PETERBOROUGH CITY COUNCIL

HEALTH AND WELLBEING BOARD

THURSDAY 17 JULY 2014
3.30 PM

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

AGENDA

Page No

1. **Apologies for Absence**

2. **Declarations of Interest**

3. **Minutes of the Previous Meeting held on 27 March 2014** **3 - 10**

4. **Health and Wellbeing Board Membership** **11 - 12**
   The Board is requested to consider membership of the HWBB and how new Members are agreed going forward.

5. **NHS England / Local Board**

   (a) **East Anglia Screening and Immunisation Performance Report** **13 - 20**
   The Board is requested to note the report and to discuss performance.

   (b) **Primary Care Strategy Update Report** **21 - 106**
   The Board is requested to note the report and to discuss the developments in the Primary Care Strategy.

   (c) **Update on PWC 'Challenged Health Economy Work'** **107 - 108**
   The Board is asked to note the report and to comment on the work of PWC to date.

6. **Clinical / Local Commissioning Groups**

   (a) **Better Care Fund Highlight Report** **109 - 114**
   The Board is requested to note the report and comment on the development of the programme.

There is an induction hearing loop system available in all meeting rooms. Some of the systems are infra-red operated, if you wish to use this system then please contact Gemma George on 01733 452268 as soon as possible.

7. Public Health

(a) Report on Health Protection, Emergency Planning and Response to Emergencies **115 - 194**
The Board is requested to note and comment on the report.

(b) Memorandum of Agreement between Public Health and LCG's - Public Health Work Plan **195 - 208**
The Board is requested to note the report.

(c) Update on Cardiovascular Disease Priority Work Programme **209 - 212**
For the Board to note and comment on the proposals for progressing cardiovascular disease (CVD) as the Board's top priority.

8. Children's Services

(a) Development of the Joint Child Health Commissioning Unit
For the Board to receive a verbal update.

OTHER ITEMS

9. Peer Review of the Health and Wellbeing Board **213 - 236**
The Board is requested to comment on the letter and draft action plan.

INFORMATION ITEMS

10. Concordat for Joint Working between Peterborough City Council, Cambridgeshire County Council and Health organisations across Peterborough & Cambridge **237 - 246**
The Board to receive and note the Cabinet report of the 30 June 2014.

11. Schedule of Future Meetings and Draft Agenda Programme **247 - 250**
To note the dates and agree future agenda items for the Board. To include frequency of reporting from other Boards, where appropriate, including Local Safeguarding Boards, Children's and Adults Commissioning Boards, LCG Commissioning Board. Also to consider how we will monitor progress against the Health and Wellbeing strategy.

Board Members:
Cllr M Cereste (chairman), Cllr D Lamb (vice chairman), Cllr Fitzgerald, Cllr J Holdich, Cllr S Scott, Gillian Beasley, David Whiles (Healthwatch), Dr M Caskey, Dr R Withers, Dr P Van den Bent, Jana Burton; Cathy Mitchell; Andrew Reed; Andy Vowles; Sue Westcott; Dr Henrietta Ewart; Wendi Ogle-Welbourn

Co-opted Members: Russell Wate and Claire Higgins

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

PETERBOROUGH CITY COUNCIL

MINUTES OF A MEETING OF THE HEALTH AND WELLBEING BOARD HELD IN THE BOURGES / VIERSEN ROOMS, TOWN HALL ON 27 MARCH 2014

Members Present:	Councillor Marco Cereste, Leader of the Council (Chairman) Councillor Fitzgerald, Cabinet Member for Adult Social Care Councillor John Holdich, Cabinet Member for Education, Skills and University Councillor Irene Walsh, Cabinet Member for Community Cohesion, Safety and Public Health Gillian Beasley, Chief Executive, PCC Jana Burton, Executive Director of Adult Social Care and Health and Wellbeing, PCC Cathy Mitchell, Cambridgeshire & Peterborough Clinical Commissioning Group Dr Richard Withers, Dr Harshad Mistry, Peterborough City Local Commissioning Group Katie Norton, National Commissioning Board Local Area Team David Whiles, Peterborough Healthwatch
Co-opted Members Present:	Russell Wate, Chairman of the Safeguarding Children's Board Claire Higgins, Chairman of the Safer Peterborough Partnership
Also Present:	Wendi Ogle-Welbourn, Director for Communities Gemma George, Senior Governance Officer Dr Peter Reading, Interim Chief Executive – Peterborough and Stamford Hospitals NHS Foundation Trust Al Marshall, Transaction Director – Peterborough and Stamford Hospitals NHS Foundation Trust Anne McHugh, Communications Specialist – Peterborough and Stamford Hospitals NHS Foundation Trust

1. Apologies for Absence

Apologies for absence were received from Councillor Sheila Scott, Sue Westcott, Dr Michael Caskey, Dr Paul Van Den Bent, Dr Ken Rigg, Andrew Reed and Andy Vowles.

Katie Norton was in attendance as a substitute for Andrew Reed and Dr Harshad Mistry was in attendance as substitute for Dr Van Den Bent.

2. Declarations of Interest

There were no declarations of interest.

3. Minutes of the Meeting Held on 16 January 2014

The minutes of the meeting held on 16 January 2014 were approved as an accurate record.

4. Submission of Petition in Relation to the Hydrotherapy Pool

Karen Oldale, a service user of St George's Hydrotherapy Pool, presented a petition to the Health and Wellbeing Board on behalf of 3611 people who had signed to save the pool and on behalf of over 1800 registered users.

Ms Oldale commented that there was a proven local need for the service and it was strongly believed that community hydrotherapy, which had been shown to improve public health and wellbeing and reduce health inequalities, fell within the remit and responsibility of the Board. It was therefore called upon the Board, through joint commissioning, to ensure the continued provision of the service until a suitable long term option became available.

Councillor Cereste advised that negotiations were underway in order to identify a way forward, and thanked Ms Oldale for presenting the petition.

COMMISSIONING ISSUES

5. Commissioning Intentions – Priorities for 2014/15

The Board received a report following development of the commissioning intentions document which set out the commissioning intentions for children, community and adult services from across the City Council.

Wendi Ogle-Welbourn presented the report and advised that the document had been shared with the Joint Commissioning Forum, the Peterborough and Borderline Local Commissioning Groups / Local Authority Commissioning Group, and would also be shared with the Health and Wellbeing Programme Board in order to explore the opportunities for further joined up working. The document had also been sent to the Clinical Commissioning Group (CCG) lead who was in the process of developing the five year strategic plan.

RESOLVED:

The Board noted the Commissioning Intentions of the City Council.

6. NHS 5 Year Strategic Planning 2014 – 2019

The Board received a report which provided an update on the process underway to develop a five year strategic plan.

The requirement for the Plan had been issued within national guidance in November 2013 and required local health authorities to produce a five year strategic plan for their local health economies.

Cambridgeshire and Peterborough Clinical Commissioning Group had been tasked with leading the development of the Plan, setting out a vision for the next five years and detailing changes that needed to take place within the system in order to deliver the vision by the end of 2018/19.

Cathy Mitchell introduced the report and advised that there were a number of challenges for the document to address including aging population; increase in long-term conditions; rising costs; rising public expectations and challenging financial environments. The Plan would also reflect the Clinical Commissioning Group's vision and values.

It was further advised that additional support was to be received from external advisors as the Cambridgeshire and Peterborough System had been identified by NHS England, Monitor and the NHS Trust Development Authority as being one of 11 challenged health economies. These external advisors would be available from April to June, and they would be utilised to create the strategy and the implementation plan required by partners to progress the strategy forward.

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

- The issues faced were wide reaching and there were competing regulatory bodies, with different levels of accountability and governance that did not always operate in a consistent fashion;
- Many foundation trusts were in severe financial distress or heading in that direction;
- The document was a work in progress and further work was required in order to capture a collective vision;
- The Plan was not solely about health issues and it provided the opportunity for all organisations to come together in order to identify what could be done better in order to make a difference going forward;
- If a shared planned vision did not come to fruition, unplanned change would occur;
- Representations should be made to national government in order address the shortfall in funding;
- 40% of trusts were facing a deficit over the forthcoming year, the government needed to address this;
- There would need to be tough decisions made going forward, some of which would be extremely challenging;
- The Plan needed to recognise the vital role of the primary and community based services as being part of the ongoing solution and how these could be transformed accordingly;
- The sustainability and pressures on the primary care system could not be underestimated;
- The underfund had been recognised nationally in the coming financial year, with a small step change towards addressing this by moving towards the allocated budget, however continued support and lobbying was required going forward to ensure the allocation that the CCG should have was realised;
- This was an opportunity for change and action needed to be taken and a plan formulated in order to address the issues faced; and
- The health landscape in Peterborough had changed drastically over the past decade.

Following discussion and comments, it was agreed that a small group would be formulated to meet, following the elections, in order to discuss and plan how to address the issues faced. This would include approaching and making representations to health ministers and senior politicians.

RESOLVED:

The Board noted the update on the development of the five Year Strategic Plan and agreed the formation of a group, to meet and discuss issues, as a way forward.

7. NHS England / Local Board

(a) Update on the Healthy Child Programme

The Board received a report which provided members with an overview of the resource tool to support the integrated commissioning and delivery of the Healthy Child Programme (HCP) from pregnancy and the first five years of life. The Board was also requested to sign up to the piloting of one aspect of the Toolkit in Peterborough between April and September 2014.

Katie Norton introduced the report and advised that the Healthy Child Programme had been started in recognition of the very complex arrangements that were in place to support the work to ensure that every child had a good start in life. It was further highlighted that the commissioning responsibilities were shared between the Local Authority, Clinical Commissioning Groups and NHS England amongst others; a number of sites had been identified to pilot certain aspects of the Toolkit in order to ensure it was fit for purpose and able to be easily implemented; Peterborough had been actively engaged in development

and Cambridge and Peterborough would pilot 'Outcomes and KPIs'; each pilot site would be fully supported; and the pilot of the Toolkit would feed into the work being undertaken as part of the Cambridge and Peterborough Children and Young People's Programme Board to redesign child health services in the area. It would also support the commissioning and delivery of an integrated Healthy Child Programme 0-5 when commissioning responsibility for health visiting and Family Nurse Partnership services moved to Peterborough City Council in 2015.

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

- Peterborough was on target in relation to the increase in the number of Health Visitors by 2015;
- A number of the new Health Visitors were newly trained. This was a steep learning curve in terms of the new specification for Health Visitors and there was development work to do; and
- Health Visitor input around Safeguarding was required and it was advised that Safeguarding responsibilities were embedded within the new specification for Health Visitors.

RESOLVED:

The Board noted the report and signed up to the piloting of one aspect of the Toolkit in Peterborough between April and September 2014.

(b) Primary Care Strategy Update

Katie Norton provided a verbal update on the work being progressed by the NHS England East Anglia Area Team to develop a strategic framework to support the development of Primary Care in East Anglia.

Members discussed the update and comments and responses to questions included:

- The Area Team had signed off the business case which would enable the re-provision of North Road and Lincoln Road into a purpose built facility on Craig Street, that would support the delivery of integrated services;
- Support had been confirmed for the changes required to support the regeneration project in Orton;
- Significant investment in infrastructure was essential to deliver the integrated vision that the Local Commissioning Group was working towards;
- Work had been undertaken around the configuration of services in Peterborough and the plans around that to support sustainability of practices. Options were still being considered and a paper would be brought back to a future meeting setting out detailed proposals;
- The Craig Street development was welcomed, however it was felt that the problems in Central Ward remained and these issues needed to be addressed. In response to these concerns, it was advised that there were discussions taking place with the practices concerned;
- There was the potential for investment to be withdrawn from various general practices and redistributed to others;
- There were issues with attracting new young doctors to the city and very few wanted to become partners. This could lead to a recruitment crisis;
- There needed to be more investment in primary care, offering treatment in the community rather than in hospitals;
- The Craig Street site could have been utilised to better effect and joined up working needed to be undertaken in future, to provide housing etc.; and

- There needed to be better engagement with GPs going forward and involvement from the Council and Partners was sought to assist with the recruitment of GPs/Clinicians/Nurses by 'selling the merits of Peterborough' e.g. by talking to housing providers/schools etc.

RESOLVED

The Board noted the update and agreed the actions going forward.

(c) Procurement to Optimise use of Peterborough and Stamford Hospitals NHS Foundation Trust's Estate and to Minimise its Long Term Deficit

The Board received a report which presented emerging thinking and sought to obtain the Board's views on the tender plan, this being the work undertaken so far by the Trust to identify the preferred approach to and scope of the transaction (tender).

Dr Peter Reading presented the report and gave a presentation to the Board, key points highlighted included:

- The Contingency Planning Team (CPT), appointed by Monitor, had concluded that the Trust was clinically and operationally sustainable, but that it was not financially sustainable in its current form;
- The CPT had recommended four courses of action, which together could deliver a sustainable solution for local patients;
- One of the courses of action was to launch a competitive tender 'designed to test whether the Trust's assets could be used in ways which would further reduce its deficit;
- All options of how the value of the Trust's assets could be maximised would be considered in an open, fair and transparent competitive tender exercise. A Tender Plan was being preparing in order to explain how this would be achieved;
- There were a number of possible responses to the tender, including 'one or more providers delivering services from the estate', 'an integrated joint venture for example secondary and primary care', 'a merger between acute hospitals (including acquisition)' or 'a new operator running the Trust's services';
- Questions to be asked would include 'whether the response maximised the value?' and 'did it meet the evaluation criteria?';
- The deficit needed to be reduced by £40m per year;
- The services would continue to be run from Peterborough City Hospital and Stamford Hospital sites whatever the outcome;
- The outcome had to be in the context of the Trust maintaining and improving the quality of both clinical outcomes and patient experience; and
- The tender outline timetable was presented and it was advised that stakeholders were being actively engaged about the evaluation of the tender at the current stage and it was planned to report back to the Board at key stages wherever possible.

Members were invited to comment on the report and presentation. Comments and responses to questions included:

- The fundamental issue faced by the Trust was one of debt, this needed to be addressed going forward. A plan to deal with debt should be implemented;
- It was requested that thought be given as to how the Council would be engaged with throughout the tender process. There was expertise available for utilisation;
- Comments had been made following the last Peterborough Regional Steering Group (PRSG) that thoughts would be given as to the role that the Council could play going forward;

- It was queried whether extrication from the PFI through government had been explored? It was advised that this option had been explored and a report commissioned. The conclusion had been that the cost of buying out the contract would be so high and risky that there was no opportunity to do so
- Any of the four possible response options would not get to the bottom of the £40m quickly; and
- The premise of more revenue was a good one, and specialising in a particular area may be a key to success.

Following discussion, Dr Reading advised that he had noted the point about involving the Council and the additional comments made would be incorporated within the project plan.

RESOLVED

The Board noted the report and presentation and commented on the tender plan.

8. Clinical / Local Commissioning Groups

(a) Better Care Action Plan

The Board received a report which sought its views on the draft Better Care Fund Action Plan in order to inform the content of the final Action Plan, which was being produced.

The Board was also requested to consider delegating its authority into the Joint Commissioning Forum and the Borderline and Peterborough Transformation Board (B&PTB) in order to implement the Better Care Action Plan from April 2014.

Cathy Mitchell introduced the report and draft plan and further requested that due to the meeting cycle of the Board, the Final version of the Action Plan be circulated to the Board electronically for virtual sign off prior to submission on 4 April 2014 to NHS England.

A number of engagement events had been undertaken and a number of comments had been collated to inform the Plan. The Plan would be high level and areas of further exploration had been agreed for 2015/16 as the Plan needed to cover two years.

With reference to recommendations arising following the Pear Review, it was recognised that the Joint Commissioning Forum and the Transformation Board were good forums that may benefit from being formalised as sub-groups of the Health and Wellbeing Board and it was requested that they be formally recognised as the delivery vehicles for the Better Care Fund going forward.

RESOLVED

The Board:

1. Discussed and commented on the proposals contained within the draft Better Care Fund Action Plan, submitted on 14/02/14;
2. Confirmed its agreement to virtually sign off the final Better Care Action Plan for submission on 04/04/14 to NHS England; and
3. Delegated to the Joint Commissioning Forum (JCF) and the Borderline and Peterborough Transformation Board (B&PTB) to implement the Better Care Action Plan from April 2014, further agreeing that they be recognised as the delivery vehicles for the Better Care Fund going forward.

9. Children's Services

(a) Joint Child Health and Wellbeing Commissioning Unit

The item was deferred to a future meeting.

10. Adult Social Care

(a) Section 256 Agreement Relating to Social Care Funding 2013-14

The Board received a report which provided an overview of the Section 256 agreement which had been agreed between the Council and NHS England Local Area Team for 2013-14 and which would also provide a basis for the agreement in 2014-15.

The CCG and Peterborough City Council were required to draw up a Section 256 agreement and to agree the outcomes that would be delivered from the funding held by the Local Area Team. The Local Area Team would release funding to Peterborough City Council Adult Social Care Health & Wellbeing based on the evidence that the outcomes had been delivered in 2013-14.

RESOLVED

The Board noted the report.

INFORMATION AND OTHER ITEMS

11. Health and Wellbeing Board Safeguarding Protocol

The Board received a report which sought its approval for the proposed framework and protocol which would secure effective joint working between the Peterborough Health and Wellbeing Board, the Peterborough Local Safeguarding Children Board and the Peterborough Safeguarding Adult Board.

RESOLVED

The Board approved the Health and Wellbeing Board Protocol.

12. Health and Wellbeing Board Peer Review

The Board received a report which provided an overview of the initial feedback from the Peer Review, which had been undertaken between 11 March 2014 and 15 March 2014.

Wendi Ogle-Welbourn presented the report and the associated presentation provided by the Peer Review Team. It was advised that over the four day period, the Peer Review Team had seen approximately 76 people, 46 forums and had looked at a vast number of documents. The review had been very thorough and although the official report had yet to be received, it was felt pertinent to consider any immediate action required.

There were a number of areas which could be progressed and agreement was sought for these issues to be taken forward by the Programme Board, they included 'a review of the terms of reference of the HWB and Programme Board and a review of membership', 'a review and refresh of the HWB Strategy, so it was more focussed' and 'to consider the health inequalities in the city, focussing on one or two areas in order to make a real difference, possibly even focussing on a particular area in the city, with recommendations

from the Programme Board to be brought back to a future HWB' and 'a review of the Board's forward plan'.

Gillian Beasley advised that another recommendation had been the reinstatement of a group which had been convened under the old PCT system. It was therefore agreed that various colleagues in CCG, Hospital and Mental Health Trust etc. would be written to with the proposal to reinstate a group of key leaders in providers and commissioning in order assist the Board to function better at a strategic level.

Councillor Cereste requested that, in time for the next Board meeting, thought should be given to a quick win project on which partners could all work together and achieve delivery.

RESOLVED

The Board noted the initial feedback presentation from the Peer Review and considered the recommended actions from this and agreed the proposed areas of progression.

13. Programme Board Membership and Terms of Reference

This item was deferred to a future meeting.

14. Relationship of Health and Wellbeing Board to Health Scrutiny

This item was deferred to a future meeting.

INFORMATION ITEMS

15. Health and Wellbeing Board Delivery Plan Update

The Board noted the updated Health and Wellbeing Delivery Plan update.

16. Schedule of Future Meetings and Draft Agenda Programme

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

1.00pm – 3.10pm
Chairman

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 4
		PUBLIC REPORT
Contact Officer(s):	Wendi Ogle-Welbourn Director for Communities	Tel. 01733 863749

HEALTH AND WELLBEING BOARD MEMBERSHIP

RECOMMENDATIONS	
FROM : Wendi Ogle-Welbourn Director of Communities	**Deadline date:** N/A

Discuss the recommendation in the Peer Review to re- consider the membership of the Health and Wellbeing Board:

- More balanced membership between the Local Authority and Health
- Consider Vice Chair being a Health professional
- Consider provider representation on the Board

Consider request by the Police to become members of the board.

1. ORIGIN OF REPORT

1.1 This report is submitted to the Board following the Peer Review in March 2014, the review suggested the Board should consider reviewing membership of the Board.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to seek the views of the Health and Wellbeing Board on the membership and makeup of the Health and Wellbeing Board.

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

3. BACKGROUND AND SUMMARY

3.1 The Health and Wellbeing Board Peer Review suggested that the Health and Wellbeing Board membership was heavily weighted towards the Local authority and that we should consider a better balance; particularly in respect of health. The Board needs to consider the number of people it thinks appropriate to be on the board, as to many people will make it ineffective, also the make-up of the board. *It is suggested* one third local authority, one third health and one third other, commissioners only, as the Programme Board membership includes providers, if they can evidence they will add value to the business of the board. *The board are asked to discuss and agree number and makeup.*

3.2 The Health and Wellbeing Board Peer Review suggested that it may be appropriate for the Vice Chair of the Health and Wellbeing Board to be someone from the CCG. *The board are asked to give a view on this suggestion and agree whether or not the vice chair should be from the CCG.*

3.3 The Police have requested a place on the Board. *It is suggested that this request is agreed and future requests should be submitted in writing, detailing value agency/organisation would bring to the Board.*

4. CONSULTATION

4.1 The Peer Review team spoke to a number of agencies and organisations and their views have informed the recommendations in this report.

5. ANTICIPATED OUTCOMES

5.1 That the Health and Wellbeing Board agree changes to the Health and Wellbeing Board membership and this will lead to a strengthened and more effective Board.

6. REASONS FOR RECOMMENDATIONS

6.1 To respond to the Peer Review feedback on how the Health and Wellbeing Board can be strengthened to become more effective.

7. BACKGROUND DOCUMENTS

7.1 Peer Review feedback

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 5 (a)
		PUBLIC REPORT

Contact Officer(s):		Tel:
Dr Henrietta Ewart	Local Authority Director of Public Health	01733207176
Dr Shylaja Thomas	Screening and Immunisation Lead for NHS England East Anglia and Public Health England	01138254915
Dr Colin Uju	Screening and Immunisation Manager for NHS England East Anglia and Public Health England	07909097651

SCREENING AND IMMUNISATION REPORT

RECOMMENDATIONS	
FROM : NHS England East Anglia Area Team Public Health Screening and Immunisation Team	**Deadline date : N/A**

1) For the Board and individual member organisations to work collaboratively with NHS England and Public Health England to promote screening and immunisation in Peterborough.

2) For the Board and individual member organisations to work in partnership with NHS England and Public Health England to address the lower uptake by particular groups, including those from deprived and ethnic communities, of:
    a. cervical screening in younger women
    b. bowel screening
    c. childhood Immunisation, to achieve 95%
    d. flu vaccination for 'at risk' groups and pregnant women, to achieve 75%

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

1. ORIGIN OF REPORT

This report is submitted to the Board following a request by the chair of the Health and Wellbeing Board

2. PURPOSE AND REASON FOR REPORT

The purpose of this report is to update the Peterborough Health and Wellbeing Board (HWB) on the current performance of screening and immunisation programmes in Peterborough. This will enable the board to review the performance indicators for the screening and immunisation programmes commissioned by NHS England with the support of Public Health England and seek assurance on the delivery of quality programmes that meet the nationally agreed specifications.

This report has been circulated for pre-reading. There will be a short PowerPoint presentation and a question and answer session at the meeting on the 17th July.

3. Background

Since April 2013, Screening and Immunisation programmes have been commissioned by NHS England as per Public Health agreement under section 7A of the 2006 Act as inserted by the Health and Social Care Act 2012.

NHS England East Anglia Area Team leads on commissioning of the following programmes for the population of Peterborough

- 3 cancer screening programmes: Breast, Cervical and Bowel
- 2 adult and young people screening programmes: Abdominal Aortic Aneurysm (AAA) and Diabetic Eye Screening(DES),
- 7 antenatal and new-born screening programmes,
- 15 immunisation programmes: neonatal and childhood, school age and adult immunisations

4. Areas of Discussion

The Key performance indicators (KPIs) for the Screening programmes are given below. All the programmes are meeting the national standards or have actions in place to meet the standards. The monitoring and governance of the screening programmes is through the quarterly programme board meetings organised and led by the Screening and Immunisation team for East Anglia, which feed into the NHS England Area Team performance and quality processes.

Breast Screening Programme (Peterborough Breast Screening Unit provided by Peterborough and Stamford Hospital Trust):

Korner return KC63 - Percentage uptake of screening by age (The definition of uptake is the percentage of women who, having been sent an invitation for screening, attend a screening unit and undergo mammography in response to that invitation). National target is > or equal to 70%. Peterborough is achieving this KPI at all age brackets.

Table 1 Breast Screening

Age at first offered appointment	Number of women invited	Number screened	Percentage uptake
<= 44	0	0	N/A
45-49	2438	1743	71.50%
50-52	2332	1706	73.20%
53-54	1908	1418	74.30%
55-59	3108	2297	74%
60-64	2518	1902	75.50%
65-69	1804	1341	74.30%
70	240	217	90.40%
71-74 self referral	0	375	N/A
>=75 self referral	0	391	N/A
All ages	14348	11390	79.40%

The screen to assessment standards are being met by the Peterborough Screening Unit. The only issue of concern is the implementation of the high risk screening - in addition to the routine 3 yearly screen of women between 47 and 73 years, women are eligible for high-risk screening if they are referred from Genetics or Oncology services, and meet agreed criteria. At the moment there is an action plan in place and this is being monitored via the programme board.

Cervical Screening Programme: Cervical Cytology Service provided by Peterborough and Stamford Hospital Trust:

The test, mainly undertaken in general practice, involves taking a sample of cells from the neck of the womb every 3 years for women aged 20 to 49 and every 5 years for women aged 50 to 64. Women aged 65+ are invited only if they have not been screened since age 50 or have had recent abnormal results. This programme has led to significant reductions in deaths from cervical cancer. The introduction of the HPV vaccination programme is also aimed at reducing the risk of cervical cancer.

Women with abnormal cervical screening tests are referred for colposcopy, a specialist test to further assess and treat the abnormalities detected. As with the other screening programmes aimed at early detection, the programme is monitored on uptake, the speed of getting results to the women tested and the speed of getting women in for assessment and treatment.

Table 2

Cervical Screening	Q1 April - June 2013	Q2 July - Sept 2013	Q3 Oct - Dec 2013
KPI CS1 standard 80% coverage for 50-64 years	75.8	75.10	75.0
KPI CS2 standard 80% coverage for 25-49 years	69.10	68.8	68.6
KPI CS3 standard 80% coverage for 25-64 years	75.7	75.4	75.0
KPI CS4/SQU22 standard 98% 14 day TAT from date of test to receipt of result letter	99.9	100	99.6
KPI CS5 standard 100% colposcopy waiting times % women seen in less than 8 weeks	100	100	100

The coverage in younger women for the Peterborough population is significantly below the national target of 80%. Although this is not just an issue for Peterborough, recent evaluation of coverage by GP practice shows a close relationship between the cervical screening coverage by practice and the practice's deprivation score. The programme is meeting the 14 day turnaround time (TAT) in cytology which is the time it takes for a woman to receive her test results measured from the day the sample was taken and the colposcopy waiting times.

Bowel Cancer Screening Programme: Hinchingbrooke and Peterborough Screening Unit-Jointly provided by Hinchingbrooke Hospital Trust and Peterborough and Stamford Hospital Trust, led by the former):

Bowel cancer is the third most common cancer in the UK with up to 5% developing it during their lifetime. The screening programme aims to detect bowel cancer at early stages when treatment is more likely to be effective. The screening programme is open to all those aged 60 – 75, with testing offered at 60 and every two years after that to age 75. All those screened receive an introductory letter followed by a testing kit, the faecal occult blood test (FOBT) that they can complete at home, posting the completed kit to one of a number of approved laboratories when completed. The test looks for hidden blood in the bowel that may indicate an abnormality such as polyps or cancer which can bleed, but not sufficiently to be visible. For positive tests, an invitation is issued for an examination of the bowel using a colonoscopy, when the bowel can be viewed to ascertain the source of the blood and, if abnormalities are seen, for samples to be taken for testing. Approximately 10% of those having colonoscopy will be found to have cancer.

Table 3

Bowel Screening	Q1 April - June 2013	Q2 July - Sept 2013	Q3 Oct-Dec 2013
KPI BCS1 standard 52% uptake for completion of FOBT kit	54.34	54.34	54.34
KPI BCS2 standard 100% patients seen by Specialist Screening Practitioner within 2 weeks	100	100	NA
KPI BCS3 standard 100% patients undergo endoscopy within 2 weeks of being seen by SSP	90.91	97.96	NA

Screening uptake is above the national target, although there is significant variation in uptake performance across the Anglia area, with comparatively lower uptake in Peterborough than neighbouring areas. Analysis of uptake data for the period January to October 2013 shows that there are 12 GP practices with uptake of less than 50%.

Bowel scope screening (an examination called 'flexible sigmoidoscopy'' which looks inside the lower bowel with the aim of finding any small growths called 'polyps', which may develop into cancer if left untreated) is an expansion to the existing programme using FOB testing. Bowel scope screening will be offered to all 55 year old people. The Peterborough programme is expected to start in 2015.

Adult and Young People Screening Programmes: Diabetic Eye Screening (DES) delivered by Cambridgeshire DES Service. The provider is Cambridge University Hospitals Foundation Trust

Diabetic retinopathy is one of the most common causes of sight loss in working age people and may cause no symptoms until it is quite advanced, which is why screening is important. It occurs as a result of damage, caused by diabetes, to the small blood vessels at the back of the eye. Screening is effective, but requires specialist equipment to take images of the retina (back of the eye) which enables the blood vessels to be assessed. It is an annual programme. As with other screening programmes, the speed of providing results and referring for further assessment and treatment is very important.

Table 4

Diabetic Eye Screening	Q1 April-June 2013	Q2 July-Sept 2013	Q3 Oct-Dec 2013	Q4 Jan-March 2013	Annual 2013/14
KPI DR1 standard 70% uptake	84.90	81.0	77.97	NA	NA
KPI DR2 standard 70% results received issued within 3 weeks of screening	99.9	100	95.50	96.7	98.8
KPI DR3 standard 80% treatment within 4 weeks of a R3 screen positive	65.0	73.7	76.47	90.0	84.6

There are concerns around the completeness of the cohort identified as eligible for screening. The national team are supporting a solution which will help to automatically extract the register of diabetic patients stored in the GP practice IT systems. This is still work in progress.

Abdominal Aortic Aneurysm (AAA) for Peterborough provided by Cambridge University Hospitals Foundation Trust

This programme aims to invite men for AAA screening during the year they turn 65. Men over 65 who have not been screened previously can arrange a screening appointment by contacting their local programme directly. This is a relatively new programme and began in 2013. The local service is functioning well. The current coverage is 97% and the 8 weeks referral to assessment and treatment is 100%.

Antenatal and New-born Screening Programmes: Delivered by the maternity unit at the Peterborough and Stamford Hospital Trust

Ante-natal screening includes routine testing for a number of conditions that can adversely affect the baby as well as the mother including: HIV, Hepatitis B, Sickle Cell and Thalassemia and Down's syndrome.
New-born screening includes a number of conditions that are not obvious at birth but would have serious consequences for the baby if not detected and treated early, including:

- New-born blood spot test which detects conditions such as congenital hypothyroidism; phenylketonuria; sickle cell disease; cystic fibrosis; and medium chain acetyl-CoA dehydrogenase deficiency
- Physical examination
- Hearing screening

Table 5 Antenatal and New-born Screening Programmes

	Q1 April-June 2013	Q2 July-Sept 2013	Q3 Oct-Dec 2013	Q4 Jan-March 2013	Q1 April-June 2014
KPI ID1 Standard >90% Infectious disease HIV coverage					
P'boro	98.2	99.1	98.6	98.6	
KPI ID2 Standard >70-90% Infectious disease timely referral of hep B + women for specialist treatment					
P'boro	66.7	100	80.0	100	
KPI FA1 Standard >97-100 Downs Syndrome completion of lab request form					
P'boro	98.3	98.4	98.9	98.8	
KPI ST1 Standard >95-99% Sickle Cell and Thalassaemia coverage					
P'boro	93.5	93.6	93.7	96.0	
KPI ST2 Standard 50-75% Sickle Cell and Thalassaemia avoidable repeat tests					
P'boro	65.1	68.0	67.8	68.4	
KPI ST3 Standard 90-95% Sickle Cell and Thalassaemia timeless of result					
P'boro	98.5	98.2	97.9	97.7	
KPI NB1 Standard 95-99% Newborn blood spot coverage					
CPFT	100	99.5	99.7	data not submitted in time	
KPI NB2 Standard 2-0.5% Newborn blood spot avoidable repeat tests					
P'boro	2.4	1.0	0.9	1.9	
KPI NB3 Standard 95-98% Newborn blood spot timeliness of result					
CPFT	100	100	100	Data not submitted in time	
KPI NP1 Standard 95-100% Newborn & Infant physical coverage					
P'boro	NA	99.9	100	99.3	
KPI NP2 Standard 95-100% Newborn & Infant physical timely assessment					
P'boro	NA	NA	0.0		
KPI NH1 standard 100% newborn hearing coverage					
P'boro	99.9	100	100	99.72	
KPI NH2 standard 100% newborn hearing timely referral					
P'boro	100	No data	75.0	100.00	

Immunisation Programmes:

Childhood and adult programmes are delivered by Primary Care, with seasonal flu for 'at risk' adults also available in community pharmacies. The school aged programmes are delivered by school immunisation teams and General Practices.

Table 6 Childhood Immunisations

Q3 and Q4 2013/14

12 months	**DTaP/IPV/Hib**	**Men C**	**PCV**	**DTaP/IPV/Hib**
Peterborough	94.5, 93.9	85.4*(Q3)	93.9, 93.6	94.5, 93.9
EOE	96.4, 95.9	93.1(Q3)	96.0, 95.6	96.4, 95.9
East Anglia	95.8, 95.2	92.0(Q3)	95.3, 94.8	95.8, 95.2
24 months	**DTaP/IPV/Hib**	**PCV B**	**Hib/Men C**	**MMR1**
Peterborough	96.4, 97.3	92.0, 93.5	92.0, 93.1	91.1, 93.1
EOE	96.9, 97.2	94.8, 95.0	95.3, 95.4	94.2, 94.4
East Anglia	96.3, 96.6	93.6, 94.0	94.1, 94.2	93.0, 93.5

* The data cannot be relied upon due to a change in schedule; the second dose at age 16 weeks was removed with effect from 1 June 2013 and the adolescent booster dose at around 14 years was introduced for the academic year 2013 -14. No data was published for Q4 until a better way of capturing the data is established.

5 years	**DTaP/IPV**	**MMR1**	**MMR2**	**DTaP/IPV B**	**Hib/Men C B**
Peterborough	94.8, 95.3	93.1, 92.8	84.5, 83.1	85.5, 84.1	89.1, 87.3
EOE	96.2, 96.1	94.6, 94.3	90.4, 90.1	91.7, 91.6	94.3, 94.0
East Anglia	95.8, 95.7	93.9, 93.8	88.3, 88.6	89.7, 90.1	92.8, 92.6

The pace of improvement in uptake rates has been slower in Peterborough than in other areas. Evidence from other programmes in Peterborough has indicated poor uptake linked to deprivation and the migrant population.

Targeted Vaccination programmes

Other childhood immunisation programmes include BCG and Hepatitis B vaccinations as targeted programmes for those identified as being at specific risk.

BCG vaccine, for prevention of TB, is recommended for new-born babies who:

- Are born in an area with a high incidence of TB – high incidence is defined by the World Health Organisation as 40 or more new cases per 100,000 population per year
- Have one or more parents or grandparents who were born in countries with a high incidence of TB

Hepatitis B vaccination is given at birth with 3 further boosters up to 12 months for babies born to Hepatitis B positive mothers. Public Health England has launched the dried blood testing (DBS) for evidence of infection in children at 1 year of age. It is important to note that the DBS service is designed to increase testing in primary care of all at-risk infants aged 12 months who are born to hepatitis B positive mothers.

Table 7 School based programmes

HPV vaccination to Year 8 girls (12 to 13 years); Period since Sept 2013

	Dose 1 %	**Dose 2 %**	**Dose 3**
Peterborough	**78.2**	**41.4**	**NA**
EOE	**85.0**	**69.8**	**NA**
East Anglia	**85.8**	**62.5**	**NA**

Dose 2 figure is low due to incomplete data received in August 2014. For previous years, the percentage uptake is comparable to what we would expect in the area.

A change in the schedule for HPV vaccination will start from September 2014. The number of doses will reduce from three to two;
1st dose given in Year 8 (12-13 years)
2nd dose can be given 12 months after the first.

Influenza Vaccination

Influenza (Flu) vaccination is recommended for specific population groups and is given from October to January each year to protect those most vulnerable to Flu infection. For the 2013/14 season the recommended groups were:

- All those aged 65 or over
- Those aged 6 months to 65 years with long term medical conditions who are in the high risk groups for flu vaccination
- Pregnant women
- Those in long stay residential or nursing homes
- Carers of elderly or disabled people
- Health and social care staff who are in direct contact with patients/clients
- All children aged two and three

In 2014-15 the new childhood seasonal flu vaccination programme is being extended to 4 year olds. Peterborough is also part of the pilot site for secondary school flu immunisation to year 7 and 8 children.

Table 8 Flu Uptake in Recommended Groups

Period to Jan 2014			
	Influenza [target 75%]		
	Over 65yrs	**Under 65yr at risk**	**Pregnant**
Cambs&P'boro CCG	**74.1**	**50.3**	**43.4**
England	**73.2**	**52.3**	**39.8**

The use of alternative providers added to the proactive efforts by the screening and immunisation team with the maternity units and GP practices, as existing providers, played a major role in the area achieving a higher percentage uptake than the England average.

Table 9 Flu Uptake 2 and 3 years

Period to Jan 2014						
	Influenza					
	2yr olds not in clinical 'at risk' group	**2yr olds in clinical 'at risk' group**	**All 2yr olds**	**3yr olds not in clinical 'at risk group'**	**3yr olds in clinical 'at risk group'**	**All 3yr olds**
Cambs&P'boro CCG	**40.9**	**53.2**	**41.3**	**40.6**	**53.8**	**41.2**
England	**42.2**	**56.1**	**42.6**	**38.9**	**56.8**	**39.6**

Shingles vaccination

This is a new programme to protect elderly people who are at greatest risk of Shingles and its adverse consequences:
2013/14 – Shingles vaccine (Zostavax) routinely offered to those aged 70 with catch-up to those 79 years on 1st September 2013 until 31st August 2014
2014/15 – Zostavax routinely offered to those aged 70 and catch-up to 78 and 79 years on 1st September 2014 until 31st August 2015

Table 10 Shingles

Shingles Sentinel						
	Feb 2104		March 2014		April 2014	
	Aged 70	Aged 79	Aged 70	Aged 79	Aged 70	Aged 79
CCG % uptake	56.2	54.0	59.8	57.0	61.8	58.5
CCG % coverage	99.1		99.1		97.2	
East Anglia Team % uptake	53.5	51.5	56.8	54.2	58.8	55.8
East Anglia Team % coverage	94.2		95.2		89.0	

5. REASONS FOR THE RECOMMENDATIONS

1) There is a statutory government requirement to improve uptake and reduce inequality.
2) High uptake of screening and immunisations programmes improves the health and wellbeing of populations and can therefore reduce the need for health and social care interventions. The number of days lost to illness and poor health for both children and adults can be reduced which has a positive effect on educational attainment and employer productivity.
3) Screening and Immunisations programmes in Peterborough are performing well, but some areas need improvement. These are:
    a. cervical screening uptake in younger women
    b. bowel screening uptake
    c. childhood Immunisation uptake to achieve 95%
    d. uptake in flu vaccination for 'at risk' groups and pregnant women to achieve 75%

6. BACKGROUND DOCUMENTS

Public Health England (PHE) COVER data
PHE Immform data
Department of Health Korner returns
National Screening Committee reports
NHS Screening Websites

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 5 (b)
17 JULY 2014		PUBLIC REPORT
Contact Officer(s):	Katie Norton, Director of Commissioning	Tel.

PRIMARY CARE STRATEGY – UPDATE REPORT

RECOMMENDATIONS	
FROM : NHS England Area Team	**Deadline date :** N/A
1. This report is intended to provide an update on the work being progressed by NHS England East Anglia Area Team and the Cambridgeshire and Peterborough CCG to establish a strategic framework to support the development of primary care in East Anglia. It is for information.	

1. ORIGIN OF REPORT

1.1 This report is submitted to Board following a request from a member – Mr Andrew Reed, Director NHS England East Anglia Area Team.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide an update to the Board on the work being progressed by NHS England to provide a strategic framework for primary care development in East Anglia.

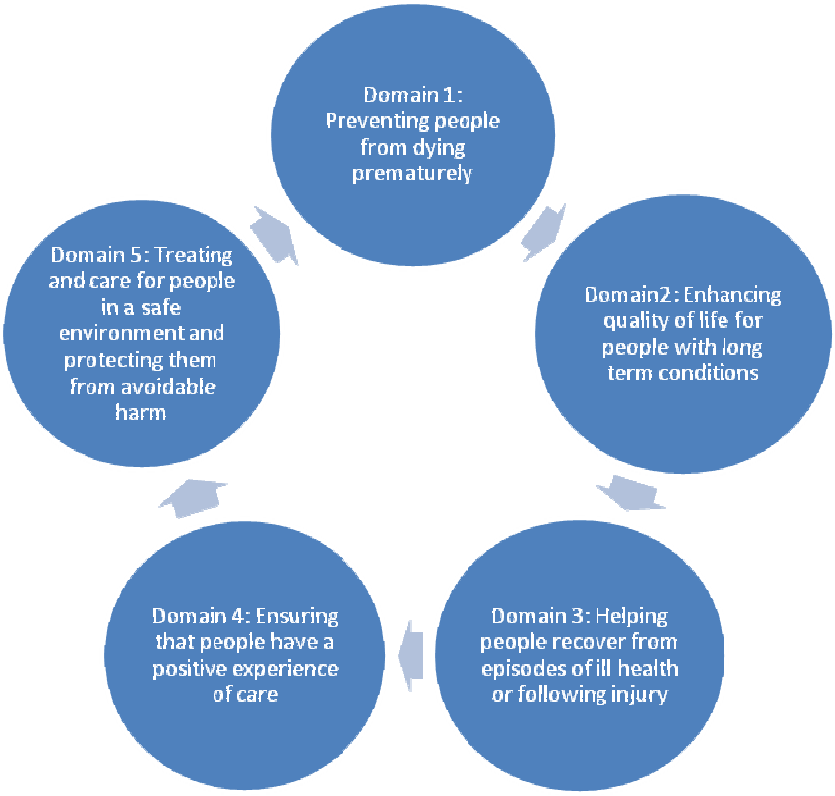
3. BACKGROUND

3.1 As part of the national NHS England *Call to Action* the NHS England East Anglia Local Area Team has been working with local Clinical Commissioning Groups and the Local Professional Networks to consider what we need to do, both at a national and local level, to be confident of ensuring our local population has access to high quality, sustainable and thriving primary care services. The final version of the Strategic Framework for East Anglia is attached at Appendix 1.

3.3 A key principle of the Area Team approach has been to ensure alignment with our local Clinical Commissioning Group and Local Health and Wellbeing Board strategic planning processes. We are confident that this approach will ensure that the key themes and issues set out within the strategic framework will support the wider health and social care planning work that is being taken forward led by the CCGs and Health and Wellbeing Boards.

4. Strategic Priorities

4.1 Our local discussions have confirmed that there is a shared ambition to create thriving, high quality and sustainable primary care that works to improve health outcomes and support a reduction in health inequalities. This is directly linked to the ambition to ensure that primary care is able to maximise its' contribution to improving outcomes against indicators in the five domains of the NHS Outcomes Framework:



4.2 To do this, we recognise that we need to create an environment that enables general practice and primary care more generally, to play a much stronger role, as part of a more integrated system of out-of-hospital care to:

- Provide proactive co-ordination of care (or anticipatory care), particularly for people with long term conditions and more complex health and care problems.
- Offer holistic care: addressing people's physical health needs, mental health needs and social care needs in the round.
- Ensure fast, responsive access to care, preventing avoidable emergency admissions to hospital and A&E attendances.
- Promote health and wellbeing, reducing inequalities and preventing ill-health and illness progression at individual and community level.
- Personalise care by involving and supporting patients and carers more fully in managing their own health and care.
- Ensure consistently high quality and value of care: effectiveness, safety and patient experience.

4.3 We recognise that there is no single blueprint for how general practice and the wider primary care community can best meet our shared ambition. It is clear that it will not be achieved simply or primarily by adopting new organisational forms. Our focus will therefore be on working collaboratively to understand how best we can work with primary care professionals to enable them to provide services for patients more effectively and productively, and how we can help practices benefit from collective expertise and resources.

4.4 Achieving our ambition will depend on harnessing the energy and enthusiasm of all those who work in and with primary care. There is also strong recognition that there are key areas of work that can, and must, be progressed locally.

These fall in to two key areas:

- Progressing work that supports the operational excellence of primary care services.

- Developing, with Clinical Commissioning Groups, a service model that supports the delivery of primary care at scale;

5 CAMBRIDGESHIRE AND PETERBOROUGH

5.1 The Strategic Framework includes separate chapters for each of the eight CCGs within East Anglia. Each chapter seeks to provide an overview of primary care services in the CCG area, sets out the opportunities and challenges and describes of the priorities for development.

6. RECOMMENDATIONS

6.1 The Health and Wellbeing Board are asked to note the progress made to develop a strategic framework to support the development of primary care services.

7. REASONS FOR RECOMMENDATIONS

7.1 To raise awareness of the work being progressed to support the development of primary care services.

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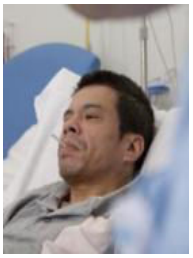
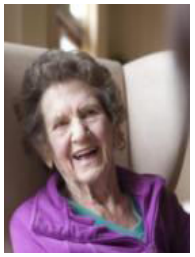
High Quality, Sustainable Primary Care
A Strategic Framework for East Anglia





Final Version 1
June 2014

THE NHS CONSTITUTION
the NHS belongs to us all

Foreword

This strategic framework is predicated on the belief that good General Practice and wider Primary Health Care is the bedrock of a high quality and cost effective health care system. Improving the nature of services provided outside hospital and supporting the public in self-care are key ingredients for a sustainable NHS.

This strategic framework aims to ensure that the NHS England East Anglia Area Team, with local Clinical Commissioning Groups and other key partners, can be confident that people living and working in East Anglia have access to thriving, high quality and sustainable general practice and wider primary care services which work as part of an integrated health and social care system. It also aims to give confidence to professionals working within primary care that there is a framework that will support them in their ambitions to provide high quality care in their local communities.

The structure of the document is as follows:

Section1: East Anglia Strategic Framework for Primary Care

Section 2: Strategic Plans for Primary Care by CCG Area

- Cambridge and Peterborough
- Ipswich and East Suffolk
- West Suffolk
- Great Yarmouth & Waveney
- West Norfolk
- North Norfolk
- Norwich
- South Norfolk

It is recognised that this framework is an iterative document that will be updated as each CCG progresses with the engagement and consultation with their public and stakeholders in the refinement of their vision and 5 year development plans.

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SECTION 1 - EAST ANGLIA STRATEGIC FRAMEWORK FOR PRIMARY CARE

1 Introduction

In response to *A Call To Action* the NHS England East Anglia Local Area Team has been working with local Clinical Commissioning Groups and the Local Professional Networks to consider what we need to do, both at a national and local level, to be confident of ensuring our local population has access to high quality, sustainable and thriving primary care services.

Underpinning this work has been our collective commitment to the NHS England vision and purpose “high quality care for all, now and for future generations” and to the goals set out within Everyone Counts: Planning for patients 2014/15 to 2018/19.

A key principle of the Area Team approach has been to ensure alignment with our local Clinical Commissioning Groups and Local Health and Wellbeing Boards’ strategic planning processes.

East Anglia Area Team is made up of 8 Clinical Commissioning Groups:

- Cambridge and Peterborough
- Ipswich and East Suffolk
- West Suffolk
- Great Yarmouth & Waveney
- North Norfolk
- West Norfolk
- South Norfolk
- Norwich

There are 4 Health and Well-being Boards:

- Norfolk
- Suffolk
- Peterborough
- Cambridgeshire

We are confident that this will ensure that the key themes and issues set out within this strategic framework will support the wider health and social care planning work that is being taken forward led by the CCGs.

2 What Primary Care is and our vision for the future

Primary care services are the entry point for people for the prevention and treatment of illness and include General Practice, Dentists, Community Pharmacists, and Community Nursing.

The NHS Primary care services, in England, have a number of internationally recognised strengths:

- General Medical Practice registered lists are a key tool in the coordination and continuity of care. Around 99% of the population are registered with a general practice in the UK;

- Primary care services are well placed to utilise their knowledge of patients in a local community gained from repeated consultations over time to improve physical, emotional and social wellbeing;

- Primary Care services play a central role in the management of patients with chronic disease and identifies those at risk of worsening chronic ill health; and

- General medical practice displays a highly systematic use of information technology to support management of long term conditions, track changes in health status and support population health interventions such as screening and immunisations.

There is however, nationally and locally, a recognition that primary care services face increasingly unsustainable pressures. In responding to these pressures, this strategy sets out a framework to take forward an ambitious programme of development to build on current strengths and ensure that primary care services are at the heart of integrated, community based health and social care services, working to actively promote health and wellbeing.

In setting out our strategic vision for primary care it is important to recognise that East Anglia is a large and complex area, largely rural in nature. The feedback we have had through our local discussions with local professionals, clinical leaders and the public has confirmed the central role of Primary Care in improving health outcomes and meeting local need. Overall, existing primary care services across East Anglia are good and improving, providing a strong base for future development.

Our vision over the next five years will build upon this strong foundation to ensure that:

- Care is increasingly integrated and provided in a joined up way to meet the needs of the whole person;

- People will be increasingly able to play a full part in the management of their health and wellbeing

- Care is clinically effective and safe, delivered in the most appropriate way

- Primary care plays a full part in helping the wider healthcare system make the best use of limited resources

- We create an environment which ensures that we are able maintain and develop a motivated, skilled and dedicated primary care workforce

- There is a clear and shared understanding among the public and professionals of individuals rights, responsibilities and expectations

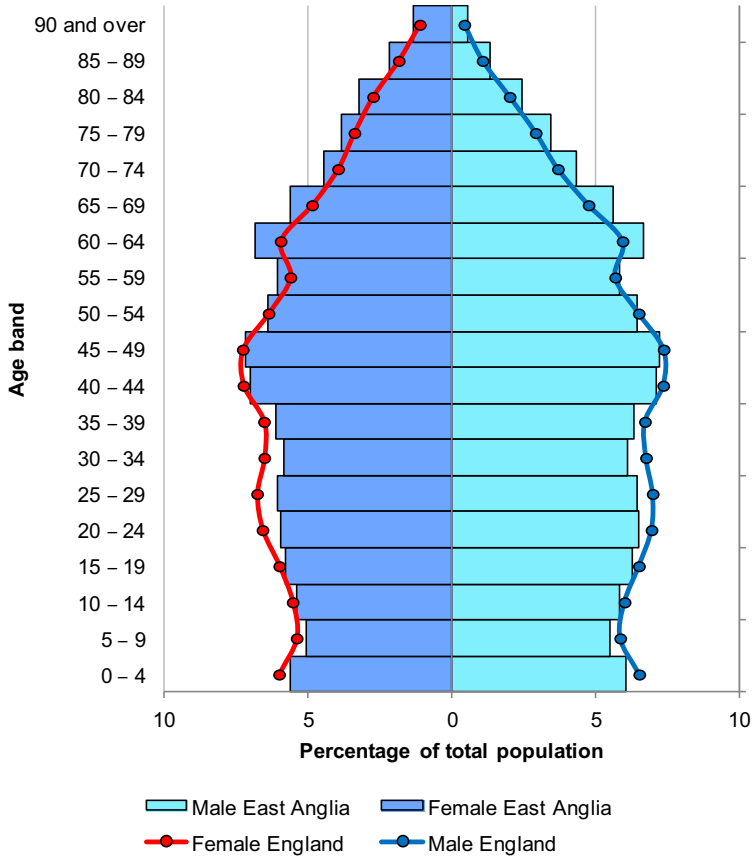
- We can be confident that there is equity across East Anglia – equity of “offer”, equity of “access” and equity of “outcome”

3 East Anglia Context

3.1 Population

The NHS England East Anglia Area Team covers an area which has a registered population of 2,457,100. There is a lower proportion of 0-39 year olds and a higher proportion of residents aged over 60 year old the England average.

