PETERBOROUGH CITY COUNCIL

# HEALTH AND WELLBEING BOARD

## THURSDAY 23 MARCH 2017
## 1.00 PM

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

## AGENDA


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

**15. Hydrotherapy Policy (Verbal Update)**

**16. Devolution 2 (Verbal Update)**

**17. Schedule of Future Meetings and Draft Agenda Programme** **237 - 238**

To note and agree the draft meeting dates scheduled for 2017/2018 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.

Recording of Council Meetings: Any member of the public may film, audio-record, take photographs and use social media to report the proceedings of any meeting that is open to the public. A protocol on this facility is available at:

http://democracy.peterborough.gov.uk/ecSDDisplay.aspx?NAME=Protocol%20on%20the%20use%20of%20Recording&ID=690&RPID=2625610&sch=doc&cat=13385&path=13385

Board Members:

Cllr J Holdich (Chairman), Dr Mistry (Vice Chairman), Cllr D Lamb, Cllr W Fitzgerald, Cllr R Ferris, C Mitchell, Dr Laliwala, Dr Howsam, D Whiles, W Ogle-Welbourn, Dr Robin, A Chapman and A Pike

Co-opted Members: Russell Wate and Claire Higgins

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 5 DECEMBER 2016**

| | |
|---|---|
| **Members Present:** | Councillor Holdich, Leader and Cabinet Member for Education, Skills, University, and Communication (Chairman)<br>Dr Harshad Mistry (Vice Chairman)<br>Councillor Lamb, Cabinet Member for Public Health<br>Councillor Ferris<br>Adrian Chapman, Service Director Adult Services and Communities<br>Dr Liz Robin, Director for Public Health<br>Cathy Mitchell, Acting Director of Primary Care and Integration<br>Russell Wate, Local Safeguarding Children's Board and Peterborough Safeguarding Adults Board Co-opted Member<br>Wendi Ogle-Welbourn, Corporate Director People and Communities<br>David Whiles, Peterborough Healthwatch<br>Claire Higgins, Deputy Chief Executive of Cross Keys Homes,<br>Dr Moshin Laliwala |
| **Also Present:** | Helen Gregg, Partnership Board Co-ordinator<br>Ryan Hyman, Senior Account Manager Athene Communications Ltd<br>Marie Alexander, General Manager, Adult & Specialist Mental Health Directorate<br>David Astley, Chair, Cambridgeshire and Peterborough STP<br>Alison Stewart, Assistant Director Legal Services<br>Paulina Ford, Senior Democratic Services Officer |

## 1. Apologies for Absence

Apologies were received from Councillor Fitzgerald, Deputy Leader and Cabinet Member for Integrated Adult Social Care and Health, Dr Gary Howsam and Andrew Pike.

The Board were informed that Dr Kenneth Rigg had resigned from South Lincolnshire CCG and was therefore no longer a member of the Board. South Lincolnshire CCG were looking to appoint a replacement.

## 2. Declarations of Interest

No declarations of interest were received.

## 3. Minutes of the meeting held on 22 September 2016

The minutes of the meeting held on 22 September 2016 were approved as a true and accurate record.

## 4. Hydrotherapy

The report was introduced by the Acting Director of Primary Care Integration**.** The report was presented in response to a request from the Health and Wellbeing Board for the CCG to develop a Hydrotherapy Clinical Policy. It had been noted that there was an inequity in the service in that in Cambridgeshire there was a Hydrotherapy service at Addenbrookes Hospital and in Peterborough there was no service at Peterborough Hospital. The CCG had been asked to review all available

evidence in order to develop a clinical policy. The Clinical Policies Forum (CPF) would be asked to review the evidence for a Hydrotherapy Policy on 10 January 2017.

The Board considered the report, and key points highlighted and raised during discussion included:

- Members expressed disappointment at the time taken for the policy to be put in place.
- A Social Return on Investment (SROI) calculation had been carried out on St George's Hydrotherapy pool proving that it was financially robust with a ratio of 16:1. This to be shared with the CCG.

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

**5. Health & Wellbeing and SPP Partnership Delivery Programme Board Update**

The report was introduced by the Partnership Board Co-ordinator and provided the Board with a summary of the progress made against the key priorities outlined in the Health & Wellbeing Strategy 2016-2019.

The Board considered the report, and key points highlighted and raised during discussion included:

- There were 12 key focus areas within the strategy which were listed on page 10 of the report. The Health & Wellbeing and SPP Partnership Delivery Programme Board received regular updates on the progress of each key focus areas. It was therefore proposed that the Health and Wellbeing Board should also be updated at each meeting on the progress of the key focus areas.
- The timescale for the Strategy was 2016-2019 although each area of focus had a specific timescale for each objective within the area of focus.
- Each area of focus had been passed to the relevant Board who would develop a specific action plan and matrix for that element.
- The Board were advised that it was unique in the way the Safer Peterborough Partnership and Health and Wellbeing Delivery Programme Boards had been brought together to work on the priorities as set out in the Health and Wellbeing Strategy. It had highlighted that there were many cross cutting issues.
- Members of the Board commented that they would like to see a clear set of outcomes for each section with a risk register against outcomes. The Board were advised that some of the outcomes were only collected on an annual basis therefore it would seem appropriate that progress was reported to the Board annually.
- Clarification was sought as to whether the Mental Health Strategy has been cross referenced with the objectives in the key focus areas. The Board were informed that it had been and a key piece of work had been completed around this.
- Members of the Board referred to the Geographical and Health Inequalities area of focus and the Selective Licencing Scheme and asked how this would impact on changes to the living environment within the areas that the scheme was operating. Board members were informed that one of the conditions of obtaining a licence referred to the environment around the property. Over 5000 applications had already been received which demonstrated a willingness on the part of the landlords to comply. How this could be measured and what effect it actually had on people was discussed.
- Members of the Board proposed that a piece of work be done around poor housing conditions and associated health issues. The Deputy Chief Executive of Cross Keys Homes advised that property related health issues had decreased considerably over the years. It was noted that without exception poor health relating to poor housing conditions related to Private Sector housing as opposed to social housing. There was a range of ways that evidence was already gathered to measure health related issues and poor housing conditions and this included national research. The Service Director for

Adults and Communities advised that a more extensive piece of work could be done around this and a report could be brought back to the Board at a future meeting.

- The strategy had not been taken into the schools but a lot of work had been done with regard to the Healthy Schools Programme. It was agreed that it was important to have representatives from schools involved and to deliver the strategy both to children and Governors using language appropriate to all age groups.
- It was noted that obesity and excess weight in children had increased but that progress on smoking cessation was generally good. Were there any lessons that could be learnt in the way the smoking cessation programme had been delivered that could be applied to the weight and healthy eating issue. The Board was advised that there had been a lot of academic evidence and research around smoking and surveys have shown that the general public wanted smoking restrictions in place. However the same could not be said of child obesity and mechanisms of behavioural change in children would not be the same as for smoking and adults.
- The more control there was over children's diets the better the results. Better results could be achieved if there was more control over school lunch time meals.

The Health and Wellbeing Board **RESOLVED** to note the report and **AGREED** that:

1. A progress report on the key outcomes of the Health & Wellbeing Strategy would be reported annually to the Health and Wellbeing Board and that progress on the focus areas would be reported to the Health and Wellbeing Board at each meeting.

2. The Board also agreed that the Service Director for Adults and Communities provide a report at a future meeting which looked further into the association between health related issues and poor housing conditions.

**6. Healthwatch Update**

The Chairman of Peterborough Healthwatch presented the report. The report provided the Board with an update on the progress being made by Healthwatch Peterborough in regards to its statutory duties in supporting the patient voice including Peterborough residents and/or those using health and social care services in Peterborough and/or those working in Peterborough and/or those volunteering in Peterborough.

Due to the uncertainty of the operational function of Healthwatch Peterborough due to the expiry of the current contract from 31 March 2017 it had not been possible to create a substantive long term priorities plan. Short term priorities had been agreed and long term priorities were in draft form only. Discussions were ongoing with Healthwatch Cambridgeshire with a view to amalgamating Healthwatch Peterborough but it had been recognised that a local perspective would need to be maintained.

David Whiles advised the Board that he would be retiring from his position as Chairman of Healthwatch Peterborough when the contract came to an end. The Chairman thanked David Whiles for the tremendous amount of work that he had put into Healthwatch Peterborough and the contribution he had made to the Health and Wellbeing Board.

The Board considered the report, and key points highlighted and raised during discussion included:

- The Prisoner Engagement Project was discussed and in particular smoking in prisons and the strategy to reduce smoking among prisoners which fell under the remit of NHS England.
- Latent TB Screening was listed as a long term priority for Healthwatch and the Acting Director of Primary Care and Integration advised that the CCG would welcome working with Healthwatch on this.

- It was acknowledged that Healthwatch in Peterborough had done some very good work under the Chairmanship of David Whiles.

The Health and Wellbeing Board **RESOLVED** to note the activity and priorities of Healthwatch Peterborough.

**7. Work in Peterborough - Recruitment and Retention Campaign**

The Senior Account Manager of Athene Communications Ltd presented the report and provided a presentation which is attached at Appendix 1 of the minutes. The report provided the Board with an update on the progress made with regards to the work on the Peterborough recruitment and retention campaign to date. The report also sought the Boards views on the proposed content plan for the Health recruitment website and sections and the best way to proceed with the 12 month marketing campaign. The Corporate Director, People and Communities explained that the project had started one year ago with the aim to get people to come and work in Peterborough and thanked Ryan Hyman for the tremendous amount of work that he had done to get the project to this point.

The Board considered the report, and key points highlighted and raised during discussion included:

- Application forms for teaching posts could be downloaded from the website however further work was required to tie in with existing NHS websites. The length of time taken to complete the on-line application form was quite lengthy but the advantage of doing it on line was that it only had to be completed once and could be reused to apply for other jobs.
- The focus of the website was limited to Peterborough.
- Successful applications were not currently being monitored as applications were paper based at the moment however when all applications were online this information could be captured.
- The need to promote good schools, local services, secondary and primary health care and living expenses on the website and feed this information into other national websites was recognised.
- The teacher recruitment video developed by the Council would also be included on the website.
- Only advertising Peterborough may be an issue as the CPFT and Hinchingbrooke may need to recruit across a wider area.

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

1. To proceed with making the Work in Peterborough website live as soon as possible
2. To agree and proceed with creating the Health recruitment micro-website
3. To agree and proceed with a 12 month PR and marketing campaign to drive visitors to the Work in Peterborough campaign website and its associated sector websites – Teaching, Social Work, and Health.

The Health and Wellbeing Board also requested that the Senior Account Manager:

1) Provide members of the Board with a link to the development site.
2) Continue to investigate the financial element and consider who would contribute to the project

**8. LGA Peer Review Of Adult Social Care**

The report was introduced by the Service Director for Adults and Communities who informed the Board that Peterborough City Council had requested a Peer Review via the Local Government Association. The was requested as a means of reviewing and assessing the current safeguarding arrangements, to learn from an independent assessment of our current position, to build on those areas the council were doing well and improve on those areas which were not so strong. The Service Director Adult Services and Communities confirmed that no evidence had been found of people at risk in Peterborough although there were some areas of recommendation which were included in the report and a delivery plan had been put in place with identified lead officers.

The Board considered the report, and key points highlighted and raised during discussion included:

- There was no intention to invite the Peer Reviewers to return for monitoring purposes as this was not normal practice, however an action plan had been put in place and this would be reviewed by the new Adults and Communities Scrutiny Committee and some areas may be reviewed by the Health Scrutiny Committee.
- The Adults Safeguarding Board as an independent Board would also monitor the progress of the action plan and outcome of the recommendations made by the Peer Review.
- The review was not only about adult social care but included the delivery of Safeguarding Adults across the system.
- The review did not highlight any surprises and none of the recommendations made had been challenged.
- It was highlighted that further work was needed to improve awareness of Mental Capacity with key partners and this would be reviewed by the CCG under Carol Davies.

The Health and Wellbeing Board **RESOLVED** to consider and comment on the Adult Social Care Safeguarding Peer Review outcomes and recommendations.

## 9. Annual Report of Peterborough Safeguarding Boards

The Chairman of Peterborough Safeguarding Children Board and Peterborough Safeguarding Adults Board introduced the reports. The purpose of the two annual reports was to ensure that the Board were made aware of the work and progress of the Peterborough Safeguarding Children Board and Peterborough Safeguarding Adult Board for the period from April 2015 – March 2016. The annual reports were published in September 2016.

The Board considered the report and congratulated the Chairman on the significant work that had been achieved. The Chairman for the Adults and Childrens Safeguarding Boards thanked the Board and advised that there was still further work to the done to move towards focusing on adult safeguarding in primary care as well as for children.

The Health and Wellbeing Board **RESOLVED** to note the contents of the Annual Reports.

## 10. PRISM (Enhanced Primary Care Mental Health Service)

The purpose of this report was to obtain the Board's views on a proposed model of mental health service delivery in primary care and was presented by the General Manager, Adult & Specialist Mental Health Directorate. The report centred around the collaboration between mental health services and GPs over a five year plan.

The Board considered the report, and key points highlighted and raised during discussion included:

- Feedback had highlighted that Primary Care would value additional links and support with mental health services.

- It was noted that cases of mental health were lower than expected across the city and there were concerns that patients were not coming forward to their GPs.
- Board members sought clarification with regard to services for young people aged 18 plus and how the transition to adult mental health care would be handled. The Board were advised that this would be a significant part of the discussions as this continued to be a problem with patients experiencing a time lag in transfer of care however some work on transitions was currently being undertaken with Mencap.

The Health and Wellbeing Board **RESOLVED** to comment on and note the Cambridge and Peterborough NHS Foundation Trust proposal outlined for developing a model of mental health service delivery in Primary Care, known as 'PRISM'.

**11. Cambridgeshire and Peterborough Sustainability and Transformation Programme Memorandum of Understanding for NHS Organisations in Cambridgeshire and Peterborough**

The report was introduced by Director for Public Health who provided the Board with a brief overview of the report. The purpose of the report was to present to the Board the Cambridgeshire and Peterborough Sustainability and Transformation Programme Memorandum of Understanding and to seek the Boards approval of Annex A, Appendix 1: Local Authorities and the Cambridgeshire and Peterborough Sustainability and Transformation Plan'.

The Health and Wellbeing Board **RESOLVED:**

1. To note the Cambridgeshire and Peterborough Sustainability and Transformation Programme Memorandum of Understanding for NHS organisations in Cambridgeshire and Peterborough;

2. To approve Appendix A, Appendix 1 of the Memorandum of Understanding: 'Local Authorities and the Cambridgeshire and Peterborough Sustainability and Transformation Plan'

2.58pm. Dr Mistry left the meeting at this point.

**12. Sustainability and Transformation Plan Update**

The report was introduced by the Chairman, Cambridgeshire and Peterborough Sustainably Transformation Plan whose role was to ensure that the plan was delivered. The report provided the Board with information on Cambridgeshire and Peterborough's latest five-year Sustainability and Transformation Plan (STP) to improve local health and wellbeing which was published on 21 November 2016.

A short discussion took place regarding the terminology used in the STP and concern was expressed that the STP sited many of the functions that the Council carried out such as housing and public health and by referring to the STP in terms of health and social care it did not convey the full objectives of the partnership.

It was acknowledged that the Sustainability Transformation Programme was a massive challenge for all authorities. The Chairman, Cambridgeshire and Peterborough Sustainably Transformation Plan advised that there was a big financial challenge ahead and he would work hard to ensure that any future changes would be explained clearly and would be honest with the public as to why the changes were being delivered.

The Health and Wellbeing Board **RESOLVED** to comment on and note the latest Sustainability and Transformation Plan, published by Cambridgeshire and Peterborough CCG on 21 November 2016.

**INFORMATION AND OTHER ITEMS**

## 13. Adult Social Care, Better Care Fund (BCF) Update

The Health and Wellbeing Board **RESOLVED** to note the update of the BCF delivery and planning for the BCF 2017/18 submission.

## 14. Devolution (Verbal Update)

The Assistant Director of Legal Services gave a brief update on the key elements of devolution and the implications of the new Combined Authority including:

- There would be a new £100m fund for affordable new homes to be built in the Cambridge and Peterborough.
- Budgets and new powers devolved for skills.
- Investment in a Peterborough University.
- Plans to increase the health and wellbeing of the communities.
- There would be opportunities for future devolution deals which would extend the transfer of power and resources including the redesign of public services which would be incorporated in the Devolution 2 deal currently being worked on. This would focus on deprived areas, health and social care, new homes, infrastructure and community safety. There would be an opportunity for everyone to feed into this.
- Progress on new affordable homes. There would be 2000 affordable homes over the next 5 years and increasing this to approximately 4500 affordable homes in the following 5 years.
- Governance and Overview and Scrutiny would oversee the Devolution 2 deal and the Committee would be a cross party balance across Cambridgeshire and Peterborough.
- There would be provision for Call-in of any decisions made by the Elected Mayor or the Combined Authority.
- Regarding Peterborough City Council there will be a protocol for the Leader of the Council and the Council's Representative on the Overview and Scrutiny Committee to present a full report to Full Council on the activities of the Combined Authority and the Overview and Scrutiny Committee to ensure transparency.

Members also commented that careful consideration would need to be given to the provision of Primary Health Care services and support services with the increase in new homes being built and the siting of any new GP surgeries.

## 15. Schedule of Future Meetings and Draft Agenda Programme

A short discussion was held on the proposal to move the Board meetings from a Thursday at 1.00pm to a Monday at 1.00pm and it was agreed that future meetings would be held on Mondays commencing in the new municipal year.

The next meeting will held on Thursday 23 March 2017.

CHAIRMAN
1.00 - 3.10 pm

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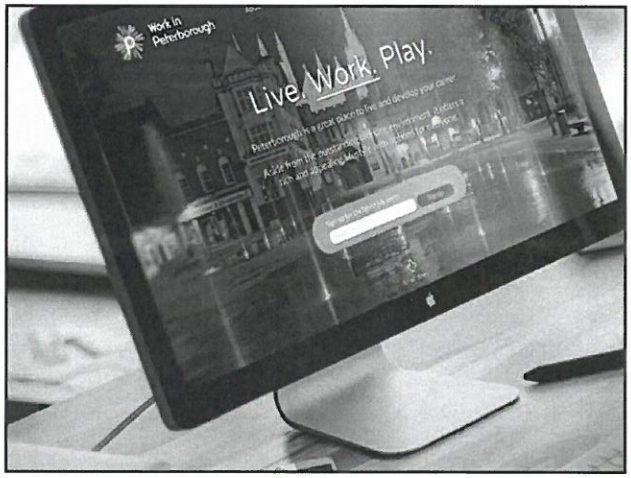
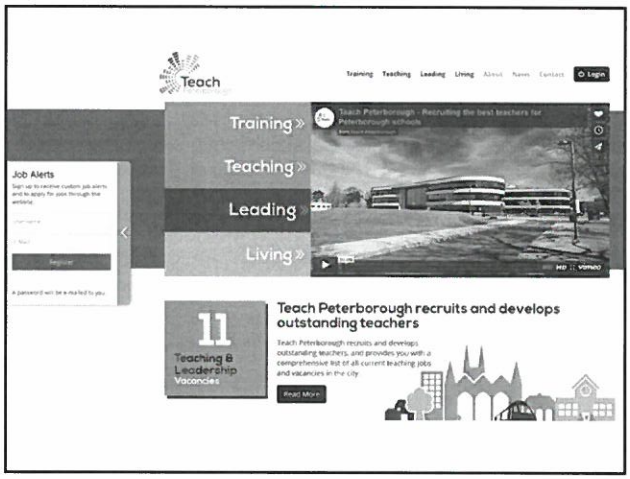
Appendix 1

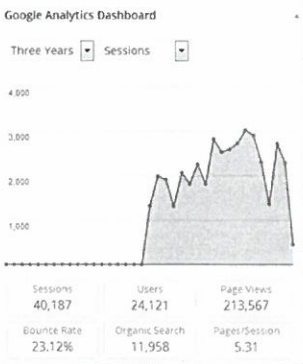



## Teach Peterborough

Teach Peterborough

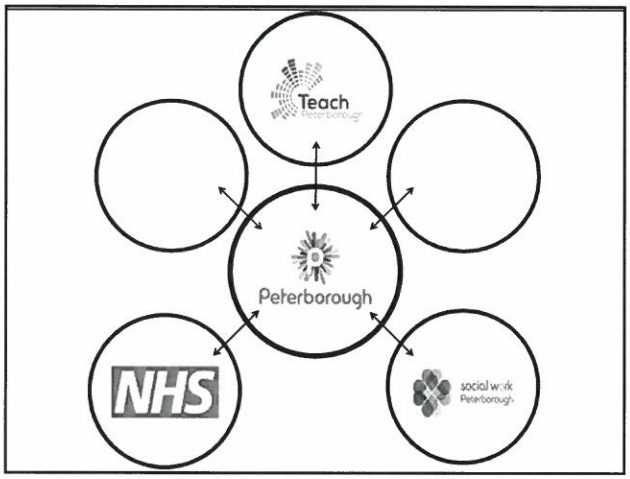
- Unique Users – 24,121
- Unique Sessions – 40,187
- Pages Per Session – 5.31
- Bounce Rate – 23.12%




## Teach Peterborough

Teach Peterborough

- Total Jobs Listed – 491
- Total Applications – 1,706 (3.47 per vacancy)
- Average spend per vacancy = £3,000.00
- Peterborough = £1,473,000.00
- Teach Peterborough = 70:1 ROI *(which will continue to rise)*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Peterborough
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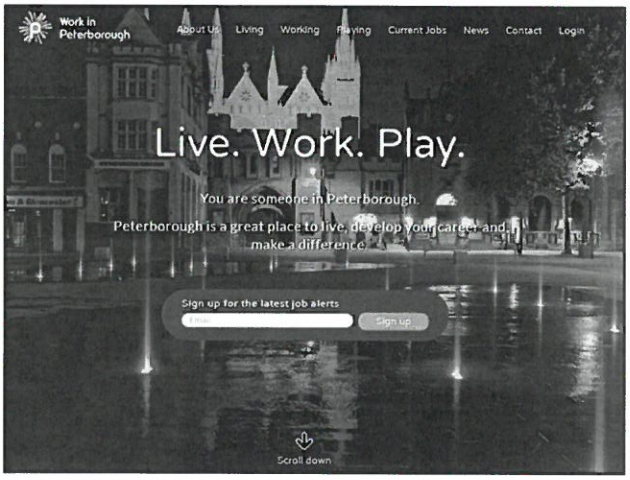
NHS
social work
Peterborough


Work in
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About Us
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Live. Work. Play.
You are someone in Peterborough.
Peterborough is a great place to live, develop your career and
make a difference.
Sign up for the latest job alerts
Sign up
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About Us
Living
Working
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Current Jobs
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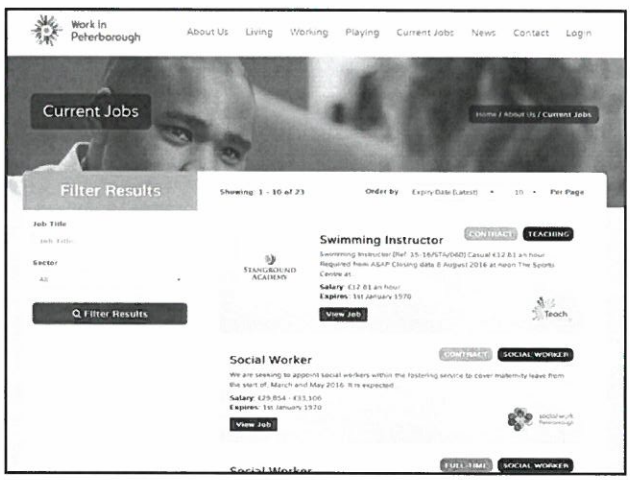
Work in
Peterborough
About Us
Living
Working
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Current Jobs
News
Contact
Login
Current Jobs
Filter Results
Filter Results
Swimming Instructor
CONTRACT
TEACHING
Salary: £12.81 an hour
Expires: 1st January 1970
View Job
Social Worker
CONTRACT
SOCIAL WORKER
Salary: £29,854 - £33,306
Expires: 1st January 1970
View Job
FULL-TIME
SOCIAL WORKER

## Health recruitment

- Create and build the health recruitment website
- GPN has provided initial content but need to gain information from other providers
- Go live and link in with Work in Peterborough

## Promotional campaign

- An ongoing marketing and PR campaign to increase visitors to the Work in Peterborough campaign website
  - Press
  - Social media
  - Stakeholder relations
  - Internal communications
  - Website updates and training
- Ongoing technical support, data analysis and website upgrades

| Item | Annual Fee |
|---|---|
| Dedicated PR and marketing campaign to support Work in Peterborough *of up to three days per months* | £17,460.00 |
| Dedicated technical website support and upgrades *of up to three days per month* | £18,000.00 |
| **Total annual fee** | **£35,460.00** |

| Item | Annual Fee |
|---|---|
| Work in Peterborough PR and marketing campaign | £ 5,820.00 |
| Technical support and ongoing upgrades and development | £ 6,000.00 |

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| HEALTH AND WELLBEING BOARD | | AGENDA ITEM No. 4 |
|---|---|---|
| **23 MARCH 2017** | | PUBLIC REPORT |
| Contact Officer(s): | Dr Penny Hazell, Clinical Psychologist & Clinical Lead, CAMHS Eating Disorder Pathway | Tel. 01480 445281 |

**UPDATE ON THE DEVELOPMENT OF THE CAMBRIDGESHIRE AND PETERBOROUGH CHILDREN AND YOUNG PERSON'S COMMUNITY EATING DISORDERS SERVICE**

| RECOMMENDATIONS | |
|---|---|
| **FROM :** Dr Penny Hazell, Clinical Psychologist & Clinical Lead, CAMHS Eating Disorder Pathway | **Deadline date :** *N/A* |
| The Health and Wellbeing Board are asked to note the contents of the report. | |

**1. ORIGIN OF REPORT**

1.1 This report is submitted to the Board from Cambridge and Peterborough NHS Foundation Trust.

**2. PURPOSE AND REASON FOR REPORT**

2.1 The report was requested in order for the Board to receive an update regarding the development of the Children and Young Person's Community Eating Disorders Service (CYP-CEDS).

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

**3. BACKGROUIND**

Eating disorders are serious mental health problems that can have severe psychological, physical and social consequences. They are characterised by severe disturbance in eating behaviour, and in perception of body weight or shape. They are often complex, chronic problems that may occur with other mental health difficulties alongside, and children and young people may present with significant medical and/or psychiatric risk. Eating disorders typically occur in adolescent girls and young women, though they can also occur in younger children and in males.

It is vital that children and young people with eating disorders, and their families and carers, can access effective help quickly. This can improve recovery rates, lead to fewer relapses and reduce the need for inpatient admissions. However, service provision for children and young people with eating disorders is variable across England, with inconsistent access to appropriate treatment. The availability of dedicated community eating disorder services has been shown to improve outcomes and cost effectiveness. Such services help avoid disruptions caused by transitions in care, and are generally preferred by children, young people and their families. It is considered good practice to offer a 'stepped care' model, with more intensive support for those who are more severely unwell.

An inquiry was carried out by the Health Select Committee in 2014, due to significant concerns about provision of children's and adolescent's mental health services (CAMHS) from prevention and early intervention to inpatient services. This led to a national drive to see improved outcomes for young people with eating disorders. Funding was announce in the Autumn Statement 2014 to improve the consistency and quality of eating disorders services, provide enhanced community care, ensure staff are adequately trained and supervised in evidence-based treatment and ensure the best us of inpatient services.

In Cambridgeshire, specialist inpatient support for children and young people with the most severe eating disorders is provided by the Phoenix Centre. Until recently, community interventions for children and young people with eating disorders in Cambridgeshire and Peterborough have been provided by specialist workers in core community child and adolescent mental health teams for children and young people up to their 17th birthday. From 17 years onwards, young people were supported by the Adult Eating Disorders Service. Last year, Cambridge and Peterborough NHS Foundation Trust secured funding to develop a dedicated children and young people's eating disorder service, to provide specialist assessment and community treatment for children and young people with eating difficulties up to the age of 18 years.

In line with recent guidance, this service aims to provide a single county wide service offering timely access to appropriate evidence-based treatments, delivered in local clinics. The service will provide family based treatment approaches that directly address the eating disorder and specifically adapted cognitive behaviour therapy for eating disorders. The service aims to treat children and young people in the community where this is possible and to work closely with our local specialist inpatient unit (the Phoenix Centre) when high levels of risk necessitate inpatient admission. In reach to the acute hospitals is provided as part of the current CAMHS duty system.

**Progress**

- The children and young person's community eating disorders service went live on 1st January 2017.
- The service is now taking referrals for children and young people up to 18 years of age.
- Close liaison with clinicians in the single point of access (SPA) ensures all referrals are processed and seen for assessment as soon as possible.
- New team members in post from 1st December 2016. However, there is some continued input from core clinicians, with recruitment continuing to appoint to permanent specialist posts.
- Weekly assessment clinics are being offered in local clinics (Cambridge, Huntingdon and Peterborough) rather than centralised clinics. Regular follow up appointments are also provided locally.
- Liaison with core team clinicians regarding complex cases, offering shared care or joint review and consultation for children and young people in core child and adolescent mental health teams.
- Close links with local specialist inpatient unit and adult eating disorders service, including supervision, consultation and shared training opportunities.
- Training provided regarding eating disorders to Anglia Ruskin University (health visitors and school nursing training) and local schools.

**Next Steps**

- Whole team to attend training in family based approaches, being provided as part of national children and young person's improving access to psychological therapies (CYP-IAPT) training.
- Service clinical lead to provide training and supervision for staff in cognitive behaviour therapy for eating disorders.

- Continuing to build links with other local partners and provide training.
- Increased early intervention and preventative work to be established as part of CAMHS transformation plans.
- Audit the use of specialist resources across the county, to consider how best to utilise these in order to provide high quality services to all children and young people with eating disorders in Cambridgeshire and Peterborough.

## 4. CONSULTATION

None

## 5. ANTICIPATED OUTCOMES

The board is requested to note the content of the report.

## 6. REASONS FOR RECOMMENDATIONS

The Board is asked to consider the report content and ask any questions regarding the service developments.

## 7. ALTERNATIVE OPTIONS CONSIDERED

N/A

## 8. IMPLICATIONS

*N/A*

## 9. BACKGROUND DOCUMENTS

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

- *Key documents guiding the development of the CYP-CEDS:*


- National Collaborating Centre for Mental Health (2015) Access and Waiting Time Standard for Children and Young People with an Eating Disorder: Commissioning Guide, Version 1.0.

- National Institute for Clinical Excellence (2004). Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. NICE guidelines (CG9).

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| HEALTH AND WELLBEING BOARD | | AGENDA ITEM No. 5 |
|---|---|---|
| **23 MARCH 2017** | | PUBLIC REPORT |
| Contact Officer(s): | Daniel Emery | Tel. 0771 4411 060 |

**MOTOR NEURON DISEASE CHARTER**

| RECOMMENDATIONS | |
|---|---|
| **FROM :** Motor Neuron Disease Association | **Deadline date :N/A** |

1. The Health and Wellbeing Board to note the Motor Neuron Disease (MNDA) Charter (attached at Appendix 1) which was adopted by Peterborough City Council at its meeting on 8 March 2017.
2. The Health and Wellbeing Board to discuss ways in which support services are able to work better together to improve the lives of those living with MND: to breathe life into the Charter so it makes a real difference in improving the health and wellbeing of people with MND and to find a way to co-ordiante the numerous health and social care functions to provide an appropriate level of respect, care and support for those living with the disease.

## 1. ORIGIN OF REPORT

1.1 This report is submitted to the Board from Daniel Emery, representing the Motor Neuron Disease Association, as their volunteer Campaign Coordinator for Cambridgeshire.

## 2. PURPOSE AND REASON FOR REPORT

2.1 MND is a complex disease and challenging to manage for health and social care professionals. Given Peterborough City Council adopt the MND Charter, to avoid it becoming little more than a gesture to current and future people living with MND, the intention of this report is to ignite discussion on how best to move forward in implementing the Charter so that it makes a real difference to real people's lives.

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

## 3. Background

### 3.1 About MND

- MND is a fatal, rapidly progressing disease that affects the brain and spinal cord.
- It attacks the nerves that control movement so muscles no longer work.
- It leaves people locked in a failing body, unable to move, talk and eventually breathe.
- It kills a third of people within a year and more than half within two years of diagnosis.
- It affects up to 5,000 adults in the UK at any one time. The Association is aware of **people** living with MND in Peterborough and the surrounding areas.
- It has no cure

### 3.2 About the Charter

The MND Charter is a statement of the respect, care and support that people living with MND and their carers deserve and should expect. The five points of the Charter are:

- The right to an early diagnosis and information
- The right to access quality care and treatments
- The right to be treated as individuals and with dignity and respect
- The right to maximise their quality of life
- Carers of people with MND have the right to be valued, respected, listened to and well-supported

### 3.3 Improvement Opportunities

Based on my personal observations as we care for our farther who lives with MND, and feedback from other people living with MND in Peterborough and the surrounding area, some of the improvement opportunities include the following: -

- Coordinating care for MND and other rare diseases so services are no longer disjointed and provided in a timely manner
- A better understanding of MND – specifically the speed of progression and how the individual's social and care needs change significantly
- Improved communication between services providers e.g. Adult Social Care and NHS
- Ensuring outsourced care providers are appropriate
- Ensuring hospital admission and discharge is timely
- Arranging appropriate care and equipment as the disease progresses
- Joint working with children's services where people with MND has children – specifically support or help with planning
- Limited support for people caring for people with the disease
- Ensuring housing adaptions and rehousing is timely and planned as opposed to reacting to emergency situations
- Raising the knowledge of MND amongst OTs
- Providing funded day care or palliative day care

## 4. CONSULTATION

4.1 Minimal consultation has taken place to date as the MND Charter has only just recently been adopted by Peterborough City Council. Thus far discussion has been limited to Alan Dowson (Councillor sponsoring the MND Charter) and Stewart Jackson MP.

4.2 My intention would be to seek guidance from the Board on the scope of future dicussions/ consultations that should take place, following the recent adoption of the MND Charter by Peterborough City Council.

## 5. ANTICIPATED OUTCOMES

The consideration for the Board is to think-though ways in which support services are able to work better together to improve the lives of those living with MND: to breathe life into the MND Charter so it makes a real difference.

## 6. REASONS FOR RECOMMENDATIONS

It is not clear at this stage what recommendations should be made. Evidence underlining the need for service improvement is provided in section 3.3 above.

## 7. ALTERNATIVE OPTIONS CONSIDERED

The obvious alternative is to do nothing i.e. keep things as they are with no change. The natural consequence is people living with MND (and their families) have reduced quality of life.

## 8. IMPLICATIONS

See section 6.

## 9. BACKGROUND DOCUMENTS

None.

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**10.** Appendix 1 – MND Charter

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mnda
motor neurone disease
association

**CHAMPION THE CHARTER** ON YOUR DOORSTEP

# themndcharter

Achieving quality of life, dignity and respect for people with MND and their carers

## The MND Charter is a statement of the respect, care and support that people living with motor neurone disease (MND) and their carers deserve, and should expect.

We believe that everyone with a connection to MND, either personally or professionally, should recognise and respect the rights of people with MND as set out in the Charter, and work towards the Charter's vision of the right care, in the right place at the right time.

About MND:

- MND is a fatal, rapidly progressing disease that affects the brain and spinal cord.
- It can leave people locked in a failing body, unable to move, talk and eventually breathe.
- A person's lifetime risk of developing MND is up to one in 300.
- It kills around 30% of people within 12 months of diagnosis, more than 50% within two years.
- It affects people from all communities.
- It has no cure.

Therefore, what matters most is that people with MND receive a rapid response to their needs and good quality care and support, ensuring the highest quality of life as possible and the ability to die with dignity. The MND Charter serves as a tool to help make this happen.

MND is a devastating, complex disease and particularly difficult to manage. We believe that if we get care right for MND we can get it right for other neurological conditions, and save public services money in the long run. But more importantly, we can make a positive difference to the lives of people with MND, their carers and their loved ones.

## 1 People with MND have the right to an early diagnosis and information

**THIS MEANS:**

- An early referral to a neurologist.
- An accurate and early diagnosis, given sensitively.
- Timely and appropriate access to information at all stages of their condition.

There is no diagnostic test for MND – it can only be diagnosed by ruling out other neurological conditions. People with MND can be halfway through their illness before they receive a firm diagnosis.

GPs need to be able to identify the symptoms and signs of a neurological problem and refer directly to a neurologist in order to speed up diagnosis times for MND.

Appropriate tests must be carried out as soon as possible to confirm MND. The diagnosis should be given by a consultant neurologist with knowledge and experience of treating people with MND[1]. The diagnosis should be given sensitively, in private, with the person with MND accompanied by a family member/friend and with time to ask questions. A follow-up appointment with the neurologist should be arranged soon after diagnosis.

At diagnosis people with MND should be offered access to appropriate information and should be informed about the MND Association. Appropriate information should be available at all stages of the person's condition in a language of their choice.

## 2 People with MND have the right to high quality care and treatments

**THIS MEANS:**

- Access to co-ordinated multidisciplinary care managed by a specialist key worker with experience of MND.
- Early access to specialist palliative care in a setting of their choice, including equitable access to hospices.
- Access to appropriate respiratory and nutritional management and support, as close to home as possible.
- Access to the drug riluzole.
- Timely access to NHS continuing healthcare when needed.
- Early referral to social care services.
- Referral for cognitive assessment, where appropriate.

People with MND may need care provided by health and social care professionals from up to 20 disciplines. This clearly needs co-ordination to work effectively. Co-ordinated care can improve the quality of life of people with MND and provide value for money for the NHS by preventing crises and emergency hospital admissions. The care should be co-ordinated by a specialist key worker with experience of MND who can anticipate needs and ensure they are met on time. Ongoing education for health and social care professionals is important to reflect advances in healthcare techniques and changes in best practice.

A third of people with MND die within 12 months of diagnosis. Early access to specialist palliative care[2] soon after diagnosis is therefore vital and should be available in a setting of the person's choice. Some hospices give preferential access to people with a cancer diagnosis. It is important that access is based on need, not diagnosis, so that people with MND have equitable access to hospice care. Hospices can

provide high-quality respite care, which can benefit both the person with MND and their carer.

As MND progresses, the respiratory muscles and muscles of the mouth and throat may be affected. People with MND may therefore need respiratory and nutritional support. It is important that these services are available as close to the person's home as possible so that travelling is minimised and support is available quickly.

In 2001 the National Institute for Health and Care Excellence (NICE) recommended riluzole as a cost-effective drug for people with MND. GPs can be reluctant to prescribe riluzole on cost grounds, despite its NICE-approved status, or to monitor for side effects during its use. However, it is vital that people with MND have ongoing access to this important treatment.

As the disease progresses, people with MND may need more intensive health care. It is important that people with MND have timely access to NHS continuing healthcare when they need it.

People with MND are likely to need help with getting up, washing, dressing and preparing food as the disease progresses. Access to social care services is therefore important to maintain quality of life. People with MND may also need access to cognitive assessment, as up to half of people with the disease experience changes in cognition.

## 3 People with MND have the right to be treated as individuals and with dignity and respect

**THIS MEANS:**

- Being offered a personal care plan to specify what care and support they need.
- Being offered the opportunity to develop an Advance Care Plan to ensure their wishes are met, and appropriate end-of-life care is provided in their chosen setting.
- Getting support to help them make the right choices to meet their needs when using personalised care options.
- Prompt access to appropriate communication support and aids.
- Opportunities to be involved in research if they so wish.

Everyone with MND should be offered a personal care plan[3] to specify what care and support they need. The plan should be regularly reviewed as the disease progresses and the person's needs change.

People with MND should be offered the opportunity to develop an Advance Care Plan[4] to make clear their wishes for future care and support, including any care they do not wish to receive. The plan should be developed with support from a professional with specialist experience and may include preferences for end-of-life care.

Some people with MND will need support to help them make the right choices to meet their needs when using personalised care options, such as personal budgets.

As the disease progresses, some people with MND will experience difficulty speaking. It is important that people with MND can access speech and language therapy to help them maintain their voice for as long as possible. However, as the disease progresses, people with MND may need access to communication aids including augmentative and alternative communication (AAC)[5]. The ability to communicate is a basic human right. For people with MND, communication support and equipment are vital in order to remain socially active and to communicate their wishes about their care, especially during hospital stays and other medical environments.

Many people with MND value the opportunity to be involved in research as it provides hope that one day an effective treatment will be developed. Everyone with MND who wishes to should be able to participate in research as far as is practicable.

## 4 People with MND have the right to maximise their quality of life

**THIS MEANS:**

- Timely and appropriate access to equipment, home adaptations, environmental controls, wheelchairs, orthotics and suitable housing.
- Timely and appropriate access to disability benefits.

People with MND may find their needs change quickly and in order to maximise their quality of life, they may need rapid access to equipment, home adaptations, wheelchairs and suitable housing. These needs should be anticipated so that they are met in a timely way. This is particularly true of wheelchairs which are important for maximising independence and quality of life.

People with MND need timely and appropriate access to disability benefits to help meet the extra costs of living with a disability. Information on appropriate benefits needs to be readily accessible in one place and easily understandable.

## 5 Carers of people with MND have the right to be valued, respected, listened to and well supported

**THIS MEANS:**

- Timely and appropriate access to respite care, information, counselling and bereavement services.
- Advising carers that they have a legal right to a Carer's Assessment of their needs[1], ensuring their health and emotional well being is recognised and appropriate support is provided.
- Timely and appropriate access to benefits and entitlements for carers.

Caring for someone with MND is physically and emotionally demanding. Carers need to be supported in order to maintain their caring role. Every carer should have their needs assessed and given timely and appropriate access to respite care, information, counselling and bereavement services. It is important to support the emotional and physical needs of the carer in a timely way so that they can continue their caring role.

Carers should also have timely and appropriate access to benefits and entitlements to help manage the financial impact of their caring role.

[1] Recomendation in the NICE guideline on MND.

[2] Specialist palliative care – palliative care is the active holistic care of patients with progressive illness, including the provision of psychological, social and spiritual support. The aim is to provide the highest quality of life possible for patients and their families. Specialist palliative care is care provided by a specialist multidisciplinary palliative care team.

[3] Personal care plan – a plan which sets out the care and treatment necessary to meet a person's needs, preferences and goals of care.

[4] Advance care plan – a plan which anticipates how a person's condition may affect them in the future and, if they wish, set on record choices about their care and treatment and/or an advance decision to refuse a treatment in specific circumstances so that these can be referred to by those responsible for their care or treatment (whether professional staff or family carers) in the event that they lose capacity to decide or communicate their decision when their condition progresses.

[5] Augmentative and Alternative Communication (AAC) – is used to describe the different methods that can be used to help people with speech difficulties communicate with others. These methods can be used as an alternative to speech or to supplement it. AAC may include unaided systems such as signing and gesture as well as aided systems such as low tech picture or letter charts through to complex computer technology.

"Many people with MND die without having the right care, not having a suitable wheelchair, not having the support to communicate.

We have got to set a standard so that people like us are listened to and treated with the respect and dignity we deserve.

We have got to stop the ignorance surrounding this disease and have to make sure that when a patient is first diagnosed with MND, they must have access to good, co-ordinated care and services.

One week waiting for an assessment or a piece of equipment is like a year in most people's lives, because they are an everyday essential to help us live as normal a life as possible and die with dignity"

*Liam Dwyer, who is living with MND*

**For more information:**

www.mndassociation.org/mndcharter
Email: campaigns@mndassociation.org
Telephone: 020 7250 8447

We are proud to have the following organisations supporting the MND Charter:

**Royal College of General Practitioners**
**Association of British Neurologists**
**Royal College of Nursing**
**Chartered Society of Physiotherapy**
**College of Occupational Therapists**
**Royal College of Speech & Language Therapists**
**British Dietetic Association**

**MND Association**
PO Box 246 Northampton NN1 2PR
www.mndassociation.org

Registered charity no 294354

| HEALTH AND WELLBEING BOARD | | AGENDA ITEM No. 6 |
|---|---|---|
| **23 MARCH 2017** | | PUBLIC REPORT |
| Contact Officer(s): | Val Thomas, Consultant in Public Health | Tel. 07884 183374 |

**DUAL DIAGNOSIS**

| RECOMMENDATIONS | |
|---|---|
| **FROM : DIRECTOR OF PUBLIC HEALTH** | **Deadline date :** *N/A* |

The Health and Wellbeing Board are recommended to:

1. Comment on the risks and issues raised in the report with regard to the current treatment and care pathways for those who have both mental health and substance misuse problems.

2. Endorse the alignment of commissioning strategies and intentions to strengthen and develop services for those who have mental health problems and misuse substances.

## 1. ORIGIN OF REPORT

1.1 This report is submitted to the Board from the Director of Public Health.

## 2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide the Health and Well Being Board with information regarding issues, concerns and recommendations relating to dual diagnosis of substance misuse and mental health conditions. For the purposes of this paper substance misuse refers to drugs and alcohol. This is a cross cutting issue and a similar paper is being taken to the Cambridgeshire Health and Wellbeing Board.

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

## 3. BACKGROUND

3.1 There is a spectrum of overlapping or co-occurring substance misuse and mental health conditions, which range from mild to severe. The severity of each of these conditions may vary greatly, and at what point, or threshold, a dual diagnosis is defined will vary. Locally the term dual diagnosis is used for patients with both severe mental illness and drug and/or alcohol use. In clinical terms severe mental illness refers to a clinical diagnosis of schizophrenia, schizotypal and delusional disorders, bipolar affective disorder, severe depressive episode(s) with or without psychotic episodes and specific personality disorder. These individuals have very complex issues and are often very vulnerable with multiple needs.

Whereas co-occurring disorder is a broader term that encompasses a wider range of people who have alcohol/drug misuse problems together with a mental health problem of any severity.

3.2 People with these co-existing mental illness and substance misuse have some of the worst health, wellbeing and social outcomes. Duality serves to amplify their health and social

problems dramatically leading to greater rates of homelessness, suicide, relapse, crime, and isolation with social function and quality of life rapidly declining.

