64
2006	57	20	53	68	74	73	54	47
2008	58	25	52	74	76	70	53	39
Women								
1994	77	44	57	70	82	95	97	93
1998	67	27	44	59	74	88	91	89
2003 unweighted	71	34	50	62	78	88	87	82
2003 weighted	66	31	55	69	79	84	77	75
2006	61	31	42	58	78	84	76	67
2008	61	36	42	56	76	83	75	66
<i>Unweighted base (2008):</i>								
<i>Men</i>	3,349	295	418	613	597	675	440	311
<i>Women</i>	3,925	276	501	741	730	781	489	407

Notes:

Data from 1994 to 1998 are unweighted data, for 2003 weighted and unweighted data is shown, for 2006 only weighted data are presented. † High cholesterol levels >5.0 mmol/l total cholesterol.

Source:

Joint Health Surveys Unit (2009) Health Survey for England 2008. The Information Centre: Leeds, and previous editions. Copyright © 2009, Re-used with the permission of The Health and Social Care Information Centre. All rights reserved.

Table 1: The prevalence of high cholesterol levels in England²⁴

No relevant local data on the local population's cholesterol levels has been identified to date.

²⁴ Coronary Heart Disease Statistics 2012. Available at: <http://www.bhf.org.uk/publications/view-publication.aspx?ps=1002097>, accessed 19.05.2014

2.2 Future cholesterol levels

A recent conference abstract²⁵ states that average cholesterol levels in the UK could be expected to fall by 0.1mmol/l by 2030. We therefore estimate that average cholesterol levels may have reduced by 0.05mmol/l by 2019. This would result in a mean blood cholesterol of 5.15mmol/l for men and 5.35 for women, a reduction in the risk factor prevalence of approximately 1% for both sexes.

3. Obesity

3.1.1 Local obesity prevalence

Figure 3 shows the percentage of patients in C&P CCG aged 16 and over with a BMI of 30 or above, from QOF data, and Figure 4 shows adult age standardised obesity prevalence in the East of England. As QOF estimates (Figure 3) are believed to underestimate obesity, we estimate that currently 25% of the population in the East of England have a BMI over 30 (Figure 4).

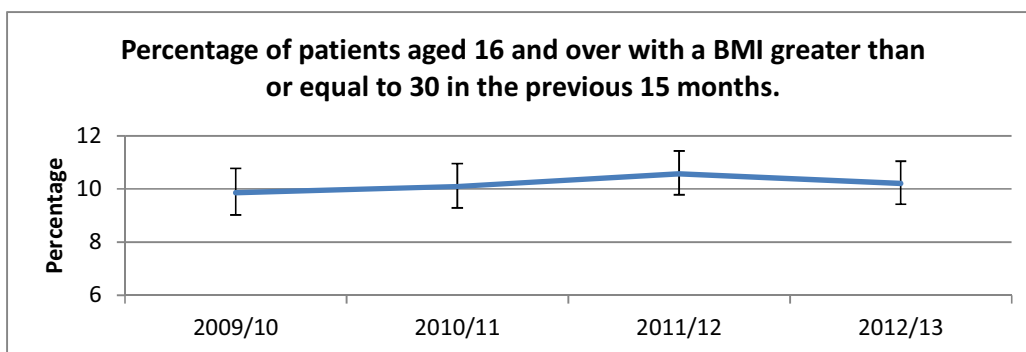


Figure 3: Percentage of patients aged 16 and over with a BMI greater than or equal to 30 in the previous 15 months (Data from QOF) in C&P CCG^{26 27}

²⁵ *Estimating the Potential of Population Level Changes in Cholesterol and Blood Pressure for Reducing UK Coronary Heart Disease Mortality Rates: A Novel Modelling Approach (M O'Flaherty et al, J Epidemiol Community Health 2012;66(Suppl 1))*

²⁶ The indicator is not recommended for measuring or comparing obesity levels in small areas. The confidence interval method is Wilson Score with a 95% confidence level.

²⁷ Public Health England National General Practice Profiles. Available at: <http://fingertips.phe.org.uk/profile/general-practice/data#mod,8,pyr,2013,pat,19,par,E38000026,are,-,sid1,2000002,ind1,-,sid2,-,ind2,->

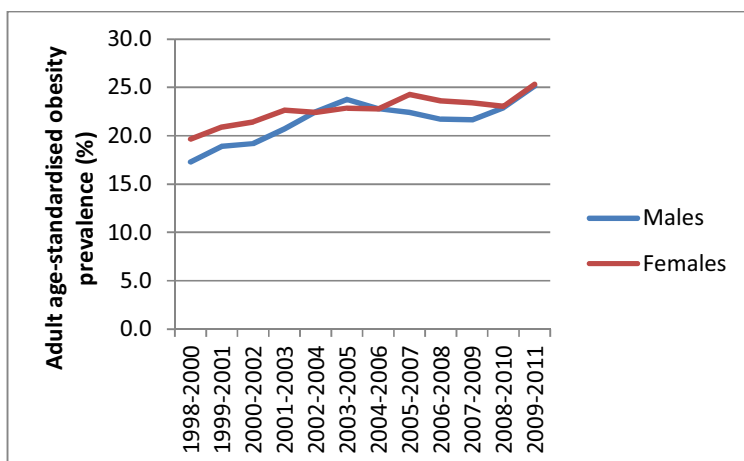


Figure 4: Adult (aged 16+ years) age standardised obesity prevalence (%) in the East of England
 Source: Health Survey for England (HSE). Obesity in adults is defined as a BMI greater than or equal to 30kg/m²

3.2 Future obesity prevalence

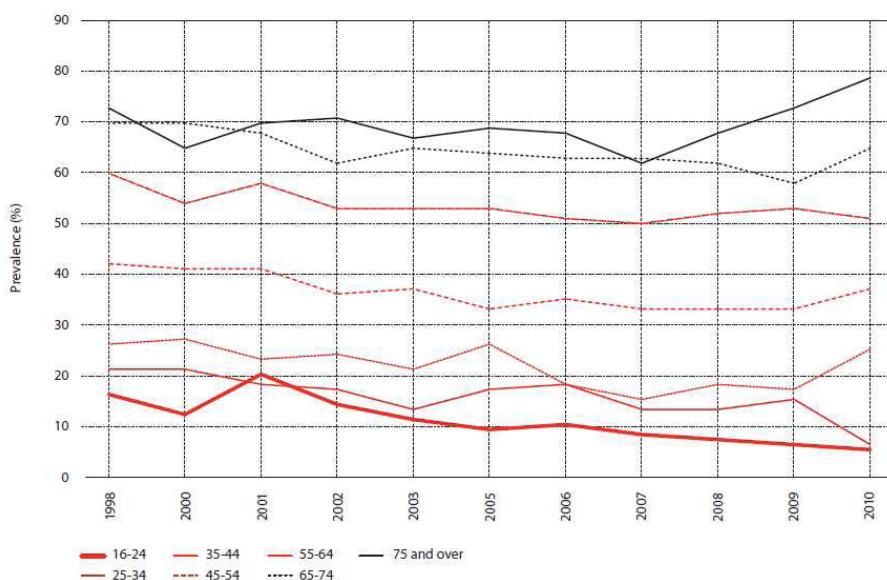
A 2007 report by the UK Government’s Foresight Programme²⁸ suggested that approximately 40% of males and 35% of females aged 21-60 would be obese or morbidly obese by 2019. This is based on an assumption that the proportion of adults who are obese/morbidly obese in 2011 would be approximately 30% (compared to 25% in Figure 4). Therefore we can estimate that the prevalence of obesity in the C&PCCG area will be approximately 30-35% in 2019.

4. Hypertension

a. 1 National data

Nationally, rates of hypertension have dropped slightly since 1998, for both men and women at all ages.

Prevalence of high blood pressure in men, by age, England 1998 to 2010



²⁸ <https://www.gov.uk/government/publications/reducing-obesity-future-choices>

Prevalence of high blood pressure in women, by age, England 1998 to 2010

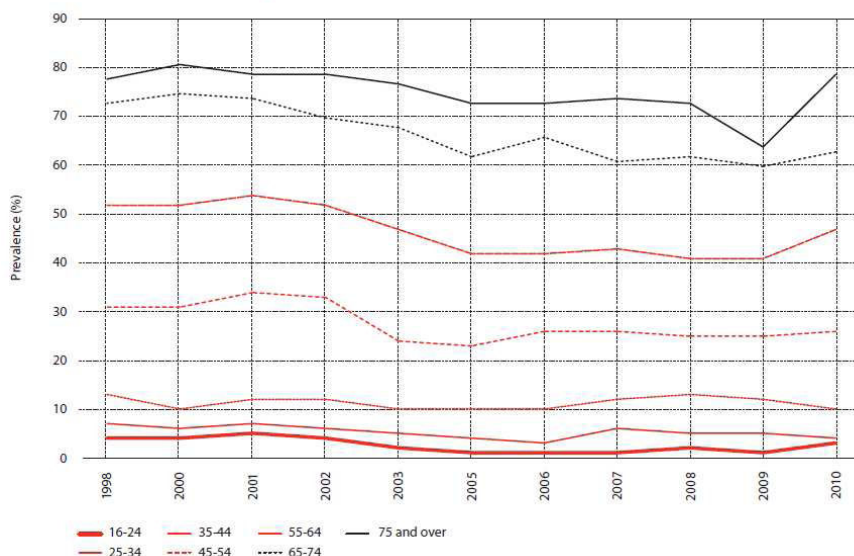


Figure 5: Prevalence of high blood pressure in England, 1998-2010²⁹

4.1.2 Local data

The indicator in Figure 6 represents the percentage of patients in C&P CCG with established hypertension, as recorded on practice disease registers as a percentage of the total practice size list.

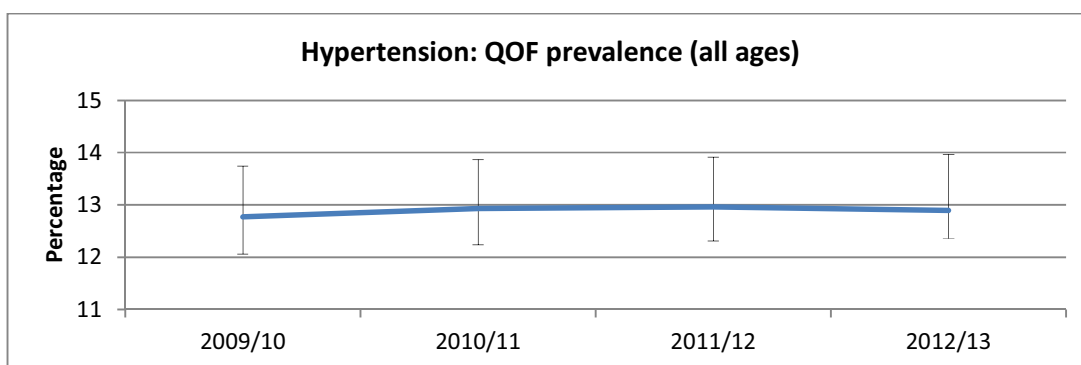


Figure 6: Hypertension prevalence³⁰ (QOF data)³¹ in C&P CCG

4.2 Future prevalence

The national data shows that rates of hypertension have dropped slightly between 1998-2010. However, the prevalence of hypertension appears to be quite stable in the CCG population with very little variation from 2009/10 to 2012/13 (less than 0.2%). As such we can predict a relatively stable hypertension prevalence looking forwards to 2019.

²⁹ Coronary Heart Disease Statistics 2012. Available at: <http://www.bhf.org.uk/publications/view-publication.aspx?ps=1002097>, accessed 19.05.2014

³⁰ The confidence intervals were calculated using the Wilson Score method with a confidence level of 95%.

³¹ Public Health England National General Practice Profiles. Available at: <http://fingertips.phe.org.uk/profile/general-practice/data#mod,8,pyr,2013,pat,19,par,E38000026,are,-,sid1,3000010,ind1,-,sid2,-,ind2,->

Future prevalence

Three major risk factors for multiple major diseases were selected for analysis based on the impact of the disease on the health of the CCG population and the levels of evidence around causation. The risk factors chosen were smoking, obesity and high cholesterol, and their contribution to CHD, stroke, colorectal cancer (CRC) and breast cancer were assessed.

Method

Population attributable fractions (from previous work on PYLL, referenced in Appendix 5) were applied to local prevalence / incidence data to determine a baseline number of cases attributable to each risk factor. The predicted risk factor % change (derived from the above sections) was applied to the number of attributable cases. The total number of cases was then recalculated to reflect the increase in the cases attributable to the risk factor in question if the total population remained constant but the risk factor exposure changed.

Limitations:

- This work is at an early stage and all forecasts should be treated as rough estimates. Confidence intervals have not been calculated. Significant further work would be required to develop this methodology if required
- Population changes (in size and demography) have not been included in the model since the prevalence trends in risk factors take into account historical demographic changes. To include them in predictive modelling could then lead to doubling of estimation of effects
- As prevalence figures are not available or appropriate for some disease states, the “number of cases” refers to either incidence or prevalence depending on the disease

Assumptions:

- A reduction in the risk factor prevalence by n% will lead to a reduction in the number of cases of disease attributable to this risk factor by n%
- Where local trend data are not available, the local picture reflects national trends

Results

Tables A7.1 and A7.2 below show the results of this preliminary modelling. Without taking population growth and ageing into account, across the whole CCG the shift in risk factors – such as a reduction in smoking prevalence and an increase in obesity – is likely to generate inappreciable changes in malignancies and stroke. However there may be a large and noticeable increase in the number of cases of CHD, driven by the increasing prevalence of obesity in the population and not significantly ameliorated by the reduction in smoking prevalence.

These calculations are however preliminary and are included to demonstrate the potential for modelling work based on shifting risk factors in our population.

Risk factors (RF)	Disease	Population attributable fractions PAF (%)	Change in Risk Factors RF(%)	Change in no. of cases
Smoking	CHD	24.4	-5.5%	-322
	Stroke	8.2	-5.5%	-3
	CRC	4.5	-5.5%	-1
Obesity	CHD	20.5	32%	1574
	Stroke	18.6	32%	37
	Breast cancer	6.2	32%	20
	CRC	4.2	32%	5
Hypercholesterolaemia	CHD	39.6	0%	0
	Stroke	26.5	0%	0

Table A7.1: modelled changes in disease cases if risk factor trends continue, by risk factor, 2014-2019

Disease	Total change in no. of cases across Risk factors (RF), 2019
CHD	1252
Stroke	34
Breast cancer	20
Colorectal cancer	4

Table A7.2: total changes in number of cases, risk factors combined, 2014-2019

Conclusions

An increase in obesity on the scale of that seen in recent years may result in increased demand on the health system beyond that which would be expected from modelling based on population growth. Changes in risk factors other than obesity are unlikely to make an appreciable difference to service demand if the risk factor trends examined continue as predicted.

Despite the small impact of other risk factors on this model, risk factor reduction should remain a priority as the effects are complex and the model simple; in addition the risk factors mentioned have negative health and social effects far beyond those considered here.

Appendix 9: Cambridgeshire and Peterborough CCG financial projections over the next 5 years

The information in this appendix shows the CCG financial projections over the next 5 years.

Modelling of our financial projections is ongoing. Here we present the latest information. There are two important assumptions that have been used in these calculations:

- That the population will increase by 1.5 % per annum
- That the acuity of the population health need will increase by 2.5% per annum for 14/15 and 15/16 increasing to 3% in 16/17 to 18/19, the higher increase in latter years is to recognise the increase in growth of our elderly population above the total population. This figure is in essence non demographic increase in demand for health care and comprises of absolute increase in health need and any increase in care delivered for the same level of need over the period.

Our population projections are subject to revision on a regular basis by the Cambridgeshire County Council Research Group and the same methodology can be used for other areas in the CCG.

Using these assumptions figure A9-1 shows how the CCG faces a gap of £99.1 m by 2018/19. The annual increase in this gap is shown in Figure A9-2.

Figure A9-1: 'Do nothing' financial projections 2014/15 to 2018/19

This shows that if the CCG does nothing about its financial position over the next five years it will face a deficit in 2018/19 of £ 99.1 m.

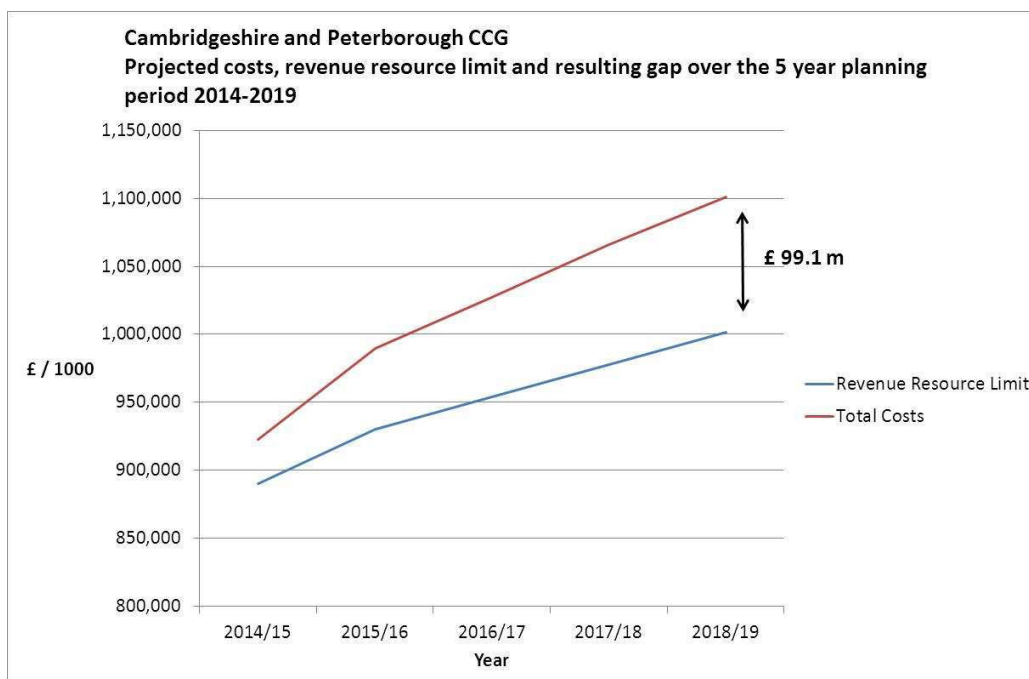
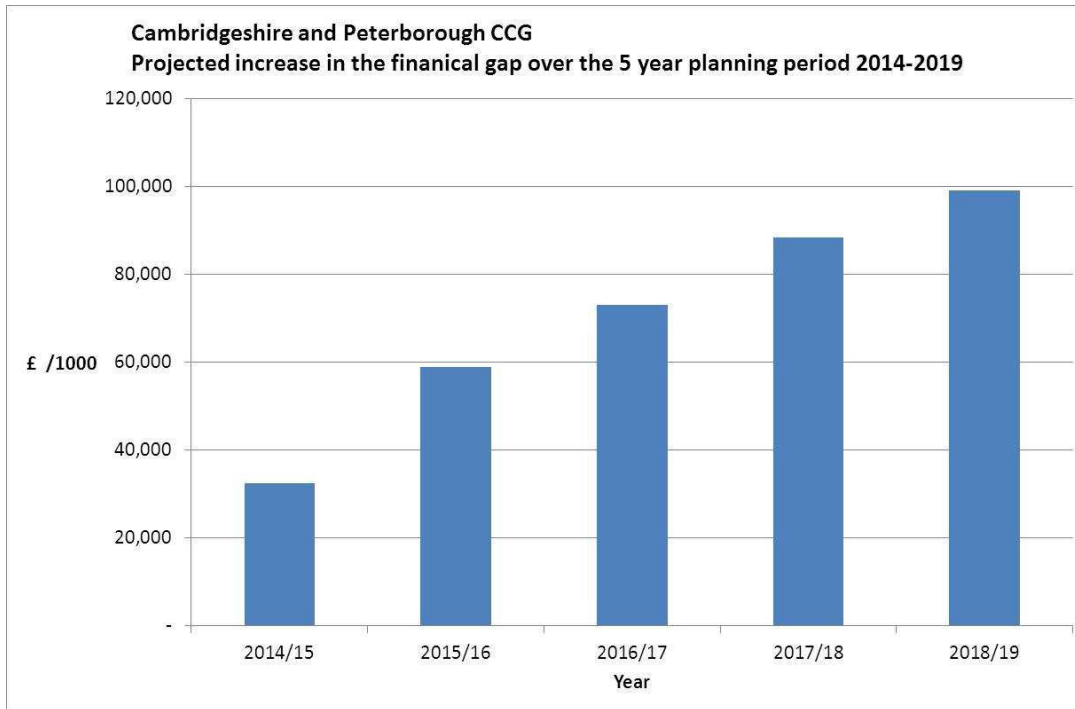


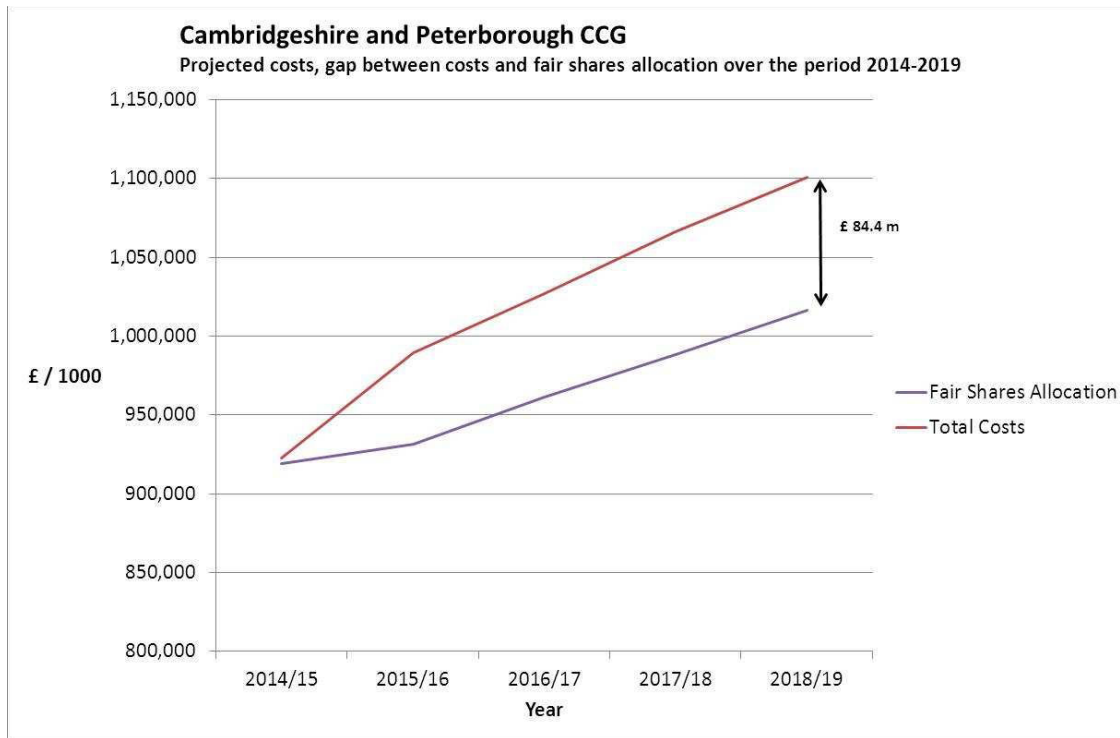
Figure A9-2 below shows the increase in the financial gap over the 5 year period.