The population as a percentage of the total in age bands for East Anglia compared to England (Census 2011)

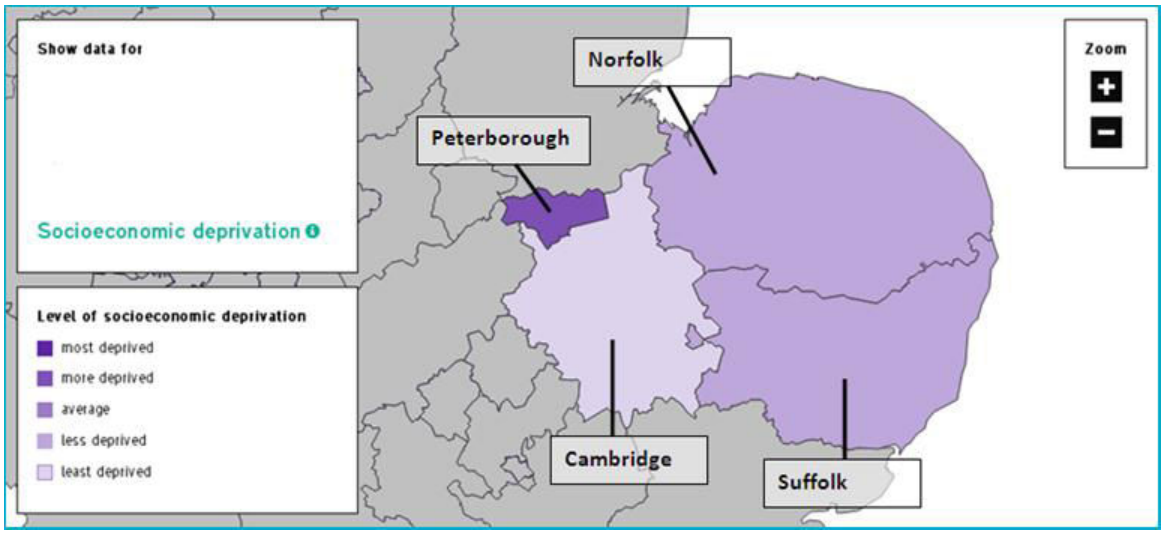


East Anglia	Census 2011
Total Registered	2,457,100
Total Resident	2.396.328
Male Resident	1,184,032
Female Resident	1,212,296
0-4 Resident	139.941
65+ resident	459,694
85+ resident	64,406

3.2 Deprivation

330 out of the 1445 Lower Layer Super Output Areas (LSOAs) in East Anglia are in the 20% Most Deprived LSOAs in the country.

Map 1 – Deprivation spread across East Anglia (Analytics Service: Midlands & East, Sept 2013)



3.3 Life Expectancy

While East Anglia experiences better health than England as a whole, there are very significant health needs and health inequalities. Across the Local Authorities within East Anglia Area Team, life expectancy at birth for men is better than the England average of 78.58 years in all authorities other than Peterborough where it is significantly worse.

For women born in East Anglia life expectancy at birth is better than the England average of 82.57 years, except in Peterborough where it is significantly worse.

Table 2 – Life expectancy across East Anglia Local Authority Areas (Analytics Service: Midlands & East, Sept 2013)

Local Authority	Life expectancy at birth		Gap in life expectancy between most & least deprived	
	Male	Female	Male	Female
Cambridgeshire	80.1	83.9	7.2	5.3
Norfolk	79.5	83.3	5.8	1.9
Peterborough	77.5	81.9	9.4	5.6
Suffolk	79.9	83.6	5.7	4.4

The slope index of inequality measures the gap in life expectancy between the most and least deprived communities within a Local Authority area. Across the four local authority areas in East Anglia:

- The gap in life expectancy for women varies between 1.9 to 5.6 years. The gap is statistically better than the England average of 5.9 years in Suffolk and Norfolk but statistically similar in the other two areas.
- The gap in life expectancy for men varies between 5.7 to 9.4 years. Cambridgeshire and Peterborough are statistically similar to the average across England of 8.9 years and Norfolk and Suffolk are statistically better.

Further detail of the health needs of our population can be found in the Joint Strategic Needs Assessments that have been developed by each of the Health and Wellbeing Boards covering each Local Authority. A Joint Strategic Needs Assessment (JSNA) is the means by which CCGs and local authorities describe the future health, care and wellbeing needs of the local populations and to identify the strategic direction of service delivery to meet those needs.
Cambridgeshire JSNA
Peterborough JSNA
Suffolk JSNA
Norfolk JSNA

3.4 In-Migration

The potential population growth through in ward migration is significant.

Planned residential growth across the 8 CCGs within East Anglia is shown in the table on the following table – the geographical distribution of this growth should be reflected in each individual CCG chapter in Section 2 of this report.

Table 1 Summary of Housing and Population Growth across East Anglia (LPP East Anglia Housing Growth Report Nov 2013)

Clinical Commissioning Group[1]	Plan Period	Local Authority	Number of Houses	Population Arising
Cambridgeshire &Peterborough CCG	2011-2031	Cambridge City Council	4,270	9,821
	2006-2026	East Cambridgeshire District Council	3,169	7,606
	2011-31	Fenland District Council	11,004	25,309
	2006-2026	Huntingdonshire District Council	5,500	13,200
	2010-2031	Peterborough City Council	24,795	61,988
	2011-2031	South Cambridgeshire District Council	18,842	45,221
Cambridgeshire & Peterborough CCG Total			**67,580**	**163,145**
North Norfolk CCG	2001-2021	North Norfolk District Council	9,488	20,873
	2008-2026	Broadland District Council (part of Greater Norwich Development Partnership)	12,900	29,670
North Norfolk CCG Total			**22,388**	**50,543**
West Norfolk CCG	2001-2026	King's Lynn and West Norfolk Borough Council	15,510	35,673
West Norfolk CCG Total			**15,510**	**35,673**
Norwich CCG	2008-2026	Norwich City Council (Part of Greater Norwich Development Partnership)	3,000	6,300
Norwich CCG Total			**3,000**	**6,300**
South Norfolk CCG	2001-2026	Breckland District Council	19,777	45,487
	2008-2026	South Norfolk District Council (Part of Greater Norwich	9,900	22,770
South Norfolk CCG Total			**29,677**	**68,257**
HealthEast CCG (Great Yarmouth and Waveney)	2014-2029	Great Yarmouth Borough Council	5,700	13,110
	2007-2025	Waveney District Council	2,875	6,325
HealthEast CCG (Great Yarmouth and Waveney) Total			**8,575**	**19,435**
West Suffolk CCG	2012-2031	Forest Heath District Council	7,338	16,877
	2010-2026	St Edmundsbury Borough Council1[2]	9,782	23,477
West Suffolk CCG Total (not including growth within Mid Suffolk District or Babergh District)[3,4]			**17,120**	**40,354**
Ipswich and East Suffolk CCG	2010-2026	Ipswich Borough Council	8,460	19,458
	2012-2027	Mid Suffolk District Council[3]	3,845	9,228
	2010-2027	Suffolk Coastal District Council	6,950	16,911
Ipswich and East Suffolk CCG Total (not including growth within the St Edmundsborough or Babergh District)[2,4]			**19,255**	**45,597**
Part combined CCG coverage	2011-2031	Babergh District Council[4]	3,955	9,097
Total for All Local Authorities and CCGs			**187,060**	**438,401**

[1] This represents LPP understanding of the LA Areas covered by each CCG however CCG and LA boundaries may not directly correlate

[2] Part of St Edmundsbury Borough Council area is covered by East and East Suffolk CCG

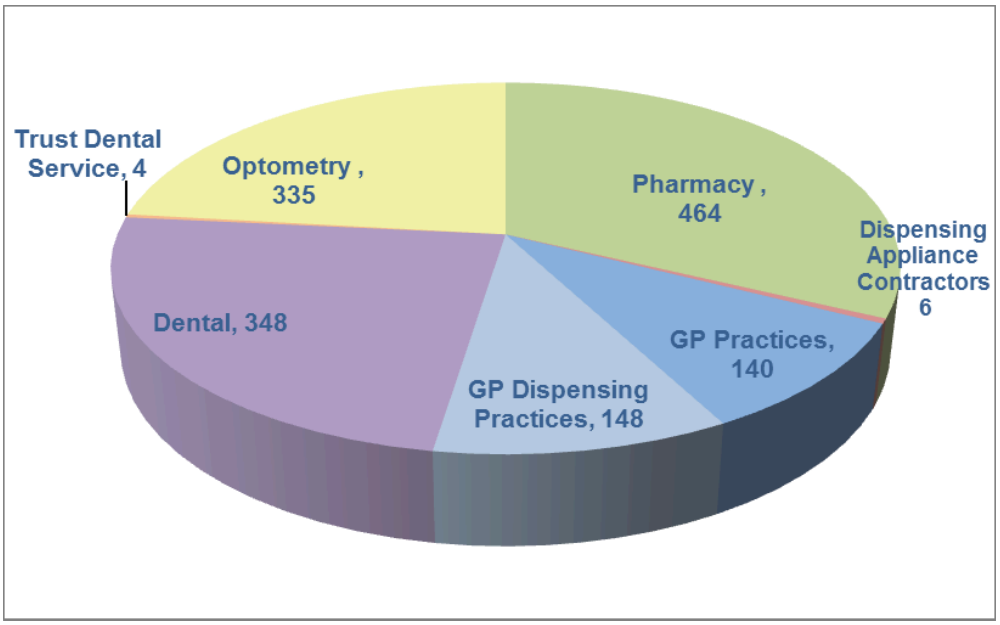
[3] Part of Mid Suffolk District area is covered by West Suffolk CCG

[4] The Babergh District Council area is covered by both West Suffolk CCG and Ipswich and East Suffolk CCG

4 Primary Care Provider Profile

Across East Anglia primary care services are provided through 1,543 independent contractors.

Graph 1 – Independent Contractors across Primary Care Disciplines (Serco data - April 2014)



4.1 General Medical Practice

4.1.1 Provider Profile and Sustainability

In East Anglia there are a total of 288 GP practices including 3 walk in centres with an annual contract value of £309.5 million. They are independent contractors with the following spread across the contractual models:

Table 2 GP Providers by Contractual model (Serco Data - June 2014)

Contracts	Number
GMS	122
PMS	150
APMS	16
Total	**288**

(Note: in 2014/15 it is expected that a further 5 GP practices (3 GMS and 2 PMS) which are aligned to Cambridgeshire and Peterborough CCG, but are located in the boundaries of another Area Team will transfer to become the responsibility of the East Anglia Area Team)

The number of GP providers is altering rapidly due to an increasing number of mergers. In addition a large number of the APMS contracts are approaching their

end date (following option for extension) and the Area Team will be embarking on procurements for these during 2014/15.

The proposed PMS review and alterations in the GMS/PMS contract changes for 2014/15 have a significant financial impact on a large number of practices across East Anglia. The Area Team are committed to working to support practices during the transition to ensure that practices remain viable and patient care is not compromised.

Table 2 Potential practice losses from PMS reviews (Area Team Finance Data June 2014)

Financial Impact	***Number of Practices***
Loss >£200K annually	42
Loss £100-199K annually	67
Loss £0-99K annually	38
Gainers	2
Total	149

Table 3 Practice losses and gains from redistribution of MPIG (Area Team Finance Data June 2014)

Financial Impact	***Number of Practices***
Loss of £50-£185k	15
Loss £0-50K	27
Gain of £0-£50k	46
Gain of £50-£165k	34
Total number of Practices	**122**

4.1.2 Scale

There is currently considerable variation in the scale of general practice provision across East Anglia with the range from less than 1,500 to almost 28,000 registered patients.

Graph 2 – Actual List Size across East Anglia Practices (Serco data April 2014)

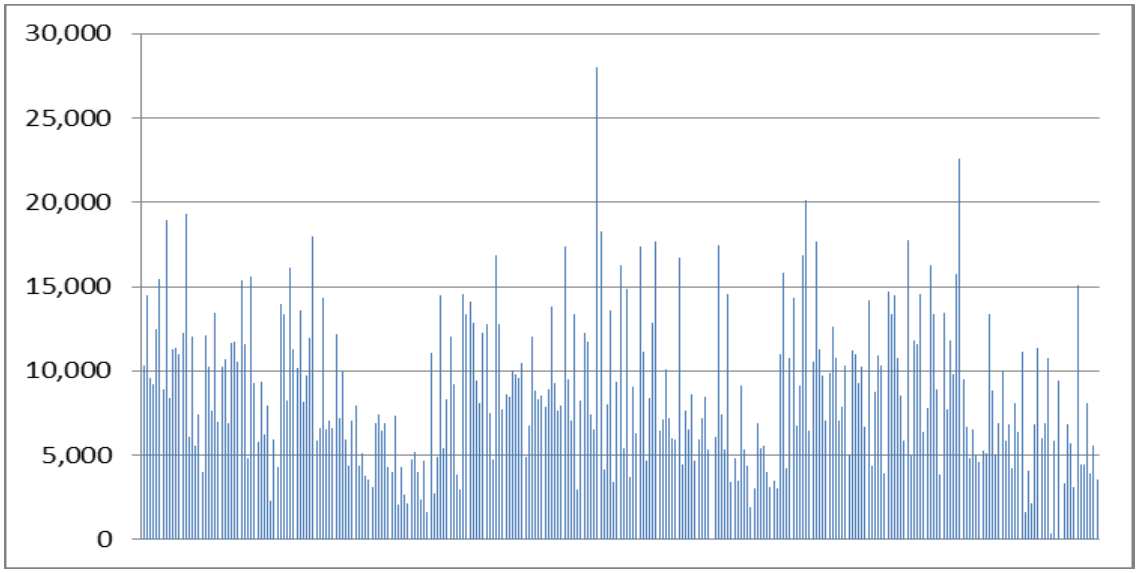


Table 5 Size of practices across East Anglia (Serco data April 2014)

Actual Registered List Size	Number of Practices
<1500	1
1500-2999	12
3000-4999	49
5000-7999	79
8000-9999	46
10000-12999	50
13000-16000	30
16000-19999	16
>20000	3

There are a large number of potential practice mergers across East Anglia as practices seek to ensure their long-term viability and to enable them to extend the services they can provide.

4.1.3 Access to Primary Medical Care

Overall satisfaction with primary medical care services across England remains high, but there are growing challenges in relation to reported patient experience of access to general medical practice care with nearly a quarter of all of patients not rating the

overall experience of making an appointment as good. In England the most recent survey found that 22 percent of people do not find it easy to get through to the surgery by telephone with significant variation reported across the country.

The position in East Anglia would suggest that the position is no different as reflected in the table 6 below.

Table 6 Patient Experience of Access

Indicator	C&P	GY&W	I&ES	Norwich	North Norfolk	South Norfolk	West Norfolk	West Suffolk	England Average
Good overall experience of GP surgery	88.16	90.80	89.71	88.26	90.53	85.44	89.07	91.13	86.74
Good overall experience of out-of-hours GP services	70.36	70.64	62.27	69.00	62.07	62.70	71.10	62.92	70.21
% of patients who find it is difficult to get through to someone at GP surgery on the phone	18.94	12.69	15.39	18.44	14.08	21.18	15.16	12.74	21.53
% of patients who were able to get an appointment to see or speak to someone	88.16	90.16	89.21	88.60	90.60	87.90	90.20	88.70	86.36
Good overall experience of making an appointment	79.58	83.32	81.10	77.53	80.96	74.41	80.96	81.49	76.34
% of patients who were able to see preferred GP on most occasions	63.70	72.54	63.70	58.35	60.51	63.39	66.26	65.64	62.78

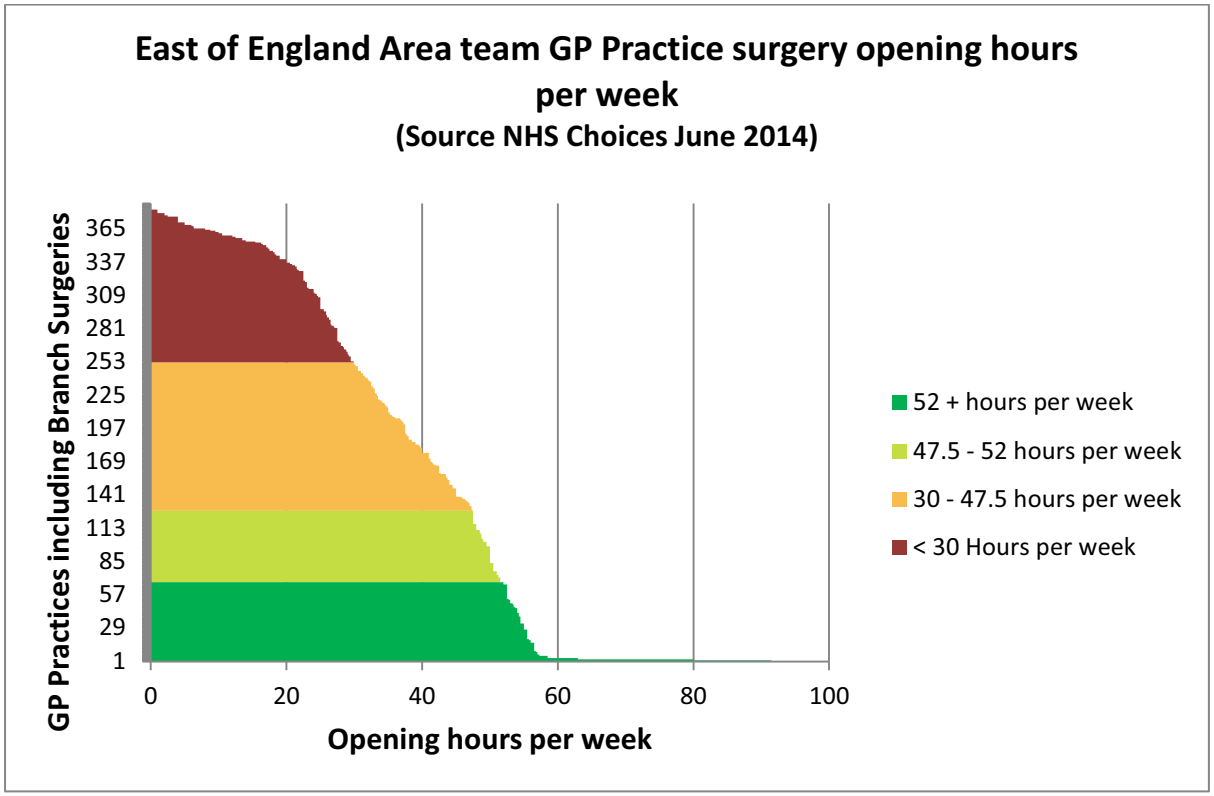
4.1.4 Ease of Access to GP Practices

In addition to patient surveyed perception of opening hours and ease of making an appointment, local analysis has been undertaken highlighting the significant differences in the degree to which a GP consultation is available at times that are convenient to all.

General practices are contracted to provide primary care services between the hours of 8.00 a.m. to 6.30 p.m. Monday to Friday. There is, however, local variation in opening times and specific opening hours are not a condition of national GMS contracts held by GPs although meeting the reasonable needs of patients is required. For example:

- in Cambridgeshire a significant number of practices provide cover from 8.30 a.m. to 6.0 p.m., with a local agreement that the out of hours service covers from 6.0 p.m. to 8.30 a.m.
- many practices close for lunch and/or for an afternoon each week

Graph 3 Distribution of Opening Hours across practices (including Branches)



The information available from NHS Choices suggest s that while 43% of practices (excluding Branch Surgeries) across East Anglia provide more than 52 hours per week in which to book appointments, 21% of practices offer fewer than 37.5 hours and 4% less than 30 hours per week. There is great variation across the CCG areas as outlined in the table below:

Table 7 Distribution of Practice Opening Hours across CCGs (NHS Choices data June 2014)

		Opening Hours per week (Source NHS Choices June 2014)							
CCG	Number of Member Practices	≥ 52		<52 and ≥47.5		<47.5 and ≥40		<40	
		Number	%	Number	%	Number	%	Number	%
Cambridge and Peterborough	103	25	24.3	35	34.0	34	33.0	9	8.7
Ipswich and East Suffolk	41	34	82.9	4	9.8	1	2.4	2	4.9
West Suffolk	25	20	80.0	4	16.0	1	4.0	0	0.0
HealthEast (Great Yarmouth and Waveney)	26	20	76.9	5	19.2	1	3.8	1	3.8
North Norfolk	20	5	25.0	9	45.0	5	25.0	1	5.0
West Norfolk	23	6	26.1	13	56.5	4	17.4	0	0.0
South Norfolk	26	5	19.2	16	61.5	4	15.4	1	3.8
Norwich	22	9	40.9	3	13.6	10	45.5	0	0.0

The distribution of opening hours illustrates times when our population is less likely to be able to secure a routine GP appointment, depending on the practice they are registered with. As general practice is supported to make a greater contribution to the health and care system, the availability of services at times that are convenient to all, together with the cost effective use of premises and workforce in primary care is a key consideration.

4.1.5 Dispensing Practices

In The UK it is generally expected that prescriptions written by a clinician will then be dispensed in a pharmacy. However in rural areas the Pharmaceutical Regulations allow for qualifying GP practices to dispense directly to their patients.

Of the 288 GP practices in East Anglia 148 are dispensing practices, which reflects the rural nature of the area. These practices have over half a million patients on their dispensing lists.

As part of the changes to the arrangements for dispensing doctors agreed as part of the GMS changes in 2006/07, a Dispensary Services Quality Scheme (DSQS) came into effect in September 2006. The Scheme rewards Practices for providing high quality services to their dispensing patients. Practices can choose to participate in the scheme and receive a payment for each dispensing patient; provided they meet the quality the standards. In East Anglia 139 practices signed up to the 2013/4 DSQS and provided evidence of meeting the quality standards. The evidence was supported by a number of quality assurance visits undertaken by the Primary Care Team to practices across the area.

In recognition of the work undertaken by practices to achieve the quality standards of the DSQS the Area Team paid £1.3 million in DSQS payments to practices.

4.1.6 Walk In Centres

East Anglia has 3 walk in centres:

Greyfriars Health Centre, Great Yarmouth
Service delivered in the centre of Great Yarmouth and has registered list of around 4200. Also provides 'walk in' services between 8am and 8pm over 7 days a week
Timber Hill, Norwich
This service is open 7 am – 9 pm, 7 days a week for walk in patients and GP registered list. GP list is approximately 8000 and rising.
St Neots Equitable Access Centre
Service delivered within the centre of St Neots with a registered patient list of approximately 4,000 patients. Also provides a walk in service over 7 days a week 8.00 am – 8.00pm Monday to Friday and 9.00am – 4.00pm Saturday & Sunday. The Practice is permitted Closure on Easter Sunday and Christmas Day.

4.1.7 Quality and Effectiveness

The Quality Assurance Management Framework for Primary Medical Services, supported by the Primary Care Web Tool, introduces high level indicators sorted by outcome standards which are a set of measurable indicators for general practice.

The General Practice Outcome Standards (GPOS) and the General Practice High Level Indicators (GPHLI) present a minimum level of service and outcomes that patients can expect from general practice grouped across the NHS Outcomes Framework domains.

The Primary Care Web Tool is intended to facilitate discussion between the Area Team, CCGs and individual practices to understand the reasons for any variation to support continuous improvement. There is recognition that the information on the Web Tool has a significant time lag and the Area Team will add more up to date information (such as uptake of DES and QOF performance) to aid these discussions

Across East Anglia there are 9 outliers against the GPHLI and the GPOS within the Primary Care Web Tool. The Area Team is developing a GP dashboard and quality improvement framework in collaboration with CCGs to continually monitor and improve the quality of general practice.

4.1.8 Premises

There are a large number of practices seeking to extend or replace their current buildings. There is a legacy of poor infrastructure in many areas resulting in a high number of premises developments in the “pipeline” and the Area Team has instigated a robust programme management processes to support practices to ensure patients are seen in safe and modern environment, maximizing the limited resources available. The area team engages with Local Authority planning departments to seek developer contributions for health care infrastructure to inform decisions on future premises developments.

4.1.9 Workforce

NHS Health of England East of England has undertaken analysis of the GP workforce census 2013 and this has identified that in East Anglia there is the following:

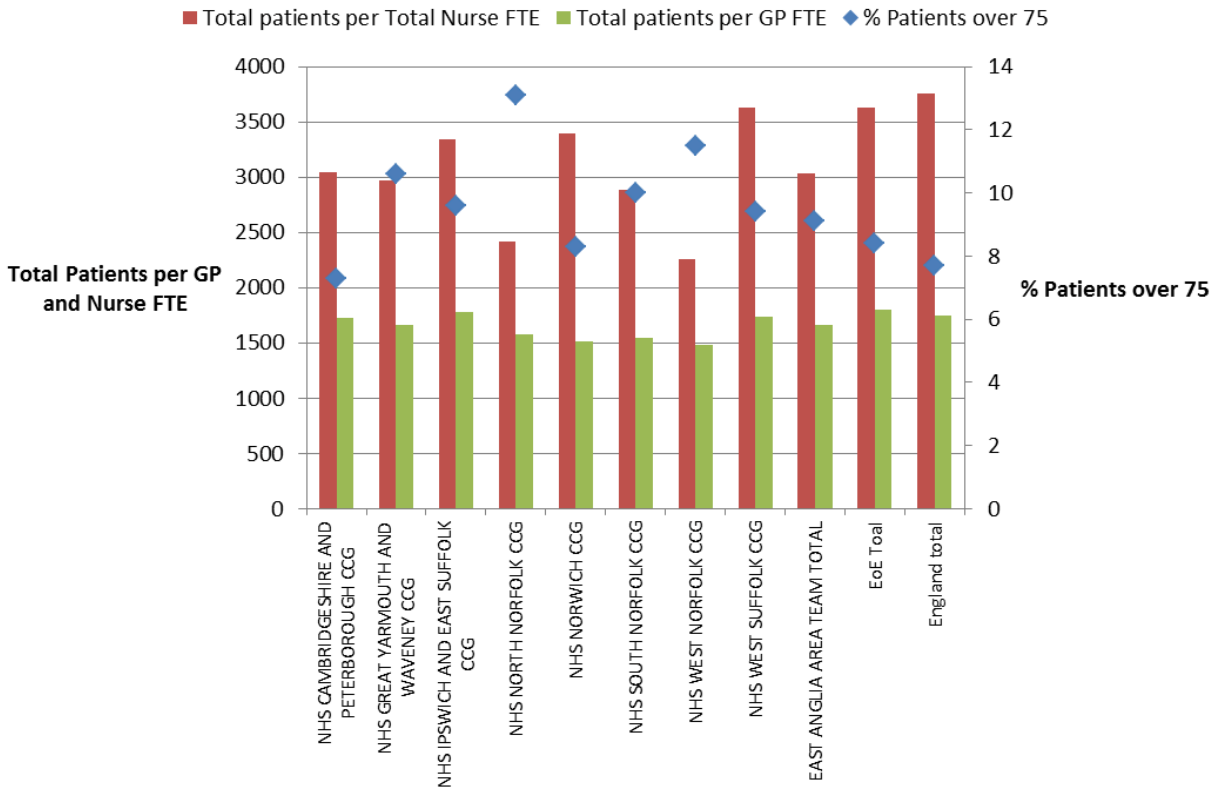
- The high ratio of GPs to GP registrar
- The proportion of non-UK GPs is lower than East of England average but in line with England average
- There are a high proportion of patients over 75 years old
- Although East Anglia is shown to have low number of patients per GP Full Time Equivalent (FTE) and per nurse FTE when viewed in the context for patients over 75 there are real pressures across CCGs
- It should be noted that many of these staff are approaching retirement age and may be hard to replace

- Nurses in East Anglia work more hours than East of England and England average levels
- High percentage of nurses who are Advanced or Extended Nurses
- Ratio of GPs to total nurses is below East of England and England average levels

Recruitment and retention is a significant issue across East Anglia, with particular pressures on general practitioners and practice nursing.

There is evidence of an increasing number of contractors who are taking extended periods of time away from the practice due to sickness and other issues which reflects the increasing pressures impacting on the services provided. The area team is committed to working with practices and CCGs to help address these issues and reduce the pressures upon general practices.

Graph 4 Number of Patients per Full Time Equivalent GP/Nurse by CCG (Workforce Census 2013)



4.2 Primary Care Dental Services

4.2.1 Overview of Provider Base

Primary dental services comprise essential mandatory services plus any agreed non-mandatory services. Since April 2006 there have been two main contractual frameworks to support the commissioning of dental services.

General Dental Services Contracts (GDS) are nationally negotiated contracts that are not time limited. They are classed as either general or mixed contracts; the latter including orthodontic services. Personal Dental Services Contracts (PDS) are negotiated locally but are underpinned by national regulations. They are time limited and generally apply to non-mandatory services such as orthodontic only practices, but can include services such as minor oral surgery, domiciliary services as well as general activity. PDS plus contracts are a variation of the PDS contracts and include quality metrics that reward the delivery of good oral health and improved access. There are a small number of Trust Dental Service Contracts (TDS) which are similar to PDS in being negotiated locally and time limited. They are utilised for 'Community Dental Services' who predominately provide general dental services, screening, epidemiology and treatment under general anaesthetic for vulnerable patients who are referred into the service.

Table 8 Dental Services Contracts by type in East Anglia (Serco data 2014)

Dental Service Contract	Type	Total Number
General Dental Service (GDS)	General	229
General Dental Service (GDS)	General/orthodontic	37
Personal Dental Service (PDS	General	41
Personal Dental Service (PDS	General/orthodontic	3
Personal Dental Service (PDS	Orthodontic	28
Personal Dental Service Plus (PDS+)	General	4
GDS Pilot	General	6
Total		**348**
TDS	General – community dental service	4
Total		**352**

The 348 Dental Contracts Value is £93.2 million per annum.

NHS England is the sole commissioner for all dental services (Primary, Secondary and Community services) and this provides the opportunity to redesign and implement end to end patient pathways for oral health cutting across historical and organisational boundaries improving the patient experience.

4.2.2 Access and Quality

The December 2013 GP Practice Survey Results (July to September 2013 data), show that 94% of patients, were successful in getting an NHS dental appointment in East Anglia in the previous two years. This is 1% above the England rate of 93%.

Overall experience of dental services for those who tried to get a NHS dental appointment in the last two years was 85% good or very good, 9% neither good nor

poor, 6% fairly or very poor. This is 1% above the England rate for good or very good and 1% below the England rate for fairly or very poor.

From the most recent Vital Signs data (March 2014) reports that 93.7% of patients reported satisfaction with the dentistry received against a national position of 93.8%. Satisfaction with the time to wait for an appointment was 91.0% against 90.9% nationally.

The Oral Health Needs Assessment and Orthodontic Needs Assessment, when completed, will guide the area team on future planning and procurement decisions for dental services.

4.2.3 Workforce

Historically there have been issues in recruiting general dental practitioners, in particular in the Norfolk and Great Yarmouth & Waveney area. However following the government initiative to train more dentists over the last past five years there are no reported difficulties in recruiting and retaining dentists within East Anglia.

Table 9 Dentists per head of population by PCT area: year ending 31 March 2013
(Source: Health & social Care Information Centre. Dental stats England 12-13)

	Year ending 31 March 2013				
	Total number of dentists	Population per dentist	Dentists per 100,000 population	Dentists difference 2012 to 2013	Percentage difference 2012 to 2013
Cambridgeshire PCT	324	1,921	52	-7	-2.1%
Great Yarmouth & Waveney PCT	124	1,716	58	-5	-3.9%
Norfolk PCT	375	2,032	49	25	7.1%
Peterborough PCT	102	1,808	55	14	15.9%
Suffolk PCT	325	1,892	53	10	3.2%
East of England	2,834	2,069	48	78	2.8%
England	23,201	2,289	44	281	1.2%

5 General Ophthalmic Services – Eye Health Services

5.1.1 Provider Profile

Table 10 Ophthalmic Contracts in East Anglia (Serco data April 2014)

Ophthalmic Service Provider	Type	Total Number
Mandatory Services Contracts	Independent Contractor (Sole/Partnerships)	73
Mandatory Services Contracts	Body Corporate	140
Additional Services Contracts	Independent Contractor (Sole/Partnerships)	46
Additional Services Contracts	Body Corporate	76
Total Contracts		335

The primary characteristic of the provider profile for general ophthalmic services is a mature retail market with an even split between larger chain and independent outlets. NHS commissioned spend is based on nationally negotiated services and prices. The annual spend on ophthalmic services is in the region of £22.4 million within East Anglia Area Team.

5.2 Community Pharmacy

5.2.1 Overview of Provider Base

The contractual framework for community pharmacy has three distinct elements:

Essential Services which must be provided by all contractors, this includes the dispensing of medicines and appliances, repeat dispensing, public health and support for self-care.

Advanced Services are nationally specified services that can be provided by all contractors if they have met the accreditation requirements and are providing all essential services. There are two advanced services particular to pharmacies – Medicine Use Reviews and the New Medicines Services. Pharmacies and Dispensing Appliance Contractors can also provide advanced services to support patients with their appliances – Appliance Usage Review and Stoma Customisation.

Enhanced Services - are services commissioned in an area or part of an area from community pharmacies and negotiated locally by the Area Team. In 2013/4 the East Anglia AT commissioned a flu vaccination service across the whole area and a service to provide potassium iodate from local pharmacies to residents near to the Sizewell Power Station in case on nuclear emergencies.

In addition to the above, which are commissioned by NHS England, ***locally commissioned services*** can be commissioned by CCGs or Local Authorities. They can include services such as smoking cessation, provision of emergency hormonal contraception and minor ailment services.

5.2.2 Access

Generally hours of availability of community pharmacies extend into the evening and weekend. In addition across the area there are 59 pharmacies that open for 100 hours per week

5.2.3 Dispensing Appliance Contractors (DACs)

Over 450,000 patients in England are currently using stoma or incontinence appliances as a result of conditions such as cancer, multiple sclerosis, and bowel disease or other serious illness or accidents. For many they are long-term conditions indicating that these patients are the most intensive users of specialist healthcare and social care services.

DACs are suppliers of appliances that have developed over the years in response to the growing needs of their patients and provided advice, care and support. DACs generally operate regionally or nationally offering delivery and related services for the supply of appliances. Their contracts are managed by the Area Team of the area where their contract is held; and their terms of service are outlined in the pharmaceutical regulations.

In East Anglia there are six DAC contracts that are managed by the primary care team

5.2.4 Workforce

Unlike the pressures seen within general practice, due to the creation of extra Schools of Pharmacy in the recent past there are plenty of qualified community pharmacists. There is opportunity to utilise this skilled and underutilised resource in addressing the workforce pressures within general practice and wider primary care service provision.

5.3 Summary

In summary,

- East Anglia is an extensive geographical area, which includes large rural areas and significant areas of deprivation.
- Significant population growth is anticipated across the whole area team which will impact on primary care commissioning and service provision
- GMS/PMS contract changes will adversely impact financially on comparatively high number of GP contractors in East Anglia

- Recruitment and retention is a significant issue across East Anglia, with particular pressures on general practitioners and practice nursing.
- There are more than enough community pharmacists who could possibly help reduce workforce pressures
- There is evidence of an increasing number of contractors who are taking extended periods of time away from the practice due to sickness and other issues which reflects the increasing pressures impacting on the services provided
- There are a significant number of time limited dental and medical contracts across East Anglia which may require procurements to be undertaken in the next 18 months
- There is a legacy of poor infrastructure in many areas resulting in a high number of premises developments in the “pipeline”

6 The Case for Change

6.1 Demographic Change

The population in England as a whole is growing and people are living longer. Both the proportion and absolute numbers of older people are expected to grow markedly in the coming decades. The greatest growth is expected in the number of people aged 85 or older – the most intensive users of health and social care.

While there are distinct differences in population profiles across East Anglia as illustrated below, the national trends are reflected locally.

Table 11 Expected Population Growth across CCG area

Population

NHS England

				By 2025			
CCG	Registered patients	Registered patients 65+	% Registered patients 65+	Registered patients	% increase in registered patients	Registered patients 65+	% Registered patients 65+
CAMBRIDGESHIRE AND PETERBOROUGH CCG	866,938	136,179	16	975,305	12.5	186,179	19
NORWICH CCG	208,024	34,627	17	226,330	8.8	45,266	20
IPSWICH AND EAST SUFFOLK CCG	388,915	77,782	20	426,640	9.7	63,372	28
WEST SUFFOLK CCG	236,834	48,973	21	263,359	11.2	63,206	24
SOUTH NORFOLK CCG	224,776	48,409	22	250,625	11.5	62,656	25
GREAT YARMOUTH AND WAVENEY CCG	231,401	52,799	23	248,293	7.3	68,200	27
WEST NORFOLK CCG	165,399	40,291	24	183,262	10.8	47,648	26
NORTH NORFOLK CCG	167,804	45,740	27	182,403	8.7	54,721	30

The health care needs of the population are also changing. In England 53 percent of people report that they have a long-standing health condition and the number of people living with more than one long-term condition is set to rise from 1.9 million in 2008 to 2.9 million in 2018.

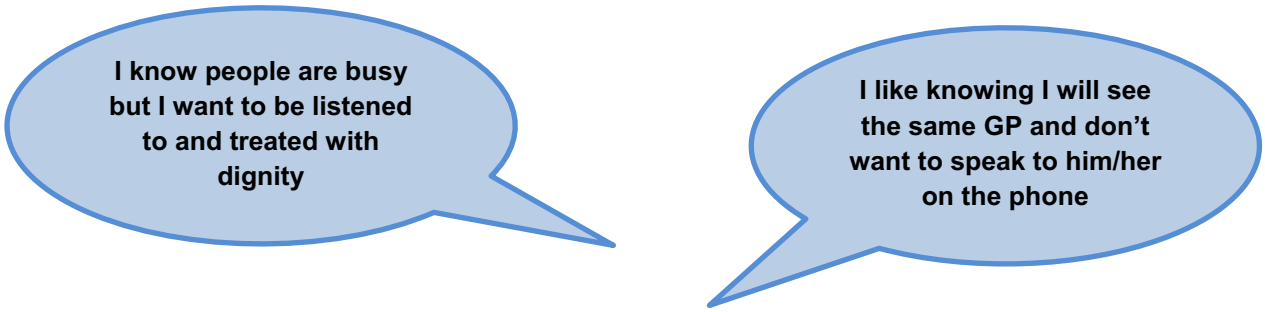
6.2 Changing Patient Expectations and improving access

The expectations of patients are changing and local discussions have highlighted what is seen by many working in primary care to be an increasing divergence between what patients are expecting/demanding and what would be clinical appropriate care i.e. need.

Although General Practice and other primary care services are generally highly valued within East Anglia the main concerns patients have expressed are:

- Please make it simpler for me, my family or carer to access and receive primary care services

- Please allow me to book in advance and not have to keep ringing day after day for an appointment
- I would like to see the same GP or nurse to ensure continuity of care
- I do not understand why referrals take so long and wish this was explained to me
- I feel that the GP is often rushed and that other staff do not treat me with respect
- I do not have access to a computer and feel disadvantaged as I can't book my appointment or order my prescription online
- I do not want to have a telephone consultation but want to see my Doctor face to face
- Please explain the difference between being registered with my Doctor and how I get Dental care
- Please make it clearer on dental charges and when people are exempt



There is a local acceptance among professionals working within primary care that this perception of poor access must be addressed through a combination of improving access AND helping patients to be effective and appropriate users of primary care services.

6.3 Increasing pressures on the wider NHS system and financial resources

Access to, and capacity within, primary care has also been linked to pressures being experienced across the rest of the NHS. Between 2003/04 and 2011/12 the number of emergency admissions for acute conditions that might not usually require hospital admissions is reported to have increased by 34 percent. There has also been a reported increase in the number of emergency hospital admissions and A&E attendances for conditions that could be treated in the community.

Financial constraints and wider health and social care system challenges also impact on how a primary care service is delivered.

Primary care will be expected to help meet the challenge of the projected 2021/22 funding gap of £28 billion, providing more personalised, accessible community-

based services for patients, particularly for older people with multiple long term conditions.

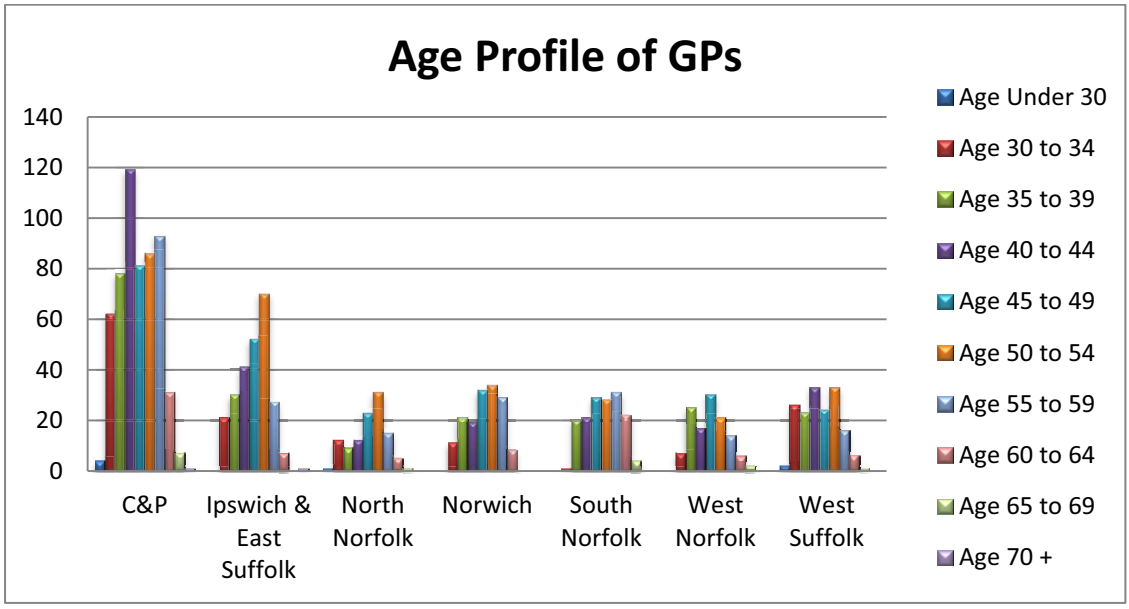
6.4 Increasing workforce pressures

The primary care workforce is also changing and there is increasing concern with regard to workforce pressures, including recruitment and retention problems particularly impacting on general practitioners and practice nurses.

The general practice workforce has not grown as quickly as other medical specialties - between 2002 and 2012 there was an average two percent increase in GPs compared to an average four percent increase in hospital consultants.
There is also a changing gender mix in general medical practice. In 2012, 57 percent of GPs were men and 43 percent were women with more women GPs under the age of 40 than men, and more men in the higher age bands, from 50 onwards. This has significant implications for workforce planning as female GPs are more likely to leave the profession earlier in their careers than their male counterparts. The peak age band for female GPs leaving the workforce is 30 – 34 years and the peak age band for males leaving is 55 - 59 years.

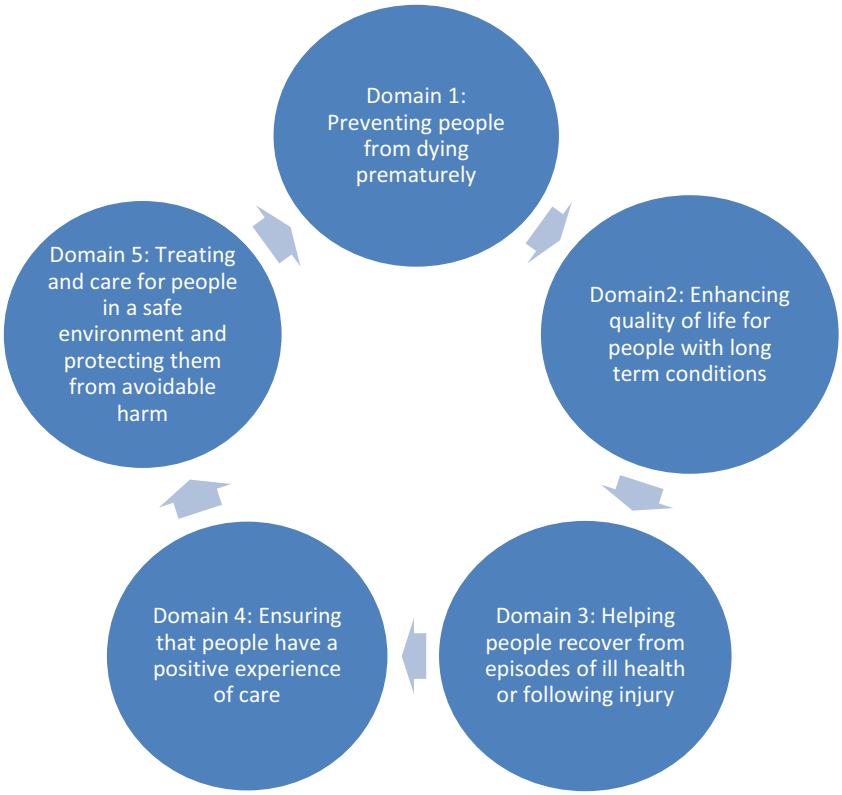
The discussions that have taken place across East Anglia would suggest that workforce pressures represent the most significant issue impacting on primary care sustainability at present.

Graph 5 Age Profile of GPs across CCGs in East Anglia (Workforce Census 2013)



7 A Shared Ambition - Locally Led, Nationally Enabled

Our local discussions have confirmed that there is a shared ambition to create thriving, high quality and sustainable primary care that works to improve health outcomes and support a reduction in health inequalities. This is directly linked to the ambition to ensure that primary care is able to maximise its' contribution to improving outcomes against indicators in the five domains of the NHS Outcomes Framework:



To do this, we recognise that we need to create an environment that enables general practice and primary care more generally, to play a much stronger role, as part of a more integrated system of out-of-hospital care to:

- Provide proactive co-ordination of care (or anticipatory care), particularly for people with long term conditions and more complex health and care problems.
- Offer holistic care: addressing people's physical health needs, mental health needs and social care needs in the round.
- Ensure fast, responsive access to care, preventing avoidable emergency admissions to hospital and A&E attendances.
- Promote health and wellbeing, reducing inequalities and preventing ill-health and illness progression at individual and community level.

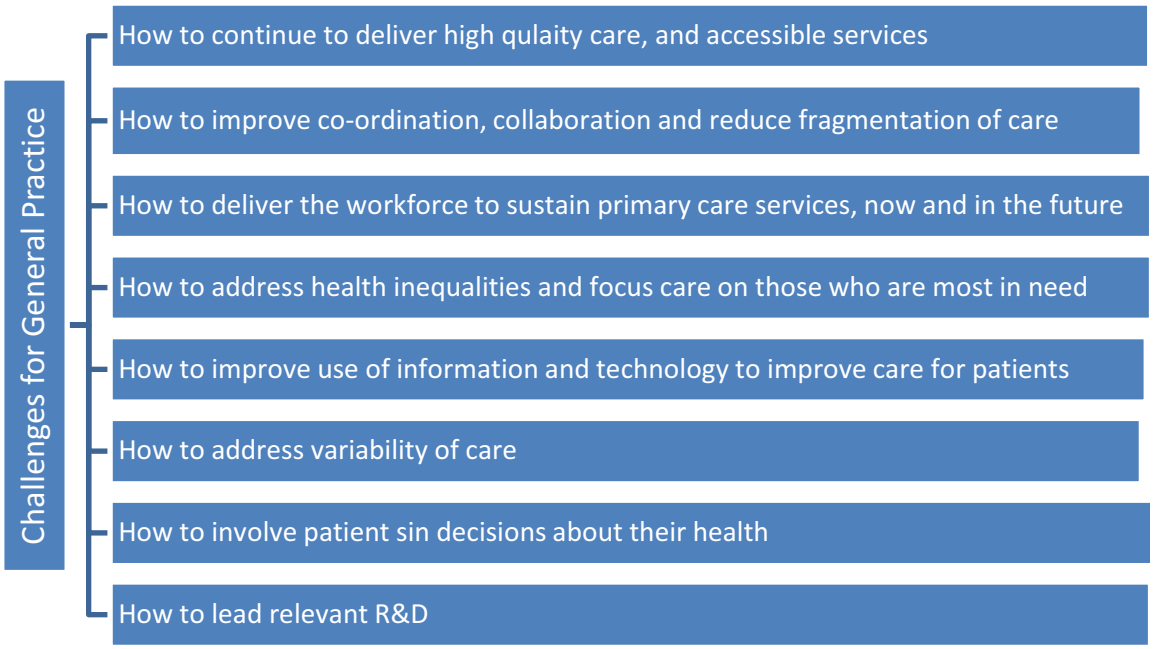
- Personalise care by involving and supporting patients and carers more fully in managing their own health and care.
- Ensure consistently high quality and value of care: effectiveness, safety and patient experience.

It is recognised that the development of primary care must be led locally, with strong collaboration between the NHS England East Anglia Area Team and the 8 Clinical Commissioning Groups and associated Health and Wellbeing Boards with which it works. Local strategies, based on the needs of local communities and the priorities that Health and Wellbeing Boards have identified will be key to informing this work.

NHS England nationally has a role in working to ensure that the national contractual frameworks can support the delivery of local approaches to enable primary care to be the best that it can be.

8 Transforming Primary Care – A Framework for East Anglia

There is a growing acceptance that general practice will be most likely be able to address these challenges and seize new opportunities if it operates at greater scale and in greater collaboration with other providers. At the same time there is also acceptance that general practice should preserve its traditional strengths of providing personal continuity of care and its strong links with local communities.[1]

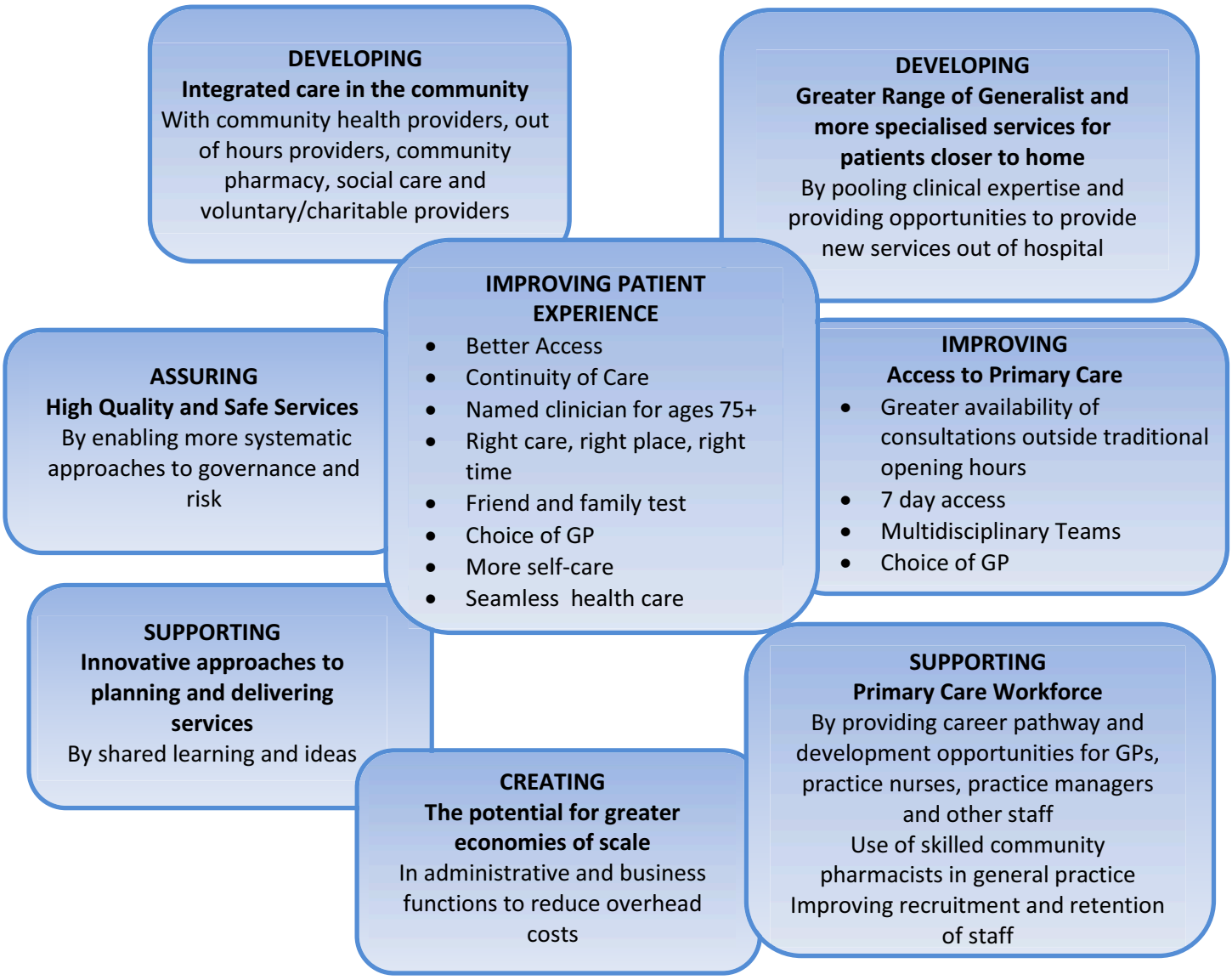


Patients, Doctors and the NHS in 2022 – Compendium of Evidence.[2]

Our local discussions have confirmed that there is no single blueprint for how general practice and the wider primary care community can best meet our shared ambition. It is clear that it will not be achieved simply or primarily by adopting new organisational forms. Our focus will therefore be on working collaboratively to understand how best we can work with primary care professionals to enable them to provide services for patients more effectively and productively, and how we can help practices benefit from collective expertise and resources.

Our Strategy is aligned to the CCG plans that have some common themes and objectives around improved access to a wider range of services; developing multi-disciplinary teams; supporting the workforce to improve patient experience.

Locally there are discussions taking place to consider how primary care providers can work more collaboratively through coming together by merging partnerships, in locality groupings, federations, networks or 'super-partnerships' that reflects their local circumstances that would enable the following:



9 Achieving Our Ambition

Achieving our ambition will depend on harnessing the energy and enthusiasm of all those who work in and with primary care. There is also strong recognition that there are key areas of work that can, and must, be progressed locally.

These fall in to two key areas:

- Progressing work that supports the operational excellence of primary care services.

- Developing, with Clinical Commissioning Groups, a service model that supports the delivery of primary care at scale;

9.1 Priorities for Supporting Operational Excellence

9.1.1 Workforce Planning and Development

What are we doing?

- We will continue to work with Health Education England and local Workforce Partnerships to develop practical proposals to address the immediate and longer term challenges. This will include:

    - A comprehensive review of the general practice workforce across East Anglia

- Proposals for a package of measures to improve recruitment in those areas which are experiencing difficult, e.g. incentives to come to the area
- Proposals for new ways of working e.g. role of clinical pharmacists, consultant nurses within the General Practice Team
- Proposals to raise the profile of general practice across East Anglia, focusing on the opportunities that exist, with specific reference to research and development etc.,
- Ensure access to appropriate professional training and development of primary care staff.