3.3 The following data taken from a range of national studies describe the scale of dual substance misuse and mental health issues, indicate that it is a long standing issue, the context and how it impacts upon different parts of the system.

a. Signs of drug dependence were evident in one adult in thirty, with a similar level found for probable alcohol dependence. Both types of substance dependence were twice as likely in men as women. (2016)
b. Approximately 40% of people with psychosis misuse substances at some point in their lifetime, at least double the rate seen in the general population. (2016)
c. 20% of mental health hospital admissions were due to alcohol use (the second highest cause after self-harm and undetermined injury. (2015)
d. More than one in five (22%) of 189 drug treatment services in England say that access to mental health services deteriorated over the 12 months to September 2014.
e. 54% of suicide and homicide by people with mental illness had a history of drug or alcohol misuse (or both): an average of 671 deaths per year. (2015)
f. 12% of homeless people have both a mental health and substance misuse problem. 41% of homeless people surveyed by Homeless Link said that they used alcohol or drugs to cope with their mental health issues. (2014)
g. Up to 70% of people in drug services and 86% of alcohol services users experienced mental health problems. (2003)
h. 14% of alcohol dependent adults also receive treatment for a mental health issue. (2007)
i. 4 in 5 prisoners who are drug dependent have 2 additional mental health problems. (2009)
j. Between 22 and 44% of adult psychiatric inpatients in England also have a substance misuse problem. (2009)

3.4 Locally, there has been an increase in concurrent mental health and substance misuse hospital admissions between 2013/14 and 2015/16 across Cambridgeshire and Peterborough. This is described and broken down in Appendix 1.

3.5 In 2015 an audit of suicides in Cambridgeshire and Peterborough was undertaken. There were 66 suicides and of these 52 of the cases were audited. Fifteen of the cases had a current or historical substance misuse problem. Of these cases 9 also had a diagnosis of a mental health condition. None fell into the definition of the local definition of dual diagnosis i.e. severe mental health and substance misuse issues. Care should be taken however in interpreting this as other factors may be implicated in the suicide.

3.6 The impact of dual substance misuse and mental health conditions impacts on physical health and is associated with a wide range of socio-economic issues that demand input from a range of services. The prevalence of health and social care needs are much higher for individuals with dual conditions than for comparable groups without duality, particularly in terms of severity of mental health symptoms, medication non-adherence, homelessness, violence and contact with the criminal justice system as either a perpetrator or a victim.

3.7 These wide ranging impacts are difficult to quantify and along with the lack of agreement with regard to definitions has affected the development of any robust economic evidence for impact and treatment. There is limited economic analysis of the costs of treating severe mental health and substance misuse issues. The costing statement for the recent National Institute for Health and Care Excellence (NICE) guidelines on dual diagnosis states that hospital episodes may be twice as long for people with psychosis and coexisting substance misuse when compared with people with psychosis alone, the costs are likely to be higher for people with both conditions. The cost of inpatient mental health episodes per occupied bed day varies between £418 in a low security service and £763 maximum secure unit. NICE recommends that effective management of these patients can avoid hospital admissions.

With regard to service configurations NICE concluded that currently there is no robust economic evidence for collaborative models for people with a dual diagnosis and the important public sector and wider societal costs are excluded in any studies to date.

3.8 The model of individually funded and commissioned mental health and substance misuse services has a risk of creating a fragmented approach which is reflected in the experience of the service user. It has the potential to exacerbate issues for those who suffer with both, given the enhancing nature of the problems. There are longstanding policies from for example NICE and the NHS's Five-year Forward View for Mental Health that call for early intervention and effective collaboration across substance misuse and mental health services along with other support organisations that address factors such as criminal justice, housing or employment.

NICE guidelines produced in 2011 and more recently in 2016 on severe co-existing mental health and substance misuse problems advocate a multi-agency approach to provide holistic care and ensure that joint strategic working is in place to provide continuity of care and services. Working between agencies should include joint assessments and agreeing joint care pathways and a protocol for sharing information between mental health, substance misuse services, health, social care, education, housing, voluntary and community services. The emphasis is on flexibility and adapting existing services, rather than creating a specialist 'dual diagnosis' service that requires a whole systems approach to commissioning.

3.9 In 2014 the Cambridgeshire and Peterborough Dual Diagnosis Strategy and Protocols were produced by a range of agencies that included the Cambridgeshire and Peterborough Clinical Commissioning Group, mental health and substance misuse providers, the Constabulary and voluntary sector. The Strategy reflects the NICE guidelines and has a focus upon those with a dual diagnosis having ready access to coordinated inter-agency assessment, treatment and support to address the complex mix of problems they present with. It calls for a consistent model for service delivery with more effective working across individual agencies with clear access arrangements. Training and upskilling of staff was seen as essential to enable them to effectively identify, assess needs and plan collaboratively a joint care plan. To support the Strategy, Protocols were developed for the shared processes and pathways used in the management of dual diagnosis.

## 4. CONSULTATION

4.1 This Report was based on information from locally generated reports across Cambridgeshire and Peterborough that included consultations with commissioners, substance misuse and mental health service providers, housing authorities and providers and the voluntary sector. In addition in the preparation of this report additional recent consultation has taken with some key stakeholders.

4.2 Additional consultation could be beneficial with specific Peterborough stakeholders relating to housing and the voluntary sector.

## 5. ANTICIPATED OUTCOMES

5.1 In summary there is an uncertain picture of both the scale and management of dual diagnosis and co-occurring disorders. As indicated the current NICE Guidelines do not recommend a bespoke dual diagnosis or co-occurring condition service but comprehensive collaborative planned services. These include not just mental health and substance misuse services but also those that help address wider socio-economic issues that are barriers to recovery. A number of recommended actions have emerged for addressing the issues highlighted in this paper and improving services in Cambridgeshire and Peterborough. The aim is to ensure that services are providing the most effective accessible collaborative treatment pathways and wider interventions for the full spectrum of dual mental health and substance misuse issues.

5.2 **Identify an inclusive collaborative delivery model.** Local stakeholders should revisit the Strategy and Protocols to ensure that pathways capture the full spectrum of mental health and substance misuse needs. They need to be supported by clear definitions of diagnoses, protocols for ensuring that all patients with either what is classified as a dual diagnosis or on the wider spectrum of co-occurring disorders, have access to a collaborative care plan that addresses both conditions, as well as their socio-economic issues.

5.3 **Evidence for service delivery**: There is a lack of evaluated evidence based service delivery models. However there are some examples from around the country where more innovative approaches to collaborative service delivery have been explored which could inform many aspects of the pathways.

5.4 **Robust alignment of commissioning strategies and intentions to underpin the local Strategy and Protocols.** A business case needs to be developed to inform the alignment of commissioning strategies and their translation into robust commissioning practice that will deliver positive outcomes. This will include the identification of the any innovation that is cost effective and has the potential for cost savings.

5.5 **Data Sharing Agreements**: An audit is required to validate the anecdotal reports of risks to patients that are linked with a lack of data sharing agreements. The feasibility of establishing data sharing agreements could be explored.

## 6. REASONS FOR RECOMMENDATIONS

6.1 In 2016 the Cambridgeshire Drugs and Alcohol Joint Strategic Needs Assessment described ongoing issues with the management of dual diagnosis that were undermining the implementation of the Dual Diagnosis and Protocols. Subsequent discussions with key stakeholders, which included commissioners and providers, working across both Peterborough and Cambridgeshire have confirmed and developed the issues associated with managing dual substance misuse and mental health problems.

6.2 As indicated above defining dual diagnosis can be problematic and this is impacting upon identification, diagnosis and treatment. The effective use of the pathways found in the Strategy and Protocols could be enhanced if definitions were universally agreed between all services and embedded into commissioned service pathways.

6.3 Training for staff working in substance misuse and mental health services is recommended by NICE and is an integral part of the Strategy and Protocols. The aim is to increase their awareness and enable them to assess, refer and manage patients collaboratively with other relevant services. Although some staff have received training this is by no means universal. A report by the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) adds a further layer of complexity to this issue. This involves the difference in philosophies and therapies traditionally used by mental health and substance misuse services. Standard psychiatric practice once was to recommend treatment for substance misuse prior to mental health treatment as it was thought that this was necessary for engagement with therapy. Furthermore, it required drug users with mental health problems to cease drug use completely for recovery. Conversely, people who worked in the drug treatment field did not have knowledge or training around recognition of mental health problems.

6.4 A strongly held view is that the lack of any data sharing agreements between substance misuse and mental health services exacerbates staff reservations relating to joint care planning. The lack of data sharing agreements has the potential to create risks for the patient. This has been referred to in the initial responses to a survey currently being undertaken by the Cambridgeshire Drug and Alcohol Commissioning Team amongst staff. However it should be noted that the results of this staff survey have not been validated through any type of audit.

6.5 There is a need for caution when interpreting data relating to dual substance misuse and mental health issues. The data provided above excludes those not seeking treatment for their mental illness or substance misuse problems. NICE estimates this to be around 50%

of those affected, which is linked to stigma. In addition patients are not routinely asked in some services about both conditions as part of a routine initial assessment. This has been attributed to staff concerns about it undermining the therapeutic relationship. These factors combined with limited training and concerns with data confidentiality have the potential to underestimate need.

It is possible to apply national prevalence figures to local populations and use small studies to identify how many patients with the conditions should be represented in local services. This analysis suggests that the numbers identified in services with these conditions are lower than that suggested by the modelling. However these kind of national study estimates, applied to local demography for mental health related issues, often generate wide ranges of estimated numbers for prevalence/cases/clients.

6.6 The local Strategy and Protocols have three core pathways and supporting protocols that reflect the severity of mental health and substance misuse issues. This includes those with lower levels of severity who do not fall into the severity associated with the term dual diagnosis. (See Appendix 2).

1. Severe mental health and severe substance misuse leads to the dual diagnosis pathway which provides a joint assessment and a collaborative care package approach.
2. Severe mental health and low substance misuse leads to a mental health pathway.
3. Severe substance misuse and low mental health issues leads to substance misuse pathway.

The concerns associated with these pathways focus most strongly upon the criteria used to access services.

a. Generally stakeholders have the view that the Dual Diagnosis pathway for those with both severe mental health and substance misuse problems is meeting their needs. However there is a strongly held view that the threshold for accessing the dual diagnosis pathway is set too high. Consequently it excludes patients with some degree of complex mental health and substance misuse issues who might not require the intensive care provided by the dual diagnosis pathway but are unable to access any appropriate provision.

b. Patients with mild to moderate mental health issues access the Increasing Access to Psychological Therapies (IAPT). However if they have severe substance misuse issues this service will not provide care. A similar situation is found amongst those assessing the personality disorder services.

The shared view amongst stakeholders that the needs of those who are unable to access the Dual Diagnosis Pathway are not being met and they are excluded from collaborative care planning processes.

## 7. ALTERNATIVE OPTIONS CONSIDERED

7.1 The alternative option to the recommendation of aligning commissioning strategies and intentions is to continue to support the implementation of the existing Dual Diagnosis and Protocols that would include increasing the numbers of staff trained and developing dual diagnosis data sharing protocols.

## 8. IMPLICATIONS

8.1 There are implications for commissioners of both mental health and substance misuse services in terms of aligning their commissioning strategies, intentions and resources. The alignment of commissioning has the potential to establish robust joint care models with patients being treated more effectively, preventing progression to more intensive possibly more costly inpatient services.

8.2 There is a risk for patients with both substance misuse and mental health issues not receiving the evidence based services that are appropriate to the severity of their problems.

8.3 There are risks when agencies that are treating patients with dual diagnosis or co-occurring conditions for either substance misuse or mental health issues have incomplete information to enable them to provide joint care plans and service delivery Positive patient outcomes and the avoidance critical incidents are more likely if clinicians have a full understanding of the patients' conditions when planning their treatment. Information sharing agreements8

8.4 Those who misuse substances and have mental health issues are vulnerable and are associated with a high risk of a range of health and socio-economic inequalities. The involvement of wide range of agencies is required to address these issues.

8.5 It is recommended by NICE that the development of collaborative services should include the engagement and inclusion of patients and their families

## 9. BACKGROUND DOCUMENTS

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


Cambridgeshire Drug and Alcohol Joint Strategic Needs Assessment (2016) http://cambridgeshireinsight.org.uk/JSNA/Drugs-and-Alcohol-2015

Crome I. et al The relationship between dual diagnoses: substance misuse and dealing with mental health Issues. Institute for Social Excellence 2009 http://www.scie.org.uk/publications/briefings/briefing30/

Co-existing alcohol and drug misuse with mental health issues: guidance to support local commissioning and delivery of Care. Draft Public Health England

NHS Five Year Forward Plan for Mental Health: Department of Health

Coexisting severe mental illness and substance misuse: community health and social care services: NICE Clinical Guideline 58 2016 https://www.nice.org.uk/guidance/ng58

Cambridgeshire and Peterborough Dual Diagnosis Strategy 2014

Cambridgeshire and Peterborough Dual Diagnosis Protocol 2014

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## 10. APPENDICES

Appendix 1 - Mental health and substance misuse hospital admissions

Appendix 2 - Cambridgeshire and Peterborough Dual Diagnosis Strategy Treatment Pathways

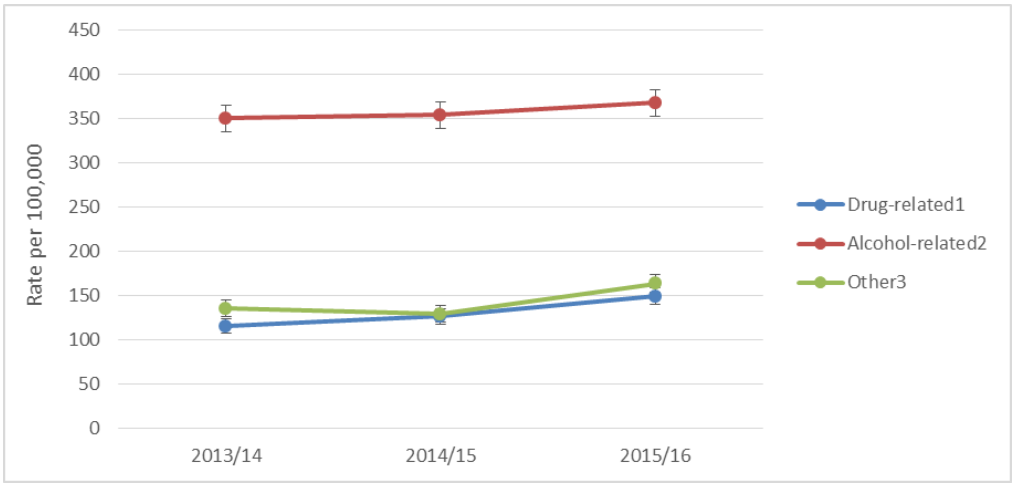
# APPENDIX 1

## Hospital Admissions

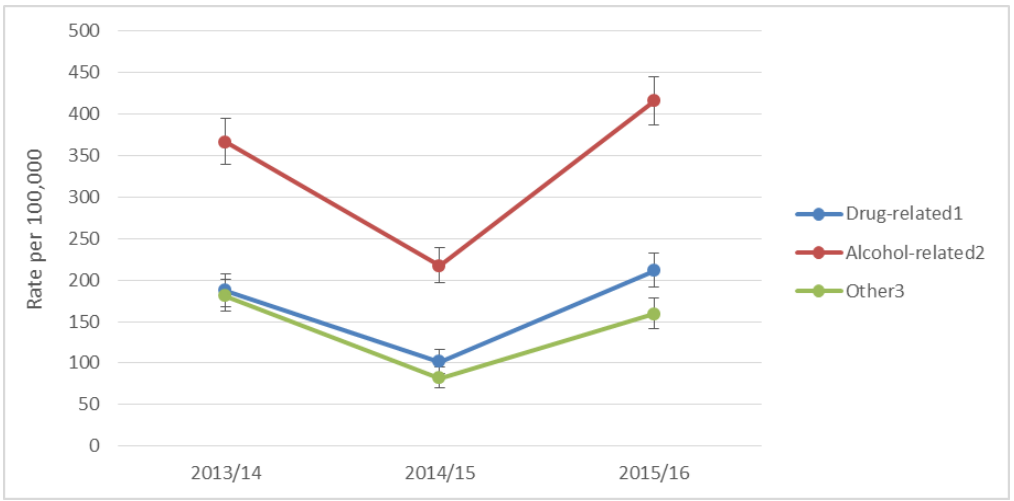
In Cambridgeshire, there was a 28% increase in concurrent mental health and drug admissions between 2013/14 and 2015/16 and a 10% increase in concurrent mental health and alcohol related admissions. In Peterborough, there was a 16% increase in concurrent mental health and drug admissions between 2013/14 and 2015/16 and a 17% increase in concurrent mental health and alcohol related admissions

This increase is shown in the graph below where 'other' relates to admissions with both a recorded mental health or behavioural condition and substance misuse problem but where the admission was for a different reason.

**Hospital Admissions with recorded concurrent substance misuse and mental and behavioural disorders Cambridgeshire 2013/14 – 2015/16**

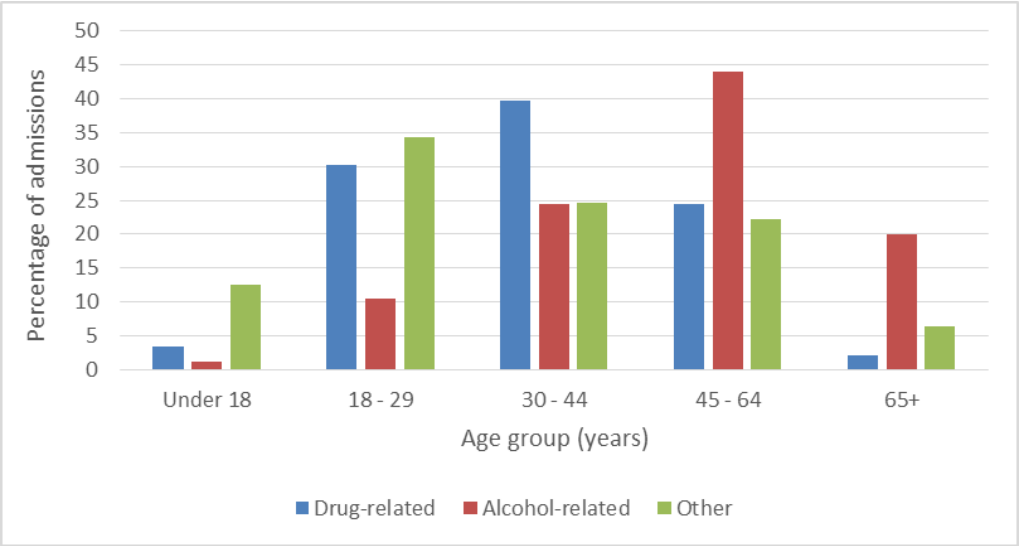



**Hospital Admissions with recorded concurrent substance misuse and mental and behavioural disorders Peterborough 2013/14 – 2015/16**

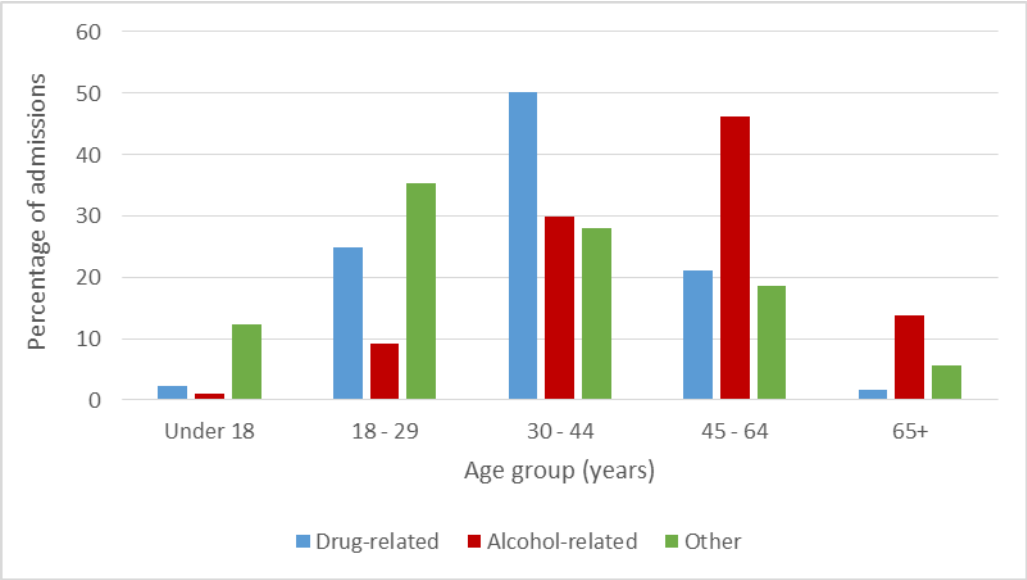


A breakdown of these admissions by demographics shows drug related admissions are highest in the 30-44 age range whilst alcohol related is highest in the 45-64 group in both Cambridgeshire and Peterborough.

**Hospital Admissions with recorded concurrent substance misuse and mental and behavioural disorders - Age Distribution Cambridgeshire 2013/14 – 2015/16**

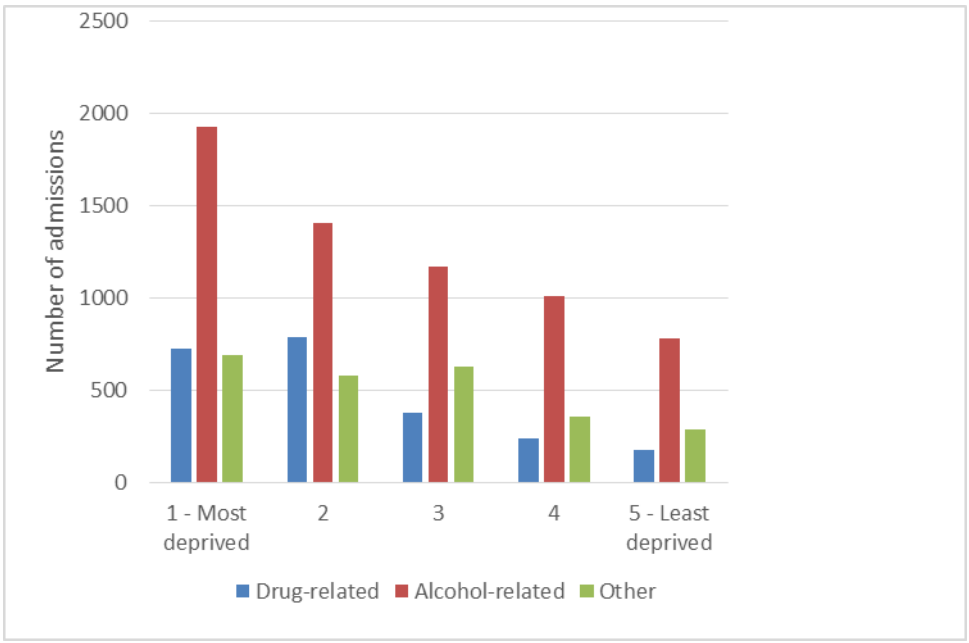



**Hospital Admissions with recorded concurrent substance misuse and mental and behavioural disorders - Age Distribution Peterborough 2013/14 – 2015/16**

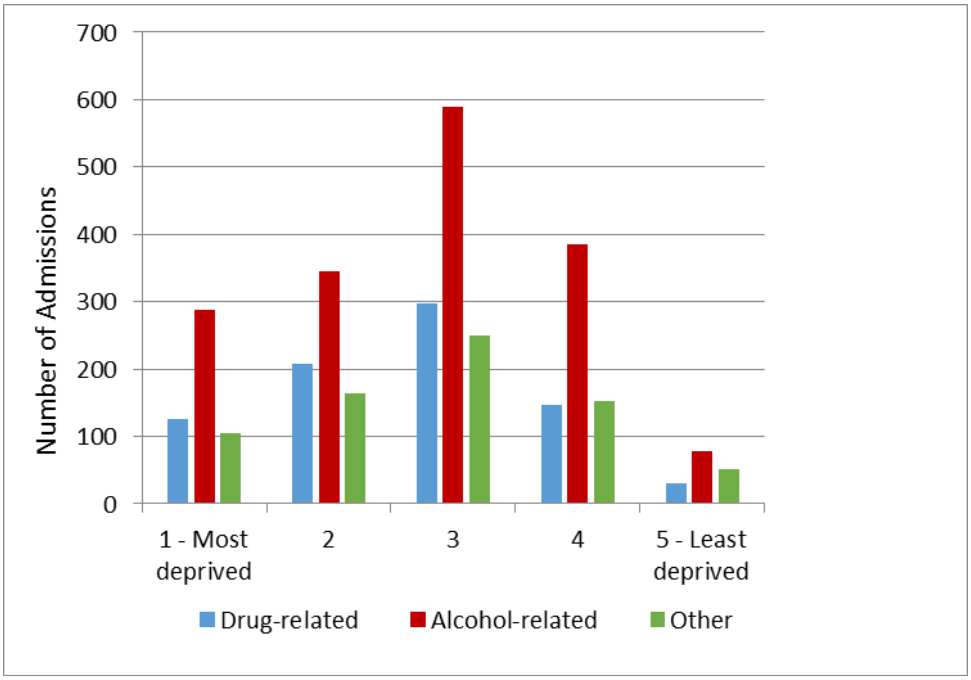


In terms of deprivation, there is a decreasing incidence of concurrent substance misuse and mental health related admissions as deprivation decreases in Cambridgeshire, although the picture is more complex in Peterborough. This can be seen on the graph below.

**Hospital Admissions with recorded concurrent substance misuse and mental and behavioural disorders - Deprivation Cambridgeshire 2013/14 – 2015/16**

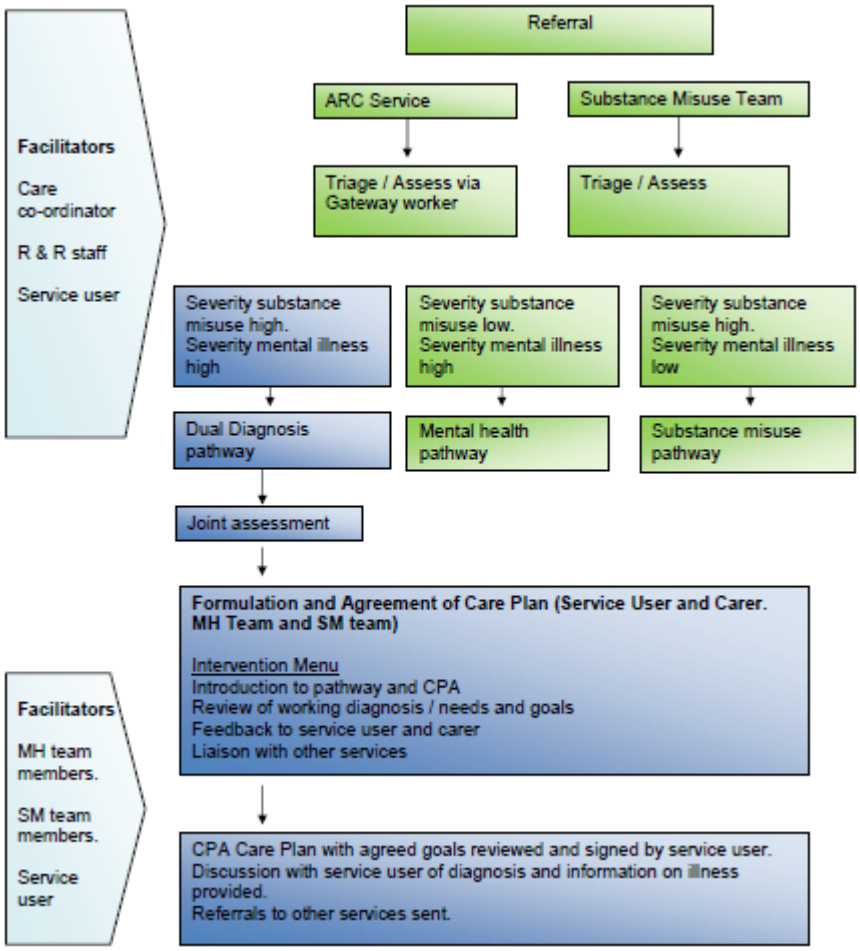



**Hospital Admissions with recorded concurrent substance misuse and mental and behavioural disorders - Deprivation Peterborough 2013/14 – 2015/16**



**APPENDIX 2**

**Cambridgeshire and Peterborough Dual Diagnosis Strategy**
**Treatment Pathways**



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| HEALTH AND WELLBEING BOARD | | AGENDA ITEM No. 7 |
|---|---|---|
| **23 MARCH 2017** | | PUBLIC REPORT |
| Contact Officer(s): | Dr Linda Sheridan, Consultant in Public Health Medicine | Tel. 07943 502672 |

## ANNUAL HEALTH PROTECTION REPORT FOR PETERBOROUGH 2016/7

| RECOMMENDATIONS | |
|---|---|
| **FROM : Director of Public Health** | **Deadline date :** *N/A* |
| The Health and Wellbeing Board is asked to comment on the Annual Health Protection Report and on future priorities for health protection in Peterborough. | |

### 1. ORIGIN OF REPORT

1.1 This report is submitted to the Board from the Peterborough City Council Public Health Office and is produced using data and information provided by partner organisations including Public Health England, NHS England and Cambridgeshire and Peterborough Clinical Commissioning Group.

### 2. PURPOSE AND REASON FOR REPORT

2.1 This report provides an annual summary on activities in Peterborough to ensure health protection for the local population and includes areas that are covered by the Peterborough Health and Well-being Strategy

2.2 The services that fall within Health Protection include:

i. communicable diseases – their prevention and management
ii. infection control
iii. routine antenatal, new born, young person and adult screening
iv. routine immunisation and vaccination
v. sexual health
vi. environmental hazards.

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

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 ISSUES

The main body of the Annual Health Protection Report is attached separately as Appendix A. In summary the report provides information on:

- Communicable disease surveillance including information on the increased levels of pertussis (whooping cough) and scarlet fever cases in the past two years.
- Immunisations which show a steady state for some and a gradual increase in uptake of many childhood immunisations and of seasonal flu vaccination
- Screening in which there is continued below average uptake of breast, cervical and bowel cancer screening in Peterborough with a recent unexplained dip in breast screening uptake
- Healthcare associated infections and the work to reduce anti-microbial resistance
- The City Council Environmental Health role in protecting health including pollution control and air quality monitoring and advice
- The national TB strategy and successful local implementation of some key areas of the strategy notably Latent TB Infection Screening (LTBI)
- Sexual health including prevention and treatment of sexually transmitted infection and prevention of teenage pregnancy, the key priorities for action and the work to develop a sexual health strategy for Peterborough
- Health emergency planning and the priorities for the coming year.

## 4. CONSULTATION

4.1 Many of the areas discussed have been subject to consultation on those individual areas.

## 5. ANTICIPATED OUTCOMES

This report helps us to identify the main problems and issues and to prioritise our activities over the next year.

## 6. REASONS FOR RECOMMENDATIONS

There are no specific recommendations included in the report, but the overarching recommendation is that the multi-agency Health Protection Steering Group should prioritise actions to address any issues over the next year. The Health and Wellbeing Board is asked to comment on future priorities for health protection in Peterborough.

## 7. ALTERNATIVE OPTIONS CONSIDERED

**N/A**

## 8. IMPLICATIONS

There are no specific implications in this report but a number of areas are reported where outcomes are below the desired level, and these will need to be addressed in partnership with those organisations that deliver the services that affect health protection.

## 9. BACKGROUND DOCUMENTS

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

The report has been produced using information and data specifically provided to the Health Protection Steering group for the purpose of writing the report. External contributors include Public Health England, NHS England and Cambridgeshire and Peterborough Clinical Commissioning Group. The report is attached as Appendix A.

Some of the data included in the report is also available on the Public Health Outcomes Framework website https://www.gov.uk/government/collections/public-health-outcomes-framework and the national immunisation statistics site https://www.gov.uk/government/statistics/cover-of-vaccination-evaluated-rapidly-cover-programme-2013-to-2014-quarterly-figures

https://www.gov.uk/government/statistics/cover-of-vaccination-evaluated-rapidly-cover-programme-2014-to-2015-quarterly-data
https://www.gov.uk/government/statistics/cover-of-vaccination-evaluated-rapidly-cover-programme-2015-to-2016-quarterly-data

## 10. APPENDICES

Appendix A: Peterborough Annual Health Protection Report 2016

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APPENDIX 1

# ANNUAL HEALTH PROTECTION REPORT FOR PETERBOROUGH 2016/7

## 1. INTRODUCTION

1.1 This report provides an annual summary on activities in Peterborough to ensure health protection for the local population and includes areas that are covered by the Peterborough Health and Well-being Strategy

1.2 The services that fall within Health Protection include:

i. communicable (infectious) diseases – their prevention and management
ii. infection control
iii. routine antenatal, new born, young person and adult screening
iv. routine immunisation and vaccination
v. sexual health
vi. environmental hazards.

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

1.4 The Director of Public Health (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.

1.5 Details of the legislative background to the role of DPH and the role of the City Council in relation to health protection has been included in previous annual health protection reports and will not be reproduced here.

## 2. PETERBOROUGH HEALTH PROTECTION COMMITTEE

2.1 To enable the DPH to fulfil the statutory responsibilities in relation to health protection, the Peterborough Health Protection Committee (PHPC) was established in October 2013 and is chaired by the DPH or nominated deputy. The PHPC enabled 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 facilitated information sharing and planning across agencies.

2.2 With the greater sharing of public health roles across the two local authorities – Peterborough City Council and Cambridgeshire County Council - and in recognition that the role of many of the organisations that contribute to the PHPC also cover the wider geography, it was agreed to bring the committees for both areas together from October 2015. Initially the agendas consisted of three sections – Peterborough only items; Joint Peterborough and Cambridgeshire items; and Cambridgeshire only items.

However it became clear that most items of concern to the committee were shared across the two areas and from October 2016 the agendas were merged and revised Terms of Reference drawn up for the Joint Cambridgeshire and Peterborough Health Protection Steering Group. To ensure that the shared membership fully protected confidentiality of any sensitive items discusssed, a Confidentiality / Non-disclosure Agreement was included with the terms of Reference.

## 3. SURVEILLANCE

### 3.1 Notifications of Infectious Diseases

Doctors in England and Wales have a statutory duty to notify suspected cases of certain infectious diseases. These notifications along with laboratory and other data are an important source of surveillance data. The table below shows the main notifiable diseases reported to the HPT from 2013 - 2016.

**Table 1: Notifiable Diseases in Peterborough 2013-2016**

| Notifiable Disease* | 2013† | 2014† | 2015† | 2016† |
|---|---|---|---|---|
| **Acute infectious hepatitis** | 9 | 7 | 17 | 14 |
| **Acute meningitis** | <5 | <5 | <5 | <5 |
| **Food poisoning** (excluding campylobacter**, but including the organisms below) | 72 | 71 | 64 | 86 |
| E coli O157 VTEC | <5 | <5 | <5 | <5 |
| Cryptosporidium | 17 | 13 | 18 | 19 |
| Giardia | 11 | 15 | 12 | 20 |
| Salmonella | 39 | 34 | 23 | 38 |
| **Infectious bloody diarrhoea** | 8 | 8 | <5 | 6 |
| **Invasive group A streptococcal disease** | <5 | 9 | <5 | 7 |
| **Legionnaires' disease** | <5 | 0 | <5 | <5 |
| **Malaria** | 0 | <5 | <5 | <5 |
| **Measles*** | 7 | 5 | <5 | <5 |
| **Meningococcal septicaemia** | <5 | 5 | <5 | <5 |
| **Mumps*** | 7 (1) | 8 (3) | 8 (4) | 11 (4) |
| **Rubella*** | <5 | <5 | <5 | 0 |
| **Scarlet fever** | 15 | 20 | 98 | 56 |
| **Whooping cough** | 17 | 18 | 15 | 49 |

*SOURCE: East of England HPT HPZone*

* *These are notifications of infectious disease and are not necessarily laboratory confirmed. Numbers in brackets indicate confirmed cases of mumps. There were no confirmed cases of measles or rubella.*

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

** *During 2016, the HPT stopped importing laboratory reports of campylobacter into its HPZone database as public health follow up is not undertaken for individual cases and there is a national system for laboratory surveillance.*

### 3.2 Pertussis (whooping cough)

There were 4535 cases of whooping cough notified in England and Wales in 2016, up from 3033 in 2015. Peterborough had a higher rate of notifications than the East of England with 23.20 per 100 000 population compared to 15.56 for the East of England. The median age of cases in Peterborough was 43.5 (range: 0 – 85). 90% of cases were laboratory confirmed pertussis. Pertussis cases usually increase in the third quarter of each year and follow a recognised epidemiological pattern of 3 – 4 yearly cyclical peaks. Following the declaration of a national outbreak of pertussis in 2012, immunisation for pregnant women was introduced in September 2012.

### 3.3 Scarlet fever

Similar to the rest of the country, scarlet fever activity has remained elevated across Peterborough. In 2016, there were 19,155 notifications of scarlet fever in England and Wales, an increase from 17,577 in 2015. This increase has also been seen in the East of England, although in Peterborough there was a drop in cases in 2016 compared to 2015. In Peterborough there were 25.78 cases per 100 000 population in 2016, slightly less than the rate for the East of England which was 29.44. The median age of scarlet fever cases in Peterborough is 4 years (range 1 to 34 years); most cases are reported in children under 10. Reporting of scarlet fever cases peaked in March but has remained at higher than normal levels throughout 2016.

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

### 3.4 Outbreaks and Incidents

In 2016, there were 9 outbreaks of gastroenteritis in Peterborough. Eight of these were in care homes (3 confirmed and 5 suspected norovirus) and one in an educational establishment (suspected norovirus).

There were also 2 pseudomonas incidents. One related to environmental contamination in a healthcare setting, where there was an intermittent problem with pseudomonas spp contamination of endoscope washers and dental chair spittoons. The other was a national incident with cases of severe *Pseudomonas aeruginosa* infection following cosmetic piercing procedures using potentially contaminated cleaning solution. A piercing studio in Peterborough was involved

## 4.0 PREVENTION

### 4.1 Immunisation programmes

The tables below detail uptake of the various vaccination programmes over time and compared to the regional level of uptake. Overall uptake is steady or has increased for most of the childhood programmes and for the seasonal influenza vaccination programme, which appears to indicate some success from the work we have undertaken with partner organisations to improve uptake. The aim for all childhood programmes is to achieve at least 95% uptake, the level which ensures Herd Immunity. However the target uptake as outlined in the Public Health Outcomes Framework is 90%

Herd immunity occurs when the vaccination of a significant portion of a population provides a measure of protection for individuals who have not developed immunity. It arises when a high percentage of the population is protected through vaccination, making it difficult for a disease to spread because there are so few susceptible people left to infect.

This can effectively stop the spread of disease in the community. It is particularly crucial for protecting people who cannot be vaccinated. These include children who are too young to be vaccinated, people with immune system problems, and those who are too ill to receive vaccines (such as some cancer patients).

Details of the UK vaccination programme and what each vaccine protects against are included at Annex 1 at the end of this report.

### 4.1.1 Childhood Primary Vaccinations

**Table 2 - Diphtheria, Tetanus, Pertussis, Polio and Haemophilus Influenza B**

| **12 months DTaP/IPV/Hib [target 95%]** | | | | |
|---|---|---|---|---|
| | **Q1 2013/14 %** | **Q2 2013/14 %** | **Q3 2013/14 %** | **Q4 2013/14 %** |
| Peterborough | 94.8 | 93.6 | 94.5 | 93.9 |
| East Anglia | 95.7 | 95.8 | 95.8 | 95.2 |
| | **Q1 2014/15** | **Q2 2014/15** | **Q3 2014/15** | **Q4 2014/15** |
| Peterborough | 94.2 | **94.2** | **96.3** | **95.2** |
| East Anglia | 95.6 | 95.0 | 96.0 | 95.6 |
| | **Q1 2015/16** | **Q2 2015/16** | **Q3 2015/16** | **Q4 2015/16** |
| Peterborough | **94.8** | **96.3** | **96.1** | **93.8** |
| East Anglia | 95.6 | 95.6 | 95.4 | 95.5 |
| | **Q1 2016/17** | **Q2 2016/17** | **Q3 2016/17** | **Q4 2016/17** |
| Peterborough | **93.5** | **93.8** | | |
| East Anglia | 95.0 | 95.2 | | |

*Source: COVER*

**Table 3 – Pneumococcal Vaccine**

| **12 months PCV [target 95%]** | | | | |
|---|---|---|---|---|
| | **Q1 2013/4 %** | **Q2 2013/4 %** | **Q3 2013/14 %** | **Q4 2013/4 %** |
| Peterborough | 93.9 | 93.3 | 93.9 | 93.6 |
| East Anglia | 95.3 | 95.4 | 95.3 | 95.6 |
| | **Q1 2014/5 %** | **Q2 2014/5 %** | **Q3 2014/15 %** | **Q4 2014/5 %** |
| Peterborough | 93.1 | **93.4** | **95.6** | **94.8** |
| East Anglia | 95.3 | 94.6 | 95.8 | 95.3 |
| | **Q1 2015/16 %** | **Q2 2015/16 %** | **Q3 2015/16 %** | **Q4 2015/16 %** |
| Peterborough | **94.5** | **95.8** | **96.6** | **93.0** |
| East Anglia | 95.4 | 95.4 | 95.5 | 95.6 |
| | **Q1 2016/17** | **Q2 2016/17** | **Q3 2016/17** | **Q4 2016/17** |
| Peterborough | **93.6** | **93.6** | | |
| East Anglia | 95.4 | 95.3 | | |

*Source: COVER*

**Table 4 - Diphtheria, Tetanus, Pertussis, Polio and Haemophilus Influenza B**

| 24 months DTaP/IPV/Hib [target 95%] | | | | |
|---|---|---|---|---|
| | **Q1 2013/14 %** | **Q2 2013/14 %** | **Q3 2013/14 %** | **Q4 2013/14 %** |
| Peterborough | 94.8 | 96.8 | 96.4 | 97.3 |
| East Anglia | 97.1 | 96.8 | 96.3 | 96.6 |
| | **Q1 2014/15 %** | **Q2 2014/15 %** | **Q3 2014/15 %** | **Q4 2014/15 %** |
| Peterborough | **96.5** | **96.0** | **95.5** | **96.9** |
| East Anglia | 96.4 | 96.6 | 96.9 | 96.4 |
| | **Q1 2015/16 %** | **Q2 2015/16 %** | **Q3 2015/16 %** | **Q4 2015/16 %** |
| Peterborough | **95.5** | **96.2** | **96.0** | **97.2** |
| East Anglia | 96.5 | 95.7 | 96.2 | 96.0 |
| | **Q1 2016/17** | **Q2 2016/17** | **Q3 2016/17** | **Q4 2016/17** |
| Peterborough | **95.6** | **96.9** | | |
| East Anglia | 96.1 | 96.2 | | |

*Source: COVER*

**Table 5- Pneumococcal vaccine**

| 24 months PCV Booster [target 95%] | | | | |
|---|---|---|---|---|
| | **Q1 2013/14 %** | **Q2 2013/14 %** | **Q3 2013/14 %** | **Q4 2013/14 %** |
| Peterborough | 91.4 | 91.9 | 92.0 | 93.5 |
| East Anglia | 94.2 | 94.0 | 93.6 | 94.0 |
| | **Q1 2014/15 %** | **Q2 2014/15 %** | **Q3 2014/15 %** | **Q4 2014/15 %** |
| Peterborough | 92.8 | **91.3** | **91.9** | **93.7** |
| East Anglia | 93.6 | 93.7 | 94.0 | 93.9 |
| | **Q1 2015/16 %** | **Q2 2015/16 %** | **Q3 2015/16 %** | **Q4 2015/16 %** |
| Peterborough | **92.8** | **92.8** | **93.7** | **92.6** |
| East Anglia | 93.6 | 93.0 | 93.5 | 93.3 |
| | **Q1 2016/17** | **Q2 2016/17** | **Q3 2016/17** | **Q4 2016/17** |
| Peterborough | **91.2** | **91.9** | | |
| East Anglia | 92.9 | 94.3 | | |

*Source: COVER*

**Table 6 – Haemophilus Influenza B and Meningoccus C**

| 24 months Hib/Men C [target 95%] | | | | |
|---|---|---|---|---|
| | **Q1 2013/14 %** | **Q2 2013/14 %** | **Q3 2013/14 %** | **Q4 2013/14 %** |
| Peterborough | 91.0 | 92.1 | 92.0 | 93.1 |
| East Anglia | 94.2 | 94.6 | 94.1 | 94.2 |
| | **Q1 2014/15 %** | **Q2 2014/15 %** | **Q3 2014/15 %** | **Q4 2014/15 %** |
| Peterborough | 93.1 | **91.4** | **91.4** | **93.4** |
| East Anglia | 93.9 | 93.7 | 94.0 | 91.5 |
| | **Q1 2015/16 %** | **Q2 2015/16 %** | **Q3 2015/16 %** | **Q4 2015/16 %** |
| Peterborough | **92.6** | **91.5** | **93.3** | **91.9** |
| East Anglia | 93.8 | 92.5 | 93.4 | 93.3 |
| | **Q1 2016/17** | **Q2 2016/17** | **Q3 2016/17** | **Q4 2016/17** |
| Peterborough | **90.8** | **92.6** | | |
| East Anglia | 92.8 | 94.3 | | |

*Source: COVER*

**Table 7 – Measles, Mumps and Rubella**

| **24 months MMR 1 [target 95%]** | | | | |
|---|---|---|---|---|
| | **Q1 2013/14 %** | **Q2 2013/14 %** | **Q3 2013/14 %** | **Q4 2013/14 %** |
| Peterborough | 91.2 | 92.1 | 91.1 | 93.1 |
| East Anglia | 92.6 | 92.9 | 93.0 | 93.5 |
| | **Q1 2014/15 %** | **Q2 2014/15 %** | **Q3 2014/15 %** | **Q4 2014/15 %** |
| Peterborough | 92.7 | **91.6** | **90.9** | **93.0** |
| East Anglia | 93.1 | 93.2 | 93.3 | 93.5 |
| | **Q1 2015/16 %** | **Q2 2015/16 %** | **Q3 2015/16 %** | **Q4 2015/16 %** |
| Peterborough | **92.6** | **92.6** | **92.1** | **92.1** |
| East Anglia | 93.4 | 92.3 | 93.1 | 93.4 |
| | **Q1 2016/17** | **Q2 2016/17** | **Q3 2016/17** | **Q4 2016/17** |
| Peterborough | **91.8** | **92.2** | | |
| East Anglia | 92.7 | 93.8 | | |

*Source: COVER*

**Table 8 - Diphtheria, Tetanus, Pertussis, Polio and Haemophilus Influenza B**

| **5 years DTaP IPV Hib [target 95%]** | | | | |
|---|---|---|---|---|
| | **Q1 2013/14 %** | **Q2 2013/14 %** | **Q3 2013/14 %** | **Q4 2013/14 %** |
| Peterborough | 92.5 | 94.2 | 94.8 | 95.3 |
| East Anglia | 95.8 | 96.5 | 95.8 | 95.7 |
| | **Q1 2014/15 %** | **Q2 2014/15 %** | **Q3 2014/15 %** | **Q4 2014/15 %** |
| Peterborough | 95.0 | **95.6** | **96.7** | **97.0** |
| East Anglia | 96.0 | 95.7 | 96.3 | 95.8 |
| | **Q1 2015/6 %** | **Q2 2015/16 %** | **Q3 2015/16 %** | **Q4 2015/16 %** |
| Peterborough | **97.6** | **92.5** | **96.4** | **95.2** |
| East Anglia | 96.2 | 95.3 | 95.6 | 96.2 |
| | **Q1 2016/17** | **Q2 2016/17** | **Q3 2016/17** | **Q4 2016/17** |
| Peterborough | **95.7** | **96.4** | | |
| East Anglia | 96.0 | 96.9 | | |

*Source: COVER*

**Table 9 - Measles, Mumps and Rubella (first dose)**

| **5 years MMR 1 [target 95%]** | | | | |
|---|---|---|---|---|
| | **Q1 2013/14 %** | **Q2 2013/114 %** | **Q3 2013/14 %** | **Q4 2013/14 %** |
| Peterborough | 90.8 | 91.0 | 93.1 | 92.8 |
| East Anglia | 93.6 | 94.4 | 93.9 | 93.8 |
| | **Q1 2014/15 %** | **Q2 2014/15 %** | **Q3 2014/15 %** | **Q4 2014/15 %** |
| Peterborough | **93.6** | **94.6** | **95.0** | **95.8** |
| East Anglia | 94.1 | 93.5 | 94.2 | 94.1 |
| | **Q1 2015/16 %** | **Q2 2015/16 %** | **Q3 2015/16 %** | **Q4 2015/16 %** |
| Peterborough | **95.5** | **89.0** | **94.6** | **93.9** |
| East Anglia | 94.2 | 93.1 | 93.8 | 95.2 |
| | **Q1 2016/17** | **Q2 2016/17** | **Q3 2016/17** | **Q4 2016/17** |
| Peterborough | **95.3** | **95.7** | | |
| East Anglia | 95.4 | 96.0 | | |

*Source: COVER*

**Table 10 - Measles, Mumps and Rubella (second dose)**

| 5 years MMR 2 [target 95%] | | | | |
|---|---|---|---|---|
| | **Q1 2013/14 %** | **Q2 2013/14 %** | **Q3 2013/14 %** | **Q4 2013/14 %** |
| Peterborough | 83.3 | 85.5 | 84.5 | 83.1 |
| East Anglia | 87.5 | 90.4 | 88.3 | 88.6 |
| | **Q1 2014/15 %** | **Q2 2014/15 %** | **Q3 2014/15 %** | **Q4 2014/15 %** |
| Peterborough | 86.5 | **86.5** | **87.9** | **89.8** |
| East Anglia | 89.5 | 89.4 | 89.8 | 89.7 |
| | **Q1 2015/16 %** | **Q2 2015/16 %** | **Q3 2015/16 %** | **Q4 2015/16 %** |
| Peterborough | **90.0** | **89.0** | **88.9** | **89.9** |
| East Anglia | 91.4 | 88.8 | 89.4 | 90.8 |
| | **Q1 2016/17** | **Q2 2016/17** | **Q3 2016/17** | **Q4 2016/17** |
| Peterborough | **89.8** | **91.6** | | |
| East Anglia | 88.2 | 89.8 | | |

*Source: COVER*

**Table 11 - Diphtheria, Tetanus, Pertussis, Polio**

| 5 years DTaP/IPV Booster [target 95%] | | | | |
|---|---|---|---|---|
| | **Q1 2013/14 %** | **Q2 2013/14 %** | **Q3 2013/14 %** | **Q4 2013/14 %** |
| Peterborough | 84.4 | 87.1 | 85.5 | 84.1 |
| East Anglia | 89.3 | 91.7 | 89.7 | 90.1 |
| | **Q1 2014/15 %** | **Q2 2014/15 %** | **Q3 2014/15 %** | **Q4 2014/15 %** |
| Peterborough | 87.7 | **86.9** | **88.9** | **90.8** |
| East Anglia | 91.1 | 90.1 | 90.8 | 90.7 |
| | **Q1 2015/16 %** | **Q2 2015/16 %** | **Q3 2015/16 %** | **Q4 2015/16 %** |
| Peterborough | **91.6** | **90.1** | **89.8** | **90.7** |
| East Anglia | 90.7 | 89.5 | 90.4 | 89.0 |
| | **Q1 2016/17** | **Q2 2016/17** | **Q3 2016/17** | **Q4 2016/17** |
| Peterborough | **86.4** | **88.2** | | |
| East Anglia | 87.6 | 88.7 | | |

*Source: COVER*

**Table 12 - Haemophilus Influenza B and Meningoccus C**

| 5 years Hib/Men C [target 95%] | | | | |
|---|---|---|---|---|
| | **Q1 2013/14 %** | **Q2 2013/14 %** | **Q3 2013/14 %** | **Q4 2013/14 %** |
| Peterborough | 83.5 | 88.1 | 89.1 | 87.3 |
| East Anglia | 91.5 | 94.3 | 92.8 | 92.6 |
| | **Q1 2014/15 %** | **Q2 2014/15 %** | **Q3 2014/15 %** | **Q4 2014/15 %** |
| Peterborough | 91.1 | **90.5** | **91.2** | **92.9** |
| East Anglia | 93.4 | 92.7 | 93.1 | 91.2 |
| | **Q1 2015/16 %** | **Q2 2015/16 %** | **Q3 2015/16 %** | **Q4 2015/16 %** |
| Peterborough | **92.0** | **91.8** | **91.4** | **89.4** |
| East Anglia | 93.1 | 93.0 | 92.9 | 92.2 |
| | **Q1 2016/17 %** | **Q2 2016/17 %** | **Q3 2016/17 %** | **Q4 2016/17 %** |
| Peterborough | **88.9** | **88.5** | | |
| East Anglia | 91.2 | 93.4 | | |

*Source: COVER*
https://www.gov.uk/government/statistics/cover-of-vaccination-evaluated-rapidly-cover-programme-2013-to-2014-quarterly-figures
https://www.gov.uk/government/statistics/cover-of-vaccination-evaluated-rapidly-cover-programme-2014-to-2015-quarterly-data
https://www.gov.uk/government/statistics/cover-of-vaccination-evaluated-rapidly-cover-programme-2015-to-2016-quarterly-data

### 4.1.2 Meningitis B

New vaccines introduced include **Meningitis B** vaccine as part of the primary vaccination for infants. This commenced **1st September 2015**. It is offered to all babies

when they attend for their first and third routine vaccinations, at 2 months and again at 4 months. A booster is offered at 12/13 months.

