PETERBOROUGH CITY COUNCIL

HEALTH AND WELLBEING BOARD

THURSDAY 24 MARCH 2016
1.00 PM

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

AGENDA

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

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

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

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Board Members:

Cllr J Holdich (Chairman), Dr Mistry (Vice Chairman),
Cllr D Lamb, Cllr W Fitzgerald, Cathy Mitchell,
Dr Moshin Laliwala, Dr Gary Howsam, Dr Kenneth Rigg, David Whiles,
Wendi Ogle-Welbourn, Dr Liz Robin, Adrian Chapman and
Andrew Pike, Cllr Richard Ferris

Co-opted Members: Russell Wate and Claire Higgins

Substitute: Dr van den Bent

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

PETERBOROUGH CITY COUNCIL

MINUTES OF A MEETING OF THE HEALTH AND WELLBEING BOARD HELD IN THE BOURGES / VIERSEN ROOMS, TOWN HALL ON 10 DECEMBER 2015

Members Present:	Councillor Holdich, Leader of the Council and Cabinet Member for Education, Skills and University (Chairman) Councillor Fitzgerald, Deputy Leader and Cabinet Member for Integrated Adult Social Care and Health Councillor Lamb, Cabinet Member for Public Health Wendi Ogle-Welbourn, Corporate Director People and Communities Adrian Chapman, Service Director, Adult Services and Communities Dr Liz Robin, Director for Public Health Cathy Mitchell, Local Chief Officer Dr Harshad Mistry (Vice-Chairman) Dr Moshin Laliwala Dr Gary Howsam, Chair of the Borderline Local Commissioning Group David Whiles, Peterborough Healthwatch
Co-opted Members Present:	Claire Higgins, Chairman of the Safer Peterborough Partnership Jo Proctor, Representative of Local Safeguarding Children's Board and Peterborough Safeguarding Adults Board
Also Present:	Mark Avery, Director for Transformation at Peterborough and Stamford Hospitals NHS Foundation Trust Will Patten, Assistant Director for Adult Commissioning Alice Benton, The Head of Primary Care for the Clinical Commissioning Group Pippa Turvey, Senior Democratic Services Officer

1. Apologies for Absence

Apologies for absence were received from Dr Kenneth Rigg and Russell Wate. Joanne Proctor was in attendance as substitute.

2. Declarations of Interest

Dr Mistry declared that he was a General Practitioner for his local practice and clinical lead for out of hours services.

Dr Laliwala, Dr Howsam and Dr Mistry declared that they were Directors of Companies within the health field.

3. Minutes of the Meeting Held on 10 September 2015

The minutes of the meeting held on 10 September 2015 were approved as a true and accurate record.

4. Amended Health and Wellbeing Board Membership and Terms of Reference

A report was submitted to the Board following agreement at the meeting held on 10 September 2015 that an 'Opposition member' position would be added to the Board's Membership. The

Leader of the Council, following consultation with Group Leaders, had nominated Councillor Ferris to fill the position.

A Member of the Board advised that Peterborough and Borderline Local Commissioning Groups were consulting their Member Practices regarding a proposal to create a single Greater Peterborough Local Commissioning Group.

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

1) Note the revised Terms of Reference; and
2) Appoint Councillor Ferris as a Member of the Health and Wellbeing Board as 'an opposition Councillor'.

The Chairman advised that apologies for absence had been received from Councillor Ferris.

5. Health and Care System Transformation Programme

The Assistant Director of System Transformation at Peterborough and Stamford Hospitals NHS Foundation Trust introduced the report which provided the Board with an update on Cambridgeshire and Peterborough Health and Care System Transformation Programme planning process.

Key points highlighted and raised during discussion included:

- On 16 November 2015, the System Transformation Programme Board and Chief Executives from across the area met to make a recommendation to the Clinical Commissioning Group (CCG) governing body to proceed with engagement with the various work streams within the programme;
- The public engagement decision sat with the CCG governing body and would take place in January;
- It was commented that the engagement campaign would be a gradual process. This would ensure that front line clinicians, from the various hospitals, and GPs would be on board to check that the ideas coming out of the process were a fair indicator of the feedback and encompass all of the differing views. It was suggested that this would be likely to begin in early 2016;
- At the point where the wider publication of work would occur, a number of information packs could be updated to include the most recently available data. The new figures could be inputted alongside older figures to show improvements.

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

6. Prevention Work for the Health System Transformation Programme

The Director of Public Health introduced the report, which covered the Health System Prevention Plan, which formed part of the wider Health System Transformation work. The report outlined the first draft of the prevention plan that the Health System Transformation Programme had asked the Public Health team to develop.

Key points highlighted and raised during discussion included:

- The report assessed research regarding what preventive initiatives and services could be put in place to save the NHS money and looked at evidence on intervention schemes that could be implemented to improve outcomes by reducing disease;
- The report was part of a prevention strategy and was quite narrow, as wider interventions were out of the scope of the report. Social preventive interventions would be included in the wider prevention strategy;

- The document had been developed since publication and the estimated savings of £1 million-£3 million per year, as stated in the published report, would rise with the further economic modelling work undertaken;
- The reduction in the public health grant potentially made new investment in the programme from the local authority more difficult, and some aspects were most appropriate for NHS investment. Once further discussions had taken place, this would be reported back to the Health and Wellbeing Board;
- It was agreed that it was very important to use the language regarding lifestyle choices and health issues correctly. Collaborative working post-health check would be imperative to offer additional support to help people make the relevant changes;
- The Director of Public Health responded that these improvements would not necessarily result in greater future expenditure as a result of individuals living longer, because the period of end of life illness would likely be greatly reduced;
- The strategy provided an evidence base and would initially be looked at in terms of the NHS, and what could be incorporated into the NHS Quality, Innovation, Productivity and Prevention Programme (QIPP) would be considered. Following this, it would broaden out into the Better Care Fund and the wider Health and Wellbeing Strategy;
- It was commented that bringing the strategy into the Joint Commissioning Forum would be welcomed and that it would be beneficial to present the strategy to a wide audience as early as possible;
- The widespread availability of health checks was questioned, and a need for lifestyle mentors and coaches which should be available at GP level and a cohesive health care package was highlighted.
- It was noted that health checks needed to be targeted to the most at risk section of the public but this section of the public were those who were statistically most unlikely to proactively attend;
- The Director of Public Health suggested that health trainers could work alongside doctors and nurses to create targeted, cost effective and successful early intervention. There was a mandated service from Central Government that health checks have to be offered to everybody between the ages of 40 to 74 over a five year period;
- It was considered that health aspirations should be engendered in the population as a whole and that this initiative should begin whilst in education;

The Health and Wellbeing Board **RESOLVED** to note the first draft of the health system prevention plan.

7. Substance Misuse Whole Treatment Service Retender

The Corporate Director of People and Communities introduced the report, following the retender and contract award of substance misuse treatment services for young people and adults in Peterborough. The report outlined the result of the re-tender of substance misuse services and the timetable to mobilise the new contract to commence April 2016, and outlined the strategic intent for tackling substance misuse in the city using the opportunity provided by the retender of treatment services.

Key points highlighted and raised during discussion included:
- It had been determined that greater flexibility was required within the substance misuse service.
- A re-tender had been completed and CRI had been awarded the contract. The TUPE transfer of staff had commenced.
- CRI were keen to work and engage with the Council and had expressed an interest in attended a meeting of the Health and Wellbeing Board in the summer.

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

1. Note the contents of the report, understanding that it will receive regular reports and presentation if requested during the mobilisation period; and
2. Ensure members support to relevant elements of mobilisation as required.

8. Adult Social Care, Better Care Fund Update

The Director for Transformation introduced the report, which was submitted at the request of the Corporate Director of People and Communities. The report set out an update on the delivery of the Better Care Fund Programme and future key activities.

Key points highlighted and raised during discussion included:

- NHS England had confirmed that the Better Care Fund would continue next year.
- The Council was required to make a submission for continued funding by February 2016.
- It was intended to keep the bid as close as possible to the original submission.
- In terms of the progress of workstreams, it would be necessary to understand the implications of the contractual arrangement between Cambridgeshire and Peterborough CCG and UnitingCare Partnership ending.
- It was noted that the requirement to submit a new bid each year created uncertainty and a three or five year programme would be more suitable.

The Local Chief Officer advised that discussions were ongoing with clinical / management leads to progress a number of workstreams.

The Health and Wellbeing Board **RESOLVED** to note the update of Better Care Fund delivery and the second quarterly monitoring return for NHS England.

9. Draft Peterborough Joint Health and Wellbeing Strategy

The Director of Public Health introduced the report following the agreement of the outline framework and chapter headings for the Strategy at the Health and Wellbeing Board meeting in September 2015. The report sought the Board's comment and approval of the text to the draft Peterborough Joint Health and Wellbeing Strategy 2016-19 as a basis for further stakeholder engagement and consultation.

Key points highlighted and raised during discussion included:

- Contributions from Board Members had allowed for a bringing together of knowledge regarding need, current action and future plans.
- The Draft Strategy was due to go through an informal stakeholder and public consultation process, to present a final proposal to the Board in March 2016.
- It was expected that response from the public would be relatively low, with more engagement expected from stakeholders.
- The Board was assured that Patient Participation Groups were involved in the informal consultation.
- It was suggested that a more visual approach be taken, in order to better communicate matters to the general public.
- Children's disabilities and mental health were identified as two areas in which additional focus could be made.

The Health and Wellbeing Board **RESOLVED** to approve the text of the draft Peterborough Joint Health and wellbeing Strategy 2016-19, subject to the comments set out above.

10. Peterborough System Winter Plan

The Local Chief Officer introduced the report from the Peterborough System Resilience Group (SRG). The report sought to inform the Board of the Planning undertaken by the Peterborough SRG Partners which enabled combined understanding of the demand and capacity

requirements to ensure the system was able to operate and manage patient flow through the services over the winter period.

Key points highlighted and raised during discussion included:

- Following a question raised with regard to the previous year's 'bed blocking' scenario, the Board were reassured that the systems in place were now more robust with greater communication between the various bodies involved;
- A number of issues regarding capacity had been encountered during recent Lincolnshire procurement process. Following this, the future timing of procurements would be closely monitored in the future;
- Following the commencement of primary care services in front of the accident and emergency department, the partnership was working effectively to manage patients who present with a Primary Care need;
- In terms of demand for nursing homes, it was commented that further discussion around this area would be welcomed.
- Primary care commented that they were 'desperate' to be involved with the earlier stages of planning for nursing or care homes due to the impact which is felt by local health facilities.
- It was commented that Ian Green, Health Improvement Specialist, had been placed into the Growth and Regeneration Directorate to make public health input into the Local Plan, the Local Transport Plan and the Housing Strategy. His role would ensure links with NHS England and NHS Properties were maintained.

The Health and Wellbeing Board **RESOLVED** to note the update set out in the report.

INFORMATION ITEMS AND OTHER ITEMS

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

11. Peterborough Safeguarding Children Board Annual Report and Peterborough Safeguarding Adult Annual Report

12. Primary Care Programme Update

The Head of Primary Care for the CCG introduced the report. The report provided an update of the primary care programme and sought to inform the Board of the CCG's intention to apply for delegated commissioning for primary medical services from NHS England.

13. Health and Wellbeing Partnership Delivery Board Terms of Reference

14. Schedule of Future Meetings and Draft Agenda Programme

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

1.00pm – 2.35pm
Chairman

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 4
24 MARCH 2016		PUBLIC REPORT
Contact Officer(s):	Jessica Bawden, Director of Corporate Affairs, Cambridgeshire and Peterborough Clinical Commissioning Group	Tel.

UPDATE ON SYSTEM TRANSFORMATION PROGRAMME AND FIT FOR THE FUTURE, SUSTAINABILITY AND TRANSFORMATION PLAN

RECOMMENDATIONS	
FROM: Jessica Bawden, Director of Corporate Affairs, Cambridgeshire and Peterborough Clinical Commissioning Group	**Deadline date:** NA
The Board is asked to note the direction of Fit for the Future as well as the CCG's Sustainability and Transformation programme for 2016/17 and beyond.	

1. ORIGIN OF REPORT

1.1 This report is submitted to Board as an update to the Sustainability and Transformation Programme.

2. PURPOSE AND REASON FOR REPORT

2.1 To update the board on the progress of the System Transformation Programme and to introduce Fit for the Future, Sustainability and Transformation Programme for the Cambridgeshire and Peterborough area.

3. BACKGROUND

3.1 Cambridgeshire and Peterborough has been identified nationally as a 'challenged health economy'. In the local System Transformation Understanding Today, Designing Tomorrow change document, published in 2014, the health system's key challenges are identified as follows:

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

3.2 Over the last year the System Transformation Programme worked to outline the issues and develop ideas to transform healthcare across the region. This work will now be carried forward by the Sustainability and Transformation programme, overseen by the Health and Care Executive, whose membership includes the Cambridgeshire and Peterborough local authority Chief Executive, Gillian Beasley.

3.3 The National Context

3.3.1 The leading national health and care bodies in England have come together to publish 'Delivering the Forward View: NHS Shared Planning Guidance 2016/17 – 2020/21', setting out the steps to help local organisations deliver a sustainable, transformed health service and improve the quality of care, wellbeing and NHS finances.

3.3.2 It is published by NHS England, NHS Improvement (the new body which will bring together Monitor and the NHS Trust Development Authority), the Care Quality Commission, Public Health England, Health Education England, and National Institute for Health and Care Excellence (NICE) – the bodies which developed the Five Year Forward View in October 2014.

3.3.3 As part of this all NHS organisations are asked to produce a local health and care system 'Sustainability and Transformation Plan', which will cover the period October 2016 to March 2021.

3.3.4 The Cambridgeshire and Peterborough Sustainability and Transformation Plan will incorporate the work of its Urgent and Emergency Care (UEC) Vanguard Programme.

3.3.5 **Vanguard:** There are currently 50 Vanguard sites across England that are part of the national New Care Models Programme. They have been chosen to lead on developing new ways of planning, delivering, and paying for sustainable health and care services. The aim is to provide safer, faster, and better care for patients, now and in the future.

3.3.6 Cambridgeshire and Peterborough UEC Vanguard Programme has received £970,000 of funding as one of eight selected 'UEC Vanguards' for the new care models programme which is playing a key part in the delivery of the Five Year Forward View – the vision for the future of the NHS. Vanguards are leading on developing new care models that will act as blueprints for the future of the health and care system in England.

3.3.7 (Note: the 'Vanguard' transformation fund monies will be combined with other national transformation funds in 2017/18 so any bids for extra money to support Vanguard/Sustainability and Transformation work will all be against this new central fund).

3.4 Fit for the Future, Sustainability and Transformation Programme

3.4.1 The Cambridgeshire and Peterborough Health System Sustainability and Transformation Programme has been formed as a cross-system team to look at how the significant challenges that Cambridgeshire and Peterborough's health economy faces can be addressed.

3.4.2 The programme is a cross-system programme involving:

- Monitor
- NHS England
- Trust Development Authority
- Cambridgeshire and Peterborough Clinical Commissioning Group
- Cambridge University Hospitals NHS Foundation Trust
- Peterborough and Stamford Hospitals NHS Foundation Trust
- Hinchingbrooke Health Care NHS Trust
- Cambridgeshire and Peterborough NHS Foundation Trust
- Cambridgeshire Community Services NHS Trust
- Papworth Hospital NHS Foundation Trust
- Cambridgeshire County Council
- Peterborough City Council

3.5 Overall Programme

3.5.1 **The Local Picture**

- Our health system needs to change to be Fit for the Future
- Our clinical models could be more effective
- We have a growing and ageing population
- We have financial pressures that are the imperative for change
- We want to work with local people to design a local health system that is Fit for the Future
- We need a health and care system that is financially and clinically sustainable.

3.5.2 **The National Picture**

- The future shortfall in funding faced by the NHS in England is estimated to be at £30 billion by 2020/21
- NHS organisations are asked to produce a local health and care system 'Sustainability and Transformation Plan', which will cover the period October 2016 to March 2021, to provide a sustainable, transformed health service and improve the quality of care, wellbeing and NHS finances
- Transforming the health system in the best interests of patients is at the heart of the Fit for the Future NHS Sustainability and Transformation Programme
- NHS England's Five Year Forward View (October 2014) recognises that the world has changed and health services need to evolve to meet the challenges NHS face
- The Sustainability and Transformation Programme is looking at all hospital-based, GP, and community healthcare services in Cambridgeshire and Peterborough
- This is very much in line with NHS England's Five Year Forward View.

3.6 New Governance Structure – Workstream Programmes

3.6.1 Under the new governance structure, the programme of work in 2016/17 will focus on the following, with a Clinical Advisory Group to oversee all the work of the clinically led workstreams, as detailed below:

3.7 Clinical Advisory Group – Summary and Scope

- To recommend a sustainable clinical five year vision for health and care, including the transformation required to deliver it
- To recommend short-term opportunities to improve the effectiveness and efficiency of care, and medium-term options for service configuration (including primary, community, mental health, acute, specialised, and social care delivered in Cambridgeshire and Peterborough)
- To assure clinically a) consultation documentation b) a Cambridgeshire and Peterborough Mental Health strategy and c) a Five Year Sustainability and Transformation Plan.

3.8 Workstream: Proactive Care and Prevention (including long-term conditions, mental health, and primary care at scale) – Summary and Scope

- To develop the long-term vision for proactive community-based care (including the sustainability of primary care, mental health, social care and community services) and care for people with long term conditions
- To identify, quantify and deliver a set of short-term opportunities to reduce admissions amongst rising-risk long-term conditions and severe mental illness (SMI) patients, including the delivery of priority public health schemes that will have short-term (1-3 yr) and longer-term impact (5+ yrs)
- To propose localised delivery plan(s) for executing against the proactive care and long-term condition (LTC) care model over a three to five year period (covering self-

care, primary care, SMI, community pharmacy, wellbeing service, hospice care, population health management).

3.9 Workstream: Urgent and Emergency Vanguard (UEC) Programme – summary and scope

- To develop the long-term vision for sustainable urgent and emergency care that will reduce preventable A&E attendances and admissions by implementing physical and mental health services that implement the national urgent and emergency care vision (covering 111, ambulance, Mental Health crisis, Joint Emergency Team, Integrated Care Teams, neighbourhood teams, acute care, supporting IT platform/Directory of Services)
- To identify, quantify and deliver a set of short-term opportunities to improve the cost-effectiveness of urgent and emergency care
- To review options for urgent and emergency care, taking into account national standards, key clinical standards, and delivery of seven day services across all settings.

3.10 Workstream: Elective Care Design Programme (incl. specialty-specific sub-groups) – summary and scope

- To develop the long-term vision for elective care (including all cancer care), with further detailed specifications on a vision for elective pathways including orthopaedics, cardiology, Ear, Nose and Throat (ENT), and ophthalmology (including care models, standards and pathways)
- To identify, quantify, and deliver a set of short-term opportunities to improve the cost-effectiveness of elective care
- To review options for elective care, as well as detailed options for orthopaedics, cardiology, ENT, and ophthalmology.

3.11 Workstream: Maternity and Neonatal Clinical Working Group – summary and scope

- To develop the long-term vision for sustainable maternity and neonatal care, in line with the National Review's recommendations.

3.12 Workstream: Children and Young People Clinical Working Group – summary and scope

- To propose a care model and service specifications for acutely unwell children and young people, children and young people with LTCs, and children and young people with life-limiting conditions
- To identify, quantify, and deliver a set of short term opportunities to improve the cost-effectiveness of children and young people's services
- To review options for paediatric and children's health services in primary, secondary, and community, linking in to the joint commissioning strategy.

4. GOVERNANCE STRUCTURE

4.1 The new governance structure for the Sustainability and Transformation Programme is attached as Appendix A.

4.2 Stakeholders and the wider public will also be very much involved at all stages of the work, with a series of Public Involvement Assemblies (PIAs) to be held in March, to which we will invite stakeholders to participate in discussions about upcoming work and share their views. They will build on the existing work of the System Transformation Programme sessions held last year, allowing residents across Cambridgeshire and Peterborough to get involved in shaping local health services.

4.3 We are currently working on a detailed Communications and Engagement plan to reinforce

this work and take it forwards following the next round of PIAs.