Figure A9-2: Increase in financial gap from 2014/15 to 2018/19



Currently the CCG is receiving a financial allocation that is below its 'fair shares' allocation. Figure A9-3 shows the difference on the gap if the CCG were to gain its fair share allocation. This shows that if the CCG were to gain its 'fair shares' allocation then there would still be a financial gap of £84.4 m by 2018/19.

Figure A9-4: Increase in financial gap from 2014/15 to 2018/19



The size of the QIPP savings required over this period is challenging with over £77m of savings required over the first 3 years. The current plan to address this financial gap is shown in Appendix 7 and more detail is given in the CCG Two Year Plan. Figure A9-5 below also highlights the impact of the implementation of the Better Care Fund on the CCG’s overall financial position.

Cambridgeshire and Peterborough health system Blueprint 2014-2019

Figure A9-5

CAMBRIDGESHIRE AND PETERBOROUGH FIVE YEAR FINANCIAL PLAN - BASE CASE

18-Jun-14	2013/14			2014/15			2015/16			2016/17			2017/18			2018/19		
	Rec	Non Rec	Total	Rec	Non Rec	Total	Rec	Non Rec	Total	Rec	Non Rec	Total	Rec	Non Rec	Total	Rec	Non Rec	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Planned Resources																		
Recurrent resource	853,942	0	853,942	849,204		849,204	875,134		875,134	911,672		911,672	935,102		935,102	958,760		958,760
Uplift			0	24,604		24,604	21,681		21,681	23,430		23,430	23,658		23,658	24,161		24,161
In year adjustments	(4,738)	7,638	2,900	(1,155)		(1,155)			0			0			0			0
Anticipated adjs Hinch specialsit		2,481	2,481	2,481		2,481			0			0			0			0
Return of prior year surplus / (deficit)		2,659	2,659		(4,874)	(4,874)			0	9,306		9,306	9,633		9,633	9,873		9,873
Running Cost	20,800		20,800	20,943		20,943	18,889		18,889	18,889		18,889	18,889		18,889	18,889		18,889
Better Care Fund (ITF)			0			0	14,857		14,857			0			0			0
Total Resources	870,004	12,778	882,782	896,077	(4,874)	891,203	930,561	0	930,561	953,991	9,306	963,297	977,649	9,633	987,282	1,001,810	9,873	1,011,683

Planned Expenditure (13/14 is FOT)																		
Bought forward recurrent spend	858,914	6,631	865,545	858,914		858,914	859,588		859,588	895,262		895,262	921,666		921,666	946,061		946,061
Running Costs	20,800	(2,197)	18,603	20,800		20,800	18,889		18,889	18,889		18,889	18,889		18,889	18,889		18,889
Inflation / deflation			0	(9,345)		(9,345)	(12,232)		(12,232)	(3,975)		(3,975)	(4,073)		(4,073)	(9,058)		(9,058)
Population growth 1.5%	0		11,623	11,623		11,623	12,608		12,608	12,817		12,817	13,142		13,142	13,336		13,336
Other growth	0		12,306	3,400		15,706	19,179		19,179	25,049		25,049	25,689		25,689	26,070		26,070
Primary care	0		4,115	4,115		4,115			0			0			0			0
Re-stating Contingency	0		4,444	4,444		4,444	4,653		4,653	4,770		4,770	4,888		4,888	5,009		5,009
Marginal rate and re-admiss reserve	0		8,442	8,442		8,442	8,442		8,442	8,822		8,822	9,219		9,219	9,634		9,634
Better care fund	0		0	0		0	36,323		36,323	0		0			0			0
1% non rec CCG requirement	0		8,904	8,904		8,904	9,306		9,306	9,540		9,540	9,776		9,776	10,018		10,018
1.5% transition to 2015/16	0	3,508	3,508	0		0	0		0	0		0			0			0
Total spend before QIPP	879,714	7,942	887,656	898,413	25,190	923,603	934,355	22,401	956,756	948,043	23,132	971,176	975,314	23,884	999,198	995,298	24,661	1,019,959
Planned QIPP Savings			0	(23,282)		(9,118)	(32,400)		(24,856)	(10,644)		(35,500)	(12,258)		(5,254)	(17,512)		(15,252)
Total Spend after QIPP	879,714	7,942	887,656	875,131	16,072	891,203	909,499	11,757	921,256	935,785	17,879	953,664	960,062	17,347	977,409	982,423	19,143	1,001,566
Surplus / (deficit)	(9,710)	4,836	(4,874)	20,946	(20,946)	(0)	21,062	(11,757)	9,305	18,206	(8,573)	9,633	17,587	(7,715)	9,873	19,387	(9,270)	10,117

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Appendix 10: Strategic Planning Concordat

Cambridgeshire & Peterborough Local Health and Care Economy

Strategic Planning Concordat

Our commitments

As the leaders and regulators of the local health and care system, we commit to working together to develop a system-wide strategic plan that will:

- embed a common vision in which the needs of the local population come first
- create a health and care system that works in a joined up way, focuses on improving health and well-being and that is accountable to the local population
- establish a culture where it is the collective and individual responsibility to do the right thing, even if to do so is not in the best interests of our own organisation
- create a more productive and financially sustainable health and care system

Our values

We will:

- Place local people at the centre of everything we do
- Empower people to stay healthy
- Focus on improving quality and outcomes
- Be transparent in our actions

Practical actions

To this end we commit to these actions:

- Our Boards will sign up to the development of a system-wide strategic plan and will share responsibility to both champion and deliver the content.
- Each organisation will contribute resources to the design and implementation of the strategic plan
- Prioritising changes that improve outcomes and quality, whilst delivering financial sustainability
- Ensuring that the initiatives within the strategic plan narrow inequalities and consider the needs of the most vulnerable
- Working alongside local people to design the right solutions – doing with people, not to them
- Sharing data openly for the purposes of implementing the system strategy
- Integrating care and break down traditional barriers between organisations, so that local people receive joined-up care

We acknowledge that this may result in the following:

- The need to develop a different relationship between health and care services and local people
- Changes in how services are commissioned and provided, for example:
 - A greater emphasis on preventative and community based care, resulting in fewer people needing hospital care
 - Community services and primary care being delivered in new ways with full availability seven days a week
 - services for adults and children integrated across current providers
 - Relocation of some services
 - better linked and more accessible urgent care provision to reduce the need on local residents using A&E services
- Changes in how we fund and pay for care, to ensure that we align incentives with benefits for the whole system
- Making changes in the range of services organisations offer as we seek to drive up quality and improve efficiency

Parties to this concordat

Health care Providers:

- CUHFT
- CPFT
- Hinchingbrooke hospital/Circle Group
- Papworth Hospital
- CCS NHST
- PSHFT
- UCC
- HUC

Commissioning organisations:

- CCG
- NHS England

Local Authorities:

- Cambridgeshire County Council
- Peterborough City Council

Health care regulators:

- Monitor
- Trust Development Authority

SCRUTINY COMMISSION FOR HEALTH ISSUES	Agenda Item No. 6
10 SEPTEMBER 2014	Public Report

Report of the Executive Director of Adult Social Care, Health and Wellbeing

Contact Officer(s) – Dr Henrietta Ewart, Interim Director of Public Health
Contact Details - Town Hall, Bridge Street, Peterborough, PE1 1HQ
Tel: 01733 207175

CARDIOVASCULAR DISEASE

1. PURPOSE

- 1.1 To inform the Scrutiny Commission that improving outcomes and reducing inequalities associated with cardiovascular disease has been identified as the priority of the Health and Wellbeing Board and to present the reasons for its prioritisation (based on Public Health Outcomes Framework data) to the Commission.
- 1.2 To inform the Commission of the work plan proposed by the Health and Wellbeing Board to take forward work on cardiovascular disease to improve health outcomes and reduce inequalities.

2. RECOMMENDATIONS

- 2.1 The Scrutiny Commission is requested to consider and comment upon the prioritisation of cardiovascular disease and the work plan proposed to address it by the Health and Wellbeing Board.

3. LINKS TO THE SUSTAINABLE COMMUNITY STRATEGY

- 3.1 The cardiovascular disease strategy and work plan will contribute to the Sustainable Community Strategy Priority 1: Creating Opportunities – Tackling Inequalities and, within this priority area, to the outcome: Improving Health - so that everyone can enjoy a life expectancy of the national average or above and benefit from speedier access to high quality health and social care services.
- 3.2 The cardiovascular disease strategy and work plan will directly contribute to improvement in the cardiovascular disease indicators within the Public Health Outcomes Framework.

4. BACKGROUND

- 4.1 Based on review of the Public Health Outcomes Framework indicators and local authority health profiles for Peterborough, the Health and Wellbeing Programme Board identified cardiovascular disease as its top priority in May 2014. The priority was ratified by the Health and Wellbeing Board in July. Peterborough City Council Public Health team were charged with scoping cardiovascular disease and proposing a work plan for adoption by the Health and Wellbeing Programme Board/Health and Wellbeing Board (HWBPB/HWBB).

Work has proceeded with agreement by the HWBPB/HWBB that this will be structured around three themed work streams:

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

- 4.2 There is acknowledgement that the adoption of cardiovascular disease as a priority by the HWBPB/HWBB does not mean that work has not previously been going on, across all partner

organisations (PCC, Peterborough and Cambridgeshire CCG, provider trusts, etc) to improve outcomes and reduce inequalities. However, adoption as a priority by the HWBPB/HWBB provides an opportunity to take a strategic overview of all pathways relating to cardiovascular disease and improve their co-ordination and ensure that each follows current best practice and delivers value for money in order to maximise their impact on health outcomes and the reduction of inequalities.

- 4.3 There is a need to engage with all stakeholders in order to map out the activity and resources currently invested in work programmes and channel it where appropriate towards cardiovascular disease. This will necessitate stakeholder engagement and mapping. This mapping exercise is currently in development.
- 4.4 An opportunity arose in June to bid for funding from the British Heart Foundation to develop their 'House of Care' model locally. This is a person centred model with four key elements:
- i. Engaged, informed individuals and carers
 - ii. Commitment to partnership working
 - iii. Organisational and supporting processes
 - iv. Commissioning (including 'more than medicine' – ie whole pathway from prevention through to re-ablement/re-empowerment)

As a result of this opportunity, initial work on scoping the cardiovascular disease work plan was linked to the completion of the British Heart Foundation bid process. However, it was agreed that the House of Care model be adopted as the vehicle for local cardiovascular disease work regardless of whether or not we are successful in achieving BHF funding. The three work streams discussed at para 4.1 will be incorporated into this model. The bid has been submitted to the BHF and shortlisting is due to be completed by October. Further work will be required to complete the mapping beyond the initial requirements for the BHF bid and this is now being scoped.

5. KEY ISSUES

- 5.1 Improving outcomes from and reducing inequalities in cardiovascular disease is complex and requires a sustained, strategic approach to prevention, health promotion, early intervention, healthcare interventions (in primary and secondary care and in specialised services) and rehabilitation/re-ablement. This will require collaboration between and ownership by all partner organisations and the engagement of local communities (particularly groups who currently experience poorer outcomes). This will be an ongoing programme of work which will extend over the medium to long term.
- 5.2 The Scrutiny Commission is requested to comment on the approach proposed above.

6. IMPLICATIONS

- 6.1 Proposals resulting from the adoption of cardiovascular disease as a priority by the HWBPB/HWBB and from the subsequent work plans may have implications including Financial; Legal; Human Resources; ICT, Environmental, Human Rights, Property, Procurement, LAA targets, Public Health Outcome Framework targets, etc. These will be identified and addressed as they arise.

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

7. CONSULTATION

- 7.1 Consultation has been undertaken with stakeholders through the HWBPB/HWBB and with other partner organisations, e.g. Greater Peterborough Partnership Health Enquiry Group. Further

consultation on specific issues arising as the strategy develops may be required.

8. NEXT STEPS

- 8.1 Comments received from the Scrutiny Commission will be presented to the HWBPB/HWBB to inform the strategy. The Scrutiny Commission may wish to request further updating reports on this item.

9. BACKGROUND DOCUMENTS

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

- 9.1 See appendices

10. APPENDICES

- 10.1
- Appendix 1 - Report to the Health and Wellbeing Board, July 2014
 - Appendix 2 - Report on Cardiovascular Disease indicators from the Public Health Outcomes Framework for the Health and Wellbeing Programme Board, March 2014.
 - Appendix 3 - Key Elements of the House of Care Project, British Heart Foundation.

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Appendix 1

HEALTH AND WELLBEING BOARD		AGENDA ITEM No.
17 July 2014		PUBLIC REPORT
Contact Officer(s):	Dr Henrietta Ewart, Interim Director of Public Health	Tel.

UPDATE ON CARDIOVASCULAR DISEASE PRIORITY WORK PROGRAMME

RECOMMENDATIONS	
FROM : Dr Henrietta Ewart, Interim Director of Public Health	Deadline date :
The Board is asked to note and comment on the proposals for progressing cardiovascular disease (CVD) as the Board's top priority.	

1. ORIGIN OF REPORT

- 1.1 This report is submitted to the Board following the decision taken by the Health and Wellbeing Programme Board (HWPB), at their May meeting, that 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.

2. PURPOSE AND REASON FOR REPORT

- 2.1 The purpose of this report is to provide an update on the work undertaken so far by the Public Health Team in response to the HWPB request.

3. LINKS TO THE HEALTH & WELLBEING BOARD STRATEGY/PLAN

- 3.1 The proposed model for delivery is to make use of the structures and work programmes already developed to deliver the Health and Wellbeing Board Strategy and Plan, but to ensure that Cardio Vascular Disease was tackled by these groups. This would involve clear mapping to existing work streams into three thematic areas on the CVD programme and holding groups to account for delivery of metrics related to the Public Health Outcomes Framework that align to CVD.

4. PROPOSED APPROACH TO STRUCTURE AND GOVERNANCE

- 4.1 At their June meeting, the HWPB agreed that they (the programme board) would act as the steering group/programme board for CVD, given its priority on the health and wellbeing agenda. It will be important to identify work streams already established for CVD to ensure that these are included in the governance arrangements and to avoid duplication. The Clinical Commissioning Group (CCG) already have a multi-agency CHD Programme Board and this needs to be included as a key component of the CVD work plan.
- 4.2 The best approach to embedding the CVD priority is to pull together all work currently taking place within the City across organisations which relates to CVD and its treatment or causes and ensure that CVD is given a higher profile in these work streams and that there are reporting streams with metrics and data collection aligned.
- 4.3 The HWPB agreed that the CVD Programme should be split into three thematic work streams
- Prevention and Early Intervention
 - Healthcare and Rehabilitation/Reablement

- Continuing Support

- 4.4 A brief description of each work stream and a suggestion of alignments is given below
- Prevention and Early Intervention** – This would include reducing risk factors for CVD through lifestyle modification, behaviour change and changes to the environment. It would also include interventions within primary care to prevent episodes of poor health caused by CVD. Existing work strands that might be aligned include: healthy schools programme, health checks, pharmacy needs assessment, access to leisure initiatives such as “Be Active” schemes, Social Impact Bonds and Asset Based Community Development.
- 4.5 Healthcare and Rehabilitation/Reablement** – This would include treatment and support for people diagnosed with CVD to prevent or slow deterioration of their condition and enable recovery from episodes of poor health as far as possible. This would include health interventions but also support with lifestyle, environment etc to support recovery and empower people to manage their condition. Existing work streams that might be aligned include smoking cessation, health trainers, intermediate care and enablement services.
- 4.6 Continuing Support** – this would include health care and social care for people with chronic and long term impacts from CVD, to provide effective treatment and promote independence as far as possible. Existing work streams that might be aligned are the Better Care Fund and the CCGs procurement of older people’s services, and assistive technology and health telecare programmes.

5. KEY ISSUES

- The HWPB supported the three work stream approach to CVD set out above. However the brief summary above is not a complete picture of all the work currently underway. We need to engage with all stakeholders in order to map out the energy currently invested in work programmes and channel it where appropriate towards CVD. This will necessitate stakeholder engagement and mapping. The HWPB has tasked the Public Health Team with organising a half-day stakeholder workshop to identify and map current activity.
- Subsequent work will be needed for gap analysis and to review current activity against best practice (NICE public health and clinical guidelines and NICE technology appraisals) and to respond to other sources of intelligence (e.g. Commissioning for Value Cardiovascular Disease Focus Packs). The HWPB (in its capacity as CVD Steering Group/Programme Board) will be required to agree the content of this work plan and its delivery. This stage will follow on from the workshop described above.
- We need to understand better where our issues are and then be able to monitor the impact we are having. The Public Health Outcomes Framework gives us a high level view but we need to drill down into the local detail. We have therefore begun work to identify the PHOF indicators aligned to CVD and to break these into the work streams in order to identify local data sets and indicators to inform our understanding and monitoring. This will effectively create a refreshed CVD JSNA.

6. IMPLICATIONS

Incorporating the CVD work programme into existing work streams to provide focus for work already ongoing or planned should limit negative impacts on the above areas. However there will be a cost for some of the target work, as in the case of the proposed half day stakeholder mapping session.