**Table 13**

| 12 months Men B [target 95%] | | | | |
|---|---|---|---|---|
| | **Q1 2016/17** | **Q2 2016/17** | **Q3 2016/17** | **Q4 2016/17** |
| Peterborough | **Data not collected** | **91.6** | | |
| East Anglia | **Data not collected** | 93.7 | | |

### 4.1.3 Men ACWY

**Men ACWY** was introduced following an increase in Men W infections. This is being delivered to adolescents by school immunisation providers. The 17-18 year old catch up offered through primary care started in August 2015.

**Table14**

| **Org Name** | **Vaccine uptake – December 2016** | | | | | |
|---|---|---|---|---|---|---|
| | **Becoming 18 (born 1st Sep 1997 to 31st Aug 1998 inclusive)** | **No. of patients that have received the MenACWY vaccine** | **% Uptake** | **Becoming 19 (born 1st Sep 1996 to 31st Aug 1997 inclusive)** | **No. of patients that have received the MenACWY vaccine** | **% Uptake** |
| Cambridgeshire & Peterborough CCG | 9926 | 3138 | 31.6% | 10250 | 3915 | 38.2% |
| East Anglia Total | **21731** | **6508** | **29.9%** | **21852** | **8079** | **37%** |

**Source ImmForm 05/01/17**

**Table 15 - School Immunisation Service – Men ACWY**

| **Local Authority** | | **Peterborough City Council** | **England** |
|---|---|---|---|
| **Catch-up Cohort 1 – School Year 11 – MenACWY 15-16 year olds born between 1 September 1999 – 31 August 2000** | **Number of adolescents** | 2,497 | **540,312** |
| | **Number vaccinated with MenACWY up to 31 August 2016** | 2,024 | **387,787** |
| | **% vaccinated with MenACWY up to 31 August 2016** | 81.1 | 71.8 |
| **Routine Cohort 2 – School Year 10 – Men ACWY 14-15 year olds born between 1 September 2000 – 31 August 2001** | **Number of adolescents** | 2,446 | **270,383** |
| | **Number vaccinated with MenACWY up to 31 August 2016** | 2,085 | **208,759** |
| | **% vaccinated with MenACWY up to 31 August 2016** | 85.2 | 77.2 |
| **Routine Cohort 3 – School Year 9 – Men ACWY 13-14 year olds born between 1 September 2001 – 31 August 2002** | **Number of adolescents** | | **303,740** |
| | **Number vaccinated with MenACWY up to 31 August 2016** | | **255,302** |
| | **% vaccinated with MenACWY up to 31 August 2016** | | **84.1** |

### 4.1.4 Seasonal Flu Vaccination

Flu vaccination uptake improved this year for most groups but especially for the younger at risk groups and for NHS staff

**Table 16: Flu vaccination uptake by key groups**

| Area | Summary of flu vaccine uptake % | | | | | |
|---|---|---|---|---|---|---|
| | 65 and over | | Under 65 (at risk) | | Pregnant women | |
| | 2015/6 | 2016/7 | 2015/6 | 2016/7 | 2015/6 | 2016/7 |
| **Cambridgeshire & Peterborough CCG** | 72.4 | **72.1** | **42.7** | **47.2** | **32.2** | **46.7** |
| **East Anglia** | **71.3** | **71** | **42.8** | **47.1** | **36.7** | **47.9** |

**Table 17: Seasonal flu vaccination uptake by age 2, 3 and 4 year olds**

| Area | All aged 2 % uptake | | All aged 3 % uptake | | All aged 4 % uptake | |
|---|---|---|---|---|---|---|
| | 2015/6 | 2016/7 | 2015/6 | 2016/7 | 2015/6 | 2016/7 |
| **Cambridgeshire & Peterborough CCG** | 37 | 39.7 | 39.3 | 42.0 | 29.7 | 33.3 |
| **East Anglia** | **39.1** | **42.1** | **40.8** | **43.9** | **32.0** | **35.4** |

Source ImmForm 06/01/17

**Table 18: Front line healthcare workers in Trusts**

| Org Name | No. of HCWs with Direct Patient Care | Seasonal Flu doses given since 1st September 2016 | | % Seasonal flu doses given since 1st September 2015 |
|---|---|---|---|---|
| | | No. | % | % |
| Papworth Hospital NHS Foundation Trust | 1510 | 1114 | 73.8 | 64.9 |
| Peterborough and Stamford Hospitals NHS Foundation Trust | 3865 | 2067 | 53.5 | 62.1 |
| Cambridge University Hospitals NHS Foundation Trust | 7833 | 5400 | 68.9 | 41.8 |
| Hinchingbrooke Health Care NHS trust | 1215 | 920 | 75.7 | 63.6 |
| Cambridgeshire and Peterborough NHS Foundation Trust | 3375 | 1358 | 40.2 | 35.8 |
| Cambridgeshire Community Services NHS Trust | 1041 | 568 | 54.6 | 54.8 |
| **East Anglia Total** | **50249** | **29012** | **57.7** | **43.1** |

### 4.1.5 Prenatal Pertussis Vaccination

In England, from April to September 2016, Pertussis vaccine coverage in pregnant women averaged 70%, 14% higher than the same period in 2015 (Figure 1). This increase is thought to be in part attributable to changes to the data extraction criteria from April 2016 and suggests coverage estimates prior to this may have been under-estimated. In addition, the extended eligibility criteria for the vaccine, available to women from 16 weeks of pregnancy since April 2016 (previously available from 28 weeks), would have started to impact coverage from September 2016, and may have contributed to the increase. Whilst the increase in uptake is great news, pertussis activity continues to be high in all age groups other than infants and therefore it remains really important that women get vaccinated at the recommended time, ideally between 20 and 32 weeks of pregnancy, as this is a safe and highly effective way to protect their baby from birth.

Please note that prior to April 2015 and again from April 2016, we have only received joint data for the Cambridgeshire and Peterborough CCG area from NHSE.

**Table 19**

| **Pertussis** | **April 2014 %** | **May 2014 %** | **June 2014 %** | **July 2014 %** |
|---|---|---|---|---|
| CCG | 59.6 | 53.0 | 53.1 | 49.0 |
| East Anglia | 60.6 | 60.5 | 57.2 | 55.8 |
| **Pertussis** | **August 2014 %** | **Sept 2014 %** | **Oct 2014 %** | **Nov 2014 %** |
| CCG | 48.1 | 51.3 | 52.0 | 50.8 |
| East Anglia | 55.5 | 58.3 | 60.3 | 60.6 |
| **Pertussis** | **Dec 2014 %** | **Jan 2015 %** | **Feb 2015 %** | **March 2015 %** |
| CCG | 59.6 | 53.1 | 54.1 | 51.6 |
| East Anglia | 65.7 | 61.6 | 60.9 | 58.1 |
| **Pertussis** | **April 2015 %** | **May 2015 %** | **June 2015 %** | **July 2015 %** |
| CCG | 49.8 | 45.9 | 52.7 | 50.5 |
| P'boro | NA | NA | NA | 40.0 |
| East Anglia | 56.8 | 53.8 | 58.9 | 56.3 |
| **Pertussis** | **August 2015 %** | **Sept 2015 %** | **Oct 2015 %** | **Nov 2015 %** |
| CCG | 51.2 | 50.5 | 54.1 | 52.5 |
| P'boro | 42.0 | 42.9 | NA | NA |
| East Anglia | 58.5 | 67.2 | 60.3 | 61.4 |
| **Pertussis** | **Dec 2015 %** | **Jan 2016 %** | **Feb 2016 %** | **March 2016 %** |
| CCG | 50.7 | 50.3 | NA | NA |
| East Anglia | 60.3 | 59.3 | NA | NA |
| **Pertussis** | **April 2016 %** | **May 2016 %** | **June 2016 %** | **July 2016 %** |
| Cambridgeshire & Peterborough CCG | 52.7 | 73.8 | 73.3 | 71.9 |
| East Anglia Total | **60.2** | **73.6** | **74.4** | **74.7** |
| **Pertussis** | **August 2016%** | **Sept 2016 %** | **Oct 2016 %** | **Nov 6%** |
| Cambridgeshire & Peterborough CCG | 70.6 | 72.8 | 71.4 | 72.3 |
| East Anglia Total | **74.1** | **76.4** | **78.7** | **78.0** |

Source: ImmForm Sentinel Survey accessed 05/01/17

### 4.1.6 Rotavirus Vaccination

Rotavirus is a highly infectious stomach bug that affects babies and young children. Infections are routinely reported in surveillance data provided by PHE which demonstrates the effectiveness of this programme as cases have dropped to tiny numbers since the vaccine was introduced.

**Table 20: Rotavirus vaccination**

| **12 months Rotavirus 2 doses [target 95%]** | | | | |
|---|---|---|---|---|
| | **Q1 2016/17** | **Q2 2016/17** | **Q3 2016/17** | **Q4 2016/17** |
| Peterborough | **90.3** | **89.1** | | |
| East Anglia | 92.5 | 92.6 | | |

### 4.1.7 School Immunisation Service

**Table 21: Data for end of school year 2015-16**

| | Target | Peterborough |
|---|---|---|
| HPV vaccination by end of school year nine dose 1 | 90% | 88% |
| HPV vaccination by end of school year nine dose 2 | 90% | 91% |
| School leaver booster (Td/IPV) by end of school year 10. | 80% | 78% |
| Men ACWY by end of school year 10. | 80% | 85% |
| Men ACWY by end of school year 11. | 80% | 81% |
| Childhood Flu vaccination school years 1 and 2 | 60% | 51% |
| Schools participating in the programme | 100% | 100% |
| Vaccine administration Training | 100% | 100% |
| Patient/ service user satisfaction. | 85% | 100% |

### 4.1.8 Shingles

The data for the Shingles vaccination programme is shown in the table below. The data is cumulative and is up to end December 2016. This is the third year of the shingles vaccination programme in England and data from September 2015 to August 2016 shows a continued decline in coverage in the routine (70 year old) and catch up (78 years old) cohorts (from 61.8% in 2013/14 to 54.9% in 2015/16 and from 57.8% in 2014/15 to 55.5% in 2015/16, respectively). PHE note several factors may have contributed to the decline, including:

- difficulties in practices identifying the eligible patients – during busy influenza immunisation clinics
- lack of call/re-call in the service specification to allow mop up of those who missed immunisation during the flu season
- possible lowering of patients' awareness of the vaccine since its introduction in 2013.

PHE are promoting the need for shingles vaccine through professional channels and considering a range of possible approaches to simplify the programme and associated eligibility criteria.

**Table 22: Shingles vaccination uptake**

| Area | Vaccine coverage for the Routine Cohort since 2013 | | | Vaccine coverage for the Catch-up Cohort since 2013 | | |
|---|---|---|---|---|---|---|
| | Registered Patients aged 70 | Received Shingles vaccine | | Registered Patients aged 78 | Received Shingles vaccine | |
| | | No of patients | % of patients | | No of patients | % of patients |
| Cambridgeshire & Peterborough CCG | 6774 | 2895 | 42.7 | 4296 | 1904 | 44.3 |
| **East Anglia Total** | **21618** | **8382** | **38.8** | **13837** | **5353** | **38.7** |

### 4.1.9 BCG

All Trusts are now able to order the new BCG vaccine- Intervax and have reinstated clinics within Maternity to ensure maximum usage of each vial of vaccine. A summary of the number

of BCG vaccinations given to eligible babies under the age of 1 year is provided below. There is no national collection of BCG data in the absence of a reliable source for the denominator.

**Table 23 – BCG vaccination uptake**

| | 2015-16 |
|---|---|
| Peterborough and Stamford Hospital Foundation trust | 794 |
| Primary care – across Cambridgeshire and Peterborough | 341 |

### 4.1.10 Immunisation Task and Finish Group

An Immunisation 'Task and Finish' group that was set up to identify the reasons for lower immunisation uptake for childhood immunisation reported 12 month ago and the group has continued to work to implement the recommendations. This has involved close working with GP practices in some areas with particularly low uptake.

Progress, includes, training local health connectors on immunisations; dispelling the myths; targeting practices with child immunisation waiting lists.; developing a pilot flag system for practices to identify children missing immunisations; and encouraging practices to run more open access immunisation clinics which have been demonstrated to improve access and increase uptake.

## 4.2 SCREENING PROGRAMMES

### 4.2.1
### Antenatal and Newborn Screening

NHS England report to us for the Cambridgeshire and Peterborough areas jointly and data for both areas are included here for this programme.

From Q1 there have been some changes to the Key Performance Indicators (KPIs). The parameters for acceptable/achievable levels have been revised for some KPIs, resulting in some KPIs that may have been previously achieved, now moving to acceptable.

A new KPI FA2 has been introduced; Foetal Anomaly Screening coverage (at 18 to 20 weeks of pregnancy a Foetal Anomaly ultrasound examination is carried out) and is reported on for the first time with all Trusts able to report and achieving the achievable standard.

**Key for following tables**:

| | |
|---|---|
| Cambridge University Hospital Foundation Trust | CUHFT |
| Peterborough and Stamford Hospital Foundation Trust | PSHFT |
| Hinchingbrooke Hospital Trust | HHT |
| Cambridgeshire Community Services | CCS |
| Cambridgeshire and Peterborough Partnership Foundation Trust | CPFT |

**Table 24: Ante-natal screening**

| | | | | 2015-16 | | | | 16/177 | |
|---|---|---|---|---|---|---|---|---|---|
| Indicator | Standard | Achievable | Provider | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 |
| ID1 Antenatal HIV test coverage | >95% | 99% | CUHFT | 97.0 | 97.8 | 96.7 | 98.0 | 97.3 | 99.5 |
| | >95% | 99% | PSHFT | 98.7 | 98.9 | 99.0 | 99.8 | 99.5 | 99.4 |
| | >95% | 99% | HHT | 99.5 | 99.3 | 99.0 | 99.2 | 99.8 | 98.9 |
| ID2 Hep B timely referral for women found to b Hepatitis B positive) | >70% | 99% | CUHFT | 100 | 100 | 83.3 | 33.3 | No case | 100 |
| | >70% | 99% | PSHFT | 66.7 | 85.7 | 100 | 75.0 | 50 | No case |
| | >70% | 99% | HHT | No case | 100 | 100 | No case | No case | 100 |

| | | | | 2015-16 | | | | 16/17 | |
|---|---|---|---|---|---|---|---|---|---|
| Indicator | Standard | Achievable | Provider | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 |
| FA1 completion of lab request form | >97% | 100% | CUHFT | 99.8 | 99.5 | 99.5 | 98.9 | 99.2 | 98.8 |
| | >97% | 100% | PSHFT | 98.0 | 97.6 | 98.4 | 98.7 | 99.6 | 97.3 |
| | >97% | 100% | HHT | 98.9 | 97.6 | 98.6 | 98.7 | 99.1 | 97.7 |
| New | | | | 16/17 | | | | | |

| Indicator | Standard | Achievable | Provider | Q1 | Q2 |
|---|---|---|---|---|---|
| FA2: Fetal anomaly screening (18+0 to 20+6 fetal anomaly ultrasound) – coverage * | >90% | >95% | CUHFT | No data* | 100 |
| | >90% | >95% | PSHFT | No data* | 98.6 |
| | >90% | >95% | HHT | No data* | 99.5 |

*New standard

| | | | | 2015-16 | | | | 2016/17 | |
|---|---|---|---|---|---|---|---|---|---|
| Indicator | Standard | Achievable | Provider | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 |
| ST1 Antenatal sickle cell and thalassaemia screening – coverage | >95% | 99% | CUHFT | 97.3 | 98.0 | 97.6 | 96.9 | 91.4 | 98.5 |
| | >95% | 99% | PSHFT | 96.4 | 95.6 | 96.3 | 99.5 | 99.7 | 97.8 |
| | >95% | 99% | HHT | 98.5 | 98.5 | 98.4 | 99 | 98.9 | 99.0 |
| ST2 Antenatal sickle cell and thalassaemia timeliness of test | >50% | 75% | CUHFT | 29.6 | 31.6 | 32.1 | 30.1 | 31.7 | *43.3 |
| | >50% | 75% | PSHFT | 67.2 | 70.2 | 67.9 | 68 | 69.1 | 65.5 |
| | >50% | 75% | HHT | No data | No data | No data | 29.9 | 49.4 | 52.0 |
| *ST2: women having a haemoglobinopathy screen within the optimum timeframe; remains an issue for Addenbrookes. The screening and immunisation team will continue to closely monitor and a remedial action plan is in place to address. Some improvement is noted. | | | | | | | | | |
| ST3 Antenatal sickle cell and thalassaemia completion of FOQ | >95% | 99% | CUHFT | 89.8 | 80.2 | 96.9 | 77.3 | 76.6 | *90.9 |
| | >95% | 99% | PSHFT | 98.3 | 98.1 | 97.9 | 98.9 | 98.3 | 98.7 |
| | >95% | 99% | HHT | No data | No data | No data | 96.8 | 98.6 | 97.5 |
| *Issues around the reliability of the data for ST3 continue as the Trust has not had a robust mechanism in place to identify Addenbrookes patients from Hinchingbrooke patients. This has been addressed and it is hoped with the circulation of the new single blood form that the laboratory will be able to provide robust data. | | | | | | | | | |

**Table 25: Newborn screening**

| | | | | 2015-16 | | | | 16/17 | |
|---|---|---|---|---|---|---|---|---|---|
| Indicator | Standard | Achievable | Provider | Q1 | Q2 | Q1 | Q4 | Q1 | Q2 |
| NB1 Newborn blood spot screening coverage | >95% | 99.9% | CCS | 98.0 | 98.0 | 98.1 | 99.4 | 98.1 | 98.2 |
| | | | CPFT | 98.5 | 98.5 | 99.7 | 99.7 | 99.6 | *No data |
| *Data has been requested from Child Health Record Department, Peterborough but has not been made available by the provider at the time of writing this report. | | | | | | | | | |
| NB2 Newborn blood spot screening avoidable repeats | <2% | 0.5% | CUHFT | No data | 2.7 | 2.7 | 4.9 | 2.4 | *3.1 |
| | <2% | 0.5% | PSHFT | No data | 1.3 | 2.5 | 3.0 | 1.8 | 1.4 |
| | <2% | 0.5% | HHT | No data | 9.0 | 3.6 | 4.5 | 3.6 | **2.1 |
| *NB2- unnecessary repeat bloodspots remain red. Training has taken place to address issues around technique and individual performance. Although some improvement was evident for Q1; Q2 sees a rise to 3.1. The Trust has action plans in place and are reviewing their automated lancets and SIT continue to monitor through the ANNB Programme board and also via contracting routes to drive quality and improvement<br>**Hinchingbrooke has an action plan in place to address performance on NB2. Excellent progress has been made in the past year and the data for Q2 is just 0.1% above the acceptable level. | | | | | | | | | |
| NB4 Newborn blood spot screening coverage- movers in | >95% | 99.9% | CCS | 80 | 78.6 | 89.5 | 72.7 | 88.2 | *80.1 |
| | | | CPFT | 100 | 90.9 | 93.3 | 93.3 | 82.4 | **No data |

*145/181 movers in were tested within the timeframe. Explanatory commentary has been requested for the 36 babies not tested within the timeframe.
**Data has been requested from Child Health Record Department, Peterborough but has not been made available by the provider at the time of writing this report.

| | | | | 2015-16 | | | | 16/17 | 16/17 |
|---|---|---|---|---|---|---|---|---|---|
| Indicator | Standard | Achievable | Provider | Q1 | Q2 | Q1 | Q4 | Q1 | Q2 |
| NH1 Newborn hearing screening coverage | >97% | 99.5% | CUHFT | | 98.0 | 98.7 | 99.4 | 99.2 | 98.6 |
| | >97% | 99.5% | PSHFT | | 99.8 | 100 | | 99.8 | 99.9 |
| | >97% | 99.5% | HHT | 100 | 100 | 99.8 | 99.5 | 99.7 | 99.2 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| NH2 Newborn hearing screening timely referral for assessment | >90% | 95% | CUHFT | | 78.9 | 72.7 | 94.1 | 77.8 | *93.8 |
| | >90% | 95% | PSHFT | | 100 | 100 | | 100 | 100 |
| | >90% | 95% | HHT | 100 | 100 | 100 | 60 | 100 | No case |

*15/16 babies were seen within the timeframe and all were offered an appointment within the timeframe.

| | | | | 2015-2016 | | | | 16/17 | 16/17 |
|---|---|---|---|---|---|---|---|---|---|
| Indicator | Standard | Achievable | Provider | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 |
| NP1 Newborn and Infant Physical Examination-coverage newborn | >95% | 99.5% | CUHFT | 93.2 | 94.0 | 96.4 | 94.6 | 97.3 | 94.5 |
| | >95% | 99.5% | PSHFT | 100 | 99.6 | 99.8 | 99.9 | 96.9 | 97.4 |
| | >95% | 99.5% | HHT | 95.9 | 95.4 | 93.3 | 92.8 | 99.7 | 96.5 |
| NP2 Newborn and Infant Physical Examination timely assessment | >95% | 100% | CUHFT | 57.1 | 0.0 | 50 | 75 | 100 | *66.7 |
| | >95% | 100% | PSHFT | 100 | 40.0 | 100 | 100 | 33.3 | **50.0 |
| | >95% | 100% | HHT | No Cases | 100 | 0 | 20 | 25 | No Cases |

*3 babies were referred for hip scan and 2 were scanned within the 2 week timeframe.

**2 out of 4 babies referred were seen within the 2 week timeframe and two were seen on day 16.

## Programme Updates

### Newborn hearing

A new national system has been launched and went live on 1st December without any significant issues. A new screener qualification has been launched and this will be a mandatory requirement for all new unregistered staff from April 2017.

### Non Invasive Prenatal Testing

It is likely that the new non- invasive screening test for Downs, Edwards and Patau's syndrome will be commissioned in 2018/19. The highly sensitive screening test will be offered to all women who have a high risk result following the combined test. It is expected that the rates of diagnostic procedures will fall as a result. Further information will be made available as it is released.

### 4.2.2 Cancer Screening programmes - Breast Screening

While uptake of breast screening is satisfactory and had reached a much improved level in quarter 1 of 2016/7, it has now dipped again and no explanation for this dip has been given. We will continue to closely monitor uptake.

**Table 26: Breast screening data**

| % of eligible women who attend for screening (age 50-70) | Minimum standard | Achievable standard | Q1 2015-16 | Q2 | Q3 | Q4 | Q1 2016-17 | Q2 2016-17 |
|---|---|---|---|---|---|---|---|---|
| **Peterborough** | **≥70%** | **>80%** | | | 70.5 | 72.7 | 75.8 | 71.3 |

| % of women first offered appt. within 36 months | Minimum standard | Achievable standard | Q1 2015-16 | Q2 | Q3 | Q4 | Q1 2016-17 | Q2 2016-17 |
|---|---|---|---|---|---|---|---|---|
| Peterborough and Stamford Hospital Foundation Trust | **≥90%** | **100%** | 98.87 | 99.05 | 99.17 | 98.7 | 98.1 | 98.3 |

| % of women who attend for assessment within 3 weeks of attending for screening mammogram | Minimum standard | Achievable standard | Q1 2015-16 | Q2 | Q3 | Q4 | Q1 2016-17 | Q2 2016-17 |
|---|---|---|---|---|---|---|---|---|
| Peterborough and Stamford Hospital Foundation Trust | **90%** | **100%** | 95.24 | 94.38 | 99.26 | 94.74 | 98.4 | 96.3 |

### 4.2.3 Cancer Screening programmes - Cervical Screening

We have been advised by NHSE that actual uptake data for the cervical screening programme is only available annually although process data for the programme are available quarterly – see below. The most recent uptake data for Peterborough shows that 70.7% of women aged 25 – 64 have taken up their invitation to be screened.

**Table 27: Cervical screening data**

| | Achievable 100% | | 2015-16 | | | | 2016-17 | 2016-17 |
|---|---|---|---|---|---|---|---|---|
| Indicator | Standard | provider | Q1 | Q2 | Q1 | Q4 | Q1 | Q2 |
| CS4 14 day TAT. From date of test to anticipated receipt of result letter | 98% | The Pathology Partnership(Newmarket) | 90.4 | 99.47 | 99.79 | 59 | 70.3 | *82 |
| | 98% | Peterborough and Stamford Hospital Foundation Trust | 90.4 | 99.47 | 99.79 | 59 | 85.7 | 100 |

*The Pathology Partnership is working tirelessly to address the 14 day Turn Around Time (TAT) from test to result. The problem is linked to workload and limited workforce to support cytology services. Contractual measures are being used to resolve this issue.

### 4.2.4 Cancer Screening programmes - Bowel Screening

**Table 28: Bowel screening data**

| Peterborough and Hinchingbrooke Screening centre | standard | Q2 15-16 | Q3 15-16 | Q4 15-16 | Q1 16-17 | Q2 16-17 |
|---|---|---|---|---|---|---|
| Uptake | 52% | 57.8% | 55.1% | 58.6% | 59.6% | |
| SSP waiting times | 100% within 14 days | 100% | 100% | 94.4% | 100% | 100% |
| Diagnostic test waiting times | 100% within 14 days | 94.3% | 94.8% | 76.3% | 89.7% | 87.6% |

An additional programme for bowel screening involving a one-off endoscopic examination at age 55 is now up and running.

### 4.2.5 Adult and Young People Screening - Diabetic Eye Screening Programme

Diabetic retinopathy is one of the most common causes of sight loss among people of working age. It occurs when diabetes affects small blood vessels, damaging the part of the eye called the retina. Diabetic retinopathy doesn't usually cause any noticeable symptoms in the early stages. If retinopathy is detected early enough, treatment can stop it getting worse. Otherwise, by the time symptoms become noticeable, it can be much more difficult to treat. This is why the NHS Diabetic Eye Screening Programme was introduced.

**Table 29 : Diabetic Eye Screening**

| **Diabetic Eye Screening- Cambridgeshire and Peterborough CCG through EA DESP** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| KPI DE1 standard 70% uptake (*% screened out of the total offered)* | Q3 (14/15)* | Q4 (14/15) | Q1 (15/16) | Q2 (15/16) | Q3 (15/16) | Q4 (15/16) | Q1 (16/17) | Q2 (16/17) |
| | 79.6% | 79.4% | 78.5% | 77.6% | 78.3% | 77.1% | 85.7% | *No Data |
| KPI DE2 standard 70% results received issued within 3 weeks of screening | Q3 (14/15) | Q4 (14/15) | Q1 (15/16) | Q2 (15/16) | Q3 (15/16) | Q4 (15/16) | Q2 (15/17) | Q2 (16/17) |
| | 99.2% | 98.9% | 99.1% | 99.4% | 99.0% | 99.0% | 99.8% | *No data |
| KPI DE3 standard 80% treatment within 4 weeks and 60% within 2 weeks of a R3 screen positive | 2wks: 94% 4wks: 94% | 2wks: 86% 4wks: 86% | 2wks: 66.7% 4wks: 83.3% | 2wks: 40% 4wks: 80% | 2wks:57.1% 4wks: 85.7% | 2wks:60.3% | 2wks: 4wks: 80% | *No data |

*Q2 yet to be released

### 4.2.6 Adult and Young People Screening - Abdominal Aortic Aneurysm (AAA) Screening annual data

**Table 30**

| AAA | | | |
|---|---|---|---|
| **KPI AA1 standard 90% (acceptable level) and 100% (achievable level) Annual data** | **14/15** | **15/16** | **16/17** |
| | **100%** | **99.9%** | ***No data** |

*Yet to be reported

Note: The data are for the combined Peterborough and Cambridgeshire population

## 5. Healthcare Associated Infection (HCAI) and Antimicrobial Resistance (AMR)

### 5.1 HCAI

During this period national mandatory reporting has remained in place for the organisms identified as MRSA bacteraemia (blood cultures) and Clostridium difficile (faecal samples).

5.1.1 There continues to be a zero tolerance to preventable infections with each individual case being reviewed, firstly using a root cause analysis (RCA) process followed by a scrutiny panel using a post infection review tool. Scrutiny panels bring together a wide range of professionals at each meeting and include Chief Nurses, Consultants, Microbiologists, Senior and junior ward staff, infection control nurses (both from the hospital and the Clinical Commissioning Group (CCG)).

5.1.2 Following national guidance and embedding it into local policies and practice provides evidence that the recognition, management and treatment of patients keeps them safe and prevents transmission to others. It is widely recognised that there are many risk factors which may lead to acquisition of such infections, however the time of this occurring is not able to be identified, but sometimes appropriate treatment for other illness predisposes the onset of symptoms.

5.1.3 Rates of infections have steadied over the past 2 years and are no longer maintaining a downward trend.

5.1.4 Nationally MRSA bacteraemia saw an increase of 2.4% in the number of cases between 2014/15 and 2015/16 but has fallen 81.6% since 2007/8. 2015/16 was the first increase since 2007/8. Assignment of cases is demonstrated in the table below:

**Table 31**

| Assigned | National No. 2015/16 | Local No. 2015/16 | Local No. 2016/17 |
|---|---|---|---|
| CCG | 294 | 1 | 1 |
| Trust | 302 | 1 | 3 |
| Third Party | 223 | 8 | 4 |

5.1.5 At the time of writing there are 2 cases outstanding. Early findings suggest these may both be attributable to Trusts and brings the total number reported in 2016/17 to 11 cases.

5.1.6 NHS Midlands and East (of which we are part) has a notably low rate nationally of cases at 1.1 per 100,000 population.

5.1.7 Performance for 2016/17 would suggest that there has been some deterioration in practice. The main cause for this has been contamination of blood culture samples used to diagnose potential blood stream infection. This is generally a technique error at the time of taking the blood culture sample.

5.1.8 Nationally the incidence of Clostridium difficile has reduced by 0.4% overall but since 2007/8 a reduction of 74.5%. Again the decline is not maintained and is being closely monitored. The number of cases reported by the local Trusts remains at the same level, however scrutiny panels have been able to identify between cases that have been well managed and those where learning needs to be applied. Removing cases from the local trajectory has seen the number removed increase and demonstrates embedding of practice that these could not have been prevented.

5.1.9 Data for 2016/17 is currently not available.

5.1.10 There is an anticipated change for 2017/18 for mandatory reporting of further organisms but it is unclear what that will entail at this time.

5.1.11 In addition to these infections there have been challenges with e.g. respiratory illnesses which have led to some bay and ward closures. Situations were managed well and as always outbreak wash up meetings are held. Norovirus (diarrhoea and vomiting) did find its way into hospitals and community settings but again, through embedding of expectations into practice, have been well managed.

5.2 **Antimicrobial Resistance**

Antimicrobial resistance has been identified as a national and international risk to human health by the Chief Medical Officer, World Health Organisation and the Government as a whole. Antibiotics are widely used with many patients in the UK failing to complete the prescribed course or demanding antibiotics for viral or self-limiting conditions. 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. Each year on European Antibiotic Awareness day in November these problems are highlighted in the media, social media and posters.

5.2.1 Managed by the Medicines Optimisation team, the focus has been on the national process of encouraging self care choices and options in preference to visiting the GP. The CCG is working to the national quality premium, however not meeting the requirements for two specific antibiotics. Prescribing data is provided for GPs each month and all practices see where these are and not just their own data. Some practices are using ScriptSwitch which takes into account the patient's clinical history. There is a countywide stewardship group working with Trusts which follows patients through. The team is hoping to help clinicians by a culture change to avoid prescribing unnecessarily. Social Media is helping to bring about this change.

## 6. Environmental Health

6.1.1 Environmental health consists of Food Safety, Health and Safety and Pollution Control and along with Licensing and Trading Standards is part of Regulatory Services. The purpose of the service is to carry out interventions to check compliance with legal requirements and where appropriate take enforcement action. The service also has a role supporting businesses to help them comply with the law. The work of Regulatory Services helps to keep people healthy and safe, reduces health inequalities and contributes to the national and local economy.

6.1.2 The food safety team carry out food inspections, investigate food complaints and infectious diseases and are responsible for regulating private water supplies. The team also operates the National Food Hygiene Rating scheme which helps consumers choose where to eat or shop for food by providing information about hygiene standards. Currently 84% of food businesses in Peterborough have a rating of 3 or above.

6.1.3 Health and Safety work in recent years has focussed on the implementation of a project to tackle illegal tattooists and the development of a toolkit to address carbon monoxide in food premises due to the indoor use of charcoal cooking equipment without adequate ventilation.

6.1.4 Licensing staff regulate the carrying on of all licensable activities by the appropriate control of licensed premises, temporary events and personal licence holders. Areas of licensing include alcohol, gambling, taxi, animal boarding establishments, riding establishments, pet shops, petroleum sites, tattooists and skin piercing, dangerous animals and adult entertainments.

6.1.5 Trading Standards deal with product safety, animal health and fair trading and credit. Fair trading and credit is extremely wide ranging and covers areas such as estate agency, hallmarking, credit arrangements, pricing, video recordings, trademarks, unfair contract terms, aggressive trade practices, scams and trade descriptions. Issues investigated by the team include rogue doorstep conmen, car clocking, counterfeit goods and illicit alcohol and tobacco sales. Recently the team secured 50K funding in partnership with Public Health England and three other local authorities to tackle illicit tobacco. The Joint Eastern Region Illicit Tobacco Control Project aims to increase the understanding of and raise awareness of illicit tobacco. Roadshows have been carried out with detection dogs to show the public how they find concealments and with experts on hand to offer help to those who wish to quit smoking. The project will provide support visits to businesses, intelligence led surveillance and follow up investigations and will result in seizure operations and prosecutions where necessary.

6.1.6 Pollution control staff are responsible for investigation of a wide range of statutory nuisances, air quality assessments, hoarding and infestations of vermin in domestic and commercial premises and the issuing of permits for industrial processes. The team also consider environmental impacts of building developments and deal with contaminated land through the planning process.

6.1.7 The Pollution Team has a significant input into the development control process, acting as a statutory consultee for planning applications and for the discharge of conditions. The Pollution Team are consulted on approximately 500 development sites each year, recommending conditions and agreeing mitigation measures where noise, contaminated land, air quality and other such environmental issues may be of concern.

6.1.8 Typical applications that are considered and advised upon in the development process are:

- New transport routes and Industrial/Commercial activities proposed in/near residential locations
- Applications for residential development adjacent to noise sources such as industry or road/rail traffic
- Proposed developments on brownfield sites when previous uses may have contaminated soils or produce ground gases with potential health impacts.

- Major developments that may have air quality impacts upon the locality, for example by emissions from associated transport or particulates.

6.1.9 Examples of developments considered in the previous 12 months include:

- The redevelopment of the South Bank and Fletton Quays, considering the impacts of historical land use; road/rail/concert noise implications for residential development; air quality impacts; and relationship between commercial activities and residential premises.
- Developments in Hampton considering road and rail traffic impacts for proposed and existing development, the impact of new traffic routes or increased traffic flows on existing development in terms of noise and air quality; mitigation measures that may be required to protect residential and other developments from any soil contamination or ground gases that may be present; considering any potential impacts upon new schools proposed on brownfield sites adjacent to major traffic routes.
- Residential development proposed adjacent to closed landfill in Stanground, considering potential for migrating ground gases and traffic noise from the Stanground by-pass.
- Johnson Press (Printworks) site, Oundle Road, considering any mitigation required for ground conditions, and noise from adjacent industrial activities that may impact upon the proposed residential development.
- Proposed quarrying activities between Eye and Thorney and potential noise and particulate impacts upon residential premises.
- Consideration of potential noise, odour and air quality impacts associated with a proposed anaerobic digester near Stanground.

**6.2 Air Quality**

6.2.1 Standards, as the benchmarks for setting objectives, are set purely with regard to scientific and medical evidence on the effects of the particular pollutant on health, or, in the appropriate context, on the wider environment, as minimum or zero risk levels. The EU Directive and the National Air Quality Strategy set air quality objectives for pollutants on the basis of scientific and medical evidence on the health effects of each pollutant, and according to practicability of meeting the standards.

6.2.2 For Nitrogen Dioxide (NO2), the principal pollutant when considering combustion engines, the UK Governments set two air quality objectives that reflected standards published by the World Health Organisation and by the Expert Panel on Air Quality Standards (EPAQS) in the UK who last reported on pollutants of national importance in 2002.

- annual mean concentration levels of NO2 do not exceed 40µg/m3 ; and
- hourly mean concentration levels of NO2 do not exceed 200µg/m3 more than 18 times a calendar year.

6.2.3 The Regulations make clear that likely exceedences of the objectives should be assessed in relation to those locations where members of the public are likely to be regularly present, and are likely to be exposed for a period of time appropriate to the averaging period of the objective. Technical Guidance is issued to Local Authorities for them to follow to identify and assess the locations most at risk of exceeding the objective laid down in the air quality strategy.

6.2.4 Peterborough City Council reports to DEFRA on the air quality findings on an annual basis. The most recent air quality report can be found on the Council's website.

https://www.peterborough.gov.uk/upload/www.peterborough.gov.uk/business/environmental-health/AirQualityProgressReport-August2014.pdf?inline=true

No exceedences of the air quality objectives have been measured in 2014, either within or outside the existing Air Quality Management Area (AQMA), although concerns remain regarding roadside locations which are identified in the report.

6.2.5 As is detailed in this report, assessment of new local developments relating to matters such as transportation, industrial installations and fugitive emissions have not identified any potential exceedences outside existing AQMAs. Additionally, no sources are identified as being significantly changed so as to result in such an exceedence.

6.2.6 The existing AQMA relates to a potential exceedance of the 15 minute air quality standard for sulphur dioxide (SO2) identified by modelling of emissions from brickworks near Whittlesey.

6.2.7 The 2015 Updating and Screening Assessment for Peterborough City Council reported that the AQMA in relation to SO2 can be revoked for the following reasons:

6.2.8 There has never been a measured exceedence of the objective;

- The area was declared following modelling without physical monitoring being undertaken;
- Since the modelling was undertaken, one of the two sites operated by Hanson which were the focus of the modelling has closed down.

6.2.9 It was therefore the opinion of Peterborough City Council, following consultation with Fenland District Council, that there is no need to undertake a detailed assessment and that the area can be revoked.

6.2.10 The Updating and Screening Assessment Appraisal Report issued by Defra confirmed this approach in the following statement:

6.2.11 “On the basis of the evidence provided by the local authority, the conclusions reached are considered acceptable for all sources and pollutants. The plan to revoke the AQMA for $SO_2$ is considered acceptable, given the closure of a plant, and the presentation of real monitoring results for the first time, which shows concentrations to be well below the limit values”.

6.2.12 Since the source of the pollution that related to the declaration of an Air Quality Management Area arises in Fenland District Council. Peterborough City Council have approached that Authority with a view to commencing the revocation.

## 7. NATIONAL TUBERCULOSIS STRATEGY

### 7.1 Latent TB Identification Project

The aim of this project is to support the early diagnosis of Latent TB and offer treatment of active disease.

7.2 NHS England and Public Health England jointly published the collaborative tuberculosis strategy on 19 January 2015. NHS England has committed £10 million for the establishment of testing for, and treatment of, latent tuberculosis (TB) in new

entrants from countries of high TB incidence. Public Health England has committed £1.5 million for the establishment of the national TB office and support teams to the nine TB control boards. It is likely that the majority of TB cases in the UK are the result of 'reactivation' of latent TB infection (LTBI), an asymptomatic phase of TB which can last for years. There is a 5% risk of a patient with LTBI developing active TB infection. LTBI can be diagnosed by a single, validated blood test and treated effectively with antibiotics, preventing TB disease in the future.

7.3 Following the publication of the national strategy a review of TB services was undertaken in Cambridgeshire and Peterborough. The key Epidemiological findings are summarised below and provide an overview of the impact of TB on the resident population of the CCG.

- There were 999 cases of TB reported in Cambridgeshire and Peterborough residents between 2004 and 2014. Peterborough had an average of 47 cases/year.
- Almost three quarters (73%) of TB cases between 2004 and 2014 were in non-UK born individuals.
- The most common countries of origin of TB cases in Cambridgeshire & Peterborough in the last three years were UK, India, Pakistan, Lithuania, East Timor and Kenya. PHE recommend screening patients born or who had spent >6 months in high TB incidence country (150 cases per 100,000 or more/Sub-Saharan Africa)

7.4 The eligibility criteria for the service are any new patient registering with a practice or retrospectively identified by the practice as being:

- Born or spent > 6 month in a country of high TB incidence
- Entered the UK within the last 5 years
- Aged 16-35 years
- No history of TB either treated or untreated
- Never screened for TB in the UK

7.5 Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) led this work supported by representatives from

- Peterborough and Stamford Foundation Hospitals (PSHFT)
- 12 Greater Peterborough GP Practices
- 2 Cambridgeshire GP Practices
- Public Health England (PHE)
- Cambridgeshire and Peterborough Foundation Trust
- Peterborough City Council – Public Health and Housing departments

7.6 GP Practices with a high crude rate of TB cases were identified by PHE. Of these, practices with a crude annual rate of active TB ≥ 20 cases/100,000 have been prioritised for the LTBI screening programme.