9.1.2 Enabling the Sharing of Information

What are we doing?

- We will establish a Task and Finish Group to provide a clear framework to support the sharing of information across health and social care in East Anglia, building local expertise and champions.

9.1.3 Fair Funding

What are we doing?

- We will continue to work with the three LMCs and CCGs to ensure an open and transparent approach to the funding of primary care services across East Anglia. This includes:
  - Collaboratively agreed process around PMS reviews and transitional support to practices that will be significantly disadvantaged to ensure service sustainability
  - Clear criteria around addressing health inequalities, work force issues and quality improvement/innovation in primary care to enable integrated service delivery for reinvestment of released primary care funding.

9.1.4 Investment in Infrastructure

What are we doing?

- We are progressing with the agreed high priority estates developments across East Anglia; ensuring developments promote integrated service delivery where possible.
- We will continue to work with CCGs to ensure that the planned investment in priority primary care infrastructure achieves real benefits to patients.

9.1.5 Improving Access

What are we doing?

- We will continue to work with Patient Groups, Practices and Healthwatch to review current access to general practice services across East Anglia and patient experience and develop proposals for improvement. We expect this to include:
    - Locally agreed access standards for urgent and routine care
    - Sharing of best practice to improve access for patients
    - Learning from the Prime Minister Challenge Fund sites

9.1.6 Tackling Variation

What are we doing?

- We are working with partners across the Region to develop a toolkit to promote best practice and tackle poor performance;
- We are developing and agreeing a Quality Improvement Framework within General practice to allow identification of outliers against a matrix of information areas in collaboration with our CCGs

9.1.7 Supporting New Models of Primary Care

The current model of primary care is such that the four primary care services (general practice, community pharmacy, dental practices and opticians) all work independently of each other, both professionally and geographically. Their links with other services, such as social care, district nursing and health visiting, which support people in maintaining their health and independence in the community, also tend to be fragmented.

Already new models of delivering primary care are beginning to emerge across East Anglia and while there are different approaches being taken by each of the Clinical Commissioning Groups there is a general theme emerging that is focused on the delivery of more integrated services for local populations by forming “locality networks”.

This new model of primary care will eventually have these characteristics:

- Primary care providers will work at larger scale within “locality networks” for provide a wider range of services to patients closer to their homes – many of which are currently only accessed in acute hospitals.
- These locality networks will be integrated with community services and aligned with social services resulting in more coordinated care for individuals
- Dentists, Community Pharmacists and Optometrists will be become a fundamental part of the primary care team within the “locality networks” to provide more integrated care

- The demand on urgent hospital care will reduce once primary care is reshaped.
- Patients will be able to access primary care services, seven days a week within the “locality networks”.
- The primary care workforce will change and respond to the changing needs of patients – with enhanced roles for nurses, community pharmacists and health care assistants. There will be staff development opportunities within the locality networks – making them able to attract and retain primary care staff, including GPs.

SECTION 2 – STRATEGIC PLANS FOR PRIMARY CARE BY CCG AREA

This section of the strategic documents has been developed in partnership with the Clinical Commissioning Groups across East Anglia as an integral part of their 5 year planning.

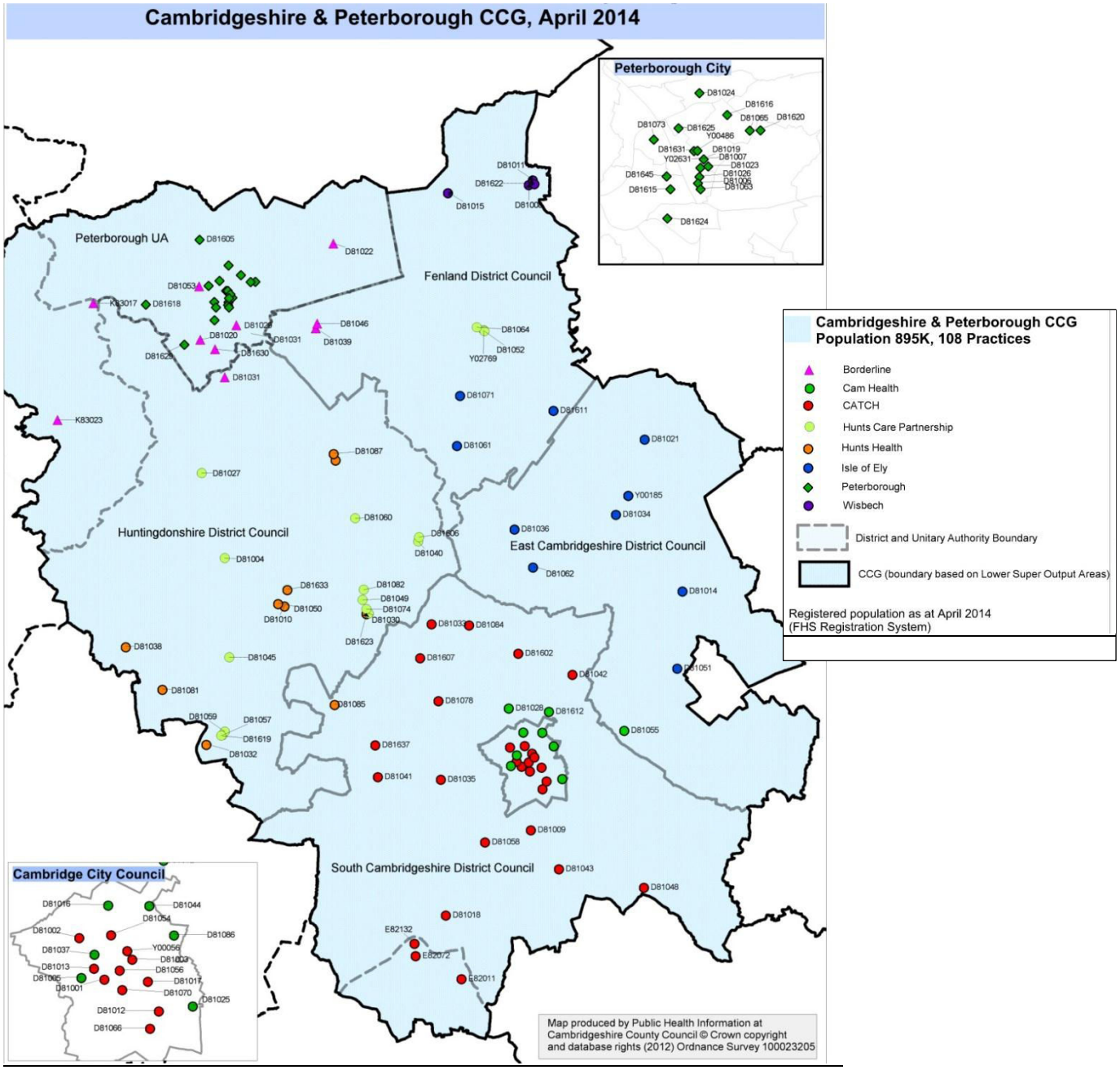
Each CCG Chapter:

- Provides an overview of primary care services in the CCG area
- Sets out the opportunities, challenges and issues specific to the CCG area and context for the development of primary care services, with particular focus on general medical practice services;
- Describes how, through working in partnership the CCG and NHS England will support the development of primary care, and specifically general medical services, to meet the needs of the local population with specific consideration of:
    - The approach to developing primary care to be able to deliver “at scale”
    - The practical actions that will be taken to improve support high quality, sustainable primary care services

10 Cambridge and Peterborough Clinical Commissioning Group

10.1 Overview of Primary Care Services

The main health care commissioner in the Cambridgeshire and Peterborough health system is Cambridgeshire and Peterborough Clinical Commissioning Group (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:



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 eight LCGs.

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

The table below illustrates how GP services fits into the wider spectrum of settings of care offered to our population.

Patient's home	GP	Community	Ambulatory	Hospital	Tertiary
Ambulance service see and treat. Early supported discharge. GP advice and care (phone and/or in person). Home rehabilitation/ recuperation. Hospital aftercare package. Integrated virtual ward. IV therapy. Pallative care. Primary care, mental health and community input into nursing homes. Rapid response team. Self care following advice. Telephone advice from case manager/ other specialist professional.	Advice and signposting from social care assessment team. Available for advice to hospital staff to support decision making. Early supported discharge. Enhanced unscheduled care access and provision by individual GP practices. Rapid access to advance from hospital specialist. Voluntary sector signposting.	Broader access to nursing homes to return patients where this is their home. Early supported discharge. Enhanced primary care service. Social care assessment providing advice and signposting. Intermediate care in a residential setting. IV therapy. Palliative care. Rapid access to social care assessment to facilitate discharge. Rapid response. Community rehabilitation/ recuperation. Step up/ down.	Certain procedures provided in an ambulatory centre or day surgery unit. Enhanced primary care service.	A&E. Drug, alcohol & mental health liaison. Early supported discharge. ICU/ HDU. MAU/ SAU. Medical and surgical inpatient care. Multi-disciplinary discharge planning from admisison. Primary care led minor injury/ illness service. Theatres.	Specialist cardiothoracic services. Specialist trauma services. Specialist drug and alcohol interventions. Specialist input provided via telemedicine. Specialist medical& surgical input. Specialist psychiatric interventions.
Virtual					
999 including hear and treat, 111, online information, directory of services.					
Source: PwC					

10.2 Opportunities, challenges and issues specific to the Cambridgeshire and Peterborough system

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 increasing 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.

10.3 Vision for Primary Care

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:

Aims March 2014	Strategic Goals April 2014	Care Design Groups by July 2014	Finalised design and system implementation plan by April 2015		Implementation for outcomes May 2015 on
Empowering people to stay healthy	Prevention of ill health and promotion of wellbeing for all	Prevention and self care	System blueprint	Detailed Implementation Plan	Reducing PYLL from causes amenable to healthcare
	Keeping people safe				Improving health related quality of life for people with Long term conditions
	People have trust and confidence in our NHS and help shape their healthcare	Older People and Vulnerable Adults			Reducing avoidable hospital admissions
Improving quality, improving outcomes	People are listened to throughout their care	Women's and Children's			Increasing the proportion of people living independently at home following discharge from hospital
	Making the best use of our NHS by giving the right care, in the right place at the right time	Mental Health			Increasing the number of people with a positive experience of hospital care
Developing a sustainable health and social care system	Services are seamless, integrated and centred around the person	Elective care			Increasing the positive experience of care in general practice and the community
	The services we commission match the needs of our population ensuring fair access in relation to need	Non elective care (including cancer)			Reducing avoidable deaths in our hospitals

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.

The CCG has worked with GPs at Member Practice events, Provider Stakeholder events, through discussion at Local Commissioning Group 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[5])
- 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

As the CCG moves into Phase 2 of the 5 year strategic planning work, the critical success factors will be discussed in detail and plans developed to ensure their delivery.

10.4 Key Enablers to Achieve Vision

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

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

11 Ipswich and East Suffolk Clinical Commissioning Group

Ipswich and East Suffolk CCG is embarking on the development of a primary care strategy. Some of the building blocks for the strategy inform this Chapter but it should be noted this work will not be complete until September 2014. Therefore some of the statements contained within this chapter will be revised.

11.1 Overview of Primary Care Services

There are 41 GP practices in Ipswich and East Suffolk within four localities: Ipswich; Suffolk Brett Stour; Deben Health Group and the Commissioning Ideals Alliance.

The overall quality of primary care services exceeds the England average for:

- overall experience;
- ability to get through to a surgery by phone,
- ability to get an appointment to see or speak to someone
- enough support from local services to manage their conditions

Emergency admission rates per 1000 population are also below the England average. This is provided within the context of an aging population with higher percentages than the England average for patients with long term conditions and people registered in nursing homes.

This position is supported by GPs involved in the re-design of services, planning and prioritisation decisions.

All 41 practices are members of the Suffolk GP Federation, a not for profit federation of 61 independent practices covering 540,000 patients. Practices remain independent organisations whilst collaborating in further development of primary care including service delivery.

Primary care services in Ipswich and East Suffolk, particularly GP services now face, however, some significant challenges including:

- GP, nurse, practice manager retention and recruitment
- Capacity to respond to changes required by service and contractual changes
- Financial viability (the scale of which will be dependent on contractual changes).

11.2 Opportunities, challenges and issues

11.2.1 Opportunities

11.2.1.1 Enhanced Integration

The CCG is ambitious to sustain and further enhance care through greater integration and alignment. This is an essential element of the Health and Independence Strategic Programme. Models which can be built upon include:

- local neighbourhood teams of social care, GPs, mental health services and community service providers
- integrated diabetes service which joins the primary and secondary care services
- dementia diagnosis services which join primary and mental health services.

11.2.1.2 Delivery at scale

The CCG, through the development of a primary care strategy will explore opportunities and constraints for delivery of services at three levels:

- Practice provided, locally delivered, list based care offering local access and continuity of care
- Practices working together on a locality basis to enable greater specialisation, achieve economies of scale and provide a wider range of services in a more local setting
- Practices working across the CCG, potentially facilitated by the local GP Federation to deliver a wider range of services at scale.

11.2.2 Challenges

A number of challenges facing primary care will be examined through the strategy development process.

11.2.2.1 Recruitment and retention

The increasing age and profile of GPs and Nurses in Suffolk means that recruiting and retaining primary care staff is increasingly critical to the continued delivery of high quality of general practice.

As part of the work on developing a primary care strategy it is planned to identify (and implement) approaches which respond to this issue.

11.2.2.2 Practice Viability

There are a number of drivers having an impact upon practice viability, the main ones being;

- Phasing out of MPIG
- Seniority allowances
- Potential reductions in PMS income
- The small uplift to contract relative to practice costs
- Reduction in investment in ICT
- Increasing operating costs

The CCG will examine these issues and action required to ameliorate these risks and enhance viability.

11.2.2.3 Service changes

The scale of changes to national policy and local ambition for improvements to the quality of services and outcomes for patients provide opportunities but also immense implementation challenges for primary care. How to ensure successful implementation of this immense change programme will be a key feature of the primary care strategy.

11.2.2.4 Growth in demand

There are a number of factors driving an increase in demand for primary care services, including:

- Overall population in line with Local Plans
- the needs of a growing elderly population
- a higher than England average of patients with multiple long term conditions
- an increase in patient expectation
- 'medicalisation' of non-medical conditions.

The CCG is examining these issues through its health and social care review and this will again inform the primary care strategy.

11.3 Vision for Primary Care

Ipswich and East Suffolk CCG is ambitious and wants to support its local practices to develop in such a way as to meet the existing and future challenges. Our primary care strategy development process will set out a clear vision and goals for the next five years in the context of our overall commissioning strategy.

11.4 Key Enablers to Achieve Vision

There are a number of enablers that need to be aligned with the CCG ambitions for primary care. These are described below;

11.4.1 Scale of delivery

Our primary care strategy will include clear statements on elements of service that need to be undertaken at a very local level and those which may be better delivered by a group of practices. This may be at a small cluster, locality or CCG wide scale.

11.4.2 Models of delivery

The strategy development process will also consider possible options for new models of delivery to respond to long term commissioning opportunities and constraints. This will include consideration of local, national and international examples.

11.4.3 Clinically-led Change Leadership

Clinically-led change leadership will be an essential element of successful implementation. Ipswich and East Suffolk CCG Clinical Executive includes 14 GP leaders and the Federation Board includes a further seven GP leaders. There is a vibrant wider leadership community. This leadership needs to be supported and sustained. The CCG's education and training events and system-wide Clinical Leaders Programme are just two platforms for this.

11.4.4 Co-commissioning

The CCG had previously agreed that it was right to take greater ownership of the issues facing primary care and to help shape the future models of primary care in East Suffolk. Co-commissioning with the Area Team provides a further potential vehicle for this ambition to be realised.

11.4.5 Recruitment, retention and workforce development

Recruitment, retention and workforce development are critical to delivery of the primary care strategy. The CCG is currently issuing a survey to understand the scale of the recruitment and retention challenge to supplement the data provided in Section 4. The CCGs will develop responsive plans with practices the LETB and Area Team and partners, as appropriate.

11.4.6 Estates and IT

Strategic planning and investment in estates and ICT are fundamental to delivery. The CCG already has an ICT strategy which includes primary care. This will be reviewed in the context of the five year strategy.

12 West Suffolk Clinical Commissioning Group

12.1 Introduction

West Suffolk CCG has 25 member practices, organised in 3 localities, with around 160 GPs. The CCG enjoys high quality GP services. There is an experienced and high quality workforce in place who provide high quality services – for example, a recent study has shown that West Suffolk GPs are in the top 5 nationally for the early diagnosis of cancer.

This position is supported by GPs involved in the re-design of services and planning and prioritisation decisions. In addition the CCG facilitates a programme of education, GP practice visits and locality meetings.

The CCG is committed to providing access to a broader range of services in the community to support those patients with moderate mental or physical long-term conditions. This entails transforming community-based services with an expanded role for GPs to coordinate and deliver comprehensive care – putting those healthcare professionals at the heart of a more integrated system of community-based services.

12.2 Opportunities and enablers, challenges and issues specific to West Suffolk

12.2.1 Opportunities and enablers

12.2.1.1 Enhanced Integration

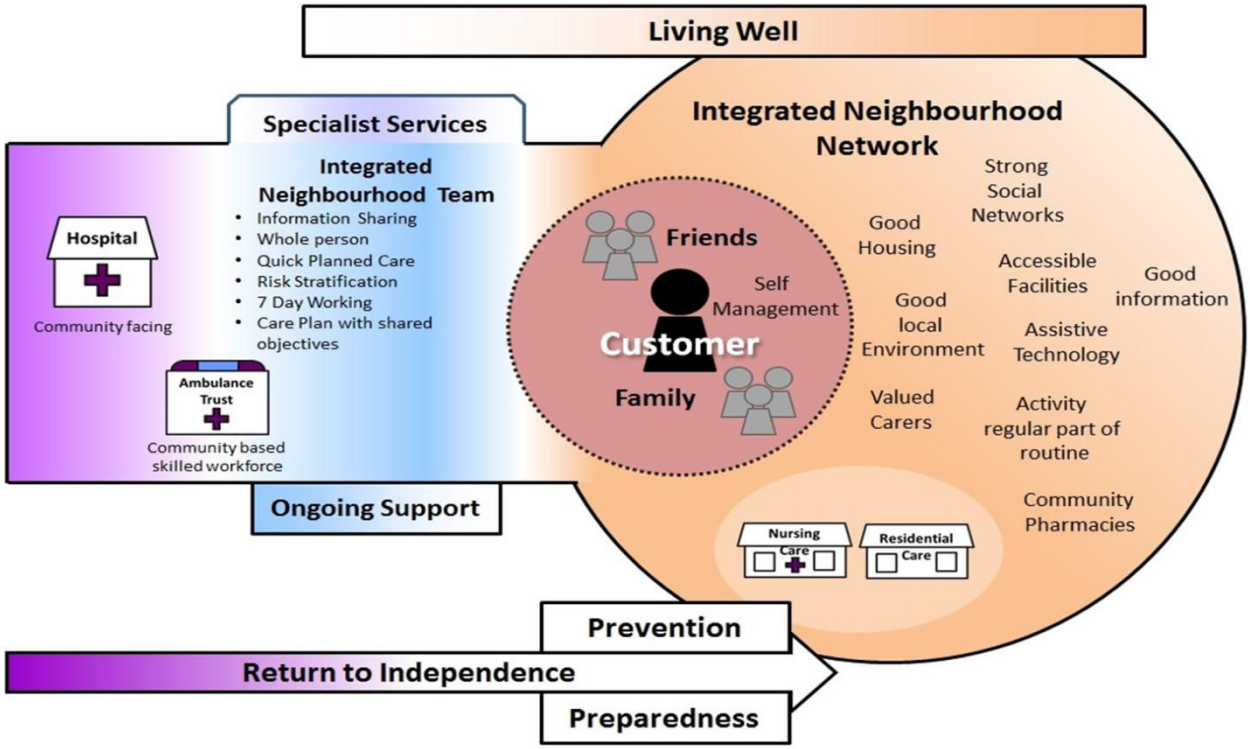
GP services sits at the heart of the 'Health and Independence' model being developed in its 5 year plan (see diagram below). The CCG recognises that it plays a critical role in the prevention of ill health and the management of people with long term conditions. The CCG places GP services at the heart of its joint plan with all partners in Suffolk to support people at home through the implementation of risk stratification, integrated neighbourhood teams, case management and care coordination.

GPs will be a key part of the integrated neighbourhood teams, which will include local mental health, social, community, and specialist out-reach services. These teams will access local neighbourhood networks which bring together local community assets.

The integrated neighbourhood teams' role will be to maintain individuals' independence, enable self-management and support admission prevention activity and effective hospital discharge. The integrated neighbourhood teams will build local health profiles, including the profiles of urgent care/admissions, cross population spend and possible cost profiles and develop shared market intelligence, business

intelligence and performance metrics. The integrated neighbourhood teams will work to the following principles:

- Holistic assessment
    - Creating an outcome focused plan with patients
    - Coordinating the health, care and other inputs into the plan
- Identifying patterns of activity in order to allocate resources to areas of high impact
- Responding to need – arrangement of services and opportunities: with social work, health interventions and therapies
- Encouraging and enabling self-management



To support the 'Health and Independence' model, the CCG is also building a Comprehensive Geriatric Assessment (CGA) pathway across West Suffolk, where GPs are central. It is a continuum of support for individuals and their family carer to reach and maintain their optimum health and well-being, so as not to hit crisis where possible.

The intention is to identify in the community, appropriate support and identify those individuals who, without intervention may tip into crisis within the next year (this will be further advanced by Risk Stratification thus turning unplanned care into planned care).

The additional components that form the CGA offer are:

- Same day diagnostics (to be offered as locally to the person as possible) with acute assessment, clinical review and a shared care plan.

- Enhanced community clinical workforce – additional advanced care practitioners (ACPs); Interface Geriatrician (IG) time to support the Community Intervention Service (CIS) and community teams for special advice; nurse consultant; rotational and secondment posts between WSFT and SCH for therapy; increased nursing within the CIS for additional IV therapy.

- Specialist advice via the Geriatrician of the Day – this service can be accessed by key healthcare professional involved in an individual patients care including GPs, ACPs, CIS and duty social care officers.

- Management of step-up/step-down and rehabilitation beds.

- Intense high level intervention and review at point of need – system-wide.

- A Care-coordinator for case management. Each person entering the CGA pathway will have an identified professional who will ensure that the shared care plan is delivered.

- The individual and their family carer may also be further supported by the voluntary and community sector. Age UK Suffolk, Suffolk Family Carers and Crossroads Care East Anglia have all been commissioned

- to provide home support services, social networking, information and advice.

There are two ways to enter the CGA pathway:

1. Through identification by the GP and/or community practitioner via a MDT approach. This will be discussed with the patient (their family carer) and any other support service they require input from.

2. Post an intense intervention period with the CIS or post an admission to the acute trust where CGA will be available at ward level across specialities. Both require timely pro-active discharge planning.

This planned approach allows the CGA to proactively work with the person and their family carers so as to optimise health and well-being. If whilst on the CGA pathway the person requires a more intensive intervention, then this will be delivered within 2 hours. The person may well remain in their own home or step up into a community bed, but diagnostics will be available on the day. This element of the pathway is known as the 'virtual ward' and will be managed by the ACP and the individuals GP under the specialist advice of the IG.

For those on the 'virtual ward', there will be twice weekly ward rounds and weekly Multi-Disciplinary Team meetings.

12.2.1.2 Delivering at scale

The CCG is currently supporting practices to find local solutions to the challenge of scale where it is helpful and encourage locality based working. There are 3 localities in West Suffolk and we would like to strengthen them further to influence the local shape of community services.

Learning will also be taken from Ipswich and East Suffolk, who are developing a vision based upon three areas:

- Practice provided, locally delivered, list based care offering local access and continuity of care
- Practices working together on a locality basis to enable greater specialisation, achieve economies of scale and provide a wider range of services in a more local setting
- Practices working across the CCG patch, potentially facilitated by the Suffolk GP Federation to deliver a wider range of services at scale. This approach also facilitates the delivery of other strategies and plans, for example the process to ensure that only activity that has to take place in hospital is delivered in a secondary care setting.

12.2.1.3 Working with NHS England

The CCG has expressed an interest in co-commissioning GP services with NHS England. It sees this opportunity as an enabler to support the CCG's vision for integration by shaping our out of hospital services and stabilising primary care where possible. It will also enable the CCG to support the Area Team's wider strategic framework for primary care.

12.2.2 Challenges

There are a number of challenges facing local GP services. Some are significant and require swift and clear action, others are equally important however will come to the fore over the next few years.

12.2.2.1 Recruitment and retention of GPs and practice nurses

The profile of GPs and practice nurses in Suffolk shows that we will have a significant number of retirements in the next 5 years. This demonstrates that recruiting and retaining primary care staff is becoming increasingly critical to the continued smooth functioning of general practice.

12.2.2.2 Practice Viability

There are a number of drivers having an impact upon practice viability, the main ones being:

- Phasing out of MPIG
- Seniority allowances
- Proposed redistribution of PMS income
- Small uplift to contract relative to practice costs
- Reduction for support in IT systems

12.2.2.3 Service changes

There are two drivers that are having and will have a significant impact on practices ability to deliver services; the continuing move to provide more care in a community setting and the related shorter lengths of stay for hospital patients with the consequent impact on their acuity. This will be added to as the move to 7 day working is implemented

12.2.2.4 Growth in demand

As the population ages and lives longer this increases the demand on local primary care services as patients in older age are often suffering for multiple long term conditions.

In Suffolk it is estimated:

- 153,000 (20.9%) people are aged over 65
- 71,700 (9.8%) are aged over 75
- 21,500 (2.9%) are aged over 85
- 78,000 people are informal unpaid carers of people with health and care needs

By 2031, it is projected that there will be a 55% increase in the number of persons over the age of 65 in Suffolk, and a 72% increase in the number of persons over 75. In addition, the number of people with dementia will double by 2030.

This GP workload is exacerbated by increasing patient expectation in response what local GP services can deliver and the increasing 'medicalisation' of some social problems.

12.2.2.5 Population growth

St Edmundsbury Borough Council, in consultation with residents, businesses and a range of organisations with a local interest, has created a blueprint for how the borough will develop to the year 2031. This is part of the process of developing the Local Plan (previously called the Local Development Framework) for St Edmundsbury. The Vision describes significant housing growth in areas of West Suffolk, notably Haverhill and Bury St Edmunds, that will require forward planning around primary care provision.

13 Great Yarmouth and Waveney Clinical Commissioning Group

13.1 Opportunities, Challenges and Specific Issues

Great Yarmouth and Waveney CCG (also known as HealthEast) has an ambitious and transformational vision to develop an integrated care system to cover all of our population.

Our 5 year strategy sets out the steps we are taking in partnership with Norfolk and Suffolk County Councils, Great Yarmouth Borough Council and Waveney District Council, our local patient groups, the third sector and our providers to create a system of Integrated Care.

Our vision is founded on full citizen design and 'buy in', to make our Health and Social Care system sustainable, affordable, and able to deliver flexible high quality services for our population. With our co-commissioners locally we are seeking to commission transformed services which can deliver:

- A high quality of care sensitive to the needs of different populations in the CCG
- Affordable care for our populations' needs - now and for the future
- Continuity of care
- A single point of entry – no more "being passed around the system"
- Seamless pathways
- A focus on prevention - "anticipatory care" and reablement
- Transparent, trustworthy and compassionate care.

Primary Care is – as noted earlier in the Area Team strategy – absolutely foundational to these plans, and we are pleased to see the themes of integration, continuity, sustainability and equity featuring strongly in the East Anglian Area Team's strategic framework. We strongly support these intentions and will work with NHS England to achieve them.

We recognise and fully concur with the Area Team's analysis that Primary Care is facing a range of increasingly unsustainable pressures. We also agree that workforce pressures are the most significant threat to sustainability that we face.

In this context we are working with our practices to help develop more robust and sustainable primary care and consider how they can collaborate, share learning and resource, and consider consolidation. These conversations are already well

developed locally with 3 practices merging in Great Yarmouth, and discussions on greater collaboration well advanced in Gorleston (discussed further below). We believe that scale is an essential part of the answer to the challenges faced by this vital sector of our health system.

The leadership displayed by three of our local practices in merging is cause for optimism that the agility and dynamism at the heart of the Independent Contractor model will meet the challenge and can deliver improved quality (including improved accessibility) and integration while preserving the continuity and localism that our population value so highly. We believe that the potential for both innovation and continuous improvement which comes from independent contractor status has been one of UK Primary Care's great unsung strengths, and we wish to preserve these strengths in our local provider market. We therefore remain committed to partner-led independent contractor models of provision, while recognising that different organisational and indeed different provider forms or contracts may be appropriate in specific circumstances. Where these circumstances arise we will work to ensure that the same principles of continuous quality improvement, clinical leadership and ongoing innovation benefit the populations served.

Discussions with our member practices about what scale means for them will continue over the years ahead. We do not believe that one size will fit all, in line with the Area Team's approach. In particular the solutions right for our urbanised areas are likely to be different for the market towns of the Waveney valley and the northern villages.

In addition to the challenges of scale, we recognise the profound challenges of an aging population and the need to "wrap" community and outreach specialist services around our vulnerable populations. We recognise the centrality of Primary Care in delivering these integrated approaches, and have already been incentivising multi-disciplinary team working. However our 2 year operational plan sets out how we will commission "Out of Hospital Teams" across our whole area (implemented in 13/14 in Lowestoft) to support general Practice in looking after patients closer to/in their own homes. This will require different ways of working which see the Primary Healthcare Team in a wider and more multidisciplinary fashion. We will work with our practices locality by locality to explore how best to do this in their contexts and will continue to invest (for example via the £5/head) to support them as they do.

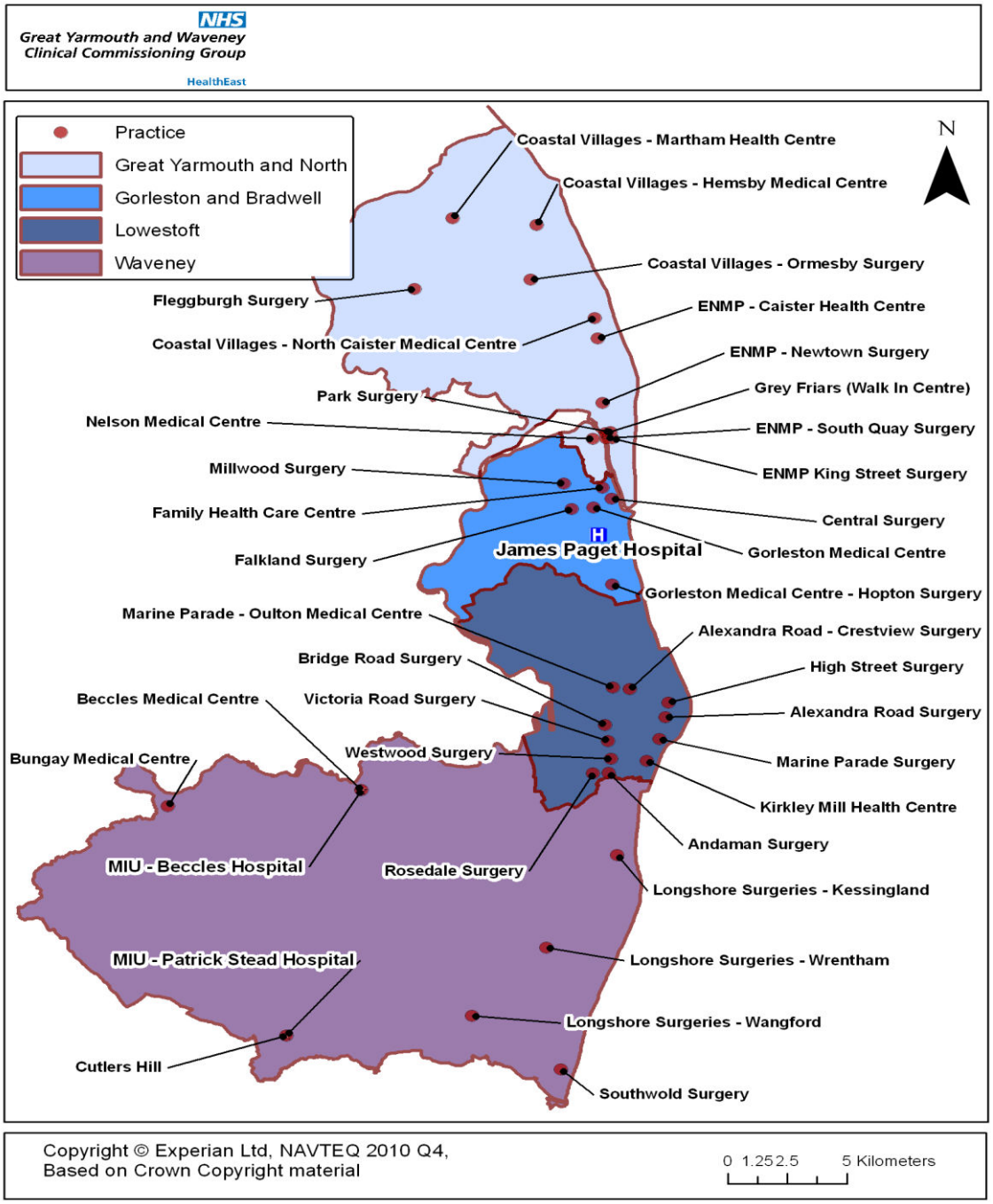
We are also considering what the implications of the Keogh urgent care review and what opportunities this may offer given the challenges of scale discussed above. Our draft Urgent Care strategy seeks to interpret the direction of travel regarding more integrated and co-located Urgent Care centres in the context of Great Yarmouth and Waveney. We will be discussing this, and the options that flow from it during the months of June and July.

13.2 Vision for Primary Care

We will work with the area team to commission robust, high quality, highly accessible Primary Care services for our whole population. We recognise that our localities have different populations and needs, each warranting focus and attention. We do not believe that "one size fits all" localities, but that all services should be able to demonstrate strategic fit with our overall intentions set out above.

13.2.1 Map of Primary Care

The Great Yarmouth and Waveney area is divided into four localities – Yarmouth and North, Gorleston and Bradwell, Lowestoft and Waveney valley.



The primary care facilities in each of the localities are:

Great Yarmouth and North	Gorleston and Bradwell	Lowestoft	Waveney Valley
12 GP Sites	6 GP Sites	11 GP Sites	7 GP Sites
1 Walk in Centre			2 Minor Injury Units

Recently we have seen services co-locate to facilitate smoother cross-agency and inter provider working, to benefit the patients of

- Lowestoft via the new Kirkley Mill Health Centre (co-locating 2 practices, Community Services and Social Care)

- Gorleston via the Shrublands site (1 practice, community services, social services and a pilot site for Multidisciplinary team working drawing in Mental Health and childrens services)

- Southwold via the new Reydon Healthy Living Centre (1 practice, community services)

We believe that there are further opportunities – mentioned above – for co-location of health and social care services on the James Paget Hospital site, as recognised by the Keogh Urgent Care review. However, to focus solely on integration between sectors would, we believe, miss an important opportunity to consider closer working between practices in Gorleston and Bradwell to provide different, more robust and integrated Primary Care services at scale on this site. We will support our practices as they explore these thoughts, and consider working more closely together.

13.2.2 The role of primary care in delivering integrated out of hospital care

GPs across Great Yarmouth and Waveney will work closely with Out of Hospital Teams (OHTs) through regular communication and attendance at Multi-disciplinary team meetings. Out of Hospital teams are made up of health and social care professionals for whom the objective of their service will be to provide care at home whenever it is safe, sensible and affordable to do so and reduce avoidable emergency admissions. The care the team is expected to provide will be organised around the patient, focusing on individual need and reablement. We have already implemented the OHT model in Lowestoft and are rolling this model out – adjusting to locality specifics and learning from each implementation – across our whole area in 2014/15.

13.2.3 Increased access for urgent and routine care

HealthEast is in the process of developing its urgent care strategy for the residents of GYW and the visiting population, ensuring a quality safe sustainable urgent care system is in place for patients when they have an urgent need. This strategy aims to help people get the right advice or treatment in the right place first time.

Patients value the advice provided by their own GP and the strategy for urgent care is underpinned by improving access to Primary Care along with maximising the services provided by GPs including the promotion of self-care, prevention and minimising ill health, provision of care plans for those with long term conditions, and encouraging patients to make the 'smart choice' when they have an urgent care need.

Our local model for urgent care, supported by the Urgent Care Board and in line with Sir Bruce Keogh's Urgent Care Review, includes the development of community hubs which will incorporate a range of services with Primary Care being core to the integration of care across a range of pathways.

These sites will be promoted as 'Urgent Care Centres' – the place for patients to go if they have an urgent care need - and will include in and out of hours GP services, minor illness and injury services, pharmacy, and out of hospital teams. Through co-locating these services patients will receive the right advice or treatment in the right place by the right professional first time.

Hubs will be strategically sited across Great Yarmouth and Waveney including an Urgent Care Centre at the James Paget University Hospital site. As noted above, this may provide a base for the co-location of a number of local practices whose current premises allow no room for increasing the numbers of patients they are caring for, and may also provide opportunities for primary care streaming at the 'front door' to ensure those patients with minor conditions are seen and treated by the most appropriate professional. This model might also address the practice capacity constraint in Gorleston and Bradwell which will arise from the home building programme being undertaken there.

Hubs will provide an opportunity for the development of outreach/hot clinics for ambulatory care to which GPs will be able to refer for those patients not requiring urgent care but some intervention/advice from specialists.

Through the development of services at these urgent care centres local provision of urgent care will be streamlined and coordinated, placing Primary Care very much at the heart of the new system, recognising the value that our population rightly place on their GP services, while simplifying and streamlining the Urgent Care system.

Our review of Urgent Care Strategy for Great Yarmouth and Waveney includes a review of services at the Greyfriars Walk In Centre in Great Yarmouth, working with the Area Team who currently commission this service. To date, a piece of market research insight work has been commissioned by the Area Team across all three walk in centres in Cambridgeshire and Norfolk. The results of this work along with a data review and detailed inquiry into the way patients use the walk-in element of this service will inform the way forward. Any proposals to substantively change how services are provided at Greyfriars will be subject to a full public consultation as appropriate.

13.3 Key Enablers to Achieve Vision

13.3.1 Priorities for Investment

New Multidisciplinary facility sited at the front door of the JPUH

North/Central Yarmouth Urgent Care Centre

Roll out of the Out of Hospital Teams across Great Yarmouth and Waveney

13.3.2 New Service Models and provider development

As discussed above we believe that the challenge of scale and need for increased access (including 7 day services) which the NHS is facing will require the development of new models of collaboration and provision. We do not believe one size fits all and we also believe in the ability of our providers to shape their thoughts on this in collaboration across the system as we integrate to the benefit of the patients of Great Yarmouth and Waveney. We do not therefore at present plan to impose new provider models but will work with our whole market and provider landscape within the area to facilitate the emergence of models fit for the future.

We also recognise that our localities have differing populations, and that these populations have different needs. The needs of the population must lead the shaping of the delivery model – in line with the overall strategic aims set out above, for example integration.

13.3.3 Workforce developments

In line with Health Education England (HEE) Primary Care Workforce plans, we can identify with the main CPD priorities HEE have set. The data is in accord with NHS England demographic information which clearly shows the ageing population we serve in Health East and the subsequent pressures on GP Practices, magnified by an aging and thinly spread workforce. Successful recruitment of GPs and Nurses into the area is crucial.

Our ambition for recruitment is linked to our vision, set out above, for strong primary care provider organisations, delivering high quality attractive services in environments which are fit for purpose; organisations which can stimulate clinical

innovation and are marked by clinical ownership and leadership of the services they provide. We expect to invest in such services, delivered by such a provider landscape, and will invest to help our provider landscape meet these challenges. We believe that such providers will be able to attract and retain high quality clinical staff of all grades.

We will work with HEE, Practices, and local workforce leads in our acute and community providers to develop training and development opportunities to increase the potential for skill mixing in Primary Care. We believe that the Primary Care nursing workforce are a vitally important professional group whose profound skills and strengths in patient care could be better utilised for some populations.

Having recently engaged with our Practice Nurses and Managers to carry out a training needs analysis, a new pathway to training and CPD funding has been developed. This has been provided to Practices to support and ensure Practice Nurses and Healthcare assistants following appraisal and assessment of needs, are aware how to access and apply for help towards their CPD.

To address priorities, such as Dementia, Learning Disabilities and COPD local training has been arranged by HealthEast for Practice Staff. Training around COPD has already begun with sessions taking place at HealthEast by a Specialist Respiratory Nurse, then followed up in Practices with a more tailored package. Learning Disability training has also been arranged and facilitated to ensure that this vulnerable and deprived population have equal access to high quality and appropriately skilled primary care.

13.4 Summary

In summary we believe Primary care is the foundation of the delivery of high quality care to our CCG population, and is central to our overall aim of integrating care and drawing multidisciplinary teams around those with ongoing care needs. We see a future shape for services where primary care sits at the heart of these integrated teams, frequently co-located with them, and where all providers work much more closely together to ensure highly accessible sustainable quality of care.

14 West Norfolk

14.1 Overview

'Future characteristic 2':
'Wider primary care, provided at scale'

Relevant elements	WNCCG current initiatives	WNCCG future initiatives
•Patients with a moderate mental or physical LTC to secure access to support and care from wider primary care •General practice, community pharmacy and other primary care services to play a stronger role at heart of integrated system of community-based services •Development of new models of primary care •Greater collaboration between general practice and other health and care organisations	•Active GP and practice member engagement via Council of Members, Practice Managers Group and GP bulletin •Integrated Care Organisation 1st wave pilot, centred on primary and community integrated care delivery •GP DES and LES initiatives to support wider WNCCG commissioning agenda •GP education programme to improve condition and referral management	•Primary Care strategy, to comprise a number of elements including support to GP practices to enable more effective commissioning, £5 per head utilisation, GP education strategy, prescribing initiatives, DES and LES alignment, NHS England interface •Exploration with NHS England of 'co-commissioning', to align commissioning activities of primary care •Wider Primary Care engagement in the 'Alliance' programme •Further exploration of innovative GP Federation, and primary/community care delivery models, to provide primary care at scale, across networks or localities

The **role of primary care** will need to adapt to link effectively with other providers of care and this could include hospital outreach of services as well as community providers. General Practice is facing a number of significant challenges including financial pressures, recruitment difficulties and increasing contractual requirements such as extended hours and pro-active care planning for vulnerable patients. As a consequence, practices will have to develop new partnerships and styles of working to continue to provide a full range of high quality medical services. WNCCG will support the development of primary care, through;

- promoting clinical networks with other professionals such as hospital consultants for advice and support on clinical decision-making in the community,
- providing activity and financial data at practice level to facilitate a better understanding of practice referrals and utilisation of health care resources,
- establishing an education programme to support GPs to make high quality referrals, adhering to best practice pathways and making best use of resources,
- consulting with practices about the most innovative and effective ways to commission services that support patients with complex health needs to receive the care they need in the community,

- developing a frailty assessment score that is universal across health and social care, negating the need for multiple assessments,
- sharing data about patients safely using ‘Eclipse Live’ and the Smart Card scheme,
- improving care home education and links with other services

West Norfolk CCG will work with NHS England Area Team to explore opportunities to ‘co-commission’ primary care where this benefits the local population, with full consideration of delegation of responsibilities, management of conflicts of interest, and resource implications.

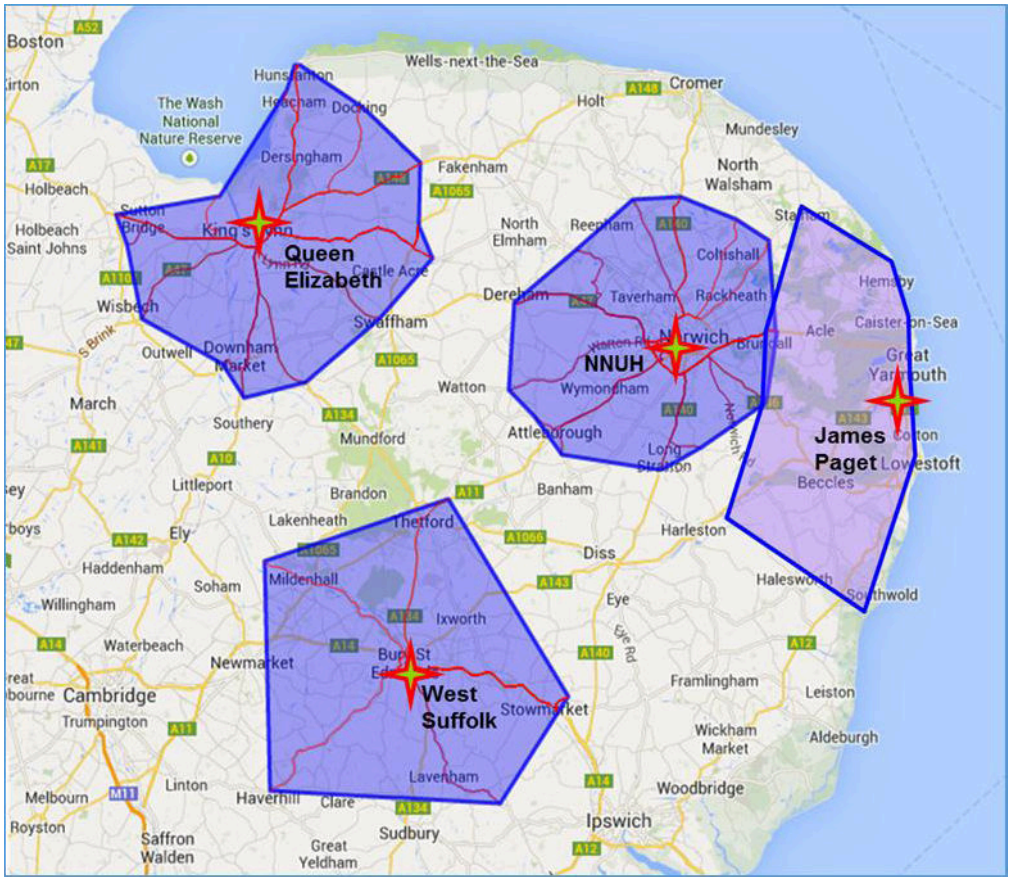
15 North Norfolk Clinical Commissioning Group

15.1 Overview of Primary Care Services in North Norfolk

North Norfolk CCG serves a large, mainly rural area with a dispersed population spread across a network of market towns and villages. The CCG has the oldest population of any CCG in England with all age groups over the age of 50 representing a greater proportion of the population than the national average, with 27% over the age of 65. Public transport links between population centres in North Norfolk are very poor and people are heavily dependent on access to private transport to access services. Locally accessible primary care is therefore an essential pre- requisite to good quality healthcare.

People have to travel significant distances to access secondary care in predominately Norwich, but also in Kings Lynn and Great Yarmouth for the populations on the west and eastern border of the CCG. Large parts of the CCG population live more than 30 minutes travel time to an acute hospital.

Map showing areas that are 30 minutes travel from acute hospitals



Primary care in North Norfolk performs well when measured by the majority of clinical indicators and patient satisfaction. Clinical indicators covering Potential Years of Life lost from causes amenable to healthcare, Under 75 Mortality Rate from cancer, and Emergency Admission rates for conditions not usually requiring admission to hospital are all better than national/comparator group averages. In the 2012/13 GP Survey 90.5% of people rated their overall experience of GP services in North Norfolk as “Very Good” or “Fairly Good”

The vast majority of practices in North Norfolk are stable, long established multi – partner practices based in the market towns and large villages, with distinct catchment areas. Most practices offer a range of extended services such as Near Patient Testing, Phlebotomy, Anti- coagulation, Minor injury, and DVT. Access to these services locally at GP Practices is consistently scored highly in patient experience questionnaires.

15.2 Opportunities, challenges & local issues

The greatest challenge facing primary care in North Norfolk is to maintain its current level of access and performance in the face of growing workload pressure from a rapidly ageing population, in some areas to expand for likely significant housing growth, whilst dealing with a chronic workforce shortage and little financial investment.

The age of the population in North Norfolk means that the prevalence of long term conditions and diseases such as CHD and cancer are particularly high.

Disease prevalence (QOF)	North Norfolk CCG	South Norfolk CCG	Norwich CCG
Asthma	🔴	🔴	🔴
Atrial fibrillation	🔴	🔴	🟡
Cancer	🔴	🔴	🟡
Chronic kidney disease (18+)	🔴	🟡	🟢
CHD	🔴	🟡	🟡
Dementia	🔴	🔴	🟡
Epilepsy (18+)	🟡	🟡	🔴
Heart failure	🔴	🔴	🟡
Hypertension	🔴	🔴	🟢
Hypothyroidism	🔴	🔴	🟡
Learning disabilities (18+)	🔴	🟡	🔴
Mental health	🟡	🟢	🔴
Palliative care	🔴	🔴	🟡
Stroke	🔴	🟡	🟡

Key	Worst quartile	Middle quartiles	Best quartile
Compared to all CCGs in England	🔴	🟡	🟢

There are plans for significant new housing developments in the Broadland District Council area, on the east side of Norwich, which will create new demands for Primary Care in that area. The development of the new Northern Distributor Road to the north of Norwich is likely to drive further significant housing growth in the Northern suburbs of Norwich served by the CCG practices.

Perhaps the greatest challenge however is workforce. Practices are already struggling to recruit new partners, salaried doctors, and even locum cover, as well as Practice Nurses. The age profile of the Primary Care workforce in the area is a cause for concern with a significant number of staff aged 50 plus.

To date the relatively recent establishment of the Medical School at UEA has done little to assist Primary Care recruitment despite a strong primary care focus on the course. The CCG believes that some urgent work on recruitment – and retention – across Norfolk is an essential short term action required of NHS England.

Access to local education programmes for Practice Nurses and Nurse Practitioners is needed to increase skills and knowledge especially to create capacity in managing patients with Long Term Conditions

15.3 Vision for Primary Care

The CCGs vision for 2019 is for North Norfolk to be nationally recognised for excellence in the quality of care and support offered to its population of older people. The CCG sees the provision of high quality, local primary care as being the bedrock of a fully integrated system of primary, community and social care. Practices are already working in a series of hubs with fully integrated community and social care teams wrapping their services around the practice grouping to better support patients at high risk of admission.

Practices will form an integral part of regular multi-disciplinary approaches to supporting complex patients. For the high risk patients practices will support one another to offer access to GP advice and support 7 days a week.
Practices will continue and extend the range of services offered locally through enhanced service arrangements either on an individual practice basis or as part of the newly formed Norfolk Federation.

Practices will be routinely using digital technology to both support patients and also communicate clinical information with other providers.

15.4 Key enablers to Achieve vision

For this vision to be realised there are a number of enablers which require to be in place:

- As highlighted above workforce shortages in Primary Care are starting to bite. There is an urgent to need to commission a review of the current recruitment, training and deployment of GPs in order to attract more applicants to the area. This should be done on a Norfolk-wide basis.

- Action is also necessary to ensure that experienced GPs are not lost to the NHS. Action should be taken to create roles which are sustainable for senior professionals and offer a balance of direct patient facing with other roles around commissioning, research and development, or training.

- In a similar vein urgent work needs to be undertaken to both recruit more Primary Care nurses and develop career structures which help retain the most experienced staff.

- Practices require certainty to make commitments and invest in their own futures. Therefore uncertainties around contract reviews need to be minimised wherever possible.

- The future of clinically focused commissioning is dependent on GPs having the opportunity to develop an interest in commissioning and understand how this can impact positively on the quality and safety of care and patient experience in North Norfolk. Again this requires workforce capacity and planning to create these opportunities.

- Though in general practice premises in North Norfolk are relatively good and there is little to be gained from major change in the physical infrastructure of primary care given the geography of the area, a number of practices are in need of significant modernisation and expansion, especially Cromer (for which NHS England has approved the Outline Business Case).A number of other practices are likely to need relatively small scale expansion and improvements to meet registration standards and keep pace with growing demand, such as is the case currently at Hoveton and Wroxham.

16 Norwich Clinical Commissioning Group

16.1 Overview of Primary Care Services in Norwich

Norwich CCG has a registered population of approximately 208,600 people. This includes males: 103,500, (49.5%); females: 105,100 (50.5%).

There are 23 general practices in Norwich CCG; practice list sizes range from 1,887 persons to 17,028 persons with an average list size of 8,922 persons.