7. NEXT STEPS

1. The PH Team will lead on a half day stakeholder and work stream mapping event to build upon the proposed work streams. This event is scheduled for late July. The

format for this workshop has changed slightly from that originally envisaged as we have been invited to bid for British Heart Foundation funding to develop their 'House of Care' model locally. This is a person centred model with four key elements:

- i. Engaged, informed individuals and carers
 - ii. Commitment to partnership working
 - iii. Organisational and supporting processes
 - iv. Commissioning (including 'more than medicine' – ie whole pathway from prevention through to re-ablement/re-empowerment)
2. We propose to focus the initial workshop around the requirements for the BHF bid in order to meet the bid deadline. However, we propose that the House of Care model be adopted as the vehicle for local CVD work regardless of whether or not we are successful in achieving BHF funding. The three work streams discussed at para 4 will be incorporated into this model. A further workshop may be required to complete the mapping exercise identified at para 5.
 3. The PH Team will complete the work around alignment of the PHOF to these work stream and the creation of drill down metrics. This will then be taken to the information working group of the HWBB to agree reporting lines and ownership.
 4. The CCG will need to consider how the CHD Programme Board will relate to the HWPB in the latter's capacity as CVD Steering Group/Programme Board.

8. CONSULTATION

The PH team is proposing wider consultation with stakeholders as part of the workshop above.

9. ANTICIPATED OUTCOMES

That the HWB note and comment on the arrangements for progressing work on CVD proposed by the HWPB.

10. REASONS FOR RECOMMENDATIONS

To ensure that the HWB are fully informed of the proposals for progressing CVD as the Board's top priority and have assured themselves that these are appropriate.

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PRIORITISATION FRAMEWORK FOR PETERBOROUGH HEALTH AND WELLBEING PROGRAMME BOARD

Cardiovascular Disease (CVD)

The framework below is intended to provide an objective and consistent approach to assessing possible topics (based on care groups, population groups or clinical areas, etc.) for inclusion as priorities within the Peterborough Health and Wellbeing Strategy. Detailed answers to each section are not required at this stage and some proposals may need further scoping before a final decision on inclusion in the strategy.

This scorecard is based on others which have been used/worked well elsewhere, with adjustments to reflect local situation.

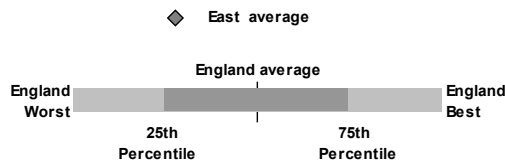
Why should CVD be a priority area for Peterborough Health and Wellbeing Board?

The chart below demonstrates that indicators relating to CVD are 'worst of the worst' amongst our Public Health Outcomes Framework indicators. (NB Male suicide is our poorest indicator: this is already being addressed as a priority through the Peterborough and Cambridgeshire Suicide Prevention Strategy and the local implementation group).

Peterborough Updated PHOF analysis - review of "poorly performing" indicators

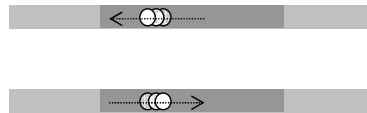
The chart below shows how P'Boro compares with the rest of England. P'Boro's result for each indicator is shown as a circle. The average rate for England is shown by the black line at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means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

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



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

- ◀ Deteriorating relative to other local authorities in England
- Remaining similar to other local authorities in England
- ▶ Improving relative to other local authorities in England



Healthy life	All cause mortality	13 Life expectancy at birth (males) in years	77.9	80.1	79.2		—	◀	2010-2012
		14 Life expectancy at birth (females) in years	82.5	83.0	83.7		◀	◀	2010-2012
		15 Gap in life expectancy (males) in years	-1.3	0.9	-		—	◀	2010-2012
		16 Gap in life expectancy (males) in years	-0.5	-0.7	-		◀	◀	2010-2012
		17 Healthy life expectancy at birth (males) in years	61.6	64.8	63.2		no data	no data	2009-2011
		18 Healthy life expectancy at birth (males) in years	60.3	66.2	64.2		no data	no data	2009-2011
	Amenable to healthcare	19 Mortality rate from causes considered preventable	210.9	165.7	187.8		—	◀	2010-2012
		20 Under 75 mortality rate from cardiovascular diseases considered preventable	71.5	48.1	53.5		◀	—	2010-2012
	Cardiovascular disease	21 Under 75 mortality rate from cardiovascular diseases	111.8	72.6	81.1		◀	◀	2010-2012
	Respiratory disease	22 Under 75 mortality rate from respiratory disease	42.5	26.6	33.5		—	◀	2010-2012
	Communicable disease	23 Mortality from communicable diseases	74.2	58.9	64.8		◀	◀	2010-2012
	Suicide	24 Suicide rate	12.4	7.9	8.5		◀	—	2010-2012
	Long term conditions	Diabetes	25 Recorded diabetes	6.2%	6.0%	5.8%		no data	no data
26 Access to non-cancer screening programmes - diabetic retinopathy			72.7%	80.9%	80.9%		◀	no data	2011-2012
Healthy Lifestyle	Cancer	27 Cancer screening coverage - cervical cancer (%)	0.7	0.8	0.7		◀	◀	2013
	Drugs	28 Successful completion of drug treatment - opiate users (%)	4.9%	9.8%	8.2%		◀	◀	2012
Health services	NHS health checks	29 Offered an NHS health check (% of eligible people aged 40-74)	46.6%	51.4%	49.1%		◀	no data	2012/2013

SCALE OF THE PROBLEM IN PETERBOROUGH

Question 1: How many people does the problem affect in Peterborough

How this question will be scored

More points will be given where large numbers of people are affected. Examples: numbers of infant deaths are low in the area. Sedentary behaviour is far more common.

Cardio-vascular disease (CVD) includes all the diseases of the heart and circulation.

The four main types of CVD are coronary heart disease (CHD), stroke, peripheral arterial disease and aortic disease.

CVD is the second largest cause of death in England causing around 130,190 deaths in 2011 (**29% of all deaths**). Around 46% of all deaths from CVD are from coronary heart disease (CHD) and almost a fifth from stroke (18%). CHD is the most common single cause of death in England (13% of all deaths in 2011).

Deaths due to cardiovascular disease account for **27.0% of all deaths under 75 in Peterborough** (23.8% in Cambridgeshire). CHD accounts for the largest proportion of CVD deaths.

GPs record information on whether their patients have CHD or have a stroke.

Currently, **5166 people** are recorded as having CHD in Peterborough (2.8% of the population). The expected number (from national prevalence data) is 10,332 people (5.6% of the population). The recorded prevalence of CHD is 50.4% of the expected number. This compares to 58.2% for England and 59.1% for East of England. This means that Peterborough is underperforming compared to England and East of England with regards to identifying people who suffer from CHD. This may mean that not everyone with CHD is being offered appropriate support and interventions.

Around 2583 people have been recorded as having had a stroke in Peterborough (1.4% of the population). The expected number (from national figures) is around **4428 people** (2.4%). The observed prevalence for stroke in Peterborough is 57.5% of the estimated prevalence. This compares to 68.4% for England and 68.2% for East England. Under recording may mean that people are not getting access to appropriate support and interventions.

About 12.3% of the population (**22,694 people**) have been diagnosed with hypertension. However, the estimated prevalence of hypertension is 29.3% (**54058 people**). The observed prevalence for hypertension in Peterborough is 41.9% of the estimated prevalence, meaning many people live with the condition in the community without it being diagnosed and treated. This compares to 46.0% for England and 45.6% for East of England. Again, this means that people may not be getting access to the appropriate support and interventions.

IMPACT OF THE PROBLEM ON INDIVIDUALS

Question 2: What is the impact of having this problem/condition on individuals, their families and carers?

How this question will be scored

More points will be given where the impact on those affected and their carers/families is severe. This would include physical and mental health and wellbeing (eg as measured by quality of life etc). Although infant mortality would be ranked low in question 1, it would score highly here.

Cardiovascular disease (CVD) was responsible for nearly 30% of all deaths in 2011 – and is **the largest cause of disability**.

Cardiovascular diseases can have a serious impact on quality of life and cause considerable disability. Stroke survivors may lose their speech, and have impaired mobility, those with peripheral arterial disease may lose a limb. The breathlessness and exhaustion of severe heart failure may preclude even minimal activities of daily living and all of these may prevent people returning to employment. And those with chronic kidney disease (CKD) can progress to the need for life long dialysis when opportunities to address CVD risk are missed.

PERFORMANCE

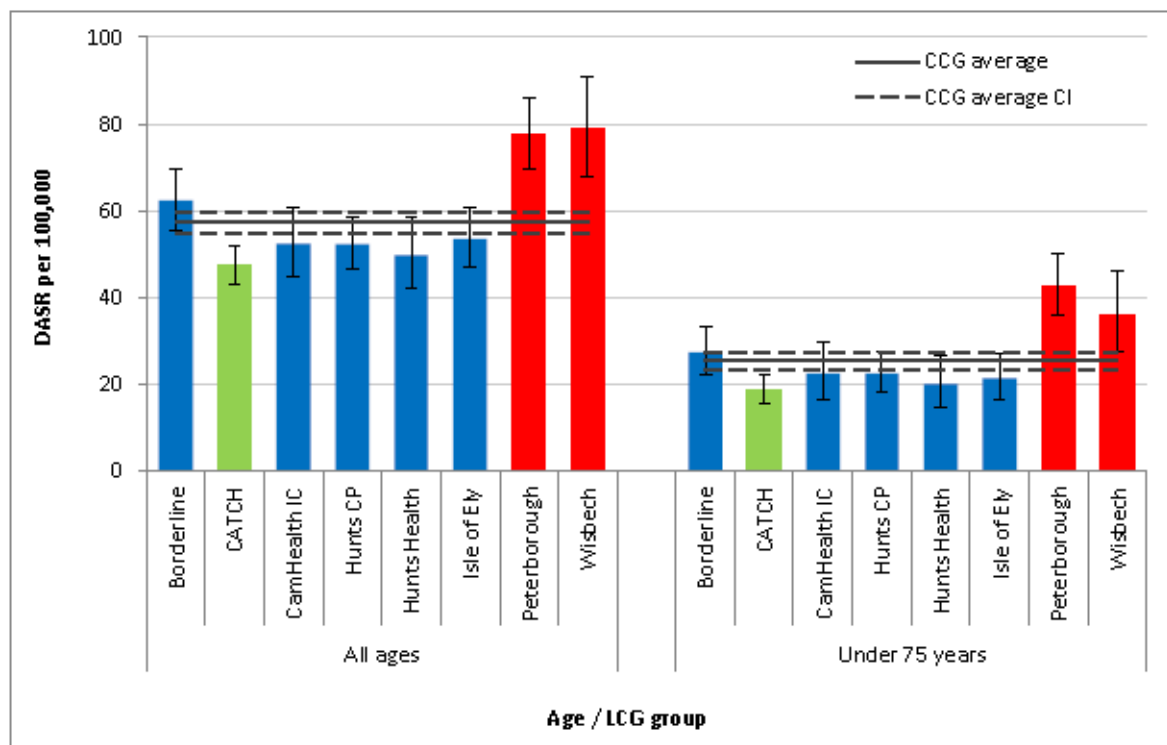
Question 3: Is there evidence to suggest that Peterborough performs less well than they could on this topic?

How this question will be scored

More points will be awarded where there is good evidence that Peterborough

performs badly, ie where this is confirmed by one or more indicators (PHOF and/or CCG Outcomes Indicator Set, and/or where poor performance on indicators has been sustained over a number of years).

The graph below shows clearly that Peterborough has worse all age mortality rates from CHD than other LCGs within Cambridgeshire and Peterborough CCG (with the exception of Wisbech) and has the worst under-75 mortality rate in the CCG. Borderline LCG has rates close to the average for the CCG.



With regards to **interventions in primary care, indicators from the QOF show that Peterborough is underperforming in a number of areas.** A detailed analysis per GP practice was undertaken for Cambridgeshire and Peterborough in 2014 as part of the CHD Programme Board. This work showed that there is a significant variation in performance among GP practices.

Quality and Outcomes Framework indicators relevant to CHD and stroke

Significantly lower than England

The same as England

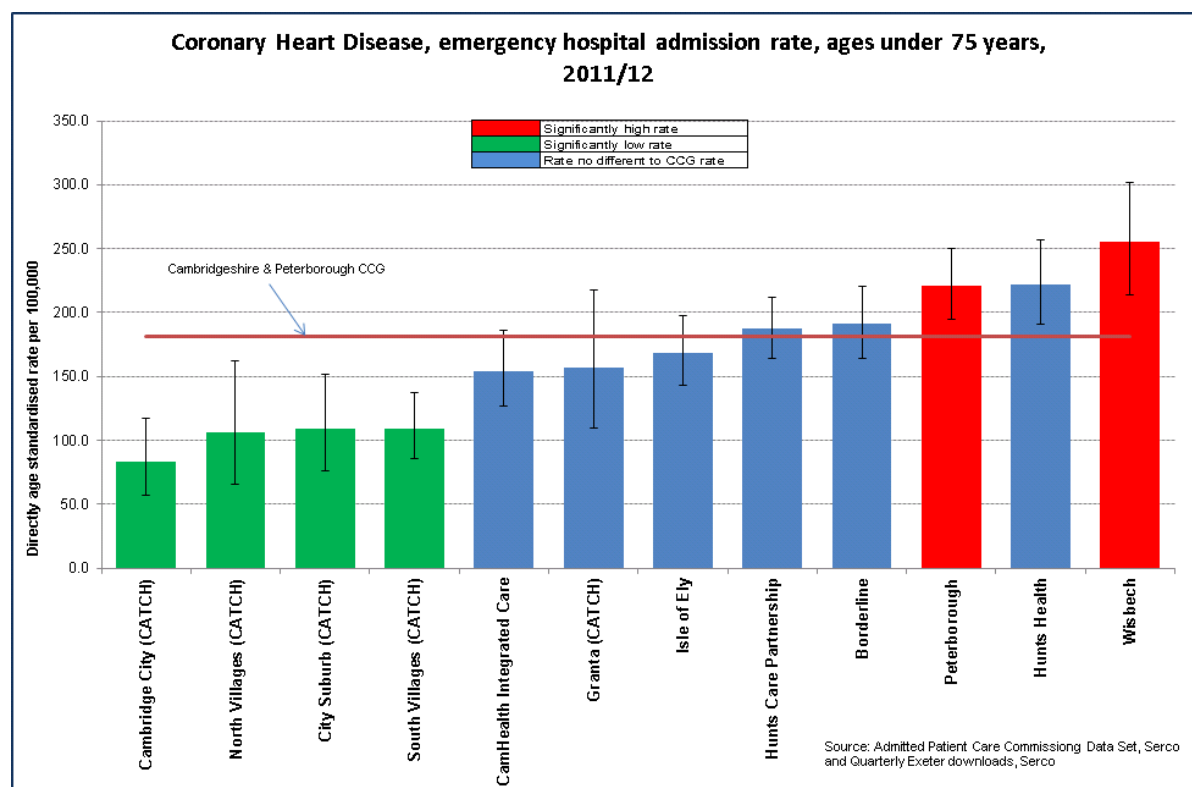
Significantly higher than England

	Peterborough	East of England	England		Peterborough	East of England	England
Coronary heart disease				Stroke			
% newly diagnosed angina patients referred for exercise testing or assessment	90.8	98.0	98.2	% stroke patients whose blood pressure was 150/90 or less	88.1	88.6	88.6
% CHD patients in whom last blood pressure reading was 150/90 or less	89.1	90.2	90.1	% stroke patients with record of cholesterol in last 15 months	89.5	90.2	91.4
% CHD patients in whom last cholesterol measurement was 5mmol/l or less	78.0	79.1	80.4	% stroke patients whose cholesterol was 5mmol/l or less	75.1	75.2	77.2
% CHD patients taking aspirin, an alternative anti-platelet therapy or an anti-coagulant in last 15 months	92.1	92.5	93.3	% stroke patients immunised preceding Sept-March	88.6	89.8	90.0
% CHD patients currently treated with beta blocker	72.6	73.6	74.2	% non-haemorrhagic/with history of TIA stroke patients taking anti-platelet agent/anti-coagulant	92.6	93.0	93.6
% patients with history of myocardial infarction currently treated with ACE inhibitor or angiotensin II antagonist	92.9	91.6	91.1	% new patients with a stroke referred for further investigation	87.6	89.1	89.6
% CHD patients immunised against influenza in Sept-March 05	91.7	92.3	92.5	Hypertension			
Atrial fibrillation				% hypertension patients with record of blood pressure in last 9 months	90.6	90.7	91.0
% atrial fibrillation patients currently treated with anti-coagulation drug therapy or an anti-platelet therapy	93.1	93.4	93.7	% hypertension patients (with record in last 9 months) in whom last blood pressure was 150/90 or less	78.2	79.6	79.7
Heart failure				Primary prevention			
% heart failure patients diagnosed after 1st April 2006 with diagnosis confirmed by an echocardiogram or specialist assessment	95.4	94.8	95.7	% hypertension patients aged 30 to 74 who have had a cardiovascular risk assessment at the outset of diagnosis	77.4	78.4	80.0
% patients with a current diagnosis of heart failure due to LVD currently treated with an ACE inhibitor or angiotensin receptor blocker	88.8	88.9	89.3	% hypertension patients who are given lifestyle advice in the for physical activity, smoking cessation, alcohol consumption and diet	79.6	80.9	81.5

Source: Quality and Outcomes Framework 2011/12

Peterborough has higher rates of emergency admissions for CHD compared to England average and East of England. In 2011/12 the emergency admission rate for CHD, all

persons, in Peterborough was 263.9 per 100,000 (522 admissions). This is significantly higher than England (198.3 per 100,000) and East of England (180.9 per 100,000).



In 2011/12 the emergency admission rate for stroke, all persons, in Peterborough was 105.7 per 100,000 (237 admissions). This is significantly higher than England (89.5 per 100,000) and East of England (82.4 per 100,000). Male stroke emergency admission rates are higher than female stroke emergency admission rates.

DEPRIVATION

Question 4: Is the condition/problem more common amongst those living in areas of deprivation or disadvantage?

How this question will be scored

More points will be awarded where there is demonstrably greater impact on those from deprived areas or backgrounds. Examples are diseases associated with smoking, since the prevalence of smoking is much greater in deprived groups. Although incidence of many diseases is related to deprivation, some have an inverse relationship with deprivation, such as breast cancer.

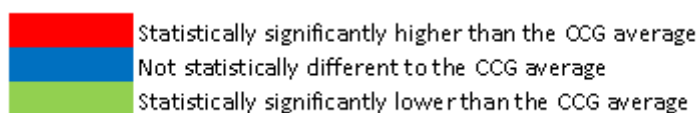
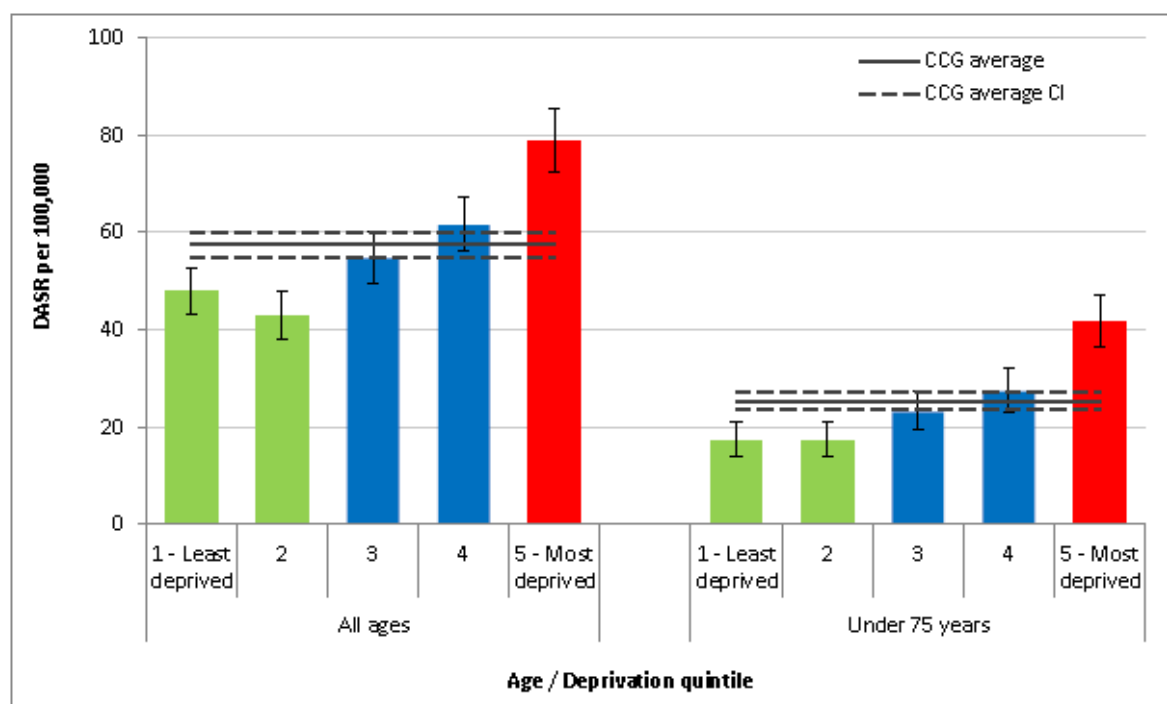
CVD prevalence and mortality are strongly correlated with deprivation. This is partly due to higher prevalence of risk factors for CVD among populations with lower socio-economic status (e.g. higher prevalence of smoking, obesity, unhealthy diet, binge drinking etc.), limited access to preventive and healthcare services among deprived populations (e.g. treatment for hypertension, statins etc.), and a small residual independent effect of poverty that is not accounted for by other known risk factors for CVD. Peterborough has higher

levels of deprivation compared to England and Cambridgeshire, and not surprisingly is experiencing higher burden of CVD. Comparison with the national deprivation structure (IMD 2010) shows that the populations of Cambridgeshire and Peterborough are very different, with Cambridgeshire having 39% of its population in the least deprived quintile and 2.5% in the most, with the trends are reversed in Peterborough where 7.9% are within the least and 34.3% in the most deprived national quintiles.¹

In both all ages and under 75s, age-standardised rates of CHD mortality are statistically significantly higher than the CCG average in the most deprived 20% of practices in the CCG but lower in the least deprived 40% of practices.