5. BACKGROUND DOCUMENTS

5.1 NHS Shared Planning Guidance 2016/17 https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

6. APPENDICES

6.1 Appendix A - STP Governance Structure

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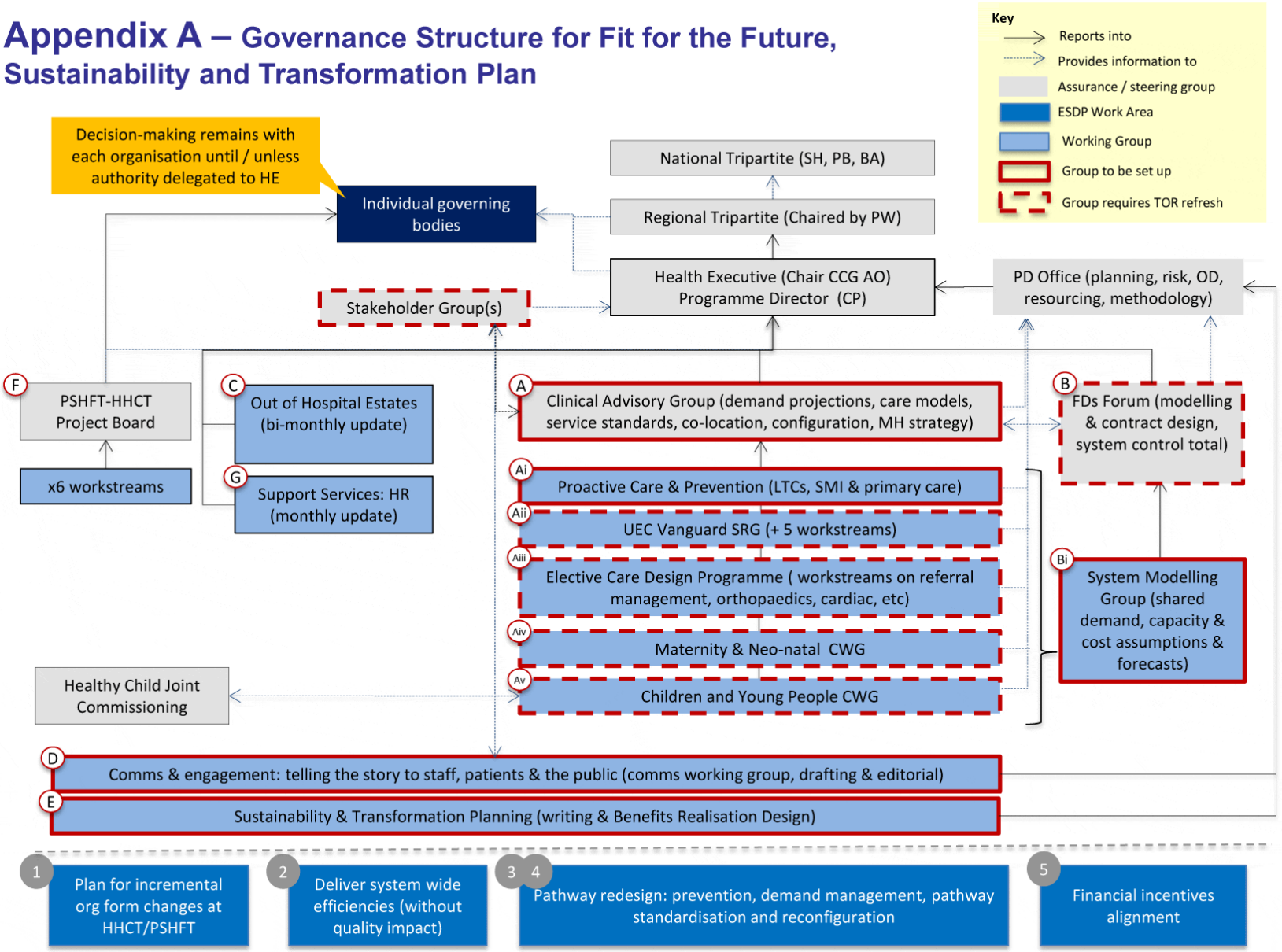
Appendix A – Governance Structure for Fit for the Future, Sustainability and Transformation Plan



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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 5
24 MARCH 2016		PUBLIC REPORT
Contact Officer(s):	CCG Engagement Team; capccg.engagement@nhs.net	Tel. 01223 725304

CLINICAL COMMISSIONING GROUP OPERATIONAL PLAN

RECOMMENDATIONS	
FROM : Catherine Mitchell, Local Chief Officer, Cambridgeshire and Peterborough CCG	**Deadline date :** N/A
The Board are requested to note the CCG's Operational Plans and to comment as appropriate.	

1. ORIGIN OF REPORT

1.1 This report is submitted to the Board from Cambridgeshire and Peterborough Clinical Commissioning Group.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to brief the Board on:

a) The changing context for planning
b) Progress being made with drafting an Operational Plan for 2016/17

3. THE CONTEXT FOR PLANNING

3.1 The additional funding allocated via the Spending Review will support the NHS to implement the Five Year Forward View and deliver financial balance and core access / quality standards. The new planning guidance published in December 2015 signals a major change to planning in the NHS, moving from single-year organisation-based plans to multi-year place-based plans.

3.1.2 During the transition to multi-year system planning, we are required to produce two separate but connected plans:

- A five year Sustainability and Transformation Plan, place-based and driving the NHS Five Year Forward View, and
- A one year Operational Plan for 2016/17, organisation-based but consistent with the emerging Sustainability and Transformation Plan.

3.1.3 Each health and care system should come together to create its own ambitious local blueprint for accelerating implementation of the NHS Five Year Forward View. The Sustainability and Transformation Plan will be an umbrella plan comprising a number of different specific delivery plans. Sustainability and Transformation Plans must include all areas of CCG and NHS England commissioned activity and better integration with local authority services.

3.1.4 Sustainability and Transformation Plans are intended to reflect the work of a health and care system which is active, has strong local leadership and is engaged with its local community. For the first time, central funding will be available to support long term system planning. Sustainability and Transformation Plans will be the single route to acceptance on programmes with transformational funding for 2017/18 onwards. For 2016/17 only, limited available transformational funding will be available through separate processes. The most

compelling Sustainability and Transformation Plans will attract the earliest additional funding from April 2017. First draft plans must be ready for submission to NHS England by the end of June 2016.

3.1.5 As in previous years, the one year Operational Plan will be produced by the CCG. The final draft plan must be ready for submission to NHS England on 11 April 2016.

3.1.6 Further detailed guidance on the content and assurance process for Sustainability and Transformation Plans should be available shortly. Where appropriate, the CCG Operational Plan will contribute to the content of the system's Sustainability and Transformation Plan.

3.2 CURRENT POSITION: Development of the Sustainability and Transformation Plan and the CCG Operational Plan

3.2.1 Work on producing both plans is underway. As we progress through this transitional phase of planning, it will be critical to ensure that there is good alignment between the longer-term Sustainability and Transformation Plan and the shorter-term, Operational Plan. The team working on the Sustainability and Transformation Plan have established a time-limited working group to oversee this process and to address any issues which may arise.

3.2.3 One of the key requisites for both plans is to ensure that there is a structured and consistent approach to guiding and implementing service transformation within the Cambridgeshire and Peterborough System.

3.2.4 Service transformation will be guided by a Clinical Advisory Group, whose remit includes developing a clinical vision and strategy for Cambridgeshire and Peterborough, providing clinical assurance for all proposals generated by the Clinical Working Groups and developing a set of coherent and sustainable medium term options for service configuration.

3.2.5 The detailed planning and implementation of service transformation programmes will be carried out by several clinical working groups who will cover:

a) Urgent and emergency care
b) Elective (planned) care
c) Proactive care and prevention
d) Maternity and neonatal services
e) Children and young people

3.2.6 Clinical leaders and management support are being recruited to the clinical working groups where needed. The Board will be kept informed as this work progresses and will have an opportunity to contribute to the longer term plan.

3.3 OPERATIONAL PLAN 2016/17

3.3.1 Plans should demonstrate how we will:

a) Reconcile finance and activity plans and achieve financial balance
b) Contribute to efficiency savings
c) Deliver the national priorities set out in the guidance
d) Maintain and improve quality and safety for patients
e) Manage risks across local health economy plans
f) Make the links with and support emerging Sustainability and Transformation Plans

3.3.2 The CCG received an increase in resource of 4.7% for 2016/17. A range of business rules are set out in the national planning guidance which CCGs should take account of during the operational planning process, including:

- Achieve a 1% financial surplus – at the very least, CCGs must deliver an in-year break-even position

- Plan to spend 1% of resources non-recurrently. Non-recurrent resources must be uncommitted at the beginning of the financial year and will be released progressively folowing agreement with NHS England
- Hold a contingency of 0.5%
- Continue to invest in mental health services – to match at least the overall expenditure increase
- Agree a joint Better Care Fund Plan with local authorities

3.3.3 The CCG is forecasting a deficit position of £8.4m at the end of the 2015/16 financial year. The first aim will be to return to in-year financial balance in 2016/17. In order to achieve this, the CCG will need to deliver QIPP savings in the region of £44m, which equates to 4.5% of the programme allocation.

3.3.4 We have structured the draft Operational Plan to match, as closely as possible, the way in which service transformation work will be organised in future. In addition, the Operational Plan will cover other areas such as the key operational priorities set by NHS England for 2016/17. Figure 1 below gives an overview of the current structure of the draft Operational Plan.

4. ANTICIPATED OUTCOMES

4.1 The content of the draft plan was informed and shaped by the 2016/17 planning intentions which were considered by the Board on 19 November 2015. Since publication of the planning intentions, the working groups have been refining their ideas and proposals for change in conjunction with relevant providers and stakeholders.

4.2 Some of the priorities set out in the national planning guidance are more strategic in nature and will require several years to achieve, for example, the requirement to return the System to financial balance. Consequently, they will be more relevant for the Sustainability and Transformation Plan; the planning team will set out how they can be achieved over the longer term.

4.3 One of the important areas to be covered by the Operational Plan is the wider commissioning and partnership agenda. The development of the Better Care Fund Plan last year provided good insight into the potential for greater service integration with health and

social care working very closely together. Learning from last year, we have established a Programme Integration Team comprising representatives from the CCG, Cambridgeshire County Council and Peterborough City Council. The team's remit is to map all relevant initiatives from our clinical working groups, Better Care Fund project work and contract leads to ensure that we identify where projects and initiatives link with each other and to plan in a fully integrated way for 2016/17 and beyond. This work includes the further development of seven day services. A separate Better Care Fund Plan document is being developed and will be ready later in February 2016. The key points from that plan will be included in the next working version of the Operational Plan for reference as well as details of how to access the full Better Care Fund Plan.

4.4 A first working draft of the Operational Plan was submitted to NHS England for internal assurance review on 8 February 2016. It is a work in progress and its content will change in the light of formal content assurance feedback from NHS England and of the work that is currently on-going to agree service contracts for the new financial year.

4.5 NHS England requires submission of a second working draft plan on 2 March 2016 and that draft will undergo further content assurance checks. Final submission of the plan is due on 11 April 2016.

5. REASONS FOR RECOMMENDATIONS

5.1 The CCG is required to share the 16/17 Operational Plan with the Health and Wellbeing Board. This paper builds on the discussion the HWB had in 2015 regarding the Local Authority and CCG Commissioning Intentions

6. BACKGROUND DOCUMENTS

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

6.1 *NHS Shared Planning Guidance:*
https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

6.2 *Understanding Today, Designing Tomorrow; Change Document 2015/16 to 2019/20:*
http://www.cambridgeshireandpeterboroughccg.nhs.uk/five-year-plan.htm

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 6
24 MARCH 2016		PUBLIC REPORT
Contact Officer(s):	Dr Liz Robin, Director of Public Health	Tel. 01733 207175

ANNUAL HEALTH PROTECTION REPORT FOR PETERBOROUGH 2016

RECOMMENDATIONS	
FROM: Dr Liz Robin, Director of Public Health	**DEADLINE:** N/A
The Board is asked to receive and discuss this report.	

1. ORIGIN OF REPORT

1.1 This report is submitted to Board on an annual basis to support partnership governance of Health Protection functions.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide information on all aspects of health protection in Peterborough since February 2015 including:

a) An update on screening and immunisations
b) Implementation of the recommendations of task & finish group aimed at improving uptake of screening and immunisation
c) An update on communicable diseases in Peterborough
d) An update on sexual health issues and the planned sexual health strategy
e) An update on health emergency planning.

2.2 This report is for Board to consider under its Terms of Reference No. 3.3:

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

3. MAIN BODY OF REPORT

3.1 The report is attached as a separate annex to this paper.

4. CONSULTATION

4.1 Not applicable.

5. ANTICIPATED OUTCOMES

5.1 The report is aimed at stimulating discussion of health protection issues in Peterborough and to seek the support of the Board for the work of the Peterborough Health Protection Committee; Cambridgeshire and Peterborough Health and social Care Emergency Planning group; Cambridgeshire and Peterborough Immunisations network; Cambridgeshire and Peterborough implementation group for improving uptake of cancer screening; and Peterborough implementation group for improving uptake of immunisations.

6. REASONS FOR RECOMMENDATIONS

6.1 The recommendations support improving and protecting population health in Peterborough.

7. ALTERNATIVE OPTIONS CONSIDERED

7.1 Not applicable.

8. IMPLICATIONS

8.1 Work is ongoing across the partner agencies involved in the Peterborough Health Protection Committee to deliver statutory health protection and health emergency planning functions, using existing resources.

9. BACKGROUND DOCUMENTS

9.1 This is an original document with data provided by colleagues in NHS England, Public Health England and Peterborough City Council.

10. APPENDICES

10.1 Appendix A - Annual Health Protection Report for Peterborough City Council for 2016

APPENDIX A

ANNUAL HEALTH PROTECTION REPORT FOR PETERBOROUGH CITY COUNCIL FOR 2016

1. Introduction

1.1. Upon implementation of the Health and Social Care Act 2012, on 1 April 2013, the Peterborough City Council, through the Director of Public Health (DPH), took on 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 Clinical Commissioning Group (CCG) and the City Council..

1.2 The Health and Well Being Board (HWB) has statutory responsibilities and is currently consulting on a draft health and wellbeing strategy 2016-19. Whilst much of this relates to health improvement, health protection is interwoven into the strategy's aims, including protecting health from communicable diseases.

1.3 The services that fall within Health Protection include:

- communicable diseases
- infection control
- routine antenatal/new born, young person and adult screening
- routine immunisation and vaccination
- sexual health
- environmental hazards.

1.4 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.

1.5 The DPH produces an annual health protection report to the Health & Wellbeing Board (HWB) which provides a summary of relevant activity. This report covers multi-agency health protection plans in place which establish how the various responsibilities are discharged. Any other reports will be provided on an ad hoc or exceptional basis where a significant incident, outbreak or concern had arisen.

2. Background

2.1 In order to have the oversight that is necessary to meet their statutory responsibilities the DPH needs:

- To be able to, on behalf of the City Council, advise on and promote local health protection plans across agencies. This role complements the statutory responsibilities of Public Health England (PHE), NHS England, and the CCG;
- To be assured, on behalf of the City Council, of Health Protection arrangements by relevant organisations in the Local Authority area;
- To be provided with information, including surveillance and other data from PHE and other partners, in order to be able to scrutinise and as necessary challenge performance;

- On the basis of this scrutiny to be able to provide strategic challenge to health protection plans/arrangements produced by partner organisations;
- To have a clear escalation plan in place agreed with PHE, NHS England, CCG, and Department of Health (DH) to enable any concerns to be escalated as appropriate, including to the Local Health Resilience Partnership (LHRP);
- To have clear agreement that information on all local health protection incidents and outbreaks, including screening incidents, are reported to the DPH such that the DPH can take any necessary action, working in concert with PHE and the NHS. This may include, for example, chairing an outbreak control committee, or chairing a look back exercise in response to an untoward incident;
- To be a member of, and to contribute to, the work of the Cambridgeshire and Peterborough LHRP. The DPH is co-chair of the LHRP;
- To provide the public health input into the city council emergency management plan;
- To be able to provide a comprehensive annual report to the HWB on all aspects of health protection to include performance, issues and incidents.

2.2 While the 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 local authority, the DPH has no managerial responsibility for other organisations that provide the services that deliver health protection.

2.3 To enable the DPH to fulfil these statutory responsibilities, the Peterborough Health Protection Committee (PHPC) was established in October 2013 and is chaired by the DPH or nominated deputy. The PHPC enables all agencies involved to demonstrate 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. In addition, a memorandum of understanding (MOU) has been agreed with partner organisations The PHPC facilitates information sharing and planning across agencies.

3 Peterborough Health Protection Committee

3.1 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.

3.2 To provide a forum for information sharing and planning between public agencies that have responsibilities in Peterborough for health protection as defined in 1.3.

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

3.4 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.

3.5 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.

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

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

3.8 The membership of the PHPC includes:

- Director of Public Health (Peterborough City Council)
- Consultant in Public Health Medicine (Peterborough City Council)
- Public Health England: CCDC
- Cambridgeshire and Peterborough CCG (rep for HCAI)
- NHS England Anglia and Essex Team (Screening & Immunisation)
- Acute Trust (Infection Prevention & Control/Microbiology)
- Environmental Health Officer (Peterborough City Council)
- Sexual Health Commissioner (Peterborough City Council)
- Adult Social Care Representative (Peterborough City Council)
- Children's Services Representative (Peterborough City Council)
- Resilience Representative (Peterborough City Council)

The Committee is chaired by the Director of Public Health or the Consultant in Public Health Medicine.

3.9 The PHPC meets quarterly in January, April, July and October. Starting in October 2015, the PHPC has been meeting jointly with the Cambridgeshire Health Protection Steering Group in recognition of the fact that many health protection issues cross geographic boundaries and are often reported by CCG geography (Cambridgeshire and Peterborough). The meetings are run in three sections – an initial section for Peterborough only issues, a middle section to discuss issues relevant to both local authorities and a final section for Cambridgeshire only issues. The joint middle section receives reports on work across both areas on issues such as immunisation, screening, emergency planning, implementation of the national TB strategy and communicable diseases common to both areas.

4 Memorandum of Understanding

4.1 The 2014, Memorandum of Understanding (MOU) for health protection, developed to ensure agreement from all relevant organisations to provide reports and assurance to the PHPC and to collaborate with other partners in the response to any incident that affects public health in the area, is due to be reviewed and revised and re-issued to partner organisations for sign-off.

4.2 In practice this MOU proved to be very helpful over the past two years during the response to public health incidents, as it clarified responsibilities, including financial responsibilities, in an incident and meant that there were no delays while this clarification was sought.

5 Joint Communicable Disease Outbreak Management Plan

5.1 Development of this plan was led by Public Health England with support from the public health teams in local authorities, it was initially ratified in 2014 by the LHRP and LRF, and has been in use since then. It was revised in 2015, and organisations are working to the consultation draft of the 2015 revision. However, due to changes in organisational structure in PHE, with the PHE Centre now covering, Peterborough, Cambridgeshire, Norfolk, Suffolk, Essex, Hertfordshire, Bedfordshire and Milton Keynes, final ratification has been delayed. The revised plan will need to be approved by all relevant LHRPs and Local Resilience Forums (LRFs) in the PHE East area.

5.2 It constitutes a joint plan to manage an outbreak or significant incident of communicable disease/infection. It covers a range of scenarios from a minor outbreak that will be managed within the PHE Health Protection Team (HPT) to an outbreak which could lead to a major incident being declared that requires a full multi-agency response.

5.3 For this plan, the term ‘outbreak’, refers both to outbreaks and significant incidents of communicable disease, infection and environmental incidents.

5.4 The plan gives clarity on roles and responsibilities in managing an outbreak - essential to providing a coordinated approach to management - including communication, investigation and control procedures.

5.5 In addition to PHE, NHS organisations (providers and commissioners) and Peterborough Public Health team, the varied nature of outbreaks will lead to the involvement of a number of partners in their investigation and management. These may include:

- Local Authority (LA) Environmental Health (EH) Services;
- School or care home representatives where the outbreak affects specific groups;

- Health and Safety Executive (HSE) where HSE enforced premises are involved;
- The Animal Health and Veterinary Laboratories Agency (AHVLA) will be involved in the event of an outbreak of a zoonotic disease;
- Water Company representatives if water supplies are affected e.g. cryptosporidiosis.

This plan has been tested and judged to be effective in both exercises and actual incidents.

6 Surveillance

6.1 In order to understand and monitor the incidence of communicable diseases, the effectiveness of prevention activities such as immunisation, and the threats posed by new and emerging infections, the UK has an active communicable disease surveillance service provided by PHE both through national centres and through their Field Epidemiology Teams. These teams provide a wide range of reports on a frequent basis ranging from weekly through to annual reports.

6.2 Eastern Field Epidemiology Unit (EFEU)

The EFEU, which is part of PHE, provides regular updates with electronic links to relevant data for a wide range of communicable diseases. As this data is available on line from PHE, it is not reproduced here. The monthly reports include data on:

- Sexual and reproductive health
- Tuberculosis
- Influenza and flu-like illnesses
- Legionnaires disease
- Healthcare associated infection
- Vaccine preventable diseases
- Anti-microbial resistance
- Sexually transmitted diseases
- HIV
- Hepatitis
- Ante-natal screening
- Notifiable infectious diseases
- Gastro-intestinal infections

6.3 Notifications of Infectious Diseases

Doctors in England and Wales have a statutory duty to notify a Proper Officer of the local authority, usually the Consultant in Communicable Disease Control in the local Health Protection Team (HPT), of suspected cases of certain infectious diseases. These notifications, along with laboratory and other data, are an important source of surveillance information. The table below shows the notifiable diseases reported to the HPT from 1 April 2013 – 31 March 2015.

Table 1: Notifications of Infectious Diseases in Peterborough by year 2013 - 2015

Notifiable Disease*	2013†	2014†	2015†
Acute infectious hepatitis	9	7	17
Acute meningitis	<5	<5	<5
Cholera	0	0	<5
Food poisoning	300	318	253
Infectious bloody diarrhoea	8	8	<5
Invasive Group A streptococcal disease	<5	9	<5
Legionnaires' Disease	<5	0	<5
Malaria	0	<5	<5
Measles	7	5	<5**
Meningococcal septicaemia	<5	5	<5
Mumps	7	8	8**
Rubella	<5	<5	<5**
Scarlet fever	15	20	98
Whooping cough	17	18	15

SOURCE: East of England HPT (Thetford) HPZone

* *Notifiable diseases with no reported cases during the three years are not listed here. These are notifications of infectious disease and are not necessarily laboratory confirmed.*

† *Because of the confidentiality risk associated with reporting very small numbers, where there are fewer than 5 cases they are reported as <5*

** *There were no laboratory confirmed cases of measles or rubella in 2015. There were 4 laboratory confirmed cases of mumps.*

6.4 It is particularly important to note the number of cases notified that are of illness which could have been prevented by immunisation, in particular mumps, measles, whooping cough, rubella (German measles), each of which can have serious long term health consequences, especially when also considering the childhood immunisation uptake data later in this report..

6.5 Scarlet fever

Scarlet fever is a common childhood infection caused by *Streptococcus pyogenes*, also known as group A streptococcus (GAS). It is most common between the ages of 2 and 8 years, although children and adults of all ages can develop it.