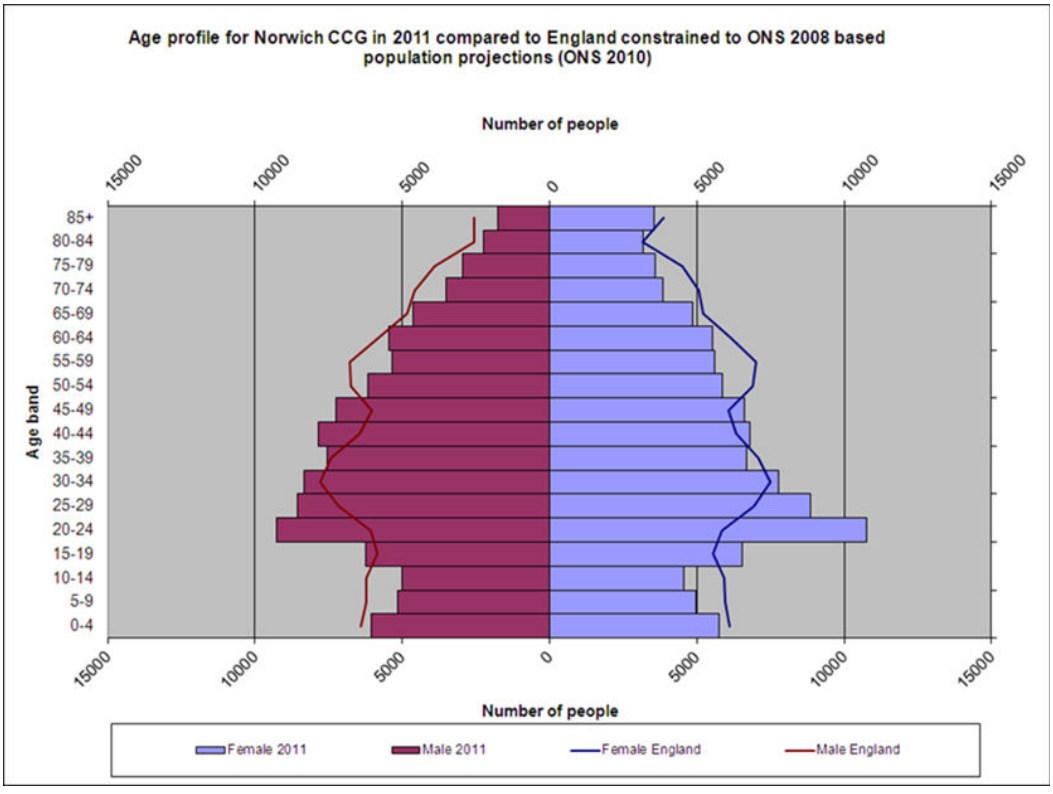
16.2 Opportunities, challenges and issues specific to Norwich

16.2.1 Our Population

Norwich has a youthful age profile, with large proportions of younger people (particularly 20 to 29 year-olds) in the population compared with the county rate. 69% of the population are of working age; well above county and national rates. Norwich has lower proportions of children and older people particularly in comparison with Norfolk as a whole.

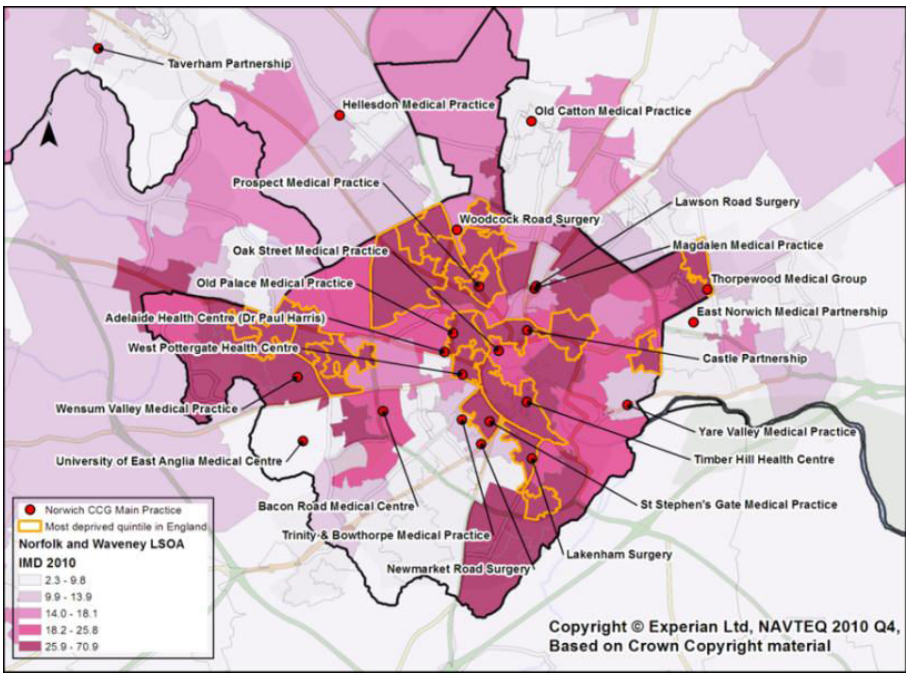
Over the next 20 years, Norwich is likely to see much larger increases in working age population as a proportion of the total population.

Norwich has the highest number and proportion of people belonging to ethnic minorities in the county.



16.2.2 Deprivation

- Deprivation is higher than average and Norwich city is the 70th most deprived district in England.
- Norwich CCG has 1 practice in the most deprived quintile in England, 2 practices in the most deprived 10 in Norfolk and Waveney
- Out of the ten per cent most deprived LSOAs in England in terms of the IMD, 27 are in Norfolk and seven of these are in Norwich. If we look at the most deprived quintile in England, 23 LSOAs fall in this category.
- The 23 Norwich LSOAs in the most deprived 20% in England have the following characteristics on average:
    - over a third of people (35.4%) are income deprived
    - one in five of women aged 18-59 and men aged 18-64 (20.3%) are employment deprived
    - Nearly 1 in 2 children (48.8%) live in families that are income deprived
    - 37.5% of older people are income deprived
- The most deprived MSOAs in Norwich include Mancroft, Milecross, Lakenham and Wensum these are areas with greatest health need.
- At 32.5%, the proportion of children affected by income deprivation in Norwich is higher than that of Norfolk as a whole (based on 2007 Indices). This means that close to 7000 children in Norwich live in poverty.



Index of Multiple Deprivation 2010, Norwich by Lower Super Output Area.

16.2.3 Life expectancy

- Life expectancy for men is lower and for women higher than the England average for people resident in Norwich. Life expectancy for both men and women is higher than the England average for people resident in Broadland.
- Life expectancy is 6.7 years lower for men and 3.2 years lower for women in the most deprived areas of Norwich than in the least deprived areas (Health profile 2012). Life expectancy is not significantly different for men and women in the most deprived areas of Broadland compared to the least deprived areas.
- Over the past ten years, death rates from all causes have fallen. The early death rate from heart disease and stroke has improved in Norwich and Broadland. They are now similar to the England average in Norwich and better than England average in Broadland.
- There is a 3 fold variation between practices for cancer mortality among females. Although the male premature cancer mortality (DSRs) are significantly worse than county, regional and national averages, the variation is less than that observed for females at approximately 2 fold.
- Premature circulatory mortality has been increasing among females over the 4 year period observed (05-07 to 08-10). This is in contrast to county, regional and national trends. There is also a 5 fold variation in circulatory mortality between constituent practices.

16.3 Vision for Primary Care

As part of the development of a combined 5-year strategic plan with NNCCG and SNCCG (See Section xx) 9 areas of intervention have been agreed to support the ambitions and outcomes framework and will form part of our strategic plan on a page. They are as follows:

Intervention 1	Development of primary care localities
Intervention 2	Implementation of integrated community care teams (based on primary care locality footprints)
Intervention 3	Proactive use of predictive modelling and risk stratification
Intervention 4	Easy to access, seven day health and social care provision for people with complex mental and physical health and care needs
Intervention 5	Enable independence, self care and self management
Intervention 6	Improved support for people with Dementia and their carers
Intervention 7	Deliver major redesign of urgent care system
Intervention 8	Ensuring effective end of life pathways and support
Intervention 9	Ensuring effective workforce planning

NHS Norwich CCG has established a strong vision and model for the delivery of integrated care, focused around primary care hubs in the city. Our Commissioning intentions are grouped around these nine areas of intervention.

Intervention 1	**Development of primary care localities**
Principle	GP Practices will be supported to develop locality clusters around populations of approximately 50,000 registered patients (4 localities within the Norwich CCG boundary). These practices will cooperate to develop shared Primary Care services for older patients, and those with long term conditions; with a particular focus on keeping patients independent, well, and at home. Enhanced care for nursing homes, coordinated domiciliary visits, and a shared model of seven day access will be developed.

Intervention 2	**Implementation of integrated community care teams (based on primary care locality footprints)**
Principle	Integrated Community Services - Community, Mental Health, and Social Care Services will be reshaped to the same locality footprints. The locality model will enable a multi-disciplinary approach to care, and build relationships, coordination, and mutual confidence between provider organisations. Through improved communication technology and the development of care coordination (below) we will place the responsible GP at the heart of an integrated virtual health and care team.

Intervention 3	**Proactive use of predictive modelling and risk stratification**
Principle	Practices will be supported to identify and manage patients at high risk of hospital admission through the implementation of risk stratification modelling. We will work with our technology partner to incorporate Primary Care and Social Care data into the model. The model will be launched in 2014, and developed and refined in preparation for the Better Care Fund investments in 2015.

Intervention 6	**Improved support for people with Dementia and their carers**
Principle	Increased awareness and diagnosis rates across Norwich practices with improved supporting networks

Intervention 8	**Ensuring effective end of life pathways and support**
Principle	Choice, control, care and support towards the end of life

Intervention 9	**Ensuring effective workforce planning**
Principle	Ensuring capacity and capability of Primary care workforce

16.4 Key Enablers to Achieve Vision

NHS Norwich CCG will support the development of our localities into 4 city teams. It is our intention that each locality will have the following:

- A named development manager whose role will be to support the locality in the development of community based teams
- A named representative (either managerial or clinical)
- A clinical lead for each locality

- The same ‘core’ services commissioned by the CCG
- The option of developing other services or ways of working depending on the needs of their population, the wishes and interest of member practices and stakeholders
- Include key delivery partners from across all sectors

There are a number of activities that will be considered by the city teams either as part of the ‘core service’ or as part of the option to develop enhanced services depending on the needs of the locality.

Medibites Education programme	Enhanced Primary Care for care Homes	Sustainable Workforce Development	Re-procurement of Community Mental health (including IAPT)
Integrated Diabetes Care	Falls Prevention	Integrated Heart failure Service	Risk Stratification
7 Day Case Management for Patients with Complex Health and Care Needs	Care Co-Ordination Teams (CCG Localities)	Unified Electronic Patient Record	Communication Technology, Virtual Team
Integrated End of Life care	Integrated dementia care	Sustainable Workforce Development	

Norwich CCG identifies that the key system constraints for Norwich as with other systems will be investment levels, workforce supply, and infrastructure.

Norwich CCG will continue to work with North Norfolk and South Norfolk CCG on development and implementation of our combined 5 year strategic plan as well engaging with our membership to produce a plan for Primary Care in Norwich that had the active support of local GPs.

17 South Norfolk

17.1 Overview of Primary Care Services in South Norfolk

South Norfolk CCG (SNCCG) comprises 26 General Practices and has a population of 223,000 (weighted 227,000). The CCG covers a predominantly rural area to the south and west of the city of Norwich and the main district towns are: Thetford, Dereham, Attleborough, Watton and Diss.

The current model of delivery in SNCCG is locality based. Its constituent member Practices are organised into four localities:

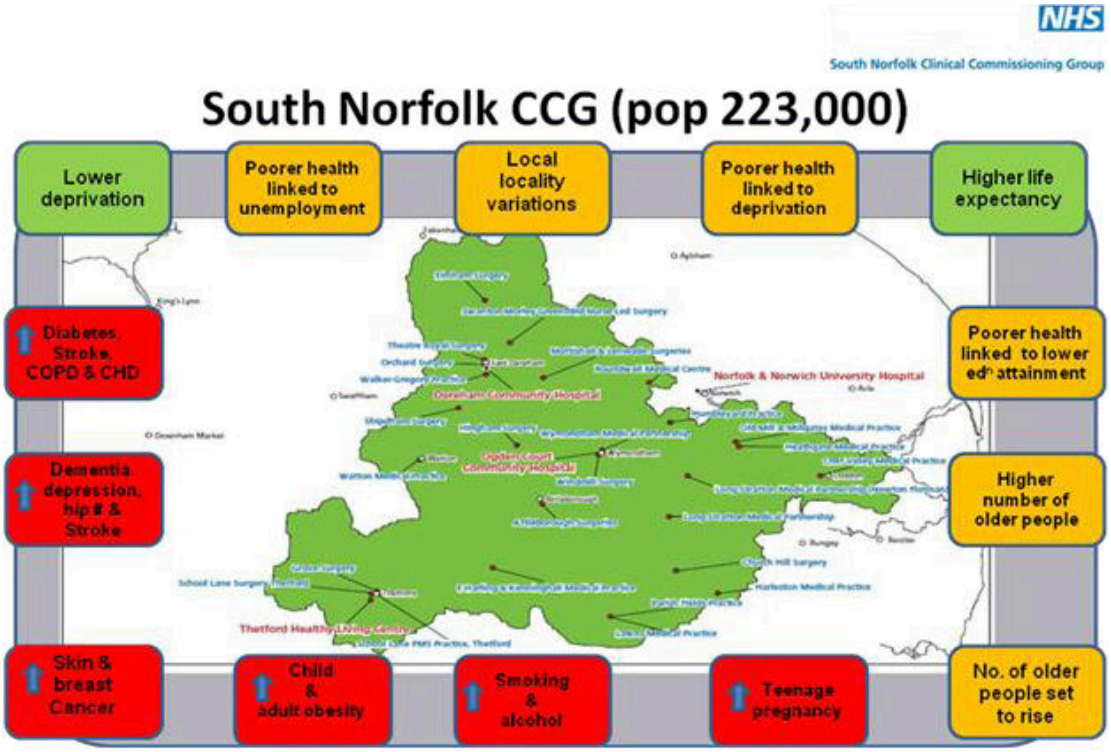
- Breckland,
- Ketts Oak,
- Mid-Norfolk,
- South Norfolk Health Improvement Partnership (SNHIP)

The Council of Members consists of 24 clinical delegates representing the 26 Practices of South Norfolk CCG, chaired by Dr Tony Palframan.

Member Practices work together in smaller localities to ensure there is a focus on local need. These groups have worked together as Practice-based Commissioning Groups and are each chaired by a local GP:

- Ketts Oak - Dr Andrew Hayward from East Harling and Kenninghall Medical Practice
- Breckland – Dr Mike Leeper from Grove Surgery, Thetford
- Mid Norfolk – Dr Elizabeth Jones from Mattishall and Lenwade Surgeries
- South Norfolk Health Improvement Partnership – Dr Tony Palframan, from Heathgate Medical Practice, Poringland.

SNCCG also commissions services for a section of population who live in Suffolk, but registered to a SNCCG Thetford Practice.



The population enjoys relatively good health compared with the rest of England. Deprivation is lower than average and life expectancy is higher than average. There is considerable variation between localities though, with some poor health largely linked to deprivation, unemployment and low educational attainment.

More than half the population is of working age, there are higher numbers of older people than across Norfolk as a whole and the number of older people is set to rise over the next 20 years. All-cause mortality rates have fallen over the last ten years but there is a high incidence of diabetes, chronic obstructive pulmonary disease (COPD), coronary heart disease (CHD), dementia, depression, stroke, cancer (skin & breast) and hip fracture. Other health improvement issues include adult and childhood obesity, smoking, alcohol consumption and teenage pregnancy.

South Norfolk has a relatively larger proportion in the 40-70 year age group compared to England and a lower proportion of all age groups under 40, except for ages 16-19, compared to England. However, the male/female ratio is comparable to the England ratio.

Around 57% of the population in SNCCG are of working age, below the county and national figures, with a higher proportion of children than Norfolk, but lower than England. There also a higher proportion of older people, particularly in comparison with England. As already mentioned there is a 6.9% of our population that are non UK residents and 3.8% from the European Union, particularly Portuguese, Lithuanian and Ukrainian

Age profile for South Norfolk CCG in 2011 compared to England (ONS 2012)

17.2 Key priorities

Although South Norfolk is overall less deprived, there are pockets of deprivation which lead to health inequalities. Health profiles published in 2012 show that while South Norfolk has relatively better scores for health indicators, Breckland has a significantly higher number of people diagnosed with Diabetes and the educational achievement is significantly lower than England average.

South Norfolk has a relatively lower prevalence of adult and childhood obesity, however, the proportion of overweight and obese children is increasing. Similarly, though the ward level teenage conception rates in Norfolk and South Norfolk are generally low, there are some wards which have levels above the England upper quartile. With an ageing population, there will be an increase in Dementia, depression and learning difficulties.

Priorities for improving health in SNCCG include:

- Stopping smoking
- Tackling alcohol misuse
- Addressing obesity by promoting healthy lifestyles.

For the ageing population the CCG will have an increased focus on:

- Prevention and management of age related LTCs such as Dementia, Diabetes, cancer and falls. The following table illustrates the predicted increase in the incidence of Dementia over the next eight years

17.3 Key challenges emerging from population demography and epidemiology

SNCCG recognise the following key challenges:

- Reducing health inequalities within the population – whilst SNCCG covers a population which enjoys relatively good health, the district population data mask variations at super output level.
- An ageing population and the percentage of older people with one or more LTCs, such as Diabetes, COPD and Dementia.
- Rurality and access to treatment and care.

17.4 Opportunities, challenges and issues specific to South Norfolk

Primary care, and in particular care delivered by general practice, is the lynchpin of the health and care system, and acts as the gatekeeper to, General Practitioner (GP), dentist, pharmacist and optician onward referral, as well as community services such as health visiting, district nursing and more specialist community services.

Whilst GP services are commissioned by NHS England, it will be imperative that South Norfolk Clinical Commissioning Group (SNCCG), Norwich Clinical Commissioning Group (NCCG) and North Norfolk Clinical Commissioning Group (NNCCG) support and encourage the development of primary care services across Norfolk.

We need to commission strong and robust primary care services that reduce inequalities of service and access, making improvements in quality and patient satisfaction. All patients should have access to the same range and quality of services to meet their health needs. We plan to make it easier for patients to get the care they need when they need it, as close to their home as possible. To achieve this, we will commission more consistent community based services.

Our strategic vision is built around redesigning and improving services in order to realise three essential deliverables in the next five years:

- High quality and equitable primary care services that improve patient outcomes
- Reduction in health inequalities
- Value for money to our residents.

Our case for change focuses on the following factors:

- Demographic changes in the population
- High health and wellbeing needs
- Variations in access to primary care medical services
- Variations in clinical quality and patient health outcomes
- A changing workforce profile and skills set needed for new models of care

GPs and their practices will play a key role in influencing the strategy and will need to understand how a primary care strategy will affect their commissioning decisions for acute, mental health and community services. The strategy will succeed with the clinical ownership of GPs and working in conjunction with our local authority and health partners.

17.5 Vision for Primary Care

17.5.1 Promoting patient choice

SNCCG will continue to ensure that it meets all of its statutory duties in relation to patient choice and decision making and will work with local Practices to promote and publicise patient entitlement to choice. The rights of patients set out in the NHS Constitution are vital and SCCCG will strive to ensure they are effectively delivered.

Our plans include:

- **Choice in Primary Care** – including choice of Any Qualified Provider (AQP) in community and MH services, providing support to people with long term conditions,
- **Choice before Diagnosis** – choice of diagnostic test provider,
- **Choice at Referral** – choice of provider, named consultant led team, MH and maternity services,
- **Choice after Diagnosis** – choice of treatment, choice of alternative provider at 18 weeks, and end of life care.

As part of the development of a combined 5-year strategic plan with NNCCG and NCCG nine areas of intervention have been agreed to support the ambitions and outcomes framework. They are as follows:

Intervention 1	Development of primary care localities
Intervention 2	Implementation of integrated community care teams (based on primary care locality footprints)
Intervention 3	Proactive use of predictive modelling and risk stratification
Intervention 4	Easy to access, seven day health and social care provision for people with complex mental and physical health and care needs
Intervention 5	Enable independence, self care and self management
Intervention 6	Improved support for people with Dementia and their carers
Intervention 7	Deliver major redesign of urgent care system
Intervention 8	Ensuring effective end of life pathways and support
Intervention 9	Ensuring effective workforce planning

SNCCG has established a strong vision and model for the delivery of integrated care, focused around our localities and commissioning intentions are grouped around these nine areas of intervention as follows:

Intervention 1	Development of primary care localities
Principle	GP Practices will be supported to continue to develop within their current localities. These practices will cooperate to develop shared Primary Care services for older patients, and those with long term conditions; with a particular focus on keeping patients independent, well, and at home. Enhanced care for nursing homes, coordinated domiciliary visits, and a shared model of seven day access will be developed.

Intervention 2	Implementation of integrated community care teams (based on primary care locality footprints)
Principle	Integrated Community Services - Community, Mental Health, and Social Care Services will be reshaped to the same locality footprints. The locality model will enable a multi-disciplinary approach to care, and build relationships, coordination, and mutual confidence between provider organisations. Through improved communication technology and the development of care coordination we will place the responsible GP at the heart of an integrated virtual health and care team.

Intervention 3	Proactive use of predictive modelling and risk stratification
Principle	Practices will be supported to identify and manage patients at high risk of hospital admission through the implementation of risk stratification modelling.

Intervention 6	Improved support for people with Dementia and their carers
Principle	Increased awareness and diagnosis rates across SNCCG practices with improved supporting networks

Intervention 8	Ensuring effective end of life pathways and support
Principle	Choice, control, care and support towards the end of life

Intervention 9	Ensuring effective workforce planning
Principle	Ensuring capacity and capability of Primary care workforce

17.6 Key Enablers to Achieve Vision

For this vision to be realised there are a number of enablers which are required:

- Workforce shortages in Primary Care require urgent attention. SNCCG support the need to commission a review of the current recruitment, training and deployment of GPs in order to attract more applicants to the area. This should be done on a Norfolk-wide basis.

- Action is also necessary to ensure that experienced GPs are not lost to the NHS. Action should be taken to create roles which are sustainable for senior professionals and offer a balance of direct patient facing with other roles around commissioning, research and development, or training.

- Urgent work also needs to be undertaken to both recruit more Primary Care nurses and develop career structures which help retain the most experienced staff.

- Practices require certainty to make commitments and invest in their own futures. Therefore uncertainties around contract reviews need to be minimised wherever possible.

- The future of clinically focused commissioning is dependent on GPs having the opportunity to develop an interest in commissioning and understand how this can impact positively on the quality and safety of care and patient experience. Again this requires workforce capacity and planning to create these opportunities.

- SNCCG will continue to work with North Norfolk and Norwich CCG on development and implementation of our combined 5 year strategic plan as well engaging with our membership to produce a plan for Primary Care in South Norfolk that had the active support of local GPs.
- SNCCG will seek to develop the primary care provider market and explore new forms of primary care cooperation and collaboration. Some of this may include the formation of new businesses.

18 North Norfolk, Norwich and South Norfolk Clinical Commissioning Groups –combined 5 year Strategic Plan

18.1 Primary care

Primary care, and in particular care delivered by general practice, is the lynchpin of the health and care system, and acts as the gatekeeper to, General Practitioner (GP), dentist, pharmacist and optician onward referral, as well as community services such as health visiting, district nursing and more specialist community services.

Whilst GP services are commissioned by NHS England, it will be imperative that South Norfolk Clinical Commissioning Group (SNCCG), Norwich Clinical Commissioning Group (NCCG) and North Norfolk Clinical Commissioning Group (NNCCG) support and encourage the development of primary care services across Norfolk.

We need to commission strong and robust primary care services that reduce inequalities of service and access, making improvements in quality and patient satisfaction. All patients should have access to the same range and quality of services to meet their health needs. We plan to make it easier for patients to get the care they need when they need it, as close to their home as possible. To achieve this, we will commission more consistent community based services.

Our strategic vision is built around redesigning and improving services in order to realise three essential deliverables in the next five years:

- High quality and equitable primary care services that improve patient outcomes
- Reduction in health inequalities
- Value for money to our residents.

Our case for change focuses on the following factors:

- Demographic changes in the populations of SNCCG, NCCG and NCCG
- High health and wellbeing needs
- Variations in access to primary care medical services
- Variations in clinical quality and patient health outcomes
- A changing workforce profile and skills set needed for new models of care

GPs and their practices will play a key role in influencing the strategy and will need to understand how a primary care strategy will affect their commissioning decisions

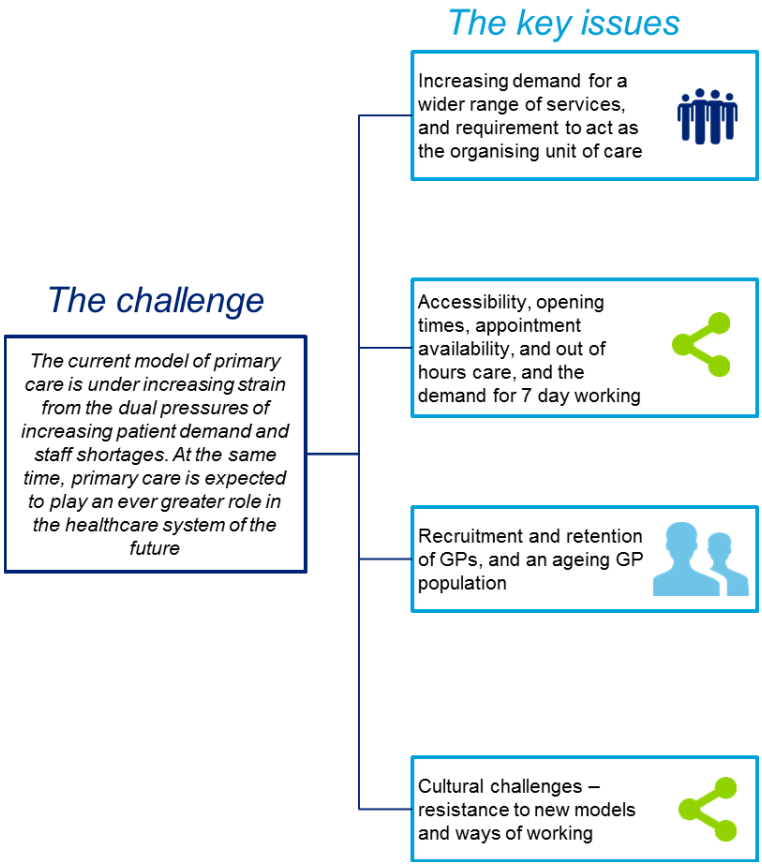
for acute, mental health and community services. The strategy will succeed with the clinical ownership of GPs and working in conjunction with our local authority and health partners.

18.2 Challenges in primary care

The heart of the challenge for primary care is the combination of rising patient demand for rapid access to primary care, an ageing population, more complex health needs, tighter financial controls and increasing staff shortages in the GP and primary care nursing workforce.

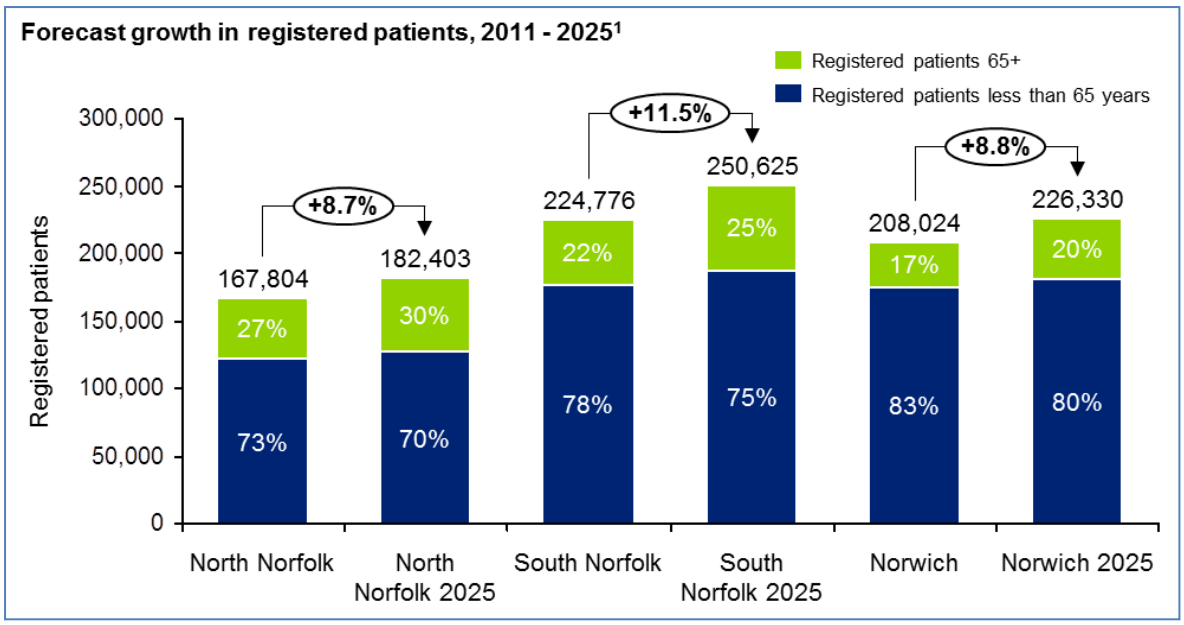
This comes at a time of rising expectations regarding the role of primary care in the health and care system, with GPs increasingly expected to act as care co-ordinators and as the named accountable health professionals for patients with LTCs.

The key challenges confronting primary care in SNCCG, NNCCG and NCCG are shown below.



18.2.1 Rising demand

GP patient numbers are forecast to rise over the coming years, with a greater proportion of patients over 65 years old, according to East Anglia Area Team projections. Between 2011 and 2025 there is estimated to be growth of in excess of 35,000 over 65s. By 2025 over 65s are estimated to comprise 30% of registered patients in North Norfolk CCG, and 25% in South Norfolk CCG, up from 27% and 22% respectively in 2011.

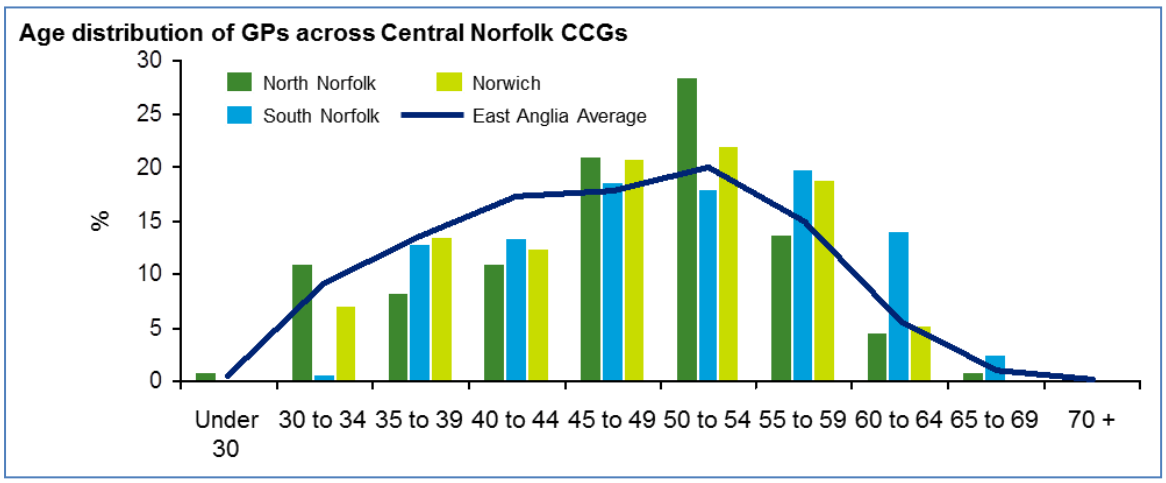


The ageing of the population in SNCCG, NNCCG and NCCG is likely to place a disproportionate pressure on GP services, within the context of rising per capita demand for primary care. Since 1995, the national average number of consultations per patient has risen from 3.9 to 5.5 in 2008. This was most pronounced in the over 65's, especially among the over 75s, among whom demand rose from an average of 7.9 consultations in 2000 to 12.3 in 2008.

18.2.2 Workforce shortages

In tandem with rising demand, there is an increasing shortage of GPs. In general, the GP workforce has not grown in line with other specialties: between 2002 and 2012 there was an average 2% increase in GPs compared to an average 4% increase in hospital consultants.

The workforce challenge is likely to intensify as the age profile of Norfolk's GPs moves towards retirement. Central Norfolk already has a GP age profile which is significantly older than the national average.



In part these workforce challenges need to be seen within a national skills and recruitment context, and are not unique to SNCCG, NNCCG and NCCG. For

example, it is reported that newly trained GPs are increasingly unwilling to become partners, and seek alternative working arrangements such as part time working, which makes sustainable provision of primary care services more challenging. However, these national trends are exacerbated by local conditions. The relative isolation of Norfolk, and other factors such as property prices, makes recruitment particularly challenging. Attracting new staff to Norfolk is therefore a key challenge in building a primary care system with sufficient capacity to meet future demand.

18.2.3 Quality and outcomes in 2014

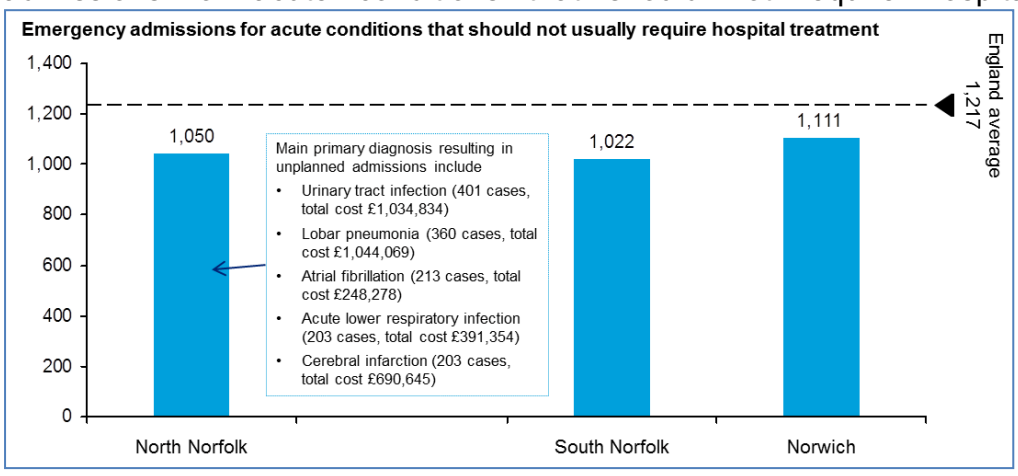
In general primary care in Norfolk is relatively accessible and patients report a good overall experience. SNCCG, NNCCG and NCCG all score above the England average for good overall experience of GP surgery, although North Norfolk and Norwich CCGs score below average for the proportion of patients who were able to see their preferred GP on most occasions.

Where the three CCGs perform less strongly is patient experience of out of hours GP care, for which all score below both the England and East Anglia averages. SNCCG and NNCCG in particular, score particularly poorly on this metric, suggesting that provision of out of hours primary care should be a key area of focus for quality improvement.

Primary care access indicators

	North Norfolk	South Norfolk	Norwich	East Anglia Average	England Average
Good overall experience of GP surgery	90.53	85.44	88.26	89.14	86.74
Good overall experience of out of hours GP	62.07	62.70	69.00	66.38	70.21
% of patients who were able to see preferred GP on most occasions	60.51	63.39	58.35	64.26	62.78
% of practices not open core hours (08:00 – 18:30)	50	36	27	58	-

The interface with secondary care, and overall demand management is a crucial area for consideration given the pressure on acute providers and demographic profile. All three CCGs perform better than the national average for emergency admissions for acute conditions that should not require hospital treatment.



Quality and outcomes in primary care will come under pressure with increasing demands on the primary care system, including 7 day working and the demand to provide personalised, proactive and joined up care (see box below on Transforming Primary Care). However, SNCCG, NNCCG and NCCG are in a strong position to build upon it existing high quality primary care services.

Transforming Primary Care

A new reports sets out plans for more proactive, personalised and joined up care

Overview

- *Transforming Primary Care* (April 2014) is the Department of Health and NHS England's joint plan to provide personalised, proactive and joined up care for people who need it most
- The initial focus will be on 800,000 people with the most complex care needs
- The key features of the proposals include:
  - a personal care and support plan (from September 2014)
  - a named accountable GP (by the end of June 2014)
  - a professional to coordinate their care
  - same-day telephone consultations
  - Improved information and support for people caring for family or friends
- These changes will be supported through the Care Quality Commission (CQCs) new approach to regulating, inspecting and rating GP practices, along with assurance via patient feedback and NHS Choices
- Access to care (such as via online appointment booking) will be enabled through improvements to technology

Implications

- *Transforming Primary Care* details a range of support which is to be provided to staff working in health and care. This includes:
  - removing some bureaucratic tasks to free up GP time for proactive care, e.g. removing some task-based payments
  - improved provision of training to staff via Health Education England, e.g. development of the skills needed to meet people's changing needs
  - New ways of working to enable staff to work across professional boundaries, ensuring staff are able to take on different roles where necessary
  - Improved information sharing across health and social care settings, e.g. timely access to information and GPs for staff in other settings
- To support joined up working this year, CCGs will provide £250m to commission services which support GPs in improving quality of care for older people and people with complex needs
- The Better Care Fund will be used to support the integration of health and social care services from next year
- A £50m challenge fund will support local pilots to explore ways to improve access to GP services over the coming year
- There will be a focus on improving recruitment and retention in primary and community care, with around 10,000 primary and community health professionals intended to be made available by 2020

18.3 The vision for primary care in 2019

Reflecting the challenges identified, the vision for primary care in 2019 is one where enhanced patient access, including extended hours and out of hours, is supported through measures to improve GP productivity and offer new ways of working. GP practices sit at the centre of a wider network of care professionals, with whom they are linked both physically, through co-location, and through improved IT system interoperability and sharing of patient records. The key components of this vision are summarised below

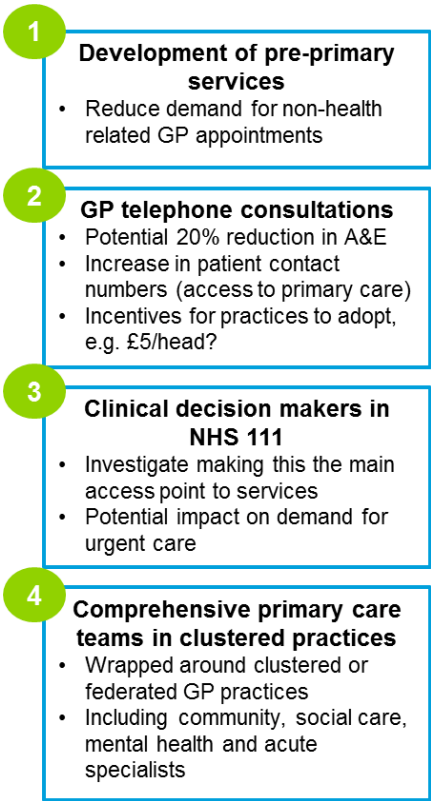
In 2019, a sustainable primary care system in central Norfolk is characterised by…

1. A network of GP practices which have **consolidated and federated** (where appropriate), enabling provision of primary care at scale
2. GP practices as the **organising unit of care**, including named accountable GPs for those patients who need them and wrapping of other services around general practices
3. **New ways of working**, via including telephone consultations, which improve the productivity of primary care and increase patient access
4. Information systems which enable **rapid sharing and updating of patient records** across the healthcare system and which enable GPs to be informed of the latest developments regarding their patients

In order to deliver this vision for primary care, a number of key transformational interventions will be implemented.

18.3.1 Transformational interventions

Following a workshop with commissioners and providers on 7th May, four key transformational schemes were identified as the main initiatives to take forward within primary care. These are focused on delivering the vision by tackling demand and increasing GP productivity, while placing primary care at the heart of integrated health and social care services. These transformational interventions are outlined below.



19 Bibliography

[1] Smith, Holders et al (2013) *Securing the Future of General Practice* The Kings Fund and Nuffield Trust
[2] Royal College of General Practitioners (2012) *Patients, Doctors and the NHS in 2022.* RCGP

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 5 (c)
17 JULY 2014		PUBLIC REPORT
Contact Officer(s):	Andrew Reed, Area Director	Tel.

UPDATE ON PWC 'CHALLENGED HEALTH ECONOMY WORK'

RECOMMENDATIONS	
FROM : NHS England Area Team	**Deadline date :** N/A
To note outputs from the Cambridgeshire and Peterborough 'Challenged Economy' programme and arrangements for making further progress	

1. ORIGIN OF REPORT

This report is submitted to Board following the meeting of local heath and care chairs, elected members and chief officers on 30 April 2014.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to update the committee of progress on the 'challenged economy' programme and its planned further progress.

2.2 This report is for Board to consider under its Terms of Reference No. 3.3 To keep under review the delivery of the designated public health functions and their contribution to improving health and wellbeing and tackling health inequalities.

3. BACKGROUND

3.1 The Cambridgeshire & Peterborough (C&P) local health system faces significant problems: the CCG posted a deficit in 2013/14 and will not meet its full financial requirements in 2014/5; Peterborough & Stamford Hospitals NHS FT has well-documented major financial problems; and other providers have faced financial challenges. As part of a national approach, NHS England, Monitor and the NHS Trust Development Authority (TDA) commissioned and funded support for eleven of the most challenged health economies, of which C&P was one, to enable them to identify and address issues within the context of developing five-year plans.

4. PROCESS

4.1 The nationally- supported programme commenced for a 12-week period on 7 April 2014. Governance arrangements included a local Steering Group comprising representation from NHS England, Monitor and the TDA, and chaired by the NHS England Area Director as the local sponsor. Cambridgeshire and Peterborough CCG was also represented on the group. Commissioned support was provided by Pricewaterhouse Cooper (PwC).

4.2 A stakeholder group was set up comprising chief officers of all NHS provider organisations within Cambridgeshire and Peterborough, Cambridgeshire County Council and Peterborough City Council. A stakeholder day was also held at the end of April for chairs and elected leaders of these organisations together with representatives of local Healthwatch groups.

4.3 In addition to providing programme management support, PwC provided analysis of the financial challenge facing the health economy, a review of the alignment of the plans of

organisations within the system, and facilitated two Clinical Design Groups in which clinicians reviewed the challenges and potential solutions in the areas of urgent and elective care.

4.4 It was recognised from the outset that the nature of the challenges facing the local health economy were such that they could not be resolved within the twelve-week period, and a key element of the programme was therefore to ensure continuing arrangements for a programme of change supported by the local health economy as a whole but led locally by the CCG.

5. PROGRESS

5.1 The outputs of the twelve-week supported programme were:

- recognition of the lack of congruence in provider five year plans;
- agreement over the size of the financial challenge faced by the local health economy;
- establishing two care design groups (for urgent and elective care) which have developed proposed options to transform health and social care;
- modelling the potential activity and financial impact of these options;
- A draft blueprint for the future delivery of services across the local health economy, which is referenced in each of the provider five year plans;
- agreement by the Chief Executives of all providers to a concordat that sets out the principles under which the local health economy will work together;
- establishing a plan for the further development and implementation of options; and
- establishing formal governance arrangements and a resourcing and funding structure that will ensure that the plans developed have the best chance of being successfully implemented.

6. Further action

6.1 The CCG will now lead the longer programme to identify and implement transformation within the health system, including the active engagement of both social services' authorities. A programme budget has been established with contributions from all NHS provider organisations, with accountability to the wider group of chief officers. As a priority the programme will seek to agree quick wins, longer term transformational goals and wil report regularly to the Steering Group. A communications strategy will also be developed to ensure wider stakeholders are also involved. This will include regular reports to the Health & Wellbeing Boards.

6.2 It is recognised that this programme will in effect determine the commissioning intentions foe PSHFT, which is already subject to actions following the recommendations of the Contingency Planning Team. Discussions are taking pace between the Trust, the CCG, NHS England and Monitor to ensure that these processes dovetail with each other.

7. CONSULTATION

7.1 The programme is at an early stage of development and a communications strategy is being developed to ensure wide involvement on service proposals.

8. RECOMMENDATION

8.1 It is recommended that the Health & Wellbeing Board note the content of this paper.

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 6.(a)
17 JULY 2014		PUBLIC REPORT
Contact Officer(s):	Jana Burton, Executive Director of Adult Social Care, Health and Wellbeing, Peterborough City Council Cath Mitchell, Local Chief Officer, Borderline and Peterborough LCG, for Cambridgeshire and Peterborough CCG.	Tel. 01733 452409 Tel: 01733 758414

Better Care Fund - Highlight Report

RECOMMENDATIONS	
FROM : Joint Commissioning Forum and Better Care Working group	**Deadline date : N/A**
To note the progress.	

1. ORIGIN OF REPORT

1.1 The £3.8bn Better Care Fund (formerly the Integration Transformation Fund) was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care. The Better Care Fund (BCF) is a single pooled budget to support health and social care services to work more closely together in local areas. The CCG and Local Authority are working together to develop and agree those plans.

At the last meeting of the Health and Wellbeing Board on March 27th the Health and Wellbeing Board received the proposals and agreed that the submission of the BCF Action plan could be virtually signed off for submission to NHS England on 4th April.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to update the Board on work undertaken since March 27th 2014.

3. MAIN BODY OF REPORT

WORK TO DATE:

3.1 The Steering Group has received feedback from the Local Government Association and CCG Area Teams have reviewed the Peterborough BCF submission. Areas of weakness, predominantly around activity metrics and finance metrics have been identified. The BCF Steering group has been working through this detail and has developed an action plan to address the gaps The BCF Steering Group will be accountable for delivery against this action plan.

The Joint Commissioning Forum and the H&WB are requested to review and endorse this work. The aim is to have developed this to the required level of detail in time for the September 2014 deadline. This work is ongoing.

3.2 The CCG are looking to align the impacts of the BCF with their 2 and 5 year operational plan and the system strategic plan and QIPP programme. This work is ongoing.

3.3 A Programme Delivery Framework has been developed and endorsed by the BCF Steering Group. The attached illustrates those deliverables/changes that will either be fully or partially funded by the BCF, who will project manage each change (resource plan), and the expected benefit/impact. The JCF/H&WB is requested to review and endorse this work.

There will be 2 change delivery programmes within PCC both of which will be responsible for delivering the changes/deliverables of the BCF in conjunction with the CCG ;

1) Transforming ASC Operational Programme. Senior Reporting Officer: Debbie McQuade. This programme will deliver all changes related to integrating care management and reablement with health services. This is through the implementation of the adult social care target operating model; changes to improve customer experience; and delivery of those required changes resulting from the Care Act that impact the care management functions of assessment, support planning, arranging care, charging for care (see attached for further detail)

2) Commissioning Programme for Health, Housing, Social Care & Wellbeing. Senior Reporting Officer; Paul Grubic. This programme will deliver all changes related to developing the market to respond to the health, housing, social care and wellbeing needs of Peterborough residents; development of local area coordination with volunteering and asset based thinking at its heart; and delivery of those required changes to the market resulting from the Care Act (see attached for further detail)

Where we have identified gaps in resource, the solutions to these gaps are being explored across the county footprint by the BCF Steering Group. This work is ongoing.

3.4 Programme templates have been completed (highlight report, decision log, action log, risk and issue log). Electronic filing system for BCF has been set up using PCC filing structure. This work is now complete.

3.5 The Section 256 between the CCG and PCC has been agreed through the JCF and the Agreement has been signed. Future quarterly report template has been agreed and reporting will commence in August 2014.

The Section 256 between the Area Team and PCC has not been agreed NOTE the CCG is acting as the Agent of the Area Team on this agreement. No feedback has been received from the Area Team at the point of writing the report to enable agreement or sign off of the Agreement for 14/15 with PCC who have drawn up the content -with the CCG Acting as Agent of the Area Team.

3.6 **Next Steps**

		Owner	Expected Completion Date
3.6.1	Recruitment underway for replacement Programme Manager who will manage the implementation of the Transforming ASC Operational Programme and have responsibility for BCF	Jana Burton	Beginning of July 2014
3.6.2	Further development of the programme delivery framework for BCF, specifically finalising the; - BCF milestone plan - BCF communication plan - BCF mechanism for monitoring spend against	Following 2.1 recruitment	End of July 2014

		Owner	Expected Completion Date
	budget - BCF mechanism for monitoring delivery against outcomes		
3.6.3	Delivery against the action plan to address gaps in the BCF submission (as mentioned in 1.1 and 1.2)	BCF Steering Group	September 2014

3.7 **Risks/Issues to be owned and monitored at Board**

	Risks / Issues	Mitigation	Mitigation Owner	Expected Completion Date
3.7.1	End of June 2014 ministers are expected to announce which BCF submissions are ready for ministerial sign off (following LGA/AT recommendation) and which BCF submissions need further work (with deadline of September 2014 to complete this work). Peterborough's BCF submission requires further work	M1: Update Peterborough's BCF submission in line with action plan mentioned in 1.1 above	BCF Steering Group	September 2014
		M2: Brief members that Peterborough will be in the group of BCF submissions that require further work	H&WB	asap
3.7.2	Deadlines not aligned. June 28 deadline for CCG to update their 2&5yr operational plans with the impacts of BCF before the work on the finance/activity metrics of the BCF is completed (September 2014 deadline)	M1: Suggested the H&WB Information/ Performance Group be tasked with quantifying the likely impact (documenting any assumptions used).	M1: Tina Hornsby	July 2014
		M2: CCG explore whether an amendment to operational plans can be submitted in September 2014	M2: Cath Mitchell	July 2014

3.8 **What action is requested from each board**

	JCF	HWB	Transformation	
3.8.1	Seeking recommendation to HWB to…	Seeking endorsement to…	FYI…	proceed with action plan outlined in section 1.1
3.8.2	Seeking recommendation to HWB to…	Seeking endorsement to…	FYI…	proceed with Programme Delivery Framework outlined in section 1.3

					Owner	Expected Completion Date
3.8.3	Recommendation already made to HWB.	Seeking endorsement to…	FYI…	proceed with s256 outlined in section 1.5		

4. BACKGROUND DOCUMENTS

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

N/A

The following table illustrates those changes/deliverables that will be either fully funded or partially funded by the Better Care Fund (BCF) and the expected impact on the 6 outcomes/benefits of the BCF. These are the changes/deliverables that are the responsibility of the PCC Transforming ASC Operational Programme to deliver (SRO Debbie McQuade, Programme Mgr TBD)

Programme	Project		Project Manager	Deliverables (Expected Due Date)		Expected Outcome/Benefit and rationale						BCF Funded or not	14/15	15/15	Additional notes on BCF funding
						Admission to residential and care homes	Effectiveness of Reablement	Delayed Transfers of Care	Avoidable emergency admissions	Patient / service user experience	Local metric - falls				
Transforming ASC Ops Programme	P1	Implementing the information & advice strategy for ASC health, social care and wellbeing	Jackie Cousins working with Serco PM	P1.D1	info & advice website and care directory (Sept'14)	yes - decrease res & care home numbers by promoting community based alternatives	yes - increase effectiveness of reablement by promoting community based solutions			yes - increase to patient satisfaction	yes - decrease in number of falls by promoting prevention & community based alternatives	BCF Funded	TBD	TBD	out of the £1,458,000 set aside for prevention & community Interventions
Transforming ASC Ops Programme	P1	Implementing the information & advice strategy for ASC health, social care and wellbeing	Jackie Cousins working with Serco PM	P1.D2	ASC / community specific content (care directory) designed to promote self service (Sept'14)	yes - decrease res & care home numbers by promoting community based alternatives	yes - increase effectiveness of reablement by promoting community based solutions			yes - increase to patient satisfaction	yes - decrease in number of falls by promoting prevention & community based alternatives	BCF Funded	TBD	TBD	out of the £1,458,000 set aside for prevention & community Interventions
Transforming ASC Ops Programme	P2	Accessing health and social care	Lesley Holt (Serco PM)	P2.D1	single point of initial contact, the new front door for social care - contact centre, telephony/IVR, electronic referrals, processing white mail / fax referrals (Sept'14). Single point of initial contact for health and social care including mental health (April'15)					yes - increase to patient satisfaction		BCF Funded	TBD	TBD	out of the £3,522,000 set aside to protect social care
Transforming ASC Ops Programme	P2	Accessing health and social care	Lesley Holt (Serco PM)	P2.D2	triage/eligibility and initial demand management with reablement & assistive technology as the default (Sept'14)		yes - increase effectiveness of reablement via AT	yes - decrease in DTOC by increasing capacity and coordination of service	yes - decrease in avoidable emergency admissions by promoting community based alternatives	yes - increase to patient satisfaction	yes - decrease in number of falls by promoting prevention & community based alternatives	BCF Funded	TBD	TBD	out of the £3,522,000 set aside to protect social care
Transforming ASC Ops Programme	P3	Care Act compliant care management	Kerry Wright	P3.D5	changing care mgmt so Assistive technology is the default (April'15)	yes - decrease res & care home numbers by promoting community based alternatives			yes - decrease in avoidable emergency admissions by promoting community based alternatives		yes - decrease in number of falls by promoting prevention & community based alternatives	BCF Funded	TBD	TBD	out of the £3,522,000 set aside to protect social care
Transforming ASC Ops Programme	P4	Integration with health to improve hospital admission / hospital avoidance	TBD *Cath - could this be a PM from health/ccg or lead integrator?	P4.D1	integrated hospital discharge pathway & team - 7 day working, strong alignment to MDT's			yes - decrease in DTOC by increasing capacity and coordination of service	yes - decrease in avoidable emergency admissions by promoting community based alternatives			BCF Funded	£100k Reablement	£150k Reablement	out of the £5,105,000 set aside for enhanced reablement services
Transforming ASC Ops Programme	P4	Integration with health to improve hospital admission / hospital avoidance	TBD *Cath - could this be a PM from health/ccg or lead integrator?	P4.D2	integrated reablement/rehab/intermediate care pathway & team - 7 day working, strong aligment to MDT's		yes - increase effectiveness of reablement by increasing capacity and coordination of service					BCF Funded	£100k Reablement	£150k Reablement	out of the £5,105,000 set aside for enhanced reablement services
Transforming ASC Ops Programme	P4	Integration with health to improve hospital admission / hospital avoidance	TBD *Cath - could this be a PM from health/ccg or lead integrator?	P4.D3	CHC pathway - funding without prejudice			yes - decrease in DTOC by increasing capacity and coordination of service		yes - increase to patient satisfaction		BCF Funded	TBD	TBD	out of the £3,522,000 set aside to protect social care
Transforming ASC Ops Programme	P4	Integration with health to improve hospital admission / hospital avoidance	TBD *Cath - could this be a PM from health/ccg or lead integrator?	P4.D4	development of reablement offer for both LD and MH		yes - increase effectiveness of reablement by increasing capacity and coordination of service			yes - increase to patient satisfaction		BCF Funded	TBD	TBD	out of the £5,105,000 set aside for enhanced reablement services
Transforming ASC Ops Programme	P4	Integration with health to improve hospital admission / hospital avoidance	TBD *Cath - could this be a PM from health/ccg or lead integrator?	P4.D5	accountable professional named for any integrated packages of care			yes - decrease in DTOC by increasing capacity and coordination of service		yes - increase to patient satisfaction		BCF Funded	TBD	TBD	out of the £3,522,000 set aside to protect social care
Transforming ASC Ops Programme	P6	Monitoring and responding to the impact of the Care Act	Philip Hammond	P6.D3	use of NHS number as prime identifier (March'15)					yes - increase to patient satisfaction		BCF Funded	TBD	TBD	out of the £442,000 set aside for capital investment
Transforming ASC Ops Programme	P7	Development of Care Sector Quality Improvement Team	Tina Hornsby	P7.D1	Development of mulit-agency quality improvement / trouble-shooting function with health and social care input (Sept'14)	yes - decrease res & care home numbers by promoting community based alternatives			yes - decrease in avoidable emergency admissions by promoting community based alternatives	yes - increase to patient satisfaction		BCF Funded	TBD	TBD	out of the £5,105,000 set aside for enhanced reablement services
Transforming ASC Ops Programme	P7	Development of Care Sector Quality Improvement Team	Tina Hornsby	P7.D2	Provide targeted/practical support to improve the quality of all commissioned care - eg care homes, daycare, home care, PA's etc (Jan'15)	yes - decrease res & care home numbers by promoting community based alternatives			yes - decrease in avoidable emergency admissions by promoting community based alternatives	yes - increase to patient satisfaction		BCF Funded	TBD	TBD	out of the £5,105,000 set aside for enhanced reablement services
Transforming ASC Ops Programme	P7	Development of Care Sector Quality Improvement Team	Tina Hornsby	P7.D3	design of kyte mark quality standards and processes to support it - links with commissioning/contracts/procurement/contract monitoring. To be published on the website & care directory (Sept'14)	yes - decrease res & care home numbers by promoting community based alternatives			yes - decrease in avoidable emergency admissions by promoting community based alternatives	yes - increase to patient satisfaction		BCF Funded	TBD	TBD	out of the £5,105,000 set aside for enhanced reablement services

Proposed Next Steps:

1) Quantify the likely impact (documenting any assumptions used). Could this be a task for the H&WB Information/Data sharing group?
2) Agree the amount of BCF funding to be used for each deliverable. Could this be a task for the BCF Steering Group once they understand the likely impact?
3) Develop the same for the "Commissioning Health and Wellbeing Programme". Could this be a task for the Commissioning Programme Manager?