CHD mortality by deprivation quintile of practice, directly age-standardised rates, NHS Cambridgeshire and Peterborough CCG, 2011-13

Deprivation quintile of practice* within the CCG	Age group							
	All ages				Under 75 years			
	Number of deaths	DASR per 100,000	95% CI		Number of deaths	DASR per 100,000	95% CI	
		Lower	Upper			Lower	Upper	
1 - Least deprived 20% of practices	418	47.8	43.1	52.8	95	17.1	13.8	21.0
2	339	42.8	38.2	47.9	91	17.2	13.9	21.2
3	452	54.7	49.5	60.2	131	23.1	19.3	27.4
4	533	61.4	56.0	67.2	150	27.3	23.1	32.1
5 - Most deprived 20% of practices	638	78.8	72.5	85.5	230	41.5	36.3	47.2
Total CCG	2,380	57.4	55.0	59.9	697	25.4	23.5	27.3

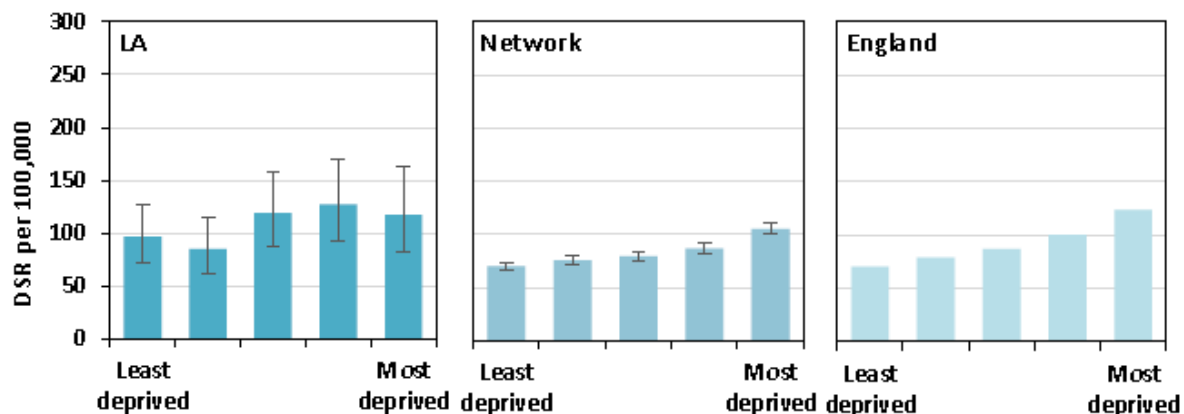


The emergency admission rate for stroke in 2011/12 for persons who live in the most deprived areas of Peterborough was 117.4 (DSR per 100,000). This is 1.2 times greater than

¹IMD 2010 Department of Communities and Local Government (DCLG)

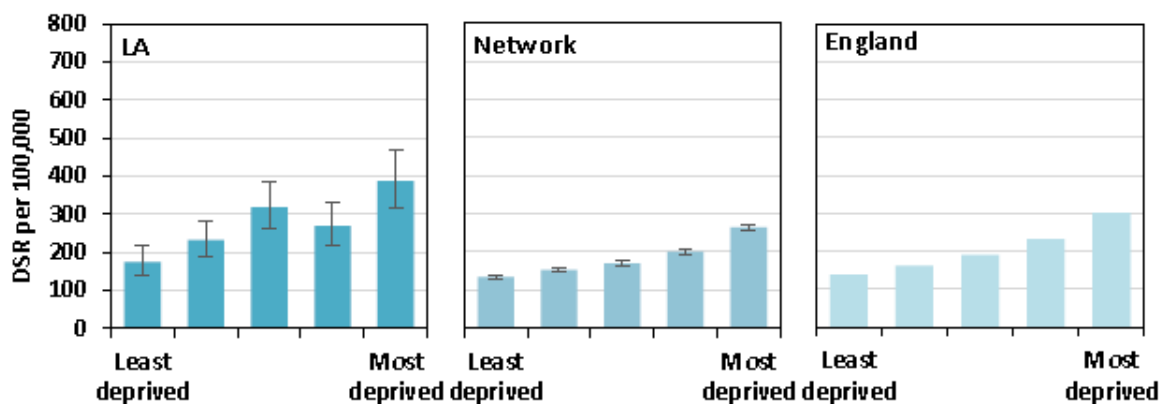
the emergency admission rates for persons who live in the least deprived areas of Peterborough (96.5).

Stroke emergency admission rates (DSRs), by quintile of relative deprivation, 2011/12



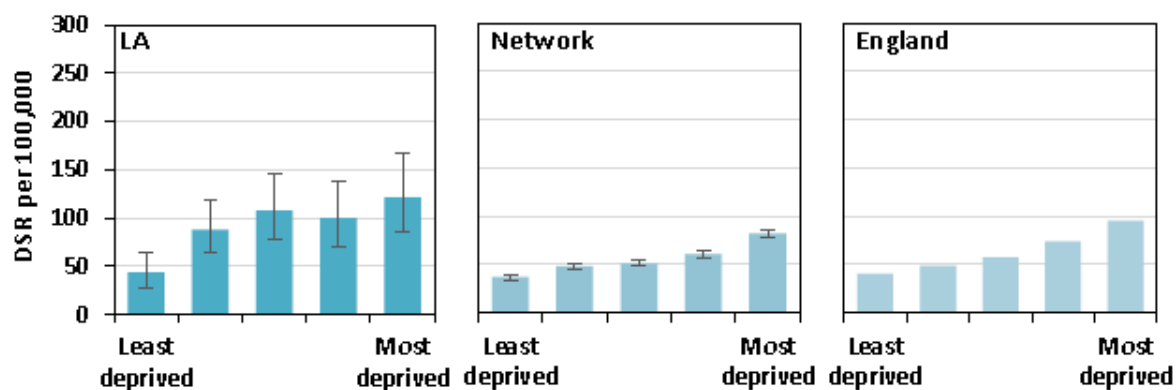
The emergency admissions for CHD in 2011/12 for persons living in the most deprived areas of Peterborough was 387.6 (DSR per 100,000). This is 2.2 times greater than emergency admission rates for persons living in the least deprived areas of Peterborough (174.7).

CHD emergency admission rates (DSRs) for all ages by quintile of relative deprivation, 2011/12



The emergency admissions for heart failure in 2011/12 for persons who live in the most deprived areas of Peterborough was 121.4 (DSR per 100,000). This was 2.8 times higher than the emergency admission rates for persons who live in the least deprived areas of Peterborough (43.2).

Heart failure emergency admission rates (DSRs) for all ages, by quintile of relative deprivation, 2011/12



EQUALITIES

Question 5: Would addressing the problem/condition contribute to advancing equality or eliminating discrimination in groups with the following protected characteristics: age, disability, race/ethnicity, religion or belief, sex/gender, sexual orientation, marriage and civil partnership, pregnancy and maternity

How this question will be scored

More points will be awarded to topics which have demonstrable potential to advance equality or eliminate discrimination in several protected groups. Examples would include issues that are particularly prevalent in specific protected groups, such as diabetes or heart disease in some ethnic minority groups, or areas where services are believed to be less accessible to one or more protected group.

Race/Ethnicity: The proportion of the population in Peterborough which is from black and minority ethnic groups is estimated to be 17.5%. South Asian men are more likely to develop CHD at younger age, and have higher rates of myocardial infarction. Black people have the highest stroke mortality rates.

Sex: Male CVD mortality rates in Peterborough are significantly higher than female CVD mortality rates (233.4 and 149.7 respectively), DSR per 100,000.

Age: Age is a strong predictor of morbidity and mortality from CVD, with disease burden increasing with age.

Addressing inequalities in CHD and stroke prevention and care would advance equality in these groups.

EVIDENCE

Question 6: What evidence is there that the scale or impact of the problem can be effectively

reduced?

How this question will be scored

More points will be awarded where there is good evidence for interventions that reduce the scale or impact of the problem. Types of evidence could be from outcome based studies (clinical trials etc) or delivery models (examples of good practice).

There is a strong body of evidence that the majority of CVD is caused by risk factors that can be controlled, treated or modified, such as high blood pressure, cholesterol, overweight/obesity, tobacco use, lack of physical activity and diabetes.

Modifiable risk factors for CVD

- Hypertension (high blood pressure)
- Tobacco use
- Raised blood glucose (diabetes)
- Physical inactivity
- Unhealthy diet
- Blood cholesterol/lipids
- Overweight and obesity

The risk factors for CVD are more prevalent in Peterborough than in England and Cambridgeshire (Table 1). This indicates that there is a potential for reducing the prevalence of major risk factors and reducing the gap in CVD mortality between Peterborough and Cambridgeshire, and reducing inequalities among areas within Peterborough.

Table 1. Prevalence of risk factors for CVD in Peterborough compared to Cambridgeshire and England

Risk factor	Peterborough	Cambridgeshire	England average
1. Deprivation (%)	34.6	2.4	19.8
2. % Obese Children (Year 6)	19.6	16.0	19.0
3. Estimated % obese (16+)	24.9	20.9	24.1
4. Estimated % smokers (16+)	26.3	20.8	20.7
5. Smoking related deaths/100,000 (DSR)	225	172	211
6. Binge drinking %	16.4	19.7	20.0
7. Healthy eating adults %	28.0	32.4	28.7
8. Physically active adults % (16+)	9.7	12.8	11.2
9. People diagnosed with diabetes % of GP reg.	5.9	5.1	5.8
10. Estimated prevalence of hypertension %	23.2	22.9	24.9

1. % people in this area living in 20% most deprived areas in England, 2010

5. Directly age standardised rate per 100,000 population aged 35 and over, 2008-2010
7. % adults, modelled estimate using Health Survey for England 2006-2008
8. % aged 16 and over, Oct 2009-Oct 2011
9. % people on GP registers with a recorded diagnosis of diabetes 2011/12 (QOF prevalence)

There is a strong evidence base on the effectiveness and cost-effectiveness of interventions directed at 1) reduction and control of risk factors for CVD; and 2) therapeutic interventions in primary and secondary care, and secondary prevention.

The National Institute for Health and Care Excellence (NICE) has published a total of 339 guidance documents relevant to CVD. These include public health guidance covering effective interventions for reduction of CVD risk factors; clinical guidelines covering best practice and pathways for conditions including hypertension, angina, heart failure, peripheral arterial disease, diabetes, obesity etc.; and technology appraisal guidance covering specific clinical interventions for established CVD.

NICE has published materials to support the implementation of their guidelines/guidance. These include quality standards and commissioning guides (for example, an integrated commissioning guide for the prevention of cardiovascular disease, CMG45).

A whole systems approach to the implementation of existing NICE guidance across Peterborough (including guidance on decommissioning) should have a major impact on CVD outcomes and could also result in cost savings.

VALUE FOR MONEY

Question 8: What is the current annual spend on this area in Peterborough? Could this proposal lead to potential savings? Could this proposal improve cost effectiveness ('getting more for less')? Could it improve quality/outcomes? Could this proposal have an impact on spend in other areas (e.g. will our actions increase/decrease spend in other public or other services)?

How this question will be scored

More points will be awarded for topics which are known areas of high spend, with clear potential for savings (eg where potential for savings has been identified from benchmarking work such as the Value for Money packs).

More points will be awarded for topics where improvement in quality/outcomes is likely.

Investment in health programmes (rather than services) and overall outcome indicators can be compared by CCG, SHA, and against English averages using the YPHO Spend and Outcomes tool. Expenditure is based on programme budgeting category with CHD included within the 'Circulation' programme and representing the 2nd highest area of spend within both PCTs per head of population (£135 in 2010/11 in Cambridgeshire and £142 in Peterborough compared to £143 across the East of England and £133 in England).

When compared against other PCTs in England, Cambridgeshire and Peterborough PCTs had very different outcomes for programme budgeting categories in 2010/11. CHD mortality under 75 years falls within the 'circulation' programme, and sits within the 'high spend, better outcomes' quadrant for Cambridgeshire and 'high spend, worse outcome' quadrant for Peterborough. Comparison of Peterborough values with 2009/10 data suggests that CHD

mortality outcomes in those aged under 75 have declined, despite a higher spend per head of the population in 2010/11.

NHS Health Checks aim to identify those at increased risk of developing several serious and preventable conditions, including coronary heart disease. Previously undiagnosed adults aged between 40 and 74 are invited for a consultation and advice session once every 5 years.

The NHS Health Check ready reckoner tool calculates the likely impact of the programme on local authority populations, including an estimate of how many individuals will complete weight loss programmes, increase physical activity, be prescribed statins or hypertensive medications, maintain glucose regulation or be diagnosed with diabetes or cease to smoke. On a yearly basis, the total cost of the programme per year is estimated as £205,398 in Peterborough respectively, with a lifetime gain of 825 Quality Adjusted Life Years (QALYs) in Peterborough at a cost of £1903 per QALY.

The NICE commissioning support materials (referenced at question 6, above) include tools to model costs and savings associated with moving to evidence-based best practice.

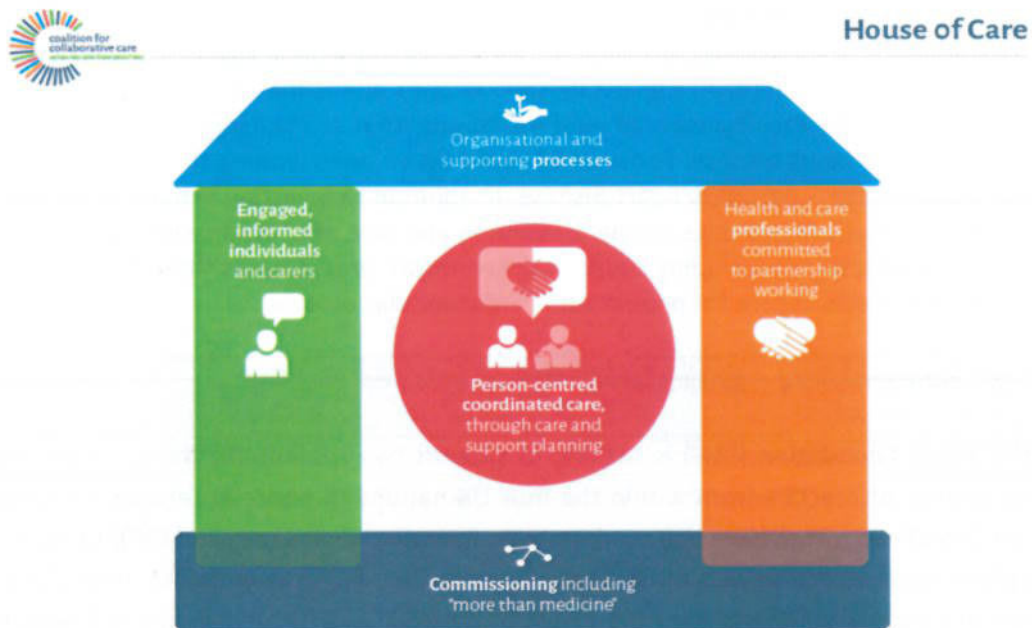
EXAMPLE SCORECARD:

PROPOSAL TOPIC: CVD

QUESTION	POSSIBLE SCORE	ACTUAL SCORE
1. SCALE	0 TO 5	
2. IMPACT	0 TO 5	
3. PERFORMANCE	0 TO 5	
4. DEPRIVATION	0 TO 5	
5. EQUALITIES	0 TO 5	
6. EVIDENCE	0 TO 5	
7. VALUE FOR MONEY	0 TO 5	
TOTAL SCORE	0 TO 40	

Key elements of the House of Care project:

- **Care and support planning as routine care** – with an emphasis of delivery of care planning in primary care to support QOF checks and recommendations from Transforming Primary Care (2014)
- **Service redesign** , driven by care and support planning and including integration of cardiovascular disease services
- **Development of support for self- management services** including the third sector



The British Heart Foundation House of Care project is funded by the BHF and supported by the Year of Care Partnerships Team (YoCP) <http://yearofcare.co.uk/> and will inform the Coalition for Collaborative Care (C4CC) <http://coalitionforcollaborativecare.org.uk/>

The Year of Care Programme (YoCP) has already shown how to deliver personalised care in routine practice for people with Long Term Conditions (LTCs), using diabetes as an exemplar. This project aims to test how the Year of Care model can be successfully implemented for CVD patients as part of a systematic change across the local community.

The British Heart Foundation House of Care project will deliver a holistic and integrated approach to care and support planning for people at high risk of developing, or who already have established cardiovascular disease (CVD) as defined by national health and social care strategies in the four nations related to long term conditions and cardiovascular disease.

These include: Heart Failure, Atrial Fibrillation (and other cardiac arrhythmias), Coronary heart disease (including post myocardial infarction and angina), Hypertension, At Risk of developing CVD as identified through an NHS health check, Stroke, Vascular Dementia, Hypercholesterolaemia, Chronic Kidney Disease, Peripheral Arterial Disease, Inherited Cardiac Conditions – including Familial Hypercholesterolaemia.

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SCRUTINY COMMISSION FOR HEALTH ISSUES	Agenda Item No. 7
10 SEPTEMBER 2014	Public Report

Report of the Executive Director of Adult Social Care, Health and Wellbeing

Contact Officer(s) – Tina Hornsby – Assistant Director Quality, Information and Performance
Contact Details – 01733 452427, tina.hornsby@peterborough.gov.uk

ADULT SOCIAL CARE UPDATE REPORT

1. PURPOSE

- 1.1 The report provides an update from Adult Social Care. It contains a brief progress report on our transformation and preparations for the Care Act 2014, and contains the annual complaints reporting and Local Account for information.

2. RECOMMENDATIONS

- 2.1 Scrutiny Commission is asked to review and note the contents of the report.

3. LINKS TO THE SUSTAINABLE COMMUNITY STRATEGY

- 3.1 The Adult Social Care outcomes have strong links to the health and wellbeing aspects of the community strategy.

4. BACKGROUND

- 4.1 The commission received an overview report from Adult Social Care in March 2014 and this report provides a 6 monthly update.

The commission are also provided with a briefing note on the Care Act at **Appendix 1**.

The commission are also provided with a copy of the Target Operating Model (TOM) **Appendix 2**.

The commission have also received a draft of the Local Account for review and comments and are asked to accept the final report attached at **Appendix 3**.

The commission are also provided with an annual complaints analysis report for information at **Appendix 4**.

5 Preparing for the Care Act 2014 – Appendix 1

- 5.1 The Care Act 2014 completed its passage through Parliament in May this year, and is scheduled to be implemented in two stages: all of the new duties and powers in April 2016, with the exception of the lifetime cap on the cost of care for any individual, and the independent appeals process, which will be introduced in April 2017.

- 5.2 The Act represents the greatest change to adult social care legislation since the National Assistance Act 1948, and the most radical change to how adult social care is planned, commissioned and delivered since the NHS and Community Care Act 1990. The Act also changes how the NHS is regulated and managed, and requires Councils and the NHS to promote an integrated approach to services.