Similar to the rest of the country, scarlet fever seasonal activity has remained elevated across Peterborough, following the increase in notifications seen last year. Since the start of 2015 there has been a rapid and higher than expected increase in notifications compared to the previous year.

Although scarlet fever is usually a mild illness, patients can develop complications such as an ear infection, throat abscess, pneumonia, sinusitis or meningitis. Clinicians should also

be mindful of a potential increase in invasive GAS (iGAS) infection which tends to follow trends in scarlet fever. Early recognition and prompt initiation of specific and supportive therapy for patients with iGAS infection can be lifesaving.

Table 2. Outbreaks and Incidents - Peterborough, January - December 2015

Gastroenteritis	Bloodborne virus	Environmental/ Chemical	Other	Total
6	1	1	3	**11**

SOURCE: East of England HPT (Thetford) HPZone

6.5.1 Food poisoning remains the most commonly notified infectious disease, with campylobacter accounting for the vast majority.

6.5.2 Whooping cough (Pertussis) is a cyclical disease with increases occurring every 3-4 years. The third quarter (running from July to September) is usually the period of highest pertussis activity annually. In Peterborough, the number of whooping cough cases has been fairly steady over the past three years

6.6 Healthcare Associated Infection (HCAI) and Antimicrobial Resistance (AMR)

6.6.1 **HCAI**

National mandatory reporting has remained in place for multi-resistance Staphylococcus Aureus (MRSA) bacteraemia and Clostridium difficile (C diff) since 2009.

There is now a zero tolerance of preventable MRSA bacteraemia with our own hospital in Peterborough having just one case in 2015/16 after a period with no cases for more than two and half years.

National processes have highlighted that some cases of C diff and MRSA are not attributable to either a hospital or the CCG, which had been the only options. Since April 2014 an assignment category of 'third party' has been in place, introduced in recognition that there are often many other providers involved in patient care within the community.

Following significant reductions in the number of C diff cases nationally since 2007, the number continues to fall at a slower rate. Peterborough has had a variable year and has just exceeded its trajectory due to a cluster of cases in December. For the rest of the year its rate of infection has been mainly in line with national and regional averages. The most important factor is to review every single case through the root cause analysis process and scrutiny panel meetings which are held for each new case. A process whereby cases identified to meet specific criteria can be removed from the local trajectory is managed locally at CCG level by the Lead Nurse for Infection Prevention and Control.

In addition to C Diff and MRSA, two other bacterial infections are also monitored – E Coli and Methicillin Sensitive Staphylococcus Aureus (MSSA) – for both of

which the level of infection in Peterborough is low and is below the regional and national average

6.3.2 **Antimicrobial Resistance**

The prescribing of antibiotics continues to be monitored by the Medicines Management Team within the CCG for primary care and by hospital pharmacists for in-patient prescriptions. Prescribing is also noted and discussed at each scrutiny panel for Clostridium difficile and following completion of the root cause analysis. Any concerns identified with primary care are either discussed with the GP directly or with the medicines management team. The medicines management team have identified high prescribing levels of two particular groups of drugs; a strategy has been developed to address the associated issues, one of which is the increased risk of developing Clostridium difficile. It should also be noted that although these groups of drugs should be limited in general use, the condition of individual patients may specifically require their prescription. PHPC is awaiting a report on the outcome of the strategy.

Antimicrobial resistance has been identified as a national and international risk to human health by the Chief Medical Officer, WHO and the government as a whole. Antibiotics are widely used in animal health and farming; are available over the counter without a prescription in many countries; and far too many people fail to complete the prescribed course or demand antibiotics for viral or self- limiting conditions here in the UK. All these factors contribute to the development of antimicrobial resistance. In addition, no new class of antibiotics has been developed by the pharmaceutical industry in recent years.

This is an area that will continue to be tackled by the CCG in collaboration with local prescribers in acute, community and primary care.

7 Prevention

The focus of this section is the delivery of the Immunisation and Screening programmes. From April 2013, Screening and Immunisation programmes have been commissioned by NHS England as per a Public Health agreement under section 7A of the 2006 NHS Act as inserted into the Health and Social Care Act 2012.

NHS England Anglia and Essex Public Health Commissioning Team guided by a specialist advice from a PHE public health screening and immunisation team, embedded in NHS England, leads on commissioning the following programmes for the population of Peterborough:

- Immunisation programmes: neonatal and childhood, school age and adult immunisations
- Cancer Screening: Breast, Cervical and Bowel cancer programmes
- Adult and Young People Screening: Abdominal Aortic Aneurysm (AAA) and Diabetic Eye Screening (DES)
- Antenatal and Newborn Screening programmes

7.1 Immunisation Programmes

7.1.1 A number of immunisation programmes are provided in the UK to protect our population against infectious diseases that, when they were common, caused considerable morbidity and mortality. As a result of the success of these immunisation programmes many of these conditions are virtually unknown today in this country. However this success can lead to complacency, in turn leading to a drop in immunisation rates.

7.1.2 The aim of our universal immunisation programmes is to provide 'herd immunity' which can be defined as the form of immunity that occurs when a sufficient proportion of a population is vaccinated to break transmission of infection and so provide protection for individuals who have not developed immunity. Some people may have weakened immune systems for a variety of reasons and do not acquire full immunity to the illness as a result of immunisation. Others, who choose not to be vaccinated, may also be protected by 'herd immunity' if sufficient people are immunised. For the majority of universal immunisation programmes, 'herd immunity' depends on 90 to 95% of the population being immunised. Where uptake is below 90%, a breakdown in herd immunity can result in cases and outbreaks occurring, most notably in Measles, Mumps or Rubella in recent years associated with low uptake of the MMR vaccine.

7.1.3 The annual coverage data for the universal childhood immunisation programmes is provided at tables 3, 4 and 5. For most of the childhood vaccination programmes, Peterborough is below the 95% level for herd immunity. There are a number of factors which cause this:

- Some families choose not to have their child immunised
- Some families may have difficulty accessing services for immunisation;
- Some children have been immunised but not according to the schedule in England, resulting in their immunisation not being recorded on the national system. This is a particular problem in Peterborough , where there is a high, relatively transient population of migrant workers and new immigrants whose

children may have been fully immunised in their home country, but not recorded by the UK system;

- Some children have been immunised according to the schedule but the data has not been recorded or properly reported. A new electronic template developed by CCG staff for Cambridgeshire and Peterborough GP practices to improve recording has not yet been implemented due to some technical problems;

- Some of the children, reported as not attending for immunisation when invited, may no longer live in Peterborough. If they had moved within the UK, their registration with a new UK GP would lead to them being removed from the register in Peterborough , so, in most of these cases, the missing children are likely to have moved overseas not knowing that they should advise their GP to de-register them.

7.1.4 A multi-agency Task and Finish group convened to try to find solutions to these issues and address the inequalities in uptake of childhood immunisations in inner city practices and deprived populations reported in 2015 and an implementation group is now working to develop the recommendations and implement them.

Table 3: Annual Childhood Vaccination Uptake for Age 12 months Peterborough, 2014/15

12 months					
	Number	DTaP/IPV/Hib % [number]	PCV % [number]		
P'boro LA	3.0	95.2	94.2		
England	663.1	95.7	92.2		

Source: Cover

Table 4: Annual Childhood Vaccination Uptake for Age 24 months for Peterborough, 2014/15

24 months					
	Number	DTaP/IPV/Hib % [number]	MMR 1 % [number]	Hib/men C % [number]	PCV B % Number]
P'boro LA	3.2	96.7	92.6	92.6	
England	691.8	95.7	92.3	92.1	

Source: Cover

Table 5: Annual Childhood Vaccination Uptake for Age 5 years for Peterborough, 2014/15

5 years						
	Number	DTaP/IPV/Hib % [number]	DTaP/IPB B % [number]	MMR 1 % [number]	MMR 1&2 % [number]	Hib Men C B % [number]
P'boro LA	3.2	95.9	88.9	94.6	87.5	90.8
England	693.9	95.6	88.5	94.4	88.6	92.4

Source: Cover

7.1.5 **Targeted Vaccination programmes**

Other childhood immunisation programmes include BCG (Bacillus Calmette–Guérin) vaccination and Hepatitis B vaccination as targeted programmes for those identified as being at specific risk.

7.1.6 BCG vaccine, for prevention of TB (Tuberculosis) is not a very effective vaccine and the universal programme was stopped many years ago, however, because it confers some immunity, it continues to be recommended for newborn 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 (the Peterborough rate is 28.7/100,000 - most recent data is for 2014)
- Have one or more parents or grandparents who were born in countries with a high incidence of TB

In Peterborough we have had a very successful programme for BCG vaccination of newborn in maternity services and via Community TB nurses to babies who fit the criteria and have moved in to the area, resulting in high uptake. However we do not have clear denominator data about the number of babies born in Peterborough that meet the second criterion.

7.1.7 Hepatitis B vaccination is given at birth with 3 further boosters up to 12 months for babies born to Hepatitis B positive mothers. PHE is working with GPs to improve the provision of the final blood test, using a dried blood spot, to confirm sero-conversion after immunisation.

Table 6: Hepatitis B vaccination

	Q1 2015	Q2 2015	Q3 2015	Q4 2015
	Peterborough %			
Hep B 12 months	100	100	NA	NA
Hep B 24 months	66.7	100	NA	NA

Source Cover NA not available yet

*The numbers of babies requiring Hepatitis B vaccination is small; therefore the percentage uptake is affected by 'small cohort number effect' on rates and ratios.

7.1.8 School based programmes

There are some immunisation programmes delivered in schools, for the school age population; others are provided via primary care. Human Papilloma Virus vaccine (HPV) is offered to girls in school. This relatively recent programme of vaccination of girls aged 12 – 13 against Human Papilloma Virus (HPV) which is a causative factor in Cervical Cancer has been very successful. It is reported annually by school year hence the latest full year data is for school year 2014/15.

Table 7: Annual HPV vaccination uptake all 3 doses by local authority

School year 2014/15	Peterborough	England
HPV uptake	92.1	89.4

Source: www.gov.uk

7.1.9 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 2013/4 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
- all two, three and four-year-olds on 31 August 2015
- all children of school years 1 and 2 age

7.1.10 Plans were developed by the [1]Cambridge and Peterborough Immunisation and Vaccination Committee for the 2015/6 programme and included commissioning community pharmacies to vaccinate the at risk groups in the community. This has complemented the existing services provided by GPs and maternity units.

7.1.11 For the City Council the most important groups are those who are in front line roles caring for vulnerable groups in the community. Immunising these staff protects them from getting flu, thus reducing the risk of them being off sick, and in turn protects both their clients and their own families. Employers of front line staff are expected to organise and fund immunisation of their front line staff. Peterborough City Council offered to provide vouchers for immunisation to front line staff in adult social care; 29 were taken up by staff. For those not directly employed, it will be helpful if commissioning contracts are explicit about an expectation that every effort will be made to ensure that care staff are offered immunisation.

[1] A multi agency forum with key stakeholders, chaired by Public Health England/NHS England

Table 8: Flu vaccination uptake (%) in Peterborough by risk groups

Risk Group	2013/14	2014/15	2015/16
Over 65yrs	72.2	71.2	72.4
Under 65yrs at risk	50.7	48.7	42.7
Pregnant and in another clinical risk group	64.8	63.5	55.6
Pregnant but not in any other clinical risk group	41.9	41.5	29.9
All pregnant	43.6	43.3	32.2
Age 2 not in a risk group	30.9	31.4	36.6
Age 2 (in a clinical risk group)	40.4	36.8	49.9
Age 3 not in a risk group	40.6 31.3	34.0	38.7
Age 3 (in a clinical risk group)	53.8 46.8	45.5	54.1
Age 4 yrs not in clinical group	n/a	22.7	33.5
Age 4 yrs in clinical group	n/a	39.7	51.6
Age 5 yrs not in clinical group	n/a	NA	57.2
Age 5 yrs in clinical group	n/a	NA	67.1
Age 6 yrs not in clinical group	n/a	NA	54.4
Age 6 yrs in clinical group	n/a	NA	64.6

Table 9: Flu vaccination uptake (%) – Peterborough NHS frontline staff

Uptake to Jan 2014 Health Care workers	2012/13	2013/14 %	2014/15	2015/16
PSHFT	71.5	75.3	69.5	62.9
CPFT	23.7	54.2	51.2	61.9
Cambridgeshire Community Services CCS)	37.0	51.5	52.6	59.2

Source www.gov.uk

7.1.12 **Pertussis vaccination in pregnancy**

In the first seven months of 2012, nationally, 235 babies under 12 weeks old had whooping cough and 13 babies died from it. This led to the introduction of a programme to vaccinate pregnant women between 28 and 38 weeks of pregnancy to protect them and their babies who were too young to be immunised themselves. Following the introduction of this programme, there was a 79% drop in cases to 85 in 2013.

Uptake rates are available for the East Anglia Area and for Cambridgeshire & Peterborough CCG but not for Peterborough residents alone.

Table 10: Pertussis vaccination uptake (%) by pregnant women

	April 2014	May 2014	June 2014	July 2014	August 2014
East Anglia	60.6%	60.5%	57.2%	55.8%	55.5%
	April 2015	May 2015	June 2015	July 2015	August 2015
Cambs & P'boro CCG	49.8	45.9	52.7	50.5	51.2
East Anglia	56.8	53.8	58.9	56.3	54.1
	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016
Cambs & P'boro CCG	50.5	54.1	52.5	50.7	NA
East Anglia	67.2	60.3	61.4	60.3	NA

7.2 New Vaccination Programmes

A number of changes have been made to the vaccination programmes over the past two years, most of which have already started. These changes are made as a result of the advice from the Joint Committee on Vaccination and Immunisation (JCVI). JCVI is an expert committee that reviews the evidence of effectiveness of vaccines and makes recommendation to Government.

7.2.1 Meningitis C (MenC) – evidence has shown that in those born after 1995, who were vaccinated in early childhood, there is declining immunity, making them more susceptible to infection. A MenC booster was introduced for teenagers aged 13-14 years. However in 2015, this was replaced by Meningococcus ACWY vaccine, covering four strains of Meningococcus following an increase in cases of meningitis and septicaemia (blood poisoning) by Meningococcus W. The group most affected were those in their first year at university, so the programme aims to vaccinate all children in year 9 (age 13 – 14) at school with a catch up offer by GPs of the vaccine to those in year 13 and university freshers. This latter programme has been poorly taken up and may need to be publicised again.

It is important to note the second dose for infants at 4 months was removed last year. Uptake of Men C vaccination, administered by GPs aimed at students in school year 13 and by University freshers is worryingly low nationally.

7.2.2 Meningitis B (MenB) –this vaccination was introduced into the national immunisation schedule from July 2015 and has been offered to all babies born since May 2015. The UK is the first country to introduce this programme and vaccine manufacturers report that, while there is sufficient supply for those in the national programme, it is in relatively short supply.

7.2.3 Seasonal flu vaccine – In 2015-16 the childhood programme has been extended to children in school years 1 and 2 with plans to extend eventually to all those up to age 16.

7.2.4 HPV vaccination – following a change in the schedule from September 2014, when the number of doses was reduced from three to two, most schools in the area have agreed to the two doses being given 12 months apart:

1st dose given in Year 8 (12-13 years)

2nd dose can be in Year 9..

7.2.5 The shingles vaccination programme is being gradually introduced – it will eventually be given to all aged 70 years with a catch up programme to ensure vaccination of all who were between the ages of 70 and 80 at the time this prorgamme was introduced.

2014/15 – Zostavax is routinely offered to those aged 70 and catch-up to 78 and 79 years on 1st September 2014 until 31st August 2015.

Table 11: initial Shingles vaccination uptake reported by NHS England

Shingles Sentinel	August 2015 %		
	70 yrs	**78 yrs**	**79 yrs**
CCG	63.0	59.6	61.1
East Anglia	61.9	59.5	60.7

7.2.6 Rotavirus vaccine – rotavirus is a highly infectious gastrointestinal infection that manly affects infants and leads to a high number of hospital admissions each year due to complication such as dehydration. The vaccination was introduced in 2013 with two doses at 2 months and 3 months as part of the routine programme. This has been a highly successful programme with cases of rotavirus reduced dramatically since its introduction.

Table 12: Rotavirus vaccination uptake reported by NHS England

Rotavirus Sentinel [dose 2]			
	April 2014 %	**May 2014 %**	**June 2014 %**
CCG	90.9	90.5	90.6
East Anglia	92.5	90.1	90.7
	July 2014 %	**August 2014 %**	**Sept 2014 %**
CCG	91.2	92.3	92.5
East Anglia	91.8	91.9	92.5
	Oct 2014 %	**Nov 2014 %**	**Dec 2014 %**
CCG	90.4	88.5	91.2
East Anglia	92.5	89.3	90.6
	Jan 2015 %	**Feb 2015 %**	**March 2015 %**
CCG	91.3	90.3	90.3
East Anglia	91.0	91.3	91.5
	April 2015 %	**May 2015 %**	**June 2015 %**
CCG	91.0	92.0	NA
East Anglia	90.4	92.2	NA
	July 2015 %	**August 2015 %**	**Sept 2015 %**
CCG	92.1	91.8	91.0
East Anglia	91.6	91.7	91.8
	Oct 2015 %	**Nov 2015 %**	**Dec 2015 %**
CCG	91.3	88.5	NA
East Anglia	92.2	90.7	NA

8 Screening Programmes

NHS England, which is the commissioner of these services, reported that all the screening programmes are delivering as planned for the population of Peterborough.

8.1. Antenatal and newborn screening

The following data have been provided by NHS England Screening and Immunisation Team. Screening data for Quarter 3 and 4 of 2015/16 will not be available until later this year. For the Antenatal and Newborn Screening programme, some units have not

returned data for some of the programmes. The provider trusts have put in place measures to improve reporting of their data.

8.1.1 Ante-natal screening includes routine testing for a number of conditions that can adversely affect the health of the baby as well as the mother including:

- HIV
- Hepatitis B
- Syphilis
- Rubella susceptibility
- Sickle Cell and Thalassemia
- Down's syndrome

8.1.2 Newborn screening includes testing for 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:

- Newborn blood spot test which detects conditions such as congenital hypothyroidism; phenylketonuria; sickle cell disease; cystic fibrosis; congenital hypothyroidism; and medium chain acetyl-CoA dehydrogenase deficiency; maple syrup urine disease, isovaleric acidaemia ; glutaric aciduria and homocystinuria(see http://www.newbornbloodspot.screening.nhs.uk/ for explanations of each of these conditions)
- Newborn infant physical examination
- Newborn Hearing screening

Table 13: Ante-natal screening coverage

	Q1 2014/15 April-June	Q2 2014/15 July-Sept	Q3 2014/15 Oct-Dec	Q4 2014/15 Jan-March	Q1 2015/16 April-June	Q2 2015/16 July-Sept
KPI ID1 >90% Infectious Disease HIV coverage						
P'boro	97.8	98.7	**98.3**	**99.4**	**98.7**	**98.9**
KPI ID2 >70-90% Infectious Disease timely referral of Hep B+ women for specialist tr.						
P'boro	75.0	50.0	**100**	**66.7**	**66.7**	**85.7**
KPI FA1 >97-100 Down's syndrome completion of lab request form						
P'boro	96.5	98.8	**99.0**	**98.4**	**98.0**	**97.6**
KPI ST1 >95-99% Sickle Cell and Thalassaemia coverage						
P'boro	95.9	95.5	**95.0**	**95.7**	**96.4**	**95.6**
KPI ST2 50-75% Sickle Cell and Thalassaemia avoidable repeat						
P'boro	65.7	65.1	**67.0**	**66.4**	**67.2**	**70.2**
KPI ST3 90-95% Sickle Cell and Thalassaemia timeliness of result						
P'boro	98.1	99.0	**98.2**	**98.5**	**98.3**	**98.1**
KPI NB1 95-99% Newborn blood spot coverage						
CPFT	99.7	100	**99.9**	**100**	**98.5**	**98.5**
KPI NB2 2-0.5% Newborn blood spot avoidable repeat tests						
P'boro	1.1	0.8	**0.4**	**0.9**	**Not available**	**1.3**
KPI NB3 95-98% Newborn blood spot timeliness of result						
CPFT	100	100	**100**	**100**	**KPI ceased**	
KPI NB4 Newborn blood spot coverage Movers in						
CPFT	NA	NA	NA	NA	**100**	**90.9**
KPI NP1 95-100% Newborn and Infant physical examination coverage						
P'boro	99.9	99.4	**98.9**	**99.8**	**100**	**99.6(↑0.2)**
KPI NP2 95-100% Newborn and Infant physical examination timely assessment for hip referral						
P'boro	100	0 no cases	0 no cases	**100**	**100**	**40**
KPI NH1 100% Newborn hearing coverage						
P'boro	100	99.8	99.9	**100**	**Not available**	**99.8*(↔)***
KPI NH2 100% Newborn hearing timely referral						
P'boro	86.6	92.3	100	**100**	**Not available**	**100(↑7.7)**

8.2 Cancer Screening Programmes

There are three cancer screening programmes in the UK for Breast, Cervical and Bowel cancer and the data for these programmes was provided by NHS England.

8.2.1 Breast Cancer screening

For breast cancer screening, measurements include uptake of screening among the targeted population, the 36 month screening round length (which is the metric which seeks to ensure that the programme offers a first screening appointment to 90% or more eligible women within 36 months of their previous screen); and the time from screening to clinical assessment for those women whose mammograms show some type of abnormality. This ensures early diagnosis and early access to definitive treatment which could improve the outcomes for those affected by breast cancer.

The Peterborough Programme's performances against these standards have remained exceptionally good. The uptake data is reported annually and has not yet been reported for 2015/16, so the most recent annual data is given in Table 12 below, with the other data for the breast screening programme depicted in the charts below.