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 7 (a)
		PUBLIC REPORT
Contact Officer(s):	Dr Henrietta Ewart, Director of Public Health	Tel.

HEALTH PROTECTION, EMERGENCY PLANNING AND RESPONSE TO EMERGENCIES

RECOMMENDATIONS	
FROM : Dr Henrietta Ewart, Director of Public Health	**Deadline date : N/A**
1. HWBB is asked to consider and agree the proposed arrangements	

1. ORIGIN OF REPORT

This report is submitted to the Board following a request by the Chair of the Health and Wellbeing Board.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to inform the HWBB of the arrangements that ensure that the responsibilities of Peterborough City Council regarding Health Protection are discharged and reported and that there is an appropriate process to address any incidents or concerns relating to health protection.

3. MAIN BODY OF REPORT

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

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

3.2 Health protection is one of three domains of public health. Health protection seeks to prevent or reduce harm caused by communicable diseases (including healthcare associated infections) and minimise the health impact from environmental hazards. The services that fall within Health Protection include:

- Communicable disease and environmental hazards
- Public health emergency planning
- Immunisation
- Screening
- Sexual health

Following implementation of the Health and Social Care Act 2012 and consequent re-organisation of the health sector in April 2013, roles and responsibilities for health protection of the population are shared between a number of organisations. The national guidance on the role of the local authorities in health protection matters is provided in Appendix 1.

3.3 Peterborough City Council (PCC), through the Director of Public Health, has statutory responsibilities to advise on and promote local health protection plans across agencies, which complements the statutory responsibilities of Public Health England, NHS England, the Cambridgeshire and Peterborough Clinical Commissioning Group and Cambridgeshire County Council.

3.4 It is important that the HWBB understands its responsibilities with regards to health protection and that there is publicly available information that demonstrates they have been fulfilled. It is also important to have processes in place to address and escalate any issues that may arise.

3.5 It is proposed that the Director of Public Health makes an annual health protection report to the Health & Wellbeing Board (HWB) which would provide a summary of relevant activity. This report would cover the multi-agency health protection plans in place which establish how the various responsibilities are discharged and identify their relationship to the Joint Strategic Needs Assessment and Health and Wellbeing Strategy priorities. Any other reports would be provided by exception where a particular incident or concern had arisen. The HWB will not be asked to determine how these plans are developed, nor should it be asked formally to approve them (as they will be developed, on a multi-agency basis and organisations are not accountable to PCC or to the HWB).

3.6 The Director of Public Health has set up the necessary operational multi-agency group (Peterborough Health Protection Committee), taking into account the reduced staff resources overall in the system and therefore ensuring that maximum efficiency is achieved. Member organisations include Peterborough City Council, Public Health England, NHS England, Cambridgeshire & Peterborough Clinical Commissioning Group, Cambridgeshire Community Services, and local acute trusts. The agreed Terms of Reference and membership of the Health Protection Committee are attached in Appendix 2. The Committee will report to the HWB via the Director of Public Health on any health protection matters that need to be brought to the attention of the HWB.

3.7 Public health emergency planning responsibility is shared between the Local Health Resilience Partnership (LHRP), which is co-chaired by the NHS England Area Team Director of Operations and the Cambridgeshire DPH and the Local Resilience Form (LRF). The Director of Public Health will report health protection emergency planning issues to the LHRP on a regular basis. In addition it will be essential to ensure that these plans are actively managed so they remain current, that interdependencies are clearly identified, that they are controlled and stored in a safe and shared environment.

3.8 It will be for the LRF and/or the LHRP to decide whether these plans should be tested through a multi-agency exercise as a main or contributory factor.

3.9 A draft Communicable Disease Outbreak Management Plan for Norfolk, Suffolk and Cambridgeshire has been approved subject to some minor alterations by Cambridgeshire & Peterborough LHRP. The Cambridgeshire and Peterborough LHRP adopted the working draft of this plan, and the Peterborough Health Protection Committee members have been consulted. The plan builds upon a previous plan for Norfolk, Suffolk and Cambridgeshire from 2011. The plan is attached in Appendix 3.

3.10 A Memorandum of Understanding (MOU) on Health Protection Governance has been developed to provide agreement between partner organisations (PCC, Public Health England, NHS England, Cambridgeshire & Peterborough Clinical Commissioning Group, and Cambridgeshire County Council) that are involved in health protection and surveillance and production of associated data (Appendix 4). The MOU defines the organisational responsibilities to provide information needed to assure the DPH that population health is protected and to enable the DPH to provide appropriate advice. The MOU has been approved by the Public Health DMT members. The MOU covers wider governance of health protection and includes agreement on funding interventions in any public health incident in line with national guidance.

3.11 This proposed structure supports the Director of Public Health in fulfilling their statutory duties and will enable the various public agencies to contribute to the planning, commissioning and monitoring of the required activity.

4. CONSULTATION

4.1 The Terms of Reference for Peterborough Health Protection Committee have been agreed by the CMT, and by the Peterborough Health Protection Committee members.

4.2 The Norfolk, Suffolk and Cambridgeshire draft Joint Communicable Disease Outbreak Management plan has been agreed by the LHRP and members of the Peterborough Health Protection Committee.

4.3 The MOU on Health Protection Governance has been agreed by members of the Public Health DMT at PCC and has been circulated for comments to the members of Peterborough Health Protection Committee.

5. ANTICIPATED OUTCOMES

5.1 The signing off of the MOU on Health Protection Governance by member organisations is pending.

5.2 Members of the Peterborough Health Protection Committee will be responsible for ensuring that regular and ad hoc reports and updates are provided by partner organisations to the PHPC on their areas of responsibility. These regular reports will provide the information from which an annual report on health protection will be produced by the DPH for the Peterborough Health and Wellbeing Board.

5.3 Additionally it is expected that the Consultant in Public Health Medicine (CPHM) with responsibility for Health protection will be routinely included in the circulation of all relevant health protection, screening and emergency planning data and information, to enable that consultant to have oversight of health protection and to be able to identify any abnormal trends or issues.

6. REASONS FOR RECOMMENDATIONS

Health Protection is a statutory requirement as outlined in Appendix 1.

7. BAKCGROUND DOCUMENTS

Appendix 1. Department of Health, PHE, LGA. Health Protection in the Local Authorities
Appendix 2. Terms of Reference for Peterborough Health Protection Committee.
Appendix 3. Norfolk, Suffolk and Cambridgeshire Joint Communicable Disease Outbreak Management Plan
Appendix 4. Memorandum of Understanding on Health Protection Governance between PCC, PHE, C&P CCG, NHS England and Cambridgeshire County Council

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Department of Health | Public Health England | Local Government Association

Protecting the health of the local population: the new health protection duty of local authorities under the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013[1]

Purpose of this document

This document explains the new health protection duty of local authorities under regulation 8 of the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013, made under section 6C of the National Health Service Act 2006 ("NHS Act 2006") (as inserted by section 18 of the Health and Social Care Act 2012[2]), which came into force on the 1st of April 2013 ("6C Regulations")[3].

The 6C Regulations and this document focus principally on arrangements for preventing and planning response to health protection incidents and communicable disease outbreaks that do not require mobilisation of a multi-agency response under the Civil Contingencies Act 2004 ("CCA")[4]. It complements the Department's publications on emergency preparedness[5], resilience and response (EPRR) arrangements[6].

The Secretary of State has the overarching duty to protect the health of the population, a duty which will generally be discharged for him by Public Health England (PHE). The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 delegate to local authorities the critical role of providing information and advice to relevant organisations (including PHE) so as to ensure all parties discharge their roles effectively for the protection of the local population.

If the Secretary of State considers that (for any reason, and in any location) the local arrangements are inadequate, or that they are failing in practice, then he must take the action that he believes is appropriate to protect the health of the people in that area.

Background

The arrangements for health protection from April 2013 build on the strengths of the existing system. The activity previously carried out by the Health Protection Agency (HPA) under the

Health Protection Agency Act 2004[7] is now the responsibility of the Secretary of State, under new statutory health protection functions (in particular section 2B of the NHS Act 2006). In practice that activity will be carried out by PHE) an executive agency of the Department of Health. Primary Care Trusts and Strategic Health Authorities were abolished on 1 April 2013[8].

The 6C Regulations provide for each local authority to "provide information and advice to every responsible person and relevant body within, or which exercises functions in relation to, the authority's area, with a view to promoting the preparation of appropriate local health protection arrangements ("health protection arrangements"), or the participation in such arrangements, by that person or body". More detail on the legislative framework is available at Annex A.

The director of public health (DPH) is responsible for the local authority's contribution to health protection matters, including the local authority's roles in planning for, and responding to, incidents that present a threat to the public's health. PHE has a responsibility to deliver the specialist health protection response, including the response to incidents and outbreaks, through the PHE Centres which take on the functions of the former Health Protection Units. These roles are complementary and both are needed to ensure an effective response. In practice this means that there must be early and ongoing communication between the PHE Centre and DPH regarding emerging health protection issues to discuss and agree the nature of response required and who does what in any individual situation.

The local health protection system therefore involves the delivery of specialist health protection functions by PHE, and local authorities providing local leadership for health. In practice, local authorities and PHE will work closely together as a single public health system. This joint working with clarity of responsibilities between them is crucial for safe delivery of health protection, and practical guidance for these arrangements is at Annex B.

The aim of the new arrangements is for an integrated, streamlined health protection system that delivers effective protection for the population from health threats, based on:

- a clear line of sight from the top of government to the frontline;
- clear accountabilities;
- collaboration and coordination at every level of the system; and
- robust, locally sensitive arrangements for planning and response[5].

Unitary and lower tier local authorities have existing health protection functions and statutory powers under the Public Health (Control of Disease) Act 1984[9], as amended by the Health and Social Care Act 2008, and regulations made under it[10] as well as other legislation, such as the Health and Safety at Work Act etc 1974[11] and

the Food Safety Act 1990[12] and associated regulations, which enables them to make the necessary interventions to protect health.

The key elements of health protection

Health protection seeks to prevent or reduce the harm caused by communicable diseases and minimise the health impact from environmental hazards such as chemicals and radiation.

As well as major programmes such as the national immunisation programmes and the provision of health services to diagnose and treat infectious diseases, health protection involves planning, surveillance and response to incidents and outbreaks.

Local authorities (and directors of public health (DsPH) who would usually act on their behalf) have a critical role in protecting the health of their population, both in terms of planning to prevent threats arising, and in ensuring appropriate responses when things do go wrong.

The scope and scale of work by local government to prevent threats to health emerging, or reducing their impact, will be driven by the health risks in a given area.

Understanding and responding to those health risks needs to be informed by Joint Strategic Needs Assessments (JSNAs)[13], Joint Health and Wellbeing Strategies (JHWS), and the health and social care commissioning plans based upon them.

Local government will work with local partners to ensure that threats to health are understood and properly addressed.

PHE, with its expertise and local health protection teams, has a critical role to play in responding directly to incidents and outbreaks, and in supporting local authorities in their responsibilities to understand and respond to potential threats.

The NHS will also continue to be a key partner in planning and securing the health services needed to protect health and in mobilising NHS resources in response to incidents and outbreaks.

Prevention

Local authorities already have existing duties and powers to tackle environmental hazards (see earlier "Background" section). The move of local public health functions from the NHS into local government opens up new opportunities for joint work with environmental health colleagues to tackle areas where there are potential threats, including infectious diseases, and environmental hazards.

The local leadership of DPH, on behalf of local authorities, is critical to ensuring that the local authority and local partners are implementing preventative strategies to tackle key threats to the health of local people.

In taking forward this preventative role, local authorities, usually led by their DPH, will work closely with local PHE centres, which will provide a range of health protection services, including collection, analysis, interpretation of surveillance data, expert epidemiological and public health advice on hazards and effective interventions, and support to develop and implement local prevention strategies. Local teams will also wish to develop relationships with NHS England Local Area Teams, for example in relation to the commissioning of screening and immunisation programmes.

Planning and preparedness

Effective planning is essential to limit the impact on health when hazards cannot be prevented. The legal duty under the NHS Act 2006 to protect the population rests with the Secretary of State and is discharged through PHE, which provides the specialist health protection expertise to support local agencies in developing their plans to respond to public health emergencies and incidents.

Upper tier and unitary local authorities also have a new health protection duty, which involves the local authority discharging aspects of the Secretary of State's duty to take steps to protect public health. The duty takes the form of a statutory requirement (under the section 6C Regulations referred to above) to provide information and advice to certain persons and bodies, with a view to promoting the preparation of appropriate health protection arrangements. Such arrangements should cover threats ranging from relatively minor communicable disease outbreaks and health protection incidents to full-scale emergencies.

In practice, this means that the DPH will provide information, advice, challenge and advocacy on behalf of their local authority, to promote preparation of health protection arrangements by relevant organisations, operating in their local authority area[14]. The DPH, on behalf of their local authority, should be absolutely assured that the arrangements to protect the health of the communities that they serve are robust and are implemented appropriately to local health needs. They also need the opportunity to escalate concerns as necessary, when they believe local needs are not being fully met. They should expect a highly responsive service from PHE and other partners in this respect.

This local authority role in health protection planning is not a managerial, but a local leadership function. It rests on the personal capability and skills of the local authority DPH and their team, on behalf of the local authority, to identify any issues and advise appropriately. But it is underpinned by legal duties of cooperation, contractual arrangements, and clear escalation routes.

Responsibility for responding appropriately to the local authority's

information and advice (and accountability for any adverse impact if that advice is not heeded) rests with other organisations[15].

The 6C Regulations serve as a key lever for local authorities to improve the quality of health protection arrangements in their local areas through the effective escalation of issues. They may raise issues locally, with the partner concerned, the Health and Wellbeing Board (HWB), or directly with commissioners if there are concerns about commissioning of services.

To help ensure that public health advice is appropriately taken account of, there is a range of legal duties and escalation routes, which are discussed further below.

Relationships and accountabilities

Successful health protection requires strong working relationships at the local level. To underpin and support good working relationships, there are a number of legal and other levers to ensure that the relevant organisations do what is required of them to protect the public and take public health advice.

The Secretary of State expects PHE, as an executive agency of the Department of Health, to cooperate with the NHS (NHS England, CCGs, commissioning support units and providers) and local authorities, and to support them in exercising their functions.

PHE is able to provide a wealth of health protection expertise to local authorities to help them in their health protection function as well as delivering directly to the public. To assist this process, PHE should agree with local authorities the specialist health protection support, advice and services that they will provide; this agreement should build on existing arrangements between the NHS, local authorities and the PHE centres.

The NHS England Standard Contract outlines what NHS organisations are expected to deliver in terms of health protection generally, as well as emergency planning (including significant incident and emergency) management and any cooperation requirements necessary to achieve those objectives.[16]

NHS England and CCGs have a duty to cooperate with local authorities on health and well-being under the NHS Act 2006[17].

This includes cooperating around health protection, including the sharing of plans.

The Health and Social Care Act 2012 makes clear that both NHS England and CCGs are under a duty to obtain appropriate advice, including from persons with a broad range of professional expertise in "the protection or improvement of public health"[18]. This includes the advice of local authorities, usually delivered

through their director of public health. The leadership of the director of public health in this context is highlighted by local health resilience partnerships being co-chaired by a director of public health, ensuring their ability to scrutinise and be assured of the plans to respond to emergencies for the communities they serve.

Putting the new mandatory function into practice

Over and above their existing responsibilities as Category 1 responders under the CCA, under the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 upper tier and unitary local authorities are required to take certain steps to protect the health of their local population. In particular, as explained above, they are required to provide information and advice with a view to promote the preparation of health protection arrangements by key health and care partners within the local area[19], recognising that PHE provides the specialist health protection functions of the Secretary of State.

The Department of Health does not expect local authorities to produce a single all-encompassing "health protection plan" for an area, but rather to promote preparation of effective health protection arrangements by local organisations, operating in their areas. This includes commissioning plans aimed at prevention of infectious diseases, as well as joint approaches for responding to incidents and outbreaks agreed locally with partners, including PHE and the NHS.

Local co-operation agreements, memorandums of understanding and protocols between key partners on response to outbreaks are already in place and work well in some areas. These need to be revised and updated for the new system, given the new statutory responsibilities of Public Health England and Local Authorities described in this factsheet. The content of these agreements is for local determination, and local partners may wish to review or update their existing documents, taking into account the core elements to local arrangements which experience suggests should be in place in every area (many of which are set out in regulation 8(7) of the section 6C Regulations) including:

- clearly defined roles and responsibilities for the key partners (comprising at least the local authority, PHE, NHS England, CCGs and primary and secondary care NHS providers), including operational arrangements for releasing clinical resources (e.g. surge capacity from NHS-funded providers) with contact details for a key responsible officer and a deputy for each organisation
- local agreement on arrangements for a 24/7 on-call rota of qualified personnel to discharge the functions of each organisation

- clear responsibilities in an outbreak or emergency response, including the handover arrangements
- information-sharing arrangements to ensure that PHE, the director of public health and the NHS emergency lead are informed of all incidents and outbreaks
- arrangements for managing cross-border incidents and outbreaks
- arrangements for exercising and testing, and peer review
- arrangements for stockpiling of essential medicines and supplies, as appropriate
- escalation protocols and arrangements for setting up incident/outbreak control teams
- arrangements for review (the Department of Health recommends this should take place at least annually).

Local authorities may wish to establish a local forum for health protection issues, chaired by DPH, to review plans and issues that need escalation. This forum could be linked to the HWB, if that makes sense locally.

Ensuring that data can flow to the right people in the new system in a timely manner will be key to making the new arrangements work.

The Public Health Outcomes Framework[20], published on 23 January 2012, contains a health protection domain. Within this domain there is a placeholder indicator, "Comprehensive, agreed inter-agency plans for responding to public health incidents". The Department of Health is taking forward work to ensure that it can effectively measure progress against this indicator.

Next steps and further work

The Department of Health and PHE will publish further guidance on the wider health protection system in due course, building on discussion with the NHS, local government and public health stakeholders. This will include guidance on escalation routes where agreement on any aspect of preparation or response cannot be reached locally.

Annex A: Legislative framework

Under section 2A of the NHS 2006 Act (as inserted by section 11 of the Health and Social Care Act 2012), the Secretary of State for Health has a duty to "take such steps as the Secretary of State considers appropriate for the purpose of protecting the public in England from disease or other dangers to health".

In practice, PHE will carry out much of this health protection duty on behalf of the Secretary of State.

Under the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 unitary and upper tier local authorities have a new statutory duty to carry out certain aspects of the Secretary of State's duty take steps to protect the health of the people from England from all hazards[21], ranging from relatively minor outbreaks and contaminations[22] , to full-scale emergencies, and to prevent as far as possible those threats arising in the first place[23]. In particular, regulation 8 requires that they provide information and advice with a view to promoting the preparation of health protection arrangements by "relevant bodies" and "responsible persons", as defined in the regulations. In addition, regulation 7 requires local authorities to provide a public health advice service to clinical commissioning groups (CCGs), which includes advice on health protection.

They will continue to use existing legislation to respond to health protection incidents and outbreaks (see above).

Directors of public health (DsPH) are employed by local authorities and are responsible for the exercise of the new public health functions. Directors will also have a responsibility for "the exercise by the authority of any of its functions that relate to planning for, and responding to, emergencies involving a risk to public health"[24].

Under new section 252A of the NHS Act 2006[25], NHS England will be responsible for (a) ensuring that clinical commissioning groups and providers of NHS services are prepared for emergencies, (b) monitoring their compliance with their duties in relation to emergency preparedness and (c) facilitating coordinated responses to such emergencies by clinical commissioning groups and providers.

The Health and Social Care Act 2012 also amends section 253 of the NHS Act 2006 (see section 47 of the 2012 Act), so as to extend the Secretary of State's powers of direction in the event of an emergency to cover an NHS body other than a local health board (this will include NHS Commissioning Board and clinical commissioning groups); the National Institute for Health and Care Excellence; the Health and Social Care Information Centre;

any body or person, and any provider of NHS or public health services under the Act.

Under the consequential amendments made by the Health and Social Care Act 2012, the NHS England and Public Health England (as part of the Department of Health exercising the Secretary of State's responsibilities in relation to responding to public health emergencies) will be Category 1 responders under the CCA, requiring them to cooperate and work together in the planning of responses to civil contingencies.

CCGs will be Category 2 responders under the Act giving them a duty to provide information and cooperate with civil contingency planning as needed. Local authorities[26] will remain Category 1 responders under the CCA.

Annex B

Local authorities and Public Health England relationship in respect of health protection

This annex is intended to provide clarity around the respective roles of local authorities and Public Health England (PHE) in relation to health protection to support a safe transition of this function into the new system after 1 April 2013, and has been agreed by PHE, the Association of Directors of Public Health and the Faculty of Public Health. It summarises the statutory responsibilities and collaborative working relationships necessary between local authorities and PHE to deliver effective arrangements to protect the public's health.

1. The statutory responsibilities of local authorities government and of PHE

Health protection includes (but is not confined to) infectious disease, environmental hazards and contamination, and extreme weather events.

The statutory responsibility to protect the health of the population transferred from the Health Protection Agency (HPA) to the Secretary of State for Health on 1 April 2013. Secretary of State's responsibility will mainly be discharged through PHE. However, there are also some specific powers delegated to local authorities under the 6C Regulations. These are to give information and advice on appropriate health protection arrangements within their local area to every responsible person and relevant body, and to provide health protection advice to clinical commissioning groups.

PHE will be responsible for providing the specialist health protection functions previously carried out by the HPA including the specialist response to incidents.

As part of the local authority's responsibilities the director of public health (DPH), on behalf of the local authority, has a duty to prepare for and lead the local authority's response to incidents that present a threat to the public's health.

District and unitary authorities also have defined responsibilities in respect of environmental health, which may be discharged in a variety of different ways in different geographical areas. For example, some districts may wish to combine their environmental health capacity across a wider area with DPH leadership from the county; some unitary authorities may wish to have environmental health within the DPH's

leadership responsibilities, whilst in others they may be entirely separate.

The DPH is a statutory member of the Health and Wellbeing Board (HWB). HWBs is to ensure leaders from health and care systems and the public work together to improve the health and wellbeing of their local population and reduce health inequalities. Board also ensure public engagement and input to joint strategic needs assessments and to health and wellbeing strategies. Boards will also ensure that commissioners work collaboratively to meet the health and wellbeing needs of the community.

2. Practical implications of statutory changes, underlying principles and collaborative support arrangements

To deliver effective planning and response arrangements at local level there needs to be constructive and collaborative working relationships between PHE and the local DPH. Whilst there will be variations in different localities, it is possible to identify a set of principles and support arrangements to enable the delivery of effective local authority and PHE health protection functions. These include:

DPH and PHE relationship

The DPH has a duty to prepare for and lead the local authority's response to incidents that present a threat to the public's health. PHE has a duty to deliver the specialist health protection response. These roles are complementary and both are needed to ensure an effective response.

PHE delivery

PHE continues to deliver the specialist health protection functions described in the HPA's previous work on the "model health protection unit".

These are:

- Responding to and managing outbreaks and incidents
- Responding to cases, enquiries and providing advice
- Surveillance and epidemiology study
- Health protection leadership/ stakeholder relationship management
- Contributing to and influencing PHE Programme Board activities and other internal work streams
- Research and development
- Underpinning activities (management, governance arrangements, continuous professional development etc.)

  This includes the provision of PHE support for DsPH addressing issues of environmental health planning applications (e.g. for waste incinerators)

Health and Wellbeing Boards

Local authorities, with their Health and Wellbeing Boards (HWBs), and through their DsPH will wish to assure that acute and longer term health protection responses and strategies delivered by PHE are delivered in a manner that properly meets the health needs of the local population. PHE Centres and DsPH will agree the reporting of health protection arrangements to HWBs to include local agreement of health protection priorities on an annual cycle and any ad hoc reporting for serious incidents or areas of concern.

We would not expect PHE to be represented on the HWB but to attend for specific health protection related discussions. Attendance would be primarily in support of the DPH who is the local leader for health in the local authority.

Mobilising resources for incidents

DsPH, with their local health leadership role, will work with colleagues from PHE to establish arrangements for mobilising resources to respond to incidents and outbreaks. This will include advice to CCGs, discussions with the Local Area Teams of NHS England, and particularly through the joint chairmanship arrangements of the Local Health Resilience Forum. We would expect the work to establish these arrangements to take place as soon as possible so that PHE staff can access support directly from providers when needed. We would also expect that DsPH would wish to be assured that these plans will work effectively when required.

Communications, information and concerns

The PHE Centre and the DPH will develop a shared understanding around communications about health protection concerns. The PHE Centre will keep the DPH informed about health protection issues and of the action being taken to resolve them.

PHE will provide to Local authorities, via their DsPH, the information, evidence and examples of best practice to support the Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWS). There needs to be a clear programme of engagement at national and local level to determine what form this information can most helpfully be provided in.

PHE will support transparency and accountability across the public health system including the provision of information and discussions with local authorities in relation to achievement of public health outcomes.

PHE will also highlight issues of concern to local authorities, for example if there is no system for Environmental Health Officer support to respond to outbreaks of infection.

Workforce and training

PHE will work with DsPH and, where appropriate, other council officers, in providing development, education and other support to the activities of HWBs on issues of relevance to the health of the local population.

PHE will support local authorities to develop a trained and knowledgeable public health workforce, including in the area of health protection.

Further guidance is to be provided separately on a number of other issues including out of hours and Science and Technical Advice Cells (STAC) arrangements.

References

[1] S.I. 2013/351; available at http://www.legislation.gov.uk/uksi/2013/351/contents/made

[2] The Health and Social Care Act 2012 is available at: http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

[3] These Regulations are made under section 6C of the National Health Service Act 2006 ("NHS Act 2006") (as inserted by section 18 of the Health and Social Care Act 2012)

[4] Available at: http://www.legislation.gov.uk/ukpga/2004/36/contents

[5] "Emergency" is defined by the Civil Contingencies Act 2004, section 1 to mean: (a) an event or situation which threatens serious damage to human welfare in a place in the UK, (b) an event or situation which threatens serious damage to the environment of a place in the UK, or (c) war, or terrorism, which threatens serious damage to the security of the UK. Civil Contingencies Act 2004. Available at: http://www.legislation.gov.uk/ukpga/2004/36/section/1

[6] Arrangements for emergency preparedness, resilience and response in the new system from April 2013 are available at: http://www.dh.gov.uk/health/2012/04/eprr

[7] See The Health Protection Agency Act 2004. Available at: http://www.legislation.gov.uk/ukpga/2004/17/contents

[8] Factsheets on the role of public health in local government and the Public Health England operating model are available at: http://healthandcare.dh.gov.uk/public-health-system

[9] The Public Health (Control of Disease) Act 1984 is available at: http://www.legislation.gov.uk/ukpga/1984/22

[10] See Health protection legislation guidance 2010 at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114510

[11] The Health and Safety at Work etc Act 1974 is available at: http://www.legislation.gov.uk/ukpga/1974/37

[12] The Food Safety Act 1990 is available at: http://www.legislation.gov.uk/ukpga/1990/16

[13] Joint Strategic Needs Assessment statutory guidance can be found at: http://healthandcare.dh.gov.uk/jsnas-jhwss-guidance-published/

[14] Regulations 8, S.I. 2013/351; available at http://www.legislation.gov.uk/uksi/2013/351/contents/made

[15] Regulations 8, S.I. 2013/351; available at http://www.legislation.gov.uk/uksi/2013/351/contents/made

[16] NHS Standard Contract 2012/2013 can be found at: https://www.gov.uk/government/publications/leave-for-will-pls-nhs-standard-contracts-for-2012-13

[17] The NHS Act 2006, section 72. Available at: http://www.legislation.gov.uk/ukpga/2006/41/section/72

[18] For NHS Commissioning Board: Health and Social Care Act 2012, part 1, section 23, inserting section 13J into the NHS Act 2006; for CCGs: HSC 2013, part 1, section 26, inserting section 14W into the NHS Act 2006. Available at: http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

[19] S.I. 2013/351; available at http://www.legislation.gov.uk/uksi/2013/351/contents/made

[20] *Improving outcomes and supporting transparency: a public health outcomes framework for England 2013-1016.* Available at: www.dh.gov.uk/health/2012/01/public-health-outcomes

[21] Building on the principle of the "all hazards" approach as outlined in health protection legislation and accompanying guidance. Available at:http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_114589.pdf

[22] All kinds of contamination, including chemical or radiation, as per section 45A of the Public Health (Control of Disease) Act 1984 as amended by the Health and Social Care Act 2008

[23] This is very similar to the principles set out in Health Services Guidance (93)56 on public health responsibilities of the NHS and the roles of others, which highlights the leadership role of the director of public health in a health authority and notes that he or she should "ensure that appropriate arrangements are in place for the control of communicable disease and of non-communicable environmental hazards and that the responsibilities of those involved are clearly defined in each case."

[24] See new section 73A(1)(d) of the NHS Act 2006, as inserted by section 30 of the Health and Social Care Act 2012

[25] Section 252A has been inserted by section 46 of the Health and Social Care Act 2012

[26] "Local authority" holds the definition as under section 2B of the National Health Service Act 2006 (as inserted by section 12 of the Health and Social Care Act 2012) means a county council in England; a district council in England, other than a council for a district in a county for which there is a county council; a London borough council; the Council of the Isles of Scilly; the Common Council of the City of London.

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Appendix 2

Health Protection Committee
Peterborough City Council

Terms of Reference

1. BACKGROUND

1.1 Peterborough City Council (PCC), through the Director of Public Health (DPH), has statutory responsibilities to advise on and promote local health protection plans across agencies, which complements the statutory responsibilities of Public Health England, NHS England, the Cambridgeshire and Peterborough CCG, and Peterborough City Council.

1.2 The services that fall within Health Protection include, but are not limited to:

- communicable diseases
- infection control
- antenatal/newborn and adult screening
- immunisation and vaccine-preventable diseases
- sexual health
- environmental hazards

1.3 It is important that there is publicly available information that demonstrates that statutory responsibilities for health protection have been fulfilled; to have the means to seek assurance of this; and to have processes in place to address and escalate any issues that may arise.

1.4 To facilitate information sharing and planning across agencies, the DPH has established the Peterborough Health Protection Committee (PHPC). In addition to this Committee, "Task and Finish" groups may be convened, taking into account the reduced staff resources overall in the system and therefore ensuring that maximum efficiency is achieved.

1.5 The DPH will develop an annual health protection report to the Health & Wellbeing Board (HWB) which would provide a summary of relevant activity. This report would cover the multi-agency health protection plans in place which establish how the various responsibilities are discharged and identify their relationship to the Joint Strategic Needs Assessment and Health and Wellbeing Strategy priorities. Any other reports would be provided on an ad hoc basis where a significant incident, outbreak or concern had arisen.

2. ROLE OF THE HEALTH PROTECTION COMMITTEE

2.1 The aim of the Health Protection Committee is to provide assurance to the Director of Public Health and Peterborough Health & Wellbeing Board that there are safe and effective mechanisms in place to protect the health of the population of Peterborough.

2.2 To provide a forum for information sharing and planning between public agencies that have responsibilities in Peterborough for health protection as defined in 1.2.

2.3 To receive reports from member agencies that enable monitoring of these arrangements and reporting of any issues or incidents.

2.4 To provide a mechanism to consider the implications of national guidance/changes for local implementation and be assured that there are mechanisms in place for their delivery.

2.5 To identify:

- Gaps and issues which need resolution by one or more of the member agencies
- Procedures/processes which need to be developed or improved
- The actions that need to be taken jointly by member agencies
- Gaps and resources needed by the Committee to function effectively, e.g. missing data or information

2.6 To support the production of an annual health protection report for submission to the HWB

2.7 Public health emergency planning responsibility is shared between the Local Health Resilience Partnership (LHRP), which is co-chaired by the NHS England Area Team Director of Operations and the Cambridgeshire DPH and the Local Resilience Form (LRF). The Director of Public Health will report health protection emergency planning issues to the LHRP on a regular basis.

2.8 The Committee has an advisory role. The minutes of the Committee meetings will be circulated for information to the Health & Wellbeing Board.

3. Membership

- Director of Public Health (Peterborough City Council)
- Consultant in Public Health Medicine (Peterborough City Council)
- Public Health England Anglia & Essex Centre (CCDC)
- Cambridgeshire and Peterborough CCG (rep for HCAI)
- Public Health England Anglia & Essex Centre (Screening & Immunisation coordinator)
- Acute Trust (Infection Prevention & Control/Microbiology)
- Principle Environmental Health Officer (Peterborough City Council)
- Strategic Housing Manager (Peterborough City Council)
- Sexual Health Commissioner (Peterborough City Council)
- Adult Social Care Representative (Peterborough City Council)
- Children's Services Representative (Peterborough City Council)
- Other members to be invited as the agenda requires.

The Board will be chaired by the Director of Public Health or the Consultant in Public Health Medicine.

4. Reporting

4.1 The PHPC will support the DPH in the production of an annual report to the Peterborough HWB

4.2 The DPH, on behalf of the PHPC, will report any significant issues for health sector resilience to the LHRP.

5. Meeting Frequency

Bi-monthly

Date: 12.12.2013

Norfolk, Suffolk and Cambridgeshire

Joint Communicable Disease Incident/Outbreak Management Plan

June 2014

DOCUMENT INFORMATION	
Title	Joint Communicable Disease Incident/Outbreak Management Plan
Lead author	Dr Bernadette Nazareth Consultant in Communicable Disease Control
Contributors	Input to its development/comments on the plan were received from the following: Norfolk, Suffolk and Cambridgeshire and Peterborough LHRPs Cambridgeshire CC: Liz Robin (DPH); Linda Sheridan (Consultant in PH), Pat Harding (Corporate Director); Chris Lloyd (EHP, Hunts DC) Kate King and Hamid Mahgoub (Anglia HPT) NHS England East Anglia Area Team: Tracy Dowling (Director of Operations & Delivery), Shylaja Thomas (Consultant Lead for Screening and Immunisation) Cambridgeshire and Peterborough and Suffolk EHPs Lynn Rodrigues (C&P CCG) Sara Fletcher (DIPC, Norfolk and Suffolk NHS Foundation Trust) Barry Wroe (Head of Resilience and Information Governance, Cambs Community Services) Mike Gooch (EPR Manager, Suffolk CCGs) Suffolk CC: Tessa Lindfield (DPH), Mary Orhewere (Consultant in PH) AHVLA: Anthony Greenleaves and Charlotte Featherstone
Approved by	Local Health Resilience Partnerships
Distribution	Clinical Commissioning Groups Directors of Public Health Directors of Infection Prevention and Control Health Protection Team Local Health Resilience Partnerships Local Health Protection Committees/Groups Local Food Liaison Groups NHS & Public Health Microbiologists NHS England Area Team (via LHRP Chair) NHS Trust IPCCs Unitary Authority/County Council Public Health Specialists Unitary/City/District Council Environmental Health Practitioners Water Companies

DOCUMENT HISTORY		
Date	**Version**	**Reason for update**
Dec 2013	1.0	New draft plan for consultation following public health reorganisation
Jun 2014	2.0	Final plan incorporating comments following consultation

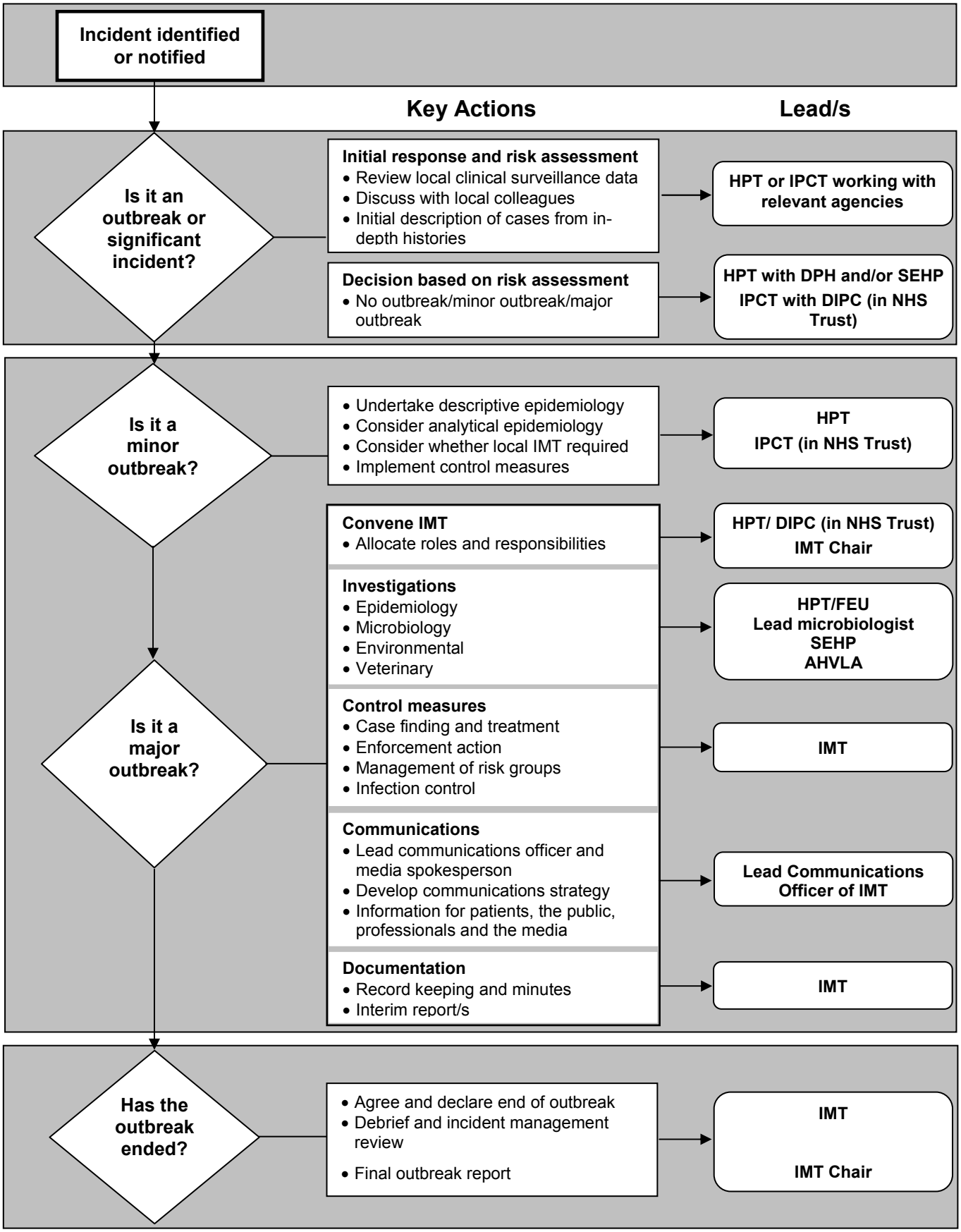
DOCUMENT REVIEW PLAN	
Lead responsibility	Dr Bernadette Nazareth Consultant in Communicable Disease Control
Next review date	January 2015

CONTENTS

ABBREVIATIONS

AHVLA	Animal Health and Veterinary Laboratories Agency
CCDC	Consultant in Communicable Disease Control
CCG	Clinical Commissioning Group
DEFRA	Department for the Environment, Food and Rural Affairs
DH	Department of Health
DIPC	Director of Infection Prevention and Control
DPH	Director of Public Health
DVM	Divisional Veterinary Manager (now ROD)
EH	Environmental Health
EHP	Environmental Health Practitioner
EHD	Environmental Health Department
EPRR	Emergency Preparedness, Resilience and Response
FEU	Field Epidemiology Unit
GP	General Practitioner
HBV	Hepatitis B Virus
HPT	Health Protection Team
HSE	Health and Safety Executive
IPCD	Infection Prevention and Control Doctor
IPCN	Infection Prevention and Control Nurse
IPCT	Infection Prevention and Control Team
IMT	Incident Management Team
LA	Local Authority
MIP	Major Incident Plan
MMR	Measles, Mumps, Rubella
NHS	National Health Service
PHE	Public Health England
ROD	Regional Operations Director (AHVLA)
SEHP	Senior Environmental Health Practitioner
STAC	Scientific and Technical Advisory Cell
TB	Tuberculosis
VIO	Veterinary Investigation Officer
WHO	World Health Organisation

INCIDENT MANAGEMENT FLOWCHART



1. INTRODUCTION

1.1 Following the implementation of the Health and Social Care Act 2012 which resulted in the reorganisation of health services on 1 April 2013, responsibility for health protection is shared between a number of organisations.

1.2 This document provides a framework for partnership working across the new public health structures including the Public Health England Centre (PHEC) local health protection team (HPT), local authority (LA) public health directorates and local authority environmental health departments (EHDs), Clinical Commissioning Groups (CCGs), NHS England and other relevant bodies. Appendix 1 provides an overview of roles and responsibilities of key organisations.

1.3 It constitutes a joint plan to manage an outbreak or significant incident of communicable disease/infection or contamination in Norfolk, Suffolk, Cambridgeshire and Peterborough.

2. AIM AND SCOPE OF THE PLAN

2.1 The purpose of this plan is to provide a structured framework within which outbreaks and significant incidents of communicable disease and infection are effectively investigated, brought under control and where possible measures taken to prevent similar outbreaks in the future. It does not cover surveillance or the routine management of individual cases of communicable diseases.

2.2 ***The term 'outbreak', used throughout this document, refers to both outbreaks and significant incidents of communicable disease and infection (see also Section 4.2). All communicable diseases and infections, defined as illnesses caused by microbiological agents including bacteria, viruses, fungi and parasites, are covered within the scope of this plan.***

2.3 Clarity over roles and responsibilities in managing outbreaks is essential. This plan enables a coordinated approach to be taken in the management of an outbreak and covers key roles and responsibilities, management and organisational aspects, communication, investigation and control procedures.

2.4 The majority of outbreaks will be caused by an enteric organism or have an environmental component. These outbreaks will require significant involvement from LA EHDs.

2.5 Incidents or outbreaks in Health and Safety Executive (HSE) enforced premises may also need HSE involvement.

2.6 The Animal Health and Veterinary Laboratories Agency (AHVLA) will be involved in the event of an outbreak of a zoonotic disease. Their role is outlined in Appendix 2.

2.7 If water supplies are implicated in an incident (e.g. contamination) or outbreak (e.g. cryptosporidiosis), the membership of the Incident Management Team (IMT) will include water company representatives. Representatives should include an officer able to make key executive decisions on behalf of the water company. This plan is also in accordance with the recommendations of the Badenoch Report on *Cryptosporidium in Water Supplies*. Further guidance is provided in Appendix 3.

2.8 Outbreaks and incidents of unusual illnesses might have any one of a number of causes in addition to infectious causes, including chemical, nutritional, radiological or even hysterical. Biological agents may be released deliberately. This document provides a framework for the initial management of these incidents, although as soon as suspicion of such an incident is raised, reference should be made to specific guidance (see Appendix 4).

2.9 Outbreaks may occur within the community or within institutions, or a combination. Outbreaks confined to specific NHS Trust premises, whether acute or community, will be managed by the relevant NHS Trust in accordance with their operational plans with the support of other professionals or organisations as needed e.g. CCDC, HPT. However, the principles within this plan apply to any identified outbreak.

3. PLANNING AND PREPAREDNESS

3.1 This plan will be reviewed at least once every two years or in the light of new guidance, changes in infrastructure or changes in practice following an incident.

3.2 The plan will need to be tested (by an exercise or management of an actual outbreak) at regular intervals (at least once every two years).

3.3 It is the responsibility of each constituent organisation to identify their key staff and their training needs and ensure that they are trained to a level that will enable them to execute this plan. This will include participation in training exercises (or an actual outbreak) at least once every two years.

3.4 Where constituent organisations have Major Incident Plans, this plan should be incorporated as an appendix to the Major Incident Plan.

3.5 Specific national guidance and plans are available for a range of situations, including avian influenza, influenza, blood-borne viruses, meningococcal disease, sexually transmitted disease, tuberculosis (TB) and zoonotic diseases. Where relevant, this plan should be augmented by the specific guidance available.

3.6 A useful resource is the PHE *Communicable Disease Outbreak Management Operational Guidance* available at www.phe.gov.uk.

4. ALERTING MECHANISMS AND TRIGGERS

4.1 Recognition of an Outbreak

4.1.1 Outbreaks may emerge in one of two ways:

- Acute outbreaks – which lead to a sudden increase in numbers of cases; often associated with a point source.
- Persisting outbreaks – which develop over a number of days and weeks; often involving a disease in which person to person spread is common (with or without an initial point source).

4.1.2 Each partner organisation has its own procedures for surveillance, detection and control. The occurrence of an outbreak may sometimes be extremely obvious. This will occur if a specific group or event is involved. However, if patients are cared for by different general practitioners (GPs) or admitted to several hospitals, awareness of the extent and severity of an outbreak may be slow to emerge.

4.1.3 Outbreaks/significant incidents of infection may be identified from the following sources:

- Statutory notifications and routine surveillance
- Laboratory services
- Informal reports from GPs and hospital clinicians
- Residential establishments

- Members of the public e.g. complaints are frequently received by EH services.
- LAs
- PHE Field Epidemiology Unit (FEU)
- PHE Colindale
- Water companies

4.2 Incidents and Outbreaks

4.2.1 The difference between an incident and an outbreak is a matter of judgement; either scenario might be handled in a similar way and either might demand significant resources.

4.2.2 Broadly, an outbreak, incident or adverse health event due to a CD or infection can be defined as follows:

- An incident in which two or more people experiencing a similar illness are linked in time/place[1]
- A greater than expected rate of infection compared with the usual background rate for the place and time where the outbreak has occurred
- A single case for certain rare, highly infectious and/or pathogenic diseases such as diphtheria, botulism, rabies, viral haemorrhagic fever or polio
- Exposure of a group of people to a person with a particularly serious infection such as open tuberculosis in a schoolteacher
- A zoonotic disease in animals/birds with the potential for significant human disease due to exposure of a group of people
- In some circumstances, a suspected, anticipated or actual incident involving microbiological or chemical contamination of food, water or the general environment may lead to activation of outbreak plans
- Malpractice or maladministration of infection related healthcare, e.g. discovery that immunisations have been incorrectly given or vaccine incorrectly stored.

4.3 Minor Outbreak

4.3.1 A minor outbreak is one that can normally be investigated and controlled within the resources of the local teams, the HPT, LA EHDs, Infection Prevention and Control Teams (IPCTs) and the appropriate microbiology laboratories. In a minor outbreak, a formal Incident/Outbreak Management Team (IMT) may not be convened but investigation and management of the outbreak will be in accordance with the principles (as for a major outbreak) outlined in this plan and will require close collaboration and communication between relevant parties with face-to-face meetings as necessary. Individual roles and responsibilities will be agreed at the outset.

4.3.2 Where set up, the IMT will function at a tactical/operational level.

Examples of Minor Outbreaks

- A small cluster of suspected measles cases in a school with good uptake of MMR.
- A suspected outbreak of food poisoning in the employees of a small firm.
- An outbreak of norovirus infection confined to a care home or hospital ward.

[1] This is an accepted definition. However, for more minor illnesses, two cases would not be considered an outbreak

4.4 Major Outbreak

4.4.1 A major outbreak is one that extends beyond an immediate locality, requires specialist expertise or is beyond locally available resources.

4.4.2 A major outbreak may be declared in the following circumstances:

- A large number of people, or multiple cohorts of people, are affected and may include residents from beyond the local HPT area.
- There is reason to believe the outbreak or incident is part of a larger problem.
- A minor outbreak but where there is evidence the situation is rapidly worsening.
- A vulnerable population at risk (e.g. immuno-compromised patients, an outbreak in a premature baby unit.
- The organism involved is highly pathogenic (e.g. toxigenic diphtheria, viral haemorrhagic fevers, etc).
- Significant maladministration of vaccines.
- Contamination of blood products.
- There have been one or more unexpected deaths that may be attributable to infectious disease *and* others are expected (ie the death(s) was not considered to be entirely due to another non-infectious cause and there is potential for further deaths).
- A hospital outbreak:
  - with immediate or continuing risk to public health outside the hospital;
  - with large numbers of cases within a short interval (e.g. >20 cases within one week);
  - requiring closure of wards or units;
- There is potential for transmission to large numbers of people (e.g. widespread distribution of food product, public water supply or point source affecting large numbers).
- Where very specialist expertise is required because of a rare or unusual nature of the outbreak.
- There is some plausible indication that the events are or may be due to deliberate release.

Examples of Major Outbreaks/Significant Incidents

- A community outbreak of Legionnaires' disease.
- Accidental biological contamination of a distributed water supply.
- An infectious hepatitis B virus (HBV) positive health care worker who has practised extensively, performing exposure prone procedures.
- A serious imported infection, e.g. viral haemorrhagic fever affecting a hospital by nosocomial transmission or significant exposure of staff.
- A meningococcal outbreak resulting in substantial morbidity and some mortality.
- A large number of individuals subject to maladministration of vaccines.

4.4.3 An IMT will be set up (see Section 5.3 and Appendix 5). The IMT will usually function at a strategic/tactical level covering both health service and public health aspects. Operational groups may also be set up to deal with particular aspects of outbreak management, e.g. undertaking mass vaccination.

4.4.4 An incident control room, which may be located at HPT or LA premises or (depending on the circumstances) within an NHS Trust may need to be established to manage the situation.

4.5 Cross-boundary/Regional Outbreaks

4.5.1 Where outbreaks cross administrative boundaries, the decision about who is leading needs to be agreed quickly by those involved. It is essential that NHS Trusts collaborate fully in this process, as appropriate.

4.5.2 The following will need to be considered in relation to the lead role:

- The area where most cases have occurred.
- The area where any function or event associated with the outbreak occurred.
- The area where the wholesaler or retailer is located.

4.5.3 In most circumstances it will be appropriate to convene a single IMT, with IMT members drawn from the HPT, NHS Trust and LA most affected (and relevant officers from other affected districts involved in meetings and decision taking, as necessary). In others a Joint IMT, with representatives from the involved HPTs, NHS Trusts and LAs, may be the best way forward, with local teams actioning decisions taken at the joint IMT.

4.5.4 Each organisation will make available at the request of the joint IMT, the necessary resources to effectively investigate and control the outbreak. It is inevitable in a cross boundary outbreak that relevant information may need to be released to a neighbouring authority/agency. Information will be released on a "need to know" basis. All authorities and agencies will ensure confidentiality of information obtained during cross boundary outbreaks.

4.6 Major Incident Status

4.6.1 On occasion, outbreaks may be of such importance or magnitude that there are significant implications for routine services and the additional resources required. At such time that a major outbreak is affecting large numbers of the population, consuming increasing health care resources and stretching the local capacity to deal with clinical, professional and media demands, the IMT may decide that a major public health incident/ health services emergency needs to be declared. In these circumstances, the IMT will alert the appropriate local agencies to consider declaring a Major Incident and bringing local major incident plans into effect.