- 5.3 At the heart of the Care Act is the new general duty to promote individual well-being for anyone with adult social care needs, whether those needs are eligible or non-eligible needs.

The existing eligibility criteria are being replaced by a new framework that requires Councils to consider 'significant impact on well-being', rather than the current 'risk to independence'. For the first time in law carers will have the same rights to an assessment of need, and for services to meet eligible needs, as the people for whom they care, applying the same 'well-being principle'.

- 5.4 'Self-funders' – people who plan and pay for their own care without reference to the Council – will, from April 2016, have the right to open a 'Care Account', so that the money they spend on purchasing services to meet eligible needs will count towards a lifetime cap on what they have to pay for their care. (The Government have announced that for older people that cap will be set at £72,000 in April 2016, though it has not said what the cap will be for working age adults.) A briefing on the Care Act is attached as **Appendix 1**

5.2 Adult Social Care Transformation – Appendix 2

- 5.2.1 In line with approval from Cabinet, Adult Social Care implemented a number of changes to prepare and build foundations in anticipation of the Care Act. This included changing eligibility criteria to critical substantial, expanding access to reablement and offering transitional support to younger adults to help them to live more independently. We also developed a preventative strategy and invested resources with partners, users and carers to be able to strengthen what can be offered locally within the community to support people.
- 5.2.2 To support these changes work has been underway within commissioning to provide alternatives to nursing residential and day care to support this approach. This work will take time, but already good progress is being made.
- 5.2.3 Adult Social Care has also been looking at how it delivers services and how it can reorganise internally to develop more cost effective and efficient ways to deliver its responsibilities in respect of assessment and care management.
- 5.2.4 All of the above are intended to place us in a stronger position to implement the Care Act and to provide modern, responsive support that is focused on prevention, personalisation and independence. It is an approach that is increasingly outcome based and addresses the key areas of performance identified within the Local Account where we have been doing less well.
- 5.2.5 The Department was extended in November 2013 to become a Directorate for Adult Social Care, Health and Wellbeing. This also neatly aligns with the requirements of the Care Act.
- 5.2.6 Adult Social Care is now pleased to report that it has agreed a new operating model which aligns with wider work across the council on customer and digital strategies.
- 5.2.7 It is expected that the new operating model will deliver:
- Clear and accessible information and advice focused on prevention and early problem resolution
 - Customers that are supported to maximise any opportunity to facilitate their own care needs
 - Customer choice around services and support which are easily accessible
 - The ability to maximise the opportunity to work more corporately with other services
 - A model which is equipped to deal with growing demand and the growth in numbers of adults living with long term and complex health conditions
 - Different and efficient ways of working to address the additional demands on services

- A front door that is the primary first point of contact, routine transactions resolved at the first point of contact and via other channels such as web and other digital platforms (channel shift)

Phase 1 is having the right structure in place. We are planning to have the new operating model live in early November, a diagram of the model can be found at Appendix 1. However, the programme of transformation is ongoing and we will adopt a phased approach. Further phases will continue thereafter, including:

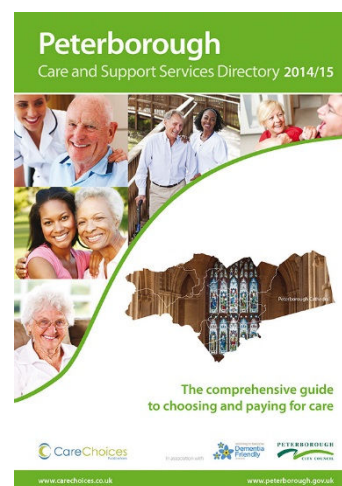
- **Commissioning initiatives** – ensuring that we have more effective preventative services and development of the third and independent care sector so as to provide viable alternatives to statutory services and to ensure the the provider market is able to flexibly meet the demands arising from the new model of working.
- **Reshaping and enlarging of enablement services**, to enable preventative action and intervention to divert demand and reduce the dependency culture.
- **Technology** – to enable us to work more effectively and efficiently, particularly with the right tools to resolve customer queries at the first point of contact, allow us to work more flexibly but to also allow our customers to self-serve

5.3 Peterborough Care and Support Directory 2014/15

Adult Social Care are developing the online directory in preparation for the Care Act 2014. However, it has been recognised that a paper directory is also still valued by the public and professionals across the system.

- 5.3.1 Adult Social Care have produced a printed Care and Support Services Directory including lots of helpful information about how to access care and support and listings of local care providers.

Hard copies are available from Peterborough Direct and an electronic version is available through the [Peterborough City Council website](#). This Directory will supplement the edirectory also available on the website.



5.4 Local Account – Appendix 3

Local Accounts form a key part of the Towards Excellence in Adult Social Care (TEASC) approach to sector led improvement in adult social care as they can provide a key mechanism for demonstrating accountability for performance and outcomes. Local Accounts are very important way to strengthen accountability and can also be used a tool for planning improvements, as a result of sharing information on performance with people who use services and engaging with them to get feedback on their experience.

The Towards Excellence in Adult Social Care (TEASC) Programme wrote to Directors of Adult Social Care in July 2011 stating that Councils may wish to publish an annual Local Account. Although Local Accounts are not a formal statutory requirement, they do form part of the ministerial line of sight and TEASC regularly check and publish progress on their production. Peterborough City Council published its first Local Account in December 2011 and the second in March 2012. The third was published in September 2013.

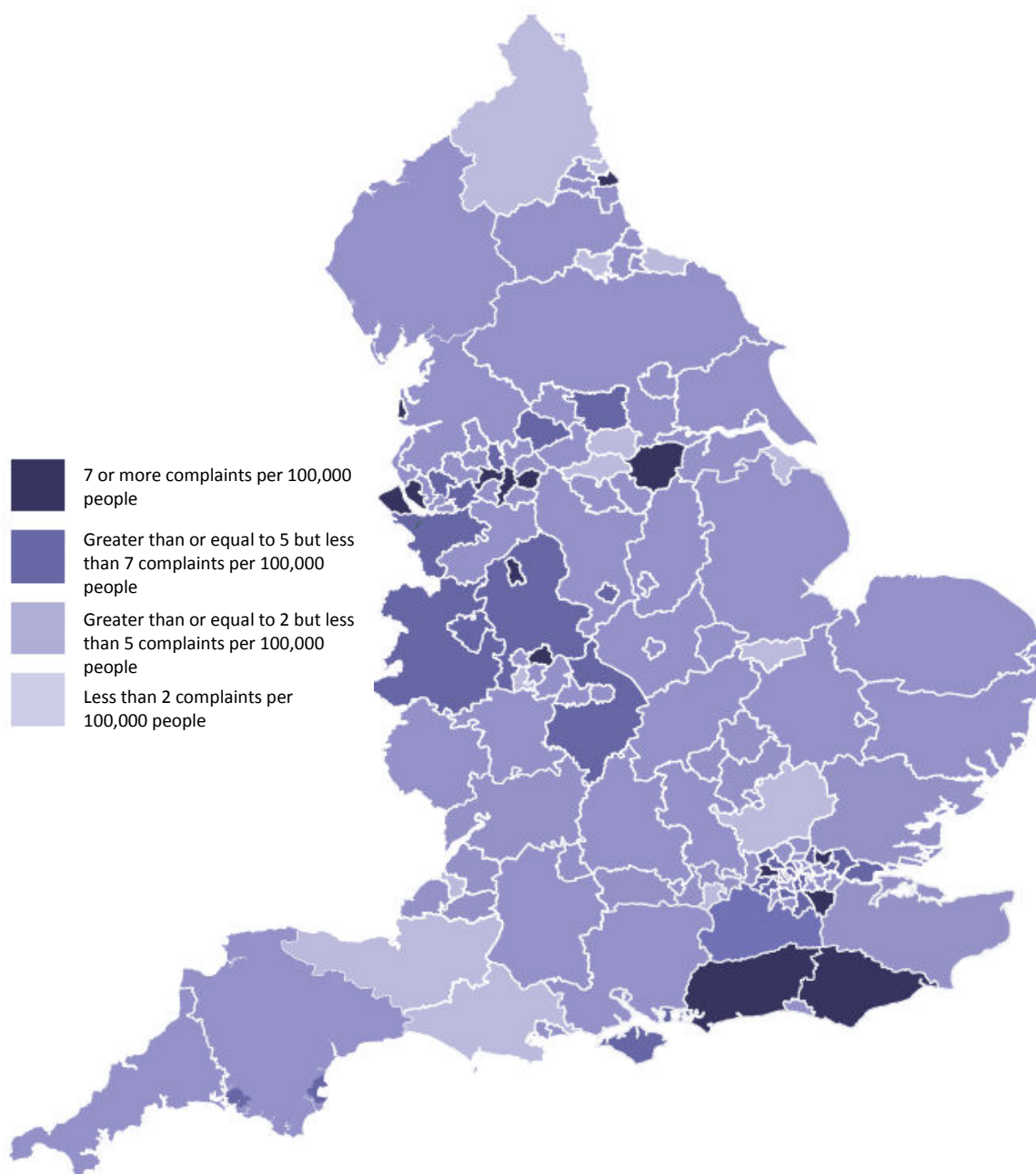
The fourth Local Account has been through consultation with service users and carers and has been circulated to Members for their comments. The designed version is included with the papers for this meeting, attached at Appendix 2. There may still be some final amendments to be made before the document is published on the Peterborough City Council website.

5.5 Adult Social Care Annual Complaints Report 2013/14 – Appendix 4

Complaints received by Peterborough City Council Adult Social Care Department are managed under The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

During 2013/14 a total of **67** complaints were logged about Adult Social Care services. This represents an increase of 97% from last year (34 complaints).

The Local Government Ombudsman's report on Adult Social Care Complaints published in May 2014 included a map of England showing complaints made to them. Peterborough was in the lowest category having had less than two complaints per 100,000 people made to the Ombudsman during the period. The graph is shown below. A low number of complaints to the Ombudsman is an indicator of good local complaints procedures which provide satisfactory responses to complainants.



Source: Local Government Ombudsman Review of Adult Social Care Complaints 2013, published May 2014.

A full report on complaints can be found at Appendix 3 and on the [Peterborough City Council website](#).

6. IMPLICATIONS

6.1 The report relates to services provided to the whole city.

7. CONSULTATION

7.1 None.

8. NEXT STEPS

8.1 A further update on the preparations for the Care act will be brought to Scrutiny Commission prior to April 2014.

8.2 The Local Account will be published on the Council's website and shared regionally as part of the sector led improvement programme.

9. BACKGROUND DOCUMENTS

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

9.1 None.

10. APPENDICES

10.1 Appendix One – Care Act
Appendix Two – Target Operating Model (TOM)
Appendix Three - Local Account
Appendix Four – Annual Complaints

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Appendix 1

Briefing note on the Care Act 2014

The Care Act is the government's response to three key public reports:

1. **The Law Commission Report, May 2011**, which described adult social care law as: "...inadequate, often incomprehensible and outdated. ...a confusing patchwork of conflicting statutes enacted over a period of 60 years.
2. **The Dilnot Commission Report, July 2011**, which stated: "...the current funding system [for adult social care] is in urgent need of reform: it is hard to understand, often unfair and unsustainable. People are left exposed to potentially catastrophic care costs with no way to protect themselves."
3. **The Public Inquiry into the NHS Mid-Staffs scandal, February 2013 ['Francis Report']**: "...a story of terrible and unnecessary suffering of hundreds of people who were failed by a system which ignored the warning signs of poor care and put corporate self-interest and cost control ahead of patients and their safety."

The Care Act is intended to deliver three key outcomes from those reports:

1. **Law Commission**: "...a single, modern statute to which service providers and service users can look to understand whether (and, if so, what kind of) services can or must be provided... a clearer, modern and more cohesive [legal] framework for adult social care."
2. **Dilnot Commission**: "Putting a limit on the maximum lifetime costs people may face will allow them to plan ahead for how they wish to meet these costs. By protecting a larger amount of people's assets, they need no longer fear losing everything."
3. **Francis Report**: "...focusing on the role of three key 'lines of defence' against poor-quality care: frontline clinical teams, the boards leading NHS organisations, and national organisations responsible for overseeing the commissioning, regulation and provision of care."

The Care Act has four Parts, reflecting those objectives:

1. **Part One [Law Commission & Dilnot]**: Consolidates adult social care law into one Statute; introduces the 'Well-being Principle' for all actions; and will impose a lifetime cap on the cost of care for any individual.
2. **Part Two [Francis]**: Mandatory health care and management standards for the NHS.
3. **Part Three [Francis]**: Regulation of Health Education & Health Research; and powers of 'Trust Special Administrators' to close hospitals
4. **Part Four [Combined]**: Promotion of greater integration between adult social care and the NHS.

Stages of enactment:

Royal Assent received

Draft Regulations and Guidance published for consultation

Consultation period ends

14th May 2014;

6th June 2014;

15th August 2014;

Final Regulations and Guidance scheduled	October 2014;
Enactment (bar the 'care cap')	April 2015
'Care cap' enactment	April 2016

Headline changes impacting on adult social care:

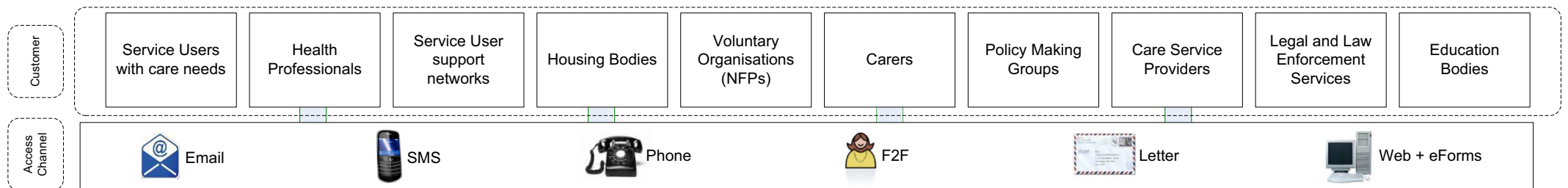
- Introduction of the 'Well-being Principle': "The general duty of a local authority, in exercising a function under this Part in the case of an individual, is to promote that individual's well-being." Part 1, 1(1).
- The deletion of the current four-tier eligibility criteria (Critical/Substantial/Moderate/Low) based on 'risk to independence', and replacing that with a single-tier functionality eligibility test based on 'significant risk to well-being'.
- New rights in law for carers to be assessed and to receive services, using a single-tier functionality test based on 'significant impact on well-being'.
- The deletion of the current criteria for a carer's assessment that the carer is providing 'a regular and substantial amount of care'.
- Enhanced rights for 'self-funders' to receive information, advice, guidance and support, from April 2015.
- New rights for all, including self-funders, to open a 'Care Account' in order to calculate costs of care towards the lifetime cap on costs, from April 2016.
- A new duty to provide independent advocacy for anyone who might have 'substantial difficulty' in being 'fully engaged' in any aspect of adult social care including: understanding how adult social care functions; and the assessment, care planning and review processes.
- An enhanced duty to provide or commission information, advice, guidance and advocacy services, including access to independent financial advice.
- An enhanced duty to prevent, reduce or delay needs for adult social care arising and to prevent loss of well-being for people with adult social care needs.
- An enhanced duty to seek out local people with unidentified social care needs.
- A duty to maintain a diverse, high-quality and sustainable market of providers of adult social care services.
- New duties for Councils to take a statutory local lead on adult safeguarding.
- New duties to ensure continuity of care and 'portability' of services for people moving to a new Local Authority.
- Enhanced duties to assess the needs of prisoners and others in secure accommodation, and to provide services to meet eligible needs.
- Enhanced duties to support young carers and young people with social care needs in transition to adulthood.
- New powers of delegation of adult social care functions.
- Enhanced duties, powers and expectations to co-operate with local agencies and to integrate with the NHS.

ASC Target Operating Model (Phase 1) v0.17

Date of last revision: 14 August 2014

Key

- R Staff rotated throughout the TOM
- Externalised service



The Courtyard - external providers, voluntary organisations

Local Area Co-ordinators

Preventative offer – TBD, e.g. Telehealth, Supplies & Provisions

Self Service

online tools, services, information & advice

Universal Service provided through Council Front Door

Information & Advice and Solve

Teams	Services	Roles
<ul style="list-style-type: none"> Information & Advice Team Emergency Duty Team 	<ul style="list-style-type: none"> Advice & Information Initial screening and assessment Signposting Access to Universal Services 	<ul style="list-style-type: none"> Serco Team Manager Information & Advice Worker
<ul style="list-style-type: none"> See & Solve Team 	<ul style="list-style-type: none"> Carer Assessments Safeguarding Ongoing Low Level Support Assessments Care Planning Crisis Management Unplanned Reviews 	<ul style="list-style-type: none"> Team Manager Occupational Therapist Social Worker Financial Assessment Officer Safeguarding Lead Business Support

Needs Analysis

Enablement

Teams	Services	Roles
<ul style="list-style-type: none"> Day Opportunities Reablement & Shared Lives Therapy Services 0-25 Service Supported Employment Employment Services 	<ul style="list-style-type: none"> Care Management & Review Reablement Supported Employment Employment Services Day Opportunities Physio Speech & Language (SALT) Occupational Therapy (OT) Sensory Support Safeguarding Carer Assessments 0-25 & Transitions 	<ul style="list-style-type: none"> Team Managers Therapy (OT/SALT/Sensory) Therapy Assistant Care Support Worker Support Worker Business Support

FACS

Financial Systems	Services	Roles
<ul style="list-style-type: none"> Financial Systems Team 	<ul style="list-style-type: none"> Financial Assessments Benefits Advice Deferred Payments Property Disregard Income Maximisation Client Income Appointeeship/Deputyship Direct Payment 	<ul style="list-style-type: none"> Financial Systems Manager Client Income Manager Client Income Officer Direct Payment Officer Financial Assessment Manager Financial Assessment Officer Business Support

FACS

Long Term

Teams	Services	Roles
<ul style="list-style-type: none"> Long Term Team Review Team Transfer of Care & Intermediate Care Team 	<ul style="list-style-type: none"> Assessment (Part B & C) Care Planning Planned Reviews Safeguarding Investigations Mental Capacity Assessments CHC Assessments Best Interest Assessments Carer Assessments 	<ul style="list-style-type: none"> Team Managers Social Worker Review Worker Care Support Worker Housing Support Worker Nurse Business Support

Care Placement
Care Placement Team
<ul style="list-style-type: none"> Home Care Reablement Meals
<ul style="list-style-type: none"> Care Placement Manager Care Placement Officer

Preventative offer – TBD, e.g. Telehealth, Supplies & Provisions

Local Area Co-ordinators

The Courtyard - external providers, voluntary organisations

Management Information

Strategy

Management Information

Strategy

Management Information

Strategy



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LOCAL ACCOUNT 2013/14

ANNUAL REVIEW OF ADULT SOCIAL CARE



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WHAT IS THE LOCAL ACCOUNT?

The Local Account is a report about the performance of Peterborough City Council's Adult Social Care Department during the year 2013/14.

It is an important part of the council's commitment to being open and transparent.

It will inform you about what we have done over the past year and what we plan to do in 2014/15 to improve services.

The report is organised around the four outcomes in the Department of Health's Adult Social Care Outcomes Framework, shown in the blue box on the right.

The four outcomes in the Department of Health's Adult Social Care Outcomes Framework are:

- **Keeping you safe** (Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm)
- **Making sure you have a good quality of life** (Ensuring quality of life for people with care and support needs)
- **Supporting you to be independent** (Delaying and reducing the need for care and support)
- **Listening to you** (Ensuring that people have a positive experience of care and support)



**Councillor Wayne Fitzgerald,
Cabinet Member for Adult Social Care**

2013/14 has been a tough year for the council with some difficult decisions to make and challenging performance and finance targets to meet. However, there have also been some great achievements. An example is the excellent work that has happened around dementia awareness, including Peterborough City Council becoming a Dementia Friendly city and

the setting up of the Dementia Resource Centre.

This Local Account details some of this work. Read more inside!



Jana Burton, Executive Director of Adult Social Care, Health and Wellbeing

I was privileged to be appointed as the Director of the new Adult Social Care, Health and Wellbeing Department in November 2013.

It is an exciting time to be leading the department, as there is much change ahead with the challenges of the new Care Act and our ambitious plans to implement a more personalised service for the people of Peterborough.

I look forward to hearing your views on the Local Account and our plans for improvement.

WHERE ARE WE GOING?