Table 14: Breast screening uptake in Peterborough 2014/15

Age group	Uptake	Coverage
All ages	***Data awaited***	73.6%

More recent but unverified data shows a further increase to 77.8% in quarter 2 of 2015/16

Figure 1: Proportion of eligible women screened within 36 months

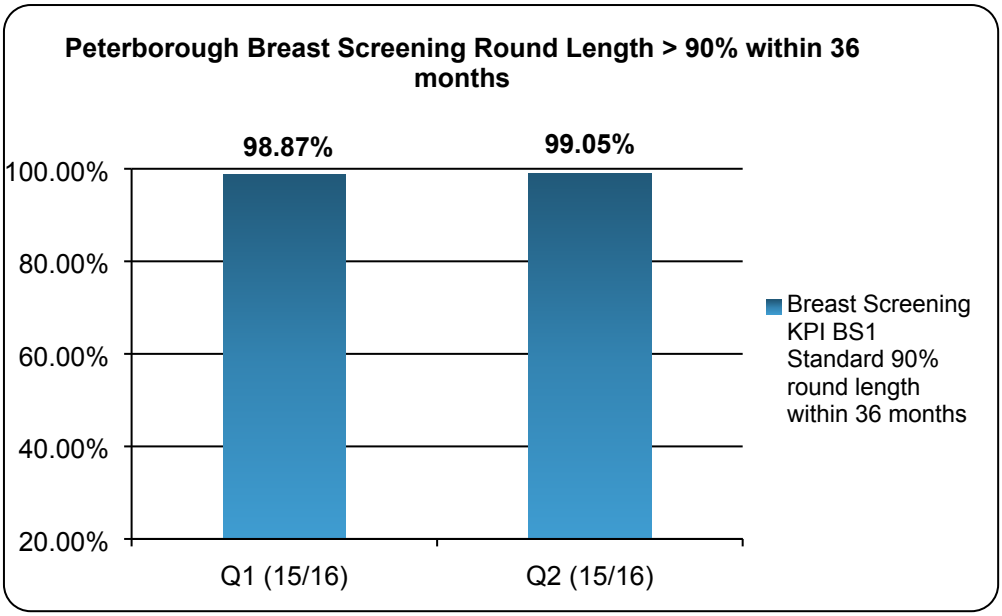
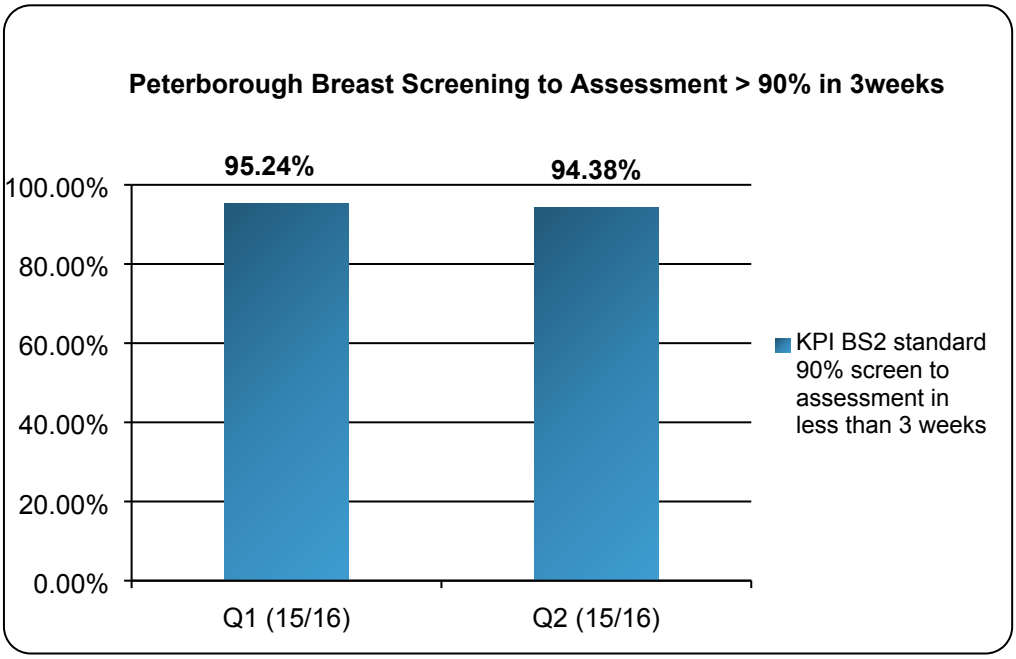


Figure 2: Proportion of women requiring assessment who are seen

within 3 weeks of the screening test



8.2.2 Bowel cancer screening

The screening programme aims to detect bowel cancer at an early stage when treatment is more likely to be effective. The screening programme offers screening every 2 years to all men and women aged 60 to 74. All eligible men and women are sent a testing kit by post, which they are asked to compete and return the completed kit to one of a number of approved laboratories when completed. The test looks for hidden (occult) blood which can indicate some problem in the bowels that is causing bleeding. The presence of Faecal Occult Blood (FOB) is not diagnostic of cancer but gives an indication that further testing is needed. The further tests are by endoscopy (examination of the bowel with a specialised scope and camera apparatus). A number of measures are reported to evaluate the success of the screening programme and these are reported in the table below.

Table 15: Bowel Cancer screening

	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16
Bowel Screening (standard 52% completion of FOBT kit)	58.6%	57.6%	Data awaited	Data awaited
Assessment by specialist screening practitioner (SSP) (standard 100% seen by SSP in 2 weeks)	100%	100%	100%	Data awaited
SSP assessment to endoscopy time (standard 100% endoscopy within 2 weeks of seeing SSP)	95.6%	94.3%	94.8%	Data awaited

8.2.3 Cervical Screening

Cervical screening is offered to all women aged 25 to 49 years every three years and those aged 50 to 64 every five years. Screening takes place in GP practices and the samples are sent to the laboratories for testing. Upon testing, women are informed of the outcome of their screening episode and those 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, coverage, the speed of getting results to service users who have been tested, as well as the timeliness of getting service users in for assessment and treatment.

From the most recent comparative data analysis available, the trend data below show a steady decline in coverage for the Cambridgeshire and Peterborough CCG area. (Coverage is a measure of the proportion of women aged 25 to 49 having an adequate sample taken in last 3 years, or in the last 5 years for those aged 50-64). The target for coverage is 80% and these trend data show that performance is now below the national (England) level. Coverage has fallen in all areas as shown in Figure 1 below; (England (national), Midlands and East Commissioning region, East Anglia Area Team (Norfolk, Suffolk, Cambridgeshire and Peterborough) and Cambridgeshire and Peterborough Clinical Commissioning Group (CCG). Also of note, is the fact that coverage remains considerably lower in the younger cohort (25 – 49) than in the 50 – 64 age group, where coverage too is now below the target of 80%. Table 14.

Figure 3: Cambridgeshire and Peterborough CCG Cervical Screening

Coverage Trend 25 – 64 years

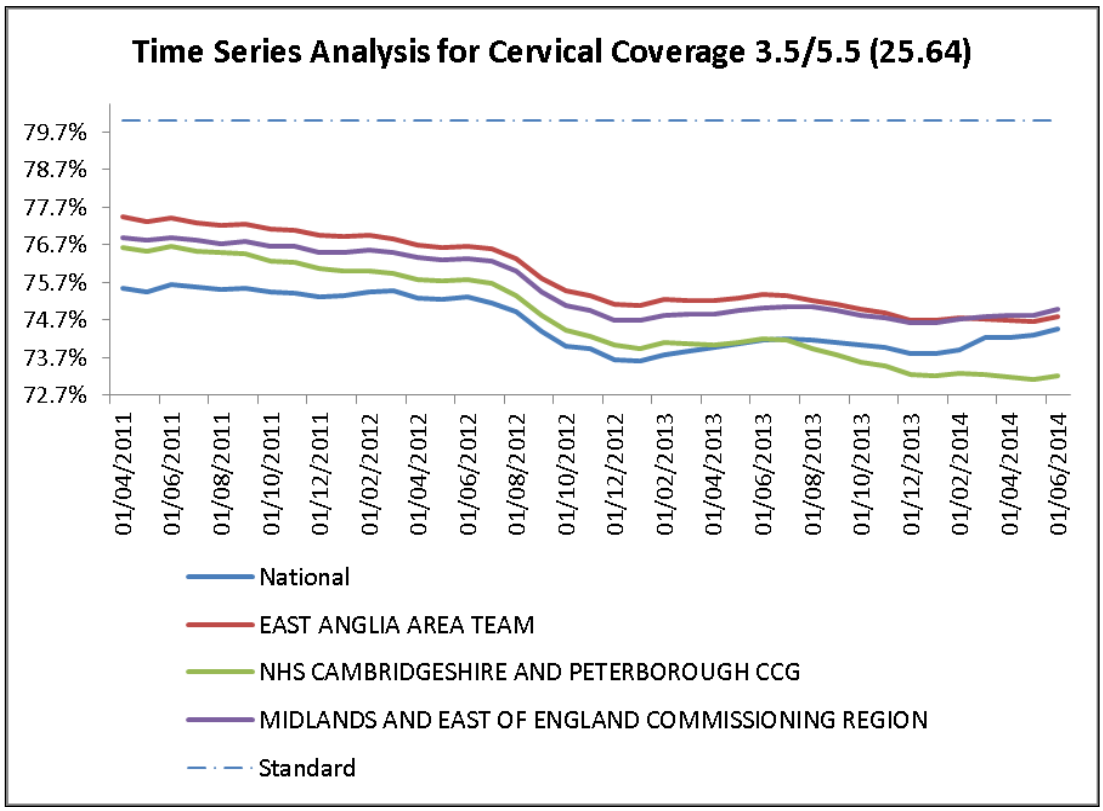


Table 16: Cervical screening measures

	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16
25-49 yrs (standard 80% coverage)	63.6%	63.5%	Data awaited	Data awaited
50-64 yrs (standard 80% coverage)	74.0%	74.1%	Data awaited	Data awaited
Turnaround time (TAT) (standard 98% 14 day date of test to receipt of result letter)	99.97%	100%	Data awaited	Data awaited
Colposcopy waiting time (standard 100% women seen within 8 weeks)	100%	100%	Data awaited	Data awaited

8.2.4 Task and finish group on bowel and cervical cancer screening

In response to concerns about the poor uptake of bowel cancer and cervical cancer screening programmes in the inner city areas of Peterborough, a multi-agency task and finish group was convened in November 2014. The group commissioned and reviewed a detailed analysis of the data for bowel and cervical screening, gathered and considered national and local evidence and subsequently developed a set of recommendations to

address the pockets of poor uptake. The group reported back its findings to the PHPC and has since morphed into an Implementation Group with responsibility for overseeing the delivery of the agreed recommendations. Some of the agreed recommendations include; collaborative work with Cancer Research UK, Jo's Trust and Bowel Cancer UK to deliver training to front line public health staff and primary care staff to ensure staff are confident and knowledgeable about discussing and promoting cancer screening As well as being able to appropriately signpost service users. Awareness campaigns on cancer screening and prevention have also been planned and agreed, with plans underway to work with specific practices in areas of poorer uptake to better understand the reasons for lack of engagement and high DNA rates.

8.3 Non-cancer Screening Programmes

There are two national screening programmes for non-cancer conditions, Retinal (eye) screening for people with diabetes, and screening for abdominal aortic aneurysm in men aged 65.

8.3.1 Diabetic eye screening

People who suffer with diabetes are at high risk of a number of serious complications and are routinely offered appointments in general practice, or, in some cases in hospital clinics, to assess their condition. One of these complications, diabetic retinopathy, is one of the commonest causes of sight loss in working age people. 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. As with other screening programmes, the speed of providing results and referring for further assessment and treatment is very important. As the data in Table 15 below indicates, the Diabetes Eye Screening programme is performing well. However, recent capacity issues have resulted in delays for referred patients being seen and treated within specified timescales at some Trusts. This issue is being addressed contractually and with the support of the Clinical Commissioning Group.

Table 17: Diabetic Eye Screening measures 2015/16

Diabetic Eye Screening				
	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16
standard 70% uptake (*% screened out of the total offered)*	78.5%	77.6%	Data awaited	Data awaited
standard 70% results received issued within 3 weeks of screening	99.1%	99.4%	Data awaited	Data awaited
standard 80% treatment within 4 weeks and 60% within 2 weeks of significant positive screen	2wks: 66.7% 4wks: 83.3%	2wks: 40% 4wks: 80%	Data awaited	Data awaited

8.3.2 Abdominal Aortic Aneurysm Screening

An abdominal aortic aneurysm (AAA) is a weakening and expansion of the aorta, the main blood vessel in the body. This weakening can lead to serious consequences due to leakage from, or rupture of, the aorta and an estimated 6000 people in England and Wales die each year from ruptured abdominal aortic aneurysms. This screening is aimed at men aged 65 and over, and involves a single ultrasound scan that takes approximately 10 minutes. It has been shown that this single screening can reduce the number of deaths from ruptured AAAs among men by 50%.

The AAA screening programme reported it achieved a 100% coverage in 2014/15 fiscal year. The coverage is an annually reported metrics and the 2014/15 data is the most up to date data available.

Table 18: Abdominal Aortic Aneurysm data

KPI AA1 standard 90% (acceptable level) and 100% (achievable level)		
	14/15	15/16
	100%	Data awaited

9 Emergency Planning

9.1 The City Council has always been a Category 1 responder under the terms of the Civil Contingencies Act 2004, as a result there is an emergency planning/Resilience team that is working in partnership with other organisations to lead emergency planning and response for the council. Some additional responsibility for health emergency preparedness passed with the move of Public Health into local authorities. In their role within local authorities the DPH is expected to:

- Provide leadership to the public health system for health Emergency Preparedness, Resilience and Response (EPRR)
  - Ensure that plans are in place to protect the health of their population and escalate concerns to the Local Health Resilience Partnership (LHRP) as appropriate
  - Identify and agree a lead DPH within the Cambridgeshire and Peterborough Local Resilience Forum (CPLRF) area to co-Chair the LHRP
  - Provide initial leadership with PHE for the response to public health incidents and emergencies. The DPH will maintain oversight of population health and ensure effective communication with local communities.

9.2 Local Health Resilience Partnerships (LHRPs) provide strategic leadership for the health organisations of the LRF area and are expected to:

- Assess local health risks and priorities to ensure preparedness arrangements reflect current and emerging need
- Set an annual EPRR work plan using local and national risk assessments and planning assumptions and learning from previous incidents
- Facilitate the production and authorisation of local sector-wide health plans to respond to emergencies and contribute to multi-agency emergency planning
- Provide a forum to raise and address issues relating to health EPRR
- Provide strategic leadership to planning of responses to incidents likely to involve wider health economies e.g. winter capacity issues
- Ensure that health is represented on the LRF and similar EPRR planning groups
- Delegate tasks to operational representatives of member organisations in line with agreed terms of reference.

9.3 The Cambridgeshire and Peterborough Local Health Resilience Partnership (CP LHRP) is co-chaired by the NHS England Cambridgeshire & Peterborough Director and the Cambridgeshire and Peterborough DPH. Member agencies share responsibility for oversight of health emergency planning in this forum. It is for the CPLRF and/or the LHRP to decide whether LHRP plans should be tested through a multi-agency exercise as a main or contributory factor The DPH reports health protection emergency resilience issues to the LHRP on a regular basis. The DPH provides a brief update report on the activities of the LHRP to the PHPC to ensure sharing of cross cutting health sector resilience issues.

9.4 The DPH has been supported in this work by an interim consultant in public health who co-chairs the Health and Social Care Emergency Planning Group (HSCEPG) with the Head of EPRR from the NHS England Area Team and has oversight of all health protection issues. The function is supported by the shared Health Emergency Planning and a Resilience Officer (HEPRO) based within Public Health. The HEPRO reports into the LHRP and the LRF through the DPH.

9.5 The HSCEPG has membership from local acute hospitals, East of England ambulance service (EEAmb), community services, mental health services, social care services, other NHS funded providers, Public Health England and NHS England. This year's deep dive for the EPRR core standards was planning for Pandemic Influenza. The working group delivered Exercise Corvus, a local adaptation of the PHE off-shelf exercise to test the arrangements for pandemic influenza. Follow up of the seven recommendations from this exercise forms part of the work plan for the working group this year. The other priorities for this group are to revise the local Mass Casualty Plan and put in place a plan for identifying vulnerable people in an emergency, both to be presented at the LHRP and CPLRF shortly.

9.6 Exercise Nimbus, a two day multiagency exercise to test eight CPLRF plans, was delivered on the 5th and 6th of November 2015. A total of 60 people from 27 agencies participated and a collated list of actions is being progressed by the CPLRF.

11 Sexual Health

11.1 Peterborough has a high rate of diagnosis of new sexually transmitted infections (STIs) at 887 diagnoses of STIs per 100,000 residents (compared to 810.9 per 100,000 in England, and the highest rate in the east of England). This likely to be associated with the level of socio-economic deprivation in some areas and its link to STI rates.

Areas prioritised for improvement include:

Rates of HIV late diagnosis

Between 2012-2014, 56.8% of HIV diagnoses were made at a late stage of infection, compared to 42.2% in England. This is an improvement on 62% late HIV diagnoses between 2011 and 2013, compared to 45% in England. Earlier diagnosis leads to an improved outcome of treatment and reduced risk of onward transmission.

Rates of teenage pregnancy

Rates remain above the national average, although the downward trend of recent years has continued. In 2013 the under 18 conception rate was 33.4 per 1,000, compared to 36 in the previous year. The England rate has also been falling and was 24.3 per 1,000 in 2013.

Chlamydia diagnoses

In 2014, the rate of chlamydia diagnoses per 100,000 young people aged 15-24 years in Peterborough was 3404, which compares favourably with 2012 for England. This exceeds the Public Health Outcomes Framework (PHOF) target, which is considered positive (as we are reaching and treating a high proportion of young people with the infection). This positivity rate resulted from screening 27.1% of the eligible 15 – 24 year old population. (2nd highest in east of England). It is possible that our positivity rate could be even higher if screening activity increased further still.

11.2 In July 2014, following a retender exercise a new integrated contraceptive and sexual health service was launched. The service integrated hospital based GUM services into community based contraceptive services to provide 'a one stop shop' for all contraceptive and sexual health needs. The aim of integration was to improve accessibility and patient experience with a view to normalising STI testing and treatment as part of managing one's sexual and reproductive health. Close monitoring of the new service shows it has been effective against these aims.

11.3 Going forward, we have established a new Contraceptive and Sexual Health Strategic Group to act as a multi-agency network responsible for overseeing and implementing our Sexual Health Strategy. The strategy identifies four key overall themes for Peterborough:

- Increase sexual and contraceptive health awareness amongst local population;
- Increase detection of STIs amongst local population;
- Reduce the number of unplanned pregnancies; and
- Improve early HIV detection within the city to reduce high rate of late diagnosis.

All partners are actively engaged in this work, which will report via the PHPC to the Peterborough Health and Wellbeing Board.

12 Environmental Health Issues - Proactive Interventions carried out by the Food and Safety Team

12.1 Illegal Tattooist

In October 2014 the team were made aware of an unregistered tattooist operating from a residential address. Any tattooist operating from any premises is required to register their business with Peterborough City Council under the Local Government (Miscellaneous Provisions) Act 1982. Registration allows the Local authority to inspect the premises and practitioner and, subject to meeting the required standard and infection controls, permit the practitioner to continue with this activity. There were concerns that this tattooist did not have the appropriate level of cleanliness and infection controls and as such was potentially exposing his clients and himself to blood borne viruses (BBVs).

Under the Health Protection Regulations 2010 Officers applied to the Magistrates Court for a Part 2A Order, which was granted on 30th March 2015 allowing officers entry to the property to seize and detain equipment, items or articles associated with the practice of tattooing, to prevent the potential spread of BBVs. The Order was executed on 31st March 2015 and five tattoo guns were seized as well as numerous disposable needles, pots of ink and a tattoo couch. The Order prohibited the activity of tattooing but only for a period of 28 days.

In May 2015 the Team received further information that two 17 year olds had been recently tattooed at this address. Officers applied for a second Part 2A Order and in June 2015 entered the property while the tattooist was tattooing a client. Again equipment and articles were seized and the activity was prohibited for a period of 28 days.

It was evident that the action we were so far taking was not effective. Consequently a formal application was made to the Health and Safety Executive to transfer the enforcement responsibility for health and safety to Peterborough City Council. This was agreed and we subsequently prohibited the activity of tattooing indefinitely at this property.

As a result of these raids and the evidence that has been collected, officers prosecuted the illegal tattooist. Offences included failing to comply with a Part 2a Order, failing to register himself and his premises for tattooing and placing his clients at risk of infectious diseases due to poor standards and infection control. The case was heard at Magistrates Court on 25th November 2015 and the tattooist. pleaded guilty to all offences, he received a 16 week custodial sentence and was ordered to pay criminal court charges and a victim surcharge to be paid on his release.

This was a successful outcome to a difficult case. Whilst dealing with the unlawful activity officers have also been liaising with other agencies and departments i.e. Public Health England, Child Protection and Cambridgeshire Police, Safer Schools, to educate individuals and highlight the health concerns associated with getting a tattoo from an unregistered tattoo practitioner. The team have also been signposting individuals to seek medical advice and health screening once it has become known that they have had a tattoo at this premises.

12.2 **Shisha smoking prosecution**

Shisha smoking is a middle-eastern custom. It is a form of smoking both tobacco and non-tobacco containing products using a water pipe. The water pipe may be referred to as a ‘shisha pipe’ or a ‘hookah’. The container at the base of the pipe is partially filled with water. The pipe is then placed into the container so that it submerges into the water. The substance smoked is called ‘shisha’ and may be a tobacco-based or herbal-based substance flavoured usually with molasses and/or fruit. The substance is placed into a clay bowl on top of the pipe and covered with foil. Holes are made in the foil with a toothpick and charcoal is burned on top of the clay bowl which burns the shisha in the bowl. The smoke created by the burning is sucked through the hose attached to the pipe to bring the smoke down into the container. The smoke is inhaled through the pipe.