4.6.2 On declaration of a Major Incident, the IMT will reconstitute itself, or be incorporated, into a Scientific and Technical Advisory Cell (STAC). In doing so, the IMT will need to ensure that the key roles and responsibilities (Appendix 6) continue to be fulfilled via the major incident groups that are set up and that operational groups implementing, for instance, epidemiological investigation or mass treatment, are incorporated into the major incident response structures. The STAC itself is a strategic group that advises the Strategic Command Group that is set up in a Major Incident.

5. INCIDENT/OUTBREAK RESPONSE

5.1 Initial Response and Risk Assessment

5.1.1 When the cases are first identified and the need to investigate an outbreak arises, the common link may already be obvious, e.g. if they are already known to have been guests at the same function. When this is not apparent, the first step will be to make an initial description of the cases, consider whether affected patients are suffering from the same illness and if there is any evidence of an association between them.

Initial Investigation: key objectives

- To identify whether a problem exists.
- To determine the nature and extent of the problem.
- To decide what immediate steps need to be taken to:
  - identify those who are ill;
  - ensure patients receive appropriate care;
  - identify those at risk;
  - control the source;
  - contain the infection.
- To identify whether the episode is of sufficient significance to require special arrangements for investigation and management.

5.1.2 Immediate control measures should be implemented as necessary and initial investigation to clarify the nature of the outbreak should begin within 24 hours of receiving the initial alert/ report. The following steps should be undertaken to establish key facts and inform the decision to declare an outbreak:

- Confirm the validity of the initial information upon which the potential outbreak is based (e.g. the possibility of ascertainment bias, laboratory false positives etc.
- Consider what the tentative diagnosis is and whether all the cases have the same diagnosis.
- Conduct preliminary interviews with cases to gather basic information including any common factors.
- Collect relevant clinical and/or environmental specimens.
- Form preliminary hypotheses.
- Carry out an initial risk assessment to guide the decision-making process.
- Consider the likelihood of a continuing risk to public health.

5.1.3 All activities conducted as part of an outbreak should be underpinned by a comprehensive risk assessment which includes consideration of factors such as disease severity and spread, possible interventions, and the context in which the case/incident has occurred. Risk assessments should be regularly reviewed throughout the outbreak investigation.

5.1.4 If the investigating team feel that the outbreak or incident is genuine, this is the trigger for declaring an outbreak and moving onto the next phase of investigating the outbreak.

5.1.5 Alternatively, there may be insufficient evidence to confirm an outbreak although suspicion may remain. It is then necessary to collect further evidence before the occurrence of an outbreak can be excluded.

5.2 Declaring an Incident/Outbreak

5.2.1 The responsibility for declaring an outbreak and its classification as minor or major will vary depending on the circumstances of the incident as follows:

Incident Site	Responsible Officers
NHS Trust premises	Infection Control Doctor (ICD)/Director of Infection Prevention and Control (DIPC)/On-call Director
General community/non-NHS premises	CCDC/DPH with Consultant Microbiologist and/or SEHP

5.2.3 A systematic approach to the investigation and control of an outbreak is required. A schematic overview is shown at the beginning of this plan. The purpose of systematic investigation is to provide timely and reliable information on which to base sound decisions about the management of the outbreak.

5.2.4 Legal proceedings may need to be considered as part of the management of the outbreak. However, the objective in outbreak management is to protect public health by identifying the source and implementing control measures to prevent further spread or recurrence of the infection. Any data collection required for criminal proceedings should not compromise the public health investigation.

5.3 Incident Management Team (see Appendix 5)

5.3.1 As a guide, an IMT should be considered when one or more of these conditions apply:

- The disease poses an **immediate health hazard** to the local population
- There are a **significant number** of cases
- The disease is **important**, in terms of its severity and/or its capacity to spread
- Cases have occurred in a **high-risk establishment**, e.g. schools, hotels, hospitals, care homes, guesthouses and food premises.

5.3.2 ***The remit of the IMT***

The remit of the IMT is to agree and coordinate the activities of the agencies involved in the investigation and control of the outbreak in order that the aetiology, vehicle and source of the outbreak are identified and control measures implemented as soon as possible and, if required, legal advice sought.

The roles and responsibilities in the management of an outbreak are provided at Appendix 6. Roles and responsibilities should be assigned to members of the IMT at its first meeting. In terms of carrying out their functions, individual members will remain managerially and professionally accountable to their employing organisations. The employing authority will remain liable for their actions unless they have been formally placed at the disposal of the other organisation e.g. using section 112 of the Local Government Act 1972.

5.3.3 ***The authority of the IMT***

The IMT will act on behalf of one of the key organisations involved in the outbreak; this may be the NHS Trust, the PHE or the LA. The purpose of the investigation, and following on from this, the lead organisation, should be agreed and recorded at the first meeting. The lead organisation will have overall accountability for the management of the outbreak and the ownership of the data generated by it. All other involved organisations will work with the lead organisation in the management of the outbreak.

It is important to note that in a number of situations LAs and other agencies, e.g. the HSE (Health and Safety Executive), DEFRA (Department for the Environment, Food and Rural Affairs), have an enforcement role which is outwith the responsibility of the IMT. However, there should still be a common purpose in the management of the incident or outbreak, agreed within the IMT.

5.4 Management of Individual Cases

5.4.1 The management of individual cases is the responsibility of their GP or clinician. Public health action in relation to individual cases (e.g. exclusion from work, the identification of contacts, infection control advice, etc) will be undertaken by investigating officers, based on appropriate advice. Investigating officers may include EHPs (for instance in food poisoning cases) or health protection/infection control staff (for instance in TB cases). As relevant, GPs, clinicians, investigating officers, etc will need clear advice from the IMT.

5.5 Public Health Investigations

5.5.1 The key objective of public health investigations is to provide reliable information on which decisions can be based to manage the incident or outbreak. It is essential that a logical approach be taken, using reliable and robust methodologies. The use of epidemiological methods should be based on advice from local health protection teams or specialists as required. The CCDC and/or the IPCD (hospital infections) or the IMT (if one is convened) should agree how the initial investigation is to proceed. In general investigations are likely to cover epidemiological and microbiological (human and environmental) aspects, but on occasions other areas will be investigated, e.g. veterinary investigations, for a zoonosis.

5.5.2 Epidemiological investigation (See Appendix 7)

Basic descriptive epidemiology is essential and should be reviewed at each IMT meeting. In some outbreaks descriptive epidemiology might be sufficient to take action. It is also crucial for generating a hypothesis as to the source of the infection. If at all possible, the patients affected should be interviewed to obtain a detailed history of the illness and of possible sources of the infection to identify factors that are common to some or all the cases. Establishing a preliminary case definition is also important.

Conducting an analytical study should be considered early in the investigation. The purpose of an analytical study is to confirm a hypothesis regarding the source of infection or mechanism of spread in order to take action to protect public health. An analytical study should only be undertaken if there is a hypothesis to test.

A realistic timescale for undertaking and completing epidemiological investigations needs to agreed and communicated to all relevant parties.

Epidemiological investigation is led by the PHE HPT.

5.5.3 ***Microbiological investigation***

Involves the appropriate microbiological analysis of samples from human cases, contacts, food, water, the environment and animals to identify the causative organism and its likely origin.

Microbiological investigation is the responsibility of the relevant NHS Trust Consultant Microbiologist/Virologist and the PHE Microbiology Service. A lead microbiologist on the IMT will coordinate the microbiological investigations.

5.5.4 ***Environmental investigation***

In some circumstances it may be appropriate to investigate the environment in a case of infection/communicable disease e.g. food-borne infection or Legionnaires' disease. This is undertaken to highlight possible vehicles of infection and modes of transmission including examination of food handling practices, review of premises and personal hygiene, scrutiny of procedural documentation and critical records and tracing all risk foods back to source (as appropriate).

Environmental investigation is led by the LA EHD.

5.5.5 ***Veterinary investigation***

If appropriate; see Appendix 2.

Veterinary investigation is led by the AHVLA.

5.6 Control Measures

5.6.1 The basic principles of communicable disease outbreak control are to:

- control the source (may be animal, human or environmental)
- control the mode of spread
- protect persons at risk
- monitor control measures.

Control measures are based on an assessment of the risk and may be directed at the source or the vehicle or both. Measures will depend on the mode of spread and the particular circumstances of the outbreak. Control may also include offering protection to persons at risk (e.g. giving immunoglobulin to those exposed to infection during an outbreak of hepatitis A).

Continued monitoring, both of the control measures and to identify any further cases of illness associated with the outbreak, is essential to ensure that the measures are working.

5.6.2 ***Responsibilities for control measures***

It is the responsibility of the IMT to:

- ensure adequate control measures are identified, implemented, and monitored to ensure their effectiveness and to confirm that no potential continuing sources of infection exist
- make recommendations on chemo/immuno-prophylaxis as necessary
- be responsible for general health advice relevant to the outbreak.

It is the responsibility of the HP/IC Medical Consultant/Nurse Specialist to:

- ensure that the IMT receive adequate information in order to take decisions regarding preventive actions
- make recommendations on isolation, exclusion and segregation of infected persons as necessary.

It is the responsibility of the NHS Trusts to:

- ensure the availability of adequate resources and staff as required for the control of the outbreak, e.g. the assistance of community staff, delivery of mass vaccination and prophylaxis
- take measures to control the spread of infection in Trust premises.

It is the responsibility of the Senior EHP to:

- take measures recommended under public health law, acting, when indicated, on the advice of the Proper Officer
- take action in relation to the relevant Food Safety Act (and relevant regulations and EU Directives)
- coordinate action in relation to the disinfection, removal or treatment of known or suspected environmental sources of infection.

It is the responsibility of the HSE/LA to:

- take action in relation to the Health and Safety at Work Act (and relevant regulations and EU Directives).

5.7 Communications

5.7.1 The IMT will identify a lead communications officer and a media spokesperson. A communications strategy will be developed by the communications officer and agreed at the outset by the IMT. This should cover all relevant communications, including communication to staff involved in the outbreak, health and local authority staff, the public and the media. The lead communications officer will link with relevant organisational and national press offices as necessary.

5.7.2 During an incident the IMT will decide on:

- the information to be made available to the press and public – there are advantages in providing a daily update for the press at an agreed time and for the production of media briefing notes
- the timing and methods (including use of social media) by which such information should be released
- whether to establish a telephone helpline for those affected/the public (Appendix 8).

5.7.3 In reaching decisions on these issues, the IMT should be alert to the importance of providing early and clear information on the nature and scale of the problem and on the action recommended, if any, and of updating this information regularly.

5.8 Documentation

5.8.1 Detailed recording of all aspects of the outbreak and its management must be undertaken. Legal action may ensue and this should always be borne in mind. All documentation, including computer-generated information relating to the outbreak must be retained and regular back-ups of electronically stored information made.

5.8.2 Detailed minutes will be taken at every meeting. The minutes will document all decisions taken, actions agreed and responsible individuals. The minutes will remain confidential.

5.8.3 A nominated person will be responsible for documentation of all the events and information related to the outbreak plan. All correspondence and minutes of meetings should be filed together in chronological order.

5.8.4 An initial report will be completed after the preliminary inquiry if possible within 48 hrs and a final report at the end of the investigation (section 6.3 and Appendix 9).

5.8.5 IMT members should keep personal logs of their activities including details of information received, conversations held and meetings attended.

5.9 Confidentiality

5.9.1 Individual clinical/food histories should be treated as medical records and managed with the same degree of confidentiality, according to Caldicott principles. Personal medical information should generally not be divulged without permission.

5.9.2 All members and co-opted members of the IMT should be fully appraised of the requirement for confidentiality.

5.9.3 Information given or obtained for one purpose should not be used for a different purpose without the consent of the provider of the information. All data, including computer-held data, are covered by the Data Protection Act 1998. Information on manual records may be subject to the Access to Health Records Act 1990.

5.9.4 The fact that the name of an ill person is already known to others and the media is no reason to breach confidentiality. General information on a need to know basis, which will not identify a person, can be provided to others.

5.9.5 The IMT may disclose information about a person in certain circumstances to prevent serious risk to public health or the health of other individuals. Each disclosure is considered on its merit after consultation with relevant people.

6. END OF OURBREAK

6.1 Outbreak Conclusion

The IMT will decide when the outbreak is over and that there is no longer a risk to public health.

Outbreak Conclusion

Issues for consideration:

- There is no longer a risk to the public health that requires further investigation or management of control measures by an IMT.
- The number of cases has declined.
- The probable source has been identified and withdrawn.

6.2 A debriefing meeting of the IMT should be convened to review the management of the outbreak, consider the lessons learned and any further preventive action required. The audit tool (Appendix 10) may be used to review the management of the outbreak.

6.3 Outbreak Report

6.3.1 The chair of the IMT will ensure the production and distribution of interim and final reports, with contributions from IMT members as relevant. Appendix 9 provides a suggested structure for the report. The nature of the outbreak, the investigations undertaken and the intended audience will influence the final format.

Purpose of Final Outbreak Report

- Record of the management of the outbreak.
- Presentation of investigative methods, control measures.
- Document for action to highlight any learning and changes required to outbreak plans.

6.3.2 In writing the report, confidentiality aspects (patients, clients, businesses, etc), media issues and legal disclosure need to be borne in mind (see Appendix 9).

6.3.2 The final report should be suitable for publication and be circulated as appropriate following agreement by the IMT. The aim should be to agree a final report within six weeks of the end of the outbreak investigation, but this may not always be possible. It should be submitted to the appropriate committees of the lead organisation as the formal route into the public domain and, as relevant, the appropriate committees of other involved organisations. In some cases, it may be necessary to delay or limit the publication of the report pending legal action.

ROLES AND RESPONSIBILITIES OF ORGANISATIONS

Public Health England

PHE is an executive agency of the Department of Health. Under the Health and Social Care Act 2012 the Secretary of State has a duty to protect the health of the population and carry out activities as described in the Health Protection Agency Act 2004. In practice these functions are carried out by PHE.

PHE delivers a specialist health protection service, including the response to incidents and outbreaks, through Health Protection Teams (HPTs), which sit within PHE Centres (PHECs). Local HPTs investigate and manage outbreaks of communicable disease, provide surveillance of communicable diseases and infections and support local authorities (including port health authorities) in their responsibilities under the Public Health (Control of Disease) Act 1984 and associated regulations. Local HPTs are staffed by Consultants in Communicable Disease Control (CsCDC)/ Consultants in Health Protection (CHP), nurses, health protection practitioners and other staff with specialist health protection skills and access to expert advice.

The Screening and Immunisation Team includes public health specialists employed by PHE and embedded in NHS England Area Teams. It is led by a Consultant in Screening and Immunisation, supported by Screening and Immunisation Managers and Coordinators. Depending on the nature of the outbreak, input from Screening and Immunisation Leads (SILs) may be required.

PHE Colindale

The Centre for Infectious Disease Surveillance and Control (CIDSC) Colindale is responsible for the collection and collation of data on outbreaks of communicable disease and is involved in prevention and control at a national level in England. Where appropriate, CIDSC Colindale can provide experts to assist in local outbreak investigations or, in the case of outbreaks with a national distribution, its experts may themselves design and carry out outbreak investigations.

The Microbiology Services comprise the reference laboratories at Colindale (which assist in the identification and investigation of outbreaks by subtyping isolates) and the Regional Microbiology Network (RMN). The RMN includes the Food, Water and Environment (FW&E) laboratories and also has Regional Microbiologists who manage or commission regional public health microbiology services (including food, water and environmental microbiology). PHE's regional laboratories undertake specialist tests and provide support for NHS microbiology laboratories. In addition, the reference laboratory at Porton deals with special pathogens.

PHE Field Epidemiology Services

The Field Epidemiology Service (FES) was created to improve the consistency of high quality epidemiological investigations including those in response to outbreaks and incidents. FES is a nationally co-ordinated but geographically dispersed service with Consultant Epidemiologists, specialising in the epidemiology of communicable disease and in the application of epidemiological methods, supported by scientists and analysts. Each PHE Centre has a nominated link FES consultant. FES supports the investigation of outbreaks/incidents, including providing on-site support where needed and would be contacted in all significant incidents.

Director of Public Health

Following the implementation of the Health and Social Care Act 2012 which resulted in the reorganisation of health services on 1 April 2013, responsibility for health protection is shared between a number of organisations. As part of the reorganisation DsPH moved to LAs, and the overarching responsibility for the health of the population served by each LA rests with that authority and is carried by the DPH. A key feature of this responsibility is that for the majority of services the DPH has this accountability with no managerial responsibility. The DPH must therefore be assured on behalf of the LA they serve that all health sector organisations in their local area have adequate plans in place to meet the health protection needs of the population in any circumstance.

The DPH is responsible for the LA's contribution to health protection matters, including the LA's roles in planning for and responding to incidents that present a threat to the public's health.

DPH and PHEC roles are complementary; both are needed to provide an effective response and they should act together as a single public health system. This means that there must be early and ongoing communication between the PHEC and DPH about emerging health protection issues and to agree the nature of response required.

Local Resilience Forums (LRF) and Local Health Resilience Partnerships (LHRP)

Local Resilience Forums (LRF) are existing multi-agency partnerships which bring together senior representatives of emergency services, LA partners, NHS bodies and other responders. The purpose of the LRF is to prepare for and respond to emergencies as part of national coordination arrangements and enable and build local resilience capability through planning and testing. There are currently 39 LRFs that map directly on to police areas. The LRF facilitates preparedness at a local level but does not have an operational role.

The Local Health Resilience partnership (LHRP) is a strategic forum for organisations in the local health sector which facilitates health sector preparedness and planning for emergencies at LRF geographic level. It supports the health representatives on the LRF in their role to represent health sector Emergency Preparedness, Resilience and Response (EPRR) matters.

NHS England

NHS England is the overarching organisation that has responsibility for ensuring that health care is commissioned for the population of England. It is a single organisation with representation at national, regional and local level. The national team is based in Leeds and London, the regional team, which mirrors the PHE geography, covers the Midlands and East of England with an office base in Cambridge. The East Anglia Area Team covers Norfolk, Suffolk and Cambridgeshire, with an office base in Cambridge.

NHS England's responsibilities include:

- Allocation of resources to CCGs
- Supporting, developing and assuring the commissioning system
- Planning for civil emergencies and making sure the NHS is resilient
- Directly commissioning some health services including primary care, some public health services and specialised health services
- Developing commissioning support

The principal areas of health protection responsibility are:

- Commissioning Immunisation and Screening services led by a PHE team embedded with the NHS England Area Team
- Providing NHS leadership for Health Emergency Preparedness, Resilience and Response (EPRR) at local, regional and national level
- Overseeing the commissioning role of CCGs and supporting commissioner development.

Clinical Commissioning Groups

CCGs have been formally established under the Health and Social Care Act 2012 as clinically led groups that include all GP practices in their geographical area and are responsible for commissioning health services for the population they serve. The services they commission include:

- Elective hospital care
- Urgent and emergency care
- Most community health services
- Mental health and learning disability services

The principal areas in which CCGs impact health protection are:

- Commissioning health services for the population they serve including services to prevent and manage communicable diseases
- Responsibility for ensuring the quality of the care they commission including issues such as prevention of healthcare associated infection
- Responsibility for ensuring the resilience of the health services they commission, with 24/7 responsibility to deal with resilience issues and ensuring robust business continuity plans are in place.

Providers of NHS Funded Health Services

These include NHS trusts and organisations that deliver acute health services, mental health services, pre-hospital services such as ambulance trusts and community health services. In addition to NHS trusts and organisations, NHS commissioners may commission services from providers in the third sector such as voluntary organisations and social enterprises as well as providers in the private sector. All NHS funded health care must meet the standards set down by the commissioning organisations and by NHS England which includes standards for patient safety and health protection.

Following implementation of the Health and Social Care Act 2012, NHS England issued core standards for EPRR for all NHS organisation and providers of NHS funded care. All organisations are required to meet the requirements of the Civil Contingencies Act 2004. This includes having a 24/7 response capability for emergencies.

Local Authorities (Environmental Health Departments)

Key health protection responsibilities include:

- Environmental health – including dealing with contaminated land.
- Community safety
- Air quality - statutory duty under the Environment Act 1995 to manage Local Air Quality which involves monitoring and identifying areas where nationally prescribed objectives are at risk.
- Occupational Health and safety – LA EHPs inspect workplaces and respond to notifications of injury, disease and dangerous occurrences.
- Legionella – investigation of cases/outbreaks and potential sources.
- Food safety - EHPs inspect food businesses and investigate food incidents and outbreaks of food-borne illness.

LAs and port health authorities play a key role in managing outbreaks of foodborne illness. The Food Safety Act (1990) and the Food Hygiene Regulations (2006), or their equivalent in devolved administrations, place responsibilities and powers of control with LAs. LAs have powers to assist both investigation and control of outbreaks, including powers of entry, sampling powers and powers to exclude food handlers, seize and detain food and close premises.

The specific statutory responsibilities, duties and powers significant in the handling of an outbreak of communicable disease are set out in the following legislation:

- Public Health (Control of Disease) Act 1984
- Health Protection (Notification) Regulations 2010
- Health Protection (Local Authority Powers) Regulations 2010
- Health Protection (Part 2A Orders) Regulations 2010
- Health and Safety at work (Etc) Act 1974
- Food Safety Act 1990
- Food Safety and Hygiene Regulations 2013 (in place December 2013)
- Food Law Code Of Practice (England)
- International Health Regulations 2005
- Public Health (Ships) Regulations 1979
- Public Health (Aircraft) Regulations 1979

Food Standards Agency

The Food Standards Agency (FSA) is a UK-wide non-ministerial Government department, established under the Food Standards Act 1999 with responsibility for the protection of public health in relation to food. This is issued under section 20 of the Act, which confers powers to issue guidance upon the FSA.

LA EHDs have a responsibility under Codes of Practice (Food Law Code of Practice 2006 section 1.7.6) to inform FSA of all national or serious localised outbreaks. The FSA Incidents Branch is the point of contact for LAs in relation to outbreaks and incidents. Where relevant, the FSA will assist in the investigation of foodborne outbreaks and lead on any food chain analysis and action that may be required for implicated foods.

Where investigations implicate a food distributed in the UK the FSA will carry out a risk assessment and work with LAs to advise the food business operator (FBO) on steps that ought to be taken in relation to the affected product(s). These steps may include the withdrawal or recall of food pursuant to EC General Food Law Regulation 178/2002, which prohibits food being placed on the market if it is unsafe (i.e. it is either injurious to health or unfit for human consumption). Under this EC regulation FBOs are also required to notify the competent authorities (i.e. both the FSA and relevant LA) where they consider or have reason to believe that food is not in compliance with food safety requirements.

Animal Health and Veterinary Laboratories Agency

In April 2011, the Veterinary Laboratories Agency merged with Animal Health to form the Animal Health and Veterinary Laboratories Agency (AHVLA). AHVLA is funded by Defra to give assistance to outbreak control teams as appropriate where a direct or indirect animal source is implicated in outbreaks of enteric (or other zoonotic) illness and where veterinary investigation (including collection of appropriate animal samples) or intervention could help reduce risks to the public. Veterinary involvement may be initiated centrally by Defra or locally following contact between the CCDC or the LA and the local AHVLA regional laboratory.

ZOONOTIC DISEASES* - ROLE OF THE AHVLA

The Animal Health and Veterinary Laboratories Agency (AHVLA) is an Agency of the Department for the Environment, Food and Rural Affairs (Defra).

- Under the Animal Health Act 1981, the Regional Operations Director (ROD)[1] from the Animal Health Service is responsible for dealing with incidents of notifiable disease of animals, including those which are or may be zoonotic (e.g. anthrax, brucellosis, tuberculosis, rabies etc). The ROD will apply the relevant legal restrictions and institute the necessary control measures.

- In cases of notifiable diseases which are, or may be, zoonotic the ROD will notify the local HPTs and will provide advice when requested.

- However, in the case of salmonella incidents, a Veterinary Investigation Officer (VIO)[2] from the AHVLA, as Nominated Officer for the purposes of the Zoonoses Order 1989, will normally notify the EHD and CCDC by sending a copy of the Statutory Incident Report Form (Form ZO2) or by other agreed means. When it is considered necessary, initial notification may be by telephone. The VIO is able to provide the farmer and private veterinary surgeon with advice regarding control of infection on the farm and preventing its spread to the environment and other premises. The VIO is also able to advise the EHO or CCDC.

- Cases of non-notifiable diseases of animals which are or may be zoonotic will normally come first to the attention of the local VIO, usually as the result of the examination of clinical material submitted to a Veterinary Surveillance Centre by a private veterinary surgeon on behalf of a client (e.g. isolation of zoonotic pathogens from milk from a dairy animal). In such cases an assessment will be made of the zoonotic risk and if considered appropriate the VIO will discuss the incident with the relevant CCDC after consulting the owner and their veterinary surgeon.

- If the CCDC is aware of a non-notifiable disease (e.g. VTEC O157, cryptosporidium, *Coxiella burnetti*) which poses a potential zoonotic risk and requests assistance, the VIO will be prepared to undertake investigations in support of the local health enquiries. Veterinary Investigation Officers are empowered to enter premises and carry out investigations into zoonotic incidents in accordance with the Zoonoses (Monitoring) (England) Regulations (2007).

- The VIO or ROD will provide the CCDC with advice regarding animal aspects of zoonotic disease when requested. This will take account of their own specific role with respect to notifiable diseases and the non-statutory zoonoses and confidential aspects of their relationships with veterinary surgeons and their clients with respect to non-notifiable diseases.

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* Guidelines for the investigation of zoonotic diseases in England and Wales are available on the HPA website http://www.hpa.org.uk/infections/topics_az/zoonoses

[1] The DVM has been replaced by the Regional Operations Director (ROD). The South East region covers Norfolk, Suffolk, Cambridgeshire, Hertfordshire, Bedfordshire, London, Essex, Kent, East & West Sussex, Surrey, Hants and Isle of Wight, Oxfordshire, Buckinghamshire and Berkshire. Contact is via its Bury St Edmunds location – ask to speak to the Duty Vet.

[2] The VIO AHVLA is co-located at Bury St Edmunds and is the Nominated Officer (Zoonoses Order 1989) for Cambridgeshire, Suffolk, Norfolk, Bedfordshire, Hertfordshire, Essex and parts of Greater London.

CRYPTOSPORIDIUM AND WATER SUPPLIES

Person-to-person spread is the most significant route of transmission of cryptosporidiosis. Waterborne transmission is uncommon, but has the potential for infecting a large number of people. Since 2000, water companies are required to carry out risk assessments to establish if there is a significant risk of cryptosporidial oocysts getting into treated water. In this case, the water companies must ensure that water leaving the treatment works is continuously sampled and analysed daily for cryptosporidial oocysts. The average number of cryptosporidial oocysts in water leaving treatment works must be less than 1 per 10L of water.

1. Surveillance and Alerting Mechanisms

Alerting information may arise from the HPT, local microbiologist, EHP, or the water company:

- HPT, local microbiologist or EHP identify an increase in the number of cases.
- Water company reports an operational event or incident likely to result in a significant risk.
- Cryptosporidial oocysts are detected during routine monitoring.

Water companies have contingency plans to address suspected or known water contamination incidents and should also have clear mechanisms for alerting and communicating with relevant organisations including the LA, local HPT, emergency services and Drinking Water Inspectorate (DWI). Effective and timely communication is important to ensure that in the event of a potential contamination incident relevant water sources are identified. Informal discussion of potential problems, including consideration of immediate control measures, is encouraged at an early stage of any potential incident.

Most of the time no additional measures are required as the water company takes appropriate remedial actions as soon as a fault is identified.

2. Health Risk Assessment

The following should be considered:

- When and where the sample was taken
- The number of oocysts detected per 10L and the results of any viability testing
- The source and treatment of the affected water supply (groundwater/surface water; full chemical treatment/filtration only/no filtration)
- The distribution area of the water supply and size of population supplied
- Whether any problems with the supply, such as treatment failure or high turbidity, have been identified
- Whether there have been any recent changes in the source and/or treatment
- How fast water travels through the distribution area (is it likely that any of the contaminated water is still in the distribution system?)
- The history of cryptosporidium sampling for this supply and whether there have been similar detections in the past

The actual risk to health from cryptosporidium in water supplies is probably related to the count, the species or type, whether the oocysts are alive or dead, and the level of immunity in the exposed population. The following factors provide an indication of an increased risk of a subsequent outbreak:

- A history of waterborne outbreaks associated with the same source
- High oocyst counts in consecutive samples
- Other evidence of treatment failure
- A relatively high turbidity in treated water for that supply
- A groundwater source
- Demonstration of oocyst viability

Where there is an increase in the number of cases, the water company will be asked to make an initial assessment of the geographical distribution of the cases in the light of the water supply distribution.

3. Incident Response

3.1 Protecting the health of the population – consider:

- What remediation/decontamination is taking place and what is the time frame?
- Need for a boil water notice (may be issued if health risk assessment indicates a continuing risk to health that outweighs the risks of a boil water notice).
- Need for alternative water supplies.

3.2 Possible action

Having been informed about the detection of cryptosporidial oocysts in drinking water and having completed a health risk assessment, the options available include:

- Taking no additional measures.
- Releasing advice to special groups.
- Enhancing surveillance for human cases.
- Requesting the water company to provide an alternative source of water.
- Issuing advice to boil water (if advice to boil water is issued there should be a clear understanding at the outset about the criteria necessary for it to be removed).

Consider whether a Major Outbreak needs to be declared and an IMT formed at a suitable location.

3.2.1 Alerting key people

- Check all affected drinking water consumers have been informed (boil water notice), including food and drink manufacturers who may be using the water.
- Consider informing the FSA if there is a threat to food.
- Consider alerting GPs, local hospitals, and neighbouring CsCDC, and ensure “at risk” groups are identified and alerted, particularly people using home renal dialysis.
- Consider alerting emergency services to potential of casualties, and in the case of the fire service, possible contaminated water from fire hydrants and possible need for removal of the contaminant.

3.2.2 Enhanced surveillance

- Via GPs.
- Via laboratories (for microbiological contamination).
- Consider requesting analyses of biological samples on sentinel cases and others exposed where symptoms are reported.
- Consider carrying out a questionnaire survey of all those exposed to identify any health effects.

4. Recovery

In deciding whether to stand down the incident and declare the end of the outbreak the following should be considered:

- Does the drinking water quality now meet regulatory drinking water standards?
- Has the area been adequately decontaminated?
- Have drinking water mains and domestic water pipes, tanks and plumbing fittings been adequately decontaminated?
- If permanent new water mains have been installed, have these been verified to be uncontaminated?
- Have those affected been informed of the end of the incident?

DELIBERATE RELEASE

These notes are based on Department of Health (DH) guidelines *Deliberate Release of Biological and Chemical Agents: Guidance to help plan the health service response* available on the DH website (http://www.doh.gov.uk/epcu/index.htm). Should a deliberate release be suspected, members of the IMT are advised to check the website to ensure that their actions meet the latest requirements.

1. General Considerations

An outbreak of communicable disease could be the result of a deliberate release of infectious organisms or toxin. A warning may be given, or the release could be covert. It is important that the possibility of a deliberate release is considered by those involved in surveillance or investigation of cases.

Possible clues to a covert deliberate release include:

- A cluster of unusual infection or a single case with no history of travel to endemic areas.
- Unusual presentations (such as higher than expected case fatality rate or a failure of the disease to respond to conventional treatment).
- Unusually high numbers of cases in a geographical area suggesting windborne infection from a point source.
- Laboratory identifies an unusual, genetically engineered or antiquated strain of agent from cases.
- Death or illness occurs among animals as well as people.

2. Principles for Responding to a Deliberate Release

The management of an incident involving deliberate release has the same objectives as the management of any outbreak but there will be important differences:

- The Police have the lead role in co-ordinating the overall response to the incident.
- It will be a highly political event conducted and reviewed under intense scrutiny.
- There will be high levels of public concern and media interest.
- There may be many more cases than in a “normal” outbreak, stretching resources for treating cases and investigating the cause. The incident is likely to escalate rapidly to major incident status.

If a deliberate release is suspected, the police must be informed. The police will take advice from national groups as to whether the threat is credible and proceed or not on the basis of that advice.

If it is felt that a deliberate release could have occurred, a Scientific and Technical Advisory Cell (STAC) will need to be set up (see section 4.6).

INCIDENT MANAGEMENT TEAM

1. Terms of Reference of IMT

The IMT must agree its terms of reference at the first meeting. Suggested terms of reference are listed below:

- To agree the purpose of the investigation and the lead organisation[1] with accountability for the management of the outbreak and ownership of the data.
- To agree membership and chair of the IMT and assign specific responsibilities to named individual members of the team.
- To identify any additional expert assistance that may be required.
- To determine the necessary commitment of personnel and resources including the establishment of an incident control room.
- To meet regularly during the outbreak and ensure a written record of each meeting.
- To investigate the source and cause of the outbreak.
- To recommend measures necessary to control the outbreak.
- To monitor the implementation and effectiveness of control measures.
- To ensure arrangements for communication with patients and the public, general practitioners, media, staff, other health and local authority services.
- To determine and declare the end of the outbreak, based on ongoing risk assessment.
- To evaluate the overall experience of controlling the outbreak, and implement the lessons learnt.
- To ensure the production of a comprehensive outbreak management report.

[1] Some principles for agreeing lead organisation:

- For outbreaks confined to NHS Trust premises, this will be the relevant NHS Trust
- For outbreaks not confined to NHS Trust premises and involving food/waterborne disease, the lead organisation will be the relevant district/city council or unitary authority.
- For other outbreaks, this will depend on the nature and circumstances of the outbreak, for instance, in the event of an avian influenza incident, the PHE will lead on the human health consequences of the incident.
- Where significant health service input is required in an incident, e.g. a meningococcal disease outbreak requiring large scale prophylaxis, the PHE HPT will take the overall lead, with NHS England leading the NHS response.
- Where there is lack of clarity and pending the first IMT, the PHE HPT will take the initial lead.

2. Membership of IMT

2.1 The core members of the IMT will, depending on the circumstances, include:

- CCDC/HPT member
- Infection Control Doctor/Nurse Specialist
- Director of Public Health (or nominated deputy)
- Senior Environmental Health Practitioner
- NHS lead – usually from NHS England, or delegated to the CCG. In an outbreak confined to one NHS Trust, this could be the Trust Senior Manager/DIPC
- Senior Clinical Microbiologist/Virologist, as necessary
- Communications Officer
- Nominated secretary

Depending on the size and nature of the outbreak, other members may be co-opted as necessary from a wide range of agencies, but need not all be accorded full member status.

2.2 Members are required to declare any possible conflicts of interest as individuals or on behalf of their organisations. Any declarations of a conflict of interest should be recorded and a decision made by the chair on that individual's status e.g. whether they are to remain on the IMT, whether they attend for specific sections of the meetings, etc.

3. Arrangements for the IMT

Full secretarial services to support the IMT will usually be provided by the lead organisation. Operational groups may need to be set up to implement particular aspects of the response e.g. epidemiological investigation, mass treatment, helpline, etc.

4. Outline IMT Agenda (possible headings – amend as appropriate)

1. Introductions and apologies

2. Purpose of meeting

3. Terms of Reference and Membership (for first meeting)
   - Agree Terms of Reference, including lead accountable organisation and chair
   - Review membership of group and allocate roles
   - Discuss confidentiality issues (if relevant)

4. Minutes of previous meeting (for subsequent meetings)

5. Review of evidence
   - Epidemiological
   - Microbiological
   - Environmental and food chain

6. Current risk assessment

7. Control measures

8. Further investigations
   - Epidemiological
   - Microbiological
   - Environmental and food chain

9. Communications
   - Lead communications officer and media spokesperson
   - Information for professionals
   - Information for the public
   - Media
   - Others

10. Agreed actions (identify responsible persons and timescales)

11. Any other business

12. Date of next meeting

5. Checklist of Matters to be Considered

5.1 Medical/nursing care of patients

- Advice to GPs, district nurses, health visitors and other primary health care staff
- Liaison with hospital clinicians who may be involved in out-patient or in-patient investigation and treatment of cases
- Additional medical and nursing staff/redeployment
- Supplies, including disposables, drugs, laundry, etc.

5.2 Investigating the source of outbreak

- Identifying the cause and extent of the problem
- Gathering data and instituting an epidemiological study
- Preparation and distribution of questionnaires
- Specimens and samples – collection, transport, laboratory examinations and reporting mechanisms.

5.3 Control measures

- Special nursing procedures
- Special cleaning/disinfection procedures
- Screening patients, staff and other contacts
- Restrictions on
    - visiting
    - continued employment (exclusions)
    - attendance at school
- Advice to employers
- Enforcement action in relation to food premises
- Immunisation
- Prophylactic medication

5.4 Monitoring

- Incidence of cases and links between cases
- Effectiveness of control measures

5.5 Communications

- With patients, relatives and the public:
    - What to tell them
    - Who will communicate
    - Method of communication, e.g. telephone helpline
- With staff:
    - Anxieties over susceptibility
    - Advice on personal protection
    - Advice for their relatives
- With other Agencies: e.g.
    - CCGs, Community and Mental Health Trusts and GPs
    - Acute NHS Trusts (including A&E)
    - Neighbouring HPTs and LAs
    - NHS England Area Team
    - Water Companies
- With the media:
    - Agreed statement
    - Reactive or proactive
    - Media briefing

CORE IMT ROLES AND RESPONSIBILITIES

Chair of the IMT/Incident Lead

To be agreed at the first meeting. Could be drawn from: DPH, DIPC, CCDC, IPCD, SEHP, etc.

- Ensure membership is appropriate and that IMT members have assigned roles and responsibilities.
- Direct and coordinate the overall management of the outbreak.
- Ensure effective and timely communications with IMT members and with other parties including professionals, public and media.
- Ensure that a full and accurate record is kept of all meetings of the IMT.
- Ensure that a comprehensive outbreak report with recommendations is produced.

Health Protection/Infection Control Specialist/s

This role may be fulfilled, for instance, by the CCDC or IPCD. Where this individual is also chairing the IMT and leading on the overall management, the roles asterisked below may be assigned to an investigation coordinator.

- Be a member of/chair the IMT as appropriate.
- *Present to the IMT relevant information relating to the outbreak in a timely fashion.
- Provide advice and guidance on the epidemiological aspects of the investigation and control of the outbreak.
- *Be responsible for coordinating work on the investigation and control of the outbreak.
- Lead or direct the epidemiological investigation and data analysis.
- Lead on or direct the development of investigative tools, such as standardised investigation forms (because of the wide range of organisms covered by this plan, it is not feasible to append a template investigation form).
- *Ensure arrangements for the collection of necessary information from all suspect cases, contacts and other relevant parties, e.g. controls.
- *Provide advice and support to investigating officers and community staff assisting in the management of the outbreak.
- *Assist in regular briefing of all staff involved in the outbreak.
- Assist with media and other relations if required.

Director of Public Health

- Overall executive responsibility for reviewing the health of the population including the surveillance, prevention and control of communicable diseases and infections
- Represent County Council/Unitary Authority public health on the IMT either in person or through a deputy.
- Work with NHS England and CCGs to ensure that appropriate resources are available to support the investigation and control of to ensure that budgetary or contractual issues will not delay a necessary response. This includes human, financial and other resources[2].
- Ensure 24-hour LA PH emergency management availability
- Inform LA elected members and senior management as appropriate

[2] The general principle will be that provider organisations will deliver the required actions within existing resources where feasible. When the scale of the incident is such that additional capacity needs to be commissioned, the costs will fall to the organisation which would normally commission the service – e.g. NHS England for vaccinations, CCG for lab tests or prescribing, County Council/Unitary Authority for sexually transmitted infection services.

Lead Clinical Microbiologist/Virologist

This role may be fulfilled by an NHS or PHE microbiologist.

- Be a member of the IMT as appropriate.
- Provide advice and guidance on the microbiological aspects of the investigation and control of the outbreak.
- Provide support for field investigation officers.
- Participate as necessary in the inspection of premises and collection of samples.
- Ensure the provision of a full microbiology service (including virology and serology) for the investigation of outbreaks.
- Ensure laboratory tests are undertaken appropriately and promptly.
- Interpret results of microbiological analyses and ensure that results are reported promptly to the relevant personnel.
- Ensure that specimens are referred and transported promptly to appropriate specialist services (e.g. PHE laboratory services) as required.
- Assist the IMT and clinical colleagues with treatment and prophylaxis protocols.

NHS England Senior Manager

When appropriate. This role may be fulfilled by the on call Senior Manager or Director.

- Represent NHS England on the IMT.
- Ensure 24-hour emergency management availability.
- Ensure the availability of adequate NHS resources and staff as required for the investigation and control of the outbreak[3] e.g. funding of vaccinations
- Ensure that hospital trusts are alerted and able to cope with a potential influx of patients.
- Liaise with other local CCGs as appropriate.
- Assist with media and other relations if required.

CCG Senior Manager

When appropriate. This role may be fulfilled by the Medical Director/Chief Nursing Officer/Senior Medical or Nursing Operations lead.

- Represent the CCG on the IMT.
- Support NHS England to co-ordinate the community care response as required.
- Ensure 24-hour emergency management availability.
- Work with NHS England to ensure availability of adequate resources and staff as required for the investigation and control of the outbreak e.g. the assistance of community staff [3].
- Support NHS England in liaising with other CCGs as appropriate.
- Assist with media and other relations if required.

NHS Trust Chief Executive/Senior Manager

This role may be fulfilled by the DIPC, Medical/ Clinical/ Operations Director or Director of Nursing.

- Ensure clinical services are available for diagnosis and treatment of cases and contacts.
- Ensure their hospitals have adopted suitable admissions policies as appropriate, including the need to stop non-emergency admissions, and arrangements for patient isolation.
- Assess the need for ward closures and emptying to allow for increased numbers of admissions and potential staff illness.
- Ensure appropriate infection control measures are being implemented in the hospital.
- Co-operate with the requests of the IMT.
- Ensure all necessary resources are available to the IMT as appropriate.
- Maintain a written plan for the response to outbreaks of infection in the Trust.

[3] The general principle will be that provider organisations will deliver the required actions within existing resources where feasible. When the scale of the incident is such that additional capacity needs to be commissioned, the costs will fall to the organisation which would normally commission the service – e.g. NHS England for vaccinations.

Investigating Officers

This will usually be Environmental Health staff for outbreaks which have or may have an environmental component. In outbreaks which do not have an environmental component the IMT will identify appropriate personnel to undertake these tasks, e.g. HP nurses or PH registrars.

- Investigate each case and, where relevant, appropriate contacts and controls.
- Complete questionnaires as fully and accurately as possible and give all necessary advice and guidance to those being investigated.
- Return completed investigation forms promptly.
- Ensure suitable provision is made for collection of specimens and submission to the laboratory.
- Collect food/ samples as necessary or as requested by the IMT, taking account of chain of evidence issues and ensuring that all specimens are clearly labelled to facilitate easy and accurate collation of outbreak data.

Senior Environmental Health Practitioner

This will usually be a Senior EHP for outbreaks which have or may have an environmental component. NB: EHPs, Technical Officers and Food Safety Officers of LAs have specific responsibilities and powers in the investigation and management of water and food-borne infection.

- Be a member of/chair the IMT as appropriate.
- Make a control room available if needed.
- Provide adequate resources, including investigative staff.
- Make the necessary arrangements for enforcement actions e.g. exclusions, closures, serving of notices, etc.
- Ensure, where relevant, that the necessary inspections of premises is undertaken.
- Arrange, as appropriate, for environmental investigations ensuring that, where relevant, evidence is gathered by appropriately authorised officers in accordance with Police and Criminal Evidence Act (PACE) and other relevant legislation.
- Manage the disinfection, removal or treatment of known or suspected environmental sources of infection.
- Inform and consult with relevant bodies/agencies, (e.g. Food Standards Agency, Health & Safety Executive).
- Liaise with other departments of the LA and/or neighbouring LAs as appropriate.
- Keep elected members and LA senior management informed as necessary.

Lead Communications Officer

The designated lead media officer may be from any of the key organisations and will be agreed at the first meeting of the IMT.

- Develop a communications strategy.
- Ensure strategy covers all relevant communications, including communication to staff involved in the outbreak, health and local authority staff, the public and the media.
- Ensure strategy covers all relevant communication methods, e.g. social media.
- Liaise with the press officers of all the key organisations and coordinate the media response.
- Provide advice to the IMT on media relations.
- Help to prepare press releases and statements.
- Ensure such material is circulated appropriately.
- Organise press conferences and media briefings as appropriate.
- Be the initial point of contact for all media enquiries.

EPIDEMIOLOGICAL INVESTIGATION STEPS

Preliminary assessment: establish that a problem exists; confirm the diagnosis; formulate initial hypothesis	A report of an outbreak of infection may be mistaken. It may result from increased clinical or laboratory detection of cases, changes in reporting patterns, changes in the size of the 'at risk' population or false positive laboratory tests. • Review clinical case histories/arrange for laboratory tests as appropriate. • Discuss the interpretation of test results with the Consultant Microbiologist. • Take in-depth histories from a few/initial cases. • Formulate initial hypothesis on nature and origin of outbreak. It is vital, in order to institute control measures, that hypotheses as to the most likely sources of illness are considered. These hypotheses are generated from a careful weighing up of data collected from a small number of cases. It is preferable to collect these data by administering a detailed semi-structured questionnaire in a face-to-face interview (or if this is not possible, by telephone). This allows the interviewer to ask probing questions, which may sometimes uncover previously unsuspected associations between cases. Self-completion questionnaires are less helpful at this stage of an investigation. It may be necessary to re-interview early cases to ask about possible exposures that are reported by later cases.
Control measures	Control measures involve either controlling the source of infection, interrupting transmission or protecting those at risk. • Advise on appropriate precautions for cases and contacts including: investigation, screening and follow-up; isolation; hygiene; exclusion criteria. • Antibiotic prophylaxis; and immunisation. • Advise on organisational issues including catering practices, disinfection and waste disposal. Serve enforcement and/or food seizure notices if appropriate.
Case definition	Cases can be diagnosed either clinically or by laboratory investigations. At an early stage it is important to produce a clear, workable case definition (using person, time and place). This is particularly important with previously unrecognised diseases in which proper definitions are needed before epidemiological studies can proceed. • A simple definition of a "case" for the purpose of the outbreak should be formulated. • The initial case definition should be designed to include all those reasonably part of the outbreak. • Geographical, clinical and temporal parameters need to be defined and any exclusion criteria. • Cases can be subdivided into "confirmed" (on appropriate microbiological criteria) and "unconfirmed" (probable or possible). • Case definition may need to be revised if it becomes necessary in the light of new information, etc.

Case finding	In an episode of infection, the cases that are first noticed may only be a small proportion of the total population affected and may not be representative of that population. Efforts must be made to search for additional cases. This allows: • The extent of the incident to be quantified • A more accurate picture of the range of illness that people have experienced • Individual cases to be treated and control measures to be taken • Identification of subjects for further descriptive and analytical epidemiology
Case finding routes	• Statutory notifications of infectious disease • Requests for laboratory tests and reports of positive results • People attending their GPs, the local A&E department, hospital inpatients and outpatients • Reports from occupational health departments • Reports from schools of absenteeism and illness • Appeals through TV, radio and local newspapers • Screening tests applied to communities and population sub-groups
Descriptive epidemiology: generating a hypothesis	Basic descriptive epidemiology is essential. In some outbreaks descriptive epidemiology might be sufficient to take action. It is also crucial for generating a hypothesis as to the source of the infection. Cases are described by the three epidemiological parameters of time, place and person. *Person*: includes age, sex, occupation, clinical features, food history, travel/ leisure activity, attack rates. *Place:* cases occurring in closed communities (e.g. care homes); semi-closed communities (e.g. schools, nurseries); open communities (general population); community linked to a specific event. *Time:* involves plotting the epidemic curve, a frequency distribution of date or time of onset. The incubation period should be related to events that may have occurred in the environment of the cases and which may indicate possible sources of infection. This detailed epidemiological description of typical cases may well provide the investigators with a hypothesis regarding the source of infection or the route of transmission. A description of atypical cases may also be helpful. The investigation may end here.
Analytical study: testing the hypothesis	Finding that consumption of a particular food, visiting a particular place or being involved in a certain activity is occurring frequently among cases is only a first step. These risk factors may also be common among those who have not been ill. Confirmation of an association between a risk factor and disease may require further microbiological or environmental investigations or an analytical epidemiological study. This can be either a cohort study or a case control study; which design is used is dependent upon the nature of the outbreak.
Special studies: verifying the hypothesis	For instance, microbiological typing of isolates. The role of reference microbiology tests should be considered in helping define the cluster and links to potential sources, as should other sources of evidence such as food chain investigations.

TELEPHONE HELPLINE

The decision to set up a helpline will be taken by the IMT. Organisation and planning should be delegated to a subgroup. The purpose of the helpline must be explicitly defined; this may include:

- Provision of general information to members of the public who are anxious
- Identification of individuals at risk/contacts/cases.

Separate numbers may be published, e.g. one for cases and one for general public. Consideration should be given to using a Regional or National helpline (e.g. NHS 111). The needs of specific groups, e.g. ethnic minorities and the hearing impaired should also be considered.

The media can be used to publicise the helpline once a press statement has been released. Other switchboards that may be contacted by callers, e.g. neighbouring hospitals, health centres, etc should be briefed.

Helpline Information Pack

Good briefing notes and data collection forms for the helpline workers are essential, to provide consistent advice and to ensure completeness of any information collected. They should cover:

- Background to the incident
- Responses to expected questions
- Procedures for following up individuals identified as at risk, contacts or cases, with a failsafe dataflow system to keep track of such individuals
- Procedures for dealing with unexpected queries
- Guidelines on confidentiality/dealing with enquiries from the press
- Details of other resources available
- Procedures for dealing with threatening or obscene calls

Staffing

Ideally, sources of an appropriate number of potential helpline workers should be identified in advance, as part of the emergency planning process. They should have both appropriate knowledge of the subject and sufficient communications skills to deal with callers effectively and sympathetically, e.g. NHS 111.
All should receive a detailed briefing before the lines open, including background information, use of the equipment and completion of any forms.

Operation

The hours of operation will depend on the circumstances: 8am to 9 pm is usually adequate, though continuing till midnight may be appropriate. An answering machine with a recorded message giving the opening hours would be available overnight.

Four-hour shifts are standard practice, though some workers may feel able to do two shifts. A rota covering at least the first week should be arranged at the outset. A shift supervisor is needed for each shift to deal with administration and cover staff breaks.

The following data should be collected for monitoring the help line:

- Date and time of call
- Sex, age, postcode of caller
- Category of caller, e.g. general enquiry/potential case/contact

The IMT must keep the helpline staff fully aware of changes in the situation and a whiteboard in the helpline room can be used to display new information. In particular, action may be required to deal with anxiety raised by misleading press coverage. Debriefing allows information gathered during the shift to be shared and may clarify issues of concern.

Closure of the help line

The decision to close the helpline will depend on the number of incoming calls and the nature of the incident/outbreak. A formal debriefing session for all staff involved is valuable. A helpline report should be prepared for incorporation into the outbreak report.

OUTBREAK REPORT

1. Suggested Report Schedule

- ***Immediate statement***: summarising the available knowledge and key issues. Present at first IMT meeting and circulate as appropriate.
- ***Interim report/s*** as necessary: should be considered if outbreak investigation extends beyond two weeks.
- ***Final report***: the aim should be to agree a final report within six weeks of the end of the outbreak investigation.

2. Suggested Structure for Outbreak Report

The following is a list of suggested headings, which is not exhaustive. Each report should be tailored to the circumstances of the individual incident.

Executive Summary	Key features of the outbreak (who, what, where, when). Main conclusions and recommendations.
Introduction	The 'initial story': how the incident/outbreak was recognised; key events leading to the involvement of members of the investigative team and, where relevant, the formation of an IMT. Aims and objectives of the investigation.
Background	Background to the outbreak as relevant: • Background on organism, clinical features, morbidity, reservoirs, transmission • The setting • Population demographics, description of population at risk • Background rates of relevant infection
Investigations undertaken: methods and results	Epidemiology: -case definition and surveillance -descriptive epidemiology (including attack rates) -analytical study design and results. Environmental: -site visit (catering outlets, etc), health and safety inspection, specimens, results Microbiology: -cases, contacts, food, water, environmental Veterinary: -site visit, specimens, results
Control measures	• Co-ordination and management of outbreak • Action taken • Advice and control measures
Communications	• Communications strategy • Advice to the public, professionals and relevant agencies • Media issues
Discussion and Conclusions	Covering the investigation and control measures, justification of conclusions drawn and any other issues. Relevant information from other outbreaks.
Incident Management Review and Recommendations	Based on incident debrief. Review of the overall management, including any changes recommended to outbreak plan.
Appendices	Can include: • Chronology of events • IMT – terms of reference and membership • Maps, if appropriate • Letters and media statements, media coverage

Legal and Confidentiality Issues Related to Final Outbreak Reports

In recent years there has been an increase in the number of requests from solicitors for outbreak reports. In light of this there are a number of issues that should be considered by the IMT and authors when preparing the report.

To be considered by IMT and authors:

- Purpose of report and who it is for. If there will be lessons identified relating to the response of individual organisations to the outbreak, consideration should be given to including these in a separate report for internal circulation only.
- Ownership of the report. If multi-agency sign-off procedure, ownership of copyright and responsibility for formal disclosures needs to be agreed.
- Disclosure and publication. Clear arrangements for formal and informal disclosure are needed. Agreement is required regarding where the report will be published. It is normal good practice to allow those affected by the report see it in advance of publication
- The identification of individuals, organisations and business. If to be identified, consideration should be given to whether they are happy with this.
- Legal and reputational risks around the report. If these are high, consideration should be given to increasing the scrutiny of the report and getting a legal opinion before publication.
- Is further assurance through independent professional/expert scrutiny or peer review needed? Are the conclusions supported by evidence and would the conclusions and opinions stand up to independent scrutiny
- Clarify where the evidence came from and who acted on this evidence.