7.7 The project commenced in March 2016 and to date, 14 practices have signed up to deliver. Using a Local Enhanced Service (LES) and two other practices have also signed up for phase 2 of the project. Training was provided by Oxford Immunotec, the provider for blood sample analysis as part of the screening.

7.8 Practices are expected to identify new patients on registration. PHE have provided the CCG with materials and letters to support the project.

7.9 There is a comprehensive action plan to cover the communication and engagement elements of this project. This aims to:

- Raise awareness of Latent TB and the need for screening
- Get people to visit their GP practice for screening
- Get people to register with a practice if not already
- To dispel myths and beliefs about TB

7.10 Communications work so far has included an article and social media posts targeted at encouraging prospective patients to come forward. These were sent to specific community contacts obtained through partnership working with Peterborough City Council Connectors, as well as posted from the CCG's social media channels.

7.11 News of the project and its progress has also been shared with stakeholders on the CCG Newsletter distribution list, as well as with GP members of the organisation. Press releases were issued in September and December 2016. King's Lynn FM provided radio coverage in October, and the December release was picked up by BBC Radio Cambridgeshire and BBC Look East. Look East's coverage was particularly in depth, focusing on TB as well as Latent TB, and aired in January 2017. Future engagement with prospective patients and the public is planned for later in 2017.

7.12 Practices identify patients and invite them for blood screening. Bloods are taken and sent off for testing. All those with positive results are seen and treated by Secondary Care Services

**Table 32: ACTIVITY TO DATE**

| **Activity** | **Data** |
|---|---|
| Negative | 264 |
| Positives | 38 |
| Borderline negative | 7 |
| Borderline positive | 9 |
| Indeterminate | 5 |
| Non reportable insufficient cells | 1 |
| Assay not run | 1 |
| **Total screened** | **325** |

Table 1: Activity to end of January 2017

7.13 This activity is higher than other pilot areas in the region. There has been a positive response by the Practices to the screening programme and the CCG is receiving positive feedback regarding the activity that is being seen and treated.

7.14 The CCG is intending to roll out to other practices and will continue to work closely with the existing practices to ensure they will identify and screen eligible people.

7.15 The CCG also has an event planned around World TB Day to raise the profile of the project further, at which material will be provided to encourage non registered patients to come forward. In addition Task and Finish group members from Peterborough City council (Housing, Social Care and Public Health) are supporting the CCG to take a targeted approach to underserved populations to ensure they are encouraged to come forward for screening.

7.16 For 2017/18 the CCG will continue to support all the Greater Peterborough Practices, to continue with the Programme due to a higher than average turnover in the

catchment population.

7.17 The CCG will also offer screening to the remaining CCG wide practices to ensure we capture eligible people who also reside in smaller rural areas due to the nature of local employment opportunities.

## 8. SEXUAL HEALTH

According to the Public Health Sexual and Reproductive Health Profiles 2015, Peterborough has a rate of diagnosis of new sexually transmitted infections (STIs) at 745 diagnoses of STIs per 100,000 residents (compared to 815 per 100,000 in England, and 620 in the East of England). There is likely to be an association between the level of socio-economic deprivation in some areas and links to STI rates.

8.1 **Areas prioritised for improvement include:**

- **Rates of HIV late diagnosis**
  Between 2013-2015, 60.5% of HIV diagnoses were made at a late stage of infection, compared to 40.3% in England. This is an increase from 56.8% late HIV diagnoses between 2012 and 2014, compared to 42.2% 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 in 2014, at 30.2 per 1,000 females aged between 15-17 years, 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 from 24.3 per 1,000 in 2013 to 22.8 per 1,000 in 2014.

- **Chlamydia diagnoses**
  In 2015, the rate of chlamydia diagnoses per 100,000 young people aged 15-24 years in Peterborough was 2,499, which is above the England average at 1,887 and the East of England at 1,472. This exceeds the Public Health Outcomes Framework (PHOF) higher target of 2,300 per 100,000, which is considered positive (as we are reaching and treating a high proportion of young people with the infection).

8.2 The integrated contraception and sexual health service (iCaSH) is now in its third year and has demonstrated to date its effectiveness in seeing patients with a 25% increase in activity since 2014/15 with a projected activity increase to 24,000 attendances per year. Further analysis around additional activity is being investigated, however clinicians suggest that this is an equal split for both GUM and contraceptive needs. It continues to meet the majority of the BASHH (British Association for Sexual Health and HIV) standards set and patient feedback is evidence that the service is working well with patient care at the forefront of the service.

8.3 ICaSH have also been responsive with the outreach team and voluntary sector, in dealing with need and trends within Peterborough and putting services in place to address the needs of population groups at higher risk. The current sexual health needs assessment for Peterborough (see para 8.7) will provide further information to ensure that more vulnerable groups are identified and reached appropriately.

8.4 Commissioners, iCaSH and Public Health England attended a local Chlamydia Care Pathway workshop specifically for Peterborough and identified key findings;

- Chlamydia coverage rate for 15-24 year olds 18.5% which is worse than the England Average (2015 data). The percentage of this from the core sexual health services is 65.4% which is below the 70% England Average.
- Percentage of positive chlamydia tests is significantly higher than expected (expected range 5%-12%) at 23.3% for 15-19 years and 18.5% 20-24 years suggesting that Peterborough has a higher than average rate of positivity.
- Detection rate is better than the national recommendation of 2,300 per 100,000 population aged 15-24 at 2,500. England Average 1,887 per 100,000.
- 100% of patients received their results within 10 working days. The BASHH indicator level is 95%.
- Proportion of positive patients that receive treatment within 6 weeks 98%. The BASHH standard is 95%.
- Proportion with agreed PN outcome documented 94% BASHH standard is 97%. Therefore an action for this is for iCaSH to complete a PN audit.
- Proportion of patients that came back for a re-test between 10 weeks and less than 14 weeks (NCSP indicator) 13% National audit data 8%.

8.5 The local Contraceptive and Sexual Health Strategic Group has met on a few occasions, with good attendance from all relevant agencies that are responsible for overseeing and implementing the local Sexual Health Strategy. The strategy continues to focus on 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.

8.6 Peterborough and Cambridgeshire multi agency strategic groups will align in the future and we are waiting for the finalisation of this. This group is currently reported to the PHPC which then reports into the Peterborough Health and Wellbeing Board.

8.7 There is currently a Sexual Health Needs Assessment being produced for Peterborough and therefore there may be further recommendations which come from this.

**9. HEALTH EMERGENCY PLANNING**

9.1 The City Council is 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 Locality Director and the DPH for Cambridgeshire and Peterborough. 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 to validate the plans. 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 HPSG to ensure sharing of cross cutting health sector resilience issues.

- The DPH has been supported in this work by a 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 Midlands and East (East) and has oversight of all health protection issues. The function is supported by the shared Health Emergency Planning and Resilience Officer (HEPRO) based within Public Health. The HEPRO reports into the LHRP and the LRF through the DPH.

- 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.

- The LHRP leads on the annual EPRR assurance process for NHS funded organisations. The aim is to assess the preparedness of the NHS, both commissioners and providers, against common NHS EPRR Core Standards.

- All NHS funded organisations have completed their self-assessment against the EPRR Core Standards for 2016/7. In addition to the general standards, this self-assessment included a deep dive on Business/Service Continuity with an emphasis on fuel. Papworth Hospital NHS FT and Cambridge & Peterborough FT

attained full compliance. Cambridge University Hospitals NHS FT, Hinchingbrooke Healthcare NHS Trust, Peterborough & Stamford Hospitals NHS FT, Cambridge Community Services NHS Trust, Cambridgeshire & Peterborough CCG, 111-Herts UK and NHS England East Locality attained substantial compliance. Work plans where required, are in place and are signed off at board level.

9.4 The LRF and LHRP priorities for this year are planning for pandemic influenza; excess deaths; mass casualty incidents; CBRN incidents; and adverse weather including flooding.

9.5 The LRF held exercises to validate all planning for all upper tier COMAH sites in Cambridgeshire.

**10. Summary**

This report has provided and update on all key areas of health protection for Peterborough including

- Communicable disease surveillance including information on the increased levels of pertussis (whooping cough) and scarlet fever cases in the past two years.
- Immunisations which show a steady state for some and a gradual increase in uptake of many childhood immunisations and of seasonal flu vaccination
- Screening in which there is continued below average uptake of breast, cervical and bowel cancer screening in Peterborough with a recent unexplained dip in breast screening uptake
- Healthcare associated infections and the work to reduce anti-microbial resistance
- The City Council Environmental Health role in protecting health including pollution control and air quality monitoring and advice
- The national TB strategy and successful local implementation of some key areas of the strategy notably Latent TB Infection Screening (LTBI)
- Sexual health including prevention and treatment of sexually transmitted infection and prevention of teenage pregnancy, the key priorities for action and the work to develop a sexual health strategy for Peterborough
- Health emergency planning and the priorities for the coming year.

**Annex 1**

**UK Vaccination programme**

**Age 2 months**

**5-in-1 (DTaP/IPV/Hib) vaccine** – this single jab contains vaccines to protect against five separate diseases: diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b (Hib, a bacterial infection that can cause severe pneumonia or meningitis in young children)

**Pneumococcal (PCV) vaccine** – pneumococcus can cause various infections including pneumonia

**Rotavirus vaccine** - Rotavirus is a highly infectious stomach bug that typically strikes babies and young children. This is an oral vaccine

**Men B vaccine** – Meningococcus B is responsible for approximately 90% of meningitis in young children

**Age 3 months**

**5-in-1 (DTaP/IPV/Hib) vaccine** - second dose

**Rotavirus vaccine -** second dose

**Age 4 months**

**5-in-1 (DTaP/IPV/Hib) vaccine** - third dose

**Pneumococcal (PCV) vaccine** - second dose

**Men B vaccine** – second dose

**Between 12 and 13 months**

**Hib/Men C booster -** given as a single jab containing meningococcus C ( another cause of meningitis) and Hib (fourth dose)

**Measles, mumps and rubella (MMR) vaccine -** given as a single jab. Measles, mumps and rubella are highly infectious conditions that can have serious, and potentially fatal, complications, including meningitis, swelling of the brain (encephalitis) and deafness. They can also lead to complications in pregnancy that affect the unborn baby, and can lead to miscarriage

**Pneumococcal (PCV) vaccine** - third dose

**Men B vaccine** – third dose

**Age 2 to 7 years including school years 1, 2 and 3**

**Seasonal influenza (Flu) vaccine - given as a nasal spray and needs to be given** annually – this programme is being gradually extended to include all children up to age 16 years.

**3 years and 4 months, or soon after**

**Measles, mumps and rubella (MMR) vaccine**, second dose

**4-in-1 (DTaP/IPV) pre-school booster -** given as a single jab containing vaccines against diphtheria, tetanus, whooping cough (pertussis) and polio

**Around 12-13 years**

**HPV vaccine,** which protects against the Human Papilloma Virus which causes cervical cancer, it is given to girls only – two jabs are given 6 – 12 months apart

**Age 14 years**

**3-in-1 (Td/IPV) teenage booster** - given as a single jab which contains vaccines against diphtheria, tetanus and polio

**Men ACWY** – School children aged 14 (year 9) are now offered this vaccination routinely and students going to university or college for the first time, including overseas and mature students up to the age of 25, are advised to contact their GP to have the Men ACWY vaccine, ideally before the start of or in the first few weeks of the academic year. Cases of meningitis and septicaemia (blood poisoning) caused by Men W bacteria are rising, due to a particularly deadly strain. The highest risk of meningitis is in the first year of university, particularly the first few months.

**65 and over**

**Flu** (every year)

Pneumococcal (PPV) vaccine

**70 years**

**Shingles vaccine** (from September 2013)

**Vaccines for special groups**

There are some vaccines that aren't routinely available to everyone on the NHS but which are available for people who fall into certain risk groups, such as pregnant women, people with long term health conditions and healthcare workers. These extra vaccines include **hepatitis B vaccination, TB vaccination and chickenpox vaccination**.

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| HEALTH AND WELLBEING BOARD | | AGENDA ITEM No. 8 |
|---|---|---|
| **23 MARCH 2017** | | PUBLIC REPORT |
| Contact Officer(s): | Wendi Ogle-Welbourn, Corporate Director, People and Communities | Tel. 863749 |

## PETERBOROUGH CITY COUNCIL COMMISSIONING INTENTIONS 2017/18

| RECOMMENDATIONS | |
|---|---|
| **FROM :** Wendi Ogle-Welbourn, Corporate Director, People and Communities | **Deadline date :** |
| The Health and Wellbeing Board is asked to note the commissioning intentions for Peterborough City Council for 2017/18 and to comment on the issues raised. | |

### 1. ORIGIN OF REPORT

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

### 2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to brief the Board on the current position relating to the commissioning planning for the financial year 2017/18. The Board is requested to note the content of this report and to discuss the issues raised. The Board's views will be taken into account throughout the operational planning process.

2.2 This report is for Board to consider under its Terms of Reference No. *3.5 To consider options and opportunities for the joint commissioning of health and social care services for children, families and adults in Peterborough to meet identified needs (based on the findings of the Joint Strategic Needs Assessment) and to consider any relevant plans and strategies regarding joint commissioning of health and social care services for children and adults.*

### 2 BACKGROUND

3.1 Peterborough City Council has the highest aspirations for its citizens and wants them to be safe, healthy, happy and fulfilled. We want them to enjoy and benefit from educational, training and social opportunities that maximise their skills and develop their abilities so that they can realise their ambitions in terms of employment opportunities and general life chances.

3.2 We will continue to develop preventative approaches and early interventions to help and support communities, coordinating the support of the voluntary, private, independent and public sectors and ensuring that delivery of services is joined up. We will collaborate with people and communities to maximise their potential for independence, helping them find their own solutions so that problems and difficulties do not escalate. Where additional support is required we will engage with other agencies and organisations to commission or deliver and secure this support. We will adopt an approach that sees prevention and intervention as a continuum so that it is never deemed too late to positively intervene and prevent the deterioration in an individual's circumstances.

3.3 Our commissioning intentions are focussed on helping people to maximise their potential for independence. The emphasis is on empowering people to take more control over their lives through promoting their independence. This means we will continue to develop a model for Peterborough to ensure people can access the right services, at the right time, delivered by the right people, at the right cost, for the right amount of time. This means providing support to enable people to help themselves and providing help when needed, but for time limited interventions. Where services are needed for a longer term we will commission services that enable people to live in their homes for longer and bringing partners, communities and families together to wrap services around people who need longer care and support.

3.4 This preventative approach is essential, but will not on its own deliver the outcomes that we need for Peterborough. It is therefore an our intention to continue that we establish demand management at the core of what we do, we need to ensure that people are able to access support when they are assessed as needing it, but we want to ensure that people are aware of support at a community/neighbourhood level that can be accessed without needing to enter the social care system; clearly, information, advice and guidance will feature very strongly in our intentions for the coming year.

## 4. COMMISSIONING PRINCIPLES

4.1 Our commissioning approach underpins everything we do. Commissioning involves meeting needs, planning, paying for and monitoring services which are delivered by the local authority, partners or external providers. We will continue to work collaboratively with people, to ensure the their voice shapes our commissioning decisions and future services and to ensure services are co-produced, delivered to a high quality, sustainable and efficient. As commissioners we work across local authority services to ensure we deliver quality services that meet people's needs. We also work closely and in partnership with the health system, district authorities and the voluntary sector to jointly commission services where appropriate.

4.2 To drive this approach, Peterborough have developed the following commissioning principles that guide decision making:-

- **Demand management** - we will prioritise the commissioning of services and solutions that will prevent or delay escalating support and service needs;
- **Efficient and effective** - we will take an evidence based approach to commissioning services and solutions that demonstrate efficient and effective use of resources. Services and solutions will be commissioned on the basis of best value;
- **Return on investment** - We will commission on the basis of a clear, whole-life costed benefits realisation for service users, PCC and other stakeholders. This will include analysis of the value of social and environmental outcomes of commissioning activities as well as financial outcomes;
- **Market Development** - We will work with providers and partners to ensure that commissioning activity across health and social care is coordinated and best value and outcomes are delivered;
- **Statutory duties** - We will ensure PCC complies with its legal duties within the statutory legislative and policy framework;
- **Policy** - Commissioning activity will take account of and be sensitive to national and local policy drivers; and
- **Collaborative commissioning** - We will work to commission services and co-produce solutions with service users and strategic partners where this best delivers PCC outcomes and objectives.

## 5 COMMISSIONING DRIVERS

5.1 Legislative changes are fundamental drivers for change, the most significant is the Care Act, the key changes which we have had to consider are:

- A new emphasis on wellbeing - The new statutory principle of individual wellbeing underpins the Act, and is the driving force behind care and support.

- Prevention - Local authorities (and their partners in health, housing, welfare and employment services) must now take steps to prevent, reduce or delay the need for care and support for all local people.

- Integration - The Act includes a statutory requirement for local authorities to collaborate, cooperate and integrate with other public authorities

- Information, advice and guidance - The Act places a duty on local authorities to ensure that information and advice on care and support is available to all and when they need it

- There must be diversity and quality in the market of care providers so that there are enough high-quality services for people to choose from

5.2 The Medium Term Financial Plan frames the commissioning approach as it sets the resource envelope in which commissioners need to operate and deliver services for the people of Peterborough.

## 6. ANTICIPATED OUTCOMES

The Board is asked to note the content of the Commissioning Intentions for 2017/18.

## 7. REASONS FOR RECOMMENDATIONS

Commissioning Intentions are an important aspect of planning for providers for both providers and commissioners, the Intentions are coupled with the Market Position Statement which articulates in some detail the demographic changes and the associated impacts, along with areas of focus. This allows organisations to focus on business planning, but it also gives a clear reference point for the commissioning priorities for the coming year.

## 8. BACKGROUND DOCUMENTS

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

8.1 Appendix 1 – Commissioning Intentions

Appendix 1

**COMMISSIONING INTENTIONS**

- People are safe
- People are independent
- People are cared for
- People are healthy
- People are listened to
- People can access the right services, delivered in the right way, at the right time through a well developed market

**People are safe**

We will:

- Review and refresh the placement and sufficiency strategies for children looked after to ensure there are sufficient services in place to provide care for children who need it.

- Recommission domestic abuse services focussing on empowering men women and children disaffected by domestic violence.

- Develop our Community Safety Partnerships across the county ensuring people have access to services which help keep them safe including substance misuse, domestic abuse and sexual health services.

- Review and recommission substance misuse services focussing on an integrated model of care that supports people with polysubstance misuse issues

**People are independent**

We will:

- Improve our approach to information, advice and signposting tailored to the needs of Peterborough and Cambridgeshire residents to enable them to make informed decisions about self help, access to local resources and more formal forms of support.

- Review and redesign our approach to the use of assistive technology,focussing on enabling people to remain in the homes for longer delaying the need for specialist residential services. We will also continue to provide advice and guidance to care providers to ensure technology is being adopted in the most efficient cost effective way.

- Develop an environment for carers to receive support on a peer to peer basis empowering carers to shape their own means of representation, support and services and opportunities. We want carers to be acknowledged as experts by experience and recognise the role they undertake.

- Review support services for people using direct payments and personal budgets including personal health budgets.

- Further establish the Home Services Delivery Model by supporting an integrated short term intervention service that avoids admissions to acute setting or more specialist services, alternatively supporting discharges from the acute in a cost effective and reabling way through the provision short term support such as enhancing the re-ablement service, increased access to assistive technology, therapy services and care and repair.

- Review and re-commission the homecare framework using an outcomes based approach and one that rewards and incentivise the market to develop much needed high quality capacity.

- Redesign day opportunities to enable greater choice and flexibility to access a spectrum of services that support people to live full and active lives.

- Review our approach to personal assistance so that people have greater choice about what, where and how they are supported to access services.

- Redesign and commission the voluntary sector with the aim of providing lower levels of support that builds capacity and capability at a local level so that people can maintain their independence in their own home with support wrapped around them.

**People are cared for**

We will:

- Establish partnership arrangements with TACT as the new provider of our Permanency service to positively transform adoption and fostering services.

- Commission residential care services on a block purchase basis ensure there is capacity in high quality services.

- Review the existing model for Extra Care and Supported Living services and respond to the impact of the anticipated Green Paper on Local Housing Allowance ensuring there is suitable capacity and quality in the market.

- Work with and support early years and childcare providers to ensure the availability of high quality places for eligible 2 year olds, including children with SEND.

- Review 0-25 services focussing on people the best use of resources to demonstrate a sustainable service which represents value for money.

**People are healthy**

We will:

- Jointly commission with health a 0-19 service for child health, adopting the i-thrive framework to empower families, parents and carers in accessing appropriate services for their children.

- With health, review our pathway to ensure children and young people have improved access to speech and language services as part of our early intervention pathway.

- Commission a counselling service with health for children and young people that provides a consistent model of across the city and county in line with the i-thrive framework providing a fair and equal offer of support for vulnerable children and young people. .

- Implement the falls prevention strategy to reduce the number of admissions to acute settings.

- Develop the recently commissioned healthy lifestyle service promoting improved health and wellbeing for people.

**People are listened to**
We will:

- Embed co-production as the starting point for all commissioned services including those that are; reviewed, redesigned and/or retendered.

- Support the development of Partnership Boards ensuring the voice of children, young people and adults are equitable and central to decision making.

**People can access the right services, at the right time….**
We will

- Review the option of an emarket platform for the commissioning of care services.

- Review and develop our approach to self funders, seeking to improve our relationship and support to broker services on behalf of self funders.

- Jointly commissioning services with the CCG to prevent duplication and benefit from the synergies of commissioning services.

- Work with the market to ensure care providers are able to flexibly respond the needs of vulnerable people and support people to have choice and control over their own care.

- Continue with our existing charging policy for adult social care ensuring our policies are clear and easily understood.

- Roll out the Quality improvement service within Adult Social Care to ensure people are cared for in a quality environment.

| HEALTH AND WELLBEING BOARD | | AGENDA ITEM No. 9 |
|---|---|---|
| **23 MARCH 2017** | | PUBLIC REPORT |
| Contact Officer(s): | Joanne Procter | Tel. 01733 863765 |

## PETERBOROUGH INTER BOARD PROTOCOL

| RECOMMENDATIONS | |
|---|---|
| **FROM : Peterborough Safeguarding Children Board** | **Deadline date :** N/A |
| The Health and Wellbeing Board to consider and endorse the Inter Board Protocol | |

### 1. ORIGIN OF REPORT

1.1 This report is submitted to the Board from Peterborough Safeguarding Children Board and Peterborough Safeguarding Adult Board.

### 2. PURPOSE AND REASON FOR REPORT

2.1 The protocol has been developed so that the relationship between the four statutory boards (Peterborough Safeguarding Children Board, Peterborough Safeguarding Adults Board, Safer Peterborough Partnership, Health and Wellbeing Board) is formalised. The protocol stipulates a clear governance arrangement, how the four Boards will agree their joint priorities, sets out a process for the Boards to report on progress and allows for formal challenge.

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

### 3. PETERBOROUGH INTER BOARD PROTOCOL

The protocol is attached as Appendix One.

### 4. CONSULTATION

4.1 The Protocol is between the four statutory boards. The protocol was considered and agreed at the Peterborough Safeguarding Adults Board and the Peterborough Safeguarding Children Board on 11th January 2017 and was considered and agreed at the Safer Peterborough Partnership on the 25th January 2017. The Protocol is being brought to the Health and Wellbeing Board for final sign off.

### 5. ANTICIPATED OUTCOMES

If the Protocol is signed off by the Health and Wellbeing Board it will result in a formalised relationship between the Statutory Boards. It will put in place a formalised reporting structure which allows for enhanced scrutiny and limits duplication/ gaps in the work undertaken by the Boards.

## 6. REASONS FOR RECOMMENDATIONS

At present there is a protocol in place between the Peterborough Safeguarding Children Board and the Health and Well Being Board but there is not a formal protocol in place between the four statutory boards.

### *ALTERNATIVE OPTIONS CONSIDERED*

It is considered good practice for a protocol to be in place between the Statutory Boards. To date the protocol only addresses the relationship between the Health and Wellbeing Board and the Peterborough Safeguarding Children Board.

## 7. IMPLICATIONS

If the Protocol is agreed and implemented it will enhance the relationships between the four statutory Boards and will provide a clear governance and reporting structure.

## 8. BACKGROUND DOCUMENTS

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

Protocol between the Peterborough Health and Wellbeing Board and the Peterborough Safeguarding Children Board

# Peterborough Inter-Board Protocol

## The relationship between:

- **Peterborough Health & Wellbeing Board**
- **Safer Peterborough Partnership**
- **Peterborough Safeguarding Children Board**
- **Peterborough Safeguarding Adults Board**

**December 2016**

| Name | Organisation/Designation | Signature |
|---|---|---|
| Dr Russell Wate QPM | Chair of Peterborough Safeguarding Children Board and Peterborough Safeguarding Adults Board | |
| Claire Higgins | Chair of Safer Peterborough Partnership | |
| Cllr John Holdich OBE | Chair of Peterborough Health and Wellbeing Board | |

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# 1. Introduction

1.1 The aim of this protocol is to define how the Peterborough Health and Wellbeing Board (HWB) and the Safer Peterborough Partnership (SPP) work together with the Peterborough Safeguarding Children Board (PSCB) and the Peterborough Safeguarding Adults Board (PSAB) in the pursuit of safeguarding and promoting the health and wellbeing of children, young people and adults in need of help and protection.

1.2 This protocol sets out the principles underpinning how the four Boards work across their defined remits, the specific function of each Board, how communication and engagement will be secured across the Boards and the practical means by which effective co-ordination and coherence between the Boards will be secured. The protocol also refers to the interface with other partnership forums in Peterborough.

1.3 The role of the PSCB and PSAB in relation to the PHWB and the SPP is one of equal partners underpinned by this protocol.

# 2. Principles

2.1 This protocol does not seek to dilute the discrete responsibilities of each Board. Its focus is on ensuring that the following simple principles underpin how the four Boards will operate.

- Safeguarding is the responsibility of all Boards
- The Boards will know each other's business
- A culture of scrutiny and challenge will exist across the Boards
- The Boards will work together collaboratively to avoid duplication and ensure consistency

# 3. Board Functions

## 3.1 The Peterborough Health and Wellbeing Board

3.2 Health and Wellbeing Boards were established by the Health and Social Care Act 2012. They are a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities.

3.3 Board members collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined up way. As a result, patients and the public should experience more joined-up services from the NHS and local councils.

## 3.4 The Safer Peterborough Partnership

3.5 Community Safety Partnerships are an important feature of the network of partnerships that help to tackle crime and reduce reoffending and were set up under Sections 5-7 of the Crime & Disorder Act 1998. Community Safety Partnerships are made up of representatives from the police, local authorities, fire and rescue authorities, probation service, prison, health and other agencies with a tangible stake in the community.

3.6 The SPP ensures agencies work together to protect their local communities from crime and to help people feel safer. They decide how to deal with local issues like antisocial behaviour, drug or alcohol misuse and re-offending. The SPP annually assesses local crime priorities and consults partners and the local community about how to deal with them.

### 3.7 The Peterborough Safeguarding Children Board

3.8 The PSCB is a key statutory body that was put in place under the Children Act 2004. It is responsible for agreeing how organisations co-operate to safeguard and promote the welfare of children and young people in Peterborough, and for ensuring the effectiveness of what they do.

3.9 The PSCB is made up of a Board with senior representatives from its member agencies and various sub-committees which undertake the Board's business.

### 3.10 The Peterborough Safeguarding Adults Board

3.11 The PSAB is a multi-agency partnership which has statutory functions under the Care Act 2014. The main objective of the board is to assure itself that local safeguarding arrangements and partners act to safeguard adults at risk of abuse in the local area.

## 4. Communication and Engagement

4.1 Under section 11 of the Children Act 2004 all agencies have a responsibility for safeguarding.

4.2 As such, all key strategic plans whether they be formulated by individual agencies or by partnership forums should include safeguarding as a cross-cutting theme. This is to ensure that existing strategies and service delivery as well as any emerging plans for change and improvement include effective safeguarding arrangements that ensure that all people in Peterborough are safe and their wellbeing is protected.

4.3 **The Health and Wellbeing Strategy** for Peterborough is a key commissioning strategy for the delivery of services to children and adults.

4.4 The Safer Peterborough Partnership produces an annual strategic assessment of community safety to inform the **SPP Strategy.** This document allows the SPP to make informed decisions about partnership priorities and target setting based on need and trends.

4.5 It is critical that in drawing up, delivering and evaluating both strategies there is effective interchange between the HWB and the SPP and the two Safeguarding Boards.

4.6 Specifically there need to be formal interfaces with the Safeguarding Boards at key points including:

- The needs analyses that drives the formulation of the annual Health and Wellbeing Strategy, the SPP Strategy and the Safeguarding Boards' Business Plans. This needs to be reciprocal in nature ensuring that the Safeguarding Boards' needs analyses are fed into the Joint Strategic Needs Assessment (JSNA) and strategic assessment for the SPP and that the outcomes of the JSNA and SPP strategic assessment are fed back into Safeguarding Boards' planning;

- Ensuring each Board is regularly updated on progress made in the implementation of the Health and Wellbeing Strategy, the SPP Strategy and the individual Board business plans in a context of mutual scrutiny and challenge;

- Annually reporting evaluations of performance on plans to provide the opportunity for reciprocal scrutiny and challenge and to enable all Boards to feed any improvement and development needs into the planning process for future years' strategies and plans.

4.7 The opportunities presented by a formal working relationship between the PHWB, the SPP, the PSCB and the PSAB can be summarised as follows:

- Securing an integrated approach to the JSNA and SPP strategic analysis, ensuring comprehensive safeguarding data is included in both (consistent with the statutory guidance contained within *Working Together 2015*)

- Agreeing cross cutting priorities that are applicable to all four boards, including overall accountability and the resultant actions for the four boards.

- Aligning the work of the PSCB and PSAB business plans with the HWB Strategy, and SPP Strategy and related priority setting.

- Ensuring safeguarding is everyone's responsibility, reflected in the public health agenda and related determinant of health strategies; together with community safety priorities and the short, medium and long term objectives of the SPP.

- Evaluating the impact of the HWB Strategy and SPP Strategy on safeguarding outcomes, and of safeguarding on wider determinants of health and community safety outcomes.

- Identifying a coordinated approach to communication, learning and improvement, performance management, change and commissioning

- Cross Board scrutiny and challenge and ''holding to account'': the HWB and SPP for embedding safeguarding, and the Safeguarding Boards for overall performance and contribution to the HWB and SPP Strategies.

## 5. Practical Arrangements to Secure Co-ordination

5.1 The following arrangements detail the effective co-ordination and coherence in the work of the three Boards.

5.2 **Bi-Annually,** the chairs of the 4 Boards will meet to ensure the coordination of leadership, the coherence of respective plans and to consider the strategic risks facing children, young people, families, adults and communities. These meetings will take place in April/May and September/October.

5.3 **Between September and December** each year, the Independent Chair of the two Safeguarding Boards will present to the Health & Wellbeing Board and the Safer Peterborough Partnership their Annual Reports outlining performance against the Business Plan objectives in the previous financial year.

5.4 This will be supplemented by a position statement on the Boards' performance in the current financial year.

5.5 This will provide the opportunity for the Health and Wellbeing Board and the Safer Peterborough Partnership Board to scrutinise and challenge the performance of the Boards, to draw across data to be included in the JSNA and SPP strategic analysis and to reflect on key issues that may need to be incorporated in the refresh of the Health and Wellbeing Strategy and the SPP Strategy.

5.6 **Between October and February**, the Peterborough Health & Wellbeing Board and the Safer Peterborough Partnership Board will present to the Safeguarding Boards the review of their respective strategies including the refreshed JSNA and SPP analysis and the proposed priorities and objectives for each.

5.7 This will enable the Safeguarding Boards to scrutinise and challenge performance and to ensure that the refreshed Safeguarding business plans appropriately reflect relevant priorities set by the HWB and the SPP.

5.8 **In April / May** the Boards will share their refreshed plans for the coming financial year to ensure co-ordination and coherence.

5.9 In addition to the scheduled interface across all four Boards, it is expected that relevant learning arising from reviews is shared; and opportunities for coordinating consultations, communications and engagement are fully utilised.

## 6. Relationships between the Safeguarding Boards

6.1 There should be equally effective co-ordination and coherence between the two safeguarding boards. This will be achieved in part by the arrangements set out above but it is critical that there are processes in place to ensure effective cross-working, scrutiny and challenge. This will be achieved in five ways:

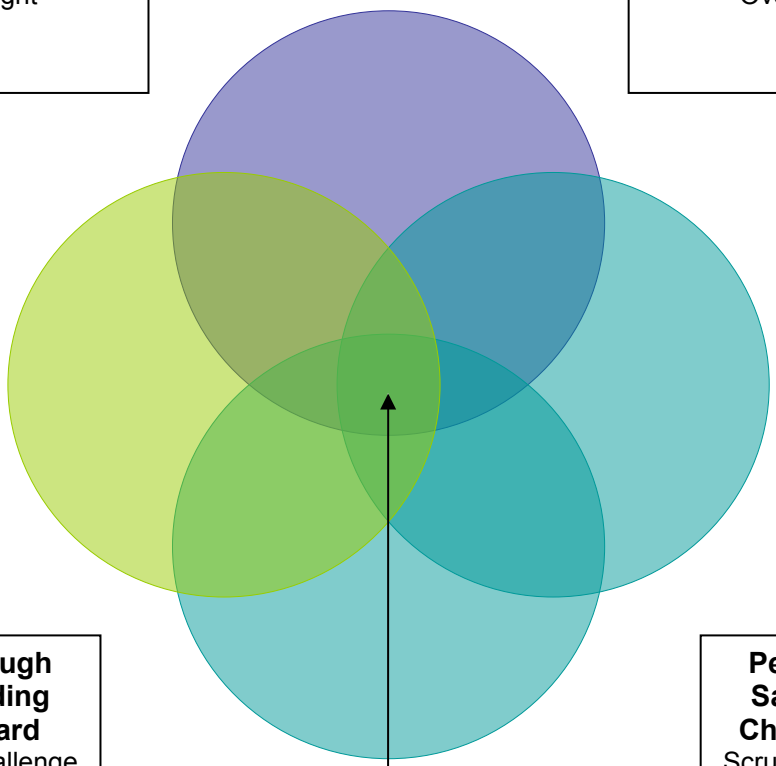
- The PSCB and PSAB are Chaired by the same person
- There is an integrated business unit that supports both the PSCB and PSAB
- Sharing annual plans during the formulation stages to enable co-ordination and coherence where there are overlaps in business.
- Agreeing the cross cutting priorities that are applicable to all four boards, including overall accountability and the actions for the four boards.

- Ensuring that there is cross-Board representation to secure on-going communication.

## Appendix 1: The Four Boards

**Peterborough Health & Wellbeing Board**
Strategic Vision / Direction / Objectives / Outcome Setting and Oversight

**Safer Peterborough Partnership**
Strategic Vision / Direction / Objectives / Outcome Setting and Oversight



**Peterborough Safeguarding Adult Board**
Scrutiny & challenge / oversight of practice, protection and safeguarding adult outcomes

**Peterborough Safeguarding Children Board**
Scrutiny & challenge / oversight of practice, protection and safeguarding children outcomes

**Shared Safeguarding Priorities**
**Strategic Risks**
**Shared Learning – lessons from reviews**
**Shared Consultation**
**Joint Communication & Engagement**

## Appendix 2: Board Responsibilities and Functions

## What the Peterborough Health and Wellbeing Board does

The Health and Wellbeing Board aims to improve the health and wellbeing of local people and tackle health inequalities by:

- identifying local health needs and priorities, and making sure commissioning plans reflect the findings of our analysis of local health needs, the Joint Strategic Needs Assessment (JSNA).
- preparing and publishing a Joint Health and Wellbeing Strategy based upon the needs identified within the JSNA. It will help us plan the delivery of integrated local services by addressing the underlying factors of health and wellbeing.
- encouraging agencies to collaborate
- communicating and engaging with the public and other stakeholders about how to achieve the best possible quality of life

Health and Wellbeing Boards have strategic influence over commissioning decisions across health, public health and social care through the development of a Health and Wellbeing strategy.

Boards are intended to strengthen democratic legitimacy by involving democratically elected representatives and patient representatives in commissioning decisions alongside commissioners across health and social care. The boards also provide a forum for challenge, discussion, and the involvement of local people.

Boards will bring together clinical commissioning groups and councils to develop a shared understanding of the health and wellbeing needs of the community.

They will undertake the Joint Strategic Needs Assessment (JSNA) and develop a joint strategy for how these needs can be best addressed. This will include recommendations for joint commissioning and integrating services across health and care.

Through undertaking the JSNA, the board will drive local commissioning of health care, social care and public health and create a more effective and responsive local health and care system. Other services that impact on health and wellbeing such as safeguarding, housing and education provision will also be addressed.

## What the Safer Peterborough Partnership does

The Safer Peterborough Partnership is accountable for the following key statutory responsibilities:

- the organisation of a strategy group to be made up of senior representatives from the responsible authorities with the objective of achieving a co-ordinated and focused approach to dealing with crime, disorder and community safety
- to prepare, implement and performance manage an evidence-led annual strategic assessment and three-yearly partnership plan that aims to reduce crime and disorder in the area
- to consult the community on the levels and patterns of crime, disorder and substance misuse and thus be informed on matters that need to be prioritised by the partnership
- to reduce re-offending
- to coordinate domestic homicide reviews
- to share information among the responsible authorities within the SPP
- to assess the value for money of partnership activities.

## What the Peterborough Safeguarding Children Board does

The key objectives of the PSCB, as set out in the statutory guidance, 'Working Together to Safeguard Children' 2015, are:

- To co-ordinate local work to safeguard and promote the wellbeing of children;
- To ensure the effectiveness of that work

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out that the functions of the LSCB, in relation to the above objectives under section 14 of the Children Act 2004, are as follows:

1(a) developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:

(i) the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;
(ii) training of persons who work with children or in services affecting the safety and welfare of children;
(iii) recruitment and supervision of persons who work with children;
(iv) investigation of allegations concerning persons who work with children;
(v) safety and welfare of children who are privately fostered;
(vi) cooperation with neighbouring children's services authorities and their Board partners;

(b) communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;

(c) monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;

(d) participating in the planning of services for children in the area of the authority; and

(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

Regulation 5 (3) provides that an LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its objectives.

## What the Peterborough Safeguarding Adult Board does

The PSAB has three main duties under the Care Act:

It must publish a strategic plan for each financial year that sets how it will meet its main objective and what the members will do to achieve this. The plan must be developed with local community involvement, and the SAB must consult the local Healthwatch organisation. The plan should be evidence-based and make use of all available evidence and intelligence from partners to form and develop its plan.

It must publish an annual report detailing what the PSAB has done during the year to achieve its main objective and implement its strategic plan, and what each member has done to implement the strategy as well as detailing the findings of any safeguarding adults reviews and subsequent action.

It must conduct any safeguarding adults review in accordance with Section 44 of the Act. In order to meet these objectives the board acts as follows:

- agrees and reviews multi-agency Peterborough safeguarding adults policy and procedures for protecting vulnerable adults, taking into account statutory requirements, national guidance and regional policies
- maintains an annual business plan, setting priorities for preventing and addressing abuse of vulnerable adults, and produces and disseminates an annual report
- monitors incidents of abuse and neglect, reviews trends and acts where appropriate to improve services and support to vulnerable adults
- regularly evaluates how agencies and providers safeguard vulnerable adults, by introducing rigorous quality assurance and scrutiny systems across partner agencies
- agrees a serious case review protocol and reviews and learns from situations where safeguarding arrangements may have been inadequate
- maintains a programme of training and development on safeguarding vulnerable adults for staff across agencies in the statutory, independent provider and voluntary sectors
- develops and promotes arrangements for adults at risk and carers to be well-informed about safeguarding arrangements and provide opportunities for service users and carers to influence and feedback on their effectiveness
- promotes public awareness of safeguarding as an issue for all citizens and engage the wider community in helping to prevent abuse and neglect and to report where they have concerns

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| HEALTH AND WELLBEING BOARD | | AGENDA ITEM No. 10 |
|---|---|---|
| **23 MARCH 2017** | | PUBLIC REPORT |
| Contact Officer(s): | Emma Wakelin, Health Education England | Tel. 01223 597 794 |

## CAMBRIDGE AND PETERBOROUGH INTEGRATED WORKFORCE STRATEGY

| RECOMMENDATIONS | |
|---|---|
| **FROM :** Cambridge and Peterborough Sustainable Transformation Programme | **Date :** 23rd March 2017 |
| The Health and Wellbeing Board are asked to:<br><br>1. Review the Cambridge and Peterborough Integrated Workforce Strategy;<br>2. Provide feedback on its core Ambitions: improving supply, improving retention, new role development, setting up new ways of working and up-skilling, and leadership development<br>3. Consider how the Board can further support the implementation of this system strategy | |

### 1. ORIGIN OF REPORT

1.1 This report is submitted to the Board from Cambridge and Peterborough Sustainable Transformation Programme (STP), led by the Workforce Committee (Local Workforce Action Board) in conjunction with Health Education England and health and care providers across Cambridge and Peterborough.

### 2. CONTEXT AND PURPOSE

2.1 Improving the shape and size of our current and future workforce is crucial to closing the gap in relation to health and wellbeing, care and quality, and finance and efficiency. Across the local health and care system there are the following challenges; high vacancy levels, skills gaps across all professional groups, difficulty moving staff and resources across traditional organisational boundaries to address workforce needs.

2.2 In order to deliver the new models of care being described by the STP, a new vision for the local workforce is required. This strategy sets out the following:

- National and local workforce context setting out a case for change.
- The emerging national workforce priorities for health and care staff, up to 2020.
- An overview of the local health and care workforce
- A series of workforce ambitions for the system

2.3 Members of the Committee are asked to review Cambridge and Peterborough Integrated Workforce Strategy and provide feedback on its core Ambitions: improving supply, improving retention, new role development, setting up new ways of working and up-skilling, and leadership development. As well as consider how the Board can further support the implementation of this system strategy.

2.4 This report is for Board to consider under its Terms of Reference No. 3.9

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

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

## 3. CONSULTATION

3.1 The Cambridge and Peterborough Integrated Workforce Strategy has been reviewed and agreed by the following:

- STP Workforce Committee (Local Workforce Action Board) 8th December 2017
- Health and Wellbeing Board Cambridge 19th January 2017
- Health and Wellbeing Board Peterborough - TBC

3.2 Once reviewed by the above committees, the Strategy will be shared with the Health Care Executive for the STP (CEO forum) for formal sign off.

## 4. OUTCOMES AND NEXT STEPS

It is anticipated the Strategy will provide a joined up vision for the health and care workforce across Cambridge and Peterborough, of which all employers will be signed up to. Following sign off of the Strategy a revised Workforce Delivery Plan will then be created to ensure ambitions are translated into specific actions for each of the New Models of Care being developed by the STP. This will then be governed by the Workforce Committee (Local Workforce Action Board) within the STP.

## 5. BACKGROUND DOCUMENTS

## 6. APPENDICES

Appendix 1 - Cambridge and Peterborough Integrated Workforce Strategy.

# Cambridgeshire and Peterborough Integrated Workforce Strategy

| | |
|---|---|
| **Submitted by:** | Lucy Dennis<br>Head of Cambridgeshire and Peterborough Workforce Partnership<br>(Health Education England) |
| **Review Dates:** | Local Workforce Advisory 8.12.16<br>Health and Wellbeing Board (Cambs) 19.01.17<br>Health and Wellbeing Board (Peterborough) 23.03.17 |



NHS
Health Education England

NHS Cambridgeshire and Peterborough Clinical Commissioning Group | Cambridge University Hospitals NHS Foundation Trust | Cambridgeshire and Peterborough NHS Foundation Trust

Cambridgeshire Community Services NHS Trust | Hinchingbrooke Health Care NHS Trust | Papworth Hospital NHS Foundation Trust

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## Executive Summary

The following outlines the aspirations for the Sustainable Transformation Programme (STP) workforce across health social and tertiary care in Cambridgeshire and Peterborough.

It identifies how the STP will achieve its ambitions which are centred around five areas; improving supply, improving retention, new role development, setting up new ways of working and up-skilling, and leadership development.

The national and local context for our population and workforce illustrates the need for transformation in the way in which we work together as a whole system.

## Our Ambition – Vision for the workforce by 2020

Improving the shape and size of our current and future workforce is crucial to closing the gap in relation to health and wellbeing, care and quality, and finance and efficiency. The local and national context section highlights the range of challenges facing the local health and care system these include: high vacancy levels, skills gaps across all professional groups, difficulty moving staff and resources across traditional organisational boundaries to address workforce needs.

To tackle these challenges, the ambition for transformation are categorised into the following areas

1 Improving supply

- Establishing Cambridgeshire and Peterborough as a health and care employer of choice
- Quality of Education
- New Roles
- Housing and Transport

2 Improving retention

3 New role development

4 Scaling up new ways of working and up-skilling

- Workforce Planning
- Workforce Optimisation
- Clinical Networks
- System Investment Plans
- Integrated Working

5 Leadership development

The way in which we train, recruit, and retain our staff must be reflective of our current and future population, and have a strong focus on integration.

## 1 Improving supply

### Establishing Cambridgeshire & Peterborough as a health and care employer of choice

**Ambition**

We will work as a system so that Cambridgeshire and Peterborough adopts a single culture across health social and tertiary care. This culture be one which provides opportunities for growth and development for all new recruits

**Transformation**

- System networks will support career and experience diversity
- Opportunities through national funding and other mechanisms to increase placements for hard to recruit to medical specialties will be optimised regionally

**How**

- All staff recruited using a values based process
- Clear and efficient recruitment process
- A co-ordinated Widening Participation and Talent for Care Programme
- Health and Social Care Ambassadors to promote career opportunities
- Promote the Cambridge reputation for excellence and research
- Promote clear access routes
- Guaranteed Job offers for trainees / students in health
- Using local brands to attract talent – Papworth, CUH etc

### Quality of Education

**Ambition**

Our Learning Environment will be commended as offering outstanding education, training and development across the system

**How**

- A progressive supportive Learning Environment and Culture
- Strong Education Governance and Leadership
- Systems that Support and Empower Learners and Educators
- Developing and Implementing Innovative Curricula and Assessments
- Strengthening educational strategies in organisations to ensure that programmes are of a consistent high quality and are attractive to future students and speciality trainees

## New Routes

**Ambition**

We will develop and expand new routes into the health and social care workforce which are capable of ensuring an adequate supply of the right values, behaviours, skills and competence to meet the needs of our population.