OUR TRANSFORMATION JOURNEY

Adult Social Care at Peterborough City Council is preparing for the new Care Act 2014 which will come into force over the next couple of years.

The Care Act represents the most significant reform of care and support in more than 60 years, putting people and their carers in control of their care and support.

Our commitment is:

- to support people to be active and independent
- to promote health and well-being
- to meet the demographic growth, particularly in older people
- to work efficiently within budgetary constraints

We will do this by ensuring our approach to personalisation supports individuals to maximise opportunities for independence, health and well-being.

WHAT IS PERSONALISATION?

Personalisation is about putting individuals firmly in the driving seat and building a system of care and support that is designed with their full involvement and tailored to meet their own unique needs.

This is a completely different approach to an historic 'one size fits all' system of individuals having to fit into care and support services that already exist, which have been designed and commissioned on their behalf by Local Authorities.

Individuals will receive their own budget and can decide how, who with and where they wish to spend that budget in order to meet their needs and achieve their desired outcomes.

WHERE ARE WE GOING?

NEW WAYS OF WORKING:

We have looked at our current model of work and have identified a number of things we need to improve. These include customers being passed around to too many different people, too many steps in our processes, not making the best use of technology and a lack of alternatives to traditional statutory services.

Over the next year we will introduce new ways of working. We will have a new 'Front Door' for our customers which will provide information and advice and try to resolve issues immediately rather than having to refer them on. This will be much more than a call centre and will be staffed by social workers and occupational therapists as well as skilled and trained call handlers.

FOR YOUNGER ADULTS WE WILL:

Provide much greater emphasis on reablement and transitional support for those not meeting eligibility criteria, but who could gain skills and confidence in living independently and, where possible, getting them into work.

FOR OLDER PEOPLE WE WILL:

Aim to regain their skills and confidence to remain active and independent within their capabilities.

For others, the aim will be to reduce or slow down deterioration. The approach will also seek to reduce loneliness and promote engagement with activities outside the home.



WHERE ARE WE GOING?

COMMISSIONING A WIDER RANGE OF SUPPORT:

We will be reviewing all forms of commissioned support to meet our vision for personalisation and independence. This will include increasing the options for people to use their personal budgets and direct payments to better meet their needs.

It will include access to a wide range of prevention initiatives in the voluntary and independent sectors.

208 REVIEW OF DAY OPPORTUNITIES FOR YOUNGER ADULTS

Following the extensive review of day opportunities for younger adults last year we ran a big consultation. We asked people who use day and employment services, their families and carers how we can help people lead more fulfilling lives. 260 people attended the consultation events and 99 people filled in a questionnaire.

A short film was available on YouTube and you can view it **here**.

WHAT DID PEOPLE SAY?

People commented that to help them have jobs and live in the community, they needed support with:

- being more independent
- managing money
- speaking up and being confident
- staying safe

People told us they would like more control over what they do, where they can meet friends, information on the support they can access and what they can do to stay healthy. To access employment people would like help in building confidence, and overcoming fear of new environments.

It was also recognised that some people with complex needs will still require more support in a more traditional building, but it would be good for them to mix with others who have less complex needs.

One option proposed was having local satellite bases to enable people to access local communities and meet people. These should be near to or in community centres and the city centre, close to bus routes and open seven days a week.

WHAT ARE WE DOING ABOUT IT?

We are developing employment support, activities and opportunities so that even more people can work. This will include investment in 'micro enterprises' - small businesses run by the people who work in them. In October 2014 the council will consider all the options and the new models will be in place from April 2015.

WHAT IS THE LOCAL ACCOUNT?

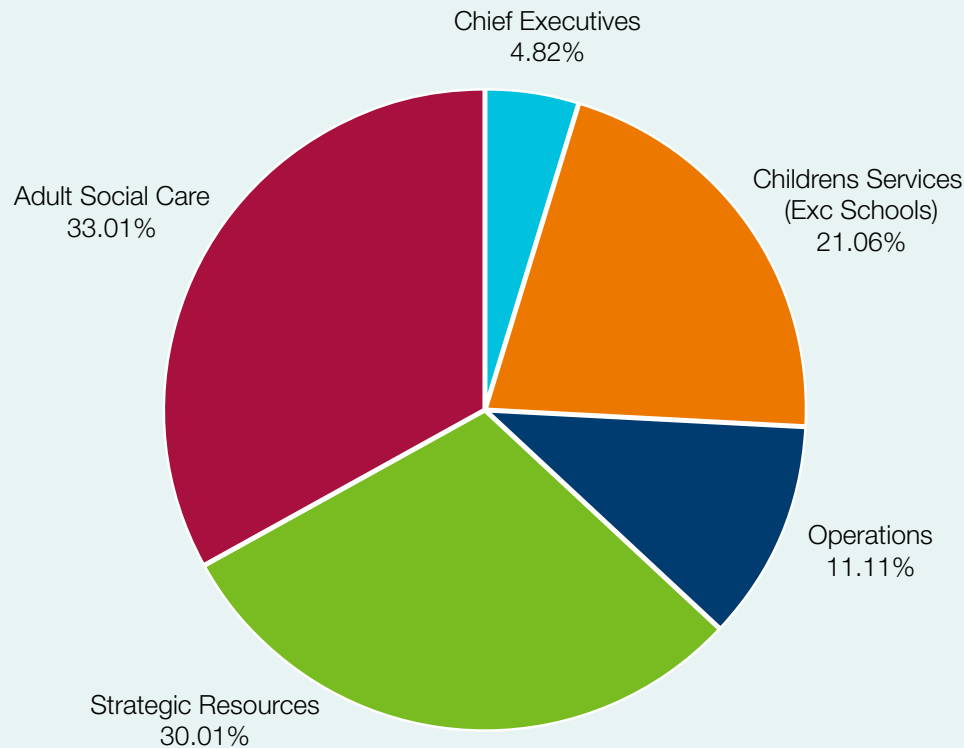
In 2013/14 Peterborough City Council spent £49 million (33% of its budget) on Adult Social Care.

During 2013/14 Adult Social Care balanced the budgets and delivered savings.

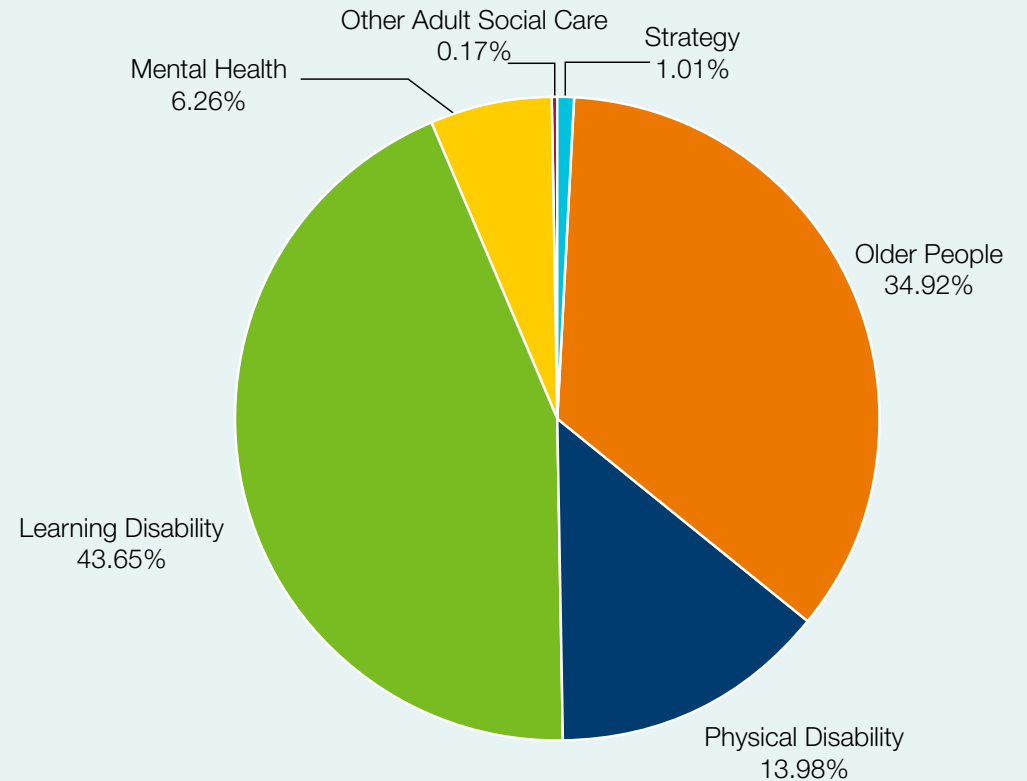
The breakdown of spend within Adult Social Care was:

Peterborough City Council Budget 2013/14

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ASC Actual Spend 2013/14



For 2014/15 the council have allocated 29% of the overall budget to Adult Social Care, Health and Well-being.

OUR PERFORMANCE IN 2013/14

WHERE WE ARE DOING WELL

- ✓ The proportion of people who use services who said that those services made them feel safe and secure was 84.2% against an England average of 79.2%
- ✓ The proportion of people who use service who find it easy to find information about services was 74.9% against an England average of 74.7%
- ✓ The proportion of adults with learning disabilities in paid employment was 8.4%, against an England average of 6.8%
- ✓ There were 592.8 permanent admissions to residential and nursing care homes per 100,000 population for people aged 65 and over against an England average of 668.4
- ✓ Delayed transfers of care from hospital attributable to adult social care were 2.8 per 100,000 population against an England average of 3.1
- ✓ Overall satisfaction of people who use services with their care and support was 64.7% against an England average of 64.9%
- ✓ The overall social care quality of life score was 18.9 against an England average of 19.0
- ✓ The proportion of people who use services who have control over their daily lives was 76.4% against an England average of 76.7%

WHERE WE ARE NOT DOING SO WELL

- ✗ The proportion of adults with learning disabilities who live in their own home or with their family was 72.3% against an England average of 74.8%
- ✗ There were 18.2 permanent admissions of younger adults (aged 18-64) to residential and nursing care homes per 100,000 population against an England average of 14.4
- ✗ The proportion of people using social care who received self-directed support was 53.2% against an England average of 62.1% and those receiving direct payments was 12.4% against an England average of 19.1%
- ✗ The proportion of older people (65 and over) who were offered reablement services following discharge from hospital was 1.7% against an England average of 3.3%
- ✗ Delayed transfers of care from hospital were 13.7 per 100,000 population against an England average of 9.7
- ✗ The proportion of adults in contact with secondary mental health services in paid employment was 4.4% against an England average of 7.1% and those who live independently with or without support was 17% against an England average of 60.9%

- ✗ The proportion of people who use services who felt safe was 64.5% against an England average of 66%
- ✗ Older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services was 73.8 against an England average of 81.9
- ✗ The proportion of people who use services who reported that they had as much social contact as they would like was 43.0 against an England average of 44.2

The department is using these results to focus improvement activities throughout 2014/15. For further information on how these percentages and scores are calculated, please go see the Health and Social Care Information Centre document:

'Measures from the Adult Social Care Outcomes Framework, England 2013-14, Provisional Release'.

KEEPING YOU SAFE



SAFEGUARDING ADULTS WHOSE CIRCUMSTANCES MAKE THEM VULNERABLE AND PROTECTING THEM FROM AVOIDABLE HARM

Peterborough City Council is dedicated to ensuring that the safeguarding of adults at risk is a key priority when we are providing services to the public. We are committed to preventing abuse and responding promptly when abuse is suspected. We believe everyone has the right to live a life free from abuse and neglect.

An adult at risk is someone aged 18 or over who may be unable to take care of themselves. They may be unable to protect themselves from harm or from being exploited by others.

During 2013 the Adult Social Care Department undertook a major review of safeguarding activities and significantly strengthened quality assurance and performance management of safeguarding.

Additionally, processes were put in place to capture and analyse the views of people who had been through the safeguarding process to find out whether their outcomes had been achieved.



84% of respondents in the annual survey said that care and support services help them feel safe

SAFE PLACE SCHEME

In December 2013 Peterborough City Council relaunched the 'Safe Place Scheme', in partnership with the Safer Peterborough Partnership.

The project helps adults with learning disabilities cope with any incident that takes place whilst they are out and about in the community – for example if they become lost, have something stolen or feel they are being harassed.

The council wants to create an equal access community; an environment where every adult can go out safely both day and night. Over 100 businesses, including Asda, Tesco Metro, Boots in The Bretton Centre and The Salvation Army charity shop in Broadway, are already signed up to the free scheme. If a business is happy to help, they are given a 'Safe Place' sticker to put into their shop window. They are also given an information sheet with guidance on how to assist an individual in distress.

An individual with a learning disability will carry a card displaying their name and personal contact telephone number, so that the manager or member of staff in the shop or business knows who to contact. Cards have been given to 150 people with learning disabilities. A short film can be viewed [here](#).

MAKING SURE YOU HAVE A GOOD QUALITY OF LIFE

ENHANCING QUALITY OF LIFE FOR PEOPLE WITH CARE AND SUPPORT NEEDS

This outcome is all about people being in control of their own lives. Personal budgets and 'self directed support' are key aspects of this, as is access to information and advice.

PETERBOROUGH LOW VISION DAY

Peterborough Low Vision Day was held on Thursday 26 September 2013. The event aimed to help anyone connected to sight loss, including family and friends, to find out just what clubs, activities and support are available in Peterborough and the surrounding areas.

Information was available about the latest products, books, magazines and newspapers.

The Exhibition Area included a wide range of items to help with daily life and maintain independence. There were hands-on demonstrations of the latest mobile and desktop equipment from the leading suppliers.

There were also various bite-sized seminars running throughout the day. Volunteer sighted guides assisted with escorting visitors around the event.

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83% of respondents in the annual survey said that they were happy with the way staff help them

MAKING SURE YOU HAVE A GOOD QUALITY OF LIFE

LEARNING DISABILITY HEALTH CHECKS

People with learning disabilities often have poorer physical and mental health than other people.

The Annual Health Check scheme is for adults with learning disabilities who need more health support and who may otherwise have health conditions that go undetected.

During 2013/14 Adult Social Care supported 269 people to access a Health Check.

HOLLYWOOD BALL

In August 2013, the Learning Disability Service held their second annual summer ball.

This year it followed a glittering Hollywood theme and all attendees got to walk the prestigious red carpet. Over 100 people attended, including the Mayor, two famous Hollywood actors, members of the public and the people supported by the service. The event was a huge success and enjoyed by all.



92% of respondents in the annual survey said that care and support services help them to have a better quality of life

MAKING SURE YOU HAVE A GOOD QUALITY OF LIFE

POSH FOOTBALL MATCH

In November 2013, the Employment Development and Supported Employment teams hosted the Peterborough City Council sponsored football match between Peterborough United and Wolverhampton Wanderers.

A number of local businesses attended and heard from service users themselves how employment can transform their lives.

214 The day was highly successful, with many of those invited indicating interest in employing someone with a disability or offering work experience.

They also pledged to help spread the word encouraging other employers to provide opportunities either by employment or commissioning one of the mini enterprises, creating further work opportunities for people with disabilities.

EMPLOYMENT FOR PEOPLE WITH DISABILITIES

Peterborough City Council is leading the way in relation to supporting people with disabilities into work.

The **Employment Development Team** delivers the national 'Work Choice' programme, providing support to people who want to work, but are facing barriers to employment due to a disability or long-term health condition. The council delivers the service on behalf of the Shaw Trust. The service has been the equal top performing Shaw Trust sub-contractor for the South and South East of England which is an excellent team achievement.

Once people are in work their confidence and self-esteem improves, and there is greater opportunity to develop even more skills. Securing employment in the open market also promotes equality and diversity in the work place.

The **Supported Employment Team** works closely with employers in a broad range of vocations to secure jobs, work experience and voluntary placements in local businesses.

Additionally, work opportunities are available in the council's mini enterprises providing services to businesses in catering, ground maintenance and car washing.



SUPPORTING YOU TO BE INDEPENDENT

DELAYING AND REDUCING THE NEED FOR CARE AND SUPPORT

The Adult Social Care department aims to support people to remain independent and to stay in their own homes as long as possible. We also want to ensure that people have opportunities to have the best health and well-being.

215

88% of respondents in the annual survey said that care and support services help them in having control over their daily life

IMPROVING CHOICE AND CONTROL

During 2013/14 the department began to review how younger adults have been spending their time. Some service users had been attending traditional day services for a very long time.

One of the social workers, who completed reviews for some of the service users commented:

"I recently completed a review for a lady attending the day centre. The support planning process suggested that this was not in her best interest. Two months later the lady is more engaged in the community. She is eating in public places, whereas the last review stated that she didn't eat when out of the home. This limited her choice and options, as she went out afternoons but had to be back in time for tea.

Her sister was not happy at first, but at the review said that she was pleased that her sister is now able to live a much more fulfilled life.

She agreed it was the best move and we are able to make more plans to introduce more fun and opportunity into her sister's life".



SUPPORTING YOU TO BE INDEPENDENT

Supporting people to regain or increase independence is a key aim of Adult Social Care. Reablement is what we call short term support which is designed to help people to increase their independence at home.

This might include supporting people with personal care or preparing meals.

The aim of the Reablement Service is to support people to manage these tasks on their own, rather than having care staff do it for them.

SUCCESS IN THE REABLEMENT SERVICE

Mr F is a 78 year old gentleman who had a fall and fractured his hip and since that time he remained upstairs in his house, due to a number of falls and lack of confidence. Occupational Therapy and Reablement Services visited Mr F and provided him with a great deal of support and encouragement.

Mr F is now managing his own personal care tasks independently and can use the stairs safely, with supervision from his wife. With the support of the Reablement Team, Mr F is now able to remain in his own home with access to all facilities. This support has prevented the need for Mr F to move to ground floor accommodation or have costly major adaptations to his home which were initially thought necessary by Mr F and his family.

CARE QUALITY COMMISSION INSPECTION

In December 2013 the Care Quality Commission inspected the Reablement Service and found that they met all standards.

Their report stated:

A person who used the service told us, *"They certainly know what they are doing."*

A relative said, *"I have given them high marks for everything they have done".*



SUPPORTING YOU TO BE INDEPENDENT

SUPPORTING PEOPLE WITH DEMENTIA

Peterborough is leading the way with a range of innovative approaches to support people with dementia.

217 LOCAL DEMENTIA ACTION ALLIANCE LAUNCH

In February 2014, the City Council hosted the launch of Peterborough's Dementia Action Alliance. The Alliance was formed to bring a range of partners together to create a dementia-friendly Peterborough. The launch was attended by over 120 people and included a range of businesses and local groups as well as people with dementia and their carers and loved ones. At the end of the event attendees were asked to leave their details if they wanted to get involved in the work of the Alliance and were given the opportunity to become a 'Dementia Friend' by attending a 45 minute information session on dementia.

DEMENTIA RESOURCE CENTRE

During 2013/14 the council developed the Dementia Resource Centre in Peterborough run by the Alzheimers Society, opening in the summer of 2014.

Residents can access the service, located in Millfield, without an appointment to learn more about memory problems and dementia.

The team based there will be able to offer advice, information and support to the person with dementia and their carers/loved ones. The centre will provide a range of support groups and activities for both people with dementia and their carers and loved ones including walking groups, gardening clubs, arts and crafts groups. There will also be groups specifically for black and minority ethnic communities and people with early onset dementia.



CARING FOR CARERS

DELAYING AND REDUCING THE NEED FOR CARE AND SUPPORT

During 2013/14 the council organised a range of activities and initiatives to support carers in their caring role.

- A conference was held in April 2013 which covered welfare changes, how to cope with challenging behaviours, healthy lifestyles, carers workshop and relaxation for carers.
- During Carers Week in June 2013 the council had a stand in Cathedral Square to advise carers of support available to them.
- In October 2013 a Carers Health Day was held in partnership with the City College. It included armchair yoga, local history, belly dancing, art workshop, healthy eating demonstration and taster and blood pressure checks.
- In November 2013 a Carer Rights Day was held for carers to hear about welfare reforms and the planned new legislation, the Care Act.
- The council worked with the Carers Trust to roll out the Family GP Carers Prescription services, to identify 'hidden' carers and give carers a break from caring.

ENSURING UNPAID CARERS ARE RECOGNISED AND VALUED

The council has been working with the local NHS to develop a joint Carers Strategy designed to provide focus and direction for supporting and working with carers in Peterborough. The local vision is that all unpaid carers are recognised and valued and have access to support that enables them to carry out their caring roles whilst leading their own lives. The strategy has been developed in consultation with carers and key partners and it incorporates the new responsibilities set out in the Care Act for local authorities to provide support to carers. Delivery of the strategy will be overseen by the Carers Partnership Board.