Legal considerations:

- Is legal advice required prior to signing off? This may be appropriate if it is known or suspected that the outbreak may be the subject of a civil or criminal prosecution, or if it is a high profile or high impact outbreak
- Does the report include: any material gained during the investigation which was NOT intended for disclosure/inclusion in a report (e.g. information from emails); which should be withheld or redacted (e.g. because it is personal, confidential or commercially sensitive) whether statements of fact or opinion; or that is defamatory?
- Has any material relevant to the subject of the document been omitted?
- Are there any active legal proceedings which could be affected by publication or disclosure of the report?
- Is there clarity about what can be disclosed, when and under what systems (eg, request from individual/solicitor; FOI or other statutory request)? Does any legislation preclude disclosure of any of the information in the report?

AUDIT TOOL FOR OUTBREAK MANAGEMENT

	Standard	
Outbreak Recognition	Initial investigation to clarify the nature of the outbreak begun within 24 hours	
	Immediate risk assessment undertaken and recorded following receipt of initial information	
Outbreak Declaration	Initial investigation undertaken and decision made regarding outbreak declaration and convening an IMT	
Incident Management Team	IMT held within three working days of decision to convene*	
	All agencies/disciplines involved in investigation and control represented at IMT meetings	
	Roles and responsibilities of IMT members agreed and recorded	
	Lead organisation with accountability for outbreak management agreed and recorded	
Outbreak Investigation and Control	Control measures documented with clear timescales for implementation and responsibility	
	Case definition agreed and recorded	
	Descriptive epidemiology undertaken and reviewed at IMT, hypothesis generated.	
	Analytical study considered and rationale for decision recorded	
	Investigation protocol prepared if an analytical study is undertaken	
Communications	Communications strategy agreed at first IMT meeting and reviewed throughout investigation	
End of Outbreak	Final outbreak report completed within 12 weeks of the formal closure of the outbreak	

* Dependant on the immediate risk assessment and this will determine the appropriate urgency according to the severity and potential risks of the illness concerned.

Peterborough City Council

Town Hall

Bridge Street

Peterborough

PE1 1HQ

DRAFT MEMORANDUM of UNDERSTANDING

BETWEEN

PETERBOROUGH CITY COUNCIL PUBLIC HEALTH

AND

PARTNER AGENCIES INCLUDING
PUBLIC HEALTH ENGLAND,
NHS ENGLAND,
CAMBRIDGESHIRE & PETERBOROUGH CLINICAL COMMISSIONING GROUP
AND
CAMBRIDGESHIRE COUNTY COUNCIL

SUBJECT: HEALTH PROTECTION GOVERNANCE

Glossary

AT	Area Team (part of NHS England)
CCC	Cambridgeshire County Council
CCA	Civil Contingencies Act 2004
CCDC	Consultant in Communicable Disease Control
CCG(s)	Clinical Commissioning Group(s)
CPLHRP	Cambridgeshire and Peterborough Local Health Resilience Partnership
DH	Department of Health
DPH	Director of Public Health
DsPH	Directors of Public Health
EHO	Environmental Health Officer
EPRR	Emergency Preparedness, Resilience and Response
GP	General Practitioner
HPN	Health Protection Nurse
HPT	Health Protection Team (part of Public Health England)
IMT	Incident Management Team
JHWS	Joint Health and Well-being Strategy
JSNA	Joint Strategic Needs Assessment
LGA	Local Government Association
LHRP	Local Health Resilience Partnership
LRF	Local Resilience Forum
MOU	Memorandum of Understanding
OIMT	Outbreak Incident Management Team
OOH	Out of Hours
NHS	National Health Service
NHSE	NHS England
PCC	Peterborough City Council
PHE	Public Health England

PARTICIPATING ORGANISATIONS

Peterborough City Council
Cambridgeshire County Council
NHS England East Anglia Area Team
Public Health England East Anglia & Essex Centre
Cambridgeshire & Peterborough Clinical Commissioning Group

1. Purpose

This Memorandum of Understanding (MOU) has been developed to provide agreement between partner organisations that are involved in health protection and surveillance and production of associated data. Following implementation of the Health and Social Care Act 2012 and consequent re-organisation of the health sector in April 2013, roles and responsibilities for health protection of the population are shared between a number of organisations. The Director of Public Health (DPH) is accountable to the Secretary of State for Health as well as to Peterborough City Council, Peterborough Health and Well-being Board and the Peterborough population for providing advice on health protection in the city. However the DPH has no managerial responsibility for other organisations that provide the services that deliver health protection. This MOU defines the organisational responsibilities to provide information needed to assure the DPH that population health is protected and to enable the DPH to provide appropriate advice.

2. Background – Protecting the health of the local population

The document: *Protecting the health of the local population: the new health protection duty of local authorities under the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013(DH, PHE, LGA: May 2013),* outlines the responsibilities that are the subject of the MOU and extracts are copied in below.

"The Secretary of State expects PHE, as an executive agency of the Department of Health, to cooperate with the NHS (NHS England, CCGs, commissioning support units and providers) and local authorities, and to support them in exercising their functions."

"NHS England and CCGs have a duty to cooperate with local authorities under the NHS Act 2006. This includes cooperating around health protection, including the sharing of plans."

"The Health and Social Care Act 2012 makes clear that both NHS England and CCGs are under a duty to obtain appropriate advice, including from the persons with a broad range of professional expertise in "the protection or improvement of public health". This includes the advice of local authorities, usually delivered through their director of public health. The leadership of the director of public health in this context is highlighted by local health resilience partnerships being co-chaired by a director of public health, ensuring their ability to scrutinise and be assured of the plans to respond to emergencies in communities they serve."

"Local co-operation agreements, memorandums of understanding and protocols between key partners are already in place and work well in some areas. These need to be revised and updated for the new system, given the new statutory responsibilities of Public Health England and Local Authorities described in this factsheet. The content of these agreements is for local determination, and local partners may wish to review or update their existing documents, taking into account core elements to local arrangements which experience suggests should be in place in every area (many of which are set out in regulation 8(7) of the section 6C Regulations) including:

- clearly defined roles and responsibilities for the key partners (comprising at least the local authority, PHE, NHS England, CCGs health and primary and secondary care NHS providers), including operational arrangements for releasing clinical resources (e.g. surge capacity from NHS-funded providers) with contact details for a key responsible officer and a deputy for each organisation.
- clear responsibilities in an outbreak or emergency response, including the handover arrangements

- information-sharing arrangements to ensure that PHE, the director public health and the NHS emergency lead are informed of all incidents and outbreaks.
- arrangements for managing cross- border incidents and outbreaks
- arrangements for exercising and testing, and peer review
- arrangements for stockpiling of essential medicines and supplies, as appropriate
- escalation protocols and arrangements for setting up incident/outbreak control teams
- arrangements for review (the Department of Health recommends this should take place at least annually)."
- local agreement on a 24/7 public health on-call rota of qualified personnel to discharge the functions of each relevant organisation

"Local authorities may wish to establish a local forum for health protection issues, chaired by DPH, to review plans and issues that need escalation. This forum could be linked to the HWB, if that makes sense locally."

"Ensuring that data can flow to the right people in the new system in a timely manner will be key to making the new arrangements work."

"The Public Health Outcomes Framework, published on 23 January 2012, contains a health protection domain. Within this domain there is a placeholder indicator, "Comprehensive, agreed inter-agency plans for responding to public health incidents".

3. **Roles and responsibilities of Directors of Public health in local government**
In October 2013, the Department of Health published 'Directors of Public Health in local government. Roles, responsibilities and context'. This document prepared by the Public health Policy and Strategy Unit, Department of Health provides guidance that 'is published under section 73A(7) of the NHS Act 2006 as guidance that local authorities must have regard to. It includes:

All DsPH should:

- be the person who elected members and senior officers look to for leadership, expertise and advice on a range of issues, from outbreaks of disease and emergency preparedness through to improving local people's health and access to health services;
- provide the public with expert, objective advice on health matters;
- work through Local Resilience Fora to ensure effective and tested plans are in place for the wider health sector to protect the local population from risks to its health;

4. Existing agreements ceased to be relevant following the re-organisation of the NHS and Public Health systems in April 2013. It is necessary to have new agreements and protocols in place that meets the needs of the organisations that are responsible for discharging health protection responsibilities after implementation of the Health and Social Care Act 2012. This document will fulfil this function.

5. The scope of this MOU includes:

- Organisational roles and responsibilities for health protection in Peterborough (outlined in Annex 1)
- The role of Peterborough Health Protection Committee (outlined in Annex 2)
- Arrangements for 24/7 on call for public health (local authority and PHE), CCG and NHS England for Cambridgeshire & Peterborough (outlined in Annex 3)
- Information sharing arrangements to ensure sharing of routine and ad hoc (outbreaks and incidents) data with the Director of Public Health, Peterborough City Council and between partner organisations (Table 1 below)

- Escalation and management arrangements for public health incidents (outlined in Annex 4)
- Arrangements for the management of cross-border incidents and outbreaks (see Annex 4)
- Arrangements for exercising and testing of plans for Cambridgeshire & Peterborough (annex 5 - extract from Cambridgeshire & Peterborough Local Health Resilience Partnership: Three Year Strategic Plan)
- Escalation protocols
- Arrangements for the review of this MOU

6. In order to provide local assurance on all aspects of health protection for Peterborough, Peterborough Health Protection Committee (PHPC) has been established, chaired by the DPH. Member organisations include Peterborough City Council, Public Health England, NHS England, Cambridgeshire & Peterborough Clinical Commissioning Group, and Cambridgeshire Community Services (see attached Terms of Reference in Annex 2). Representatives of these organisations and groups have been nominated and will be responsible for ensuring that regular and ad hoc reports and updates are provided to the PHPC on their areas of responsibility as outlined in the table below. These regular reports will provide the information from which an annual report on health protection will be produced by the DPH for the Peterborough Health and Wellbeing Board.

Partner organisations will provide routine updates to Peterborough Health Protection Committee to the frequency outlined in Table 1 (below).

Additionally it is expected that the Consultant in Public Health Medicine (CPHM) with responsibility for Health protection will be routinely included in the circulation of all relevant health protection, screening and emergency planning data and information, to enable that consultant to have oversight of health protection and to be able to identify any abnormal trends or issues.

Table 1

Subject	**Source of report**	**Frequency**
Immunisation coverage data for routine programmes	NHS England / PHE though the Screening and Immunisation Lead	Report to PHPC meetings that will: • highlight issues relevant to Peterborough as identified in analysis of the routine data; • DPH and Consultant lead for health protection will receive all routine data updates from PHE;
Immunisation – annual seasonal programmes (‘Flu) –	NHS England / PHE though the Screening and	• give an update on seasonal programme delivery in

coverage data and issues	Immunisation Lead	Peterborough; • report on any issues or incidents relevant to Peterborough
Immunisation – new programmes, incidents and other issues	NHS England / PHE though the Screening and Immunisation Lead	
Screening – uptake and performance data for all screening programmes	NHS England / PHE though the Screening and Immunisation Lead	Report to PHPC meetings that will: • highlight issues relevant to Peterborough as identified in analysis of the routine data; • DPH and CPHM with responsibility for Health Protection will receive all routine data updates from the screening and immunisations team (PHE based in NHS England); • report on any issues or incidents relevant to Peterborough
Screening – incidents, quality assurance issues or other issues such as planned procurement of screening services	NHS England / PHE though the Screening and Immunisation Lead	
Communicable diseases – general report on trends, outbreaks and emerging communicable disease risks	PHE Health Protection Team	Exception report to each meeting of PHPC with information on any trends, incidents or outbreaks relevant to Peterborough (nil return if applicable)
Communicable diseases and environmental hazards – update on reports and briefings	PHE Health Protection Team	Exception report to each meeting of PHPC with information on any incidents relevant to Peterborough (nil return if applicable)
Communicable disease and environmental issues	Environmental health officers through lead EHO member of the PHPC	Exception report to each meeting of PHPC with information on any incidents relevant to Peterborough (nil return if applicable)
Contaminated land remediation	Environmental health officers through lead EHO	Annual report.

	member of the PHPC	
Healthcare associated infections	CCG member of PHPC	Monthly data reported to CCG Governing Body ; Report with amalgamated data with benchmarking, issues of concern and poor performance to each meeting of PHPC Report by exception of work of the HCAI Steering Group on issues such as anti-microbial resistance
Tuberculosis	PHE Health Protection Team	Exception reports covering trends in TB prevalence and incidence including resistant strains of TB; and an outline of issues raised in TB network meetings and TB cohort reviews.
Sexual health – routine data on Sexually transmitted infections	PHE Field Epidemiology Team, through routine reporting to Peterborough City Council Public Health team	Quarterly
Sexual health – updates on services for sexual health and any related issues	Peterborough City Council and CCG	Ad hoc reports, but at least annual
Health emergency planning – routine information on health sector preparedness and resilience, including training and exercises	Local Health Resilience Partnership via DPH, supported by Consultant lead for health protection and Health Emergency Planning Officer	Quarterly to include updates on revision and approval of plans; audits of preparedness when undertaken; and updates on training and exercising within the health sector.
Health emergency planning – reports on incidents, planned events	DPH supported by PCC Consultant lead for health protection, the Health Emergency Planning Officer and PCC emergency planning team as appropriate	Exception reports to meetings of PHPC including information on any specific events that require planning across the health sector or with other partners

All reports should be written reports and provided at least one week prior to the PHPC meeting, unless they refer to a new or on-going incident, in which case a verbal update report may be accepted at the meeting,

Through these and other ad hoc reports, an Annual Health Protection Report will be developed to provide assurance to the Peterborough Health and Well-being Board on health protection matters.

7. In addition to commitment to the provision of reports and updates to ensure that the Committee has an overview of health protection issues in Peterborough, this MOU requires the support of all member organisations for the following:

- Communication according to a plan attached of all relevant information about outbreaks and incidents. Communication should follow an agreed escalation plan (Annex 6)
- The Civil Contingencies Act 2004 (CCA) requires all organisations to cooperate with partner agencies in planning for and response to major incidents – this includes the provision of support when reasonably requested by partner agencies. This MOU confirms an agreement by all signatory organisations to provide all necessary support in major incidents either directly or through commissioning the capacity to provide this support – e.g. staff and/or premises to provide a mass vaccination or immunisation programme in response to an incident. These requests may be initiated by the DPH or PHE and must be reasonable in terms of the level of support requested to adequately respond to the incident.
- For public health incidents, that do not constitute a major incident, the CCA does not apply. This MOU provides an opportunity to ensure that support is available from partner agencies in the event of a public health incident that is not a major incident as defined by the CCA. As outlined above, this MOU represents an agreement by all signatory organisations to provide the necessary support in public health incidents either directly or through commissioning the capacity to provide this support – e.g. staff and premises to provide a vaccination or immunisation programme in response to an incident. These requests should be initiated through the Incident Management Team, generally led by PHE and following a PHE risk assessment, and must be reasonable in terms of the level of support requested to adequately respond to the incident.
- Signature organisations agree that budgetary or contractual issues will not delay a necessary response, and issues identified will be resolved as part of the recovery from any incident. The general principle will be that provider organisations will deliver the required actions within existing resources where feasible. When the scale of the incident is such as additional capacity needs to be commissioned, the costs will fall with the organisation which would normally commission the service. (e.g. additional laboratory tests and antibiotic prescribing costs would normally fall to the CCG to commission, additional immunisation costs to NHS England, additional sexual health screening to the City Council).
- All signatory organisations agreed that all additional expenditure incurred as a result of the response to any incident shall be recorded.
- Any other dispute between partner agencies should not lead to a delay in response and will be addressed as part of the recovery phase of the incident.
- Where dispute resolution is not possible through direct discussion between partners it may be discussed initially at the Peterborough HPC, which may make a recommendation to the Chief Executives of the relevant organisations.

More detailed guidance is available in the working draft Norfolk, Suffolk and Cambridgeshire Joint Communicable Disease Outbreak Plan, and the 'Health Protection Pack for Local

Health Resilience Partnerships' which has been jointly agreed by the Local Government Association, Public Health England and NHS England.

8. In summary, signatory organisations are asked to make a commitment to the following, in line with detail in this MOU

   I. Commitment to active engagement in the Peterborough Health Protection Committee
   II. Provision of timely reports in writing to the DPH via the PHPC as outlined in 6 above
   III. Provision of ad hoc reports on incidents and other issues in writing or verbally to the PHPC
   IV. Contributing to the writing of an annual Health Protection Report to Peterborough Health and Wellbeing Board
   V. Support for the escalation arrangements for public health incidents and to communication using these arrangements
   VI. The provision of all necessary and reasonable support for the response to public health incidents
   VII. Support to the agreed Public Health on call arrangements, where relevant

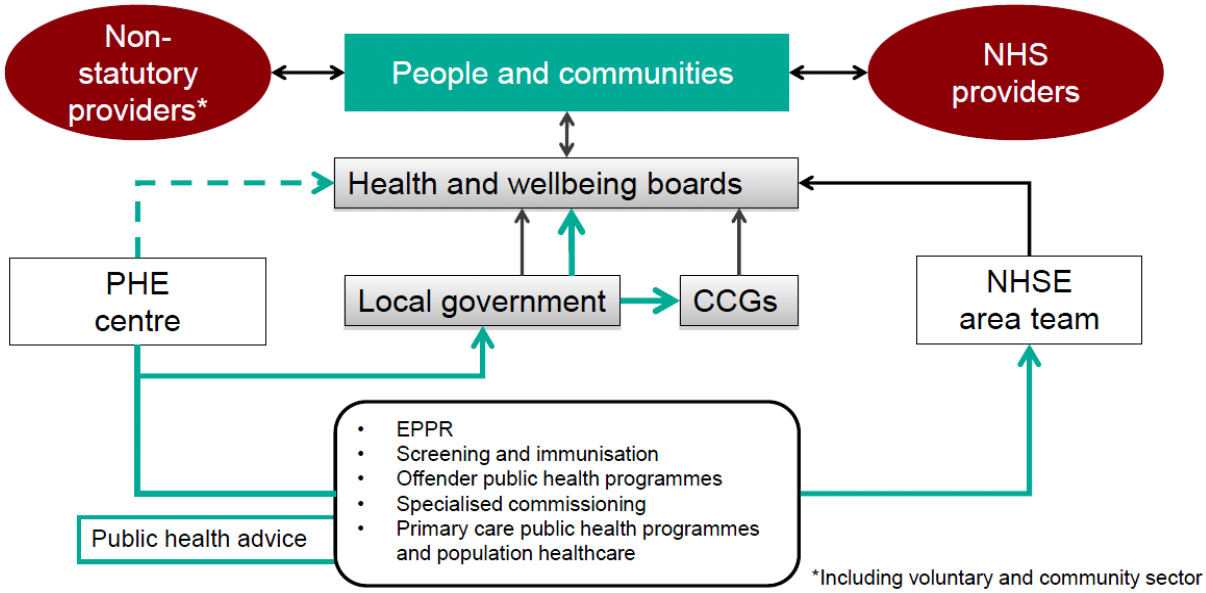
9. This MOU will be reviewed by 31 March 2015, and the MOU with any revisions will be submitted to all signatory organisations by 31 March 2015 for ratification

SIGNATURE:	SIGNATURE
DIRECTOR OF PUBLIC HEALTH	XXXXXXXX, XXXX XXXXXXX, XXXXXX
(Date)	(Date)

Annex 1

Organisational roles and responsibilities for health protection in Peterborough

Place-based approach to public health



1. Public Health England (PHE)

PHE is an executive agency of the Department of Health; it is a single organisation with representation at national, regional and local level and lists its responsibilities as:

- Making the public healthier by encouraging discussions, advising government and supporting action by local government, the NHS and other people and organisations
- Supporting the public so they can protect and improve their own health
- Protecting the nation's health through the national health protection service, and preparing for public health emergencies
- Sharing our information and expertise with local authorities, industry and the NHS, to help them make improvements in the public's health
- Researching, collecting and analysing data to improve our understanding of health and come up with answers to public health problems
- Reporting on improvements in the public's health so everyone can understand the challenge and the next steps
- Helping local authorities and the NHS to develop the public health system and its specialist workforce

For Peterborough, the main link with PHE will be through the Anglia and Essex PHE Centre, which covers Cambridgeshire, Peterborough, Norfolk, Suffolk and Essex. Regional links are with the Midlands & East Region, whose office base is in Birmingham and the national team and headquarters are based in London.

The principal areas of PHE health protection responsibility of concern to the DPH are:

- Specialist health protection services including proactive and reactive advice to local authorities, NHS commissioners and providers of NHS funded care, aimed at

preventing and appropriately responding to illness or incidents due to communicable and environmental hazards.
- Responsible, jointly with DsPH, for planning for and responding to public health emergencies at local level
- Specialist advice to health care providers on areas such as prevention and management of healthcare associated infection, management of TB and of blood borne viruses
- Providing advice to the public

.

2. Cambridgeshire & Peterborough Clinical Commissioning Group (CCG)

CCGs have been formally established under the Health and Social Care Act 2012 as clinically led groups that include all GP practices in their geographical area and are responsible for commissioning health services for the population they serve. The services they commission include:

- Elective hospital care
- Urgent and emergency care
- Most community health services
- Mental health and learning disability services

The Cambridgeshire and Peterborough CCG covers a geographic area that includes Cambridgeshire, Peterborough and two small areas in Hertfordshire and Northamptonshire. The CCG is therefore responsible for commissioning services, as outlined above for the population of Cambridgeshire and Peterborough. Many of these services impact on health protection and also must respond in the event of any incident that threatens the health of the population.

The principal areas in which CCGs impact health protection are:

- Commissioning health services for the population they serve including services to prevent and manage communicable diseases
- Responsibility for ensuring the quality of the care they commission including issues such as prevention of healthcare associated infection
- Responsibility for ensuring the resilience of the health services they commission, with 24/7 responsibility to deal with resilience issues and ensuring robust business continuity plans are in place
- Joint responsibility with the local authority for preparation of a Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS) to deliver services to meet the needs identified in the JSNA.

3. NHS England

NHS England is the organisation that has overarching responsibility for ensuring that health care is commissioned for the population of England. It is a single organisation with representation at national, regional and local level. The national team is based in Leeds and London, the regional team, which mirrors the PHE geography, covers the Midlands and East of England with an office base in Cambridge while the East Anglia Area Team covers Cambridgeshire, Peterborough, Norfolk and Suffolk with an office base in Cambridge.

NHS England's responsibilities include:

- Allocation of resources to CCGs. Supporting, developing and assuring the commissioning system
- Planning for civil emergencies and making sure the NHS is resilient
- Directly commissioning some health services including primary care, some public health services, specialised health services and health and justice services

- Leading strategy, research and innovation for outcomes and growth
- Developing commissioning support
- Promoting a world class customer service through better information, transparency and participation
- Working in partnership for quality
- Empowering patient, clinical and professional leadership at every level of the NHS

The principal areas of health protection responsibility are:

- Commissioning Immunisation and Screening services led by a PHE team embedded with the NHS England Area Team.
- Providing NHS leadership for Health Emergency Preparedness, Resilience and Response (EPRR) at local, regional and national level.
- Overseeing the commissioning role of CCGs and supporting commissioner development

4. Peterborough City Council

In April 2013, top tier local authorities (county councils and unitary authorities), including Peterborough City Council, took over a wide range of public health activity ranging from cancer prevention and tackling obesity to drug misuse and sexual health services. To support this work, local authorities have employed a specialist director of public health (DPH) appointed jointly with the Secretary of State for Health as a statutory chief officer and principal adviser on all health matters to elected members and officers, with a leadership role spanning all three domains of public health practice.

The DPH :

- Is the person who elected members and senior officers look to for leadership, expertise and advice on a range of issues, from outbreaks of disease and emergency preparedness through to improving local people's health and concerns around access to health services
- Knows how to improve the population's health by understanding the factors that determine health and ill health, how to change behaviour and promote both health and wellbeing in ways that reduce inequalities in health
- Provides the public with expert advice on health matters
- Is able to promote action across the life course, working together with local authority colleagues including the Executive Director for Adult Social Care and Wellbeing, the Director of Communities, and with NHS colleagues
- Works through local resilience fora to ensure effective and tested plans are in place for the wider health sector to protect the local population from risks to public health
- Works with local criminal justice partners and police and crime commissioners to promote safer communities
- Works with the wider civil society to engage local partners in fostering improved health and wellbeing

The Health and Social Care Act 2012 gives the DPH responsibility for carrying out the functions of the local authority in relation to planning for and responding to emergencies involving a risk to public health.

The DPH with PHE will lead the initial response to public health incidents at a local level, in close collaboration with the NHS lead.

Local Health Resilience Partnerships (LHRPs) have been established to deliver national EPRR strategy in the local context. For Cambridgeshire the LHRP maps onto the Local Resilience Forum and Police boundary – that is it covers Cambridgeshire and Peterborough

(CPLHRP). The CPLHRP is jointly chaired by the lead DPH (Cambridgeshire DPH) and the NHS England East Anglia Area Team Director of Operations and Delivery.

Specific local authority responsibilities that impact health protection are:

- Responsibility for commissioning services for sexual health including services to deal with sexually transmitted infections
- Joint responsibility with the CCG for preparation of a Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS) to deliver service to meet the identified needs.
- Responsibility, jointly with PHE to plan for and respond to public health emergencies
- Responsibility for commissioning services for school age children including the school nursing service
- Environmental health – including dealing with contaminated land. City and District councils have responsibilities to encourage regeneration of contaminated land, and prevent any harmful effects on public health. Contaminated sites may be identified through the planning process but they also have a duty to seek out contaminated sites, in both cases ensuring their remediation to a suitable standard
- Housing and housing standards including dealing with homelessness and with fuel poverty and winter warmth
- Community safety and nuisance control
- Air quality - statutory duty under the Environment Act 1995 to manage
- Local Air Quality which involves monitoring and identifying areas where nationally prescribed objectives are at risk.
- Food safety - EHOs inspect food businesses and investigate food incidents and outbreaks of food-borne illness.

City and District councils have health protection powers and responsibilities under:

- The Public Health (Control of Disease) Act 1984 under which Environmental Health Officers (EHOs) can investigate and take action where infection or contamination presents a significant risk to human health.
- Under the Civil Contingencies Act 2004 district councils have responsibilities in relation to civil protection and are Category 1 responders in the event of a local emergency

5. Providers of NHS funded health services

These include NHS trusts and organisations that deliver acute health services, mental health services, pre-hospital services such as ambulance trusts and community health services. In addition to NHS trusts and organisations, NHS commissioners may commission services from providers in the third sector such as voluntary organisations and social enterprises as well as providers in the private sector. All NHS funded health care must meet the standards set down by the commissioning organisations and by NHS England which includes standards for patient safety and health protection.

Under the terms of the Health and Social Care Act 2012, each provider of NHS funded care, where relevant will comply with relevant legal Emergency Planning Resilience and Response (EPRR) requirements including the Civil Contingencies Act 2004 and will ensure a 24/7 response capability for emergencies.

Annex 2

Role of Peterborough Health Protection Committee

1 To provide a forum for information sharing and planning between public agencies that have responsibilities, in Peterborough, for health protection, as defined in 1.2 above.

2 To review and seek assurance that appropriate mechanisms are in place to protect public health.

3 To receive reports from member agencies that enable monitoring of these arrangements and reporting of any issues or incidents.

4 To provide a mechanism to consider the implications of national guidance/changes for local implementation and be assured that there are mechanisms in place for their delivery.

5 To identify:

- gaps and issues which need resolution by the one or more of the member agencies
- procedures/processes which need to be developed or improved
- the actions that need to be taken jointly by member agencies

6 To identify gaps and resources needed by the Committee to function effectively e.g. missing data/information

7 To support the production of an annual health protection report for submission to the HWBB

8 The Local Health Resilience Partnership (LHRP) is a forum across Cambridgeshire and Peterborough which is co-chaired by the NHS England Area Team Director of Operations and the Cambridgeshire DPH. Member agencies share responsibility for oversight of health emergency planning in this forum. The DPH will report health protection emergency planning issues to the LHRP on a regular basis. The DPH will provide a brief update report on the activities of the LHRP to the PHPC to ensure sharing of cross cutting health sector resilience issues.

Annex 3

Arrangements for 24/7 on call for public health

During normal working hours.

All calls relating to communicable disease or environmental hazards and incidents should be directed to the PHE Anglia Health Protection Team (HPT), based in Thetford. The HPT Consultants in Communicable Disease Control (CCDC) will make a judgement as to whether the public health incident is of sufficient significance to alert the DPH.

Contact details:
Thetford Community Healthy Living Centre
Croxton Road
Thetford
IP24 1JD

Tel: 0844 225 3546

Norfolk, Suffolk & Cambridgeshire Public Health out of hours on call Procedure

Out of hours advice
For health professionals: To contact a public health professional in an emergency out of hours; in the evenings, at weekends or during bank holidays, please phone: 01603 481221

The out of hours on call hours for the NSC public health rota are:

- From 17.00 – 09.00hrs, Monday to Thursday
- From 17.00hrs Friday to 09.00hrs Monday
- For bank holidays – from 17.00hrs on previous working day to 09.00 on next working day

Staffing of the rotas

- The 1st tier is staffed by Specialty Registrars in Public Health (StRs) and Health Protection Nurses (HPNs)
- The 2nd tier is staffed by the Local Authority Public Health Specialists
- The 3rd tier is staffed by PHE CsCDC

Co-ordination of the rotas

The rota will be co-ordinated, administered and circulated by the Anglia Health Protection Team.

- The 1st and 3rd tiers of the rota cover Norfolk, Suffolk Cambridgeshire & Peterborough.
- The rota will be compiled on a quarterly basis by the Anglia HPT following a request for availability.
- The 2nd tier will cover only the one county / LRF area. For Cambridgeshire, the 2nd on call rota covers Cambridgeshire and Peterborough and consists of public health consultants in Cambridgeshire County Council, Peterborough City Council, and Cambridgeshire & Peterborough CCG

- The 2nd tier rota will be circulated to the 1st and 3rd tiers but **will not** be sent to Medicom. Contacting the 2nd tier will be via 1st or 3rd tier.
- **Circulation of the rotas will be via the Anglia HPT only**

On call procedure

- All calls received by Medicom will go to the 1st tier on call staff.
- If they require supervision regarding prioritisation they should discuss with the 3rd on call CCDC who is covering the wider area
- Supervision on public health and health service aspects of the case/incident should be first sought from the 2nd on call for the county in which the call originated. In some circumstances it may be appropriate to contact the 2nd on call where the incident is based e.g. case in one county relating to hospital incident in another
- The CCDC is there for specialist health protection guidance and for matters crossing county boundaries. They can also co-ordinate on-call resources (1st and 2nd, and escalation) across the patch.

Monitoring and evaluation

- All StRs and HPN should complete a detailed on-call log for all calls
- Any immediate issues should be flagged up at the time with the 3rd on CCDC and also at the next available handover.
- The on call arrangements will be subject to review by a team made up of representatives from each tier of the rota.

Below is the guidance given to Medicom

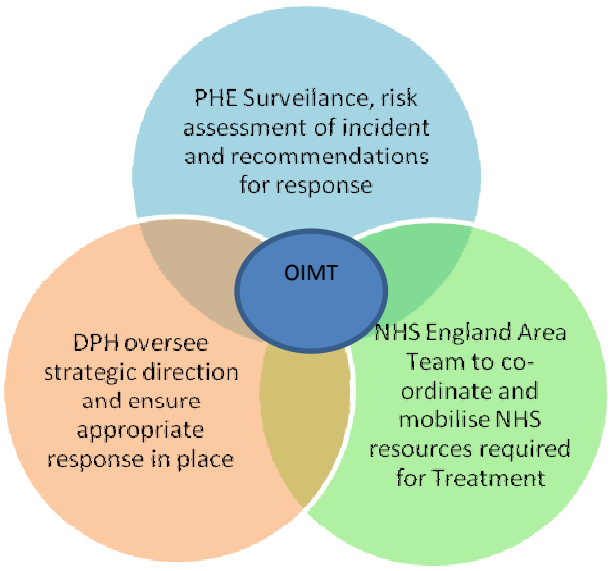
- *Contact On Call A on their first choice number.*
- *If there is no answer call the second choice number. If they have a third you can try this*
- *You can leave a brief message on a mobile phone requesting a call back to Medicom but please **do not** leave a message on a land line as the person may be out of the house for some time and never receive it*
- ***Please ensure that you have dialled the correct telephone number and that the name stated in the voicemail greeting corresponds with the name on the on call rota.***
- *If On Call A has not responded within **30 minutes** then call On Call B using the procedure above*
- *If you get no response from On Call A or On Call B within 60 minutes contact the PHE Consultant (CCDC) named on the rota*
- *If you have to contact the on call person between 17.00 and 18.00 hrs it is quite likely that they may be travelling home and unable to take the call immediately. In this instance please let the caller know that there may be a small delay in responding*

Annex 4

Escalation and management arrangements for Public Health incidents

The successful management of Public Health incidents involves facilitating mutually supportive three-way working between the NHS England Area Teams, local PHE Centres and Directors of Public Health in Local Authorities.

Management Roles



The Emergency Preparedness Framework (NHS England 2013)[1], PHE Concept of Operations (PHE 2013) [2] articulates the roles and responsibilities of NHS England, Directors of Public Health and Public Health England in response to a significant/major incident as follows:

Local Authority Director of Public Health	Overall responsibility for strategic oversight of an incident, ensuring an appropriate response is put in place by NHS England and Public Health England, but with no authority to direct, command or take decisions relating to mobilisation of NHS resources. The DPH should brief Local Authority colleagues and local politicians and mobilise any local authority resources necessary to support.
Public Health England	Lead the epidemiological investigation and specialist health protection response. Responsibility to declare a health protection incident, major or otherwise. PHE would normally Chair the 'Outbreak' Incident Management Team (OIMT). Keep the health protection risks under review. Provide expert health protection advice. PHE will normally coordinate the public communications/ media response as required in

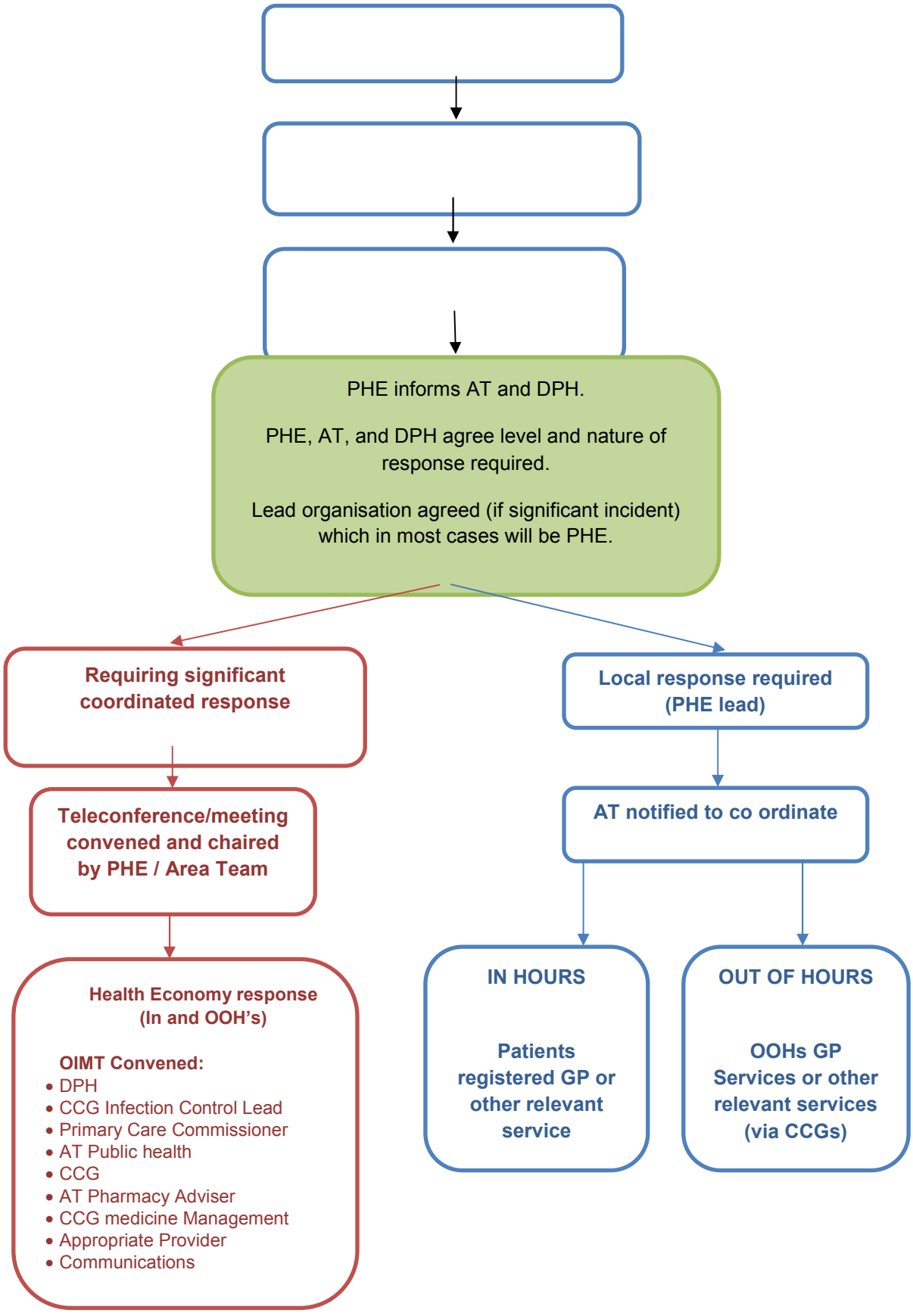
[1] NHS England Emergency Preparedness Framework 2013 Chpt 9 – Roles & Responsibilities
[2] Public Health England Concept of Operations 2013

	collaboration and agreement with other local organisations represented in the OIMT.
NHS England Area Team	Responsible for managing/overseeing NHS response to incident, ensuring that relevant NHS resources are mobilised to support the incident and commanding/directing NHS resources as necessary. NHS England is a key player within the OIMT and may, on occasions, take the lead role instead of PHE in responding to an incident. Transfer of the lead response role from PHE to NHS England would be dependent on : a. The size and spread of the incident requiring the deployment of significant NHS resources with significant cost implications b. Where the incident requires complex coordination and/or communications in order to mobilise the NHS response c. Where provider organisations and PHE are not co-operating with each other. The decision to transfer the lead response role from PHE to NHS England will be undertaken with the agreement of the IMT.
NHS Providers	Response to a public health incident frequently requires the assistance, both in and out of hours, of NHS providers, particularly when clinical investigations and treatment of patients is necessary (e.g. taking swabs, prescribing medicines or vaccinating patients). Normally PHE organise this through local general practitioners for their own registered patients (without needing to convene an OIMT), however sometimes this is not feasible, and other providers may need to be involved, such as community health service trusts. In these circumstances NHS England Area Team will work with the CCG to mobilise the response.

Cross boundary incidents

Where an incident occurs in which people are affected in more than one county or more than one PHE Centre, or NHS England Area Team geographic area, responsibility for coordination of the response may pass to the regional tier of these organisations with the DPH maintaining oversight for their own local population. On such occasions, the DPH may agree with neighbouring DsPH to share the responsibility and membership of the Outbreak or Incident Management team in a way that enables a sustained response if needed. Decisions about the DPH role in cross boundary incidents will be agreed with the neighbouring DsPH, PHE, and NHS England as early in the response as possible.

Escalation and information sharing for Public Health Incidents



Annex 5

Extract from 'Cambridgeshire and Peterborough Local Health Resilience Partnership Three Year Strategic Plan

Training & Exercising

Strategy	**The CPLHRP will provide the leadership for the development of EPRR competencies and capabilities within the Cambridgeshire & Peterborough local health community.**
Outcomes	A trained and competent local health community that is able to respond effectively to emergencies and have validated health community response plans in place.
Objectives	1. Support the development of a local Training Needs Analysis mapped against National Occupational Standards for Civil Contingencies including the identification of ad-hoc specialist training requirements. 2. Promote collaborative cross-boundary training opportunities. 3. Conduct a communications exercise every six months. 4. Participate in an annual CPLHRP Tabletop exercise aligned to prioritised risks. 5. Participate in a major live or simulated exercise every three years to test inter-operability of all CPLHRP member organisations. 6. Develop an 'outcomes for review' programme that will capture what lessons have been identified through testing and exercising and incidents and use this to set the next planning, testing and exercising priorities. 7. Develop a CPLHRP record of training and exercises and link to the Cambridgeshire & Peterborough Resilience Forum Training & Exercise matrices. 8. Support the Cambridgeshire & Peterborough Resilience Forum with

	their exercise programme ensuring appropriate health representation.

Performance Monitoring

Strategy	**The CPLHRP will be committed to assessing and assuring the ability of the local Health Community to respond effectively in partnership.**
Outcome	A local health community that is compliant with legislation and best practice guidance with appropriately trained staff and integrated incident response and recovery plans.
Objectives	1. Develop an annual EPRR audit and assurance process against EPRR Core Standards. 2. Identify deficiencies within the local health sector's EPRR arrangements and agree rectification actions and priorities of work. 3. Provide a process to escalate and secure resolution for issues concerning underperforming member organisations. 4. Performance monitor the delivery of the EPRR Work Programme. 5. Promote peer review of plans and procedures. 6. Manage the expectations of member organisations and provide appropriate support and guidance to the Cambridgeshire & Peterborough Resilience Forum Health & Social Care Emergency Planning Group.

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 7 (b)
		PUBLIC REPORT
Contact Officer(s):	Dr Henrietta Ewart, Interim Director of Public Health	Tel.

MEMORANDUM OF UNDERSTANDING BETWEEN PUBLIC HEALTH AND LCGS – PUBLIC HEALTH WORK PLAN

RECOMMENDATIONS	
FROM : Dr Henrietta Ewart, Interim Director of Public Health	**Deadline date :** N/A
The Board is asked to note the attached Memorandum of Understanding (MoU) and to note and comment on the draft work plan	

1. ORIGIN OF REPORT

1.1 This report is submitted to Board following sign off of the MoU for provision of a healthcare public health advice service from the Peterborough City Council Public Health Team to Peterborough and Borderline LCGs and Peterborough and Cambridgeshire CCG. The draft work plan for delivery of services under the MoU during 2014-15 is also attached.

2. PURPOSE AND REASON FOR REPORT

The purpose of this report is to inform the Board of the arrangements under which the healthcare public health advice service will be supplied to the LCGs/CCG (as per the attached MoU which has been signed off by Peterborough CC and the LCGs/CCG) and to inform and invite comment on the draft work plan, particularly with respect to the extent to which it reflects the agreed priorities of the Board.

3. CONSULTATION

The MoU was signed off after consultation with the LCGs/CCG. The draft work plan has been developed in conjunction with the LCGs/CCG.

4. ANTICIPATED OUTCOMES

That the Board will note the MoU and note and comment on the draft work plan, with particular reference to its fit with Board priorities.

5. REASONS FOR RECOMMENDATIONS

To ensure that the Board are aware of the healthcare public health advice service to the LCGs/CCG and are assured that the work of this service will contribute to driving forward Board priorities and objectives.

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Local Authority Healthcare Public Health Advice Service

Memorandum of Understanding between Cambridgeshire and Peterborough Clinical Commissioning Group and Peterborough City Council

Authors	Cath Mitchell, Local Chief Officer, Cambridgeshire and Peterborough CCG and Dr Henrietta Ewart, Interim Director of Public Health, PCC
Date	This memorandum covers the period 1 January 2014 to 31 March 2015
Status	Final
Introduction	The purpose of this Memorandum of Understanding is to establish a framework for the working relationship between Peterborough City Council's Public Health Department and Cambridgeshire and Peterborough Clinical Commissioning Group for 2014/2015.
Context	Provision of a healthcare public health advice service is one of a limited number of mandated public health services to be provided by unitary and upper tier Local Authorities following the transfer of public health functions in April 2013. The resource to deliver this service has been transferred nationally to unitary and upper tier Local Authorities, as part of the ring-fenced public health budget, so there is no cost to the Cambridgeshire and Peterborough Clinical Commissioning Group (the 'CCG').
Local Authority Healthcare Public Health Advice Service	Priority areas of work for the Local Authority Public Health Advice Service and allocation of consultant and other staff time, covered by this memorandum, are shown in the table:

Priority area	Resource WTE
Healthcare public health specialist advice and input to ongoing CCG-wide work on clinical prioritisation – including specialist public health advice and input to Clinical Priorities Forum, Joint Prescribing Group, Exceptional Cases and Individual Funding Request processes, or new committees/processes which replace these.	0.2 wte PH consultant
Healthcare public health input to projects identified by Borderline and Peterborough LCGs and identified as priorities against the joint prioritisation framework	0.4 wte PH consultant

agreed between the LCGs and Peterborough PH Department. Projects may have a Borderline-Peterborough focus or be part of a wider Cambridgeshire project as appropriate against LCG priorities. A work programme for PH input to the LCGs will be agreed annually with some resource retained for high priority input which may arise in-year. Attendance by public health consultants at meetings, as agreed with the LCG, to provide brief PH advice and, where appropriate, access further input/support from the wider Peterborough PH Department.	
Public Health Intelligence – knowledge and intelligence support, analytical support and advice, methodological and technical support and management input for the public health advice service This support will be provided within the context of the annual work programme and projects as above, with additional input as appropriate.	0.6 wte public health analyst

National benchmarking for the delivery of the healthcare public health advice service indicates an approximate input of one whole time equivalent (wte) public health consultant per 270,000 population (or 40% of the total public health consultant workforce). The benchmarking used the NHS weighted capitation population. For Peterborough this equates to 0.6wte public health consultants.

Input from non-consultant public health staff has not been benchmarked centrally, but national guidance makes clear that input from other public health staff, such as analysts, will be needed to

	support the consultants. It is proposed that 0.6wte public health analyst resource will be included in the service.
Quality	In line with national guidance the service will be required to achieve the following quality standards: • Inputs are led by appropriately trained and accredited public health specialists, as defined by the Faculty of Public Health. • Inputs are sensitive to the needs of, and individual priorities of the CCG, its member practices and Local Commissioning Groups (LCGs). • Inputs result in clear, understandable and actionable recommendations to assist clinical commissioners, with sources appropriately referenced where applicable and based on public health analysis/skills. • Requests for input receive a timely response. • The inputs are closely linked to the outcomes in National Outcome Frameworks, and the priorities of the JSNA and Joint Health and Wellbeing Strategy and it is possible to demonstrate the contribution the advice made to the achievement of those outcomes.
Monitoring of the MoU	An annual work programme to deliver the healthcare public health advisory service will be agreed between Borderline and Peterborough LCGs (on behalf of the CCG) and the Public Health Department (on behalf of Peterborough City Council). The work programme will include clearly specified objectives which will be monitored against the quality standards set out above.
Dispute resolution	Any concerns from the CCG about the delivery of the healthcare public health advice service should in the first instance be raised with the Peterborough DPH then the Director of Adult Social Care and Health and Wellbeing. Any concerns from the Local Authority regarding the CCG's actions in relation to the healthcare public health advice service should be raised in the first instance with the Local Chief Officer and then with the CCG Accountable Officer. If the Local Authority Director of Adult Social Care and CCG Accountable Officer are not able to reach a resolution, they will decide if a process of mediation with an independent mediator (selected by agreement between the parties and appointed in writing) is required to resolve the issue. The findings of the mediator shall be binding upon both parties, with costs borne equally.
	This Memorandum of Understanding refers solely to the mandated healthcare public health advice service. Other aspects of ongoing joint interest and joint working between GP commissioners and Local Authority public health teams are not covered here. Areas which are

Exclusions	**not** covered include joint strategic leadership through the Health and Wellbeing Board, screening, immunisations, healthcare acquired infections, GP practice delivery of preventive services and local authority commissioning of public health services. The scope of public health advice covered by this memorandum is set out in Annex A.

Signatures:

…….

For Peterborough City Council

……..

For Cambridgeshire and Peterborough Clinical Commissioning Group

Date:……

Annex A: Public health advice to NHS commissioners
National guidance covering the scope of a Healthcare Public Health Advice Service to Clinical Commissioning Groups.

Strategic planning: assessing needs

Public health advice to NHS commissioners	Examples
Supporting clinical commissioning groups to make inputs to the joint strategic needs assessment and to use it in their commissioning plans	Joint strategic needs assessment and joint health and wellbeing strategy with clear links to clinical commissioning group commissioning plans
Development and interpretation of neighbourhood/locality/practice health profiles, in collaboration with the clinical commissioning groups and local authorities	Neighbourhood/locality/practice health profiles, with commissioning recommendations
Providing specialist public health input to the development, analysis and interpretation of health related data sets including the determinants of health, monitoring of patterns of disease and mortality	Clinical commissioners supported to use health related datasets to inform commissioning
Health needs assessments for particular conditions/disease groups – including use of epidemiological skills to assess the range of interventions from primary/secondary prevention through to specialised clinical procedures	Health needs assessments for condition/disease group for intervention/commissioning recommendations

Strategic planning: reviewing service provision

Public health advice to NHS commissioners	Examples
Identifying vulnerable populations, marginalised groups and local health inequalities and advising on commissioning to meet their health needs. Geo-demographic profiling to identify association between need and utilisation and outcomes for defined target population groups, including the protected characteristics covered by the equality duty.	Vulnerable and target populations clearly identified; public health recommendations on commissioning to meet health needs and address inequalities
Support to clinical commissioning groups on interpreting and understanding data on clinical variation in both primary and secondary care. Includes public health support to discussions with primary and secondary care clinicians if requested	Public health recommendations on reducing inappropriate variation
Public health support and advice to clinical commissioning groups on appropriate service review methodology.	Public health advice as appropriate

Strategic planning: deciding priorities

Public health advise to NHS commissioners	Examples
Applying health economics and a population perspective, including programme budgeting, to provide a legitimate context and technical evidence base for the setting of priorities	Review of programme budget data Review of local spend/outcome profile
Advising clinical commissioning groups on prioritisation processes – governance and best practice	Agreed clinical commissioning group prioritisation process
Work with clinical commissioners to identify areas for disinvestment and enable the relative value of competing demands to be assessed	Clear outputs from clinical commissioning group prioritisation
Critically appraising the evidence to support development of clinical prioritisation policies for populations and individuals	Clinical prioritisation policies based on appraised evidence
Horizon scanning: identifying likely impact of new National Institute for Health and Clinical Excellence guidance, new drugs/technologies in development and other innovations within the local health economy and assist with prioritisation	Public health advice to clinical commissioners on likely impacts of new technologies and innovations

Procuring services: designing shape and structure of supply

Public health advice to NHS commissioners	Examples
Providing public health specialist advice on the effectiveness of interventions, including clinical and cost effectiveness (for both commissioning and decommissioning) Providing public health specialist advice on appropriate service review methodology	Public health advice on focusing commissioning on effective/cost effective services
Providing public health specialist advice t the medicines management function of the clinical commissioning group	Public health advice to medicines management, for example ensuring appropriate prescribing policies

Procuring services: planning capacity and managing demand

Public health advice to NHS commissioners	Examples
Providing specialist input to the development of evidence-based care pathways, service specifications and quality indicators to improve patient outcomes	Public health advice on development of care pathways/specifications/quality indicators
Public health advice on modelling the contribution that interventions make to defined outcomes for locally designed and populated care pathways and current and future health needs	Public health advice on relevant aspects of modelling/capacity planning

Monitoring and evaluation: supporting patient choice, managing performance and seeking public and patient views

Public health advice to NHS commissioners	Examples
Public health advice on the design of monitoring and evaluation frameworks, and establishing and evaluating indicators and benchmarks to map service performance	Clear monitoring and evaluation framework for new intervention/service public health recommendations to improve quality, outcomes and best use of resources
Working with clinicians and drawing on comparative clinical information to understand the relationship between patient needs, clinical performance and wider quality and financial outcomes	
Providing the necessary skills and knowledge, and population relevant health service intelligence to carry out health equity audits and to advise on health impact assessments	Health equity audits Public health advice in health impact assessments and meeting the public sector equality duty
Interpreting service data outputs, including clinical outputs	Public health advice on use of service data outputs

Source: Department of Health, June 2012. Healthcare Public Health Advice Service to Clinical Commissioning Groups. Guidance to support the provision of healthcare public health advice to CCGs.

Peterborough and Borderline Healthcare Public Health Advice Service: Work Plan 2014-15

Notes of the meeting held on 9 May 2014 at Peterborough Town Hall

Present: Henrietta Ewart, Cath Mitchell, Boika Rechel, Remi Omotoye, Tina Hornsby, Julian Base, Cheryl McGuire, Shakeela Abid, Charles Ryan, Fiona Head (via dial-in, for first part of meeting).