**Transformation**

- Development of Apprenticeship Trailblazers designed around our systems health and social care needs
- The development of a framework for implementing IM1-3 (the “replacement” for core medical training)

**How**

- Clear Apprenticeship routes which lead to registration
- Flexible routes which produce AHP, Social Care and enhanced support roles such as Nursing Associate
- Fast track routes such as MSc registrant
- Work based approaches which support expertise development and a GROW OUR OWN culture
- Consistent system approach to staff release for learning

## Housing and Transport

**Ambition**

All our current and future workforce will have access to, and a choice of, good quality housing which is affordable to them and meets their needs, and will be able to travel to their place of work using affordable means of transport

**Transformation**

- Work with our partners in local government to ensure new housing developments meet the needs of the health and social care workforce
- Work together as a health and social care system to seek out recruitment and employment initiatives that will enable our workforce to live nearer to and travel more easily to work

**How**

- Work with Local Authorities and planners toprovide information on areas of workforce growth and need in relation to housing a transport
- Work with all partner organisations to prepare clear, consistent and accessible information on local housing and transport for Cambridge and Peterborough so that our recruits can make informed choices about their future residence
- Ensure new developments (eg Biomedical campus) have adequate cycle parking provision and good transport links
-

**Case Study: Healthy New towns – Northstowe**

A partnership between Cambridge University Hospitals (CUN), the Homes and Community Agency (HCA) and South Cambridgeshire District Council is one of 10 national sites in an innovation programme which puts health at the heart of new neighbourhoods and towns across the country.

Northstowe is being developed between Histon and Cottenham and over the next 20 years will become a community of 10,000 new homes encompassing everything a vibrant community needs, including a new town centre with shops, businesses, schools and other facilities. The focus on health and well-being will mean sports facilities, parks and play areas are integrated into the community. It will also be designed to encourage people to walk or bike to school, work and around the town.

This new development poses the following important questions for our system in relation to workforce:

- Healthy New Towns stipulate the inclusion of doctors' surgeries. Consideration must be given to the viability of this – would the new population justify the development of new premises or would patients be added to nearby lists? How would a workforce be recruited to a new site when there a significant difficulties recruiting to practices at present?
- 40% of homes will be designated 'starter homes' with a combined salary of £68k required to purchase. A deeper understanding of this designation is needed to ensure allowances are made for our health and social care workforce on lower salaries.

## 2 Improving Retention

**Ambition**

We will reduce the staff and skills that choose to leave our system and create a flexible and adaptable workforce proud to remain working here.

**Transformation**

- Development of a system wide staff health and wellbeing framework

**How**

- Flexible working and learning opportunities
- Consistent Healthy Workplace Strategies
- Quality Preceptorship Programmes
- Use of 'mind the gap' philosophy to design career pathways and ways of working which optimise outputs from different generations of workers
- Career Pathways which adapt and accommodate a diverse workforce
- Coaching and Leadership Programmes which identify and support talent
- Diverse opportunities to develop and acquire experience and education across a range of settings
- Links to national partners to identify any risks associated with Brexit early on

## 3 New Role Development

**Ambition**

The STP will take a population based planning approach to design new roles which have been designed around the needs of the community. New roles should be integrated, embrace autonomous working (within a supervised area if required), and challenge the way we currently deliver care and support to our population.

**How**

- Adopting a population planning methodology to deliver the change required
- Use an adoption and spread approach to test out the effectiveness of new roles prior to whole system implementation
- Integrated Workforce Development Group to support workforce and OD priorities ensuring integration is at the heart of new role development

## Case Studies: New role development

**Clinical pharmacists in General Practice**

The role of the Clinical Pharmacist in General Practice working as part of the practice team is starting to show positive outcomes for both patients and general practice teams. 6 Practices currently employ pharmacists who consult with and treat patients directly, control medicines management and reviews, prescribe, and liaise with community and secondary care colleagues. These activities enhance patient care and reduce GP time.

**Integrated workers**

The Integrated Care Worker (ICW) role has been developed and is currently out to advert across the STP. Within the interdisciplinary community healthcare team, working across health and social care boundaries, the ICW will use skills from the professional areas of; Nursing, Allied Health Professionals and Medicines Management, to undertake tasks as delegated in order to meet the individual needs of service users. The role will be autonomous with access to expert guidance and will work closely with Neighbourhood Teams, Reablement, JET and local GP practices to reduce the necessity for acute hospital admission, supporting timely hospital discharges and promoting independence in a safe environment.

**Emotional Health and Wellbeing Workers**

As part of work with the Joint Commissioning Unit to address the rising urgency of an under supported system for children and young adults with emotional and mental health needs across the STP, a new team of Emotional Health and Wellbeing Workers has been designed and will be hosted by CCS. The team will build capacity and confidence in the workforce that will provide an effective offer to the increasing numbers of children and young people at risk or experiencing mental and emotional health difficulties.

Working from the Early Help the team of 7 AfC band 6 workers and 1 AfC band 8a Clinical lead will offer expert advice to practitioners working from the Early Help hub/service. These practitioners will be from across agencies, to include school nursing; pastoral school staff; locality staff; GP's; and voluntary organisations. The EHWB Lead will have clinical CAMHS senior leadership experience to deliver the service. The role of the EHWB workers will be to signpost and provide advice and therefore can be appointed from a health, social care, locality, education or voluntary sector background; thus widening the pool of applicants. The team (who aim to be in post early 2017)

Will be based from the Early Help Hubs and aligned to local authority districts in Cambridge (5 workers) and Peterborough (2 workers). The will provide advice and signposting; assessment; support; brief interventions and upskill staff in the locality to feel more confident and capable in providing the right support to young people in their care.

**Nursing Associate**

The STP is one of 11 national test sites for the implementation of the Nursing Associate (NA) role commencing January 2017. C&P have agreed to support 36 NA trainees which will be placed throughout Cambridgeshire and Peterborough.

The partnership comprises of representatives from ARU, CCS, CCG, CPFT, CUH, HHT, Papworth, primary care and PSHFT. NA Trainees will undertake a two year diploma; training will take place in clinical placement based in C&P and the academic component at ARU. Funded at band 3 level with the expectation of working in a band 4 post upon successful completion. The NA's will be a new type of care worker with a higher skillset to assist, support and complement the care given by registered nurses. They will be agile, having trained in a number of health and social care settings and their experience through their training will mean that they will be ready, willing and able to deliver the high quality care patients need. Whilst the pilot will pool trainees from existing headcount, the ambition is in future to use the role as a values based entry route to recruit new people into the system.

## 4 Scaling up new ways of working and up-skilling

### Workforce Planning

**Ambition**

We will develop a new approach to workforce planning to ensure that the health, social care and PVI data we gather is meaningful and informs the decisions we make in planning our future workforce

**Transformation**

- An accessible, integrated data set across all organisation boundaries.
- Process that applies anticipative models of demand mapping
- Profile workforce scenarios which will apply to an integrated system.
- Aligned outcome, workforce and efficiency data will be used to assess optimum workforce configuration

**How**

- Understand supply, demand and resource across the entire health and social care system
- Strong collaborative relationships which understand workforce demand.

### Workforce Optimisation

**Ambition**

We will modernise the delivery of health and social care by utilising digital technology to redesign processes. This will increase connectivity between patients, clinicians and organisations, and allow information to be accessed remotely across a range of settings.

**Transformation**

- Work with external stakeholders to develop technologies for local adoption

**How**

- Support staff to promote the use of Health Apps in Health Prevention Initiatives
- Develop our staff to be equipped with the skills to spread the use of Tele-health/remote monitoring to enable patients and service users to manage their conditions in their own home
- Support the development of our staff and system to be able to use the IT solutions which will achieve real time information exchange

## Clinical Networks

**Ambition**

Our clinical networks will combine the experience of clinicians and the input of patients to improve the way we deliver care to patients across primary, secondary and tertiary care

**Transformation**

- Clinical networks will share protocols for appropriate referral and best practice treatment
- Share out-of-hours rotas
- Offer flexibility to match staffing with available physical capacity.

**How**

- Build workforce resilience through an enhanced career development offer.
- A passport approach to employment
- Application of a range Quality Improvement roles such as Fellows

## System Investment Plans

**Ambition**

We will create a Cambridge and Peterborough Workforce Investment Plan in order to prioritise investment into apprenticeships, undergraduate training and wider development funds for health and social care staff

**Transformation**

- Apprenticeship Levy Maturity Plan
- A business model to ensure Cambridge and Peterborough provides high quality education which meets the emerging policy agenda for Self-Funding

**How**

- System register with Digital Apprenticeship Services to access funding and monitor spend
- Apprenticeship standards for priority roles
- System Plan to grow numbers of apprenticeships
- Implement a system procurement model to maximise spending power,
- Employers to become education providers in delivering apprenticeship training (apprenticeship academy for Cambridge and Peterborough)
- A workforce development fund to up-skilling requirements for the existing workforce (coaching, case management)

## Devolution

**Ambition**

We will work with the shadow combined authority and the new authority and Mayor to ensure that devolved powers include being able to improve our skills strategy for health and care in Cambridgeshire and Peterborough.

**How**

- Development of the devolution 2 and 3 offer around the apprenticeship levy
- Greater collaboration with Health and Wellbeing Boards.

## Integrated working

**Ambition**

Better joined-up and integrated services to meet the needs of people using health and social care services in our local communities

**Ambition**

Clarity as a system on how and where we will adopt different routes to achieve integration.

Management plans for where we will achieve integration through:

- integrated pathways
- integrated teams
- integrated management and governance
- integrated commissioning and planning

A workforce intelligence, planning and development plan for the majority of staff who deliver social/health care and are in the independent and voluntary sector

Implementation of partnerships, governance and leadership which achieve integrated care for people using services

A culture and PD plan that specifically addresses the culture shift required for integrated and better joined up care
A culture and OD plan that specifically addresses the culture shift required for integrated and better joined up care

### CASE STUDY: New ways of Working

**Agile working by the Wisbech Neighbourhood Team**

Agile working is starting to change the way the Wisbech neighbourhood team operates. They were the first in the integrated care directorate to trial tablet devices to remotely download and update patient records and visits. More than 50 staff in the team took part in a three-month pilot.

Sue Heanes, Wisbech neighbourhood team manager, explained: “The days when frontline staff need to go to an office to log on to their computers are starting to be a thing of the past. They can now visit a patient straight from home and download their records on to their tablet. Before, they would have to come into the office to print off patient lists, which can be time consuming. It also means that after they’ve seen their last patient for the day they don’t have to return to base.”

## 5 Leadership development

**Ambition**

The STP will move to a systems leadership culture which with supports working across traditional boundaries on issues of mutual concern. This multi agency approach enable the system act as a change agent to improve overall performance and a focus on the health and wellbeing of the whole population

**How**

- Develop a leadership and OD plan for staff at all levels which identifies four domain areas upon which collaborative system behaviours can be demonstrated
    - Individual effectiveness
    - Innovation and improvement
    - Relationships and connectivity
    - Learning and capacity building
- Use existing relationships and collaborations as the building blocks to shape our collective vision with a focus on equal representation from both health, social and tertiary care.
- Assure collaboration across organisations and sector boundaries, engaging staff at all levels with transparency and openness to promote a philosophy where we learn from each other

## National and Local Context

### Service

As one of England's most challenged health economies, the Cambridgeshire and Peterborough system have agreed a unifying ambition for health and care; this being to develop the beneficial behaviours of an 'Accountable Care Organisation' (ACO) by acting as one system, jointly accountable for improving our population's health and wellbeing, outcomes, and experience, within a defined financial envelope.

In 2014 The Better Care Fund (BCF) programme was launched across Cambridge and Peterborough to create greater collaboration between a wide range of health and social care organisations in order to build:

- services around the needs of the most vulnerable older people within the community in order to provide care closer to home wherever possible.
- better support for carers (those who look after and care for loved ones)
- more efficient services through closer joint working between, health, local authorities and the voluntary sector.
- a system that is better equipped to meet the needs of the growing older population.

The transformation programmes during 2016/17 from the BCF include:

- Healthy ageing and prevention
- Data sharing
- Information and communications
- Intermediate care teams
- Developing social prescribing
- Older people's accommodation review
- Seven day services
- Care home support

The NHS Planning framework launched in January 2016 set to build upon the collaboration from the BCF and create a unified model for how health and social care can plan, re design and deliver improvements to services to enhance patient outcomes through a Sustainable Transformation Plan (STP). The STP strategy 'Fit for the Future' sets out a single overall vision for health and care, including:

- supporting people to keep themselves healthy
- primary care (GP services)
- urgent and emergency care
- planned care for adults and children, including maternity services
- care and support for people with long term conditions or specialised needs, including mental ill health.

Fit for the Future has four priority areas for change and has developed a ten point plan to ensure delivery:

| Priorities for change | 10 point plan |
|---|---|
| At home is best | 1. People powered health and wellbeing<br>2. Neighbourhood care hubs |
| Safe and effective hospital care, when needed | 3. Responsive urgent and expert emergency care<br>4. Systematic and standardised care<br>5. Continued world-famous research and services |
| We're only sustainable together | 6. Partnership working |
| Supported delivery | 7. A culture of learning as a system<br>8. Workforce: growing our own<br>9. Using our land and buildings better<br>10. Using technology to modernise health |

Table 01

The STP priority areas focus on whole system, as such, integrated health and social care must be the heart of the STP to improve the quality outcomes for the local population. This will require health and care organisations to work in collaboration beyond their traditional boundaries.

## Workforce

The Comprehensive Spending Review (CSR) announced a number of significant changes to education funding which impacts on health and care roles.

From August 2017, new students in England on nursing, midwifery and most allied health professional (AHP) pre-registration courses will no longer receive NHS funding for their course fees or living costs but will have to apply for the standard student support package. This will remove the cap on Higher Education Institutes in terms of numbers of pre-registration students they train each year; however placement capacity will continue to result in some restriction on numbers. Furthermore the impact of CSR resulted in reduced funding available for continual professional development education provision via Health Education England.

An apprenticeship levy on employers will also be introduced in April 2017. It will be set at 0.5% of the pay-bill to be collected monthly via PAYE and applicable to organisations with an annual pay-bill of over £3m. The total cost to the NHS in 2017/18 will be £200m, within Cambridgeshire and Peterborough the annual cost is estimated at £3.8m. Smaller NHS organisations such as GP practices will be required to co-invest 10% towards the training cost of any apprenticeships they wish to purchase. Any unused levy funds will 'redistributed' after 24 months – i.e. risk the NHS losing these funds despite paying the money into the levy.

The impact of Brexit for the NHS and wider economy is still unknown but the STP recognises this may cause concern for overseas and EU members of the workforce. The STP recognises the importance of identifying and valuing the contribution of EU nationals working in the health and social care system now and in the future. The STP will maintain close links with national partners to ensure information from government on the STP's ability to train, recruit and retain people from the EU and beyond, as well as providing certainty to the existing workforce of 'right to remain' in the UK is received and actioned in a timely manor. In the meantime the STP will continue to work with EU and overseas workforce in the same way as domestic employees, by providing motivating and rewarding roles, opportunities to develop, and safe working environments.

## Governance

This strategy is not intended to replace or supersede inter-organisational strategies but instead to support their direction setting so that organisational workforce strategies demonstrate alignment with the Cambridgeshire and Peterborough Integrated Workforce priorities. The Cambridgeshire and Peterborough (C&P) system has a long history of partnership working in relation to workforce. Through Health Education England's (HEE) local governance structures, the healthcare system has been able to work collaboratively to strategically plan; commission and quality assure education and training, workforce transformation, and support leadership development across the system
As one of the STPs delivery units, the Local Workforce Action Board (LWAB) will bring together health, social care, and other stakeholder organisations across a broad range of workforce issues so that the people elements of the STP strategy can be identified and delivered across the health and care system. It will also be responsible for the local delivery of HEE's Mandate and strategic priorities, these will include areas such workforce planning, training and wider development, leadership, and organisational development.

The LWAB will develop four key products these are:

- A comprehensive baseline of the NHS and care workforce within the STP footprint and an overarching assessment of the key issues that the relevant labour markets present. This will describe the workforce case for change.
- A high level workforce strategy that sets out the workforce implications of the STP's ambitions
- A workforce transformation plan focused on what is needed to deliver the service ambitions set out in the STP
- An action plan that proposes the necessary investment in workforce required to support STP delivery, identifying sources of funds to enable its implementation

The LWAB in Cambridgeshire and Peterborough is chaired by Matthew Winn, the CEO of Cambridgeshire Community Services NHS Trust (CCS). Representatives from our six provider trusts, two local authorities, and primary care are joined by our HEI to ensure a quorum for decision making. As described below, there is accountability through the LWAB Chair to the STP Executive, HEE's Executive Director Lead (Professor Bill Irish, Postgraduate Dean) and HEE's Engagement Lead (Lucy Dennis, Head of C&P Workforce Partnership).

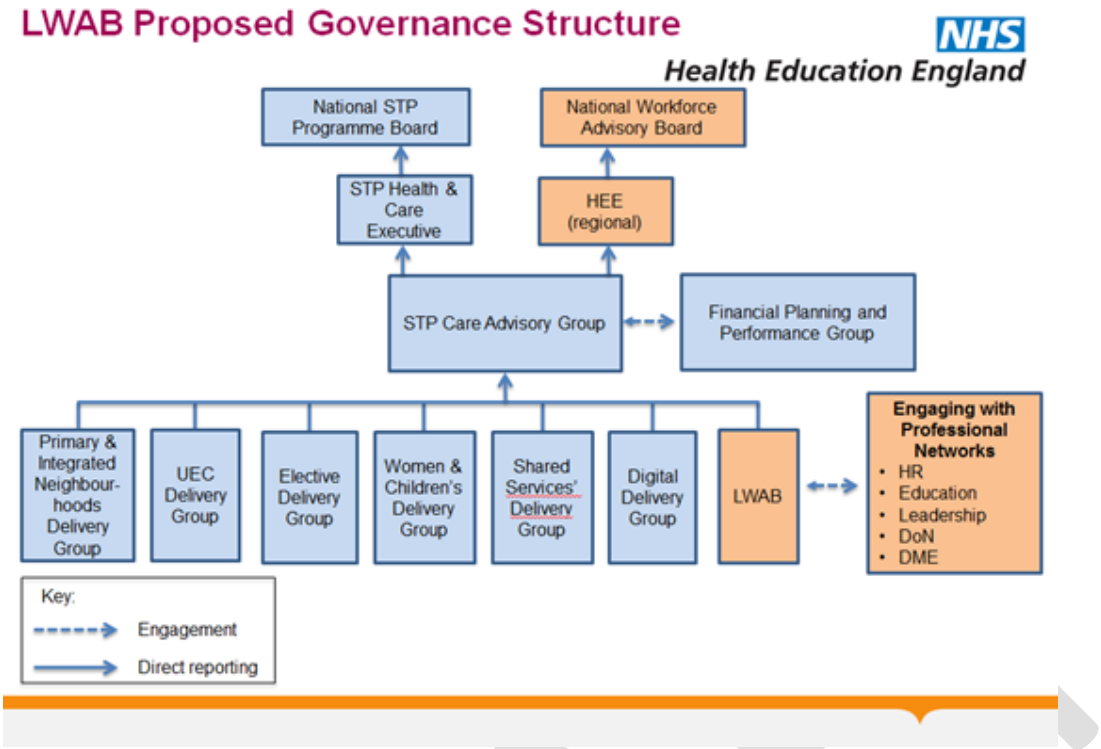



Image 1: LWAB proposed governance structure (HEE, 2016)

## The Workforce context to 2020

### Local demography

#### GROWTH

**Cambridgeshire** was the fastest growing county authority between 2001 and 2011 and is expected to continue to grow.

627,000 people living in Cambridgeshire
>25% over next 20years

73,000 new dwellings forecast up to 2036

By 2026 the number of people aged over 90 years is forecast to more than double
**Peterborough** has a young population with a **higher than average number of children and young people** – forecast to **rise** by **23% by 2023**

One of the **fastest growing cities** in the UK with 30,000 new dwellings forecast by 2036

Predicted **population growth of 34.9%** between 2010-2031.

The city is ethnically diverse, with **29.1% of residents** not self-identifying as White English/Welsh/Scottish/Northern Irish/British.

The **population aged 65 and over is forecast to rise by 28% by 2023.**

The number of **people aged 90 or over will almost double** in this time.

#### LONG TERM CONDITIONS

**Cambridgeshire**

**31.7%** of residents reported having **at least one LTC** in the GP survey

**90,420 people**
(15.1% of household residents) **reported a long term activity-limiting illness** (2011 census)

**Peterborough** hospital service demand - forecast to **rise by about 20% over the next 5 years**

Population change and **rising obesity**

Rapid rise in the older population **= increase in older peoples hospital services**

**Premature deaths (<75yrs) from CVD and respiratory disease** = higher than the national average

**1 in 16** adults suffer from **diabetes**

Approximately **1,660 people living with dementia** in Peterborough
**2,660 by 2030**

Estimated **18,000 adults with two or more long term conditions with mental ill health and/or limitation**, and a further 10,500 people aged 65 and over in these groups

#### MENTAL HEALTH

**Cambridgeshire and Peterborough** has **growing numbers** of people with **mental illness.**

In 2016, it was estimated that **over 88,000 adults** (aged 18-64 years) in Cambridgeshire and Peterborough **have a common mental health disorder**
**2021 > 95,200**
**2026 97,500**

**Suicide rates** have at times over the past ten years been **higher than England rates in Peterborough**

**Hospital admissions rates for self-harm in those aged <25 years in Peterborough = highest in the East of England.**

Suggested that acute 'crisis' services are being used more for mental health across STP, particularly in Peterborough

By 2023:
Number of **older people with depression >12%*** (1,500ppl)
Number with **dementia >64%** (4,700 people)

**Children and young people with mental health problems:**
**- 5,000** children **under 5yrs old**
**- 8,000** between **5-16yrs old**
**- 1,275 16-17 year-olds**

## Housing and Transport

Our local population is anticipated to increase by ¼ million in the next 20 years; with 70,000 new homes being developed in and around Cambridge, and another 30,000 in the Peterborough area.

Affordability of housing is a key issue for Cambridgeshire, those people on lower incomes find it particularly hard to access the private housing market. This includes many households that form key staff for organisations providing health, social care and service industries.

As illustrated below, one common rule of thumb is that house prices of 3 to 3.5 times income are considered affordable. Cambridge sees the highest ratios, where the median house price was 18.8 times the median income. Lowest ratios were seen in Peterborough with median house price 8.8 times median income.

### Affordability Ratios

| | |
|---|---|
| Cambridge City | 18.8 |
| South Cambridgeshire | 12.2 |
| East Cambridgeshire | 10.6 |
| Huntingdonshire | 9.1 |
| Fenland | 9.2 |
| Peterborough | 8.8 |
| Note: Large areas of South Cambridgeshire District Council and some areas of East Cambridgeshire District Council also have ratios similar to that of Cambridge. Appendix 2 illustrates the affordability 'heat map' for Cambridgeshire & Peterborough. | |

**Source:** Housing Market Bulletin March 2016
Calculated using lower quartile house prices to lower quartile incomes

Over the next 20 years the affordable housing need for the Cambridge area is 49,000. This is what the Local Plans demonstrate can be met through 30/40% affordable homes policy requirements. However the need for affordable housing may be higher as it does not necessarily cover the need for intermediate/key worker housing that could be regarded as affordable in the broader sense. Significant subsidy is required to secure the housing local government estimates is needed.

Fenland is Cambridgeshire's most deprived district (ranking as 94th most deprived authority out of 326 nationally). Growth in employment in Fenland has not matched workforce expansion and out-commuting is increasing. Currently, almost 40% of Fenland's working population commute out of the district for work. East Cambs district similarly is predominantly rural with a dispersed population, which creates challenges in providing a comprehensive public transport network. Many local communities are reliant on the car as their only transport option. So although housing maybe more affordable access to private transport is an important factor when thinking about the shape of the systems workforce.

When applying this information to the health and social care workforce we can see from Table 03 below that the annual income for our support and junior roles mean that access to affordable housing and transport creates a significant issue for the local workforce.

| Health | | | Social Care | |
|---|---|---|---|---|
| **Band** | **Role** | | | |
| 2 | Support worker | £15,100 | Average FTE annual pay of managerial staff | £26,000 |
| 3 | HCA | £16,663 | Average FTE annual pay of regulated professionals | £26,900 |
| 4 | HCA | £19,027 | Average hourly pay of direct patient care staff | £7.74 |
| 5 | Registrant | £21,692 | | |

## Local Labour Market Context

This section will cover the following:

- Workforce profile
- Establishment
- Vacancy
- Retirement
- Net Loss
- Progression
- Temporary workforce
- Projected growth

### Workforce profile

#### HEALTH

In health, the majority (72%) of the workforce in Cambridgeshire are female and the **average worker is aged between 26 and 30 years old**. Around **79% of the workforce in Cambridgeshire are British**, 9% are from within the EU and 10% from outside the EU, therefore there is a similar reliance on both EU and non-EU workers. Around 83% of the workforce in Cambridgeshire are of white ethnicity and 17% are from Black, Asian or Minority Ethnic groups (BAME).

#### SOCIAL CARE

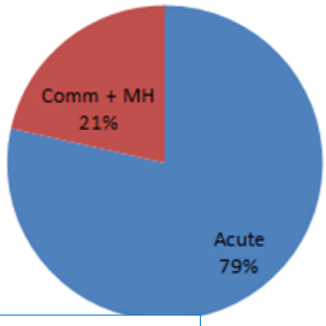
In social care, the majority (83%) of the workforce in Cambridgeshire and Peterborough are female and **the average age is 41-42 years old**. Cambridgeshire and Peterborough have similar profiles with around 82% of the workforce being British, 8-10% are from within the EU and 8-10% from outside the EU, therefore there is a similar reliance on both EU and non-EU workers. Around 88% of the workforce in Cambridgeshire are of white ethnicity and 12% are from Black, Asian or Minority ethnic groups. In Peterborough 79% of the workforce were of white ethnicity and 21% were BAME

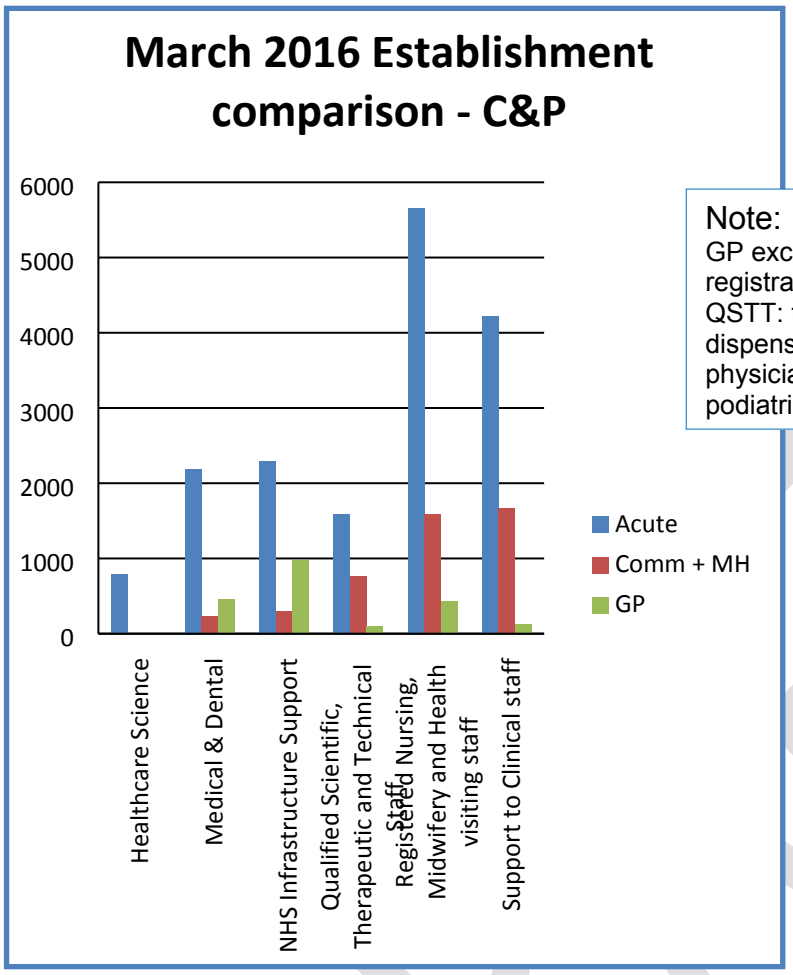
### Establishment

#### HEALTH

The STP has an **NHS workforce of just over 20,000** contributing to the delivery of care. Appendix X provides a breakdown of staff group by trust. **Adult nursing and clinical support staff are the largest of our staff groups** across acute and mental health/community. Cambridge University Hospitals Foundation Trust is our largest employer, with Cambridgeshire and Peterborough Foundation Trust and Peterborough and Stamford Foundation Trust headcounts each being around 55% smaller.

As illustrated, the **delivery of care is heavily weighted to our acute providers with 79%** of our workforce here and just **21% in community and mental health settings**. This presents a **large challenge** for the STP as its ***At home is best*** priority describes a need to shift the balance of care delivery back into the community.




Note:
GP excludes locum, retainers, registrars
QSTT: therapists, pharmacists, dispensers, physiotherapists, physician associate, phlebotomists, podiatrists

**General Practice**

**105 Practices**

**3 GP Federations**

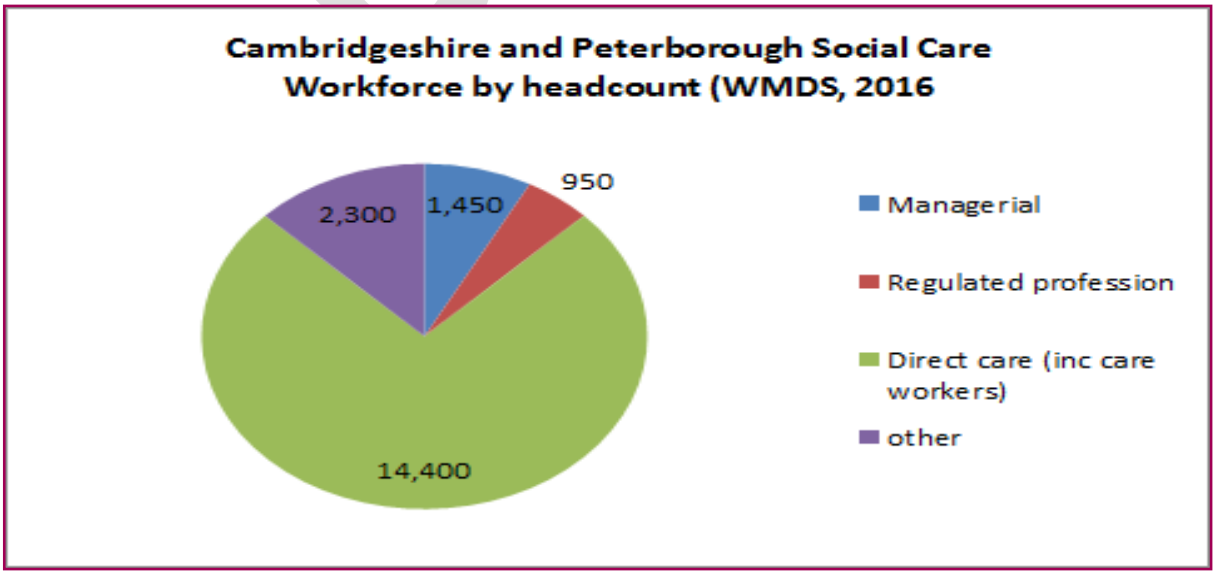
**Headcount = 2,737 staff.**

- 544 GPs
- 522 nurses
- 337 direct patient care staff

Table 04 NHS workforce (May 2016)

**SOCIAL CARE**

Our social care workforce is in a precarious position. **In contrast to the NHS, the majority of its workforce is employed in direct care roles, with regulated professions being the smallest of staffing groups** In June 2016, it was calculated that the workforce consisted of 19,000 staff across Cambridgeshire and Peterborough.



## Vacancy rates

### HEALTH

Our provider returns show that **all nursing groups in the STP have above average vacancy rates**, particularly child nursing (24.9%) and learning disability nursing (22.1%). Physiotherapists (7%) and operating department practitioners (11.9%) have the highest rates in AHP, and in medical; accident and emergency (12.6%), anaesthetics (13.4%). **Psychiatry vacancy rates** are reportedly becoming a problem.

Source: Trust forecasts, May 2016

### SOCIAL CARE

Skills for Care REFERENCE estimates that in Cambridgeshire, 5.0% of roles in adult social care carry vacancies which gives an average of **approximately 650 vacancies at any one time**. In addition, **the turnover rate of directly employed staff was 22.6%, which translates to approximately 3,050 leavers per year.** In Peterborough Skills for Care estimates that in Peterborough, 4.8% of roles in adult social care were vacant, this gives an average of approximately 300 vacancies at any one time. The turnover rate of directly employed staff was **35.2%**, this means approximately 2,000 leavers per year. This turnover rate was higher than the region average, at 25.8% and higher than England at 27.3%.

## Retirement

### HEALTH

The STP has the second lowest retirement rate across the 6 STPs in the east of England. Larger professional groups and specialities tend to have the highest forecast retirement rates with **Mental Health Nursing** a key area of concern with the **highest retirement rate of all nursing roles** (3.1% of SIP pa). General Practice nursing is also high, with **33% of GPNs predicted to reach retirement in the next 10 years**. **Obstetrics and Gynaecology** (4.4% of SIP pa), and **Paediatrics** (4.5% of SIP pa) have the highest medical retirement rates. This is consistent with the rest of the EoE but presents a cause for concern when considering future supply.

Source: ESR Data Warehouse 2016

### SOCIAL CARE

In Cambridgeshire 23% of the **workforce are aged over 55**, Peterborough is slightly lower with 19% of the workforce aged over 55. This means that throughout Cambridgeshire & Peterborough **4,150 people may retire over the next 10 years.**

## Net Loss

Net loss or attrition is classified as staff who have left the NHS (excluding retirements) per year. This will include staff moving to Primary Care. Overall attrition across all staff groups is **5.9%. Mental Health nursing has the highest attrition of all nursing groups at 6.1% as well as the highest retirement rate.**
Clinical Support and Infrastructure support staff groups have the highest attrition overall at **11%** however this is common across EoE.
Cambridgeshire and Peterborough has the highest rates of staff leaving Occupational Therapy **8.8%** and Physiotherapy **8.0%** of all EoE STPs.
The **repatriation of 900 posts which are currently managed by London programmes** but which will now be recruited to and part of East of England programme rotations is part of our strategy to attract and retain doctors in training within the east of England. The intension is to encourage doctors to set down roots in the east of England working as Consultants and GPs in our Practices and Trusts.

## Progression

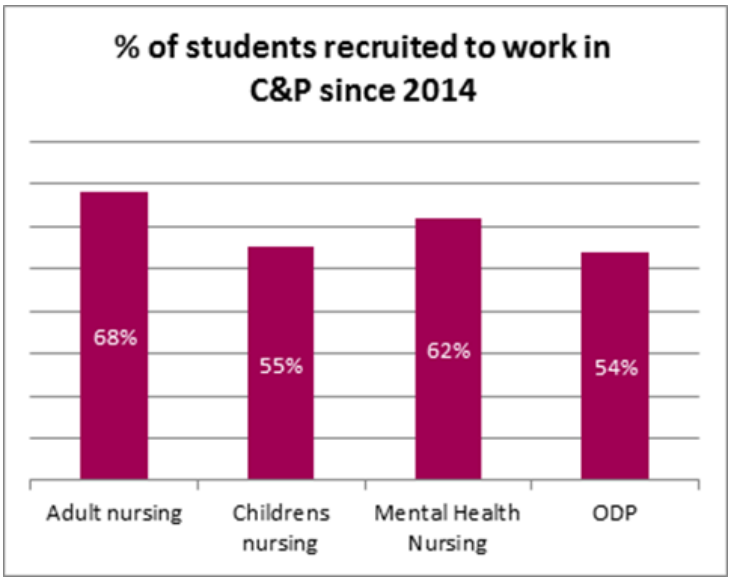
### HEALTH

### Non-medical and AHP

As a system, the STP is successful in its recruitment against commissions to nursing and ODP (95% to 100%). We have seen increases in the numbers of students **with 100% of children's nursing and 80% of mental health nursing programmes completing their programmes** in the expected timeframe.

Reasons for attrition tend to be related to personal issues for students such as illness, however financial reasons are also cited as a personal reason. Anecdotally students also report **difficulties travelling to placements** in Hinchingbrooke and Papworth due to poor transport links and lack of transport available at shift start and end times.

Recognising that 50% of the student's learning is based with employers, there is a clear need for employers to work with training providers to ensure a high quality, supportive experience for students in a range of health and social care settings. **The experience employers provide to students is key to retaining them on programme.** A good placement experience will give students a **sense of belonging and commitment to the organisation and a higher likelihood of their seeking employment in that organisation** (Andrews et al, 2005). The table below outlines the success of C&P in recruiting nurses and ODP they have supported in training



## Progression Contd…

### HEALTH

### Medical

We understand that **30% of Cambridge Medical School graduates** undertake their **foundation training** within the region, the figure is **40% for UEA.**

Across the east of England an estimated **1,000 medical programmes are recruited to** from core training through to higher specialty and GP programmes. Programme lengths differ between specialties and **Doctors may progress through at different rates**. A number of doctors who undertake out of programme experiences during their training to enhance their learning and improve their skills – this extends the total training time.

There are three established GP Speciality Training Schemes (GPST) in our local system which place around **54 trainees (GPST)** each year. Whilst the training pathway is 3 years (4 for academic GPSTs), as with other specialities; many do not progress in the time period, with requests for less than full time training (LTFT), opportunities for out of programme experience, and exams failures extending the length of training. The **Cambridge and Huntingdon systems tend to retain around 84% of their GPSTs** within the system upon completion of training; either in salaried or Partner contracts, or as locum or out of hour GPs on flexible contracts. In stark contrast, the **Peterborough system struggles to retain its GPSTs (est 35%).** As described for smaller professional groups in non-medical specialties, the national structure of centralised placements means that many GPSTs placed in the Peterborough system are often there as a second choice and so seek employment opportunities back in London after completion of training.

A range of Fellowships, opportunities to undertake chief resident programmes with associated management and leadership training, and a vast array of academic programmes have been implemented to encourage retention and enhance training for all medical specialties. The academic programmes are very popular in C&P with excellent relationships between University and CUH to create excellent academic research opportunities which attract high calibre trainees to the region.

### SOCIAL CARE

At ARU, there are currently **136 students on social work Degree or Masters programmes in Cambridge** which lead to a social work registration.

In the period 1st September 2014 to 30th November 2016**, 112 students achieved the intended award.**

## Temporary Workforce

### HEALTH

Cambridgeshire and Peterborough ranks among the best STPs for the **lowest bank and agency (B&A) staff usage (2015/16)**.

Whilst as much as 15-17% of SIP at Hinchingbrooke and CCS are B&A, the very low rates seen at CUH and PSHFT significantly reduce the average. **A significant reduction in B&A is predicted by Trusts in future**

| WTE | As of 31st March 2016 | As of 31st March 2017 | Forecast change 16-17 |
|---|---|---|---|
| **Bank and Agency Staff** | 1,826 | 1,022 | -44% |
| **% of SIP** | 8% | 5% | -4% |
| **Midlands and East Average** | 11% | 8% | -3% |

### SOCIAL CARE

Around a **quarter (23%) of the Cambridge workforce** were recorded as being on **zero-hours contracts** and a **third (32%) in Peterborough.**

The social care system have been experiencing **significant difficulties recruiting experienced social workers** with 72 agency social workers (40 of those in adult care) required in 2015/16.

## Projected Growth

### HEALTH

- Cambridgeshire and Peterborough's total staff forecast change is roughly aligned with national forecasts at less than 1%, however the granular view is more disparate
- There is **slight growth forecast in Adult Nursing 2.5%** in the face of slight reductions both regionally and nationally, with the bulk coming from Addenbrooke's and Peterborough and Stamford
- Physiotherapy and Occupational Therapy project increases of 7.3% and 6.9% respectively
- Child Nursing shows a significant decrease 10.4% while the national picture shows steady state
- Therapeutic Radiographers and Operating Theatre staff show significant decreases at 15.9% and 26% respectively. This contrasts with small growth forecast nationally

### SOCIAL CARE

Adult social care is a **growing sector that had increased by 18%**, in terms of jobs, since 2009 in England.

If the adult social care workforce grows proportionally to the projected number of people aged 65 and over in the population then **the number of adult social care jobs in England will increase by a further 18% to 1.83 million jobs by 2025.**

## Workforce Context to 2020 - Summary

Key Issues

The workforce and labour market context for the STP has identified that Cambridgeshire and Peterborough is facing increasing health and social care challenges, and in order to describe the vision for the workforce by 2020, the following significant issues should be considered:

**Population**

- We have areas of fast growing populations where **emotional wellbeing and life style choices** are **impacting on individual health and social care requirements**
- Our population is **aging and developing more LTC**

**Operational risk**

- **Two thirds of our acute hospitals** are under **severe operational pressure**. The **pressures upon general practice** are also well documented.
- Our existing workforce pressures and capacity mismatch are **unable to adequately support increasing demand**
- Safe and effective hospital care, when needed, **requires a shift from reactive to proactive care**

**Workforce risk**

- **Shortages in adult, children, learning disability and mental health nurses**
- The impact on future supply of our non-medical workforce as a result of changes to funding routes is currently unclear
- **Low retention** of newly qualified **physiotherapists and OTs**
- **Shortages in consultant grad A&E doctors, anaesthesiologists and GPs**
- Access to affordable housing and transport has a significant impact on future supply and existing workforce

## Underpinning Documents

Cambridgeshire and Peterborough data pack HEE. 2016.09.28

Skills for Care (2016a). A summary of the adult social care sector and workforce in Cambridgeshire.

Skills for Care (2016b). A summary of the adult social care sector and workforce in Peterborough.

Cambridge & Peterborough Health and Care System GPFV Plan Skeleton Structure.

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The Cavendish Coalition (2016). http://www.nhsemployers.org/your-workforce/need-to know/brexit-and-the-nhs-eu-workforce/the-cavendish-coalition

2014. FIVE YEAR FORWARD VIEW.

2016d. GENERAL PRACTICE FORWARD VIEW General Practice Forward View General Practice Forward View 3.

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Outline Workforce Strategy Checklist PDF.

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Mental Health Taskforce, I., 2016. THE FIVE YEAR FORWARD VIEW FOR MENTAL HEALTH.

Scully, E. et al., Title: Better Care Fund, Policy Framework 2016/17. Available at: www.nationalarchives.gov.uk/doc/open-government-licence/.

Thomas, J., 2013. Evidence review -integrated health and social care.

(Council 2012; Mental Health Taskforce 2016; Scully et al. n.d.; Thomas 2013; Anon 2016d; Anon n.d.; Anon 2014; Anon n.d.; Anon 2016a; Anon 2016b; Anon n.d.; Anon n.d.; Anon n.d.; Anon n.d.; Anon 2016c; Anon n.d.)

| HEALTH AND WELLBEING BOARD | | AGENDA ITEM No. 11 |
|---|---|---|
| **23 MARCH 2017** | | PUBLIC REPORT |
| Contact Officer(s): | Adrian Chapman – Service Director Adult Services and Communities | Tel. 863887 |

## SAFER PETERBOROUGH PARTNERSHIP PLAN 2017-2020

| RECOMMENDATIONS | |
|---|---|
| **FROM :** *Service Director Adult Services and Communities* | **Deadline date :** N/A |
| The Health and Wellbeing Board are asked to consider the Safer Peterborough Plan 2017 - 2020 and the priorities contained therein. | |

### 1. ORIGIN OF REPORT

1.1 This report is submitted to Board following a review of the Safer Peterborough Partnership Plan.

### 2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is for the Health and Wellbeing Board to consider the Safer Peterborough Plan for 2017 – 2020. The plan sets out the community safety priorities for the partnership over the coming three years.

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

### 3. KEY ISSUES

3.1 The Safer Peterborough Partnership (SPP) brings together the responsible authorities as set down in the Crime and Disorder Act 1998, as amended by the Police and Justice Act 2006 for the purposes of tackling local community safety priorities.

3.2 The SPP has a statutory duty to develop and implement a Partnership Plan (contained below), which describes how responsible authorities and other partners will work together to tackle crime, disorder, substance misuse and re-offending in the city.

3.3 This Plan defines the priorities for the Safer Peterborough Partnership over the next three years. The Plan also identifies how the Partnership will respond to the impact of national policy changes and new and emerging risks.

3.4 The Safer Peterborough Partnership Plan 2017 - 2020 will be implemented when approved by Full Council and will be active for three years. The Plan and its priorities are revised annually to take account of changes in crime and disorder, the changing nature of local priorities, available resources and changes within communities.

3.5 Every year, Safer Peterborough completes an assessment of community safety in Peterborough. The Strategic Assessment was presented to the SPP Board in November 2016, when the priorities for the coming three years were agreed.

3.6 In times of reducing resources and increasing challenges, the Board agreed to make a commitment to prioritise a small number of themes which our assessment process has identified as having the highest risk of harm to communities in Peterborough. The plan therefore does not seek to address every community safety issue that can occur in the city.

3.7 There are a number of other crime and disorder types which we assess as having a lower level of risk which do not generally require a focused partnership approach to address. The plan suggests that we will continue to work proactively in these areas to ensure that we meet our statutory responsibilities, monitor performance and where required provide a partnership response to tackle entrenched or escalating issues.

3.8 We will use our existing robust performance management framework to monitor crime and disorder trends, ensuring that we are able to respond to areas of emerging risk where appropriate.

3.9 The plan outlines:

- The Partnership's successes in reducing crime and anti-social behaviour over the past three years.
- Our priorities for the next three years – based on what the public told us and our detailed assessment of crime and antisocial behaviour in Peterborough.
- Where we will focus our efforts as a partnership over the next three years.

## 4. CONSULTATION

4.1 Consultation with the public on the priorities in the plan is a statutory requirement for the Partnership. The Safer Peterborough Partnership Public Consultation Survey has been developed to ask people who live, work or have some other connection with the City, to tell us what they think the priorities for Safer Peterborough should be and their perceptions of crime and disorder more generally. This consultation closed on the 31st January 2017 and the findings of the survey have been analysed, the results of which are set out in the plan.

## 5. ANTICIPATED OUTCOMES

The anticipated outcomes are outlined in the plan, together with a number of performance indicators to ensure continued scrutiny of the themes in the plan.

## 6. REASONS FOR RECOMMENDATIONS

The Safer Peterborough Plan fulfils the partnership's statutory requirement to have a community safety plan. The plan sets out the multi-agency approach to tackling community safety issues and ways in which the city can build stronger communities.

## 7. ALTERNATIVE OPTIONS CONSIDERED

There is an opportunity not to adopt the Safer Peterborough Partnership Plan, however this is not recommended due to the statutory requirements placed upon Community Safety Partnerships to have a community safety plan.