Shisha smoking is a serious potential health hazard to smokers and others exposed to the smoke emitted. The World Health Organisation (WHO 2005) state that a typical 1 hour water pipe smoking session involves inhaling 100-200 times the volume of smoke inhaled with a single cigarette. Smoke from shisha and the fuel source contain high levels of toxic compounds including carbon monoxide, heavy metals and cancer-causing chemicals.

Smoking is not permitted inside a premises if it is open to the public or if it is used as a place of work by more than one person or where members of the public might attend.

Outdoor smoking shelters or areas must not be enclosed or substantially enclosed. The walls must have openings, which are at least half of the total area of the walls including other structures, which serve the purpose of walls. No account can be taken of doors, windows or other fittings that can be open or shut.

On 12 March 2013 a man was prosecuted for 'Failing to prevent smoking in a smoke free place (a restaurant in Peterborough) on 30 November 2012' under the Health Act 2006 – an offence under Section 8. The restaurateur pleaded guilty and was fined.

Despite further advice given, more complaints were received and a warning letter was issued.

On 13 January 2016 the restaurateur was prosecuted a second time for 'Failing to prevent smoking in a smoke free place at (the restaurant) on 7 August 2015, was found guilty in his absence and was fined.

13 Looking Forward

13.1 Collaborative Tuberculosis strategy

In January 2015, PHE published a Collaborative Tuberculosis (TB) Strategy for England 2015 – 2019. This strategy recognises that TB rates have increased in England in recent years and also takes on board evidence from other countries that a systematic approach to tackling TB is effective in reducing the incidence. The Strategy focuses on ten evidence based areas for action:

- Improving access to services and early diagnosis
- High-quality diagnostics
- High-quality treatment and care services
- Contact tracing
- Vaccination
- Tackling drug resistance
- Tackling TB in underserved populations
- New entrant screening for LTBI
- Effective surveillance and monitoring
- Workforce strategy

In line with the strategy a Local TB Control Board has been established for the East of England with CCG leadership on the Board provided by Cambridgeshire and Peterborough CCG. One of its earliest actions has been to approve plans for the introduction of Latent TB Infection (LTBI) screening for new entrants to the country. In the first phase a number of GP practices in Peterborough will be undertaking this screening. The Health Protection Committee receives regular reports on implementation of this stratgey.

Dr Linda Sheridan, FFPH

Consultant in Public Health

February 2016

GLOSSARY

AAA	Abdominal Aortic Aneurysm
AHVLA	Animal Health and Veterinary Laboratories Agency
AT	Area Team (part of NHS England)
BBV(s)	Blood Borne Virus(es) (Hepatitis B & C and HIV)
BCG	Bacillus Camille Guerin (vaccine fro TB)
CCC	Cambridgeshire County Council
CCA	Civil Contingencies Act 2004
CCDC	Consultant in Communicable Disease Control
CCG(s)	Clinical Commissioning Group(s)
CCS	Cambridgeshire Community Services
CPLHRP	Cambridgeshire and Peterborough Local Health Resilience Partnership
CPLRF	Cambridgeshire and Peterborough Local Resilience Forum
CUHPT	Cambridge University Hospital Foundation Trust
DH	Department of Health
DPH	Director of Public Health
DsPH	Directors of Public Health
DTaP	Diphtheria, Tetanus and Pertussis (Whooping Cough) vaccine
EH	Environmental Health
EHO	Environmental Health Officer
EPRR	Emergency Preparedness, Resilience and Response
GP	General Practitioner
HiB	Haemophilus Influenza B vaccine
HIV	Human Immunodeficiency Virus
HHT	Hinchingbrooke Hospital Trust
HPN	Health Protection Nurse
HPSG	Health Protection Steering Group
HPT	Health Protection Team (part of Public Health England)
HPV	Human Papilloma Virus
HSE	Health and Safety Executive
HWB	Health and Well-being Board
IMT	Incident Management Team
IPV	Inactivated Polio Vaccine

JHWS	Joint Health and Well-being Strategy
JSNA	Joint Strategic Needs Assessment
KPI	Key Performance Indicator
LA	Local Authority
LGA	Local Government Association
LHRP	Local Health Resilience Partnership
LRF	Local Resilience Forum
MMR	Measles, Mumps and Rubella (vaccine)
MOU	Memorandum of Understanding
NHS	National Health Service
NHSE	NHS England
OIMT	Outbreak Incident Management Team
OOH	Out of Hours
NHS	National Health Service
NHSE	NHS England
PCT	Primary Care Trust
PCV	Pneumococcal Vaccine
PHE	Public Health England
Q 1,2,3,4	Reporting quarters for each year
TB	Tuberculosis

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 7
24 MARCH 2016		PUBLIC REPORT
Contact Officer(s):	Janet Dullaghan, Head of Commissioning Child Health and Wellbeing	Tel. 01733863730

UPDATE ON PROGRESS WITHIN JOINT COMMISSIONNG UNIT

RECOMMENDATIONS	
FROM: Janet Dullaghan, Head of Commissioning Child Health and Wellbeing	**DEADLINE:** N/A

The Board is asked to:

1. Note current activity and performance in child health commissioning and delivery
2. Agree actions highlighted in the paper

1. ORIGIN OF REPORT

1.1 This report is submitted to the board following agreement of the actions at the Joint Commissioning Unit (JCU).

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to update the Health and Wellbeing Board on performance within the Joint Child health Commissioning Unit. The data for the Healthy Child Programme (HCP) is up until January 2016 and is provided quarterly. The rest of the data is provided monthly. The narrative provides the latest updates on the priorities and issues to date.

2.2 To also inform the Board of the joint working initiatives, developments and priorities within the JCU.

3. HEALTHY CHILD PROGRAMME

3.1 The Healthy Child Programme (HCP) is the national public health Programme, based on best knowledge/evidence to achieve good outcomes for all children. The Government's aim is to enable local services to be shaped to meet local needs.

3.2 The HCP includes input from all partners working within universal services and includes midwifes, health visitors, children's centres and early support services, GPs, schools and school nurses. The HCP offers every family a programme of screening tests, immunisations, developmental reviews and information and guidance to support parenting and healthy choices. Health Visitors are a core part of the healthy child programme and from the 1 October the responsibility for the commissioning of this service along with Family Nurse Partnership transferred to the City Council under the Public Health grant.

3.3 Service delivery across Peterborough is based on the 4,5,6 model:

4 Levels of Service	Community Universal Universal plus Universal partnership plus

5 Universal Health Reviews	Antenatal New baby 6-8 weeks 1 year 2-2.5 years
6 High Impact Areas	Transition to parenthood Maternal mental health Breastfeeding Healthy weight Managing minor illnesses and accident prevention Healthy 2 year olds and school readiness.

4. KEY TARGETS WITHIN THE HV SERVICE PETERBOROUGH

Description	Target	Q3 result
No. of first antenatal contacts	765	357
NBVs within 14 days	90%	92%
All NBVs completed	100%	97%
6-8 week reviews completed	90%	97%
BF coverage at 6-8 weeks	99%	99%
BF prevalence at 6-8 weeks	45%	40%
Maternal health check at 6-8 weeks	95%	98%
12 month review by 12 months	90%	95%
12 month review by 15 months	100%	96%
2.5 year review	90%	90%
3-4 month checks (universal pathway)	90%	59%
3-4 month checks (universal plus/ partnership plus)	90%	Not recorded

4.1 Summary of Activity

4.1.1 The number of first antenatal contact are red as it is accumulative.

4.1.2 Breast feeding figures are down 5% this is a worrying trend and the breast feeding strategy group has been reconvened with midwifery, health visitors and breast feeding co-ordinator to agree a plan to improve these rates. 3-4 month check is not a mandatory check and one that may be changing in light of the review of the HCP.

4.1.3 The Family Nurse Partnership (FNP) is been reviewed alongside the Healthy Child Programme to look at achieving the savings required as a result of the reduction in the public health grant allocation. It is a national preventative program for vulnerable, young first-time mothers under 19 years of age. It offers intensive and structured home visiting, delivered by specially trained family nurses, from early pregnancy until the child is two. The FNP team work in partnership with other health professionals, social care professionals and other agencies to ensure the best possible outcomes for young people, their children and families. The family nurse and the young parent(s) commit to an average of 64 planned home visits over two and a half years. Building this relationship over a long period allows the family and nurse to establish a trusting, therapeutic relationship. Weekly and fortnightly visits take place from early pregnancy. The current FNP programme in Peterborough only funds places for 20% of the teenage population and once caseloads are full there are no places for others, regardless of need. This also potentially excludes some teenage parents who are leaving care or who are in care. These limitations mean that some vulnerable teenagers may 'miss the window of opportunity' for help and support from this intervention.

4.1.4 The proposal is to review and redesign the service as an enhanced service for all vulnerable teenagers as a core part of the Health visiting service, closely attached to midwifery and linking with social care colleagues and children's centres when appropriate. This would be a dedicated health visiting support service for all teenage parents across the city (instead of just 20%), needs-based and with a focus also on reducing inequalities

4.2 Child Care Settings

4.2.1 To ensure that children are accessing high quality child care settings and are supported to arrive in school ready to learn and socialise. The following areas are assessed by Ofsted this Statistical data was published on the 24th November for the period ending 31st August 2015.

4.2.2 For all provisions we have 88% rating of good or above, which is an increase of 2% on the last quarter and is 3% above the current national figure. This places us higher in the ranking against our statistical neighbours and is only 1% lower than the highest scoring local authority.

4.3 % of Pre-school Setting Rated Good or Above by Ofsted

4.3.1 For child-minders, the % Good or above has increased by 2% since the last quarter, to 88% and is 4% above the national figure.

4.4 Access to Two Year Old Funding

4.4.4 A number of two year olds are eligible for two year old funding in Peterborough. For the autumn term (1 September to 31 December), the following was achieved:

	Number	%
Total number of eligible two year olds in Peterborough	1554	n/a
Number of two year olds offered the funding entitlement	1367	88%
Number of two year olds accessing the funding	1175	76%

4.5 Immunisations

4.5.1 Following evidence of low uptakes for some vaccination programmes in Peterborough, Peterborough Local Authority, Public Health England and NHS England set up a Steering Task and Finish Group. A full report on the immunisation uptake in Peterborough was completed and this was presented to the Healthy Child Programme Board to agree actions. A group has been established to take forward the action plan based on the recommendations outlined in the report. This group, which consists of key stakeholders, have met on a number of occasions to drive the implementation of the identified actions. The group will continue to meet until March 2016, to ensure full implementation of the action plan.

4.5.2 Key recommendations include:

- Improving access to immunisations
- Increasing parents awareness and knowledge of the benefits of vaccinations
- Improving data quality

5 EARLY SUPPORT PATHWAY

5.1 As part of the Local Authority's duty to provide information, advice and assistance to parents of disabled/complex needs children and children with special educational needs, Peterborough City Council, CPFT, NHS, Spurgeons, Barnardos, Family Voice and other partners work in partnership to deliver Early Support, to provide or facilitate access to information and services for parents who might otherwise find it difficult to do so.

5.2 The new Early Support pathway across Peterborough started at the end of the first financial quarter (June 2015). In total to date there has been 74 referrals into the Early Support pathway. The majority of the referrals received are from the health visiting team and early years settings although a small number have been received from other professionals such as health therapists.

5.3 Initially the caseload was low; however the caseload appears to be stabilising with approximately 12 – 16 new cases being presented each calendar month (with two Multi-agency meetings being held per month). All referrals are made via an Early Help Assessment and are processed via the Early Help team who process for quality control and safeguarding. This ensures a robust assessment of the family's needs.

Referrals since June 2015

Referrals and Outcomes	
Total number of referrals	74
Number accepted on the pathway	68
Number not accepted on pathway	6

5. SCHOOL NURSING

5.1 School Nursing Key areas of monitoring are:

- Referral, intervention and referral on for pupils seen for weight management, sexual health, smoking intervention and substance misuse.
- The number of pupils presenting with mental health issues, including assessment, length of intervention and number referred on.
- The number of CAF's initiated by school nurses and the number that school nurses support partner agencies to complete but do not have a lead role.
- Drop-in service for senior schools.

5.2 Issues:

- The number of referrals around emotional health and wellbeing from schools
- The number of pupils presenting with mental health issues and once seen by CAMH if on the waiting list for treatment passed back to school nursing to hold.

5.3 Speech and Language Therapy

5.3.1 Redesign of the pathway is urgent due to increase in referrals and a large waiting list accumulating. The JCU have agreed a needs analysis to be done externally by Marie Gascoigne who is very experienced in this area and completed similar reviews of SLT services in other areas. This review started in January 2016. In the meantime the JCU has committed 40k extra funding, with this CPFT are tackling the waiting list by offering parents an appointment through the Choose and Book system, putting the emphasis on parents to book an appointment if they still want their child to be seen by a therapist. Half hourly appointments have been offered and for the pre-school children they are offered one of two

groups according to the child's individual needs i.e. Talking Together Group or Unclear Speech.

6. CHILDREN LOOKED AFTER INITIAL HEALTH ASSESSMENTS

6.1 CLA Current Situation

6.1.1 The chart and graph below show the last six months figures for the completion of Initial Health Assessments:

	June 15	July 15	August 15	September 15	October 15	November 15
Number of IHA's requested by CSC	6	14	12	7	16	9
Number of IHA's completed within timescale	6	10	10	7	13	9
Percentage completed	100%	71%	83%	100%	81%	100%

6.1.2 This is excellent progress and weekly meetings now takes place to monitor that assessments are completed on time.

6.2 Strengths and Difficulties Questionnaire (SDQ's)

6.2.1 Ofsted in their last inspection of children's social care made the recommendation that all children in care should have an SDQ completed to give an indication of their emotional well-being. This has now been commissioned from the health Children Looked After (CLA) team and started in December 2016.

6.3 Strategic issues

6.3.1 It is still proving difficult to get the same health service for children placed out of county due to other areas prioritising their own CLA and not having capacity. This out of county issue is being addressed as the second part of the CLA review. A new strategic designated doctor and nurse post have been appointed to by the CCG who has taken the strategic lead for CLA from February.

7. EMOTIONAL WELLBEING AND MENTAL HEALTH

7.1 Child And Adolescent Mental Health Services (CAMH)

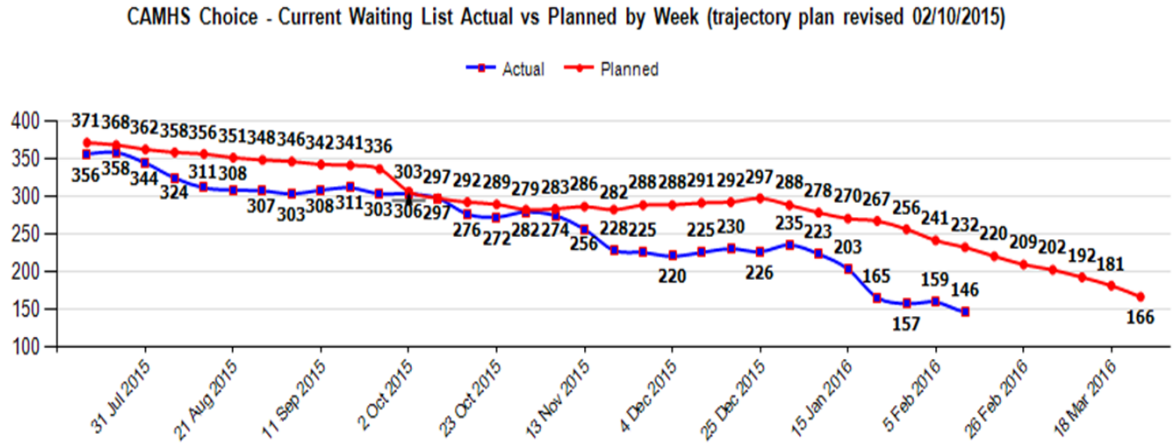
7.1.1 Over the past 18 months, the Clinical Commissioning Group (CCG) have worked closely with Cambridgeshire and Peterborough Foundation Trust (CPFT), Cambridgeshire County Council (CCC) Peterborough City Council (PCC) and Public Health colleagues to develop and agree a revised Child and Adolescent Mental Health (CAMH) service specification and performance indicators within an agreed resource envelope. Despite this work and some investment from the CCG, as well as increased investment from public health in commissioned voluntary sector provision, waiting lists for services have continued to increase. From April 2015 additional money (600k recurring and 150k non-recurring) was allocated to address the waiting times, this is reducing the waiting times for core CAMH services and to a lesser degree ASD/ADHD.

7.1.2 In Addition the Government has made £143m available nationally to fund improvements in CAMHS services. The local CAMHS Transformation Plan was submitted to NHS England in

November and has been approved, this released an additional £1.5m per year to support the development of better access to CAMHS and Eating Disorder services. Use of the additional funding by CPFT has been focussed on reducing core waiting list times for CAMH services.

7.1.3 The following graph shows the proposed and actual trajectory until March 2016. This is monitored fortnightly.

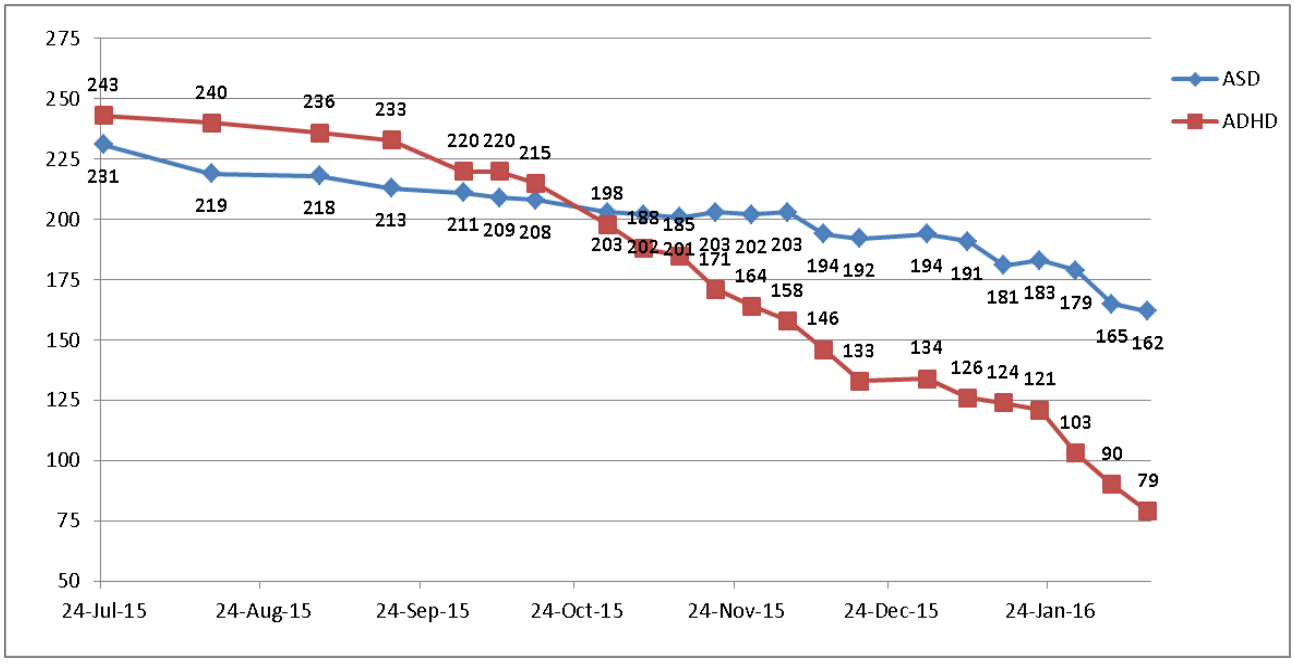
7.1.4



7.1.5 The waiting list for ASD/ADHD was closed from July 2015 – December 2015. £340k was made available by Cambridgeshire and Peterborough CCG to reduce waiting times to under 18 weeks by the end of March 2016.

7.1.6 In Addition the CCG has recently released a further tranche of the funding to reduce ADHD/ASD waiting list times and CPFT have commissioned Cambridgeshire Community Services to help with this pathway.

7.1.7 See following trajectory:



7.1.8 Waiting times to treatment have improved with 19 children awaiting treatment for CBT (13 over 18 weeks) and 36 for for other CAMH treatments (22 over 18 weeks)..

7.1.9 A series of workshops have been held with partners to agree a whole system approach to transformation of CAMHS and services for emotional health and wellbeing with a broad stakeholder input, including, service providers, third sector, Local Authority representatives, Parent representatives, Healthwatch, and commissioners, a plan was subsequently developed to address 4 key agreed priority areas.

- Waiting times – the JCU is leading on work to reduce waiting times to below 18 weeks.
- ASD and ADHD pathways – work between Local Authorities, Cambridgeshire Community Services (CCS) and CPFT is underway to ensure that pathways and processes are effective. A redesigned integrated ASD/ADHD pathway has been agreed between CPFT, CCS which enabled ASD/ADHD waiting lists to be reopened in December.
- Development of a Combined Single point of referral through the continued development of the advice and co-ordination team (ACT) The development of this pathway is seen as a key priority for the JCU and all partners. It is a core part of the redesign of CAMH services and a multiagency approach to ensure, Children, young people and families will be able to access services at the appropriate level at the appropriate time, reducing demand on specialist services by providing a swift and knowledgeable response to emerging concerns that prevent problems from escalating.
- Emergency Assessments and support – A 'task and finish' group has developed plans for providing Emergency assessment and intensive support services for Children and Young people in Mental Health crisis.