Apologies: Wendi Ogle-Welbourn, Adrian Chapman, Richard Withers, Andrew Jepps, Val Thomas, Jana Burton, Charlotte Black

1. **Healthcare Public Health Advice Service**. Henrietta Ewart (HE) outlined the Memorandum of Understanding between PCC and the LCGs/CCG for provision of healthcare public health advice (the Healthcare Public Health Advice Service – HCPHAS). The MoU covered provision of 0.8wte CPH (split 0.2 and 0.6 wte between CCG and LCG work) and 0.8 wte analyst support. HE noted that the HCPH input was currently delivered by a locum part-time CPH who had insufficient sessions to deliver the full 0.8 wte under the MoU. Recruitment to substantive consultant posts would be underway shortly and the appointee(s) would deliver the full 0.8 wte commitment within their job plans. The recruitment was not sufficiently advanced to gauge a likely start date for the substantive post. In the meantime there would be a slight shortfall in PH capacity for this work.
   ACTION: If the shortfall in capacity begins to have significant impact on high priority work within the HCPHAS, it will need to be elevated/escalated within PCC with a view to securing necessary resources (HE and CM to take forward should the need arise).
2. **Work Plan Proposals**
   Discussion and decisions/actions as per table below:

Topic	Discussion	Actions
Regular PH support to CCG priority 'tackling inequalities in CHD'	Will be covered under the 0.2 wte CPH input for 'CCG' priorities. This resource will also provide Peterborough's contribution to the IFR process	BR and FH to liaise and agree workplan
Adult Autism and Asperger's Syndrome	The proposal requires further scoping into a better defined 'project' before final decision. There was discussion about whether the focus should be adult only or whether it should include children (work on the 0-24 group is already planned by the LD and Autism Partnership Board).	HE to pick up with Dr Sohrab Panday re further discussion/scoping with LD and Autism Partnership Board
Forensic and Offender Health	NHSE is responsible for commissioning these services. This topic had previously been identified as a local priority but it may now be more appropriate for NHSE to progress – linking with Pboro for interface issues.	HE to discuss with Gina Radford and NHSE in first instance.
Suicide Prevention	The short term funded project (1 year) will need robust evaluation built in from the start for reporting back to JCF at end of	BR to meet with Dr Sohrab Panday to discuss and ensure arrangements in place (with PH

	project. Funding for this may be available through the PH Institute but, if not, evaluation needs to be built in locally. Ongoing PH input (leadership and support) was also requested – would replace input from a senior PH registrar who will soon be leaving.	input as necessary). PH unable to provide an ongoing designated PH lead to support this strategy. Agreed not a priority for HCPHAS.
Integrated Comprehensive Mental Health Needs Assessment	The proposal focussed on uptake of IAPT services by different groups within Pboro population and gaining an understanding of why some groups do not access IAPT at levels that would seem indicated by need (from epidemiology). HCPHAS could do a focussed piece of work analysing/auditing referral and uptake but this should be supported by a bigger, qualitative piece of work to understand why members of certain communities do not access service in line with predicted need. Discussion indicated that this could be part of a much bigger piece of work looking at the preventive agenda more widely and also spanning community cohesion, asset based community development etc. HCPHAS would not have either capacity of expertise to do all of this. The CLARHC may be able to support this. Other partner organisations (Greater Peterborough Partnership, Safer Peterborough Partnership) should also be involved.	HE and CM to arrange an initial scoping/planning meeting. HE and CM to identify who should be invited.
Psycho-sexual Counselling needs assessment	It was not clear how broad this work needed to be (eg focussed on victims of sexual abuse or all forms of psycho-sexual dysfunction). It was understood that a key problem was lack of understanding of current services, pathways and levels of demand.	BR and RO to do some further workup with Sohrab Panday and Malcolm Bishop
Link to Cambridgeshire work on JSNA for primary prevention for older people	Cambridgeshire are already undertaking JSNA work on their own population and would be willing for us to access relevant components of this (in particular, evidence reviews around 8 sub-topics). We would need to do the Pboro specific work including population data, service mapping and stakeholder engagement.	TH will do some further work on this through the Information Working Group and will check how Cambs have approached/funded the engagement work. TH will lead on progressing this with a view to taking forward within the Better Care Fund Group
Evaluation of Health Checks Programme for	CR is already leading on this and template for consistent evaluation has been agreed across Cambs and Pboro. The completed	CR will take through CHD Programme Board. The evaluation (with a response

Peterborough	evaluation will go to the CHD Programme Board (will be done annually). As this is already in hand, there is no need for a new piece of work through the HCPHAS.	from CHD PB, including forward plan) should then be brought to HWB PB as part of the CVD strategy monitoring arrangements.
Community bed based capacity review	This needs to be developed through the Better Care Fund Group rather than through HCPHAS.	CM to pick up with Paul Grubic
Evaluation of LCG MDTs	The published evidence base for MDT working with older people (to reduce non-elective admissions) is not currently conclusive. Therefore, robust evaluation of local projects is essential in order to understand their effectiveness. Some work has already been done but more is needed. Feasibility of this will depend on clarifying the outcomes of interest and what data has been collected to measure these.	TH to liaise with CM to see what is available/what could be done. TH/CM to feedback to MDT Steering Board.
Diabetes JSNA/equity audit	A lot of data is already available indicating areas where Pboro performance/outcomes could be improved. Diabetes is already identified as an LCG priority with an action plan. This includes work around practice diabetes nurses and whether they are currently covering practices with highest need. Work on diabetes needs to be linked in with the HWB CVD priority.	BR to link with CCG project manager and lead GP (CM to provide details) to scope whether HCPHAS input needed.
Mobilisation of Older People's Pathway and Adult Community Services Contract	The provider will be implementing this contract in Oct/Nov. HCPHAS input would be useful in checking the provider's plans. The LCG is looking for innovative services but these need to be checked for likely effectiveness.	No work at present. CM will notify when required.
Chronic Fatigue Syndrome/ME	A service is commissioned from CSS (service specification and service model available) but the JCF are concerned that demand outstrips supply. There may be an issue about IFRs for interventions not commissioned within CSS pathway.	CM and BR to liaise re further scoping.
Alcohol	A request for work may come in from Safer Peterborough Partnership. They are currently at an early stage on this.	No action yet. Await contact from SPP.

3. Next steps

We will take forward the actions as per table above. PH team actions will be reported to DMT and then to CM for feedback to JCF. Completion of actions should give clarity re work plan for HCPHAS. Once actions are completed and we have feedback from CM/JCF we can take a view on whether a further meeting of today's group is needed or whether initial work

plan can be agreed/progressed without. We will then need to agree project management arrangements for the work to ensure deadlines are met etc.

Dr Henrietta Ewart
Interim Director of Public Health
Peterborough City Council

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 7 (c)
		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** : N/A
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 steams 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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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 9
17 JULY 2014		PUBLIC REPORT
Contact Officer(s):	Wendi Ogle-Welbourn Director for Communities	Tel. 01733 863749

PEER REVIEW OF THE HEALTH AND WELLBEING BOARD

RECOMMENDATIONS	
FROM : Wendi Ogle-Welbourn Director of Communities	**Deadline date:** N/A
The Board is asked to note and comment on the feedback letter from the Peer Review and draft action plan. (Attached Appendices).	

1. ORIGIN OF REPORT

1.1 This report is submitted to the Board following the feedback letter being received from the Peer Review and development of a draft action plan.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to inform and seek the views of the Health and Wellbeing Board on the Peer Review feedback and the draft action plan.

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

3. BACKGROUND AND SUMMARY

3.1 The Health and Wellbeing Board has a critical role to play in ensuring agencies and organisations across Peterborough and the border line areas are efficiently and effectively focusing their resources on improving the health and wellbeing of residents, also where joined up activity between Partners would secure further improvements and efficiencies this happens.

3.2 The Board commissioned a Peer Review in March 2014, the purpose being to help us identify where we as a Board are doing well and where we need to improve.

3.3 The feedback from the review identified great commitment from all agencies and organisations, but identified a number of areas for improvement. The Health and Wellbeing Programme Board has developed a draft action plan in response to the areas of improvement identified. (Attached) If the Health and Wellbeing Board agrees the draft action plan the programme board will take responsibility for driving the actions required.

4. CONSULTATION

4.1 The Peer Review letter and draft action plan have been shared with Programme Board members. The peer Review letter and draft action plan will be shared with Health Scrutiny.

5. ANTICIPATED OUTCOMES

5.1 That the Health and Wellbeing Board will note the feedback letter from the Peer Review, comment on the draft action plan and agree for the programme board to drive the actions within the plan.

6. REASONS FOR RECOMMENDATIONS

6.1 To ensure the board are fully informed of the recommendations from the Peer Review and agree to actions arising from this.

7. BACKGROUND DOCUMENTS

7.1 None

8. APPENDICES

8.1 Appendix 1 – Peterborough Health and Wellbeing Peer Challenge Feedback letter
Appendix 2 – Health and Wellbeing Board Action Plan 2014/2015

Councillor Marco Cereste, Leader & Chair of Health and Wellbeing Board
Gillian Beasley, Chief Executive
Peterborough City Council.
Town Hall,
Bridge Street,
Peterborough,
PE1 1HF

15th April 2014

Dear Marco: Dear Gillian

Health and Wellbeing Peer Challenge 11th – 14th March 2014

On behalf of the peer team, I would like to say what a pleasure and privilege it was to be invited into Peterborough City Council to deliver the health and wellbeing peer challenge as part of the LGA's health and wellbeing system improvement programme.

This programme is based on the principles of sector led improvement that:

- Councils are responsible for their own performance and improvement and for leading the delivery of improved outcomes for local people in their area
- Councils are primarily accountable to local communities (not government or the inspectorates) and stronger accountability through increased transparency helps local people drive further improvement
- Councils have a collective responsibility for the performance of the sector as a whole (evidenced by sharing best practice, offering member and officer peers, etc).

Challenge from one's peers is a proven tool for sector led improvement. The LGA's peer challenges are delivered by experienced elected member and officer peers. The make-up of the peer team reflected your requirements and the focus of the peer challenge. Peers were selected on the basis of their relevant experience and expertise and agreed with you. The peers who delivered the peer challenge at Peterborough City Council were:

- John Garrett, Deputy Chief Executive, Sandwell MBC
- Cllr Steve Charmley, previous member of the HWB/Cabinet Member for Health & Wellbeing, Shropshire Council
- Professor Kate Ardern, Executive Director of Public Health, Wigan Council
- Joe Gannon, Local Government Adviser to Public Health England

- Richard Cienciala, Deputy Director for Health and Wellbeing, Department of Health for England
- Satvinder Rana, Programme Manager, Local Government Association

Scope and focus of the peer challenge

The purpose of the health and wellbeing peer challenge is to support councils in implementing their new statutory responsibilities in health from 1st April 2013, by way of a systematic challenge through sector peers in order to improve local practice. It also supports health and wellbeing boards become more confident in their system wide strategic leadership role, have the capability to deliver transformational change, through the development of effective strategies to drive the successful commissioning and provision of services, and to create improvements in the health and wellbeing of the local community.

Our framework for the challenge was five headline questions:

1. Is there a clear, appropriate and achievable approach to improving the health and wellbeing of local residents?
2. Is the HWB at the heart of an effective governance system? Does leadership work well across the local system?
3. Are local resources, commitment and skills across the system maximised to achieve local health and wellbeing priorities?
4. Are there effective arrangements for evaluating impacts of the health and wellbeing strategy?
5. Are there effective arrangements for ensuring accountability to the public?

You also asked us to focus on childhood obesity and we have used the following five headline questions to form a view on how you are doing in this area of public health:

6. Is there a clear and appropriate approach to reducing childhood obesity within the community? Does this approach include an understanding of childhood obesity as it affects the local population?
7. Does the council provide effective system leadership to support and promote a reduction in childhood obesity?
8. How effectively has the council and its partners put the strategy into action?
9. Are there effective arrangements for evaluating what works? Are these arrangements comprehensive and pull together the various local interventions into one place so the system and public can see the difference that is being made?
10. How effective is community and user engagement?

It is important to stress that this was not an inspection. Peer challenges are improvement focused. The peers used their experience and knowledge to reflect on the information presented to them by people they met, things they saw and material they read.

This letter provides a summary of the peer team's findings. It builds on the feedback presentation delivered by the team at the end of their on-site visit. In presenting this feedback, the peer challenge team acted as fellow local government and health officers and members, not professional consultants or inspectors. We hope this will help provide recognition of the progress Peterborough City Council and its Health and Wellbeing Board (HWB) have made whilst stimulating debate and thinking about future challenges.

1. Headline Messages

Peterborough is a rapidly changing city and it is apparent that this change is embraced by the council and its partners. The people we met spoke very positively about the changing demography of the city, and they understood the challenges this brings to providing good public services.

There is an impressive cadre of talented and committed people with a genuine desire to make a difference to the quality of life of local people. There is also a strong sense of place and pride in Peterborough. Members, staff and partners had passion for the place and genuinely wanted to make improvements and serve their citizens well. This is a key strength for the city.

Whilst there are significant health & wellbeing challenges across the city, these are understood by everyone we spoke to within the health and wellbeing system. There is a strong information and data base and a good understanding of the wider determinants of health, including a good grasp of the inter-relationship between the built environment, economic prospects and improved health. There was also a degree of consensus on what the main issues were.

We feel the council and its partners are ready for take-off. This is evidenced by a strong focus on commissioning within the council and the creation of the Programme Board and the Joint Commissioning Group. Both these initiatives are seen as very positive by all partners within the system. There are also many examples of good practice delivered through efficient and effective services, outreach programmes and projects.

However, there are a number of critical issues that need to be addressed in a bold and decisive way. These include strengthening relationships across the system, particularly with the CCG and your significant NHS providers, having a stronger focus on your shared and agreed priorities, being properly sighted on your statutory public health responsibilities, and clarifying the leadership within the Public Health function.

Relationships across the system are developing, but 'history is weighing heavy'. The past is acting as a block to taking these relationships forward into

trusting and meaningful partnership working within the health and wellbeing system. For example, there is still considerable work to be done to bring the Clinical Commissioning Group (CCG) and your significant NHS providers into the loop. 'Parking the past' and developing a mutual understanding of each other's challenges will help to forge more positive and productive relationships with key individuals within the system.

There are shared financial imperatives across the system and this makes having strong and trusting relationships through partnership working paramount. There is a shared desire to work together and integration is a priority for all partners. They see this as going some way in improving services and dealing with the financial imperatives. However there was yet no consistent narrative about what to do and how to do it together. The shared narrative should recognise three key issues of: the significant number of health challenges faced within the city; the need to manage demand across the system; and the need to reduce expenditure. Priority actions should be selected on the basis that they will have the biggest impact on these three demands across agencies.

There is also a need to widen political engagement within the council with the health and wellbeing agenda. Although there are a number of cabinet members on the HWB, we think you need to strengthen the role of the identified portfolio holders who have full responsibility for public health and health improvement. There needs to be a greater visibility of political leadership for public health and health improvement in the council.

We observed that health scrutiny in the council is not as strong as it needs to be. We were told that health scrutiny lacks a forward work programme based on the JSNA that is focused on providing challenge within the system and to hold the HWB to account. Having a robust challenge mechanism within the system is important in providing accountability to the public and pushing for innovations.

The next stage is to review and strengthen membership and functioning of the HWB through stronger relationships with partners, secure wider political engagement within the health and wellbeing system and develop a mutual understanding of each other's challenges. In reviewing the membership of the HWB we would suggest you to focus on three elements:

i. How you strengthen the involvement of the CCG in the work of the HWB and ensure it is an equal partner

ii. How you bring your significant NHS providers into the loop on the big strategic debates

iii. In the absence of effective scrutiny what kind of robust arrangements should you have in place to ensure there is sufficient challenge in the system, to push you to innovate, to take the risks and to justify what you do?

There is also a need for a greater focus on priorities across the system. This can be achieved by refreshing the health and wellbeing strategy, developing a

shared narrative about what needs to be done and how to do it together, and clearly prioritising actions so that both health improvements and financial demands and sustainability can be addressed.

We believe you need to be more fully aware of the council's statutory public health responsibilities. This means both the council and the HWB need to be properly sighted on their statutory public health assurance responsibilities with regard to health protection including emergency planning and response; and the HWB needs to seek assurance from PHE and NHS England with regard to the performance, commissioning and quality of the screening and immunisation programme.

Currently the Public Health function is a weak link in the system. While the council sees the embedding of the Public Health specialists into teams across the council as integration, this is perceived by the Public Health team and partners as disintegration. And while the council considers the current lull in the recruitment of the Director of Public Health as a period of re-evaluation, other people see this as drift and disinterest. Therefore one of our main recommendations is for the council to establish Public Health leadership and appoint a Director of Public Health in a substantive post.

In terms of childhood obesity, whilst the problem is acknowledged within the system and there are some examples of work being done within some schools, there is no clear ownership for tackling childhood obesity and there does not seem to be a strategy in place or a partnership approach to tackling it. That said, we do not think it is one of your most acute issues to deal with in the immediate future.

So in summary, we think you have got the basic structures in place and you are now ready to push ahead and develop strategic approaches to dealing with some of the major challenges you face as a city and as a health and wellbeing system. Our message is about building strong *relationships*, being clear about *priorities* and being *focused* on delivery of those priorities.

2. Is there a clear, appropriate and achievable approach to improving the health and wellbeing of local residents?

There is strong ambition to improving the health and wellbeing of local residents in Peterborough. All the necessary structures within the health and wellbeing system are in place and there is clear evidence of the ability to make bold decisions. The council's move toward a commissioning organisation and the recent agreement for development are good examples.

The transfer of the Public Health function to the council was smooth and the Health and Wellbeing Board (HWB) brings together the key organisations that can contribute to improving public health and wellbeing. The decision to create a Programme Board and a Joint Commissioning Group is seen, by all parties, as very positive steps toward delivery of shared actions. However, the absence of a substantive Director of Public Health post has given rise to uncertainty about the leadership of the Public health function.

There is a very strong sense of place and pride in Peterborough and the health challenges are clearly understood by councillors, staff and partners – including the Third sector. There is also a degree of consensus on what the main issues are, and these main issues are backed up with some very good information and analysis. These are key strengths in improving the health and wellbeing of local people.

The JSNA provides a systematic and systemic method for reviewing the health and wellbeing needs of the local population. The last JSNA was published in 2011 and following a review it is now structured thematically which enables you to look at differences and challenges within the city to better understand both the issues faced and the segments of the population facing them. This will enable you to deliver better targeted interventions.

The Health and Wellbeing Strategy was published by the HWB in 2012. The strategy was informed by the JSNA of 2011 and identifies five priorities of: securing the foundations of good health; preventing and treating avoidable illness; healthier older people who maintain their independence for longer; supporting good mental health; and better health and wellbeing outcomes for people with life-long disabilities and complex needs. Progress on these priorities is under-pinned by a multi-agency delivery plan which is periodically reviewed by the HWB.

However, at the moment it is difficult to see how and where action is prioritised or whether there is logic to the prioritised work that you've got. You really need to now make some bold decisions at speed about developing a focused strategy and focused yearly action plan based on:

i. what are the most important health challenges

ii. where do you have clear evidence that if you intervene using a particular methodology it will make a difference

iii. how will those interventions impact on the big challenges all the organisations in the system have about money and capacity

Also one of the things the HWB will need to think about is what are its key priorities and what are the implementation processes to support those priorities and how will the HWB know they have been done. This will necessitate the HWB receiving progress and performance reports against its key priorities and periodic reviews of the impact these are having on the health and wellbeing determinants of the local population. You should agree a small number of priorities which address health improvement, financial demands and sustainability. Two or three of these priorities should then be delivered jointly by the partnership on an industrial scale that will enable you to secure commitment, build and strengthen your relationships and share success.

In getting to this stage we feel you first need to strengthen the HWB with a more focused membership that brings partners, especially the CCG, into the mainframe of the HWB. This will require a concerted effort on the part of the

leadership of the council to develop more trusting and productive relationships with the CCG and your significant NHS providers.

3. Is the HWB at the heart of an effective governance system? Does leadership work well across the local system?

The shadow HWB was established in April 2012. The HWB is chaired by the Leader of the council and the vice chair is the cabinet member for adult services and health. The HWB has agreed its main role as promoting the health and wellbeing of the city's population. Its main focus is on reducing health inequalities by coordinating the commissioning and delivery of health and wellbeing services and ensuring the integration of services where it improves efficiency and effectiveness.

At present the HWB is neither a driver of delivery nor a champion of health and wellbeing across the system. It does not work well as a partnership vehicle because it is seen as too council-dominated with a large representation of elected members and council officers skewing debate. Whilst meetings of the HWB are chaired well and in an open and inclusive manner, partners have described them as "akin to council committee meetings held in 'wood-panelled rooms' cramping others' style". They are always held in the Town Hall and partners we spoke to say the HWB felt very much like a scrutiny committee that behaves as if it is there to hold external partners to account.

We further observed that the council and external partners sat at opposite ends of the table and this did not promote a sense of partnership working or alleviate the above perception. We would suggest that some thought should be given to the seating arrangements to ensure that council members and officers and partners do not sit at opposite ends of the table. We would further suggest that agenda items should have a greater focus on reports that call for strategic debate, initiate action and drive decisions with fewer reports 'to note' or to 'seek permission'.

The council should now exercise bold and courageous leadership and move the partnership forward. This will require the Leader of the council and chair of the HWB to publically invite everyone to 'park the past' and reach out to the CCG and your significant NHS providers as equal partners. We would suggest that perhaps the vice chairmanship should be offered to the CCG and a mechanism found to involve NHS providers in the big strategic debates on health improvement and better services. This could either be by offering full membership of the HWB to your providers, thereby building their ownership of the decisions of the board; or by setting up a Strategic Advisory Group, a forum for strategic discussions around innovation and long term systems planning. We would also recommend more informal mechanisms be established for building mutual understanding of each organisations' issues and challenges outside of the formal constraints of the HWB. A couple of potential ideas are for chief executives to informally meet over dinner or other such informal gathering and for the Leader to host a *"Leader's Summit'* for politicians.

There are some shared financial imperative across the system that need to be tackled together and jointly. Each of the organisations we met face major financial challenges and none of them thought they would be able to deal with the demands on their services and make the necessary financial savings alone. But we did come across a shared desire to work together. Health improvements, balancing the books and better services (in part through integration) are priorities across the system. This is an opportunity to invigorate partnership working within the health and wellbeing system.

Following the refresh of the membership and the health and wellbeing strategy the HWB should further develop its role and aim to strike a balance around three pillars of: providing leadership across the system, championing health improvement and pushing for better services (in part through integration). All three pillars are important to improve and protect the health and wellbeing of the local population and clarity of purpose and a good balance between these pillars will enable the HWB to remain on the front foot. For example, a focus on system leadership will allow the HWB to tackle some of the local systemic issues such as roles the different parts of the system play and challenging each other for continuous improvement. Similarly, a focus on health improvement and better services will allow the HWB to initiate new ways of doing things and ensuring that the system focuses on service integration and the reconfiguration of services, where that makes sense.

4. Are local resources, commitment and skills across the system maximised to achieve local health and wellbeing priorities?

We came across many examples of good practice where the council and its partners are delivering innovative solutions to the challenges they face. We saw a number of very popular and worthwhile projects and spoke to practitioners about the range of work they are doing around weight management, physical activity, tobacco control, etc. *'The NHS Health Checks Programme'*, emergency planning, '*MoreLife'* project – focusing on reducing childhood obesity, *'Inspire Peterborough'* - which promotes physical activity among disabled people, involving voluntary and private sector as well as the council are all good examples of how the health and wellbeing of the local population is being improved on the ground .

There is some evidence of synergies between public health and other council goals being identified and harnessed since transition. For example, we heard that "housing is now around the table in key areas of public health i.e. *'Family Nurse Project'*, and there are three housing posts funded from Public Health ring-fenced budget". We also heard that "causality is better understood by all" and there is greater public health insight being brought to bear to enable health to be targeted alongside skills development i.e. through a project based at local football ground.

Partners within Peterborough have a clear commitment to work collaboratively across shared priorities. This was relayed to us through our discussions with

key partners. There are good relationships with Healthwatch, and its chair is a member of the HWB and Programme Board.

However, we did observe that PHE and NHS England are not as engaged as they should be given the scale of the health challenges in Peterborough. There is potential for the local system to draw on expertise and support from regional PHE and NHS England resources. You should explore this relationship and source of support further and encourage PHE and NHS England to be more prominent in forming relationships and setting out what they can offer. We would advise that the HWB should invite the local PHE Centre Director to attend and present her annual prospectus and work plan as PHE is there to provide expert support to local authorities in their leadership of health and well-being.

There is good reporting mechanism into the HWB. The Better Care Fund working group, Children and Families Joint Commissioning Board, JSNA Working Group all report into the HWB. The Local Joint Commissioning Forum, led by the Local Clinical Commissioning Groups, but comprising of Local Authority Commissioners acts as a forum for agreement of joint commissioning activities and reports into the HWB on relevant issues.

The Director of Public Health (DPH) and Public Health specialists have been integrated within the new directorate of adult social care, health and wellbeing. The Public Health Team are located within teams in the adult social care, health and wellbeing directorate and the communities directorate and form an integral part of those functions whilst maintaining their specialisms.

Public Health commissioning and delivery functions have been merged with other commissioning and delivery functions within a new communities directorate. This leaves the DPH with the strategic public health leadership role and removes day to day management of commissioning work and direct delivery of health improvement. The post of DPH is currently covered on an interim basis whilst a permanent appointment is being sought.

The Public Health function has been all too often invisible since its move into the council and has not punched its weight. For example, we were told by some partners that they were not sure who the Public Health team were and we sensed that Public Health professionals lacked focus to their work. Whilst it may be right for you to integrate your Public Health function into the councils (and you are not alone in doing this) and to take your time in making a permanent appointment to the post of DPH, it has meant that there has been a void in robust leadership of the Public Health function. This is perceived by the Public Health team and partners as disintegration and disinterest.

To address these perceptions and to provide solid leadership to the Public Health function we would recommend that you quickly appoint a DPH in a full time substantive post, complete your plans for moving commissioning of adult social care responsibility to the communities directorate, and that you identify separate portfolio responsibilities for Public Health and Health Improvement.

This will send out a strong message within the system that the council is serious about public health and its health and wellbeing responsibilities.

There is clear evidence of the council's ability to bring energy and resource promptly to bear on pressing issues. For example, the way you dealt with child protection following the OFSTED report creates confidence that the same energy and resource could be successfully brought to bear on the new health and wellbeing system.

5. Are there effective arrangements for evaluating impacts of the health and wellbeing strategy?

The HWB meets quarterly and receive regular updates from partner agencies which link to the priorities within the strategy. This tracks progress against action and performance metrics as well as citing examples of the difference made. However, because of the long term nature of the priorities the differences made currently tend to reflect outputs rather than outcomes.

As mentioned above, the strategy, the priorities within it and the delivery plan are all due for a refresh. This will be an opportune time to develop a robust performance management arrangement by the HWB. The role of the HWB in relation to the delivery of agreed priorities and how the delivery plan will be held to account needs to be clarified and agreed.

Once it has agreed the strategy and priorities the HWB will need to think about the implementation processes to support those priorities and how it will know they have been done. This will necessitate the HWB receiving progress and performance reports against its key priorities and periodic reviews of the impact these are having on the health and wellbeing determinants of the local population. A move to an integrated strategic planning and performance management framework across the health and wellbeing system may assist in ensuring there are effective arrangements in place for evaluating impacts of the health and wellbeing strategy.

Further, the role of Healthwatch and scrutiny should be critical in evaluating impacts and holding the HWB to account. In our discussions Healthwatch was described to us as trusted and a 'critical friend' to the HWB and that it is punching above its weight, given its limited infrastructure and resources. In relations to health scrutiny we do feel that this needs to be strengthened within the council and that its role and work programme needs developing substantially so that it has a forward plan aligned with the strategic priorities in the JSNA and the big health and wellbeing issues within the local population.

Our other observation is for the council and the HWB to be properly sighted on two very important statutory public health responsibilities.

Firstly, the HWB needs to seek assurance from PHE and NHS England with regard to the performance, commissioning and quality of the screening and immunisation programme.[1]

This assurance should ideally be sought by inviting the consultant in screening and immunisation from the embedded PHE team in the local NHS England area team to attend the health protection committee and present an annual report to the HWB with the option to be called in to report on any incidents that arise.

Secondly, both the council and the HWB need to be properly sighted on their statutory public health assurance responsibilities with regard to health protection including emergency planning and response.[2]

Good emergency planning in the council gives you a structure to build on in relation to your own responsibilities, but the HWB also need to assure itself that NHS England is delivering on its responsibilities. You could utilise the experience and expertise of the council's Emergency Planning Officer by including him in the membership of the newly-formed health protection committee (which should be an integral part of the HWB sub-architecture) to ensure that the council's new health protection responsibilities are visibly embedded within the council's existing arrangements for civil contingencies and response. The HWB should assure itself via the health protection committee that there are robust arrangements in place within the council for planning and responding to public health emergencies and that those arrangements have been tested via an appropriate exercise programme and training.

6. Are there effective arrangements for ensuring accountability to the public?

Our discussions did not identify discrete arrangements for ensuring accountability for health and wellbeing to the public. We have already outlined the need for sufficient challenge in the system, to push you to innovate more, to take the risks and to justify what you do. At present this role seems to have been adopted by the HWB to a certain extent and by scrutiny to a lesser extent. We would observe that neither of these

[1] The legislative framework states that: "Under the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 unitary and upper tier local authorities have a new statutory duty to carry out certain aspects of the Secretary of State's duty to take steps to protect the health of the people of England from all hazards, ranging from relatively minor outbreaks and contaminations, to full-scale emergencies, and to prevent as far as possible those threats emerging in the first place. In particular, regulation 8 requires that they promote the preparation of health protection arrangements by "relevant bodies" and "responsible persons", as defined in the regulations. In addition, regulation 7 requires local authorities to provide a public health advice to clinical commissioning groups (CCGs), which includes advice on health protection. Local authorities will continue to use existing legislation to respond to health protection incidents and outbreaks".

[2] Directors of Public Health (DsPH) are employed by local authorities and responsible for the exercise of local authorities' new public health functions. Directors will also have a responsibility for "the exercise by the authority of any of its functions that relate to planning for, and responding to, emergencies involving a risk to public health".

arrangements is right or well developed enough for ensuring proper accountability to the public.

The roles of scrutiny and Healthwatch are critical in ensuring accountability, and in Peterborough we would suggest that both these organisations need developing, particularly scrutiny. A significant proportion of the work of scrutiny needs to be externally focussed so that its purpose is to make healthcare organisations more accountable to local communities. Clearly, as in many local authority areas, there is work to be done on thinking this through and it is clear that partners would welcome this being debated.

7. Childhood Obesity

There is a good understanding of the problem of childhood obesity in Peterborough. There is good NCMP (National Child Measurement Programme) data and good analysis of the issues, both problems and assets which could be brought to bear. People we spoke to knew where the problem areas were and which sections of the local population should be targeted for intervention.

The council recognises the need to promote a reduction in childhood obesity and has supported a number of initiatives in schools. There are good relationships with dietetics services. We also heard about '*MoreLife'* - the weight management and health improvement referral programme aimed at 4-17 year olds and we heard about '*After School Clubs'* for children and families aimed at increasing physical activity and improved diets.

However we could not identify systemic leadership to support and promote a reduction in childhood obesity. Nor could we identify a clear and strategic approach to reducing childhood obesity within the community, or whether it had been discussed and agreed by the HWB and/or owned at a senior level. We could not identify where responsibility for reducing childhood obesity rests within the system.

We formed an impression of dedicated staff finding themselves beleaguered by tight resources and an absence of clear priorities over how these should be focused. Though, we were told that a strategy for tackling childhood obesity is being developed. Our recommendation is that this strategy should be developed in partnership and consultation with schools, school nurses, primary care, health visiting services and dietetics services. Once the strategy has been developed then robust arrangements for evaluating what works should be put in place. In addition, community and user engagement should also form part of the process of development and agreement of the proposed strategy – and continue as implementation plans are subsequently put in place. Our recommendation is that leadership and co-ordinating responsibilities for childhood obesity should be identified in the communities directorate to take this work forward.

This commentary on childhood obesity should, however, be read in light of our recommendation that HWB priorities should be chosen which are able to

impact upon: health need; financial challenges within the system; and demand management challenges across the system. In view of this, it is not clear to us that childhood obesity would be a natural HWB priority.

8. Moving forward

In moving forward our key recommendations are:

a) Build relationships across the system and revitalise the Health & Wellbeing Board. This means publically 'parking the past', reaching out to the CCG and your NHS providers as equal partners through both formal and informal mechanisms, and reviewing membership of the HWB, ensuring it is not council dominated.

b) Refresh your health and wellbeing strategy, the priorities within it, the delivery plan, and a performance management framework. The small number of priorities you agree should address health improvement, demand for services and financial sustainability. You should then, with your partners, jointly deliver two or three of these priorities on an industrial scale that will enable you to secure commitment, build and strengthen your relationships, achieve outcomes and share success.

c) Focus on the integration of health and care through a shared vision. The shared vision should recognise three key issues of: the significant number of health challenges faced within the city; the need to manage demand across the system; and the need to reduce expenditure. Priority actions should be selected on the basis that they will have the biggest impact on these three demands across agencies.

d) Widen political engagement within the council with the health and wellbeing agenda by having more visible separate portfolio responsibilities for public health and health improvement. Furthermore, strengthen challenge and public accountability within the system by developing the public health scrutiny function.

e) Quickly complete the plan for moving commissioning of adult social care responsibility to the communities directorate and establish public health leadership by appointing a Director of Public Health to a substantive post.

f) Ensure you are properly sighted on the council's statutory public health responsibilities with regard to health protection including emergency planning and response; and the HWB seeking assurance from PHE and NHS England with regard to the performance, commissioning and quality of the screening and immunisation programme.

9. Next steps

The council's political leadership, senior management and members of the HWB will undoubtedly wish to reflect on these findings and suggestions

before determining how the council wishes to take things forward. As part of the peer challenge process, there is an offer of continued activity to support this. We made some suggestions about how this might be utilised. I look forward to finalising the detail of that activity as soon as possible.

In the meantime we are keen to continue the relationship we have formed with you and colleagues through the peer challenge to date. Rachel Litherland, Principal Adviser for the East of England is the main contact between your authority and the Local Government Association. Rachel can be contacted at rachel.litherland@local.gov.uk (or tel. 07795 076 834) and can provide access to our resources and any further support.

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In the meantime, all of us connected with the peer challenge would like to wish the council every success going forward. Once again, many thanks for inviting the peer challenge and to everyone involved for their participation.

Yours sincerely,

Satvinder Rana
Programme Manager
Local Government Association

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On behalf of the peer challenge team

APPENDIX 2

Health and Wellbeing Board
Action Plan 2014/15
June 2014

Priority One: Strengthening relationships with partners and providers					
Accountable Leads: Wendi-Ogle Welbourn, Jana Burton, Cathy Mitchell and Director of Public Health					
Num	**Recommendation**	**Action**	**Performance Measure**	**By Whom and When**	**Rag Rating**
1	Reinstate chief executive meetings	• Chief Executive to contact CEO's of partners and organise a programme of meetings/dinners	• Regular meetings have been scheduled, ToR provided and areas of focus are identified	Gillian Beasley Sept 2014	
2	Workshop to be organised with partners, including providers to ensure mutual understand all health challenges and actions required	• The programme board to be the lead on the organisation and delivery of the workshops and to report back to the HWB on progress and outcomes	• All partners, including providers to feel their voice has been heard and their challenges have been considered	Jana Burton / Wendi Ogle-Welbourn / Cath Mitchell October 2014	
3	Build and improve relationships with the local PHE and NHS England representatives	• PHE Centre Director to attend HWB to present annual prospective and work plan • Review of joint working opportunities	• The local PHE and NHS England are fully engaged with the HWB, the shared vision and tackling of the priorities/challenges	PHE Jana Burton, Director of PH, Andrew Reed (NHS England Area Team Director)	

Priority Two: Health & Wellbeing Board					
Accountable Leads: Chairman and Vice Chairman of the HWB, Jana Burton, Director of Public Health					
Num	**Recommendation**	**Action**	**Performance Measure**	**By Whom and When**	**On Track**
1	Create a shared vision for the future, incorporating the three pillars (the health challenges faced within the City, the management of demand across the system and the need to reduce expenditure)	• Refresh vision and ToR of the Board to include the three pillars • Refresh delivery plan incorporating the three pillars and with clear accountability • Invite the LGA peers to be involved in the future planning of the shared vision and priorities • Create a new logo for the HWB	• Partners see a significant difference in their involvement and contribution to improving health services across the City	The HWB Lead officer Jana Burton HWB GP Representative Lead Officer	
2	Commence review of Board membership	• Partners/providers to complete a form detailing why they wish to be added as a member for the HWB to review when agreeing the revised membership • Partners/providers to be formally invited as a member of the Board • Board meeting seating plan to be refreshed to encourage partnership working	• Revised multi agency Board in place	The HWB, Lead officer, Jana Burton, July 2014	
3	Improve political engagement within the HWB	• Leader to hold a 'Leader's Summit' for politicians and agree a programme of regular meetings	• Politicians are regularly updated with progress and performance of the HWB and the delivery plan	Cllr Cereste, Cllr Lamb, Cllr Fitzgerald, Lead officer, Jana Burton	
4	Strengthen the involvement of the CCG	• Consider CCG representative to be vice chair of the HWBB	• CCG are fully engaged with the HWB	HWBB Chair	
5	Refresh agenda setting and decision making of future HWB meetings	• Include NHS providers on strategic debates • Consideration made to setting up a Strategic Advisory Group to enable strategic discussions around	• Future HWB are more robust with clear decision making and partnership engagement	The HWB Lead officer, Jana Burton, Alan Sadler	

		innovation and long term systems		(Business Manager CCG)	
HWB Programme Board					
6	Identify and agree health priorities / challenges	• Programme Board to develop and present suggested priorities and challenges to the HWB after consultation with partners. The priority actions should be selected on the basis of the biggest impact on shared vision and the three pillars • Drive through agreed priorities and challenges, reporting regularly to the HWB on progress and outcomes	• Two-three priorities which address health improvement, financial demands and sustainability are identified and noticeable impacts / outcomes are being delivered	The Programme Board The Programme Board	
7	Undertake horizon scanning / research of best practice models	• Attendance at regional and national learning sets and contacting other LA's to identify best practice models	• Guidance document to be produced and presented to the Programme Board for discussion and for consideration when reviewing the vision and strategy	Lead officer Sept 2014	

Priority Three: Management of demand across all agencies					
Accountable Leads: Jana Burton, Wendi Ogle-Welbourn, Cathy Mitchell					
Num	**Recommendation**	**Action**	**Performance Measure**	**By Whom and When**	**On Track**
Enhance cost-effectiveness					
1	Reduce expenditure by looking at ways to share demands and deliver joint services	• Develop joint services, including prevention	More for less / value for money / reduced expenditure	HWB Programme Board/JCF	
Childhood Obesity					
2	Finalise and publish strategy	• Presentation to the HWB and scrutiny panel for consultation and approval • Organise consultation with schools, school nurses, primary care, health visiting services and dietetics services • HWB to provide clear leadership and guidance in the future direction of the strategy, evaluation and accountability	Reduction in childhood obesity	Adrian Chapman Julian Base The HWB	
3	Improve partnership working to tackle issues from a multi agency prospective	• Organise community based workshops to consult on the strategy, improve the understanding and priority of childhood obesity • The Communities Directorate to establish the ownership of childhood obesity, co-ordination of implementation plans and reporting on performance	Increased understanding and action across the City to tackle childhood obesity	Adrian Chapman / Julian Base Wendi Ogle-Welbourn	

Priority Four: Leadership and Governance					
Accountable Leads: Jana Burton, Director of Public Health					
Num	**Recommendation**	**Action**	**Performance Measure**	**By Whom and When**	**On Track**
1	Presentation of statutory responsibilities to the HWB with regard to health protection including emergency planning and response	• Health protection and emergency planning report to be tabled at the HWBB on regular basis • Kevin Dawson to be included as a member of the Health Protection Committee • Feedback on actions agreed at future Health Protection Committee for HWB to debate if the arrangements in place are robust and effective • HWB to consult on current 'test exercise programme' to ensure staff are prepared	Robust health protection plan in place and understood by all members of the HWBB	Director of PH, Jana Burton, Area Team PHE The HWB	
Create an established performance management framework					
2	Improve the performance management framework	• Refresh of current performance reporting to include the shared vision and agreed priorities/challenges and how impact and outcomes are measured and monitored effectively • Create an integrated strategic framework across the health and wellbeing system	• Robust performance framework in place	The HWB, Jana Burton, Tina Hornsby Alan Sadler (Business Manager CCG)	
3	Review the current immunisation programme	• Invite the accountable consultant in screening and immunisation from the embedded PHE team to attend the health protection committee • Consultant to present an annual report to the HWB for debate and to feedback on ad hoc incidents that may arise • The HWB to review the	• Presentation of findings to the HWB • Clear reporting mechanism in place • Review of contract	Director of PH, Area Team PHE	

		commissioning arrangements for the current immunisation programme and the performance monitoring in place		The HWB	
Leadership within PH function					
4	Establish PH leadership	• Communications programme to be instigated showing how and where the PH functions fit into the Council • Identify and agree separate portfolio responsibilities for PH and Health Improvement	• Visible public health expertise employed as part to the councils responsibilities. Partners and agencies are fully aware of the role of public health and responsibilities	Jana Burton, Director of PH, Cllr Lamb Jana Burton, Director of PH, Cllr Lamb	
5	PH Intelligence	• Identify where other LA's perform well against health and equalities objectives	• Research paper to be produced and present to the programme board which will include benchmarking against Peterborough	Director of PH, Lead Officer, Jana Burton	
Scrutiny of Health & Wellbeing provision					
6	Strengthen effectiveness of the scrutiny panel	• Refresh of scrutiny's role with the HWB and work programme to include a focus on the JSNA • Create a robust challenge mechanism in line with the work programme • Training offered to the panel members on leadership and challenge	• Clear challenge processes in place • Panel members held to account	Cllr Brian Rush Jana Burton	
7	Review reporting procedures	• Chair of scrutiny to have standard agenda item on work of HWB to review action plan and make recommendations	• Lead scrutiny member to attend Programme Board • Scrutiny panel scrutinise action plan and make recommendations	Cllr Brian Rush Jana Burton	
8	Lines of accountability	• Review to be undertaken on how scrutiny holds the HWB, the Public and partners accountable to deliver the strategy and delivery plan, in conjunction with Healthwatch	• Progress and impact is successfully monitored by the panel	Cllr Brian Rush and the HWB	
Policies and procedures					

9	HWB Strategy to be updated and published	• The Programme Board to facilitate an LGA/peer led workshop with partners and providers to refresh the strategy and consider priorities • Communications strategy to be put in place to publicise the revised strategy, vision, key priorities and objectives across the City	• The revised strategy is successfully communicated and implemented across the city with clear deliverables and performance monitoring in place	HWB Programme Board Andy Carter, Helen Gregg, Julian Base	
Structure					
10	Relocation of the adults commissioning service into the Communities Directorate	• Service is scheduled to move in May 2014	• Integrated commissioning service across the Council	Wendi Ogle-Welbourn Sept 2014	
11	Appointment of a Director of Public Health in a substantive post	• Job description has been approved • Vacancy for Director of PH to be advertised • Interview Panel to be created and interviews to be scheduled	• Director of PH in post with clear focus on improving communication across partners and providers	Jana Burton June 2014	

Recommendation Report Cross Reference

Priority	Recommendation	Report Page References
Strengthening relationships with partners and providers	1 Reinstate chief executive meetings	7
	2 Partners providers workshop	*Suggestion*
	3 Improve relationships with PHE/NHS England	9, 11
Health & Wellbeing Board	1 Create a shared vision	7, 8, 13, 14
	2 Review of membership	4, 6, 7, 11, 13
	3 Improve political engagement	4, 13
	4 Strengthen the involvement of the CCG	4, 7
	5 Refresh agenda setting and decision making of future HWB meetings	4, 7
	6 Improve the performance management framework	10
	7 HWB Programme Board – identify and agree health priorities / challenges	6, 7
Management of demand across all agencies	1 Reduce expenditure	8
	2 Finalise and publish Childhood Obesity strategy	5, 12
	3 Improve partnership working to tackle issues from a multi agency prospective	12
Leadership & Governance	1 HWB review statutory responsibilities	5, 10, 11, 13
	2 Review of current immunisation programme	11, 13
	3 Establish PH leadership	5, 9
	4 Strengthen effective of the scrutiny panel	4, 10, 13
	5 Review reporting procedures	4
	6 Lines of accountability	4, 10, 11, 12, 13
	7 HWB strategy	4, 5
	8 Relocation of Adults Commissioning	9, 13
	9 Appointment of Director of PH	5, 9

CABINET	AGENDA ITEM No. 6
30 JUNE 2014	PUBLIC REPORT

Cabinet Member(s) responsible:	Cllr Wayne Fitzgerald, Cabinet Member for Adult Social Care Cllr Diane Lamb, Cabinet Advisor for Health	
Contact Officer(s):	Jana Burton Executive Director Adult Social Care, Health & Wellbeing	Tel. 452409

CONCORDAT FOR JOINT WORKING BETWEEN PETERBOROUGH CITY COUNCIL, CAMBRIDGESHIRE COUNTY COUNCIL AND HEALTH ORGANISATIONS ACROSS PETERBOROUGH & CAMBRIDGE

RECOMMENDATIONS	
FROM : Executive Director of Adult Social Care and Health and Wellbeing	**Deadline date : 30 June 2014**

1. To endorse the Concordat for joint working across Peterborough & Cambridgeshire Health & Social Care Economy; and

2. To note the external assistance being offered to Peterborough and Cambridgeshire as one of the 11 Challenged Health Economies.

1. ORIGIN OF REPORT

1.1 This report is submitted to Cabinet to seek approval for a Concordat for joint working between Peterborough City Council, Cambridgeshire County Council and all Health Organisations across Peterborough and Cambridgeshire.

2. PURPOSE AND REASON FOR REPORT

2.1 Cambridgeshire and Peterborough has been identified as one of 11 Local Health Economies nationally who are being supported with external assistance in their development of aligned strategic plans to address the financial challenges they face.

2.2 This joint work is being sponsored by NHS England Monitor and the Trust Development Authority and supported locally by Cambridgeshire and Peterborough Clinical Commissioning Group. Price Waterhouse Coopers (PwC) have been selected to undertake an initial 3 month exercise to scope the work that needs to be undertaken. This work will result in a report which will be produced at the end of this month. The Council along with Cambridgeshire County Council have been included in the joint working because of our responsibility for social care.

2.3 A Concordat has been drawn up to describe how all the organisations included in this work are tasked with working together to develop solutions for the future. The Cabinet is asked to approve the Concordat on behalf of the Council

2.4 This report is for Cabinet to consider under its Terms of Reference 3.2.3, 'to take a leading role in promoting the economic, environmental and social wellbeing of the area'.

3. TIMESCALE

Is this a Major Policy Item/Statutory Plan?	**NO**	If Yes, date for relevant Cabinet Meeting	n/a

4. DETAILS OF THE CONCORDAT

4.1 The case for change across the health system results from the increasing gap between funding and the costs of care across the region, so that even if each organisation achieves its cost improvement programmes the financial gap remains significant in the order of £246m by 2018/19. Population growth coupled with clinical activity projections show that there will be an increase in urgent care inpatient episodes by 17.2% together with elective growth of 16.7% by 2018 with an overall increase in inpatient activity by approximately 16%. To address this challenge significant change in the way all organisations work together must be achieved.

4.2 System leaders have been meeting regularly i.e. the Chief Executive Officers from all Health Trusts together with the Directors of Adult Social Care for Peterborough CC and Cambridgeshire CC to oversee the development of this work and together the Concordat describing future working relationships has been drawn up. Key features of this Concordat are as follows

- To have partner agencies leading strategic changes across Cambridgeshire and Peterborough health and care systems
- To enable continued improvements in outcomes for people and to ensure the local sector is financially sustainable
- Organisations are working across boundaries collectively to deliver 24/7 services to ensure that acute services prioritise urgent and specialist care and to look at community based alternatives and prevention where ever possible

5. CONSULTATION

5.1 Clinically led workshops to consider and develop new models of health delivery and alternatives to acute provision have been debated and considered during this initial scoping phase. Adult Social Care staff have been engaged in the process. This will help inform the recommendations in the initial report expected next month.

6. ANTICIPATED OUTCOMES

6.1 The anticipated products of the work being undertaken by Peterborough and Cambridge are a clear system blueprint that all organisations can sign up to and a governance mechanism that will enable progress to be made post June.

6.2 These will be presented to Members for consideration as soon as they are available.

7. REASONS FOR RECOMMENDATIONS

7.1 To ensure in the proposed transformation that due consideration is given to the health and social care needs of the population in Peterborough.

7.2 The particular demographics and health inequalities in Peterborough are often masked in the wider health profiles across Cambridgeshire. Participation in this work is essential to ensure new ways of working to address local need and requirements for delivery.

8. ALTERNATIVE OPTIONS CONSIDERED

8.1 The option not to participate in this work would disadvantage the opportunity for the population of Peterborough to ensure main health and social care needs are being addressed.

9. IMPLICATIONS

9.1 The scale of financial challenge across Cambridgeshire and Peterborough requires a system wide approach to transformation to ensure the continuation of health and social care support in the local population.

9.2 Each organisation will contribute resources to the design and implementation of the strategic plan

9.3 Signing of the concordat does not commit us to any money at this stage and all work will be assessed under a business case for any future funding

10. BACKGROUND DOCUMENTS

List of acronyms attached at Appendix A to the report.
Please see the Concordat attached at Appendix B to the report.

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APPENDIX A

APPENDIX OF ORGANISATIONS IN THE PETERBOROUGH & CAMBRIDGESHIRE CHALLENGED HEALTH ECONOMY

ACRYNOMS

CUHFT	Cambridge University Hospital NHS Foundation Trust
CPFT	Cambridge & Peterborough Foundation Trust
CCS NHST	Cambridgeshire Community Services NHS Trust
PSHFT	Peterborough & Stamford Hospital Foundation Trust
UCC	Urgent Care Cambridgeshire
HUC	Herts Urgent Care
CCG	Clinical Commissioning Group
PwC	Price Waterhouse Coopers

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APPENDIX B

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

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UPDATED: 9 JULY 2014

HEALTH AND WELLBEING BOARD
PROPOSED AGENDA PLAN 2014/15

MEETING DATE	ITEM	CONTACT OFFICER
17 July 2014	• Report on Health Protection, Emergency Planning and Response to Emergencies • Memorandum of Agreement between Public Health and LCG's – Public Health Work Plan • Priority CVD – Work to Date • Peer Review Letter and Draft Action Plan • Concordat for Joint Working Between Peterborough City Council, Cambridgeshire City Council and Health Organisations across Peterborough and Cambridge • Report from NHS England on Screening and Immunisations Q3 Performance • Report from NHS England on Development of Primary Care Strategy • Update on PWC 'Challenged Health Economy Work' • Revised Terms of Reference and Membership • Report on Development of the Better Care Fund Action Plan • Development of Joint Child Health Commissioning Unit Where appropriate tabled reports from CCG/LA/Healthwatch/NHS England and others.	**Dr Henrietta Ewart** **Dr Henrietta Ewart/Cathy Mitchell** **Dr Henrietta Ewart** **Wendi Ogle-Welbourn** **PHE/NHSE** **PHE/NHSE** **NHSE** **Wendi Ogle-Welbourn** **Cathy Mitchell/Jana Burton** **Wendi Ogle-Welbourn**
25 September 2014	Programme Board Performance report on activity focused on identified priorities and activities in the refreshed Health and Wellbeing Strategy Report from NHS England on Screening and Immunisations performance Report from NHS England on development of Primary Care Strategy Report from Director of Public Health on health protection - emergency planning and response to emergencies that present a risk to the public's health arrangements Report on development of the Better Care Fund Action Plan Report on CSE work Report on sexual health services Update on SARC Review S256 Agreements Where appropriate tabled reports from CCG/LA/Healthwatch/NHS England	**Wendi Ogle-Welbourn** **PHE/NHSE** **PHE/NHSE** **Dr Henrietta Ewart** **Cathy Mitchell** **Russell Waite/ Gary Ridgeway** **Jo Melvin/Wendi Ogle-Welbourn** **Tracey Cogan / Mark Hopkins Cambs Constabulary** **Cathy Mitchell / Nick Blake**

MEETING DATE	ITEM	CONTACT OFFICER
	and others.	
11 December 2014	Programme Board Performance report on activity focused on identified priorities and activities in the refreshed Health and Wellbeing Strategy Report from NHS England on Screening and Immunisations performance Report from NHS England on development of Primary Care Strategy Report from Director of Public Health on health protection - emergency planning and response to emergencies that present a risk to the public's health arrangements Report on development of the Better Care Fund Action Plan Report on DV Report on substance misuse services Where appropriate tabled reports from CCG/LA/Healthwatch/NHS England and others.	**Wendi Ogle-Welbourn** **PHE/NHSE** **PHE/NHSE** **Dr Henrietta Ewart** **Cathy Mitchell** **Wendi Ogle-Welbourn** **Andy Barringer/Wendi Ogle-Welbourn**
26 March 2015	Annual DPH report on health of the local population Standard agenda items will always be: Programme Board Performance report on activity focused on identified priorities and activities in the refreshed Health and Wellbeing Strategy Report from NHS England on Screening and Immunisations performance Report from NHS England on development of Primary Care Strategy Report from Director of Public Health on health protection - emergency planning and response to emergencies that present a risk to the public's health arrangements Report on development of the Better Care Fund Action Plan	**Jana Burton** **Wendi Ogle-Welbourn** **PHE/NHSE** **PHE/NHSE** **Dr Henrietta Ewart** **Cathy Mitchell**
For Consideration at Future Meetings	Tobacco Control Healthy Child Programme (including breastfeeding, 2.5 health checks) Public protection and regulatory activity to support reduction in health inequalities (including takeaways/fast food/alcohol, air pollution and fire safety) Healthy schools and pupils Warm and safe homes	**Julian Base**

MEETING DATE	ITEM	CONTACT OFFICER
	Helping people find good jobs and stay in work Active and safe travel Access to green and open spaces and the role of leisure activities Strong communities, wellbeing and resilience Health and spacial planning	

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