## 8. IMPLICATIONS

There are no major implications to note. Once approved, the Plan will be adopted by the Safer Peterborough Partnership and progress of the plan will be scrutinised and monitored through the Partnership Board.

## 9. BACKGROUND DOCUMENTS

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

*None.*

# Safer Peterborough Partnership Plan
# 2017 - 2020

## Introduction

***Chair of the Safer Peterborough Partnership, Claire Higgins***

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I am delighted to introduce the Safer Peterborough Partnership Community Safety Plan 2017 - 2020. Our plan sets out how the Safer Peterborough Partnership will tackle crime and disorder over the course of the next three years.

Peterborough published its first Crime and Disorder Reduction Strategy over 15 years ago. During that time we have achieved significant reductions in crime, anti-social behaviour and improvements in those problems that negatively impact on the quality of life of people living and working in the city.

Over the last three years, we have focussed on reducing the numbers of people who become victims of crime, safeguarding those who do become victims and bringing more offenders to justice. We are incredibly proud of what we have achieved as a partnership, however we know that there is more to do. For example, we know that, in some areas of the city, there is a negative perception of how crime and disorder is dealt with. We also know that some people are worried about visiting some areas of the city both in the daytime and late at night.

The foundations on which this plan are built are to ensure that Peterborough's communities and neighbourhoods are safe places to live, visit and work. The challenge facing the city is how to deliver this ambitious vision during a period of ever reducing public sector resources, against a backdrop of a growing and increasingly complex population.

Our plan outlines how we will work together to continue to reduce crime, tackle quality of life issues and address issues which have the most significant risk of harm to the city. We will work together, using real life examples and realistic interventions, to build on the successes of previous years. We will continue to forge constructive partnerships; no one agency can influence change alone and, as a partnership, we will support and challenge what each other does to ensure we protect the vulnerable and our wider communities, to make Peterborough a safer place for everyone.

I hope you enjoy reading it.

## About this Plan

The Safer Peterborough Partnership has a statutory duty to develop and implement a Partnership Plan, which describes how responsible authorities and other partners will work together to tackle crime, disorder, substance misuse and re-offending in the city.

This Plan defines the priorities for the Safer Peterborough Partnership over the next three years. The Plan also identifies how the Partnership will respond to the impact of national policy changes and new and emerging risks.

The Safer Peterborough Partnership Plan 2017 - 2020 will be implemented on 1st April 2017 and will be active for three years. The Plan and its priorities are revised annually to take account of changes in crime and disorder, the changing nature of local priorities, available resources and changes within communities.

## Our Partnership

The Safer Peterborough Partnership is a multi-agency strategic group set up following the Crime and Disorder Act 1998. The partnership approach is built on the premise that no single agency can deal with, or be responsible for dealing with, complex community safety issues and that these issues can be addressed more effectively and efficiently through working in partnership.

The Safer Peterborough Partnership is made up of a number of responsible authorities who work together to deliver the partnership priorities. These organisations include:

- Peterborough City Council
- Cambridgeshire Constabulary
- Cambridgeshire Fire and Rescue Service
- Cambridgeshire and Peterborough Clinical Commissioning Group
- National Probation Service
- Bedfordshire, Northamptonshire, Cambridgeshire and Hertfordshire Community Rehabilitation Company

The Partnership is also supported by key local agencies from both the public and voluntary sectors. Registered Social Landlords have a key role to play in addressing crime and disorder and they are represented by Cross Keys Homes.

The Safer Peterborough Partnership co-ordinates the work of all the partners across the city by:

- Undertaking an annual strategic assessment to identify community safety priorities across Peterborough and set priorities;
- Developing a three year Partnership Plan, refreshed annually, to co-ordinate activity to address community safety priorities across Peterborough;
- Monitoring delivery against our objectives and performance through targeting resources to deliver efficient and effective outcomes for everyone who lives, visits and works in the city

One key area of focus for the Partnership over the coming 12 months, will be to improve integrated working across partnerships by continuing to strengthen our relationships with other local partnerships, such as the Health and Wellbeing Board, the Safeguarding Boards and the new county partnership board focussing on domestic abuse, sexual health and substance misuse. We will engage with these partnerships to explore options for co-delivery of key areas of work which impact on community safety.

We will also seek to improve working across geographical boundaries by forging relationships with community safety partnerships and other organisations working in Cambridgeshire and beyond.

## Our Approach

Every year, Safer Peterborough completes an assessment of community safety in Peterborough, called the Strategic Assessment. The findings from this assessment, together with findings from the public consultation, are used to identify Peterborough's community safety priorities.

In times of reducing resources and increasing challenges, we are making a commitment to prioritise a small number of themes which our assessment process has identified as having the highest risk of harm to communities in Peterborough. This plan therefore does not seek to address every community safety issue that can occur in the city.

There are a number of other crime and disorder types which we assess as having a lower level of risk which do not generally require a focused partnership approach to address. We will continue to work proactively in these areas to ensure that we meet our statutory responsibilities, monitor performance and where required provide a partnership response to tackle entrenched or escalating issues.

We will use our existing robust performance management framework to monitor crime and disorder trends, ensuring that we are able to respond to areas of emerging risk where appropriate.

Other priority areas that influence the Plan, but are not led by the Safer Peterborough Partnership, include the Cambridgeshire and Peterborough Road Safety Partnership Plan, Safeguarding Children and Adults Board and the Cambridgeshire Domestic Abuse, Substance Misuse and Sexual Violence Board. We will strengthen our relationships with these partnerships to improve integrated working.

This plan will outline:

- Our successes in reducing crime and anti-social behaviour over the past three years.
- Our priorities for the next three years – based on what you told us and our detailed assessment of crime and antisocial behaviour in Peterborough.
- Where we will focus our efforts as a partnership over the next three years.

Local delivery of our priorities is key to the success of this strategy. We know that the neighbourhoods making up the city face different challenges and have different strengths. That is why the community safety priorities will be integrated into existing local delivery plans. By doing this we will 'join up' our resources and efforts at a local level, ensuring that we are focused on the most important issues in that area.

## Consultation and Engagement

Central to planning community safety activity in Peterborough is how we engage and listen to the concerns of our communities. The Safer Peterborough Partnership Public Consultation Survey has been developed to ask people who live, work or have some other connection with the City, to tell us what they think the priorities for Safer Peterborough should be and their perceptions of crime and disorder more generally.

This year 149 people responded to our survey which was open between 1st December 2016 and 31st January 2017. The demographic profile of the respondents was as follows:

- 55.7% were female, 41.6% male, and 2.7% did not say.
- 87.2% of respondents were British or English, and 8.1% did not disclose their nationality. 4.7% of respondents were non-British nationals.
- The most represented ethnicity was White (85.9%), followed by Black/African/Caribbean/Black British (3.4%), Mixed/multiple ethnic groups (3.4%), and Asian or Asian British (2%). 5.4% left this question blank.
- The survey was answered mostly by people from older age categories, with 71.1% of respondents over 45: 25.5% of respondents were aged 65 and over, 23.5% were 55-54 and 22.1% were 35-44. 2% were aged 18-24, 10.1% aged 25-34 and 14.8% aged 35-44.
- 10.1% of respondents stated they have a disability.

The key findings from this year's survey are:

- Respondents were able to pick from a list of 14 community safety concerns, the top issue that most respondents were concerned about in Peterborough is environmental crime (fly-tipping, fly-posting, graffiti). 78.5% of respondents stated they were either concerned or very concerned about this issue. Anti-social behaviour (75.2%), road safety issues (such as speeding, mini-motorbikes, drink driving – 71.8%) and alcohol and drug misuse (71.1%) also ranked highest among people's concerns.
- Arson ranked lowest in people concerns, with only 32.2% of respondents stating they were either concerned or very concerned about this issue. Cold calling (at the door and by phone – 51.7%), begging (57%) and violent crime (57.7%) also ranked lowest in people's concerns.
- 53.7% of respondents indicated that they are concerned or very concerned about being a victim of crime. 32.9% stated that they were not concerned or not very concerned.
- People are consistently more concerned about going out in the City Centre than their local area, both day and night.
- More than half of respondents indicated that they thought people from different backgrounds got on together in their neighbourhood.

The survey findings have been considered as part of the priority setting process for Safer Peterborough, issues identified by the survey such as alcohol and drug misuse, violent crime and becoming a victim of crime are key issues already identified by Safer Peterborough and are priorities within this Plan. Fortunately, the lives of most people living and working in Peterborough are not affected by the issues that present the greatest risk of serious harm, and the survey has mostly highlighted low level nuisance as top concerns. The majority of these low level issues fall within the remit of the Prevention and Enforcement Service and some of the other key partners who form part of Safer Peterborough such as Registered Social Landlords, and are prioritised by these teams.

## Building on Success

Since the first Safer Peterborough Partnership Plan in 2008, by working together, we have reduced crime by 21% over an eight year period, with the total number of crimes falling from 22,021 in 2008 to 17,322 in 2016, which is in line with national trends.

Below are some examples of how we have worked in partnership to reduce offending and protect victims and communities from harm over the last 12 months.

- ***Total crime continues to reduce*** over the longer term, however whilst the Police are increasingly dealing with a lower volume of crime, it is often much more complex in nature and impacts on the most vulnerable in our communities, taking longer to resolve. Short term increases in both violent and sexual offences can be attributed to the renewed focus on the quality of crime recording by the police, rather than reflecting changing levels of criminal activity. This has led to improved compliance with the National Crime Recording Standard, leading to the recording of a greater proportion of crimes that come to the attention of the police.

- We have seen the ***number of offenders diminish*** significantly, particularly over the last three years, for both adult and young offenders. Linked to this, the number of first time entrants into the criminal justice system continues to decrease. However, re-offending is increasing and the percentage of offenders that re-offend in Peterborough is higher than the England and Wales average rates.

- Our Integrated Offender Management Scheme, which targets a cohort of offenders identified as being the most prolific and at high risk of re-offending, has seen ***significant and sustained reductions in crime*** for those offenders who form part of the scheme.

- The ***Prevention and Enforcement Service*** was established in 2016, the team is one of the first in the country to bring together Council, Police and Fire Service staff into one integrated, centrally managed team. The service undertakes a range of prevention and enforcement activities including civil enforcement of parking issues, enforcement against environmental crime, housing enforcement anti-social behaviour, fire safety and road safety. In addition to this, the service also includes police officers and PCSOs who work across the city.

- The numbers of people killed or seriously injured on our roads ***continues to reduce year on year***, and at a higher rate than the national average.

- There has been a ***continued reduction in anti-social behaviour*** over the last year, with 353 fewer incidents recorded than the previous 12 months. We have been using the new anti-social behaviour powers that are available to us and this year and have issued a number of criminal behaviour orders to perpetrators of anti-social behaviour. This has resulted in significant reductions in anti-social behaviour in a number of communities across the city where families were being targeted.

- We continue to ***respond quickly and effectively to unauthorised traveller encampments***. Between April and December 2016, the Partnership have dealt with 53 unauthorised encampments on local authority land. We have robustly enforced all available legislation to resolve these issues on 30 occasions. The Prevention and Enforcement Service have worked closely with businesses who have had unauthorised encampments on their land by providing support and guidance on evictions. We have also sought to install defence measures at various locations across the city, in an attempt to prevent further unauthorised encampments.

- We have undertaken ***widespread training on the Prevent programme*** which supports staff to identify individuals who may be at risk of radicalisation and gives information on where to report any concerns. There has been widespread training across the City Council

and the Police and almost all educational establishments in the city have had some kind of Prevent training.

- ***Restorative justice is being used in Peterborough to help tackle conflict*** in the city and provides an opportunity for victims to have their say. For the victim, restorative justice can help to provide a sense of closure, enabling them to move on. For the offender, restorative justice provides an opportunity for them to face the consequences of their actions and recognise the impact it has had upon others. Emphasis has been placed on restorative justice being 'victim-led' and it being available to victims at every stage of their journey. From April to December 2016, there were over 1,800 restorative reparations in Peterborough, which include face to face conferences, community resolutions and letters of apology from the offender to the victim.

- The Partnership and licensed premises take part in the NightSafe Pubwatch scheme where information is freely shared in relation to problematic offenders who are known to cause trouble in the night time economy and exclusions are enforced. Currently 118 individuals are excluded from NightSafe registered premises in Peterborough. Exclusions are pro-actively enforced and have been highly effective in preventing and deterring alcohol related harm. Whether it's a formal warning letter or absolute exclusion, ***at least 98% of those excluded do not come to the Police's attention again***.

- An ***alcohol diversion scheme*** has been developed in conjunction with drug and alcohol treatment provider, Aspire. Following an alcohol related arrest, a conditional caution is put in place whereby the offender is offered one to one support, medical prescribing, and detoxification as well as structured group work, structured and peer led activities and counselling.

### Changing Population

The population of Peterborough is projected to increase by 9% over the next 10 years and the 65+ age group is projected to grow by 10.9% by 2021. Whilst England has experienced a 7% increase in 0-14 year age group, Peterborough has seen a 22% increase in this category. The 15-29 age group in the city has experienced a 6% increase with the city as a whole experiencing a much faster than average growth of the 45+ age groups.

As well as greater volume, the changing demographics will pose new challenges. Older people represent a significant proportion of vulnerable people in society and ageing population may lead to an increase in vulnerable adult related crime such as adult abuse, fraud, rogue trading and distraction burglary. Older people also commit crime – whilst still low overall, the percentage of older people committing crime has increased over recent years with the most common crime type violence against the person (domestic assaults).

The increased level of inward migration to Peterborough over the last 10 years, has resulted in a cultural change in the city. Outside the White British population, 'Asian or Asian British' and 'White Other' populations form the largest communities (12% and 11% respectively). Peterborough has the second highest proportion of the population who cannot speak English or cannot speak English well of local authorities in the East of England (4.86% of the population).

### Selective Licensing

The Housing Act 2004 has given local authorities the power to introduce selective licensing of privately rented properties to improve conditions for tenants and the local community, if there is a high level of privately rented housing stock in the area and one or more criteria are met.

In 2016, a selective licensing scheme began in Peterborough within 22 Lower Super Output Areas (geographical areas with an average of 1,500 residents) in the Central, North, East, Park, Fletton, Bretton North, Stanground Central, Walton and Orton Longueville areas. The scheme is proposed to cover the potential 22,000 properties in the areas, representing 4.8% of the city's geographic area and will initially last for five years. Through Selective Licensing, the quality, management and safety of all private rented properties in the designated areas of the city will improve.

### Police and Crime Commissioner

In 2016 a new Police and Crime Commissioner was elected for Cambridgeshire and Peterborough. A new Police and Crime Plan has been published in draft for the period 2017-20, setting out the Commissioner's vision for policing and community safety across Cambridgeshire. The Commissioner's priorities are:

- Victims and witnesses are placed at the heart of the criminal justice system and have access to clear pathways of support
- Offenders are brought to justice and are less likely to reoffend
- Communities have confidence in how we respond to their needs
- We deliver improved outcomes and savings through innovation and collaboration.

These priorities have been reflected in this plan, the links between the two plans are outlined in Appendix 1.

### Prevention and Enforcement Service

The Prevention and Enforcement Service (PES) came into effect on the 1 April 2016 and builds upon the work of the Safer Peterborough Partnership (SPP) in tackling crime, community safety and quality of life issues. The PES brings together officers from a range of public sector organisations into a single service led by a joint management structure.

The PES is hosted by Peterborough City Council and is made up of staff and resources from the Council, Police, Fire and Rescue Service and Prison.

The PES is a Community Safety Accredited Scheme which will allow all front officers to access to a range of powers to tackle anti-social behaviour and quality of life issues such as:

- Issuing fixed penalty notices for fly-posting, graffiti, dog fouling, littering, etc;
- Powers to deal with begging;
- Powers to stop cycles; and
- Powers to remove abandoned vehicles.

This builds on the powers the council and the police already have in tackling quality of life issues across the city but provides a single joined up service that can jointly address routine and priority issues affecting Peterborough.

**Devolution**

Council and Local Enterprise Partnership leaders across Cambridgeshire and Peterborough have approved a devolution to deal that will deliver £770million of new funding for local infrastructure projects and to build housing.

The devolution deal includes significant benefits for the communities of Cambridgeshire and Peterborough including:

- Investment in a Peterborough University with degree-awarding powers.
- Devolved skills and apprenticeship budget – to give more opportunities to young people.
- Working with Government to secure a Peterborough Enterprise Zone – attracting investment from business leading to more and better quality jobs for residents.
- Working with Government on the continued regeneration of Peterborough City Centre.

**Changes to Policing**

The Crime and Policing Bill, which is likely to receive Royal Assent in 2017, aims to build on the police reform carried out through the introduction of Police and Crime Commissioners, the strengthening of the Independent Police Complaints Commission and establishment of the College of Policing.

The Bill comprises nine parts, one of the key areas for consideration is the Emergency Services Collaboration which introduces a new duty on the police, fire and rescue and ambulance emergency services to collaborate, where doing so would improve efficiency or effectiveness. It also enables Police and Crime Commissioners to take on the functions and duties of Fire and Rescue Authorities and to delegate police and fire to a single Chief Officer for police and fire.

## PRIORITIES FOR 2017 - 2020

The approach agreed by the Safer Peterborough Partnership for this plan is to adopt a small number of priorities which our assessment process has identified as having a high risk of harm to communities in Peterborough. This section covers in more detail how we will work together to tackle these issues, support victims and reduce offending.

The Safer Peterborough Partnership has established four priorities which have been identified as key delivery areas and which the Partnership places high importance on providing effective, innovative and improving services. The priorities are:

- Offender Management
- Domestic Abuse and Sexual Violence
- Building Resilient Communities

In addition, the Partnership has identified two further areas which are recognised as significant cross-cutting themes across the partnership landscape. These cross-cutting issues already feature in thematic plans and the Partnership recognise that a more collective approach will have a more significant impact and bring about lasting change. The cross cutting themes are:

- Substance Misuse
- Mental Health

The section below describes how the Safer Peterborough Partnership will tackle these priority areas over the coming three years, it also describes how each theme will be performance managed to ensure the Partnership can accurately measure progress.

## PRIORITY 1: OFFENDER MANAGEMENT

**Key Outcome**
To reduce the number of offenders in Peterborough and the number of offences they commit, with a specific focus on those most prolific offenders and young offenders.

**Why is it a priority?**
Offenders are amongst the most socially excluded in society and often have complex and deep-rooted health and social problems, such as substance misuse, mental health, homelessness and financial problems. Understanding and addressing these underlying issues in a co-ordinated way plays a key role in reducing crime and breaking the cycle of offending behaviour from one generation to the next.

Offender management has undergone a significant transition under the Government's Transforming Rehabilitation programme, with delivery of Probation services now split between the public and private sector. The BeNCH Community Rehabilitation Company (CRC) provides services aimed at rehabilitating medium to low risk offenders given community sentences by the Courts and short sentence prisoners. The new public sector National Probation Service is tasked with protecting the public from the most high risk offenders. A more integrated working model with the new Community Rehabilitation Company and the National Probation Service is developing and this will be a key area of work for the partnership over the coming 12 months.

Information on re-offending in Peterborough shows that re-offending is increasing and the percentage of offenders that re-offend in Peterborough is higher than the England and Wales average rates. However, whilst re-offending rates are increasing, the actual number of re-offenders is reducing, indicating that this smaller group of offenders are more prolific.

For young people, identifying problems early is key as they are statistically more likely than adults to re-offend. There are also changes being proposed in the way that the youth justice system operates, the local impact of this is as yet unknown but the recent review by Government recommends that education is put at the heart of the youth justice system. Offenders would be supported in smaller, local secure schools where they can benefit from behavioural expertise, therapies, and the skills needed to get on in life after release.

**What we plan to do**
The Partnership will formulate and implement a strategy to reduce re-offending by adult and young offenders. The strategy will ensure that re-offending is considered in all contexts and will be closely linked to our strategies on substance misuse, homelessness, mental health and domestic abuse.

The Youth Offending Service will work with partners to identify those young people who are committing the most offences, and engage them in effective activity and rehabilitation to reduce their re-offending. There are a number of areas for development over the coming 12 months, including:

- Developing and extending early help services - the service continues to make an offer to young people either to prevent them becoming involved in offending or to keep them out of the criminal justice system if they have committed a low level offence for the first time. Over the next 12 months we will be developing a more integrated approach to working with adolescents and a targeted youth support service is now being developed in the city.
- Working with victims and Restorative Justice - there has been some very positive work undertaken in developing both service links to and support for victims of crime and Restorative Justice. We will continue to develop more restorative approaches over the next 12 months.
- Developing a systemic approach to working with families - the Youth Offending Service have always maintained a good level of engagement with young people and their families, however we want to expand the degree of parental involvement in both the planning and delivery of our interventions over the next 12 months.

- Improving the service response to recidivism, particularly higher risk young people - we will put in place extra additional training and support to improve rates of recidivism.
- Tackling resettlement issues, particularly those linked to education, training or employment - a system of early planning in cases where custody has been given to ensure more effective resettlement outcomes is now fully in place.
- The Integrated Offender Management programme continues to support some of the most problematic offenders in Peterborough. The scheme allows local and partner agencies to come together to ensure that the offenders, whose crimes cause most damage and harm locally, are managed in a co-ordinated way. Over the next 12 months, we will consider expanding the remit of the scheme beyond serious acquisitive crime offenders. Proposals being considered by the group include adopting offenders on a risk based approach, which means more offenders will benefit from the success of the management of the scheme, leading to reductions in offending.

**How we will measure success**

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|---|
| Reducing the number of people who become victims of crime |
| Reduce the number of first time entrants into the criminal justice system |
| Increase the number of offenders participating in restorative interventions |
| Reduction in the number of proven offences for offenders managed through the Integrated Offender Management programme |
| |

## PRIORITY 2: DOMESTIC ABUSE AND SEXUAL VIOLENCE

**Key Outcome**
To prevent domestic abuse and sexual violence and reduce the associated harm, ensuring all victims of domestic abuse and sexual violence have access to the right help and support and that services are available to address their needs.

**Why is it a priority?**
Demand on domestic abuse and sexual violence services continues to rise, particularly as vulnerable families struggle to cope with the financial and emotional pressures of unemployment, reduced household income and increased financial hardship.

There is still an unknown volume of hidden, unreported domestic abuse. Nationally it is estimated that only 16% of domestic abuse is reported to the Police, we know that awareness of domestic abuse reporting for the public needs to be improved, particularly amongst minority ethnic groups and male victims.

Although there are positive developments at a national and local level with regards to the successful prosecution of more domestic abuse and sexual violence offenders, the rate of attrition between the volume of incidents reported to the police and the volume of cases being brought before the courts by the CPS is of concern.

The government's programme of welfare reform is having an impact on families' budgets and this could be inadvertently causing financial abuse. Universal Credit, when fully introduced to include families in November 2017, is currently planned to be paid monthly and as a single payment to the 'head of the household'. This could lead to an increased need to bargain and negotiate within the household, decreasing one partner's financial autonomy and independence.

**What we plan to do**
Domestic abuse and sexual violence services in Peterborough are well established and are currently delivered by Specialist Abuse Services Peterborough, a service commissioned by Peterborough City Council. An action plan is monitored and delivered through the Domestic Abuse and Sexual Violence Strategic Board which reports to the Safer Peterborough Partnership.

There are a number of priorities which include:

- Intervening earlier to prevent domestic abuse and sexual violence from happening and challenging the attitudes and behaviours which foster it and intervene as early as possible to prevent it.
- Providing support to victims and their families where violence occurs.
- Taking action to reduce the risk to victims of these crimes and to ensure that perpetrators are brought to justice.

Over the next 12 months we will prioritise a number of areas of work in support of these priorities.

- We will ensure that domestic abuse and sexual violence services are able to respond to increasing demand for services.
- We will support in the development of a countywide partnership response to reduce the harm, risks and costs of domestic abuse, child abuse (including child sexual exploitation), serious sexual offences, trafficking and modern day slavery' which keeps victims safe from future victimisation.
- Enhance community engagement and awareness of domestic abuse and sexual violence support services to incldue the lesbian, gay, bi-sexual and transgender community with the aim of increasing the number of victims accessing support and reporting incidents to the Police.
- Develop a local offer to meet the needs of children and young people who are, or at risk of becoming, perpetrators and/or victims of domestic abuse and sexual violence, to improve specialist support services.

- There is a need to work towards increasing referrals from mental health care settings, ensuring all mental health professionals are providing their service users with the opportunity to access domestic abuse and sexual violence support services.
- Review and monitor the implementation of the recommendations from Domestic Homicide Reviews and hold partners to account for their actions.

**How we will measure success**

Performance indicators for this area of work will be developed in line with the countywide partnership focusing on domestic abuse and sexual violence, once this Board is established from April 2017. We will ensure we monitor performance data in line with the guidance from the National Institute of Clinical Excellence, taking into account the national focus on Violence Against Women and Girls.

## PRIORITY 3: BUILDING COMMUNITY RESILIENCE

**Key Outcome**
To strengthen the resilience of our communities by ensuring that those who commit hate crime and other acts which break down the fabric of our communities, do not succeed.

**Why is it a priority?**
Community's cohesion builds strong and safe communities. In its simplest form, community cohesion is about people from different backgrounds getting on with each other, people contributing to how their community runs and people in the community having a sense of belonging.

Peterborough continues to benefit from its reputation as a tolerant and welcoming place, but tensions can develop in communities that undergo rapid demographic change and these must be effectively managed. The current economic and political climate has the potential to exacerbate community tensions, drive up hate crime and raise the level of fear in our communities. Nationally, support for extreme right wing views is becoming more visible and acceptable, particularly around emotive issues such as the EU refugee crisis, Brexit and fears about ISIS. Online and remote radicalisation makes those in more isolated communities vulnerable, with limited access to alternative narratives.

Issues such as hate crime and extremism can undermine a community's resilience, whilst both these issues have been assessed as a comparatively low risk and threat to our communities, since Brexit we know that the risk has increased. Hate crime and extremism are separate but linked issues in terms of identifying and responding effectively to vulnerability, discrimination and radicalisation in our communities. We recognise that crime motivated by hostility, or a particular prejudice towards an individual's personal characteristic or perceived characteristic, is particularly corrosive in relation to victims and communities. This type of act can leave people feeling vulnerable and can impact negatively on many aspects of their lives, including their self-confidence and health, as well as contributing to feelings of isolation.

The UK faces a severe and continuing threat from terrorism, however there is no intelligence to suggest an attack in Cambridgeshire is imminent and the risk of radicalisation is assessed as low within the city. The Safer Peterborough Partnership works with partners across Cambridgeshire to review the Counter Terrorism Local Plan and ensure that all identified risks are addressed.

**What we plan to do**

<u>Tackling Extremism</u>
Prevent is one of the four strands of CONTEST, the UK strategy for countering terrorism. It is aimed at working closely with individuals who are likely to adopt extremist views, and work in partnership with other agencies and our communities to identify individuals who may need our support.

The Safer Peterborough Partnership, along with other key partners, will develop an annual counter terrorism local plan to mitigate identified risks around terrorism and radicalisation. We are also able to provide intervention and support for those who are identified at risk of radicalisation and extremism.

A process called 'Channel' has been developed to support people at risk of being drawn towards terrorism and violent extremism. Peterborough City Council, Cambridgeshire Police and other partners, including Probation, health agencies, community organisations and individuals within local communities work together to support vulnerable individuals who are prone to radicalisation. A range of options are available including mentoring, welfare support and access to key services. The Partnership will continue to support this process ensuring that people who are risk of radicalisation are appropriately referred to Channel.

<u>Hate Crime</u>

We will work together to strengthen the resilience of our communities, we recognise that community cohesion is driven by people making an effort to support one another in their communities and neighbourhoods. Hate crime poses a direct threat to achieving this and we will continue to ensure that we make it clear to perpetrators that their behaviour is unacceptable and will not be tolerated. There are a number of key priorities in our hate crime strategy which we will focus on over the next 12 months, these include:

- Increasing the confidence of hate crime victims to report hate incidents to the police and third parties.
- Work with community and voluntary organisations to develop more effective approaches to understanding, preventing and tackling hate crimes and incidents in our communities.
- Taking effective action against perpetrators, challenging the attitudes of offenders in relation to hate crime and engaging more perpetrators in reparation type activities.

**How we will measure success**

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| Increasing the number of hate crimes and hate incidents reported |
| Increasing the proportion of Police detections for hate crime offences |
| Increase the number of hate incidents reported to third party reporting centres, including through the online portal, True Vision |

## CROSS CUTTING THEME 1: SUBSTANCE MISUSE

**Key Outcome**
To reduce the number of people who experience crime and anti-social behaviour as a result of alcohol and drug misuse, whilst providing effective treatment and rehabilitation to those who have alcohol and drug problems.

**Why is it a priority?**
Some people experience multiple problems which have a cumulative impact on their ability to make positive life choices and avoid criminal, anti-social behaviour or other behaviour that has a negative impact on others. The themes of domestic abuse, mental health and drug and alcohol problems in particular are recurrent themes and we can establish that substance use is a common feature in criminality and family breakdown. This in turn can lead to inter-generational cycles of behaviours such as abuse, drug use and offending.

Substance misuse impacts across many areas of community safety and drug dependency remains a significant contributory factor to a number of crime and disorder types. Drug misuse and crimes such as burglary and robbery are closely linked and anti-social behaviour can also be related to alcohol and drug misuse. We know that violent crime such as assault and domestic violence and abuse often involve alcohol. A recent night time economy review has shown that between January to August 2016 at least 56% of city centre violent crime is attributable to alcohol.

**What we plan to do**
We will continue to provide services for people who want help to stop their misuse of alcohol and drugs, and to divert into treatment programmes those who commit crime to support their alcohol and drug misuse. We will take strong enforcement action against alcohol and drug-related crime, and work together to tackle the things that can cause alcohol and drug misuse.

The long term objectives of our substance misuse intervention system partnership are to:

- Increase the number of people free from drug and alcohol dependence (and substitute medication) and in sustained recovery.
- Improve the health and wellbeing of people with substance misuse issues.
- Reduce harm experienced by individuals, families and the community arising from problematic substance misuse.
- Reduce crime experienced by individuals, families and the community associated with problematic substance misuse.
- Prevent future demand on health, criminal justice and treatment services.

We have a detailed substance misuse action plan which reflects the three key themes underpinning our approach to tackling substance misuse, each section of the action plan contains detailed actions and dates for completion. There are a number of areas of focus over the coming 12 months which include:

- Develop public awareness campaigns to promote awareness of alcohol and drug related harm.
- Support the development of substance misuse education, awareness and access to help in schools.
- Develop targeted awareness raising with higher risk groups and communities.
- Develop awareness and skills regarding the use of new psychoactive substances.
- Develop work with individuals resistant to engagement in treatment services.
- Ensure effective and appropriate care for substance misusers who suffer with mental health problems.
- Ensure there are effective pathways in the criminal justice system for people misusing substances.
- Improve the use of information gathered for patients with assault related injuries in Peterborough City Hospital's Emergency Department, to improve the safety of licensed premises and to safeguard staff and customers.

**How we will measure success**

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| Increase the number of people successfully completing drug and alcohol treatment programmes, whilst reducing the proportion who re-present to services |
| Reduce the number of alcohol-related admissions to hospital |
| Reduce alcohol and drug related crime |

## CROSS CUTTING THEME 2: MENTAL HEALTH

**Key Outcome**
To identify the challenges and the impact of mental health on the successful delivery of community safety.

**Why is it a priority?**

Mental health is a theme impacting all areas of delivery across the Safer Peterborough Partnership. The impact of mental health on community safety is recognised as important but has been difficult to impact upon, made more complex because data is not always routinely collected and accessible.
Mental ill health is the largest cause of disability in the UK, representing 23% of the burden of illness. At least one in four people will experience a mental health problem at some point in their life and one in six adults has a mental health problem at any one time.

The information drawn from a recent Joint Strategic Needs Assessment on Mental Health suggests that Peterborough faces potential challenges with promoting mental health and preventing mental illness. Many of the recognised risk factors for poor mental health are found at a higher rate in the Peterborough Unitary Authority area compared with England, East of England and Cambridgeshire. These risk factors include higher rates of socio-economic deprivation, children in care, violent crime, some types of drug misuse, homelessness, relationship breakdown, lone parent households and household overcrowding compared with East of England and most England averages.
High levels of crime, undermine mental wellbeing. Violent crime is linked to mental health problems including depression, anxiety and post-traumatic stress disorder, suicide, and misuse of drugs and alcohol. A strong negative relationship has been found between rates of violent crime in an area and the mental wellbeing of residents living there.

**What we plan to do**

The Cambridgeshire and Peterborough Health and Wellbeing Board are responsible for improving the mental health of people across the county, including Peterborough, and this board take the lead in this area of work.

The focus of Safer Peterborough's work around mental health will focus on identifying and understanding how mental health impacts on community safety. This will include mapping mental health provision and pathways in the context of community safety. Once this is understood, the Partnership will identify how they can work with the Cambridgeshire and Peterborough Health and Wellbeing Board to reduce the impact of mental health on community safety, both in terms of offenders' mental health and understanding more about how we can ensure people with mental health problems are less likely to become victims of crime.

## GETTING INVOLVED

The Safer Peterborough Partnership are committed to reducing crime and improving quality of life and every agency involved in the Partnership wants to make Peterborough a safer place. However, we cannot do this alone. We know that people working together in their communities are helping to prevent crime and many of the achievements set out in this strategy have happened because local people have been actively engaged in tackling crime and disorder.

There are lots of ways you can get involved to make Peterborough safer and below is some information about how you can get involved.

**Neighbourhood Watch**
Neighbourhood Watch is about local communities working together and with the police to help make their neighbourhood safer. Neighbourhood Watch schemes can help reduce crime in local areas, so they are a great way to help you protect yourself, your family and friends and home. Visit the website Neighbourhood Watch.

**Salvation Army's Good Neighbour Scheme**
Today, older people live longer and are also encouraged to live independently in their own homes. The Salvation Army's Good Neighbour Scheme volunteers support the elderly to live life in all its fullness by promoting independent living, tackling isolation, promoting a healthier lifestyle, giving a voice in things that affect them and helping to build confidence. To volunteer, visit the website here.

**Victim Support Volunteers**
The Police have new team of Police Support Volunteers, the volunteers are fully trained and focus on crime prevention, examples of the work they conduct includes house to house enquiries, CCTV collection, victim support visits, and offering crime prevention advice. For more information, contact kerry.grice@cambs.pnn.police.uk.

**Victims' Hub**
If you or someone you know has been affected by crime, the Victim and Witness Hub can give you the support needed to enable you to cope and recover from your experiences. Victim and Witness Hub Community Volunteers provide emotional support for victims of crime. To find out more, visit the website.

**Police Cadets**
Cambridgeshire Constabulary runs a Volunteer Police Cadet scheme which aims to strengthen the voice of younger people in policing we well as steering those at risk of criminality away from a life of crime. The scheme encourages a spirit of adventure and good citizenship and can count towards formal qualifications and evidencing voluntary work for the Princes Trust/Duke of Edinburgh Award schemes. Find out more information here.

**Do-It**
For information on other volunteering opportunities, visit the Do-It website here

**Appendix 1**

The table below shows how the Safer Peterborough Partnership Plan reflects the priorities of the Police and Crime Commissioner.

| Police and Crime Plan 2017-2020 | How are the PCP priorities reflected in the Safer Peterborough Partnership Plan 2017-2020 |
|---|---|
| **Victims – safeguarding the vulnerable**<br>Aim: deliver a victim first approach<br>Shared Outcomes: victims and witnesses are placed at the heart of the criminal justice system and have access to clear pathways of support | Safeguarding the vulnerable is a theme running through the SPP Plan. Reducing the number of people who become victims of crime is a key priority, the SPP have also prioritised a number of high risk victim groups including **domestic abuse, sexual violence** and **hate crime** victims. |
| **Offenders – attacking criminality**<br>Aim: reduce re-offending<br>Shared Outcomes: offenders are brought to justice and are less likely to reoffend | **Offender management** is a priority in the SPP plan and bringing more offenders to justice, using traditional and restorative solutions are priorities within the plan. Reducing re-offending is a key area of focus. |
| **Communities – preventing crime, reassuring the public**<br>Aim: support safer and stronger communities<br>Shared Outcomes: communities have confidence in how we respond to their needs | **Building Resilient Communities** is a priority in the SPP Plan, our focus is on reducing hate crime and tackling violent extremism which can undermine the fabric of our communities. |
| **Transformation – achieving best use of resources**<br>Aim: ensure value for money for tax payers now and in the future<br>Shared Outcomes: we deliver improves outcomes and savings through innovation and collaboration | Collaboration between agencies is at the heart of the SPP plan, the priorities are owned by a variety of partners where we co-deliver key areas of work which impact on community safety. |

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| HEALTH AND WELLBEING BOARD | | AGENDA ITEM No. 12 |
|---|---|---|
| **23 MARCH 2017** | | PUBLIC REPORT |
| Contact Officer(s): | Helen Gregg, Partnership Manager | Tel. 863618 |

# HEALTH & WELLBEING STRATEGY 6 MONTH PROGRESS REPORT

| RECOMMENDATIONS | |
|---|---|
| **FROM :** HWB & SPP Partnership Delivery Group | **Deadline date :** N/A |
| That the Health and Wellbeing Board consider the content of the progress report and raise any questions. | |

## 1. ORIGIN OF REPORT

1.1 This report is submitted as part of the monitoring process for the Peterborough Health & Wellbeing Strategy 2016-2019.

## 2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide Board members with a 6 month summary of progress against the Future Plans identified for each of the focus areas outlined in the Health & Wellbeing Strategy 2016-2019.

2.2 This report is for the Board to consider under its Terms of Reference Numbers:

*3.1 To develop a Health and Wellbeing Strategy for the city which informs and influences the commissioning plans of partner agencies*

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

## 3. BACKGROUND

3.1 The Health & Wellbeing Strategy 2016-19 identified the following key focus areas:

- Children and Young People's Health
- Health Behaviours and Lifestyles
- Long Term Conditions and Premature Mortality
- Mental Health for Adults of Working Age
- Health & Wellbeing of People with Disability and Sensory Impairment
- Ageing Well
- Protecting Health
- Growth, Health and the Local Plan
- Health and Transport Planning
- Housing and Health
- Geographical Health Inequalities
- Health & Wellbeing of Diverse Communities
- Sustainable Transformation 5 Year Plan

3.2 For each of the focus areas listed above, a progress report is contained within Appendix 2. The reports outline current activities, key milestones and risks associated with the future plans.

3.3 Progress Summary – please refer to Appendix 1 for the list of RAG ratings for all future plans identified within the Strategy and a Risk Register.

3.4 The majority of future plans are still in progress (amber), but a number have been completed and are coloured green. There have been delays against expected milestones in some areas – for example the Older People and Primary Prevention of Ill Health for Older People JSNA will now be delivered in 2017 rather than 2016, and there have been some changes to the Housing Partnership, which temporarily affected the Vulnerable People's Housing Sub-Group. The performance monitoring process for the HWB Strategy through the Health and Wellbeing Board/Safer Peterborough Partnership Delivery Board enables challenges and/or delays to delivery to be identified and addressed collaboratively.

3.5 The two focus areas with the greatest proportion of completed future plans are:

- Mental Health for Adults of Working Age
- Geographical Health Inequalities

3.6 We have invited the Cambridgeshire and Peterborough Mental Health Commissioner, Fiona Davies, along to today's meeting to present an update on the key areas of progress for Mental Health for Adults of Working Age (please note the full report is contained in Appendix 2).

3.7 For each focus area, the Public Health Team have prepared, or are preparing/working with the relevant partnership board, performance metrics and target trajectories for key outcomes. An annual performance report of progress against key outcomes will be presented to the Board at the next meeting and an example of performance metrics and target trajectories for the focus area 'Long Term Conditions and Premature Mortality' has been provided in Appendix 3.

## 4. CONSULTATION

4.1 The progress reports will be reviewed at the Health & Wellbeing and SPP Partnership Delivery Group on 27 March 2017.

## 5. ANTICIPATED OUTCOMES

5.1 The Board is asked to review the information contained within this report and respond / provide feedback accordingly.

## 6. REASONS FOR RECOMMENDATIONS

6.1 It is recommended that the HWBB consider the content of the progress report and raise any questions in order for the Board to monitor progress being made on the Health and Wellbeing Strategy.