8. TRANSFORMATION PLAN AND REDESIGN OF EMOTIONAL HEALTH AND WELLBEING SERVCIES INCLUDING CHILD AND ADOLESCENT MENTAL HEALTH SERVCIES

8.1 Transformation Plan

8.1.1 The local CAMHS Transformation Plan was submitted to NHS England and approved in November. This has meant another £1.5m per year will be available to support development of better access to CAMHS and the Eating Disorder services.

8.1.2 The focus of the redesign and transformation is to ensure:-

- Better use of resources through the system to meet mental health needs.
- Moving more resources to meet needs at an earlier stage.
- There are clear pathways that parents and professionals follow so that they know what is available and how to access it.
- That interventions are evidenced based and have a positive impact on improving the mental health needs of the child or young person.

8.1.3 To do this, there will be a focus on ITHRIVE as the framework for redesigning the service model. ITHRIVE is a nationally developed model. The model focuses on needs rather than a structured 'tier' system. It is focused on ensuring that children and young people are thriving in their community and that their emotional and mental wellbeing is being supported through schools, locality teams, community groups, school nurses.
We have been successful in being chosen as one of the 10 NHS accelerator sites to implement this I thrive framework locally. Being accepted as an accelerator site for IThrive model provides a way to deliver the 'Future in Mind' recommendations and the CAMHS transformation Plan and could also give a possible framework to develop an integrated model across Children's services.

8.1.4 Thriving in the community is supported by ensuring that parents and professionals get the right advice at the right time to address any emerging mental health needs. This is through training for professionals and community groups on mental health issues and how to

address them, parenting programmes and whole school approaches to improving emotional health and wellbeing in children and adolescents.

8.1.5 The next focus is on getting timely help when it is needed. This ensures that where necessary there are evidenced based interventions that have a positive impact on a child's mental health needs. This work is supported by a family based approach ensuring that the needs of the whole family are addressed to prevent escalation of mental health needs. This is an aspirational model but one which is supported by all partners.

8.1.6 Redesigning CAMH services will be challenging, however it will be much more effective if all partners are able to look at how to address issues across the whole system and involve all partners and organisations in developing solutions. There is a real commitment for all parties to work at this together. To support this work an investment in tier 2 service comprising of a range of evidenced based parenting programmes for children with behavioural and emotional difficulties/ possible neurological problems – as a step prior to accessing more specialist services, if necessary.

9. REASONS FOR RECOMMENDATIONS

9.1 To ensure the health and wellbeing board are fully informed of the work of the JCU and enable support and challenge where appropriate.

10. ALTERNATIVE OPTIONS CONSIDERED

10.1 N/A

11. IMPLICATIONS

11.1 The transformation grant money gives us the opportunity to address waiting times and shortfalls in service's and to enable partners to work in a much more integrated way, to help meet the needs of children and families.

12. BACKGROUND DOCUMENTS

12.1 None.

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 8
24 MARCH 2016		PUBLIC REPORT
Contact Officer(s):	Dr Liz Robin, Director of Public Health	Tel. 01733 207176

JOINT HEALTH AND WELLBEING STRATEGY CONSULTATION – PROGRESS REPORT

RECOMMENDATIONS	
FROM : Dr Liz Robin, Director of Public Health	**Deadline date :** N/A

The Health and Wellbeing Board is asked to:

1. Note progress with the public and stakeholder engagement and consultation process for the draft Joint Health and Wellbeing Strategy (2016/19), and

2. Approve extension of the current Peterborough Health and Wellbeing Strategy (2012/15) until the next Health and Wellbeing Board meeting, when the outcome of the consultation and the final draft JHSW (2016/19) will be brought to the Board for approval.

1. ORIGIN OF REPORT

1.1 This report is submitted to Board as an update following previous items to the Board on developing the Joint Health and Wellbeing Strategy (2016/19)

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to update the Health and Wellbeing Board on progress with public and stakeholder consultation on the draft Joint Health and Wellbeing Strategy (2016/19) and to request the Board's approval for a further extension of the JHWS (2012/15) to allow for a full three month period of engagement and consultation.

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

3. PROGRESS WITH THE CONSULTATION AND ENGAGEMENT PROCESS

3.1 The draft Peterborough Joint Health and Wellbeing Strategy (JHWS) was brought to the December 2015 meeting of the Health and Wellbeing Board for approval prior to a period of stakeholder and public engagement and consultation. It was suggested at the HWB Board meeting that a summary version of the JHWS with graphics and pictograms, that would engage interested members of the public should be prepared in addition to the full draft JHWS, to maximise engagement.

3.2 Over December and early January a summary version of the JHWS was prepared by Peterborough City Council Communications team, and questionnaires for stakeholders and the public for both the 'long' and 'summary' versions of the JHWS were written by HealthWatch. All draft documentation was taken to Health Scrutiny Commission in January for comment. The Health Scrutiny Commission responded favourably to the summary JHWS, and recommended that a full three month period of stakeholder engagement and consultation would be appropriate.

3.3 The consultation on the Peterborough Joint Health and Wellbeing Strategy was launched on February 1 2016 and will run until April 30th. All documentation and details are available on weblink:
https://www.peterborough.gov.uk/council/consultations/health-and-wellbeing-strategy-consultation/

3.4 The consultation and engagement process has been promoted in the following ways:

- The consultation weblink was distributed to a wide range of local stakeholders by e-mail.
- Hard copies of the Summary JHWS, with freepost envelopes for return of the questionnaire, were distributed to libraries, GP surgeries, parish councils, Town Hall and Bayard Place receptions, HealthWatch.
- An All Party Policy seminar on the JHWS was held in February and hard copies of the summary JHWS provided to all attendees.
- The draft JHWS has been or is intended to be discussed/distributed at the following meetings and Boards:
    - Health and Wellbeing Programme Delivery Board
    - Borderline and Peterborough Joint Commissioning Board
    - Peterborough City Council Public Health Board
    - Safer Peterborough Partnership
    - Peterborough Housing Partnership
    - Childrens and Families Joint Commissioning Forum
    - HealthWatch Peterborough
    - Cambs & Peterborough NHS Clinical Commissioning Group Patient Forum
    - Peterborough NHS Local Commissioning Group Patient Forum
    - Borderline NHS Local Commissioning Group Patient Forum
    - Adult Joint Commissioning Board
    - Mental health stakeholder forum
- The City College is running sessions with young adults with learning disabilities, vocational trainees and people learning English as a second language, asking participants for feedback on the JHWS.
- Arrangements are in development through Peterborough City council links to engage with members of South Asian communities.

3.5 Initial feedback from the consultation web page is attached at Annex A. This is based only on completion of questionnaires, and doesn't yet include feedback received via minutes of meetings and Boards, City College sessions, or e-mailed responses, which will all be incorporated into the final Consultation feedback document.

4. CONSULTATION

4.1 Please see section 3.

5. ANTICIPATED OUTCOMES

5.1 It is anticipated that the Joint Health and Wellbeing Strategy will be improved and amended following the findings of the engagement and consultation process, and that a summary of consultation responses together with a final draft of the Joint Health and Wellbeing Strategy (2016/19) will be brought to the next meeting of the Health and Wellbeing Board.

6. REASONS FOR RECOMMENDATIONS

6.1 Peterborough Health and Wellbeing Board has a statutory duty to have a Joint Health and Wellbeing Strategy in place. Therefore the Board is asked to extend the Peterborough Health and Wellbeing Strategy (2012/2015) until the next meeting of the Health and Wellbeing Board, at which point the final draft of the Peterborough Joint Health and Wellbeing Strategy (2016/19) will be brought for approval.

7. ALTERNATIVE OPTIONS CONSIDERED

7.1 An alternative option would have been to cease the engagement and consultation process at the end of February, so that the response to consultation and final draft JHWS could be brought to the 24th March meeting of the Health and Wellbeing Board. However this would have left very limited time for engagement and consultation and would have been against the recommendation of the Health Scrutiny Commission that a full three month period of engagement and consultation should be carried out.

8. IMPLICATIONS

8.1 The approval of a draft Joint Health and Wellbeing Strategy 2016/19 for further engagement and consultation does not have immediate service change, financial or legal implications. It supports the Health and Wellbeing Board in delivering its statutory duty to prepare this Strategy.

9. BACKGROUND DOCUMENTS

- Peterborough Health and Wellbeing Strategy (2012/15)
- Draft Peterborough Joint Health and Wellbeing Strategy (2016/19)
- Summary draft Peterborough Joint Health and Wellbeing Strategy (2016/19)

10. APPENDICES

10.1 Appendix A - Health & Wellbeing Strategy 2016-19 Consultation – Summary of received responses as at 14/03/2016

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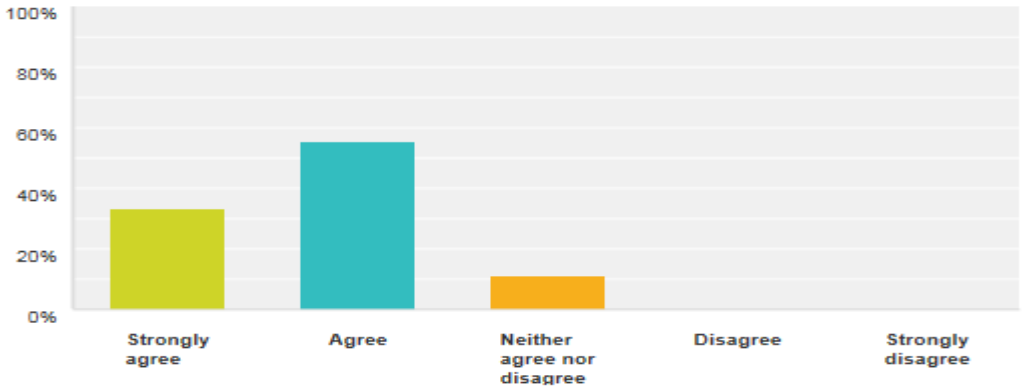
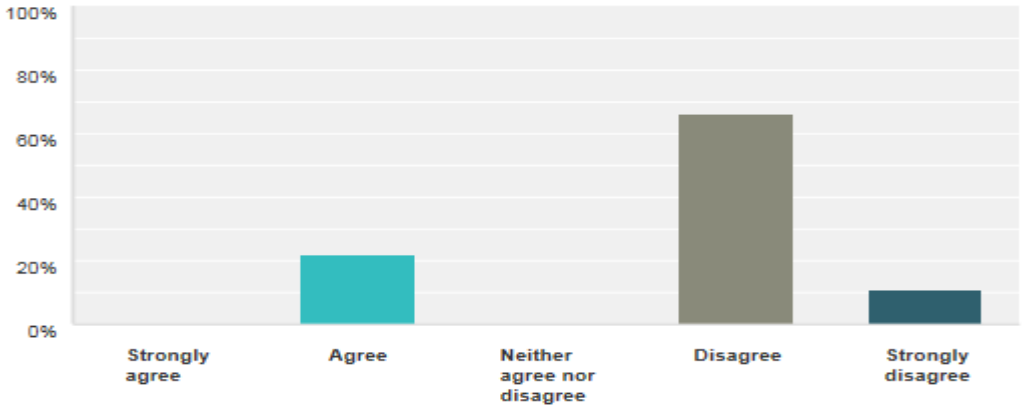
Health & Wellbeing Strategy 2016-19 Consultation – Summary of received responses as at 14/03/2016

Q1: The information presented in the strategy was easy to understand



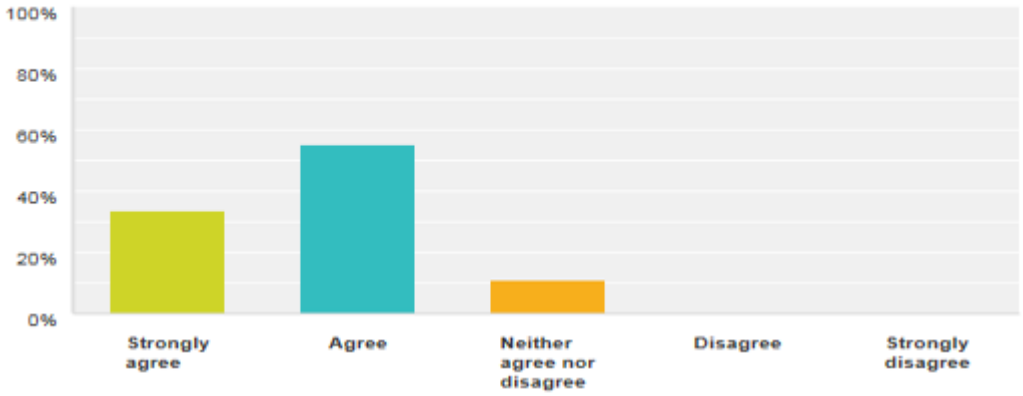
Answer Choices	Responses	
Strongly agree	33.33%	3
Agree	55.56%	5
Neither agree nor disagree	11.11%	1
Disagree	0.00%	0
Strongly disagree	0.00%	0
Total		9

Q2: The strategy used too much medical jargon



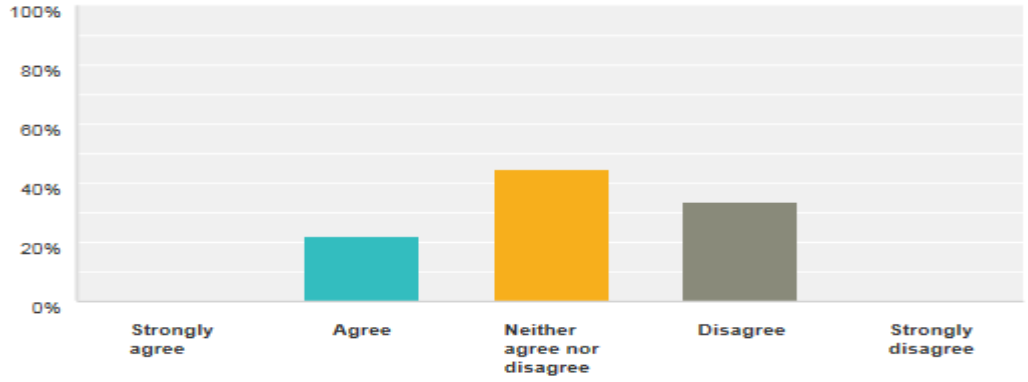
Answer Choices	Responses	
Strongly agree	0.00%	0
Agree	22.22%	2
Neither agree nor disagree	0.00%	0
Disagree	66.67%	6
Strongly disagree	11.11%	1
Total		9

Q3: The graphs and statistics provided helped to improve my understanding of health in Peterborough



Answer Choices	Responses	
Strongly agree	33.33%	3
Agree	55.56%	5
Neither agree nor disagree	11.11%	1
Disagree	0.00%	0
Strongly disagree	0.00%	0
Total		9

Q4: The different sections made sure the health needs of every group of people in Peterborough were addressed

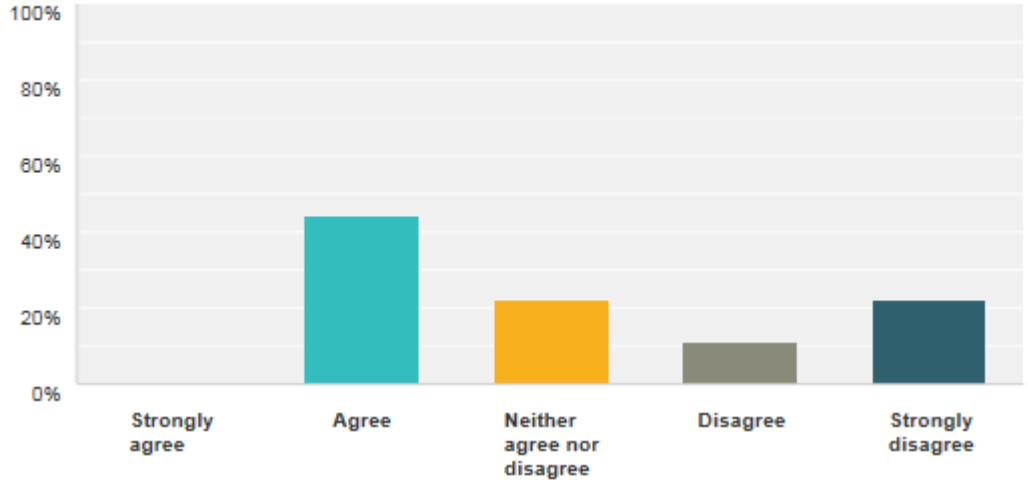


Answer Choices	Responses	
Strongly agree	0.00%	0
Agree	22.22%	2
Neither agree nor disagree	44.44%	4
Disagree	33.33%	3
Strongly disagree	0.00%	0
Total		9

Q5: If there are any groups whose needs you felt weren't addressed, or weren't addressed thoroughly enough, who were they and what should we be doing for them?

- Working aged families
- Lesbian, gay, bisexual & transgender – more preventative work re: sexual health including HIV. Work on wellbeing, mental health and substance misuse – suicide prevention etc.
- People with disabilities
- There is no mention of children with disabilities/long-term illnesses/terminal health problems.
- The 40-60 age group needs more support.

Q6: In general, I could see how the plans and projects outlined in the survey would benefit the health and wellbeing of the community.

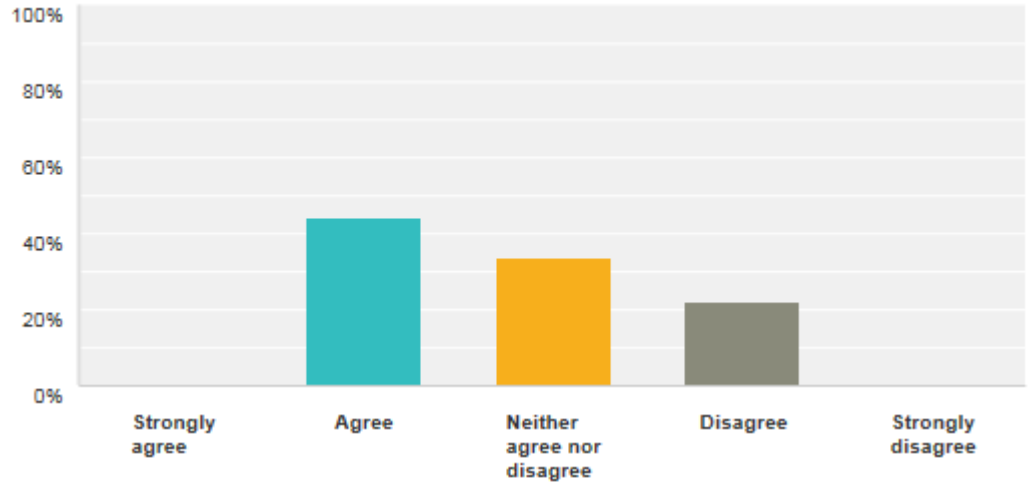


Answer Choices	Responses	
Strongly agree	0.00%	0
Agree	44.44%	4
Neither agree nor disagree	22.22%	2
Disagree	11.11%	1
Strongly disagree	22.22%	2
Total		9

Q7: If there were any projects you couldn't see the benefit of, what were they?

- Health in relation to migrant workers
- Where is the funding coming from?
- Day centres for people to find help advices plus workshops and courses to aid and support people.

Q8: I could see that for every health issue included in the strategy, it described a plan to address that issue.



Answer Choices	Responses	
Strongly agree	0.00%	0
Agree	44.44%	4
Neither agree nor disagree	33.33%	3
Disagree	22.22%	2
Strongly disagree	0.00%	0
Total		9

Q9: Please add any additional comments regarding this strategy.

- The issue of loneliness, especially but not only among older people, does not seem to have been fully addressed. Simple things like visiting schemes can have a major positive impact.
- The strategy seems adult/senior citizen based.

Summary of additional feedback/comments received from 'full' version of consultation document (7 additional responses):

- I feel that the local CCG needs to be tested. Is the current CCG fit for purpose keeping in mind its previous commissioning failures including Circle Health, Hinchingbrooke Hospital, Uniting Care Partnership?
- In the housing section, the strategy has failed yet again to address specialised housing for disabled people. Extra care cannot cater for this group.
- The strategy should include a section on discouraging bullying especially through social media in relation to young people.
- Is CPFT management team fit for purpose considering the organisation was part of Uniting Care Partnership?

- More robust communication should go to people who are carers. Carers in general are a neglected group. Peterborough City Council adult social care and CPFT need to make sure they have fulfilled their duties to carers under the Care Act.
- The mental health for adults of working age section ignores the increasing levels of unmet need due to year on year disinvestment from CPFT.
- Plans regarding older people need to be communicated better via non-electronic means.
- Disgusting lack of thought about how people with disabilities can be helped in to suitable fit-for-purpose housing.
- The housing section is very light, no mention of the effects of housing on health.
- No mention of improving cancer outcomes.
- More information is needed in the public domain such as libraries, supermarkets, pubs etc.
- Involve more end users in policy and direction of services.
- Develop local projects in helping people to help themselves.

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 9
24 MARCH 2016		PUBLIC REPORT
Contact Officer(s):	Angela Burrows, Chief Operating Officer, Healthwatch	Tel.

HEALTHWATCH PETERBOROUGH UPDATE

RECOMMENDATIONS	
FROM : Healthwatch Peterborough	**Deadline date :** N/A
To update the Health and Wellbeing Board on the progress of Healthwatch Peterborough over the previous year up to and including March 2016.	

1. ORIGIN OF REPORT

1.1 This report is submitted to Board to keep the members informed of the progress being made by Healthwatch Peterborough in regards to its statutory duties and specifically supporting the patient voice including Peterborough residents and/or those using health and social care services in the Peterborough and/or those working in Peterborough and/or those volunteering in Peterborough.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to inform the Health and Wellbeing Board of progress to date and seek members' views.

2.2 To adhere to one of local Healthwatch's four statutory core functions of under ***Community Voice and Influence.***

3. UPDATE

3.1 To provide a summary overview of Healthwatch Peterborough's activity with reference to supporting the patient voice. See Appendix A.