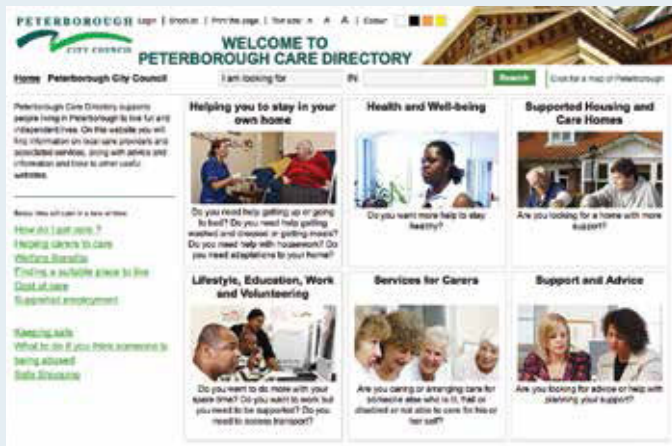


LISTENING TO YOU

Ensuring people have a positive experience of care and support

ONLINE CARE DIRECTORY

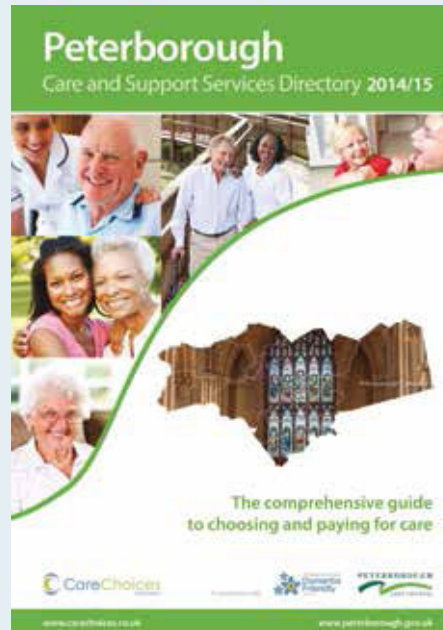
During 2013/14 the Adult Social Care Department launched the new online Care Directory, which can be found at www.peterboroughcaredirectory.org.uk



The Care Directory has information on local care providers and services available.

PETERBOROUGH CARE AND SUPPORT SERVICES DIRECTORY 2014/15

Also, following feedback from service users, carers and members of staff, a paper Care Directory has been commissioned to complement the online version. A copy can be obtained by calling **01733 747474** or by downloading it from <http://www.carechoices.co.uk/region/east-of-england/cambridgeshire/peterborough>.



MONITORING CARE PROVIDERS

As much of the care provided both in the community and in care homes is provided by the independent sector, the Adult Social Care Department has robust contract compliance and quality assurance processes to monitor the service provided.

During 2013/14 a procedure was introduced to monitor intelligence received about providers, whether received through complaints, contract monitoring visits, safeguarding investigations or direct from the providers themselves. This intelligence is collated and scrutinised by managers at monthly meetings and action plans are requested from providers.

SERVICE USER SURVEYS

The Adult Social Care Department has a range of methods of consulting with service users and carers about the quality of the service they have received, including a comprehensive annual service user survey.

LISTENING TO YOU

QUALITY ASSURANCE

In April 2013 the Adult Social Care Quality Board met for the first time. The Quality Board, which has service users and carers sitting on it, is responsible for agreeing and monitoring the implementation of the Adult Social Care Quality Framework.

Service users and carers on the group have identified areas that need improvement through the year. This has resulted in a review of the Carers Assessment process and also clear guidance being produced on the Mental Capacity Act and Power of Attorney.

020

53% of respondents in the annual survey said that it was very or fairly easy to find information about advice and support

COMPLAINTS, COMMENTS AND COMPLIMENTS

The Adult Social Care department welcomes complaints, comments and compliments and ensures that these are used as learning opportunities. Complaints are reported on a quarterly basis and are discussed at team meetings and at the department's Quality Board. During 2013/14 the Adult Social Care department received 67 complaints. The highest number of complaints were logged against 'delayed/failed service.

Plans are in place for further improvements to complaints handling during 2014/15 including producing the following guides for managers:

- Investigating complaints
- Writing effective complaints response letters

To contact the Complaints Manager write to:
The Central Complaints Office, Customer Services Centre, Bayard Place, Broadway, Peterborough, PE1 1FZ

Tel: **01733 296331**

Email: **ASCcomplaints@peterborough.gov.uk**



TELL US WHAT YOU THINK

The Adult Social Care Department at Peterborough City Council is always keen to hear what local people think about the services we deliver.

If you have a comment, suggestion, compliment or complaint, please do contact us:

CONTACT DETAILS:

Freepost RTCH-TLLZ-JGEC
The Quality Assurance Manager
Adult Social Care
Peterborough Town Hall
Bridge Street
Peterborough
PE1 1HF



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Appendix 4

ADULT SOCIAL CARE ANNUAL COMPLAINTS REPORT 2013/14

Complaints received by Peterborough City Council Adult Social Care Department are managed under The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

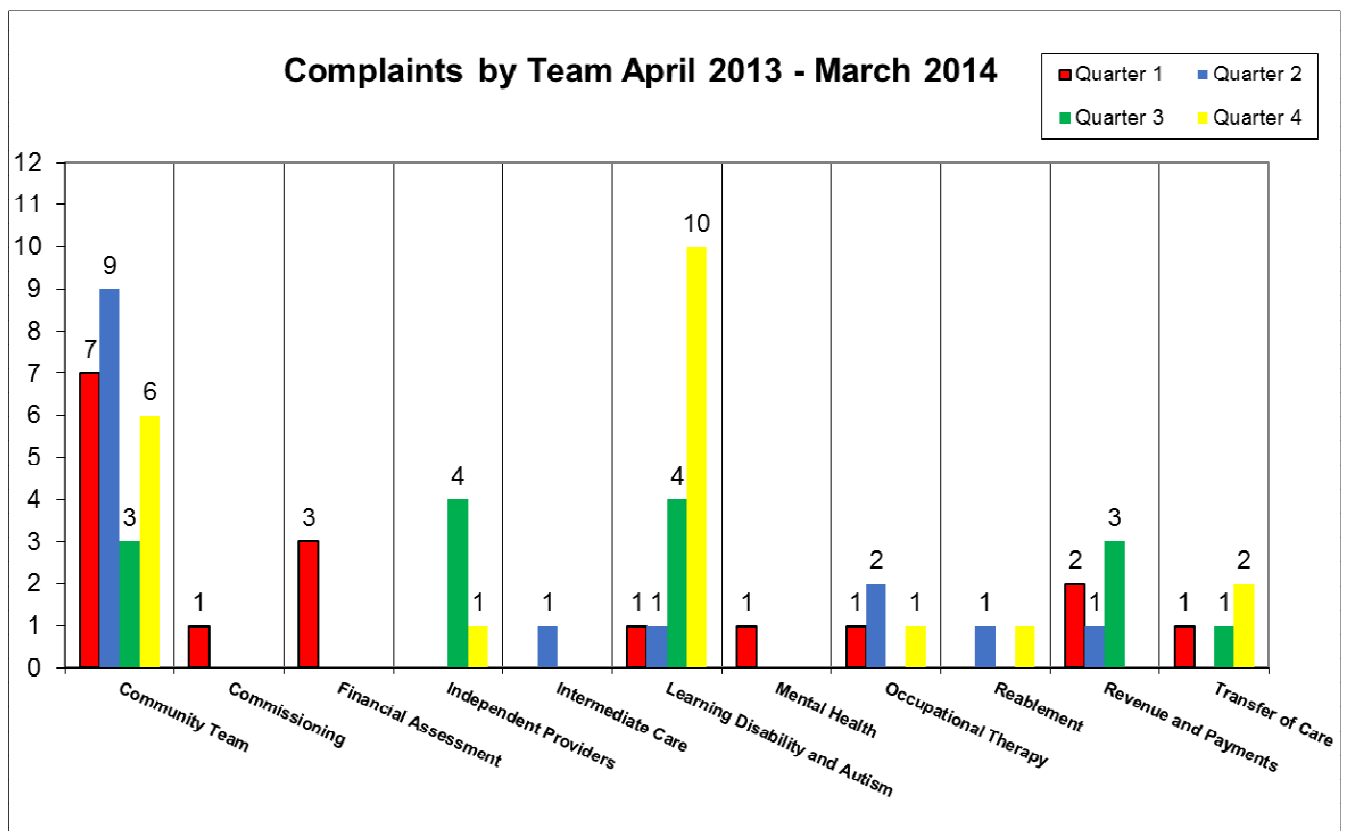
Since January 2013 complaints have been managed by the Peterborough City Council Central Complaints Office, run by Serco for the Council.

Complaints Received by Team

During 2013/14 a total of **67** complaints were logged about Adult Social Care services. This represents an increase of 97% from last year (34 complaints).

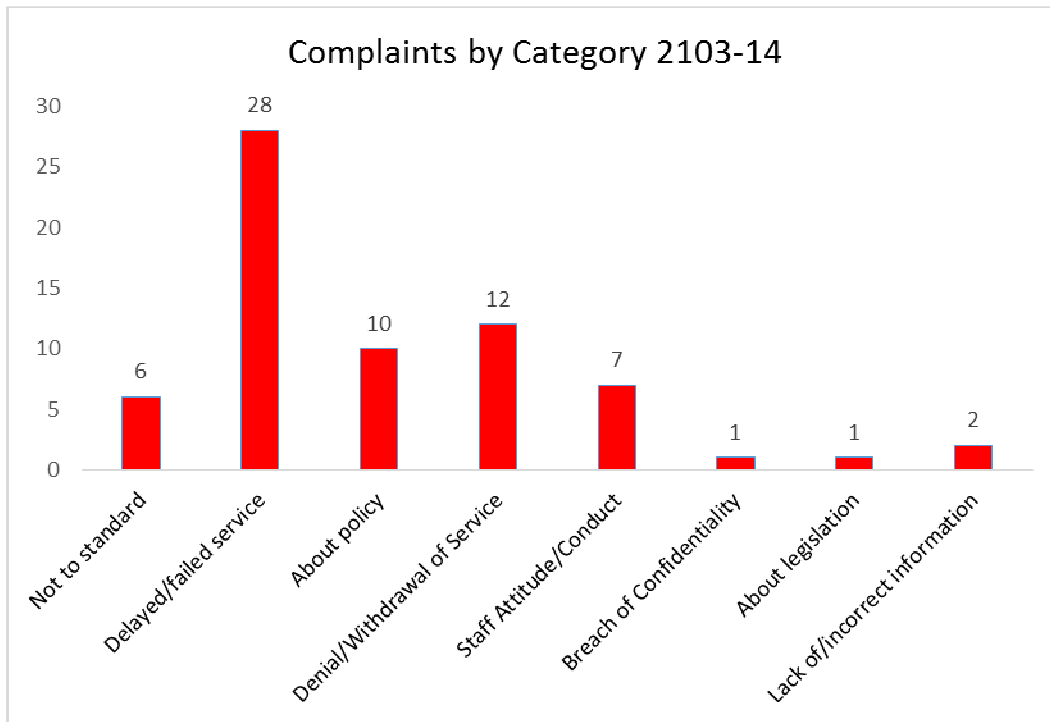
Reasons for the increase could include a wider understanding amongst staff and managers about how to manage complaints resulting in more complaints being formally reported and logged, along with more promotion of the complaints procedure to service users and families.

A further reason is the change to eligibility criteria at the beginning of the year, resulting in complaints further through the year about reduction and withdrawal of services. The breakdown by Team is shown below.

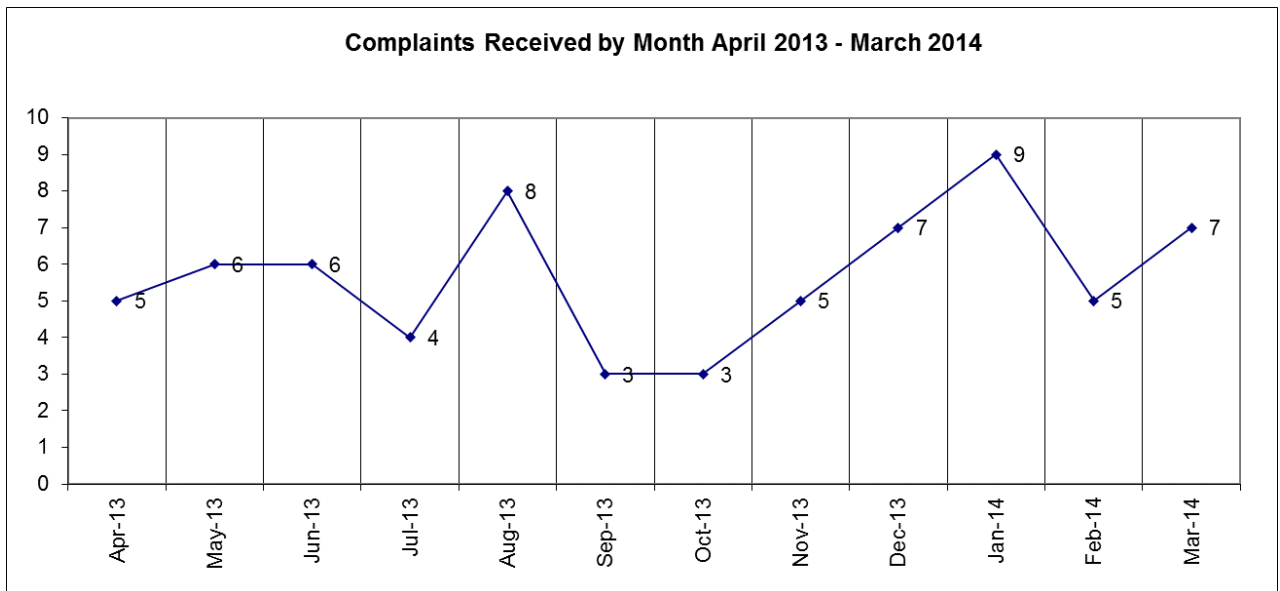


Complaints Received by Category

The breakdown by category is shown below.



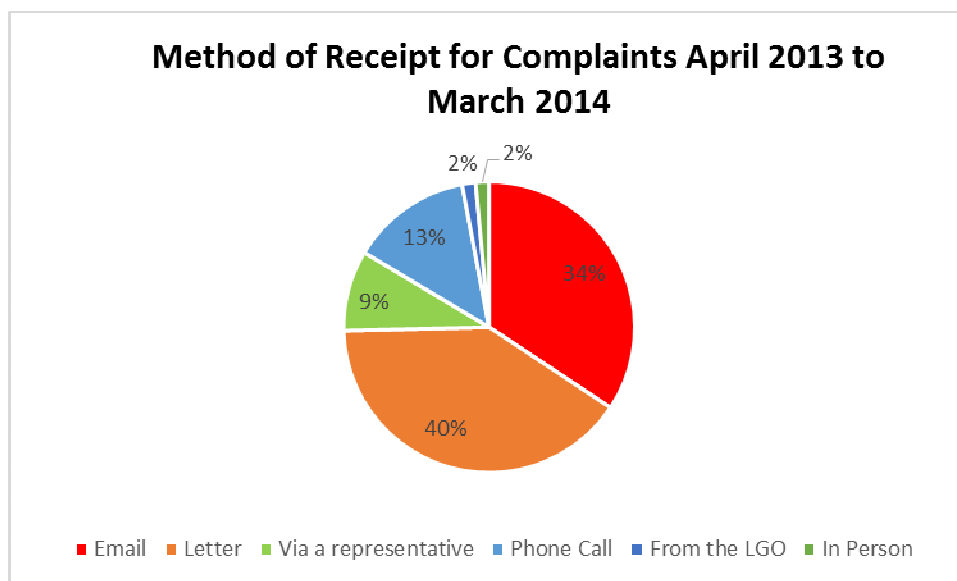
Complaints Received by Month



The steady rise from October 2013 to January 2014 could be due to the effect of the change in eligibility criteria earlier in the year and as people were reviewed and found not to be eligible for all, or some, of the services they were receiving this resulted in complaints.

How Complaints were received

40% of complaints were received by letter and **34%** by email.



25% of complaints were received from service users. For the **75%** that were not, a Third Party Authority was received for **27%** and was not received for **10%**. For the remaining **37%** a Third Party Authority was not applicable.

Complaints Upheld or not Upheld

31.3% of complaints were upheld, **26.9%** were partially upheld and **28.4%** were not upheld. **13.4%** were still being investigated at the end of the year.

Compliments

During the year a total of 25 compliments were formally logged.

Themes and Topics from Complaints

Complaints covered the following topics and themes:

- Following the tightening up on the correct use of Direct Payments, complaints were received about service users being informed that they were using them inappropriately and having their Direct Payment reduced or being told that they had to use it in a different way
- Withdrawal or reduction of support following a review. This was often due to service users no longer meeting the new eligibility criteria.
- Lack of support provided by the department
- Delays including inability to contact the department, cancelled appointments, delays to assessments and delays in authorising funding
- Issues around incorrect invoices
- Staff conduct and attitude
- Lack of care at independent sector care homes
- Conduct of safeguarding investigations

- Discharge from hospital
- Transition plans for young people moving from Childrens Services

Learning from Complaints and Action Taken as a Result of Complaints

The department is committed to learning from complaints and to continuously improving the processes for handling complaints. To ensure that complaints are handled in the most appropriate way during 2013/14 two guides were produced for managers on investigating complaints and writing complaints response letters and training sessions were held.

Changes that have been made as a result of complaints include:

- Following complaints that it is difficult to find information about Adult Social Care, the department reviewed all public information and produced a range of leaflets. A full colour printed care directory has been commissioned at no cost to the Council. Additionally, the online Peterborough Care Directory was formally launched and includes a wealth of information about local care providers.
- Following complaints about the processing of invoices the process was reviewed and improved
- Clear information on mental capacity and power of attorney has been produced and put on the Council website
- The Direct Payments Policy has been rewritten and a leaflet produced to support it

Local Government Ombudsman Complaints

During the year four complainants referred their complaint to the Local Government Ombudsman (LGO). One was a premature complaint and the LGO referred it back to the department. It is currently being investigated through safeguarding procedures. In two of the other three cases the LGO reported the following:

The Commission will include this complaint in the published figures for the year ending 31 March 2014. We will record the category as: Adult Care Services and the decision as: Investigation complete and satisfied with authority actions or proposed actions and not appropriate to issue report S30(1B).

The Commission will include this complaint in the published figures for the year ending 31 March 2015. We will record the category as: Adult Care Services and the decision as: Not upheld: no Maladministration.

The third case has not yet had a final judgement from the LGO.

SCRUTINY COMMISSION FOR HEALTH ISSUES	Agenda Item No. 8
10 SEPTEMBER 2014	Public Report

Report of the Director of Governance

Report Author – Paulina Ford, Senior Governance Officer, Scrutiny

Contact Details – 01733 452508 or email paulina.ford@peterborough.gov.uk

FORWARD PLAN OF KEY DECISIONS

1. PURPOSE

- 1.1 This is a regular report to the Scrutiny Commission for Health Issues outlining the content of the Forward Plan of Key Decisions.

2. RECOMMENDATIONS

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

3. BACKGROUND

- 3.1 The latest version of the Forward Plan of Key Decisions is attached at Appendix 1. The Plan contains those key decisions, which the Leader of the Council believes that the Cabinet or individual Cabinet Member(s) can take and any new key decisions to be taken after 19 September 2014.
- 3.2 The information in the Forward Plan of Key Decisions provides the Commission with the opportunity of considering whether it wishes to seek to influence any of these key decisions, or to request further information.
- 3.3 If the Commission wished to examine any of the key decisions, consideration would need to be given as to how this could be accommodated within the work programme.
- 3.4 As the Forward Plan is published fortnightly any version of the Forward Plan published after dispatch of this agenda will be tabled at the meeting.

4. CONSULTATION

- 4.1 Details of any consultation on individual decisions are contained within the Forward Plan of Key Decisions.

5. BACKGROUND DOCUMENTS

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

None

6. APPENDICES

Appendix 1 – Forward Plan of Key Decisions

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PETERBOROUGH CITY COUNCIL'S FORWARD PLAN OF KEY DECISIONS

PUBLISHED: 22 AUGUST 2014

FORWARD PLAN OF KEY DECISIONS

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

If the decision is to be taken by an individual cabinet member, the name of the cabinet member is shown against the decision, in addition to details of the councillor's portfolio. If the decision is to be taken by the Cabinet, it's members are as listed below:

Cllr Cereste (Leader); Cllr Elsey; Cllr Fitzgerald; Cllr Hiller, Cllr Holdich (Deputy Leader); Cllr North; Cllr Seaton; Cllr Serluca and Cllr Scott.