## 7. ALTERNATIVE OPTIONS CONSIDERED

7.1 N/A

## 8. IMPLICATIONS

8.1 N/A

## 9. BACKGROUND DOCUMENTS

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

9.1 None

## 10. APPENDICES

Appendix 1 Health & Wellbeing Strategy 2016-2019 Future Plans RAG Ratings and Risk Register
Appendix 2 Focus Areas Progress Reports
Appendix 3 Example of performance metrics and target trajectories for Long Term Conditions and Premature Mortality

Appendix 1

**HEALTH AND WELLBEING STRATEGY – FUTURE PLANS RAG RATINGS**

**Colour code:**
**Green – complete**
**Amber – in progress and within timescales**
**Red - delayed**

| Focus Area | Future Plan | RAG Rating |
|---|---|---|
| **CHILDREN AND YOUNG PEOPLES HEALTH** | Develop a CAMH pathway that better meets need and manages demand so that pressures on specialist services are minimised | AMBER |
| | Continuing a pilot approach where additional CPN capacity is aligned with schools to enable better support to be offered to C&YP with emerging emotional and mental health difficulties | AMBER |
| | Working with the PSCB to develop a more effective multi-agency response to neglect, focused particularly on addressing early indications of neglectful parenting and offering support to prevent patterns becoming established | AMBER |
| | Renew the Child Poverty Strategy in 2016 | GREEN |
| | Develop a joint strategy to address high rates of teenage pregnancy | AMBER |
| | Jointly review the commissioning and delivery of services for C&YP with SEND, from age 0-25 | AMBER |
| | Consideration of the needs of single parent families in these workstreams | AMBER |
| **HEALTH BEHAVIOURS AND LIFESTYLES** | Commission an integrated healthy lifestyle service with the aim that people can access one service for help and support with stopping smoking, healthy eating, physical activity, weight management and mental wellbeing, linked with services for people with mental and physical health, disability and ageing issues | GREEN |
| | Improve our communication with local residents on health issues and to develop local campaigns and access to health information sources in a range of settings, which can be trusted to provide reliable advice on healthy lifestyles | GREEN |
| | Recognise the vital role schools play in supporting the health and wellbeing of children and young people through a Healthy Schools Peterborough programme | AMBER |
| | Reduce the number of local people developing Type 2 Diabetes | AMBER |
| **LONG TERM CONDITIONS AND PREMATURE MORTALITY** | Develop and implement a joint strategy to address CVD in Peterborough | AMBER |
| | Explore a specific programme to work with South Asian communities to address higher rates of diabetes and coronary heart disease | AMBER |
| | Explore options to reduce the risk of stroke within the local population by improved identification of atrial fibrillation | AMBER |
| | A long term conditions needs assessment will be carried out which will cover the wider range of long term conditions including cancer and musculo-skeletal disorders | AMBER |

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| **MENTAL HEALTH FOR ADULTS OF WORKING AGE** | Bring together findings from the Peterborough Mental Health JSNA (2015) and refresh the Mental Health Commissioning Strategy in 2016, to tailor implementation plans to address unmet mental health need | AMBER |
| | A new recovery coach service to support people after discharge from secondary care and during transitions by connecting between third sector, local authority and mental health services | GREEN |
| | An enhanced Primary Care Mental Health Service is planned to support people with greater needs upon discharge from secondary care. This will operate through community based teams | GREEN |
| | The new Mental Health Commissioning and Delivery Partnership Board which includes representatives of carers and the voluntary sector, will ensure that the needs of carers are considered in joint planning of services | GREEN |
| | Service user representation will also be invited to the Partnership Board | GREEN |
| **PEOPLE WITH DISABILITY / SENSORY IMPAIRMENT** | Implementation of strategy for supporting older people and adults with long term conditions | AMBER |
| | Work with users of St George's hydrotherapy pool to explore future options for sustainability | AMBER |
| **AGEING WELL** | The HWB has commissioned an 'Older People: Primary Prevention of Ill Health' JSNA for Peterborough, which is due for completion during 2016 | AMBER |
| | Develop a joint 'Healthy Ageing and Prevention Agenda' to ensure that preventative action is integrated and responsible to best support people to age well, live independently and contribute to their communities for as long as possible, including isolation and loneliness | AMBER |
| | Review and refresh the joint dementia strategy for Peterborough | AMBER |
| | A specific programme of work, in collaboration with older residents, will explore the main health and care issues faced by this group to inform future commissioning of services across the system and how stronger communities can empower people to self-manage with minimal support | AMBER |
| | Recognise that some older people prefer face to face communication rather than digital, through community hubs which are part of the Council's wider strategy for communicating with the public | AMBER |
| **PROTECTING HEALTH** | Develop a TB commissioning plan for Cambridgeshire and Peterborough | AMBER |
| | Develop a joint strategy to address poor uptake of screening including improved communication with communities and individuals | AMBER |
| | Develop a joint strategy to address poor uptake of immunisation including improved communication with communities and individuals | AMBER |
| | Develop a Peterborough Joint Sexual Health Strategy, covering a range of issues | GREEN |

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| **GROWTH, HEALTH, LOCAL PLAN** | The health of residents is being specifically considered in the new Local Plan, consideration will be given to the access needs of vulnerable and marginalised groups | AMBER |
| | Public Health outcomes and/or objectives will be added to the Plan | AMBER |
| | Public Health advice will be embedded into the City Council's Growth and Regeneration Directorate, through a post which will work with local land use and transport planners to consider the impact of land use planning on health | GREEN |
| **HEALTH AND TRANSPORT PLANNING** | Collect further JSNA information on transport and health for Peterborough, using locally developed methodologies | AMBER |
| | Permanently embed public health advice in to the City Council's Growth and Regeneration Directorate, through a post which will work with local land use and transport planners to consider the impact of transport planning on health and health inequalities | GREEN |
| **HOUSING AND HEALTH** | Peterborough City Council is working in partnership with registered providers to provide new supported housing schemes including accommodation for people with learning disabilities and mental health disorders to enable them to live independently with a live-in carer where necessary or floating support | GREEN |
| | A Vulnerable People's Housing Sub-Group has been established, which will review how local housing needs for vulnerable people, including people with disabilities, should be addressed | AMBER |
| | The Peterborough Market Position Statement has identified a significant shortfall of nursing and residential care accommodation and it will be a priority to increase this provision for the ageing population | GREEN |
| | A task and finish group including housing managers and hospital managers is reviewing complex cases causing hospital discharge delays, and how use of disabled facility grants could address this | GREEN |
| **GEOGRAPHICAL HEALTH INEQUALITIES** | The NHS CCG has a statutory duty to reduce health inequalities and to carry out health inequalities impact assessments of any significant services changes | GREEN |
| | City Council proposals for selective licensing of private sector housing in parts of the city could impact on geographical health inequalities in the longer term | GREEN |
| | There is potential to target preventive public health initiatives and services so that they focus more on areas of the city with the greatest health and wellbeing needs | AMBER |
| **DIVERSE COMMUNITIES** | The benefits of tailoring preventive programmes, working with South Asian communities to prevent diabetes and CVD, are increasingly recognised nationally. The CCG and the City Council will work together to assess the feasibility of local schemes | AMBER |
| | Outcome measures for health and wellbeing of diverse communities/migrants will be developed following completion of the JSNA | AMBER |

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| **SUSTAINABLE TRANSFORMATION 5 YEAR PLAN** | Greater alignment of BCF Activity with the STP and local authority transformation plan | AMBER |
| | Greater alignment of Peterborough and Cambridgeshire BCF Plans | AMBER |
| | A single commissioning board for Peterborough and Cambridgeshire | GREEN |

## HWB Strategy Progress Risk Register - March 2017

| Ref | Description of risk, i.e. what is the threat or opportunity to the achievement of a business/project objective, use format "**If** <event happens> **then** <consequence of event>" | Raised on Date | Impact (1-4) | Probability (1-6) | RAG Rating | Action or Mitigation Previous Updates | Owner | Status Open / Closed |
|---|---|---|---|---|---|---|---|---|
| **Children and Young People's Health** | | | | | | | | |
| 1 | Lack of embedding of Neglect strategies in community and specialist services | 01 March 2017 | 3 | 3 | | Monitoring to be established | Lou Williams | Open |
| **Health Behaviours and Lifestyles** | | | | | | | | |
| 2 | Mobilisation of the new integrated healthy lifestyle service in time for April 2017 | 01 March 2017 | 3 | 2 | | Implementation is on track | Liz Robin | Open |
| **Long Term Conditions and Premature Mortality** | | | | | | | | |
| 3 | STP / National Funding not allocated to address the local priorities in the HWB Strategy | 01 March 2017 | 4 | 4 | | Bid submitted for funding to deliver work for Diabetes and Cancer patients across CCG footprint | Cath Mitchell | Open |
| 4 | Ability to recruit skilled workforce in the local area | 01 March 2017 | 4 | 3 | | Workforce Review taking place in STP Business Cases / considering Secondments from Secondary Care | Cath Mitchell | Open |
| **Mental Health for Adults of Working Age** | | | | | | | | |
| 5 | Insufficient resource across the health and social care system to support all the developments identified as being required to improve access to services and outcomes by the various workstreams | 01 March 2017 | 3 | 3 | | Minimise inefficiencies and improve promotion including effective information, advice and signposting | Wendi Ogle-Welbourn | Open |
| 6 | Complexities and time needed to meet the internal governance requirements of each organisation slows progress and sufficiently slows delivery of the potential benefits of working collaboratively | 01 March 2017 | 3 | 2 | | Progress the proposed exploration of models of joint commissioning for mental health | Wendi Ogle-Welbourn | Open |
| **H&WB of People with Disability / Sensory Impairment** | | | | | | | | |
| 7 | Managing demand from service users | 01 March 2017 | 3 | 3 | | Work with key stakeholders and organisations to develop local solutions | Adrian Chapman | Open |
| **Ageing Well** | | | | | | | | |
| 8 | LDR investment will not be available for NHS Digital until April 2017 | 01 March 2017 | 3 | 5 | | | Adrian Chapman | Open |
| 9 | BCF planning will not incorporate plans for achieving health and social care integration by 2020 | 01 March 2017 | 3 | 3 | | A multi agency strategic framework is being developed | Adrian Chapman | Open |
| **Protecting Health** | | | | | | | | |
| 10 | Continued availability of funding for strategy implementation especially LTBI screening | 01 March 2017 | 2 | 4 | | | Liz Robin | Open |
| **Growth, Health and the Local Plan** | | | | | | | | |
| 11 | H&WB amendments to the Local Plan not incorporated into the next draft of the Plan | 01 March 2017 | 3 | 3 | | | Simon Machen | Open |
| 12 | Significant objections to the H&WB policies in the Local Plan result in the policies being removed or changed at the examination in public stage of the Local Plan | 01 March 2017 | 3 | 2 | | | Simon Machen | Open |
| **Health and Transport Planning** | | | | | | | | |

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|---|---|---|---|---|---|---|---|---|
| **13** | Lack of capacity to compile Transport and Health data | 01 March 2017 | **3** | **4** | | Task and finish group to be established | Simon Machen | Open |
| **Housing and Health** | | | | | | | | |
| **14** | Once the funding for Supported Housing changes from the current model, there may be a risk of ensuring that the full rent level on these units are met through the proposed top up funding. | 01 March 2017 | **3** | **3** | | Government proposals are currently at the consultation stage | Adrian Chapman | Open |
| **Geographical Health Inequalities** | | | | | | | | |
| **15** | Lack of agreement on how to use the proposed £7.5m investment into the Can Do Area | 01 March 2017 | **3** | **3** | | | Adrian Chapman | Open |

Appendix 2

**HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD**
**PERFORMANCE REPORT**
**DATE: MARCH 2017**
**SUBJECT: CHILDREN AND YOUNG PEOPLE'S HEALTH**
**LEAD: LOU WILLIAMS**

| **HWB STRATEGY 2016/19: CURRENT ACTIVITIES:**<br><br>• Managing the transition of commissioning arrangements for health visiting from NHS England to the Local Authority;<br>• Developing a healthy child programme that ensures that emerging needs for support are identified early and are acted upon effectively in partnership with children and families;<br>• Reviewing the Child and Adolescent Mental Health (CAMH) offer across the area, including overseeing action related to reducing waiting list for specialist CAMH services and remodelling support for children and young people with emotional health and wellbeing needs to make the best use of additional funding from Central Government. | |
|---|---|
| **Current Activities: Performance narrative and statistics (please refer to relevant performance indicators and measures of success)** | The healthy child programme is well-established and considerable work has been undertaken to develop pathways and links between resources to ensure that emerging needs are identified early. The early support panels are established and develop coordinated support for young children where there is evidence of complex needs.<br>Initial health visitor contacts between 10 and 14 days post birth are above the target of 90% as are the more substantive developmental check at 6-8 weeks. Performance in relation to the 12 month review is generally good, but there has been a fall in performance in respect of the two year developmental check and this is now being monitored closely. Performance in this latter indicator had been above 90% for most of the current financial year but declined to just about 80% in November.<br>90% of children aged 2 benefit in funded day care settings benefit from attending settings that are judged good or outstanding.<br>CAMH waiting times have mostly remained within target timescales. In only two months since the beginning of the financial year has any child or young person waited for longer than 18 weeks between referral and assessment, and this indicator has remained above the 95% target throughout.<br>Waiting times between referral and assessment for ASD/ADHD have much improved, although small numbers continue to wait for longer than 18 weeks, with approximately 10 children and young people in this position as of December 2016. |

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| **Current Activities: narrative update on workstreams** | A number of the work-streams that contribute to this overall area are coordinated within the remit of the Children and Families Joint Commissioning Board. The remit and function of this board is currently under review. This is in order to develop the Board so that it can take the role of being the main governance board of the Family Safeguarding approach in Peterborough, while continuing its role in delivering key health and wellbeing board priorities. |
| **HWB STRATEGY 2016/19: FUTURE PLANS**<br><br>• Develop a CAMH pathway that better meets need and manages demand so that pressures on specialist services are minimised<br>• Continuing a pilot approach where additional CPN capacity is aligned with schools to enable better support to be offered to C&YP with emerging emotional and mental health difficulties<br>• Working with the PSCB to develop a more effective multi-agency response to neglect, focused particularly on addressing early indications of neglectful parenting and offering support to prevent patterns becoming established<br>• Renew the Child Poverty Strategy in 2016<br>• Develop a joint strategy to address high rates of teenage pregnancy<br>• Jointly review the commissioning and delivery of services for C&YP with SEND, from age 0-25<br>• Consideration of the needs of single parent families in these workstreams | |
| **Future Plans: Progress against key milestones** | Milestone 1: review the function and membership of the Children and Families Joint Commissioning board and develop this as the basis for the principal governance board for developing Family Safeguarding in Peterborough, mapping and monitoring key health and wellbeing priorities in the process.<br><br>Milestone 2: Neglect strategies have been developed and launched by PCC and the LSCB. The next step is to monitor implementation of the strategies – the extent to which they and their associated tools are being used within the community [and the graded care profile in particular].<br><br>Milestone 3: Monitoring the impact of the child poverty strategy following the allocation of lead officers and lead Member responsibilities. |
| **Risks** | Current risks include lack of embedding of neglect strategies in community and specialist services. |
| **Key considerations** | Need to develop a new governance board that can meet requirements of Family Safeguarding but have a broader reach so that it can also support the prevention of needs becoming complex through |

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| | effective early intervention. |

Note: an overarching report against the outcome metrics in the HWB Strategy will be prepared annually, co-ordinated by the Public Health Intelligence team.

## Performance Indicators:

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Current Value | Agreed Target |
|---|---|---|---|---|---|---|---|---|
| 1.1a | CAMH - Number of Children & Young People commencing treatment in NHS-funded community services | - | Indicator will be available as of end of Q3 2016/17 (part of NHS 5 Year Forward View) | - | - | - | - | - |
| 1.1b | CAMH - Proportion of Children & Young People with an eating disorder receiving treatment within 4 weeks (routine) and 1 week (urgent) | - | Indicator will be available as of end of Q3 2016/17 (part of NHS 5 Year Forward View) | - | - | - | - | - |
| 1.1c | CAMH - Proportion of Children & Young People showing reliable improvement in outcomes following treatment | - | Indicator will be available in 2018/19 (part of NHS 5 Year Forward View) | - | - | - | - | - |
| 1.1d | CAMH - Total bed days in CAMHS tier 4 per CYP population/total CYP in adult in-patient wards/paediatric wards | - | Indicator will be available as of end of Q3 2016/17 (part of NHS 5 Year Forward View) | - | - | - | - | - |
| 1.2 | Prevalence of obesity - reception year (proportion, %) | Decreasing - getter better | Statistically similar to England | 2015-16 | 259 | 9.3% | 9.3% | Match or exceed average of CIPFA neighbours |
| 1.3 | Prevalence of obesity - year 6 (proportion, %) | Increasing - getting worse | Statistically similar to England | 2015-16 | 460 | 19.8% | 19.8% | Reduction of 1.6% per year, to reach 13.3% by 2018/19 |
| 1.4 | Number of young people Not in Education, Employment or Training (NEET) (Proportion, %) | Decreasing - getter better | Peterborough higher (worse) than England. Statistical significance unavailable | 2016 | - | 5.0% | 4.2% | Reduction to 3.5% by January 2019 |
| 1.5 | Successful implementation of a multi-agency neglect strategy resulting in increased early intervention to prevent such patterns becoming entrenched | - | Strategy launched by Peterborough Safeguarding Children Board 13/09/2016 | - | - | - | - | Jo Procter (Head of Service for Adult & Children's Safeguarding Boards) to provide periodic audit data to measure success of implementation |
| 1.6 | Under 18 conceptions (crude rate per 1,000) | Decreasing - getter better | Statistically significantly worse than England | 2014 | 102 | 30.2 | 22.8 | Reduce by at least same rate as England |
| 1.7 | Under 16 conceptions (crude rate per 1,000) | Increasing - getting worse | Statistically similar to England | 2014 | 22 | 6.7 | 4.4 | Reduce rate by 1.3 per year to match previous Peterborough best (4.7/1,000) |

**HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD**
**PERFORMANCE REPORT**
**DATE: MARCH 2017**
**SUBJECT: HEALTH BEHAVIOURS AND LIFESTYLES**
**LEAD: DR LIZ ROBIN**

| **HWB STRATEGY 2016/19: CURRENT ACTIVITIES:**<br><br>• Develop a joint 'Prevention Strategy' to ensure that supporting people to improve and maintain their own health is a key part of managing demand on local NHS services<br>• Commissioning a joint Drug and Alcohol Service through the Clinical Commissioning Group and Peterborough City Council, which reaches into the Hospital.<br>• Commission an integrated healthy lifestyle service with the aim that people can access one service for help and support with stopping smoking, healthy eating, physical activity, weight management and mental wellbeing, linked with services for people with mental and physical health, disability and ageing issues | |
|---|---|
| **Current Activities: Performance narrative and statistics (please refer to relevant performance indicators and measures of success)** | Smoking prevalence among adults continues decline with most recent data showing a smoking rate of 17.7% compared to a national smoking rate of 16.9. Smoking prevalence among routine and manual workers also continues to decline but at a faster rate. Local smoking rates among this group of workers is 25.1% compared to a national rate of 26.5%. Provision of stop smoking services across the City is being extended to support local smokers motivated to quit and reduce prevalence further.<br><br>As part of the National Child Measurement Programme 2,771 reception children and 2,320 year 6 children across Peterborough had their height and weight measured during 2015/16. Among reception children, 258 were recorded as obese (a decrease from the previous year) and 632 with excess weight (an increase from the previous year). Among year 6 children, 459 were recorded as obese (an increase from the previous year) and 793 with excess weight (an increase from the previous year).<br><br>Excess weight among adults is higher than the England average, with over two out of three adults in Peterborough classified as overweight or obese. The proportion of adults who are classified as active (doing at least 150 minutes of at least moderate intensity physical activity per week) is slightly lower than the England average, with approximately one out of two adults active. The number of adults who |

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| | are classified as inactive (doing less than 30 minutes of at least moderate intensity physical activity per week) has however increased to one in three, significantly higher than the England average. |
| **Current Activities: narrative update on workstreams** | Healthy Lifestyle services have been developed throughout 2016/17 with existing interventions and programmes extended and new healthy lifestyle support programmes established. Stop smoking clinics for motivated smokers that want to quit have extended, health trainer services have been established in a GP practices and community settings and physical activity and weight management Tier 2 and Tier 3 programmes have been increased.<br><br>These services will form the foundation for a new commissioned integrated healthy lifestyle service that will begin delivery from April 2017. |

| **HWB STRATEGY 2016/19: FUTURE PLANS**<br><br>• Commission an integrated healthy lifestyle service with the aim that people can access one service for help and support with stopping smoking, healthy eating, physical activity, weight management and mental wellbeing, linked with services for people with mental and physical health, disability and ageing issues<br>• Improve our communication with local residents on health issues and to develop local campaigns and access to health information sources in a range of settings, which can be trusted to provide reliable advice on healthy lifestyles<br>• Recognise the vital role schools play in supporting the health and wellbeing of children and young people through a Healthy Schools Peterborough programme<br>• Reduce the number of local people developing Type 2 Diabetes | |
|---|---|
| **Future Plans: Progress against key milestones** | Milestone 1: Monthly health campaigns are being delivered through local and social media and are supported with events. An associated website has been established www.healthypeterborough.org.uk An evaluation of the campaign is being undertaken to inform future plans.<br><br>Milestone 2: The Healthy Schools programme has engaged a number of secondary schools who are working towards their Bronze accreditation. Interest has been received from primary schools interested in the accreditation programme and the programme will therefore be extended to support these schools. |

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| | Milestone 3: The Diabetes Prevention Programme is in place locally while a Health Check programme for those with an increased risk of Type 2 Diabetes is being developed, targeted at the South Asian community to where prevalence of Type 2 Diabetes is higher.<br><br>Milestone 4: The new integrated healthy lifestyle service is on track to begin delivery from April 2017. |
| **Risks** | Immediate risks are associated with the mobilisation of the new integrated healthy lifestyle service to ensure the service can begin delivery from April 2017. However, these are being managed as part of the mobilisation plan. |
| **Key considerations** | |



Note: an overarching report against the outcome metrics in the HWB Strategy will be prepared annually, co-ordinated by the Public Health Intelligence team.

## Performance Indicators:

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Agreed Target |
|---|---|---|---|---|---|---|---|---|
| 2.1 | Smoking Prevalence - All (proportion, %) | Increasing - getting worse | Statistically similar to England | 2015 | - | 17.7% | 16.9% | Reduce disparity between Peterborough and England |
| 2.2 | Smoking Prevalence - Routine & Manual Occupations (proportion, %) | Decreasing - getter better | Statistically similar to England | 2015 | - | 25.1% | 26.5% | Match or exceed England performance |
| 2.3 | Excess weight in adults (proportion, %) | Increasing - getting worse | Statistically significantly worse than England | 2013-15 | - | 70.8% | 64.8% | Reduce disparity between Peterborough and England |
| 2.4a | Physically active adults (proportion, %) | Increasing - getter better | Statistically similar to England | 2015 | - | 54.7% | 57.0% | Reduce disparity between Peterborough and England |
| 2.4b | Physically inactive adults (proportion, %) | Increasing - getting worse | Statistically significantly worse than England | 2015 | - | 34.3% | 28.7% | Reduce disparity between Peterborough and England |
| 2.5 | The numbers of attendances to sport and physical activities provided by Vivacity (observed numbers) | Increasing - getter better | 2016/17 forecast to be 1,360,934, 3.6% higher than 2015/16 value of 1,313,384 | 2015-16 | 1,313,384 | - | - | Increase of year-on-year number |
| 2.6 | Admission episodes for alcohol-related conditions - Persons (directly standardised rate per 100,000) | Decreasing - getter better | Statistically similar to England | 2014-15 | 1,169 | 679 | 641 | Reduction in DSR of 1.0% per year |
| 2.7 | Admission episodes for alcohol-related conditions - Males (directly standardised rate per 100,000) | Increasing - getting worse | Statistically significantly worse than England | 2014-15 | 744 | 900 | 827 | Reduction in DSR of 1.0% per year |
| 2.8 | Admission episodes for alcohol-related conditions - Females (directly standardised rate per 100,000) | Decreasing - getter better | Statistically similar to England | 2014-15 | 425 | 478 | 474 | Reduction in DSR of 1.0% per year |
| 2.9 | The annual incidence of newly diagnosed type 2 diabetes (observed numbers) | - | Awaiting provision from CCG | - | - | - | - | TBC - Awaiting data from CCG |

**HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD**
**PERFORMANCE REPORT**
**DATE: MARCH 2017**
**SUBJECT: LONG TERM CONDITIONS AND PREMATURE MORTALITY**
**LEAD: CATH MITCHELL**

| **HWB STRATEGY 2016/19: CURRENT ACTIVITIES:**<br><br>• The Health & Wellbeing Board commissioned a detailed CVD JSNA for Peterborough, which is now completed<br>• The Local NHS Clinical Commissioning Group 'Tackling Health Inequalities in Coronary Heart Disease Programme Board' has worked closely with City Council's public health services to improve uptake of CVD 'health checks' for 40-74 year olds and to promote smoking cessation services for people at risk of heart and respiratory disease | |
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| **Current Activities: Performance narrative and statistics (please refer to relevant performance indicators and measures of success)** | Health checks performance in Peterborough continued to be above the national average in 2015/16 (comparative data on 2016/17 is not yet available)<br>http://www.phoutcomes.info/public-health-outcomes-framework#page/1/gid/1000042/pat/6/par/E12000006/ati/102/are/E06000031/iid/91101/age/219/sex/4<br>The percentage of people who smoke in Peterborough has fallen over the most recent three years and is now similar to the national average, as is the 2015/16 performance of smoking cessation services (national comparative data on 2016/17 is not yet available)<br>http://www.tobaccoprofiles.info/profile/tobacco-control/data#page/1/gid/1938132885/pat/6/par/E12000006/ati/102/are/E06000031 |
| **Current Activities: narrative update on workstreams** | • The CVD JSNA was used to inform the development of the Cardiovascular Disease Strategy, and the development of outcome metrics and trajectories.<br>• Outreach health checks for hard to reach communities, workplaces etc have been commissioned as part of the new Integrated Lifestyles contract.<br>• A publicity campaign in March 2017 is promoting local stop smoking services in line with national 'No Smoking Day' including a community bus providing on the spot advice in the Millfield area and outside the Town Hall. |

| **HWB STRATEGY 2016/19: FUTURE PLANS**<br><br>• Develop and implement a joint strategy to address CVD in Peterborough<br>• Explore a specific programme to work with South Asian communities to address higher rates of diabetes and coronary heart disease<br>• Explore options to reduce the risk of stroke within the local population by improved identification of atrial fibrillation<br>• A long term conditions needs assessment will be carried out which will cover the wider range of long term conditions including cancer and musculo-skeletal disorders | |
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| **Future Plans: Progress against key milestones** | Milestone 1: The Joint CVD Strategy has been completed and approved by the HWB Board. A Strategy Implementation Group is now meeting to ensure that key elements of the Strategy are taken forward and to identify co-dependencies with NHS Sustainability and Transformation Plan (STP) workstreams and avoid duplication.<br><br>Milestone 2: Progress with programmes to work with South Asian Communities to address higher rates of diabetes and heart disease are covered in feedback on the 'Health and Wellbeing of Diverse Communities' section.<br><br>Milestone 3: A business case has been developed to reduce the risk of stroke within the local population by improved identification of atrial fibrillation and is being further assessed for implementation through the STP. Business Case completed will be submitted to the STP Investment Panel on the 15/3/17 to secure investment. If approved this will deliver savings in Social Care Packages based on National Evidence.<br><br>Milestone 4: Work will start on the Long Term Conditions Needs Assessment following completion of the Joint Strategic Needs Assessment on primary prevention of ill health in older people, which is due for presentation to the HWB Board in May 2017. In the meanwhile, much of the relevant national research evidence on long term conditions which applies to Peterborough as well as to Cambridgeshire is included in the Cambridgeshire Long Term Conditions JSNA – and the relevant data for Peterborough has been included in 'CCG data supplements' for this JSNA which cover both Cambridgeshire and Peterborough, available on weblink http://cambridgeshireinsight.org.uk/JSNA/LTCs-across-the-lifecourse-2015<br><br>National bids have been submitted for funding to deliver a Programme of work for Diabetic and Cancer Patients across the CCG Footprint . Feedback on outcome of the Bids expected at the end of March 17 |

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| **Risks** | STP/ National funding not allocated to address the local priorities in the Health and Wellbeing Strategy<br>Ability to recruit the skilled workforce in the local area |
| **Key considerations** | The System LA's / NHS Secondary Care / NHS Community Care / NHS Primary Care and Community and Voluntary Sector need to develop relationships to maximise outcomes that can be achieved through robust Pathways. |

Note: an overarching report against the outcome metrics in the HWB Strategy will be prepared annually, co-ordinated by the Public Health Intelligence team.

## Performance Indicators:

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Agreed Target |
|---|---|---|---|---|---|---|---|---|
| 3.1 | Under 75 mortality rate from all cardiovascular diseases - Persons (directly standardised rate per 100,000) | Decreasing - getter better | Statistically significantly worse than England | 2013-15 | 349 | 86.3 | 74.6 | Reduction in DSR of 0.5% per year |
| 3.2 | Under 75 mortality rate from all cardiovascular diseases - Males (directly standardised rate per 100,000) | Decreasing - getter better | Statistically similar to England | 2013-15 | 230 | 116.6 | 104.7 | Reduction in DSR of 1.0% per year |
| 3.3 | Under 75 mortality rate from all cardiovascular diseases - Females (directly standardised rate per 100,000) | Decreasing - getter better | Statistically significantly worse than England | 2013-15 | 119 | 57.7 | 46.2 | Continue recent trend of reduction in DSR of 2.45/100,000 per year |
| 3.4 | Inequalities between electoral wards in emergency CVD hospital admissions (disparity in directly standardised rate per 100,000) | Increasing - getting worse | Disparity between most deprived 20% and least deprived 80% has increased between 2013/14 and 2014/15 | 2014-15 | N/A | 305.8 | N/A | Reduction in DSR of most deprived 20% of Peterborough electoral wards of 2% per year |
| 3.5 | Recorded Diabetes (proportion, %) | Increasing - getting worse | Statistically similar to England | 2014-15 | 9,740 | 6.5% | 6.4% | Match or exceed England trend |
| 3.6a | The rate of hospital admissions for stroke (directly standardised rate per 100,000) | Decreasing - getter better | Rate has reduced, national benchmark unavailable | 2014-15 | 369 | 250.7 | N/A | Reduction in DSR of 1% per year |
| 3.6b | The rate of hospital admissions for heart failure (directly standardised rate per 100,000) | Decreasing - getter better | Rate has reduced, national benchmark unavailable | 2014-15 | 335 | 235.2 | N/A | Reduction in DSR of 1% per year |
| 3.7 | Outcomes for a wider range of long term conditions will be defined following completion of the long term conditions needs assessment | - | To be decided upon completion of relevant Joint Strategic Needs Assessment | N/A | N/A | N/A | N/A | - |

**HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD**
**PERFORMANCE REPORT**
**DATE: MARCH 2017**
**SUBJECT: MENTAL HEALTH FOR ADULTS OF WORKING AGE**
**LEAD: WENDI OGLE-WELBOURN**

<table>
<tr><td colspan="2">HWB STRATEGY 2016/19: CURRENT ACTIVITIES:<br><br>• The Joint Suicide Prevention Strategy and implementation plan for Cambridgeshire and Peterborough is being delivered<br>• A local ‘Crisis Care Concordat’ implementation plan aims to prevent mental health crisis in community settings and reduce the use of Section 136 of the Mental Health Act. A new crisis care telephone helpline and a community place of safety are proposed for the coming year<br>• Implementation of the Joint Peterborough Mental Health Commissioning Strategy includes redesign of the mental health accommodation pathway, increased choice of housing options, a placement model of employment support, stronger links between commissioners and clear focus on the right support, the first time, at the right place, by the right people</td></tr>
<tr><td>Current Activities: Performance narrative and statistics. (Please refer to relevant performance measures of success).</td><td>1. Suicide Prevention<br>Metrics: Suicide Rates: Persons/Males/Females: Standardised rate per 100,000 population<br>Performance: All persons: 8.4% Decreasing, getting better and better than the England value (10.1%)<br>Males: 11.5% Decreasing, getting better and better than the England value (15.8%)<br>Females: Data redacted due to low numbers (not statistically significant)<br><br>2. Crisis Prevention<br>Metric: Rates of use of Section 136 under the Mental Health Act<br>Performance: Instances of use of Section 136 have decreased but this partly attributable to the closure of the Cavell Centre. The Constabulary suggests that the target should be based around use of police stations as a place of safety.<br><br>3. Mental Health Housing and Accommodation<br>Metric: Adults in contact with mental health services in settled accommodation<br>Performance: Increasing (30.7%) – getting better although statistically worse than England (58.5%)</td></tr>
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| | **4. Employment**<br>***Metric:*** *Adults in contact with mh services in employment*<br>***Performance:*** *4.8%: Increasing – getting better although remains statistically significantly worse than England (8.8%)*<br><br>**5. Stronger Links Between Commissioners**<br>***Performance:*** *Performance is improving in 5 out of the 6 areas with meaningful measures*<br>***Metrics:*** *Improvement in performance against the prioritised metrics*<br><br>**6. The Right Support, the First Time, at the Right Place, by the Right People**<br>***Performance:*** *Performance is improving in 5 out of the 6 areas with meaningful measures*<br>***Metrics:*** *Improvement in performance against the prioritised metrics* |
| **Current Activities: narrative update on workstreams** | **1. Suicide Prevention**<br>i) The Suicide Prevention Strategy is being refreshed with completion in the Autumn of 2017..<br>ii) A key workstream within the refreshed strategy will be to seek support and sign up to a policy of Zero Suicide by organizations across Peterborough and Cambridgeshire. Work to progress this was initiated on 21.02.17. The initiative is based on East Of England Region approach and support for this target. More work is needed to refine and state what the objective means – is it an approach to quality and continuous improvement and/or a target for all across the health and social care system.<br>iii) A bid for £60k investment to the STP to support delivery of the Suicide Prevention Strategy has been made. The proposal is to train GPs in suicide prevention, expansion of the workforce invested in the project to deliver the Suicide Prevention Strategy and a suicide bereavement counselling service.<br>iv) The STOP suicide project commissioned from MIND is continuing.<br><br>**2. Crisis Prevention**<br>i) A Delivery Manager was recruited for one year to support the work of the MH Delivery (Crisis Concordat) Group and started their role on 01.02.17. Significant work having been undertaken to improve the crisis and acute pathway within and at the front end of secondary services through the Vanguard First Response Service development, the priority is now prevention of crisis, including early intervention. Building on knowledge of crisis services gained through Programme Management of the First Response Service, this individual has scoped priorities and held a workshop on 21.02.17 to develop a prioritised action plan. This will be finalised shortly with implementation of any new workstreams |

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| | scheduled to follow soon afterwards.<br><br>**3. Mental Health Housing and Accommodation**<br>i) Housing and accommodation has been prioritised by Peterborough mental health commissioners. Significant work is being undertaken with providers to develop the market to increase both the range and choice of accommodation and the capacity available. This includes increasing capacity in the accommodation available for people stepping down from forensic/secure services.<br><br>**4. Employment**<br>i) Improvement of employment outcomes has been prioritised by PCC, CCC and P&C CCG which are working increasingly collaboratively.<br>ii) The service currently commissioned for Peterborough residents from Richmond Fellowship is being closely monitored with action taken to address concerns relating to performance.<br>iii) Employment services in Peterborough and Cambridgeshire are to be reviewed jointly with the CCG and CCC and re-specified as a key component of the wellbeing and recovery services that are also being reviewed and re-tendered.<br>iv) Employment is being prioritised as part of the Devolution Bid. A workshop has been convened to bring agencies involved in improving employment opportunities for people with mental health issues together. A national procurement for a provider to support this work in Cambridgeshire and Peterborough is underway with commissioners from Peterborough and Cambridgeshire directly involved.<br><br>**5. Stronger Links Between Commissioners**<br>i) Work to develop a joint commissioning unit for mental health has been strengthened by the appointment of a Head of Mental Health for Peterborough and Cambridgeshire. The brief is to work with P&C CCG to align mental health commissioning and to explore the potential/benefits of establishing a joint commissioning unit. The outcomes, benefit and options for establishing a joint commissioning unit are being developed. Papers will be taken through the internal governance processes of each organization when the scoping is complete. Timescales for this are to be confirmed.<br>ii) A MH Joint Commissioning Group has been established involving key individuals from PCC, CCC and P&C CCG. Bi-monthly joint commissioning meetings have been scheduled.<br>iii) All mental health services commissioned by PCC, CCC and P&C CCG have been mapped – service type, provider and investment. The next step is to analyse this across C&P and to identify and address |

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| | gaps, synergies and duplication. This mapping is being used to inform the re-tendering of the Wellbeing and Recovery and Employment services through which approaches to joint commissioning are being tested.<br>iv) Commissioners within PCC are working increasingly closely together to develop the mental health market, improve relationships with providers and to monitor performance, addressing under performance. This has included 2 joint – PCC, CCC and P&C CCG – events with the voluntary sector related to the the re-tendering of the Wellbeing and Recovery and Employment services – in November 2016 and January 2017.<br>v) The STP MH Strategy Group provides the opportunity for commissioners for children, young people and adults of all ages from PCC, CC and P&C CCG to meet with service user and carer representatives and CPFT as the main mental health services provider to agree and progress priorities, to develop a strategic view of the current status of services and priorities for improvement and to provide both co-ordination between the many and varied mental health service developments and initiatives underway across Peterborough and Cambridgeshire and also to interface with the STP workstreams in which specific improvement areas for mental health services feature e.g. Urgent and Emergency Care, Primary Care and Peri-natal mental health care.<br><br>**6. The Right Support, the First Time, at the Right Place, by the Right People**<br>i) Links have been made between the MH social care service delegated to CPFT and with the PCC Customer Service to ensure that Peterborough residents with mental health issues have access to effective advice, information and signposting from both services and to minimise duplication and delays.<br>ii) The social care role within the CPFT PRISM enhanced primary care mental health service is being developed as part of Phase 2 of the PRISM project. The purpose of PRISM is to ensure that people are assessed and offered the support they need as early as possible in the course of their illness and to ensure that they are signposted or referred to the appropriate information or services quickly.<br>iii) The focus on both crisis and prevention and suicide prevention (above) and the workstreams within them, demonstrates recognition across Peterborough and Cambridgeshire of the importance of appropriate and effective early intervention. |

| **HWB STRATEGY 2016/19: FUTURE PLANS** |
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| • Bring together findings from the Peterborough Mental Health JSNA (2015) and refresh the Mental Health Commissioning Strategy in 2016, to tailor implementation plans to address unmet mental health need<br>• A new recovery coach service to support people after discharge from secondary care and during transitions by connecting between third sector, local authority and mental health services<br>• An enhanced Primary Care Mental Health Service is planned to support people with greater needs upon discharge from secondary care. This will operate through community based teams<br>• The new Mental Health Commissioning and Delivery Partnership Board which includes representatives of carers and the voluntary sector, will ensure that the needs of carers are considered in joint planning of services<br>• Service user representation will also be invited to the Partnership Board | |
| **Future Plans: Progress against key milestones** | **Milestone 1**: **Bring together findings from the Peterborough Mental Health JSNA (2015) and refresh the Mental Health Commissioning Strategy in 2016, to tailor implementation plans to address unmet mental health need**<br><br>i) A number of standalone strategies relating to Mental Health services priorities have been drawn together and reviewed to produce a single integrated mental health strategy for P&C. The findings from the Peterborough MH JSNA informed the priorities. This has been agreed in principle by both the Cambridgeshire and Peterborough Health and Wellbeing Boards. The Cambridgeshire Health and Wellbeing Board requested that outcomes that demonstrate impact should be developed. They also request that further engagement – with service users and carers be undertaken so that they have the opportunity to comment on the strategy as a whole, albeit it that these groups were fully involved in the development of the strategies from which it was developed.<br><br>**Milestone 2: A new recovery coach service to support people after discharge from secondary care and during transitions by connecting between third sector, local authority and mental health services**<br>i) A number of Recovery Coaches have been recruited and are successfully working with people to gain/regain independent and meaningful lives in the community.<br><br>**Milestone 3: An enhanced Primary Care Mental Health Service is planned to support people with greater needs upon discharge from secondary care. This will operate through community based teams**.<br>See 6 ii) above.<br><br>**Milestone 4: The new Mental Health Commissioning and Delivery Partnership Board which includes representatives of carers and the voluntary sector, will ensure that the needs of carers are considered in joint planning of services** |

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| | i) PCC, CCC and P&C CCG have initiated a review of the strategy for carers. The mental health specialist service/investment is included within the scope of the project in order to help to ensure that the needs of carers of people with mental health issues are identified and addressed and to ensure equity and parity of esteem for carers of this group.<br>ii) Rethink Carers Support are included in the MH Stakeholder Group, representing carers (See 5 i) and ii) below).<br>iii) An additional Schedule which will give clearer definition to the requirements of CPFT in relation to Carers has been included in the list of Schedules to be included in the revised MH Section 75 Partnership Agreement which will be mobilised on 01.01.18.<br><br>**Milestone 5: Service user representation will also be invited to the Partnership Board**<br>i) The Peterborough MH Stakeholder Group met on 02.02.17. It was agreed that the group should continue to meet and that it should be extended to include Cambridgeshire. The TOR fulfil the role of the Partnership Boards.<br>ii) The SUN Network which is commissioned to ensure effective mental health service user representation is a member, representing service users.<br>iii) It was agreed that at each meeting, 2 service users and 2 carers would be invited to join the group by each organization for the focussed conversations on the specific topics selected by members which will be addressed within the meeting. In advance of the meeting, organizational representative agreed to engage with the wider staff, service users and carers with who, they have contact in order to inform discussions. The Group operates as a Reference Group for the MH Strategy Group, thereby ensuring that mental health service user views are represented effectively across the STP workstreams. |
| **Risks** | i) That there is insufficient resource, despite efficiencies being achieved by addressing duplication and improving joint working and synergies, across the health and social care system to support all the developments identified as being required to improve access to services and outcomes by the various workstreams. Mitigation: to minimise inefficiencies e.g. duplication and overly complicated processes and pathways and to improve promotion/prevention and early intervention including effective information, advice and signposting.<br>ii) That the complexities and time needed to meet the internal governance requirements of each organization slows progress and significantly slows delivery of the potential benefits of working collaboratively. Mitigation: Progress the proposed exploration of models of joint commissioning for mental health. |
| **Key considerations** | i) The work to identify and interrogate opportunities to work jointly across the whole system requires support from the senior managers and others within the key organizations involved to maximise the benefit of the opportunities.<br>ii) Reporting and governance within the 3 organizations can be time consuming and slow progress. Exploration of models to establish joint commissioning for mental health will help to address this. |

## Performance Indicators:

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Agreed Target |
|---|---|---|---|---|---|---|---|---|
| 4.1 | Hospital admissions caused by unintentional and deliberate injuries in young people (15-24 years, crude rate per 10,000) | Increasing - getting worse | Statistically significantly worse than England | 2015-16 | 431 | 189.5 | 134.1 | - |
| 4.2 | Rates of use of section 136 under the mental health act | - | Instances of S136 use in Peterborough have fallen but this is partly attributable to closing of Cavell Centre. Constabulary suggest target should be based around avoiding use of police stations as place of safety | 2015-16 | 20 | - | - | - |
| 4.3 | Suicide Rate - Persons (directly standardised rate per 100,000) | Decreasing - getter better | Statistically similar to England | 2013-15 | 42 | 8.4 | 10.1 | - |
| 4.4 | Suicide Rate - Males (directly standardised rate per 100,000) | Decreasing - getter better | Statistically similar to England | 2013-15 | 29 | 11.5 | 15.8 | - |
| 4.5 | Suicide Rate - Females (directly standardised rate per 100,000) | - | Data redacted due to low numbers | 2013-15 | - | - | - | - |
| 4.6 | Hospital readmission rates for mental health problems | - | Awaiting provision from CPFT | - | - | - | - | - |
| 4.7a | Adults in contact with mental health services in settled accommodation | Increasing - getter better | Statistically significantly worse than England | 2012-13 | 410 | 30.7% | 58.5% | - |
| 4.7b | Adults in contact with mental health services in employment | Increasing - getter better | Statistically significantly worse than England | 2012-13 | 65 | 4.8% | 8.8% | - |
| 4.8 | Carers for people with mental health problems receiving services advice or information | Increasing - getter better | Remains below England (statistical significance not calculated | 2013-14 | 5 | 2.9% | 19.5% | - |

**HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD**
**PERFORMANCE REPORT**
**DATE: MARCH 2017**
**SUBJECT: HEALTH AND WELLBEING OF PEOPLE WITH DISABILITY AND/OR SENSORY IMPAIRMENT**
**LEAD: ADRIAN CHAPMAN**

| **HWB STRATEGY 2016/19: CURRENT ACTIVITIES:**<br><br>● The Council and CCG have agreed a strategy for supporting older people and adults with long term conditions within the BCF plan, working together to support people with disabilities through data sharing, 7 day working, person centred system, information / communication / advice, ageing healthily and prevention<br>● The Learning Disability Partnership maintains an overview of needs and services for people with a learning disability in Peterborough<br>● A Vulnerable People's Housing Sub-Group has been established, which will review how local housing needs for vulnerable people, including people with disabilities, should be addressed | |
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| **Current Activities: Performance narrative and statistics (please refer to relevant performance indicators and measures of success)** | Peterborough's Housing Partnership is to be relaunched, and the work of the Vulnerable People's Housing Sub-Group will form part of these arrangements.<br><br>Terms of Reference for a new Physical Disability and Sensory Partnership Board are being developed and the membership scoped. The first meeting of that Board is scheduled for mid-May and will report directly into the Health and Wellbeing Board.<br><br>The Learning Disability employment projects continue to deliver positive outcomes for service users, and more small enterprises are being created to provide employment opportunities. |
| **Current Activities: narrative update on workstreams** | Adult Social Care Commissioning have plans in place with social landlords and other developers for 25 units to be opened by April 2017 for people with Learning Disabilities. A further 17 units are planned for people with more complex Learning Disabilities and Mental Health problems to be opened by May 2017. Not all these units will necessarily be occupied by people from Peterborough. The services will offer some shared hours of support from registered care providers and some specific individually based care or support hours for people living in the schemes. |

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| | 2015/16 performance from the performance reporting for Adult Social Care shows Peterborough as being ahead of the Eastern Regional and National Performance for People with a Learning Disability in Settled Accommodation. Current performance shows this trend continuing.<br><br>Work for People with a Learning Disability continues to be a focus for local services. 2015/16 performance from the monthly performance reporting for Adult Social Care shows Peterborough as being ahead of the Eastern Regional and National Performance. Current performance shows performance above target at 10% compared to a target of 8%.<br><br>Permanent admissions to Residential Care for Adults aged 18-65 is much lower than Eastern Region comparators for 2015/16. The target for total admissions for 2016/17 is 13 with 7 people admitted so far this year.<br><br>An action plan is in place to improve the results from the Carers survey in relation to carer's quality of life, although the results of the most recent survey will soon be available which will give an indication of progress made. |



| **HWB STRATEGY 2016/19: FUTURE PLANS**<br><br>● Implementation of strategy for supporting older people and adults with long term conditions<br>● Work with users of St George's hydrotherapy pool to explore future options for sustainability | |
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| **Future Plans: Progress against key milestones** | **Milestone 1: Improving Respiratory Services**<br><br>Main proposal: Increasing community and primary care respiratory resources with the aim of<br><br>adopting an integrated team approach across Primary Care, Community Services and Acute Services<br><br>**Milestone 2: Implementation of an integrated CCG-wide Falls Prevention programme**<br><br>Strengthening falls prevention delivery and integration in the community<br><br>Primary prevention campaign |

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| | Falls prevention Health Trainer<br><br>Physical activity Strength & Balance<br><br>Fracture Liaison Service<br><br>Public Health Falls Coordinator<br><br>Inclusion of a specific targeted question on the statutory Adult Social Care Service User satisfaction survey to determine the reasons that people state that they do not feel safe. The data, which is being collected across the region, will be analysed to identify the main reasons. If the reasons include falls or fear of falls, as is anecdotally expected, the data will feed into the Falls Prevention programme.<br><br>**Milestone 3: Dementia - Preventing Well**<br><br>Build strategy to include evidence based and equitable primary, secondary and tertiary prevention efforts across the life course incorporation of dementia risk reduction into current long term disease approaches and locally targeted messaging and campaigning<br><br>Work with key stakeholders, health and care sectors, local communities, people living with dementia, their carers and family to develop local solutions that in addition to healthy environments & lifestyles, foster social connectedness, age supportive communities and intergenerational links<br><br>Model and evaluate impact of primary, secondary and tertiary prevention to advocate sustained focus on proactive preventative interventions<br><br>Working with the Alzheimers Society to develop a dementia friendly Personal Budgets Charter and also to review our current literature to ensure that it is dementia friendly. |
| **Risks** | Managing demand from service users. |
| **Key considerations** | Outcomes of latest ASC Carers Survey.<br><br>Impact of new supported accommodation for service users. |

## Performance Indicators:

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Agreed Target |
|---|---|---|---|---|---|---|---|---|
| 5.1a | Adults with learning disabilities in employment (proportion, %) | Increasing - getter better | Statistically similar to England | 2013-14 | 55 | 8.4% | 6.7% | Match or exceed England performance |
| 5.1b | ASCOF - Percentage of adults known to Adult Social Care in employment (to increase) (proportion, %) | Increasing - getter better | Statistically significantly worse than England | 2012-13 | 65 | 4.8% | 8.8% | Match or exceed England performance |
| 5.2a | Adults with learning disabilities in settled accommodation (proportion, %) | Decreasing - getting worse | Statistically similar to England | 2013-14 | 475 | 72.5% | 74.9% | Improve by 0.5% per year |
| 5.2b | Adults in contact with mental health services in settled accommodation (proportion, %) | Increasing - getter better | Statistically significantly worse than England | 2012-13 | 410 | 30.7% | 58.5% | Improve at greater rate than national average |
| 5.3 | ASCOF - Permanent residential admissions of adults to residential care (to decrease) (65+, proportion, %) | Increasing - getting worse | Statistically similar to England | 2013-14 | 20 | 17.3% | 14.4% | 1% decrease per year |
| 5.4 | Numbers of adults in receipt of assistive technology | Increasing - getter better | Green RAG status to reflect consistent increase in recipients | Sep-16 | 5,136 (predicted end of year) | - | - | Year-on-year increase |
| 5.5a | Adult Social Care service user survey quality of life measure - carer-reported quality of life | Decreasing - getting worse | Statistically similar to England | 2014-15 | - | 7.3 | 7.9 | Improve each year |
| 5.5b | Adult Social Care service user survey quality of life measure - social care-related quality of life | Increasing - getter better | Statistical significance not calculated - Peterborough value has fallen between 2012-13 and 2013-14 and is now below that of England | 2015-16 | - | 19.1% | 19.1% | Year-on-year increase |
| 5.6 | Number of adults with social care needs receiving short term services to increase independence | Increasing - getter better | Green RAG status to reflect consistent increase in recipients | Sep-16 | 1,536 (Predicted end of year) | - | - | Year-on-year increase |
| 5.7 | Number of adults with social care needs requesting support, advice or guidance | Increasing - getter better | Rate per 100,000 is 566, currently below target rate of 658/100,000 | Sep-16 | 669 (average of previous 6 months) | 565.9 | - | 658.0/100,000 |

**HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD**
**PERFORMANCE REPORT**
**DATE: MARCH 2017**
**SUBJECT: AGEING WELL**
**LEAD: ADRIAN CHAPMAN**

| **HWB STRATEGY 2016/19: CURRENT ACTIVITIES:**<br><br>● A service model has been developed by local NHS commissioners and community service providers, local Councils and voluntary organisations to enable people to age well and to live the life they want to lead by:<br>o Providing high quality, responsive care and support<br>o Integrated working across health, social care and third sector services in Peterborough to ensure that care is joined-up around the needs of individuals within local communities, and avoidable admissions to hospital and care can be prevented<br>o This is supported by jointly agreed plans for the Better Care Fund | |
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| **Current Activities: Performance narrative and statistics (please refer to relevant performance indicators and measures of success)** | Care & Repair will deliver £1.8 million of Disabled Facility Grant works and commit a further £0.4 million in 2017/18. Over £1 million of repairs work will also be arranged. The majority of this work is for older people. It will also deliver 3,000 to 4,000 interventions via the Handyperson Scheme. Alongside the HP scheme the Gas Safety Council and Warm at Home funded work (£11,000 mainly boiler and heating repairs) will also be completed. As many as 1,400 minor aids and adaptations will also be completed mainly for older people. They enable hospital discharge, hospital services to be delivered at home, prevent accidents, relieve anxiety and help them remain living independently in warm and safe homes.<br><br>A multi-agency/cross-system Falls Working Group is in place for Peterborough. A gap analysis is currently being completed to identify which agencies provide services relating to falls, how best to join these up and to inform commissioners what services could be commissioned to fill gaps in provision or need. This will lead to an updated Falls Strategy. |
| **Current Activities: narrative update on workstreams** | The Older People Dementia Delivery Board is bringing together agencies across the health and social care system to develop an integrated plan to improve outcomes for people living with dementia across Cambridgeshire and Peterborough. A multi-agency strategic framework that reflects local need and responds with current evidence-based practice to inform future provision and support is being |

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| | developed. Opportunities to jointly commission whilst building on existing services and assets to deliver responsive services and improved outcomes are being explored.<br><br>A pan-Peterborough and Cambridgeshire strategic framework that aims to ensure the continued improvement of dementia care and support is being developed by members of the Older People Dementia Delivery Board and led by Public Health, CPFT and the CCG. This has offered the opportunity to refresh the Peterborough Dementia strategy and to identify the synergies, gaps and opportunities for improved efficiency and effectiveness in both Local Authority areas. The framework contains specific plans for service development in both areas, as well as plans for improvement across both where this will support improved outcomes for residents. There are opportunities for the latter at all points in the dementia pathway.<br><br>Prevention and Early Intervention: the council is undertaking further work to refine the Home Services Delivery Model to ensure integrated and strengthened intermediate care tier provision. A single Head of Service has been appointed across PCC's Care and Repair, Assistive Technology, Therapy Services and Reablement teams (renamed the Home Services Delivery Model). PCC and CPFT are working closely to ensure integration is achieved across system-wide intermediate care provision. There is a continued focus on the expansion and embedding of assistive technology across social care and health.<br><br>Point of Access (Front Door): a detailed model is now in development to achieve alignment of the PCC Adult Social Care Front Door with health, including integration discussions with the GP Network. Further benefits analysis is also being undertaken. The LGA Digital Transformation Fund awarded £40k to support the development of a Local Information Platform (LIP) (previously referred to as the Information Hub), which will support the consistency, quality and accuracy of information.<br><br>The results of the latest Carers Survey will soon be available including data on social isolation of carers. |

| HWB STRATEGY 2016/19: FUTURE PLANS | |
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| ● The HWB has commissioned an 'Older People: Primary Prevention of Ill Health' JSNA for Peterborough, which is due for completion during 2016<br>● Develop a joint 'Healthy Ageing and Prevention Agenda' to ensure that preventative action is integrated and responsible to best support people to age well, live independently and contribute to their communities for as long as possible, including isolation and loneliness<br>● Review and refresh the joint dementia strategy for Peterborough<br>● A specific programme of work, in collaboration with older residents, will explore the main health and care issues faced by this group to inform future commissioning of services across the system and how stronger communities can empower people to self-manage with minimal support<br>● Recognise that some older people prefer face to face communication rather than digital, through community hubs which are part of the Council's wider strategy for communicating with the public | |
| **Future Plans: Progress against key milestones** | **Milestone 1: Falls Prevention**<br><br>District level leads group is looking at further development to support local implementation of the joint falls pathway.<br><br>**Milestone 2: Mental Health and Dementia**<br><br>Final draft of Cambridgeshire and Peterborough Dementia Strategic Plan completed by Public Health.<br><br>**Milestone 3: Continence and UTIs**<br><br>Further development of gaps and priorities is being undertaken.<br><br>**Milestone 4: Community VCS**<br><br>Procurement options are being explored for the Wellbeing Network and Social Prescribing pilots. The Community Serve project is underway to build community resilience and 'meet and eat' social dining sessions are running regularly across all three pilot areas (Can-Do area, Westwood & Ravensthorpe and the Ortons). Community hubs have been established and area coordinators are in place. A volunteer time-credits pilot is being explored. |
| **Risks** | As below |

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| **Key considerations** | ● STP governance is currently being reviewed by SDU for greater clarity on board roles and alignment with BCF governance.<br>● LDR investment will not be available from NHS Digital until April 2017.<br>● Better Care Fund planning for 2017/18 will need to incorporate plans for achieving health and social care integration by 2020 and future initiatives, e.g. devolution, will need to be factored into those plans. |

Note: an overarching report against the outcome metrics in the HWB Strategy will be prepared annually, co-ordinated by the Public Health Intelligence team.