4. ANTICIPATED OUTCOMES

4.1 To provide the Board with details of Healthwatch Peterborough activity to ensure adherence of core function and to be reviewed and feedback on any development where appropriate.

5. APPENDICES

5.1 Appendix A - Overview of Healthwatch Peterborough's Activity

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Peterborough City Council Health and Wellbeing Board

24 March 2016

Introduction: This paper specifically looks at the work undertaken in the previous year to adhere to one of the four key statutory roles of a local Healthwatch in: ***Community Voice and Influence***

Range of events attended, facilitated, supported and/or engaged in throughout 2015-16 to provide the widest range of opportunity for local people's experiences to be captured and to be used to drive improvements and a better understanding of service delivery from the patient and carer's perspective. Obtaining the views of local people regarding their needs for, and experience of, local health and social care services and importantly to make these views known.

This 'soft intelligence' has significance to both commissioners and providers of local services to enable them to provide person and community centred approaches for health and wellbeing locally.

Further, the activities provide opportunity for raising awareness of Healthwatch Peterborough (HWP), opportunities for active signposting and development of best practice in community engagement and to represent the views of local users into local forums and feedback information to services users.

We have attended numerous local, regional and national events to promote our services and to hear from those key groups, including BME, veterans, young people, women's Institute, cancer patients and carers, carers and Learning Disability groups. We raise awareness of local, regional and national consultations to ensure public feed in to the development of any new and/or redeveloped service. These will all be shared in our Annual Report.

Activity	Outcome
Monthly Community Meetings held in public Provides open and transparent means to share information on workings of HWP. Commissioners and providers provide updates of local matters. Local people have opportunity to share their experiences.	Raises awareness of HWP and activity of local providers and commissioners. Number of issued shared by public attendees have been escalated to relevant bodies including; C&P CCG, PSHFT, CCS, CQC, HWEngland, NICE, GMC, CPFT. Updates from feedback/soft intelligence are shared to show action has been followed up.
Mental health research with 16-25 year olds of current understanding of mental health, commonly held views, experiences of talking, working and supporting those experiencing mental health difficulties and current information and support available to them. In collaboration with Peterborough Regional College. Attended a number of events over four months to share survey and get feedback from students. Also staff surveyed as responsible on day-to-day basis for students wellbeing.	Raised profile of HWP Total response: • 265 staff survey responses • 584 students survey responses Full report due for publication end March. Findings will be used for C/YP event to be facilitated by HWP on 31st March. Findings will be shared with commissioners.
Sharing short video created by HWP in local secondary schools assemblies.	Raise awareness of basic information on mental health using age-appropriate means. Support awareness of HWP with young people. Over 4,500 hits on YouTube.

Enter and View of local Care Homes Three visits in first phase. Target of three per quarter. Using data from CQC/PCC ASC.	Share findings with CQC and PCC ASC to provide soft intelligence for contract and oversight of commissioned care services. Enabled targeted inspections from our findings.
Prisoner Engagement Project Training and supporting prisoners to provide peer-to-peer support and led on new initiatives.	National award 2014-15; selected as one of six schemes as Best Practice' by CLiNKS for service users involvement 2016; training to Healthwatch network nationally; referrals from public re: prisoner health; Provides opportunity for support orgs to share info/campaigns in prison setting (for first time).
Non-clinical cancer services (RHMC) Since 2012 have been continuing to provide support and evidence to support development of local cancer centre. 2015-16: presented at a number of events, carried out surveys at Race for Life and Beale's Breast cancer fashion show. Provided evidence and written support to fund redevelopment.	First phase completed to explore possibility of centre re-development. Currently with Macmillan for decision for re-launch/furb of centre. Feb 2016: HWP provided patient-led support communication.
Dementia friends Sessions Providing HWP facilitated events at The Fleet. Delivering at rural community centres, local workers and care staff.	Raise awareness of Dementia and HWP. Opportunity for first-time engagement with public.
Maternity services Attend and promote Maternity Forum led by PSHFT. Enter and View Maternity Dept. at PCH.	Raise awareness of platforms to share experiences. Supported CQC national campaign to increase feedback from maternity services. Historically low levels of engagement. Raise awareness of HWP.
Enter and View ED (A&E) at PCH (Out of Hours 6pm-midnight) To review urgent/emergency care at point of access. To review patient/carer knowledge of other urgent care/access to GPs.	TBC – looking to triangulate with other national/local data to establish picture and support targeted campaigns to reduce avoidable A&E admissions.
PLACE and 15 Steps Audits With local health partners (CCS, CPFT, PSHFT, SLCH)	Supports patient-led review of local sites delivering care. Provides our trained volunteers with ongoing development in lay-person reviews.
PCC Health and Wellbeing Strategy Create and promote surveys to provide feedback tool to gather views of local people and stakeholders in the three year development of key services.	Provided opportunity for feedback in to consultation/engagement

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 10
		PUBLIC REPORT
Contact Officer(s):	Dr Liz Robin	Tel. 01733 207175

MENTAL HEALTH AND MENTAL ILLNESS OF ADULTS OF WORKING AGE: JOINT STRATEGIC NEEDS ASSESSMENT 2015/16

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

1. The Health and Wellbeing Board is asked to approve the Mental Health and Mental Illness of Adults of Working Age Joint Strategic Needs Assessment 2015/16.

2. The Health and Wellbeing Board is asked to consider how to take forward addressing the needs identified in the JSNA, through the Joint Health and Wellbeing Strategy (2016/19) and associated joint strategies and action plans.

1. ORIGIN OF REPORT

1.1 This report is submitted to Board following an earlier request by the Health and Wellbeing Board to deliver a Joint Strategic Needs Assessment on Adult Mental Health.

2. PURPOSE AND REASON FOR REPORT

2.1 Production of a Joint Strategic Needs Assessment (JSNA) of the health and wellbeing needs of Peterborough's population is a statutory duty of the Health and Wellbeing Board. This is delivered through production of a core JSNA dataset, accompanied by specific themed JSNAs on priorities requested by the Board. The purpose of bringing this JSNA to the HWB Board is firstly to ask the HWB Board to formally approve the JSNA document, and secondly to consider now the HWB Board can work jointly to address the adult mental health needs outlined in the JSNA.

2.2 This report is for 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*.

2.3 The full Mental Health and Mental Illness of Adults of Working Age JSNA document will be sent as a late circulation, due to requirements to clarify a small number of data issues with service providers, following internal review of the final draft JSNA.

3. SCOPE AND FINDINGS OF THE JSNA

3.1 The JSNA covers the following topics relevant to adult mental health and mental illness

- Demographics
- Risk Factors For Mental Illness
- Alcohol and Substance Misuse and Dependence
- Factors that Promote Mental Health
- Epidemiology of Mental Health Disorders
- Common Mental Disorders
- Severe Mental Illness
- Other Mental Health Disorders
- Self-harm, Suicide and Mental Health Crisis

- Cambridgeshire and Peterborough Foundation Trust Services for People with Mental Health Disorders
- Social Care for People with Mental Health Disorders
- Mental Illness and Physical Illness
- Evidence of Effectiveness of Mental Health Interventions

3.2 The key findings of the JSNA are presented in the Executive Summary at the start of the full JSNA document, which will be circulated as Annex A.

4. CONSULTATION

4.1 This JSNA has involved collection of information from both public sector and voluntary/ community sector organisations.

5. ANTICIPATED OUTCOMES

5.1 The key findings of this JSNA will inform development of the Joint Health and Wellbeing Strategy (2016/19), other joint strategies relevant to Adult Mental Health, and the service and commissioning plans of Health and Wellbeing Board member organisations.

6. REASONS FOR RECOMMENDATIONS

The reasons for the recommendations made are made are to enable the Health and Wellbeing Board to deliver its statutory duty to produce a Joint Strategic Needs Assessment of the health and wellbeing needs of the Peterborough population, to jointly address these needs through a Joint Health and Wellbeing Strategy, and to promote integrated working to deliver the objectives of the strategy.

7. ALTERNATIVE OPTIONS CONSIDERED

Consideration of options took place at the point when Adult Mental Health was prioritised by the Board as a future JSNA topic.

8. IMPLICATIONS

The findings of this JSNA will inform commissioning and service planning of Health and Wellbeing Board member organisations and are relevant to wider partnership working, for example with the police and criminal justice system, on mental health issues.

9. BACKGROUND DOCUMENTS

The wide range of documents and web resources used to prepare this JSNA are listed in the 'Reference' section at the end of the full JSNA document.

ANNEX A

The full 'Mental Health and Mental Illness of Adults of Working Age: Joint Strategic Needs Assessment 2015/16' will be circulated as Annex A to this Report. This will be a late circulation due to requirements to clarify a small number of data issues with service providers, following internal review of the final draft JSNA.

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 11
24 MARCH 2016		PUBLIC REPORT
Contact Officer(s):	Dr Gary Howsam, Clinical Director, Greater Peterborough Network, and GP Access Fund Clinical Lead	Tel.

PRIME MINISTER'S GP ACCESS FUND DELIVERY IN THE GREATER PETERBOROUGH LOCALITY

RECOMMENDATIONS	
FROM : Dr Gary Howsam, Clinical Director, Greater Peterborough Network, and GP Access Fund Clinical Lead	**Deadline date :** N/A
The Health and Wellbeing Board is asked to note the contents of this update.	

1. ORIGIN OF REPORT

1.1 This report is submitted to the Board as a routine update following previous update reports during 2015.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to update the Board on progress in the locality on implementing the Prime Minister's GP Access Fund Programme (formerly known as the Prime Minister's Challenge Fund).

3. BACKGROUND AND PROGRESS TO DATE

3.1 The original Prime Minister's Challenge Fund (PMCF) for Primary Care was launched by NHS England (NHSE) in October 2013 to help improve access to general practice and stimulate innovative ways of providing primary care services. Twenty Wave 1 sites were announced in April 2014, and invitations to submit bids against Wave2 of the PMCF were publicised by NHSE in October 2014. Clinical and management leads in Borderline and Peterborough worked hard to develop wide engagement from Primary Care providers and other stakeholders and from this to develop a bid to Wave2 of the fund. The system were informed on 27 March that the bid for funding, developed and submitted in January, had been successful.

3.2 The Peterborough GP Access Fund Programme represents £2.5m of investment to enhance the Primary Care offer locally, and is intended to "prove" itself over the initial period with a view to developing a Business Cases where applicable for sustainable local funding for new models. The work includes:

- delivery of "extended hours" (8.00am to 8.00pm) routine (bookable) weekday primary care appointments, delivered through shared "hub-working" arrangements;
- delivery of a primary care weekend service at the Emergency Department of Peterborough Hospital, aimed at supporting and reducing demand on that service;
- delivery of innovative use of technology both to facilitate the above, and more widely to improve and increase access to primary care;
- delivery of workforce and collaborative working innovations to support sustainable primary care in the Greater Peterborough locality.

3.3 Work on all of the above items have progressed well during 2015/16. Evening appointments (6.30-8.00pm) have been available Monday to Friday to the vast majority of the local population from January 2016 (supported by "hub working" arrangements as planned); slightly more limited availability to the whole population has been available on a rotad basis since October 2015. The primary care service at the "front" of the Emergency Department of Peterborough Hospital was successfully established on 7 November, and has run on every weekend and Bank Holiday (between 9.00am and 9.00pm) since that date; it has now seen well in excess of 1000 patients, and has subsequently been commissioned to provide additional ad hoc support on some weekday evenings. A web-based product "E-consult" is now being offered by 18 practices, and Skype-based products are being trialled at the present time to support virtual consultations. Alongside this a number of workforce and collaborative innovations are being trialled in or between practices across the locality.

3.4 All of the above developments have been supported by the creation of four "hubs" of GP practices, and a new overarching primary care provider organisation, Greater Peterborough Network Ltd. This new organisation not only provides management, governance, and oversight for the work, but also offers the opportunity for further collaborative and partnership developments in the future, as well as providing a collective "voice" for (and means to engage with) the primary care sector locally.

3.5 Confirmation has now been received that the original funding can be used to ensure that the main elements of the bid can all run for a full year from their original start dates (i.e. to the end of September for the evening extended hours appointments, and to the end of October for the weekend service at Peterborough City Hospital). This will allow a full evaluation to be developed (including feeding into the evaluation process for the GP Access Fund nationally), business cases to be submitted for ongoing / future funding, and for the various service models to be further developed to ensure that that they are robust, sustainable, and meeting the needs of local patients and the wider health and social care economy.

3.6 A Programme Board oversees the work, and includes clinical and management leads, patient representatives, NHSE and CCG representatives, and others involved in the work. Monthly reports have been provided throughout 2015/16 to NHSE, the Borderline and Peterborough Executive Partnership Board, and the Cambridgeshire and Peterborough CCG Primary Care Programme Board; quarterly reports have also been provided to the Cambridgeshire Executive Partnership Board, and the Peterborough Health and Wellbeing Board.

4. CONSULTATION

4.1 Patient representatives were consulted in the development of the original bid, and have been involved in monthly Programme Board meetings throughout 2015/16. In addition, presentations have been made to both the local Patient Forums, and an update provided to Healthwatch Peterborough. The outcomes associated with the bid (in terms of increased and more flexible access, and increased care and support delivered in the community and via Primary Care) are generally seen as positive in more general planning and service development. Patient satisfaction measures are one of the key metrics associated with the centrally delivered evaluation of the GP Access Fund pilots, and feedback from patients and patient groups will also be gathered locally to inform further developments, and to support Business Cases for future funding arising from the present work.

5. ANTICIPATED OUTCOMES

5.1 The Primary Care Transformation Programme represents a major development in primary care delivery in Peterborough, not only in terms of short-term benefits for patients and carers, but also in medium and longer term changes in the structure and practice of primary care. It is anticipated that the Board may wish to monitor and review these changes over time, and in particular as part of medium term oversight and review of local service provision.

6. REASONS FOR RECOMMENDATIONS

6.1 Whilst there is no decision required of the Board relating to the delivery of the Primary Care Transformation Programme at this time, it is hoped that the Board will be interested to review this development as it progresses, and the Programme Board will be pleased to receive any views on the programme offered by the Board.

7. ALTERNATIVE OPTIONS CONSIDERED

7.1 In deciding whether or not to put in a bid to the GP Access Fund the view was taken that much of the work which might be required in delivering it would most likely become necessary in the near future in any case, and whether funding was available to support it or not (on the basis of rising demand on Primary Care, workforce pressures, and wider system pressures). It was considered therefore a beneficial option to bid for funds to support the commencement of this work, and to help drive it forwards at pace.

8. BACKGROUND DOCUMENTS

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

8.1 None.

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 12
24 MARCH 2016		PUBLIC REPORT
Contact Officer(s):	Will Patten, Interim Assistant Director, Adult Commissioning, Peterborough City Council	Tel. 07919 365883

ADULT SOCIAL CARE, BETTER CARE FUND UPDATE

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

1. ORIGIN OF REPORT

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

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide information for the Board; it sets out an update on the delivery of the Better Care Fund (BCF) Programme and presents the third quarterly monitoring return for NHS England which was approved by the Borderline and Peterborough Executive Partnership Board, Commissioning (BPEPB) and submitted on the 19 February 2016.

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

3. BETTER CARE FUND BACKGROUND

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

3.2 Governance

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

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

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

3.3 Monitoring

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

3.3.2 Since the last report, the third quarterly monitoring return for NHS England has been approved by the BPEPB and submitted on the 19 February 2016. Please refer to the attached document entitled *BCF Quarterly Data Collection Template Q3 15-16 Peterborough (final).*

3.4 Workstream Updates

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

Project	Lead Organisation	Design		Delivery	
		Accountable Officer	Project Support	Accountable Officer	Project Support
Data Sharing	CCC	Charlotte Black, CCC	Isla Rowlands and Geoff Hinkins	Charlotte Black, CCC	Isla Rowland, CCC
7 Day Working	SRGs	Nominated leads from SRGs: Peterborough Cambs and Ely Hunts Wisbech/Norfolk	Peterborough – WP/CH Cambs and Ely – GK/CCC Hunts – GK/CCC Wisbech and Norfolk – GK/CCC	Nominated leads from SRGs: Peterborough Cambs and Ely Hunts Wisbech/Norfolk	Peterborough – WP/CH Cambs and Ely – GK/CCC Hunts – GK/CCC Wisbech and Norfolk – GK/CCC
Person Centred Systems	C&P CCG	Gill Kelly/Cath MitchellC&P CCG	Graham Johnston, CCC	Gill Kelly/Cath MitchellC&P CCG	Graham Johnston, CCC
Information Advice and Guidance	PCC	Adrian Chapman	Damian Roberts, PCC	Adrian Chapman	Damian Roberts, PCC
Healthy Ageing and Prevention	Public Health	Angelique Mavrodaris	Graham Johnston, CCC	Angelique Mavrodaris	Graham Johnston, CCC

3.4.2 <u>Data Sharing</u>

3.4.2.1 In January, the CCG formally announced the decision not to progress with the implementation of OneView, but remains committed to data sharing as a priority. The immediate focus of the project is to review options and decide on an alternative for progressing data sharing.

3.4.2.2 A joint Information Sharing Framework has been agreed across Peterborough and Cambridgeshire. Data sharing agreements have been sent to all GP practices and the development of practical tools to support the Framework and encourage sign up are being explored. Further work is being undertaken to develop a paper on consent models for consideration at the next Project Board meeting. The next Data Sharing Project Board meeting is scheduled for April 2016.

3.4.3 <u>7 Day Working</u>

3.4.3.1 There is an inclusive project plan and a dashboard established. A set of nine principles for 7 day working were developed following county-wide workshops. These have been agreed by Peterborough SRG. Funding from national and regional BCF bids has been secured for a pilot Pathways Coordinator to support discharge planning. The CCG have committed match funding for this project. Implementation of the pilot is being finalised.

3.4.3.2 A review of the Joint Emergency Teams (JET) has been undertaken by CPFT, which has highlighted the need for further work to increase referrals from local GPs. Further review of JET operating times and referral processes is currently being finalised by CPFT.

3.4.3.3 Peterborough SRG are reviewing their 10 Point Urgent Care Plan to ensure incorporation of BCF priorities. Service mapping of provision of 7 days services is being undertaken to facilitate identification of current gaps.

3.4.4 Person Centred Care

3.4.4.1 The project was being led by UnitingCare (UC). The CCG have published an OPACS recommendation paper, which includes proposals for who will lead on key areas of BCF work. The CCG have confirmed their ongoing commitment to supporting the UC model of delivery. The Case Management Group have now met and agreed membership, terms of reference and a draft project plan. Further analysis in relation to case finding is required to develop a methodology and initial scoping will be led by CPFT.

3.4.5 Information and Communication

3.4.5.1 There is an inclusive project plan and dashboard established. The Information and Communication Project Board last met in February 2016 and continues to meet monthly. An agreed set of principles, outcomes and joint terminology has been agreed. The current priority is to understand the options for an Information Hub. Ongoing agreed objectives include; mapping of three directories (FIS, Local Offer and Care Directory); develop shared data standards; determine the scope of information to be held; explore technological options for delivery and develop a joint business case. A Local Government Association (LGA) Digital Transformation Grant application was submitted at the end of December 2015, to support the development of the information hub. A decision is still awaited.

3.4.6 Ageing Healthily and Prevention

3.4.6.1 An inclusive project plan and dashboard are established. This project is being led by Public Health. The Healthy Ageing and Prevention (HEAP) Project Board met on the 14 January 2016 and agreed to progress the following key objectives:

- **Falls prevention:** Led by Public Health. Development of a joint falls pathway across Cambridgeshire and Peterborough. The Falls Working Group met on the 22 February 2016 and a detailed falls project plan is being finalised.
- **Primary prevention:** Led by Public Health. The focus will be social isolation and malnutrition. The primary prevention working group met on the 4 January 2016 and agreed to undertake service mapping to identify gaps and facilitate the development of a joint pathway.
- **Dementia:** Further development of a clear vision and objectives are needed. Public Health to lead on the development of some discreet actions to feed back to the next HEAP Project Board meeting on 24 February 2016.
- **Continence/UTIs:** To be led by CPFT. Primary focus will be to develop a clear scope and vision for this work-stream.
- The project also incorporates the development of the Voluntary Sector-led Wellbeing Service, which is currently under review by the CCG in light of the termination of the UC contract.

3.5 Better Care Fund Plans for 2016/17

3.5.1 NHS England have confirmed that funding for the BCF will continue into 2016/17. NHS England BCF allocations have been published and represent a small uplift to local BCF monies. Local budget allocations have been agreed between the CCG and PCC. PCC funding is committed at the same level as last financial year.

3.5.2 A Policy Framework and Planning Guidance for the BCF have now been published. A briefing note explaining these documents is attached at Appendix A. An initial high level finance and metric return is due to be submitted on the 2 March. First draft narrative and detailed plan due 21 March, with final plans submitted prior to the 25 April 2016. The

submission and assurance process has been simplified with a regional assurance process in place for 2016/17.

4. CONSULTATION

4.1 As previously reported, in the developing and drafting of the BCF Plan there were detailed discussions and workshops with partners. Joint working across Cambridgeshire and Peterborough continues and regular monitoring activities have been solidified across all five projects to ensure clear and standardised reporting mechanisms.

4.2 Discussions and workshops with partners are underway to support planning for the BCF 2016/17 submission. Programme Integration Meetings are happening weekly to ensure integration and reduce duplication across different programmes of work; e.g. BCF, Vanguard and Local Authority Transformation Programmes.