This Plan should be seen as an outline of the proposed decisions for the forthcoming month and it will be updated on a fortnightly basis. Each new Plan supersedes the previous Plan and items may be carried over into forthcoming Plans. Any questions on specific issues included on the Plan should be included on the form which appears at the back of the Plan and submitted to Gemma George, Senior Governance Officer, Chief Executive's Department, Town Hall, Bridge Street, PE1 1HG (fax 08702 388039). Alternatively, you can submit your views via e-mail to gemma.george@peterborough.gov.uk or by telephone on 01733 452268.

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

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

You are entitled to view any documents listed on the Plan, or obtain extracts from any documents listed or subsequently submitted to the decision maker prior to the decision being made, subject to any restrictions on disclosure. There is no charge for viewing the documents, although charges may be made for photocopying or postage. Documents listed on the notice and relevant documents subsequently being submitted can be requested from Gemma George, Senior Governance Officer, Chief Executive's Department, Town Hall, Bridge Street, PE1 1HG (fax 08702 388038), e-mail to gemma.george@peterborough.gov.uk or by telephone on 01733 452268. For each decision a public report will be available from the Governance Team one week before the decision is taken.

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

KEY DECISIONS FROM 19 SEPTEMBER 2014

KEY DECISION REQUIRED	DECISION MAKER	DATE DECISION EXPECTED	MEETING OPEN TO PUBLIC	RELEVANT SCRUTINY COMMITTEE	CONSULTATION	CONTACT DETAILS / REPORT AUTHORS	DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER (IF ANY OTHER THAN PUBLIC REPORT)
Care and Repair Heating Framework Agreement - KEY/19SEP14/01 To approve a framework agreement and schedule of rates to deliver Repairs Assistance grant work, specifically the installation of central heating systems in domestic properties.	Councillor Peter Hiller Cabinet Member for Planning and Housing Services	September 2014	N/A	Strong and Supportive Scrutiny Committee	Relevant internal and external stakeholders.	Russ Carr Care & Repair Manager Tel: 01733 863864 russ.carr@peterborough.gov.uk	It is not anticipated that there will be any further documents.
PREVIOUSLY ADVERTISED DECISIONS							
Delivery of the Council's Capital Receipt Programme through the Sale of Dickens Street Car Park - KEY/03JUL/11 To authorise the Chief Executive, in consultation with the Solicitor to the Council, Executive Director – Strategic Resources, the Corporate	Councillor David Seaton Cabinet Member for Resources	September 2014	N/A	Sustainable Growth and Environment Capital	Consultation will take place with the Cabinet Member, Ward councillors, relevant internal departments & external stakeholders as appropriate.	Richard Hodgson Head of Strategic Projects Tel: 01733 384535 richard.hodgson@peterborough.gov.uk	It is not anticipated that there will be any further documents.

<p>Section 75 Agreement with the Clinical Commissioning Group (CCG) for the Provision of a Joint Child Health and Wellbeing Commissioning Unit - KEY/21FEB14/01</p> <p>Authorisation for the entry into a statutory Section 75 Agreement, for an initial two year period, with the CCG for the provision of a borderline and Peterborough joint child health and wellbeing commissioning unit.</p>	<p>Councillor Marco Cereste Leader of the Council and Cabinet Member for Growth, Strategic Planning, Housing, Economic Development and Business Engagement</p>	<p>October 2014</p>	<p>N/A</p>	<p>Scrutiny Commission for Health Issues</p>	<p>Relevant internal and external stakeholders.</p>	<p>Oliver Hayward Head of Business Management Tel: 01733 863910 oliver.hayward@peterborough.gov.uk</p>	<p>It is not anticipated that there will be any further documents.</p>
<p>Award of Contract for the Extension of Discovery Primary School - KEY/21MAR14/01</p> <p>Award of contract for the extension of the Discovery Primary School to accommodate increased pupil numbers.</p>	<p>Councillor John Holdich Cabinet Member for Education, Skills and University</p>	<p>September 2014</p>	<p>N/A</p>	<p>Creating Opportunities and Tackling Inequalities.</p>	<p>Relevant internal and external stakeholders.</p>	<p>Brian Howard Programme Manager - Secondary Schools Development Tel: 01733 863976 brian.howard@peterborough.gov.uk</p>	<p>It is not anticipated that there will be any further documents.</p>

Sale of Greenwood House - KEY/21MAR14/02 Delivery of the Council's Capital Receipt Programme through the sale of Greenwood House, South Parade.	Councillor David Seaton Cabinet Member for Resources	September 2014	N/A	Sustainable Growth and Environment Capital	Relevant internal and external stakeholders.	Simon Webber Capital Projects Officer Tel: 01733 384545 simon.webber@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Sale of the Herlington Centre - KEY/21MAR14/03 Delivery of the Council's capital receipts programme through the sale of the Herlington Centre, Orton Malborne.	Councillor David Seaton Cabinet Member for Resources	September 2014	N/A	Sustainable Growth and Environment Capital	Relevant internal and external stakeholders.	Simon Webber Capital Projects Officer Tel: 01733 384545 simon.webber@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Peterborough City Council Customer Strategy 2014 - KEY/21MAR14/06 To approve the Customer Strategy. The vision is to provide a range of high-quality services whilst maximising customer satisfaction and delivering these services through different channels at the lowest reasonable cost, whilst also reducing or diverting demand.	Cabinet	22 Sep 2014	Yes	Strong and Supportive Scrutiny Committee	Relevant internal and external stakeholders.	Ricky Fuller Head of Strategic Commissioning/Transformation Tel: 01733 452482 ricky.fuller@peterborough.gov.uk	It is not anticipated that there will be any further documents.

Award of Contract for the Extension of Nenegate School - KEY/05SEP14/02 To authorise the construction of an extension at Nenegate School and give authority to the Executive Director of Resources to award the construction contract within the approved budget.	Councillor David Seaton Cabinet Member for Resources	September 2014	N/A	Creating Opportunities and Tackling Inequalities	Relevant internal and external stakeholders.	Alison Chambers Principal Assets Officer (Schools) Tel: 01733 863975 alison.chambers@peterborough.gov.uk	It is not anticipated that there will be any further documents
Formalise Integrated Community Equipment Service Funding and Commissioning Arrangements - KEY/18APR14/01 To formalise integrated community equipment service joint funding arrangements.	Councillor Wayne Fitzgerald Cabinet Member for Adult Social Care	September 2014	N/A	Scrutiny Commission for Health Issues	Relevant internal and external stakeholders.	Nick Blake Head of Commissioning for Older People, Physical Disabilities and Sensory Impairment Tel: 01733 452406 nick.blake@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Award of Contract for Build of a Waste Transfer Station - KEY/18APR14/02 To award a contract for the build of a waste transfer station.	Councillor Gavin Eisey Cabinet Member for Street Scene, Waste Management and Communications	September 2014	N/A	Sustainable Growth and Environment Capital	Relevant internal and external stakeholders.	Paul Robertson Waste Project Officer Tel: 01733 864740 paul.robertson@peterborough.gov.uk	It is not anticipated that there will be any further documents.

Award of Contract for Build of a Household Recycling Centre - KEY/18APR14/03 To award a contract for the build of a household recycling centre.	Councillor Gavin Eisey Cabinet Member for Street Scene, Waste Management and Communications	September 2014	N/A	Sustainable Growth and Environment Capital	Relevant internal and external stakeholders.	Paul Robertson Waste Project Officer Tel: 01733 864740 paul.robertson@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Future of the Eight Former Play Centres - KEY/02MAY14/01 To approve the recommendations for the eight former play centres.	Councillor Nigel North Cabinet Member for Communities and Environment Capital	September 2014	N/A	Sustainable Growth and Environment Capital	Relevant internal and external stakeholders.	Cate Harding Neighbourhood Manager Tel: 317497 cate.harding@peterborough.gov.uk	It is not anticipated that there will be any further documents.
Contract Award for 16+ Supported Accommodation - KEY/02MAY14/04 To award a contract for 16+ supported accommodation.	Councillor Sheila Scott Cabinet Member for Children's Services	September 2014	N/A	Creating Opportunities and Tackling Inequalities	Relevant internal and external stakeholders.	Oliver Hayward Head of Business Management Tel: 01733 863910 oliver.hayward@peterborough.gov.uk	It is not anticipated that there will be any further documents.
The Expansion of Pheonix School - KEY/02MAY14/05 To award a contract for the expansion of Pheonix School, including the approval of property, legal and financial arrangements for various enabling with third parties.	Councillor David Seaton Cabinet Member for Resources	September 2014	N/A	Creating Opportunities and Tackling Inequalities	Relevant internal and external stakeholders.	Brian Howard Programme Manager - Secondary Schools Development Tel: 01733 863976 brian.howard@peterborough.gov.uk	It is not anticipated that there will be any further documents.

<p>Print Managed Services - KEY/13JUN14/01 To enable Council officers to be able to print, copy and scan.</p>	<p>Councillor David Seaton Cabinet Member for Resources</p>	<p>September 2014</p>	<p>N/A</p>	<p>Sustainable Growth and Environment Capital</p>	<p>Relevant internal and external stakeholders.</p>	<p>Ricky Fuller Head of Strategic Commissioning/Transformation Tel: 01733 452482 ricky.fuller@peterborough.gov.uk</p>	<p>It is not anticipated that there will be any further documents.</p>
<p>Peterborough Flood Risk Management Strategy - KEY/25JUL14/01 For Cabinet to approve the Draft Peterborough Flood Risk Management Strategy for public consultation.</p>	<p>Cabinet</p>	<p>22 Sep 2014</p>	<p>Yes</p>	<p>Sustainable Growth and Environment Capital</p>	<p>Relevant internal and external stakeholders.</p>	<p>Julia Chatterton Flood and Water Management Officer Tel: 01733 452620 julia.chatterton@peterborough.gov.uk</p>	<p>It is not anticipated that there will be any further documents.</p>
<p>Joint Venture Implementation - KEY/25JUL14/02 To approve the implementation of the Joint Venture.</p>	<p>Councillor Marco Cereste Leader of the Council and Cabinet Member for Growth, Strategic Planning, Housing, Economic Development and Business Engagement</p>	<p>September 2014</p>	<p>N/A</p>	<p>Sustainable Growth and Environment Capital</p>	<p>Relevant internal and external stakeholders.</p>	<p>Simon Machen Director of Growth and Regeneration Tel: 01733 453475 simon.machen@peterborough.gov.uk</p>	<p>It is not anticipated that there will be any further documents.</p>

<p>Installation of Solar Voltaic (PV) Panels to Schools - KEY/25AUG14/01 To award a contract for the installation of Solar Voltaic (PV) Panels and energy performance measures to schools under the renewable energy and energy efficiency scheme and energy performance contracts (ENPC)</p>	<p>Councillor David Seaton Cabinet Member for Resources</p>	<p>September 2014</p>	<p>N/A</p>	<p>Sustainable Growth and Environment Capital</p>	<p>Relevant internal and external stakeholders.</p>	<p>Steven Morris Client Property Manager Tel: 01733 384657 steven.morris@peterborough.gov.uk</p>	<p>It is not anticipated that there will be any further documents.</p>
<p>New Model for Transforming Day Opportunities for Adults Under 65 - KEY/25AUG14/02 To approve the proposed model for implementation.</p>	<p>Cabinet</p>	<p>3 Nov 2014</p>	<p>Yes</p>	<p>Scrutiny Commission for Health Issues</p>	<p>Relevant internal and external stakeholders.</p>	<p>Mubarak Darbar Head of Commissioning Learning Disabilities Tel: 01733 452509 mubarak.darbar@peterborough.gov.uk</p>	<p>It is not anticipated that there will be any further documents.</p>
<p>Residential and Nursing Care Contracts - KEY/22AUG14/03 To seek approval for the award of contracts to providers of 24 hour residential and nursing care support.</p>	<p>Councillor Wayne Fitzgerald Cabinet Member for Adult Social Care</p>	<p>September 2014</p>	<p>n/a</p>	<p>Scrutiny Commission for Health Issues</p>	<p>Relevant internal and external stakeholders.</p>	<p>Nick Blake Head of Commissioning for Older People, Physical Disabilities and Sensory Impairment Tel: 01733 452406 nick.blake@peterborough.gov.uk</p>	<p>It is not anticipated that there will be any further documents.</p>

<p>Southfields Primary School Expansion - KEY/05SEP14/01 To authorise the construction of an extension to accommodate the expansion of Southfields Primary School.</p>	<p>Councillor John Holdich Cabinet Member for Education, Skills and University</p>	<p>September 2014</p>	<p>N/A</p>	<p>Creating Opportunities and Tackling Inequalities</p>	<p>Relevant internal and external stakeholders.</p>	<p>Emma Everitt Project Support Officer Tel: 01733 863660 emma.everitt@peterborough.gov.uk</p>	<p>It is not anticipated that there will be any further documents</p>
<p>Renewable Energy and Energy Efficiency Scheme - KEY/05SEP14/03 Installation of Solar Photovoltaic (PV) Panels to PCC's Commercial Properties including industrial estates.</p>	<p>Councillor David Seaton Cabinet Member for Resources</p>	<p>September 2014</p>	<p>N/A</p>	<p>Sustainable Growth and Environment Capital</p>	<p>Relevant internal and external stakeholders.</p>	<p>Steven Morris Client Property Manager Tel: 01733 384657 steven.morris@peterborough.gov.uk</p>	<p>It is not anticipated that there will be any further documents.</p>

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

Strategic Finance
Internal Audit
Schools Infrastructure (Assets and School Place Planning)
Corporate Property
Waste and Energy
Strategic Client Services (Enterprise Peterborough / Vivacity / SERCO including Customer Services, ICT and Business Support)

CHILDREN'S SERVICES DEPARTMENT Executive Director's Office at Bayard Place, Broadway, PE1 1FB

Safeguarding Family and Communities
Education
School Improvement
Special Educational Needs / Inclusion and the Pupil Referral Service

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

Care Services Delivery (Assessment and Care Management and Integrated Learning Disability Services)
Mental Health
Public Health (including Health Performance Management)

COMMUNITIES DEPARTMENT Director's Office at Bayard Place, Broadway, PE1 1FB

Strategic Commissioning
Safer Peterborough, Cohesion, Social Inclusion and Neighbourhood Management

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

Communications
Legal and Governance Services
HR Business Relations (Training and Development, Occupational Health and Reward and Policy)
Strategic Regulatory Services
Performance Management

GROWTH AND REGENERATION DEPARTMENT Director's Office Stuart House, St Johns Street, Peterborough, PE1 5DD

Strategic Growth and Development Services
Strategic Housing
Planning Transport and Engineering (Development Management, Construction and Compliance, Infrastructure Planning and Delivery, Network Management and Passenger Transport)
Commercial Operations (Strategic Parking and Commercial CCTV, City Centre, Markets and Commercial Trading and Tourism)

**SCRUTINY COMMISSION FOR HEALTH ISSUES
WORK PROGRAMME 2014/15**

Meeting Date	Item	Progress
<p>8 July 2014 <i>Draft report 19 June</i> <i>Final report 26 June</i></p>	<p>Health and Wellbeing Board LGA Peer Review Letter and Action Plan</p> <p>To note the contents of the review, scrutinize the action plan and make any recommendations.</p> <p>Contact Officers: Wendi Ogle-Welbourn/Jana Burton</p>	
	<p>Peterborough and Stamford Hospitals NHS Foundation Trust, CQC Report</p> <p>Contact Officer: Jane Pigg</p>	
	<p>Personality Disorder Community Service/Complex Cases Service, including Lifeworks Consultation</p> <p>Contact Officer: Neil Winstone, Associate Director of Performance Delivery</p>	
	<p>Older Peoples Procurement Programme Board End of Consultation Paper</p> <p>Contact Officer: Jessica Bawden</p>	
	<p>Review of 2013/14 and Future Work Programme 2014/15</p> <p>To review the work undertaken during 2014/15 and to consider the future work programme of the Committee.</p> <p>Contact Officer: Paulina Ford, Senior Governance Officer</p>	

Meeting Date	Item	Progress
10 September 2014 <i>Draft report 22 August</i> <i>Final report 29 August</i>	Local Health Economy Five Year Strategic Plan Contact Officer: Jessica Bawden / Andy Vowles Adult Social Care Update To scrutinise and comment on the Adult Social Care transformation update, Adult Social Care Complaints 2013-2014 and Adult Social Care Account. Contact Officer: Jana Burton Cardio Vascular Disease Contact Officer: Dr Henriette Ewart	
14 October 2014 <i>Draft report 25 Sept</i> <i>Final report 2 Oct</i>	Children's Health Care Performance Contact Officer: Wendi Ogle-Welbourn Health and Wellbeing Board Peer Review Action Plan Contact Officers: Wendi Ogle-Welbourn / Jana Burton Primary Health Care Strategy for East of England Contact Officer: Jessica Bawden / Andrew Reed Better Care Fund Contact Officer: Jana Burton	

Meeting Date	Item	Progress
<p>11 November 2014 <i>Draft report 23 Oct</i> <i>Final report 30 Oct</i></p>	<p>CPFT - Personality Disorder Community Service/Complex Cases Service, including Lifeworks Consultation Outcome</p> <p>Contact Officer: Neil Winstone, Associate Director of Performance Delivery</p> <p>Portfolio Progress Report for Cabinet Member for Adult Social Care</p> <p>To scrutinise and comment on the progress of the portfolio of the Cabinet Member for Adult Social Care including the Performance of Public Health and Adult Social Care.</p> <p>Contact Officer: Jana Burton</p>	
	<p>Peterborough and Stamford Hospitals NHS Foundation Trust</p> <p>Contact Officer: Jane Pigg</p>	
	<p>Older Peoples Programme Preferred Bidder</p> <p>Contact Officer: Jess Bawden</p>	
	<p>MIIU Update</p> <p>Contact Officer: Jessica Bawden</p>	
<p>8 January 2014 <i>Draft report 17 Dec</i> <i>Final report 24 Dec</i></p>	<p>Scrutiny in a Day – Outcomes Impact Report</p>	
	<p>Response to the Francis Report from Commissioners Perspective</p>	

Meeting Date	Item	Progress
	<p>Contact Officer: Jessica Bawden</p>	
<p>(Joint Meeting of the Scrutiny Committees and Commissions) T.B.A. February 2015 <i>Draft report</i> <i>Final report</i></p>	<p>Budget 2015/16 and Medium Term Financial Plan To scrutinise the Executive's proposals for the Budget 2014/15 and Medium Term Financial Plan. Contact Officer: John Harrison/Steven Pilsworth</p>	
<p>10 March 2015 <i>Draft report 19 Feb</i> <i>Final report 26 Feb</i></p>	<p>Health and Wellbeing Board Action Plan Quarterly Update Contact Officers: Wendi Ogle-Welbourn / Jana Burton</p>	

Meeting Date	Item	Progress

Possible Items for Scrutiny:

<p>Adult Social Care</p> <ul style="list-style-type: none"> Transformation of Day Opportunities for Adults Under 65 	
<p>Healthwatch</p>	
<p>Public Health</p> <ul style="list-style-type: none"> Portfolio Progress Report from the Cabinet Member for Growth, Strategic Planning, Housing, Economic Development and Business Engagement (Portfolio includes Responsibility for all Public Health Functions of the Council and lead spokesperson for all matters relating to the commissioning and provision of health services by the CCG, NHS and any other bodies for Peterborough) Young Peoples Sexual Health and Wellbeing Strategy Suicide Prevention Strategy, Contact Officer: Kathy Hartley 	
<p>The Cambridgeshire & Peterborough Clinical Commissioning Group</p> <ul style="list-style-type: none"> Business Plan Six monthly progress report 	
<p>Peterborough and Stamford Hospital NHS Foundation Trust</p> <ul style="list-style-type: none"> Response to Recommendations from the Francis Inquiry Post CPT Quality Accounts – Jane Pigg 	
<p>Health and Wellbeing Board</p> <ul style="list-style-type: none"> Quarterly Update – Wendi Ogle-Wellbourn 	
<p>CPFT –Update– June 2014 – contact officer: Lisa Hunt, Chief Operating Officer</p>	

Updated: 28 August 2014

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