5. IMPLICATIONS

Financial

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

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

6. BACKGROUND DOCUMENTS

- BCF Quarterly Data Collection Template Q1 15-16 Peterborough (final)
- BCF Quarterly Data Collection template Q2 15-16 Peterborough (final)
- BCF Quarterly Data Collection Template Q3 15-16 Peterborough (final)

7. APPENDICES

7.1 Appendix A - BCF 2016/17 Guidance Briefing

Briefing Note
Planning Guidance for the Better Care Fund 2016/17

On 23rd January 2016 the Department of Health and Department for Communities and Local Government published the Better Care Fund Planning Requirements for 2016-17.

The document needs also be read alongside:

- BCF Policy Framework 2016/17 https://www.gov.uk/government/publications/better-care-fund-how-it-will-work-in-2016-to-2017
- BCF Local Financial Allocations 2016/17 https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/
- NHS Mandate for 2016/17 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/486674/nhse-mandate16-17.pdf

The BCF return template for the 2016/17 BCF plan has not yet been published, but is expected imminently.

How will the Planning Guidance be used?
NHS England expect local authorities to use the planning guidance to structure their plans and delivery of BCF for 2016/17. Timescales for submission of plans is:

- 2nd March 2016: BCF planning return; to include agreed funding, scheme level spending plan, national metric plans and any local risk sharing agreements.
- 21st March 2016: High level narrative plan and revised BCF planning return.
- 25th April 2016: Final BCF plans submitted, having been signed off by Health and Wellbeing Boards.

The national assurance process for BCF Plans for 2016/17 has been removed. Instead regional teams will work with the Better Care Support Team to provide the assurance process.

Key Changes in BCF for 2016/17

- The removal of the performance for pay element of the fund
- Two new national conditions:
  (i) an "agreement to invest in NHS commissioned out of hospital services, which **may** include a wide range of services including social care". This replaces the payment for performance element of the fund. These fund are ring-fenced in line with the specified BCF allocations amount. Local areas who did not need their emergency admission target are expected to consider putting an appropriate proportion of the ring-fenced budget into a local risk sharing agreement;
  (ii) a new requirement for a plan, with locally determined stretch targets, for reducing delayed transfers of care (DTOC). This appears to be a broad plan, focussing on community assets, flow through the system, and emphasising the need for integrated, collaborative whole system working
- The Disabled Facilities Grant (DFG) will continue to be allocated through the BCF. However, the Adult Social Care Grant will be included in a single DFG payment for 2016/17. This is to strengthen the housing element of the BCF, with a new national condition that requires local housing authority representatives to be involved in developing and agreeing BCF plans.

What stays the same?

- Existing national conditions remain (plus the two new national conditions outlined above):
  - Jointly agreed plans
  - Maintain provision of social care services
  - Better data sharing between health and social care, based on the NHS number
  - 7 Day services to support discharge
  - Joint approach to assessment and care planning, with an accountable lead professional
- Metrics remain the same (plus a local DTOC metric, as outlined above):

- Non-elective admissions
- Admissions to residential and care homes
- Effectiveness of reablement

We await clarity on

- The template for the BCF plan return

Caroline Hills
21/02/2016

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 13
24 MARCH 2016		PUBLIC REPORT
Contact Officer(s):	Dr. Liz Robin, Director of Public Health	Tel. 01733 207175

JOINT PROCUREMENT – INTEGRATED LIFESTYLE AND WEIGHT MANAGEMENT SERVICES

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

The Health and Wellbeing Board is asked to:

1. Note Peterborough City Council's and the Cambridgeshire and Peterborough's Clinical Commissioning Group's intention to jointly procure integrated lifestyle and weight management services for Peterborough.

1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing Board under its terms of reference 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.'*

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide the Health and Wellbeing Board with background information related to this procurement and to outline the identified procurement stages.

3. MAIN BODY OF REPORT

3.1 Following an options appraisal undertaken by the Peterborough Public Health Board and in partnership with the Cambridgeshire and Peterborough Clinical Commissioning Group a decision to establish a new integrated lifestyle and weight management service has been agreed.

3.2 An evidence based specification for an integrated service has been developed with the following key components and settings for the programmes proposed as follows:

3.3 Core services:

- Smoking cessation programme
- NHS Health checks programme
- Child weight management programmes
- Adult weight management programmes (including Tier 2 and Tier 3)
- Health trainer programme
- Physical activity programme
- Training for Health champions
- Health promotion campaigns

3.4 Core settings:

- Healthcare settings (GP surgeries, pharmacies, hospital etc.)
- Schools

- Workplaces
- Communities with increased or diverse needs (e.g. South Asian, Eastern European)

3.5 The main funding for the service to be procured is from Peterborough City Council public health budgets, with additional contributions from the Better Care Fund and Cambridgeshire and Peterborough CCG (specifically for tier 3 obesity services).

4. ANTICIPATED OUTCOMES

4.1 It is anticipated that following a successful procurement a new contract will be awarded towards the end of November 2016 with implementation of the new service in April 2017.

5. REASONS FOR RECOMMENDATIONS

5.1 The procurement of an integrated service will further support the health and wellbeing needs of Peterborough through the provision of key lifestyle services.

6. IMPLICATIONS

6.1 The procurement of an integrated service will have implications for staff currently employed within existing Public Health lifestyle services. It is anticipated that these staff will TUPE to the appointed provider.

7. BACKGROUND DOCUMENTS

7.1 Appendix A - Draft Integrated Lifestyles Procurement Project Plan

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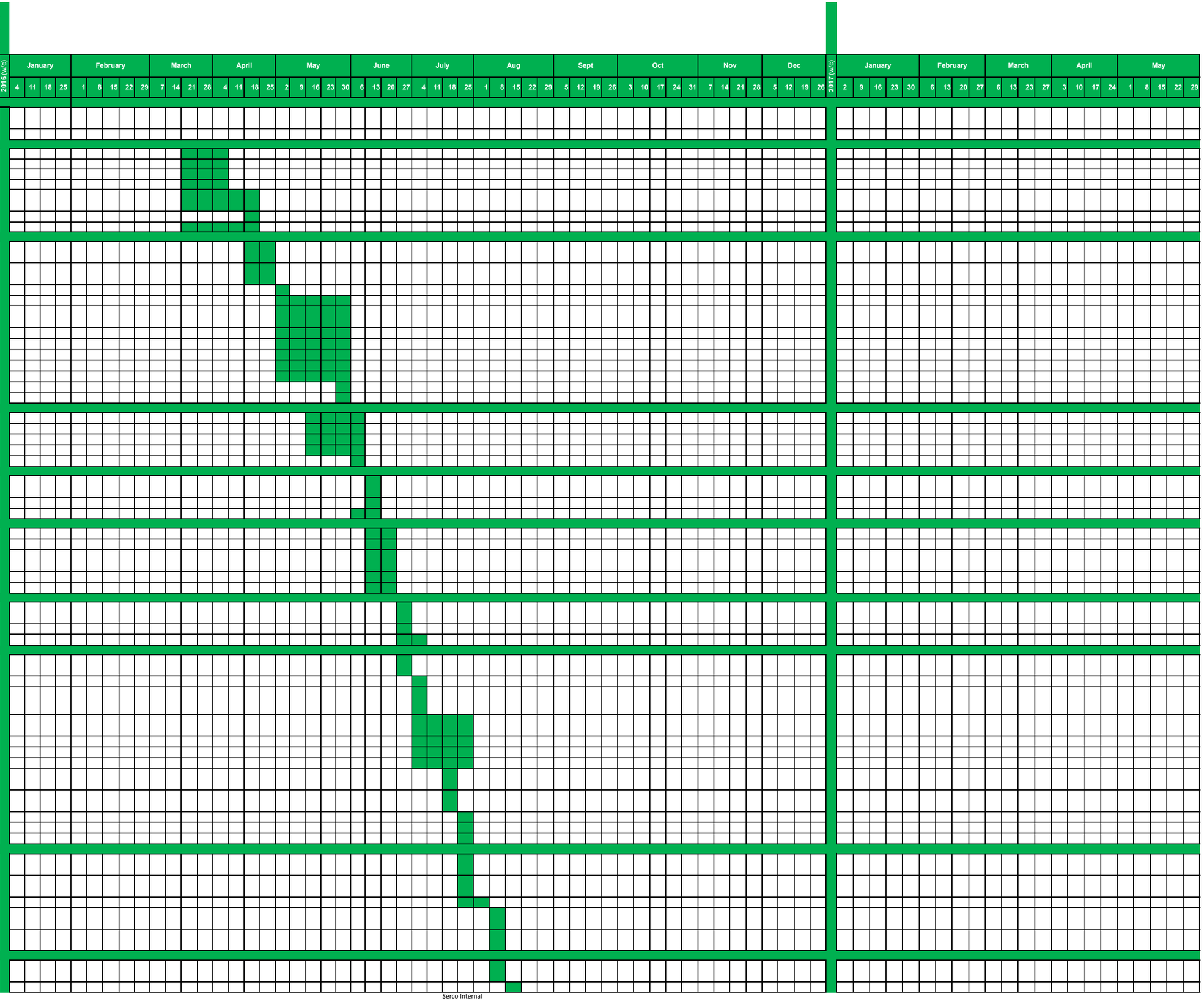
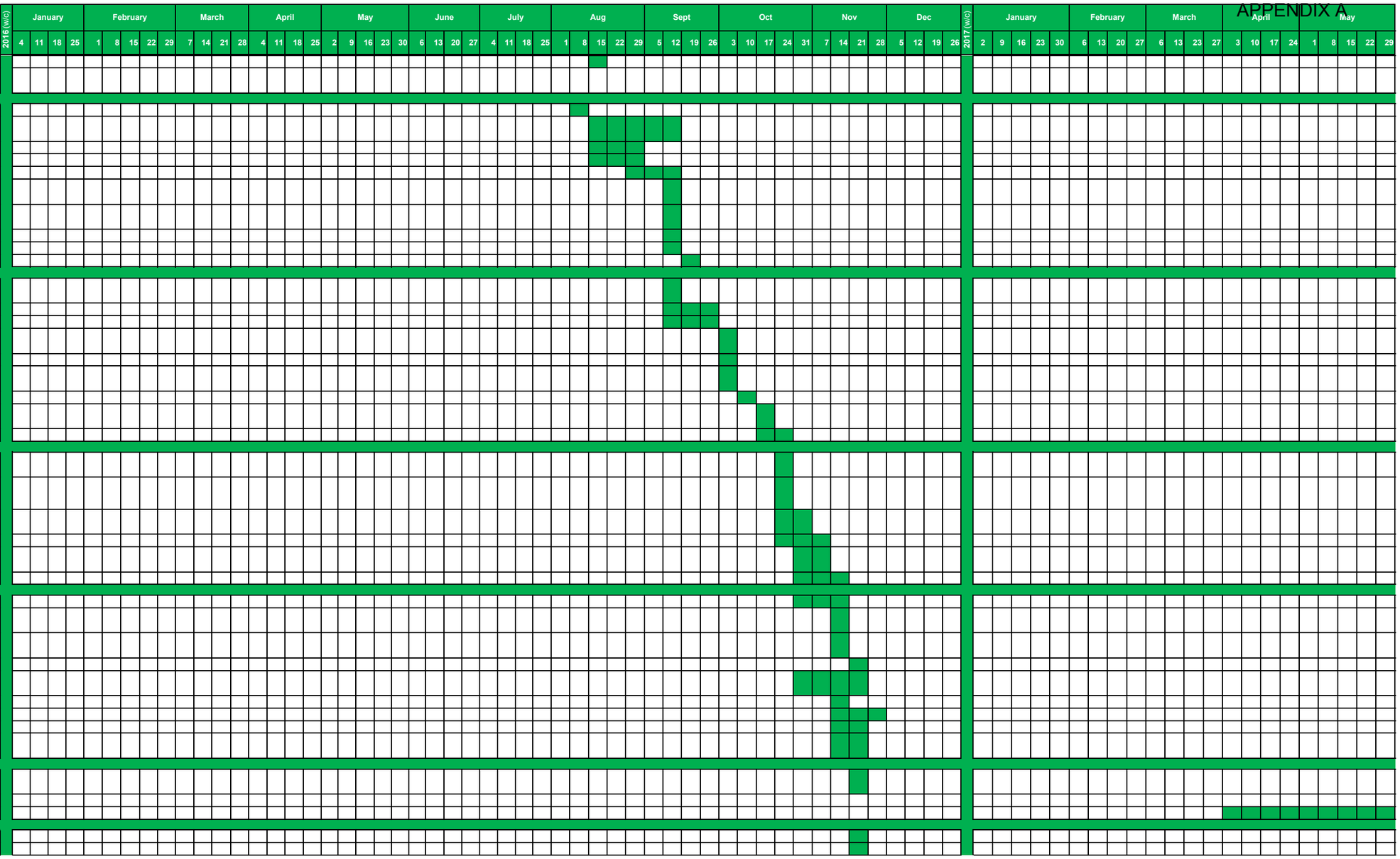
Project Plan	
Project Title:	Healthy Lifstyle
Project Reference (Verto):	0
Project Manager:	Oliver Hayward

Ref No.	Activity	Resources (Initials)	Progress Status	Task Start Date	Task End Date
Project Management					
P-01	Create Healthy Lifestyles Project Board				
P-02	Project Update				
Stakeholder Engagement Stage 1					
P-03	Identify key stakeholders		On Track	21/03/16	10/04/16
P-04	Identify Project Team		On Track	21/03/16	10/04/16
P-05	Identify TUPE issues		On Track	21/03/16	10/04/16
P-06	Identify Risks		On Track	21/03/16	10/04/16
P-07	Production of commissioning model and initial Category Plan		On Track	21/03/16	18/04/16
P-08	Agree the commissioning model		On Track	18/04/16	24/04/16
P-09	Equality Impact Assessment		On Track	21/03/16	18/04/16
Stakeholder Engagement Stage 2					
P-10	Results evaluated, analysed and timescales are agreed		On Track	18/04/16	01/05/16
P-11	Prapare the Soft Market Testing (SMT) Document		On Track	18/04/16	01/05/16
P-12	Issue PIN		On Track	02/05/16	02/05/16
P-13	Issue SMT Document		On Track	02/05/16	05/06/16
P-14	Consult other stakeholders - Councillors/Cabinet Member		On Track	02/05/16	05/06/16
P-15	Consult with Service Users		On Track	02/05/16	05/06/16
P-16	Consult with GP's		On Track	02/05/16	05/06/16
P-17	Consult with Operations/Staff		On Track	02/05/16	05/06/16
P-18	Consult with Providers		On Track	02/05/16	05/06/16
P-19	Consult with Performance Team		On Track	02/05/16	05/06/16
P-20	Update Sourcing Plan		On Track	30/05/16	05/06/16
P-21	Seek Approval from the Board		On Track	30/05/16	05/06/16
Draft Adverts and Procurement documents					
P-22	Draft specification		On Track	16/05/16	12/06/16
P-23	Draft TUPE information		On Track	16/05/16	12/06/16
P-24	Draft Award criteria		On Track	16/05/16	12/06/16
P-25	Draft Terms and Conditions		On Track	16/05/16	12/06/16
P-26	Draft Domestic Contract Notice		On Track	01/06/16	06/06/16
Approvals Stage 1					
P-27	Commissioning and Procurement Group		On Track	13/06/16	19/06/16
P-28	CE Delivery Board		On Track	13/06/16	19/06/16
P-29	People and Commissioning Board		On Track	06/06/16	19/06/16
Finalise Adverts and ITT documents					
P-30	Final service specification		On Track	13/06/16	26/06/16
P-31	Final TUPE information		On Track	13/06/16	26/06/16
P-32	Finalise Commercial Specification and Award criteria		On Track	13/06/16	26/06/16
P-33	Finalise Terms and Conditions		On Track	13/06/16	26/06/16
P-34	Finalise Domestic Advert		On Track	13/06/16	26/06/16
Approvals Stage 2					
P-35	Commissioning and Procurement Group		On Track	27/06/16	03/07/16
P-36	CE Delivery Board		On Track	27/06/16	03/07/16
P-37	People and Commissioning Board		On Track	27/06/16	10/07/16
Advertising - Stage One (PQQ)					
P-38	Place Opportunity on E-Tendering system		On Track	27/06/16	03/07/16
P-39	Place OJEU Advert		On Track	04/07/16	04/07/16
P-40	Place Advert on Local Voluntary Organisations e.g. Business Link, Chamber of Commerce		On Track	04/07/16	04/07/16
P-41	Supplier download documents and return		On Track	04/07/16	25/07/16
P-42	Prepare Evaluation Documents		On Track	04/07/16	25/07/16
P-43	Produce training pack		On Track	04/07/16	25/07/16
P-44	Evaluators trained		On Track	04/07/16	25/07/16
P-45	Deadline for receipt of clarification questions		On Track	18/07/16	18/07/16
P-46	Deadline to answer clarification questions		On Track	18/07/16	20/07/16
P-47	Closing Date		On Track	25/07/16	25/07/16
P-48	Documents Opened		On Track	25/07/16	25/07/16
P-49	Download Submitted Document		On Track	25/07/16	25/07/16
Tender Evaluation					
P-50	Compliance check and selection questions evaluations		On Track	25/07/16	28/07/16
P-51	Evaluation panel receive responses		On Track	25/07/16	28/07/16
P-52	Evaluate response in your own time		On Track	25/07/16	07/08/16
P-53	Send individual evaluation scores to VM to Consolidate		On Track	08/08/16	08/08/16
P-54	Evaluation team meeting 1 - moderation		On Track	08/08/16	14/08/16
Selection					
P-55	Finalise Specification for final approval		On Track	08/08/16	14/08/16
P-56	Invite successful tenderer		On Track	15/08/16	15/08/16



Ref No.	Activity	Resources (Initials)	Progress Status	Task Start Date	Task End Date
P-57	Notify unsuccessful tenderers		On Track	15/08/16	15/08/16
P-58	Prepaire debrief letter for unsuccessful suppliers		On Track		
Advertising ITT and Return					
P-59	Place ITT on E-Tendering system		On Track	08/08/16	14/08/16
P-60	Supplier download ITT documents and return		On Track	15/08/16	12/09/16
P-61	Prepare ITT Evaluation Documents		On Track	15/08/16	04/09/16
P-62	Produce ITT training pack		On Track	15/08/16	04/09/16
P-63	ITT Evaluators trained		On Track	29/08/16	18/09/16
P-64	Deadline for receipt of clarification questions		On Track	12/09/16	12/09/16
P-65	Deadline to answer clarification questions		On Track	12/09/16	15/09/16
P-66	ITT Closing Date		On Track	12/09/16	12/09/16
P-67	Download ITT Submissions		On Track	12/09/16	12/09/16
P-68	Supplier Presentations		On Track	19/09/16	25/09/16
Tender Evaluation					
P-69	Evaluation panel receive responses		On Track	12/09/16	12/09/16
P-70	Evaluate response in your own time		On Track	08/09/16	02/10/16
P-71	Price evaluations		On Track	08/09/16	02/10/16
P-72	Send individual evaluation scores to VM		On Track	30/09/16	03/10/16
P-73	Consolidate evaluation scores		On Track	03/10/16	03/10/16
P-74	Evaluation team meeting 1 - moderation		On Track	03/10/16	09/10/16
P-75	Post tender clarifications		On Track	10/10/16	16/10/16
P-76	Evaluation team meeting following clarifications (if required)		On Track	17/10/16	23/10/16
P-77	Draft PCC Mobilisation Plan		On Track	17/10/16	30/10/16
Approvals Stage 4 (CMDN)					
P-78	Completion of tender evaluation report - CMDN drafted		On Track	24/10/16	30/10/16
P-79	Informal notification of recommended contract award to providers		On Track	24/10/16	30/10/16
P-80	Send to Cabinet member for approval		On Track	24/10/16	06/11/16
P-81	CMDN published on PCC website		On Track	24/10/16	13/11/16
P-82	Approval of Award (CMDN), also includes CMT approval		On Track	31/10/16	13/11/16
P-83	Call in period for CMDN finishes		On Track	31/10/16	14/11/16
Contract Award					
P-84	Prepare Alcatel letters		On Track	31/10/16	14/11/16
P-85	Notify successful tenderer - Intention to award Alcaltel stage		On Track	14/11/16	20/11/16
P-86	Notify unsuccessful tenderers - Alcatel stage		On Track	14/11/16	20/11/16
P-87	Debrief unsuccessful suppliers		On Track	21/11/16	27/11/16
P-88	Send all relevant documents to Legal for contract preparation		On Track	31/10/16	27/11/16
P-89	Contract Award		On Track	14/11/16	20/11/16
P-90	Contract documents signed		On Track	14/11/16	04/12/16
P-91	Publish contract award notice		On Track	14/11/16	27/11/16
P-92	Update E-Tendering with award details		On Track	14/11/16	27/11/16
Implementation					
P-93	Finalise PCC mobilisation/implementation plans		On Track	21/11/16	27/11/16
P-94	Go Live with new contracts		On Track	03/04/17	09/04/16
P-95	Contract monitoring		On Track	03/04/17	02/04/20
Lessons Learned					
P-96	Complete lessons learned log		On Track	21/11/16	27/11/16
P-97	Formally close project		On Track	21/11/16	27/11/16



UPDATED: 17 FEBRUARY 2016

HEALTH AND WELLBEING BOARD
PROPOSED AGENDA PLAN 2016/2017

MEETING DATE	ITEM	CONTACT OFFICER
(TBC)	Annual DPH Report Health and Wellbeing Strategy i) Consultation Report ii) Final Approval iii) Progress Delivery Board Priorities Domestic Abuse and Substance Misuse Update Migrant Workers JSNA Care and Health System Transformation Programme Update **For Information:**	**Liz Robin** **Liz Robin** **Wendi Ogle-Welbourn** **Liz Robin** **Cathy Mitchell**
(TBC)	Cardiovascular Disease Strategy (requested via email by Liz Robin on 24/2/16) **For Information:**	**Liz Robin**
(TBC)	 **For Information:**	
(TBC)	 **For Information:**	

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