## Performance Indicators:

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Agreed Target |
|---|---|---|---|---|---|---|---|---|
| 6.1a | Injuries due to falls in people aged 65 and over (Persons, Directly Standardised rate per 100,000) | Increasing - getting worse | Statistically significantly worse than England | 2014-15 | 665 | 2,373 | 2,125 | Match or exceed England performance |
| 6.1b | Numbers of over 40s taking up NHS health check offers | Increasing - getter better | Total of health checks delivered remains significantly above England average | 2016/17 Q2 | 1,119 | 2.2% | 2.1% | Match or exceed England performance |
| 6.1c | Report on take up of any preventative service commissioned directly as part of STP in the future | - | TBC | - | - | - | - | - |
| 6.2 | Reducing avoidable emergency admissions (BCF), (crude rate per 100,000) | Decreasing - getter better | Statistically similar to England | Apr-12 | 332 | 178.1 | 167.5 | Match or exceed England performance |
| 6.3a | The proportion of people who use services who feel safe (proportion, %) | Increasing - getter better | Statistically significantly worse than England | 2015-16 | 1,514 | 65.0% | 69.2% | Exceed England performance in order to reach statistical similarity |
| 6.3b | The proportion of people who use services who say that those services have made them feel safe and secure (proportion, %) | Decreasing - getting worse | Statistically significantly better than England | 2015-16 | 2,059 | 88.0% | 85.4% | Match or exceed England performance |
| 6.4 | Using an Outcomes Framework - covering several key priority areas for older people in relation to their NHS care and the Social Care Outcomes Framework | - | Will be expanded as part of on-going work with Clinical Commissioning Group on Sustainability & Transformation (STP) Plans | - | - | - | - | - |
| 6.5 | Social Isolation: % of adult carers who have as much social contact as they would like (proportion, %) | Decreasing - getting worse | Statistically significantly worse than England | 2014-15 | - | 29.7% | 38.5% | Match or exceed England performance |
| 6.6 | Carer-reported quality of life score for people caring for someone with dementia | - | Indicator provided for the first time in 2014-15. Peterborough has a lower score than England | 2014-15 | - | 6.7% | 7.7% | Match or exceed England performance |

**HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD**
**PERFORMANCE REPORT**
**DATE: MARCH 2017**
**SUBJECT: PROTECTING HEALTH**
**LEAD: DR LIZ ROBIN**

<table>
<tr><td colspan="2">HWB STRATEGY 2016/19: CURRENT ACTIVITIES:<br><br>• Cambridgeshire and Peterborough CCG has convened a joint TB commissioning group, to develop a plan to commission accessible and responsive services. The first task has been to develop a plan for implementation of Latent TB (LTBI) screening in line with the national TB strategy and a successful bid for pilot funding was submitted to Public Health England<br>• The Health Protection Steering Group, which involves the City Council, local NHS and Public Health England, has oversight of immunisation and screening uptake, task and finish groups to look at uptake issues for immunisation and screening have completed reports and implementation groups are due to take forward the recommendations<br>• A multi-agency sexual health strategy group is due to commence work shortly, convened by Peterborough City Council, to look at a range of sexual health issues, not just communicable diseases</td></tr>
<tr><td>Current Activities: Performance narrative and statistics (please refer to relevant performance indicators and measures of success)</td><td>A more detailed update is include in the annual health protection report but good progress is being made in Peterborough especially on Latent TB (LTBI) screening in certain at risk groups, which has been the initial focus of the TB commissioning Group led by the CCG.<br>High active TB rates are used as a proxy for an anticipated high incidence of latent TB. Engagement of the designated practices is on going and all have agreed to deliver the project. The eligibility criteria for the service are any new patient registering with a practice or retrospectively identified by the practice as being:<br>• Born or spent > 6 month in a country of high TB incidence<br>• Entered the UK within the last 5 years<br>• Aged 16-35 years<br>• No history of TB either treated or untreated<br>• Never screened for TB in the UK<br><br>practices with a crude annual rate of active TB ≥ 20 cases/100,000 have been prioritised<br>The project commenced in March 2016 and to date, 14 practices have signed up to deliver.</td></tr>
</table>

**ACTIVITY TO DATE**

| Activity | Data |
|---|---|
| Negative | 264 |
| Positives | 38 |
| Borderline negative | 7 |
| Borderline positive | 9 |
| Indeterminate | 5 |
| Non reportable insufficient cells | 1 |
| Assay not run | 1 |
| **Total screened** | **325** |

Data to end of January 2017

This is the highest level of screening in the region
Communication activity is planned in support of this and linked to World TB Day, Friday 24th March

In addition work is progressing on mapping TB specialist clinical staff to ensure adequate coverage and also to support discharge planning for TB patients who, as TB is a disease that is associated with deprivation, often have significant social problems including homelessness and temporary employment or unemployment.

**Current Activities: narrative update on workstreams**

- Expanding the LTBI screening programme
- Specialist Workforce planning
- Discharge planning

| HWB STRATEGY 2016/19: FUTURE PLANS | |
|---|---|
| • Develop a TB commissioning plan for Cambridgeshire and Peterborough<br>• Develop a joint strategy to address poor uptake of screening including improved communication with communities and individuals<br>• Develop a joint strategy to address poor uptake of immunisation including improved communication with communities and individuals<br>• Develop a Peterborough Joint Sexual Health Strategy, covering a range of issues | |
| **Future Plans: Progress against key milestones** | Milestone 1: TB commissioning plan: Latent TB screening implementation is entering its second wave of GP practice recruitment. Workforce mapping for TB management is complete.<br><br>Milestone 2: Strategy to improve screening uptake: A task group led by NHS England has been set up including voluntary sector organisations: Strategy to improve communications. Promotional materials for cervical screening have been used in a range of PCC and partner venues. 'Healthy Peterborough' focussed on cancer prevention and screening in February 2017. Focus group work with diverse communities is being conducted.<br><br>Milestone 3 Strategy to improve immunisation uptake: The recommendations of the Immunisations task group led by NHS England are being taken forward and work has included: training local health connectors on immunisations; dispelling the myths; targeting practices with child immunisation waiting lists.; developing a pilot flag system for practices to identify children missing immunisations; and encouraging practices to run more open access immunisation clinics which have been demonstrated to improve access and increase uptake.<br><br>Milestone 4: Develop a Peterborough joint sexual health strategy: The local multi-agency Contraceptive and Sexual Health Strategic Group has agreed a strategy and action plan. The strategy continues to focus on four key overall themes for Peterborough:<br><br>● Increase sexual and contraceptive health awareness amongst local population;<br>● Increase detection of Sexually transmitted infections amongst the local population;<br>● Reduce the number of unplanned pregnancies; and |

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| | • Improve early HIV detection within the city to reduce high rate of late diagnosis.<br>A sexual health needs assessment for vulnerable groups is close to completion. Peterborough and Cambridgeshire multi agency strategic groups will align in the future and we are waiting for the finalisation of this. |
| **Risks** | Continued availability of funding for strategy implementation especially LTBI screening |
| **Key considerations** | Good progress and commitment of all organisations involved around TB commissioning plan. Ability to engage representatives from Housing and Benefits expertise has been particularly helpful for discharge planning in Peterborough. |

Note: an overarching report against the outcome metrics in the HWB Strategy will be prepared annually, co-ordinated by the Public Health Intelligence team.

## Performance Indicators:

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Agreed Target |
|---|---|---|---|---|---|---|---|---|
| 7.1 | Percentage of eligible people screened for latent TB infection | - | Awaiting provision from CCG | | | | | - |
| 7.2 | Percentage of eligible newborn babies given BCG vaccination (aim 90%+) | - | Awaiting provision from NHSE | | | | | - |
| 7.3 | Proportion of drug sensitive TB cases who had completed a full course of treatment by 12 months (proportion, %) | Decreasing - getting worse | Statistically similar to England | 2014 | 276 | 81.4% | 84.4% | Match or exceed England performance |
| 7.4 | Evidence of increasing uptake of screening and immunisation | - | Peterborough currently reaching national benchmark goal for 9/10 relevant indicators | 2014-15 | 9/10 | - | - | • Achieve 95% performance for years 2016/17, 2017/18 and 2018/19 where this is already being achieved or close to being achieved (Dtap/IPV/Hib (1 year old and 2 years old), MMR for one dose (5 years old)<br>• Improve MMR for two doses (5 years old) to national benchmark goal of 90% by 2018/19<br>• For all other indicators, maintain 90% performance for years 2016/17 and 2017/18 and improve to 95% for 2018/19 |
| 7.5 | HIV late diagnosis (proportion, %) | Increasing - getting worse | Remains above benchmark goal of 50.0% | 2013-15 | 23 | 60.5% | 40.3% | Return to 25% to 50% (PHOF Amber 'Rag') by 2017-19 |
| 7.6a | Chlamydia- proportion aged 15-24 screened (proportion, %) | Decreasing - getting worse | Statistically significantly worse than England | 2015 | 4,203 | 18.5% | 22.5% | Increase to at least previous best of 24.7% (requires increase of 2.05% per year) |
| 7.6b | Increase in chlamydia detection rate (proportion, %) | Decreasing - getting worse | Remains above benchmark goal of 2,300/100,000 | 2015 | 569 | 2,499 | 1,887 | Benchmark goal already reached - maintain and improve by 1% per year |

**HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD**
**PERFORMANCE REPORT**
**DATE: MARCH 2017**
**SUBJECT: GROWTH, HEALTH AND THE LOCAL PLAN**
**LEAD: SIMON MACHEN**

<table>
<tr><td colspan="2">HWB STRATEGY 2016/19: CURRENT ACTIVITIES:<br><br>• A sustained increase in the number of people who are physically active<br>• A sustained reduction in the number of overweight or obese children and adults<br>• A sustained increase in the number of people who utilise outdoor space for exercise/health reasons.<br><br>In addition the Environmental Capital Action Plan describes the following actions:<br>• Secure funding to increase the number of Green Flag awards to 6<br>• Nene Park Trust will continually raise the quality of its facilities and improve the participation and engagement of visitors<br>• Seek funding to carry out a feasibility study into local, sustainable food production<br>• Achieve Fairtrade city status<br>• Develop planning guidance to support local food</td></tr>
<tr><td>Current Activities: Performance narrative and statistics (please refer to relevant performance indicators and measures of success)</td><td>The Peterborough Local Plan Further Draft (December 2016) has been reviewed against the evidence base contained in the Cambridgeshire New Housing Developments and the Built Environment Joint strategic needs assessment (JSNA). The JSNA contains a review of the evidence on the health impacts of the built environment, namely:<br>• Generic evidence supporting the built impact on health<br>• Green space<br>• Developing sustainable communities<br>• Community design (to prevent injuries, crime, and to accommodate people with disabilities)<br>• Connectivity and land use mix<br>• Communities that support healthy ageing<br>• House design and space<br>• Access to unhealthy/“Fast Food”<br>• Health inequality and the built environment</td></tr>
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| | Recommendations have therefore been made on areas where the local plan policy could be improved.<br><br>The Environment Capital Action Plan has been refreshed and new Health and Wellbeing actions have been added. |
| **Current Activities: narrative update on workstreams** | A workshop is planned to explore what metrics and data Peterborough City Council can use to measure health outcomes related to the Environment. In addition environment related actions have been incorporated into the Cardio Vascular Disease Strategy, namely:<br>• Consider restricting location of new applications for takeaways, for example not near schools<br>• Development of Peterborough Active Lifestyles Strategy. |

| **HWB STRATEGY 2016/19: FUTURE PLANS**<br><br>• The health of residents is being specifically considered in the new Local Plan, consideration will be given to the access needs of vulnerable and marginalised groups<br>• Public Health outcomes and/or objectives will be added to the Plan<br>• Public Health advice will be embedded into the City Council's Growth and Regeneration Directorate, through a post which will work with local land use and transport planners to consider the impact of land use planning on health | |
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| **Future Plans: Progress against key milestones** | Milestone 1: "The health of residents is being specifically considered in the new Local Plan, consideration will be given to the access needs of vulnerable and marginalised groups.<br>In Progress" and "Public Health outcomes and/or objectives will be added to the Plan" – see current activities above<br><br>**June/July 2017**: Proposed-Submission Publication (The Council publishes the Local Plan which is followed with a 6 week period when formal representations can be made on the Local Plan.)<br>**September 2017**: Submission (The Council submits the Local Plan to the Secretary of State)<br>**November/December 2017**: Independent Examination Hearing<br>**March 2018**: Inspector's Report This will report whether if the Plan is 'Sound' or 'Not Sound'.<br>**May 2018**: Adoption of DPD (Local Plan) |

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| | Milestone 2: "Public Health advice will be embedded into the City Council's Growth and Regeneration Directorate" – Complete, Public Health resource based within the Growth and Regeneration Team.<br><br>RAG Rating = Green |
| **Risks** | • Health and Wellbeing amendments to the local plan not incorporated in to the next draft of the plan.<br>• Significant objections to the health and wellbeing policies in the local plan result in the policies being removed or changed at the examination in public stage of the local plan. |
| **Key considerations** | None |

Note: an overarching report against the outcome metrics in the HWB Strategy will be prepared annually, co-ordinated by the Public Health Intelligence team.

## Performance Indicators:

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Agreed Target |
|---|---|---|---|---|---|---|---|---|
| 8.1 | Excess weight in 4-5 year olds (% of all pupils) | Increasing - getting worse | Statistically similar to England | 2015-16 | 632 | 22.8% | 22.1% | Match England trend (Peterborough already below England value) |
| 8.2 | Excess weight in 10-11 year olds (% of all pupils) | Increasing - getting worse | Statistically similar to England | 2015-16 | 794 | 34.2% | 34.2% | Match England trend (Peterborough already below England value) |
| 8.3 | The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more during the day time (proportion, %) | Decreasing - getter better | Statistical significance not calculated - Peterborough percentage is now below England | 2011 | 5,020 | 2.7% | 5.2% | Retain indicator within dataset but without target |
| 8.4 | The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more during the night time (proportion, %) | Decreasing - getter better | Statistical significance not calculated - Peterborough percentage is now below England | 2011 | 8,190 | 4.5% | 12.8% | Retain indicator within dataset but without target |
| 8.5 | Utilisation of outdoor space for exercise/health reasons (proportion, %) | Increasing - getter better | Statistically similar to England | 2013-14 | - | 22.2 | 17.1% | Reduce disparity between Peterborough and England |

**HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD**
**PERFORMANCE REPORT**
**DATE: MARCH 2017**
**SUBJECT: HEALTH AND TRANSPORT PLANNING**
**LEAD: SIMON MACHEN**

<table>
<tr><td colspan="2">HWB STRATEGY 2016/19: CURRENT ACTIVITIES:<br><br>• The City Council's Travelchoice initiative encourages people to walk, cycle, use public transport and car share, as well as the uptake of low emission vehicles<br>• Increase the number of pupils receiving Bikeability training from 951 to 1,300 annually<br>• The Cambridgeshire and Peterborough Road Safety Partnership (CPRSP) works with a number of organisations to look at the causes of road accidents, understands current data and intelligence regarding the County's roads and develop multi-agency solutions to help prevent future accidents and reduce collisions<br>• Addenbrooke's Regional Trauma Network is a key partner in the CPRSP, and through various data sources to allow the serious accident data to be broken down into more detail to gain a clear understanding on the impact of severe collisions to the NHS and longer term social care and other partners<br>• The fourth Local Transport Plan (2016-2020) emphasises the role transport can play in the health of Peterborough residents</td></tr>
<tr><td>Current Activities: Performance narrative and statistics (please refer to relevant performance indicators and measures of success)</td><td>A task and finish group is yet to be established to scope out possible Transport and Health Joint Strategic Needs Assessment (JSNA) data collection. The scope of the JSNA will be taken to a stakeholder event for comment and amending.<br><br>The Environment Capital Action Plan has been refreshed and new Health and Wellbeing actions have been added.<br><br>The Local Transport Plan now contains health and wellbeing aims and objectives throughout the plan.<br><br>Adults are being supported to improve their physical activity through the Let's Get Moving programme that supports referred patients to increase and sustain their physical activity,<br><br>In addition environment related actions have been incorporated into the Cardio Vascular Disease</td></tr>
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| | Strategy, namely:<br>• Development of Peterborough Active Lifestyles Strategy. |
| **Current Activities: narrative update on workstreams** | A workshop is planned to explore what metrics and data Peterborough City Council can use to measure health outcomes related to the Environment and transport |

| **HWB STRATEGY 2016/19: FUTURE PLANS**<br><br>• Collect further JSNA information on transport and health for Peterborough, using locally developed methodologies<br>• Permanently embed public health advice in to the City Council's Growth and Regeneration Directorate, through a post which will work with local land use and transport planners to consider the impact of transport planning on health and health inequalities | |
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| **Future Plans: Progress against key milestones** | Milestone 1: provide a data set on transport and health for Peterborough to align with the Cambridgeshire Transport and Health JSNA – In progress, steering group yet to be established.<br>RAG Rating Amber |
| **Risks** | • Lack of capacity to compile Transport and Health Data. |
| **Key considerations** | None |

Note: an overarching report against the outcome metrics in the HWB Strategy will be prepared annually, co-ordinated by the Public Health Intelligence team.

## Performance Indicators:

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Agreed Target |
|---|---|---|---|---|---|---|---|---|
| 9.1 | The number of businesses with travel plans | - | 48 business in Peterborough have travel plans | 2016 | 48 | - | - | Increase from 48 to 60 businesses in line with existing PCC target |
| 9.2 | To further develop a robust monitoring network to enable in depth transport model data to be measured | - | In progress | | | | | Workstream is on-going, updates to be provided periodically |
| 9.3 | Measures of air quality | - | Peterborough currently has 1 Air Quality Assessment Area | 2015 | 1 | - | - | Maintain or reduce Peterborough's number of Air Quality Management Areas (currently = 1 AQMA) |
| 9.4 | The numbers of adults and children killed or seriously injured in road traffic accidents (crude rate per 100,000) | Decreasing - getter better | Statistically similar to England | 2013-15 | 229 | 40.1 | 38.5 | Reduce disparity between Peterborough and England |

**HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD**
**PERFORMANCE REPORT**
**DATE: MARCH 2017**
**SUBJECT: HOUSING AND HEALTH**
**LEAD: ADRIAN CHAPMAN**

<table>
<tr><td colspan="2">HWB STRATEGY 2016/19: CURRENT ACTIVITIES:<br><br>● Housing related support funds support to a variety of providers and settings to ensure their clients are supported into move on accommodation, can maintain tenancies and therefore prevent them from becoming homeless<br>● The Peterborough Older Persons Accommodation Strategy identified that over 90% of people wished to remain at home to be supported through the provision of aids and adaptations and a demand for extra care accommodation. To date 262 additional units of extra care accommodation have been provided in partnership with registered providers. A further scheme of 54 dwellings is under construction<br>● Care and Repair provides a handyperson (HP) scheme to help aged and vulnerable people with small scale works. The minor aids and adaptations installations and the HP scheme assist hospital discharge and enable health services to be delivered in people's homes. The agency provides advice and has a network of contacts for onward referral and works with other voluntary sector groups on winter warmth initiatives<br>● The City Council's Cabinet has approved introducing selective licensing in 5 areas of the city covering privately rented properties. This would help raise the standard of private rented accommodation and therefore improve the health and wellbeing of those residents. Since its launch in December 2016 over 6,000 applications for a licence have been received.</td></tr>
<tr><td>Current Activities: Performance narrative and statistics (please refer to relevant performance indicators and measures of success)</td><td>Almost 3,000 interventions have been completed by the Handyperson Scheme to date this financial year. Alongside the Handyperson scheme the Gas Safety Council and Warm at Home-funded work (£11,000 mainly boiler and heating repairs) has also been completed. Over 1,000 minor aids and adaptations have also been completed to date during 2016/17. This equates to assisting over 4,000 local people to remain living independently in warm and safe homes. This will have risen to over 5,000 by the end of the financial year.<br><br>The Council is one of 9 Local Authorities piloting a Local Energy Advice Programme (LEAP) fuel poverty project funded through the Warm Homes Discount Industry Initiative. The project provides a home energy visit, energy efficiency advice, supplier switching and simple measures as well as onward referrals for larger energy efficiency measures. Householders can be referred to Incomemax which</td></tr>
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|---|---|
| | provides benefit entitlement checks, advice about budgeting and managing debt. The main source of referrals are from householders contacting Care & Repair, Peterborough Environment City Trust and Peterborough Council for Voluntary Service. The target number of referrals is 500 by the end of June and if successful, funding will become available to continue and expand the programme for the next 4 years.<br><br>A new Housing Renewals Policy 2017 - 2019 has been adopted by the City Council. As well as setting the criteria for Mandatory Disabled Facility Grants (DFG) and Repairs Assistance Grants which remedy defects in properties which have a significant risk to the health and/or safety of occupiers, the refreshed Policy also introduces two discretionary Disabled Facility Grants. The first is a Top Up discretionary grant which will be in addition to the Mandatory DFG which has a maximum of £30,000. Currently ground floor extensions to provide accessible bedrooms and shower rooms are exceeding this maximum amount by £15,000 - £20,000 depending on complexity. The second is a Discretionary DFG to Support Health. These grants have a £6,000 limit and can be used in a flexible way to provide measures in properties to prevent admission to hospital, prevent re-admission and to facilitate the early discharge from hospital. The Repairs Assistance Grant in the policy also tackles high priority hazards to address health issues such as poor heating and excess cold, as well as repairs which impact of the residents' health and wellbeing. |
| **Current Activities: narrative update on workstreams** | The Housing Programmes Team are working closely with Adult Social Care Commissioners to review the current Housing Related Support Programme. Grant Agreements to existing providers will be issued for 2017/2018 to allow opportunity to fully explore the range of housing related provision required from April 2018 onwards.<br><br>The anticipated date for completion of the new Cross Keys Homes Extra Care scheme at Matley is the end of July 2017. The scheme comprises 21 x 1 bed flats and 33 x 2 bed flats and it is intended that all the flats will be let as affordable rent tenure. Cross Keys Homes are intending to target applicants who are self-funders for the scheme to avoid the potential problem of rent shortfall once the Government's new system for funding supported housing is introduced in April 2019. If there are not enough applicants who are self-funders to fill all 54 units at the scheme, then Cross Keys will consider their options for the vacant units and will discuss with the council the best way forward. |

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| | Selective Licensing was approved by the Secretary of State and was introduced in December 2016. To date licences have been applied for 6242 properties across the area. These are currently being processed and to date 84 full licences have been issued and 233 rejected. Part of the application required that current gas safe certificates, energy performance reports and tenancy agreements were in place and that properties had working smoke alarms and carbon monoxide detectors installed and working. Many of the certificates were issued just prior to the applications being submitted which demonstrates the scheme has already led to improvements in the safety of the properties within these areas at this early stage. Enforcement action to identify and either licence or take legal action against those landlords who have failed to apply for a licence began in February 2017, and early results are that once identified these landlords are applying for their licences immediately. Each property will undergo an inspection and risk assessment prior to the issue of the licence followed by a full Housing Health and Safety Rating Scheme inspection during the schemes 5 year term. |

| HWB STRATEGY 2016/19: FUTURE PLANS | |
|---|---|
| <ul><li>Peterborough City Council is working in partnership with registered providers to provide new supported housing schemes including accommodation for people with learning disabilities and mental health disorders to enable them to live independently with a live-in carer where necessary or floating support</li><li>A Vulnerable People's Housing Sub-Group has been established, which will review how local housing needs for vulnerable people, including people with disabilities, should be addressed</li><li>The Peterborough Market Position Statement has identified a significant shortfall of nursing and residential care accommodation and it will be a priority to increase this provision for the ageing population</li><li>A task and finish group including housing managers and hospital managers is reviewing complex cases causing hospital discharge delays, and how use of disabled facility grants could address this</li></ul> | |
| **Future Plans: Progress against key milestones** | **Milestone 1 - New supported housing schemes for people with Learning Disabilities and Mental Health.**<br><br>Adult Social Care Commissioning have plans in place with registered social landlords and other developers for 25 units to be opened by April 2017 for people with Learning Disabilities. A further 17 units are planned for people with more complex learning disabilities and mental health problems to be opened by May 2017. Not all these units will necessarily be occupied by people from Peterborough. The services will offer some shared hours of support from registered care providers and some specific individually based care or support hours for people living in the schemes.<br><br>**Milestone 2 - The Vulnerable Persons Housing Sub Group.**<br><br>The group is currently on hold until the leadership of the Peterborough Housing Partnership has been determined.<br><br>**Milestone 3 – Delayed Transfers of Care.**<br><br>Fortnightly delayed transfer of care meetings take place, including housing services, to ensure any issues are addressed and remedied. Daily information on the cases is shared across the system to |

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| | ensure timely and appropriate actions are taken to prevent delays. |
| **Risks** | Once the funding for Supported Housing changes from the current model, there may be a risk to ensuring that the full rent level on these units are met through the proposed top up funding. Government proposals are currently at consultation stage. |
| **Key considerations** | Development of the Home Services Delivery Model to provide services to keep clients in warm and safe homes, bringing together reablement, therapy services and Care and Repair to ensure the needs of the client are met in a timely and proactive way. |

Note: an overarching report against the outcome metrics in the HWB Strategy will be prepared annually, co-ordinated by the Public Health Intelligence team.

## Performance Indicators:

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Agreed Target |
|---|---|---|---|---|---|---|---|---|
| 10.1 | Excess winter deaths index (3 years, all ages, Persons, Ratio) | Increasing - getting worse | Statistically similar to England | Aug 2012 - Jul 2015 | 268 | 19.6 | 19.6 | Match or exceed England performance |
| 10.2 | Excess winter deaths index (3 years, all ages Males, Ratio) | Increasing - getting worse | Statistically similar to England | Aug 2012 - Jul 2015 | 81 | 11.8 | 16.6 | Match or exceed England performance |
| 10.3 | Excess winter deaths index (3 years, all ages Females, Ratio) | Increasing - getting worse | Statistically similar to England | Aug 2012 - Jul 2015 | 187 | 27.3 | 22.4 | Match or exceed England performance |
| 10.4 | Reduction in unintentional injuries in the home in under 15 year olds | Decreasing - getter better | Statistically similar to England | 2015-16 | 464 | 113.5 | 104.2 | Match or exceed England performance to improve to statistically similar to England |
| 10.5 | Reduction in delayed discharges from hospital related to housing issues (observed numbers) | Decreasing - getter better | Has reduced, statistical significance unavailable | 2015-16 | 694 | - | - | Reduction in observed numbers |

**HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD**
**PERFORMANCE REPORT**
**DATE:** **MARCH 2017**
**SUBJECT:** **GEOGRAPHICAL HEALTH INEQUALITIES**
**LEAD:** **ADRIAN CHAPMAN**

| **HWB STRATEGY 2016/19: CURRENT ACTIVITIES:** | |
|---|---|
| • The City Council has a focus on economic development and regeneration in the city, together with improving educational attainment. In the long term these measures should improve both socio-economic circumstances and health<br>• City Council children's centres work closely with health visitors and are located to ensure focus on the areas of the city with the highest levels of need. Early child development, which children's centres help to support, is important for future health and wellbeing<br>• The City Council has identified the 'Can Do' Area around Lincoln Road, which includes parts of Central ward, Park ward and North ward. The 'Can Do' Board focusses on supporting environmental and service improvements for the area and includes senior staff from the City Council | |
| **Current Activities: Performance narrative and statistics (please refer to relevant performance indicators and measures of success)** | There are some key proposals for investment into the Can Do area contained in the council's budget proposals:<br>• £7.5million of capital investment to fund public realm improvements and potentially a community building, all subject to public consultation<br>• An environmental crime enforcement pilot with a private sector enforcement agency. This would tackle issues such as littering, graffiti and flytipping<br><br>The social cohesion sub group of the Skills Partnership continues to meet and is identifying a number of projects and interventions targeted towards addressing inequalities. These include projects aimed at targeted nationalities, projects for men, additional ESOL provision and projects to support volunteering.<br><br>An extensive programme of work is continuing with the city's mosques through the Joint Mosques Group, which brings together 5 mosques, council and police leaders.<br><br>The Community Connector team is now fully staffed meaning there are four community connectors available to the city to support cohesion and integration work. |

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| **Current Activities: narrative update on workstreams** | The Can-Do area has been the focus of pilot work on a potential devolution (phase 2) bid, which has included creating a data profile of the area, reviewing interventions which help improve outcomes in similar areas, creating a model of the economic benefits of improving outcomes which are below the national average, and meeting with community leaders from the area to identify community priorities.<br><br>We are currently in direct discussion with DCLG staff regarding potential bids for submission to the Migration Impact Fund, a national funding stream aimed at supporting established communities who have faced significant inward migration. |

| **HWB STRATEGY 2016/19: FUTURE PLANS**<br><br>• The NHS CCG has a statutory duty to reduce health inequalities and to carry out health inequalities impact assessments of any significant services changes<br>• City Council proposals for selective licensing of private sector housing in parts of the city could impact on geographical health inequalities in the longer term<br>• There is potential to target preventive public health initiatives and services so that they focus more on areas of the city with the greatest health and wellbeing needs | |
|---|---|
| **Future Plans: Progress against key milestones** | **Milestone 1**<br>The Clinical Commissioning Group is now carrying out health inequality impact assessments for significant service changes as part of their routine processes.<br><br>**Milestone 2**<br>Selective Licensing was approved by the Secretary of State and was introduced in December 2016. To date licences have been applied for 6242 properties across the area. These are currently being processed and to date 84 full licences have been issued and 233 rejected. Part of the application required that current gas safe certificates, energy performance reports and tenancy agreements were in place and that properties had working smoke alarms and carbon monoxide detectors installed and working. Many of the certificates were issued just prior to the applications being submitted which demonstrates the scheme has already led to improvements in the safety of the properties within these |

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| | areas at this early stage. Enforcement action to identify and either licence or take legal action against those landlords who have failed to apply for a licence began in February 2017, and early results are that once identified these landlords are applying for their licences immediately. Each property will undergo an inspection and risk assessment prior to the issue of the licence followed by a full Housing Health and Safety Rating Scheme inspection during the schemes 5 year term.<br><br>**Milestone 3**<br>The Public Health Delivery Unit is now delivering health trainer and similar services into community venues in the Central Ward area.<br>The new Integrated Lifestyles Service is required to target their services into areas of greatest need as part of their contract.<br>Local Sustainable Transport funding is being used to survey households in the Central Ward and encourage use of active transport (walking, cycling, public transport). |
| **Risks** | Lack of agreement on how to use the proposed £7.5million investment into the Can Do area.<br><br>Limited take-up of projects to tackle social cohesion.<br><br>Too great a focus on the Can Do area. |
| **Key considerations** | Deployment of and maximising the impact from community connectors.<br><br>How best to ensure that communities in addition to the Can Do area benefit from support and interventions |

Note: an overarching report against the outcome metrics in the HWB Strategy will be prepared annually, co-ordinated by the Public Health Intelligence team.

## Performance Indicators:

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Agreed Target |
|---|---|---|---|---|---|---|---|---|
| 11.1a | Increase in levels of education and economic attainment in electoral wards with highest levels of deprivation (GCSE attainment) | - | In 2014/15, Attainment of 5+ A*-C GCSEs in most deprived 20% of Peterborough wards is 34.6% (least deprived 80% = 51.8%). | 2014-15 | 223 | 34.6% | 57.3% | - |
| 11.1b | Increase in levels of education and economic attainment in electoral wards with highest levels of deprivation (Benefits Claimants) | - | In May 2016, the rate of benefit claimants in the most deprived 5 wards of Peterborough is 173.3/1,000 (other 80% of wards in Peterborough = 113.3/1,000) | May-16 | 5,350 | 173.3 | 111.2 | - |
| 11.2 | Increase in life expectancy in wards with highest levels of deprivation | Increasing - getter better | Life expectancy has increased at higher rate for most deprived 20% than least deprived 80% in each of past 5 pooled periods | 2011-15 | - | 79.5 | - | - |
| 11.3 | Reduction in emergency hospital admissions from wards with the highest levels of deprivation (Central, Dogsthorpe, North, Orton Longueville, Ravensthorpe) (directly standardised rates per 100,000) | Increasing - getting worse | Rate per 100,000 has increased from 2013-14 to 2014-15 | 2014-15 | 4,727 | 11,235 | - | - |
| 11.4 | Smoking cessation rates in wards with highest levels of deprivation (proportion, %) | Decreasing - getting worse | 4 week quit percentage fell between 2014-15 and 2015-16 from 38.0% to 34.5%. Suggested target = 40.0% | 2015-16 | 229 | 34.5 | - | - |
| 11.5 | Health checks completion in wards with highest levels of deprivation | - | TBC | - | - | - | - | - |

**HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD**
**PERFORMANCE REPORT**
**DATE: MARCH 2017**
**SUBJECT: HEALTH AND WELLBEING OF DIVERSE COMMUNITIES**
**LEAD: ADRIAN CHAPMAN**

| **HWB STRATEGY 2016/19: CURRENT ACTIVITIES:**<br><br>• The HWB has commissioned a JSNA on the health and wellbeing needs of migrants<br>• Eastern European 'community connectors' employed by the City Council are working closely with the local NHS on issues such as promotion of screening and immunisations | |
|---|---|
| **Current Activities: Performance narrative and statistics (please refer to relevant performance indicators and measures of success)** | The actions contained in the JSNA are being developed by various teams, services and organisations. For example, the Skills Partnership is focussing on ESOL provision, and the Community Connectors are focussed on integration and awareness raising projects.<br><br>There is now a full Community Connector team in place – two officers support EU nationals and their wider communities to integrate, whilst two provide thematic support – one to empower women and the second to support youth engagement. |
| **Current Activities: narrative update on workstreams** | The 'Diverse Ethnic Communities JSNA has been approved by the Health and Wellbeing Board and taken to the Peterborough City Council CMT and the CCG CMET. Elements have also been included in the STP plan.<br><br>Various proposals have been received for the Migration Impact Fund via a council working group. Detailed advice is now being sought from DCLG. |

| **HWB STRATEGY 2016/19: FUTURE PLANS**<br><br>• The benefits of tailoring preventive programmes, working with South Asian communities to prevent diabetes and CVD, are increasingly recognised nationally. The CCG and the City Council will work together to assess the feasibility of local schemes | |
|---|---|
| **Future Plans: Progress against key milestones** | **Milestone 1**<br>The CCG and City Council are assessing the feasibility of extending NHS Health Checks to a younger age group for the South Asian population (as recommended by NICE).<br><br>**Milestone 2**<br>Salaam Radio are receiving public health funding and working with the Public Health Delivery team to deliver health messages targeted for the local Muslim community.<br><br>**Milestone 3**<br>The new Integrated Lifestyles contract includes requirements to recognise the diversity of Peterborough and ensure that services are appropriately targeted for diverse communities. |
| **Risks** | There is a risk that communities will not engage with the services on offer and they will therefore be less effective. This needs to be mitigated by effective publicity, including a greater focus in 2017/18 on the 'Healthy Peterborough' campaign working with local community events.<br><br>Public perception of significant investment targeted to non-UK national communities. |
| **Key considerations** | Other ways to reach diverse communities, and to address cultural or deeply entrenched behaviours. |

Note: an overarching report against the outcome metrics in the HWB Strategy will be prepared annually, co-ordinated by the Public Health Intelligence team.

## Performance Indicators:

| Indicator Ref | Indicator | Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Agreed Target |
|---|---|---|---|---|---|---|---|---|
| 12.1 | We will work with local health services to improve data collection on ethnicity, both generally and to assess the success of targeted interventions | - | To follow via Peterborough City Council policy team in collaboration with Public Health Intelligence | - | - | - | - | - |
| 12.2 | Outcome measures for health and wellbeing of migrants will be developed following completion of the JSNA | - | To follow via Peterborough City Council policy team in collaboration with Public Health Intelligence | - | - | - | - | - |

**Health & Wellbeing & SPP Programme Delivery Board**

**Performance Report: March 2017**

| **Subject: Sustainable Transformation 5 Year Plan (including BCF)** | |
|---|---|
| **Subject lead:** | Will Patten / Liz Robin |
| **OVERALL RAG RATING** | |

**Key Priorities:**

- Health system transformation planning
- Customer experience strategy

**Performance Narrative and statistics**

The following outlines current performance against Better Care Fund metrics in Quarter 2 of 2016/17:
**Non-elective admissions:** There was an under performance against target by 5.5% in Q1. This is a decrease of 1.4% since the 2016/17 Q1 return.
**Delayed transfers of care (DTOC):** Despite a slight 10.6% decrease in Q2, data shows a significant under performance against plan, with DTOCs 54.6% above the planned target for this quarter.
**Injuries due to falls:** Based on performance to date in Q1 (155) and Q2 (148) we saw improved performance in Q2.
**Residential admissions in over 65s:** Admissions year to date are on track to meet target, although the winter period may present some challenges.
**Effectiveness of reablement (% of people still at home 91 days after discharge):** Outcomes for people receiving intermediate care in Q2 reflect on target levels of performance.
**Friends and Family metric:** The rate of 93% was over achieved in Q2.

**Activities Narrative**

**Better Care Fund Planning Approach 2017-19 and Alignment of Peterborough system plans**

Better Care Fund (BCF) planning is currently underway, but at the time of writing, BCF guidance and funding allocations for 2017/18 and beyond have not yet been published. From information released to date, the following changes are expected:

- The policy framework and guidance will be wider in scope than purely BCF and will incorporate the wider integration agenda.
- The plan will cover a period of two years - 2017/18 and 2018/19.
- It is anticipated that a new BCF settlement will also see additional funding allocated to local authorities.
- The national conditions will be reduced to three: plans must be jointly agreed; maintenance of Adult Social Care and a requirement to invest in NHS-commissioned out of hospital services. However, areas will likely still be required to discuss their approach to meeting previous national conditions.

Since the agreement of 2016/17 BCF plans, the local system has collectively signed up to the Sustainability and Transformation Plan (STP) and new STP governance arrangements have been established. Over the same period there has been a significant increase in joint working between local public sector organisations in Peterborough and Cambridgeshire through the development of proposals for local devolution. These developments offer an opportunity to review the local approach to BCF plans to reduce the risk of duplication and improve the chance of success. The following proposals are presented for discussion by the Health and Wellbeing Board:

- **Greater alignment of BCF activity with the STP and local authority transformation plans.** In its first two years, the BCF has maintained a separate project structure for many of its transformation projects. Given the fact that many BCF performance targets are dependent on activity across the STP Delivery Boards, further alignment is necessary. It is proposed that the BCF should shift to commissioning activity either from the HCE/ STP or local authority transformation programmes as appropriate, to reduce duplication and ensure that all partners can be engaged with the correct pieces of work. The BCF plan would describe activity to be commissioned, and responsibility for implementation would be passed to the most appropriate group. It would include specific targets in relation to performance indicators for BCF-commissioned activity as well as clarity on the primary governance.
- **Greater alignment of Peterborough and Cambridgeshire BCF Plans.** BCF transformation activity has always been aligned to some extent between Cambridgeshire and Peterborough. As most health and social care service transformation activity is now system wide, it is proposed that there should be further alignment of the two plans. Separate BCF budgets would still be maintained in line with statutory requirements, and each Health and Wellbeing Board would still be responsible for agreeing plans.
- **A single commissioning Board for Peterborough and Cambridgeshire.** At present there are two separate boards in Cambridgeshire and Peterborough overseeing BCF activity – the Cambridgeshire BCF Delivery Board and Greater Peterborough Area Executive Partnership Commissioning Board. To support more effective joint commissioning it is proposed

that these are replaced by a single board across Cambridgeshire and Peterborough. This would support a more joined up approach to planning and allow a more coordinated approach between the two areas and enable streamlined reporting into the two Health and Wellbeing Boards.

Please see Appendix 1 for an update on health and social care programme activities to date.

**Next Steps**

**BCF Planning 2017/18**

Planning for the local 2017/18 BCF plan continues. Planning guidance and policy is further delayed and at time of writing there are no confirmed dates.

**NHS England Quarter 3 BCF return**

The BCF Q3 NHSE reporting template has been issued and the submission deadline is 3rd March 2017.

**Alignment with STP**

Ongoing review of new STP governance structure to ensure integration projects continue to be aligned and appropriate representation across the system is involved at both design and implementation phases of projects, whilst maintaining traction to progress local priorities.

**Key Considerations**

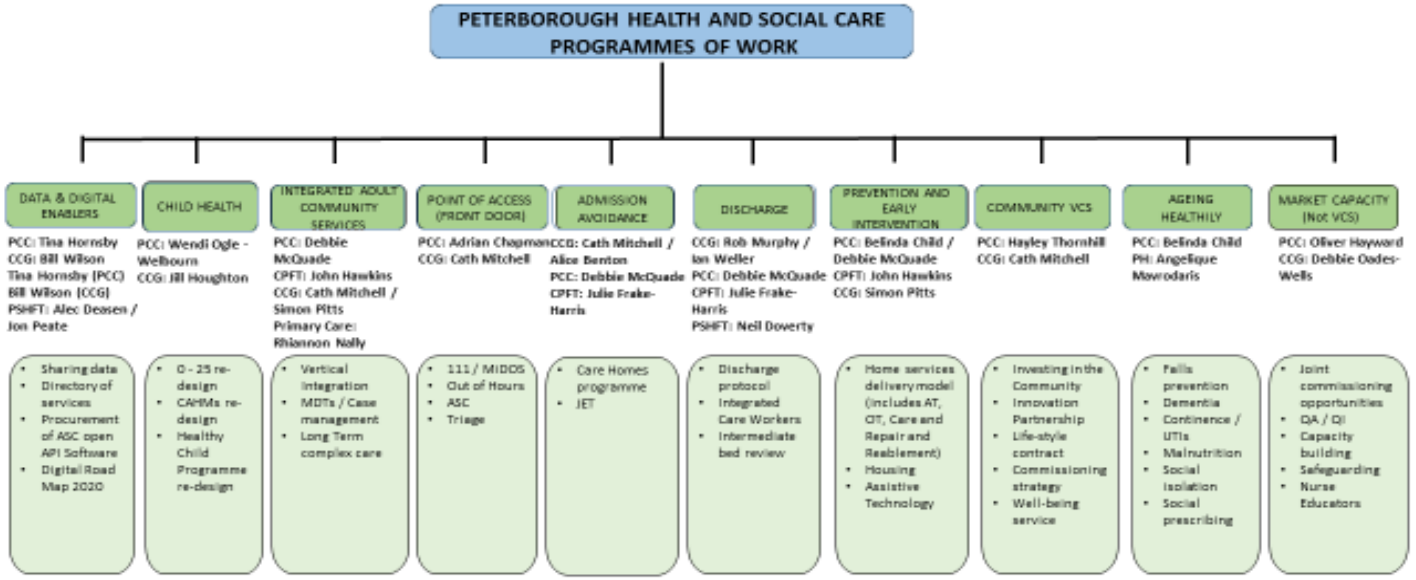
- STP governance is currently being reviewed by SDU for greater clarity on board roles and alignment with BCF governance.
- LDR investment will not be available from NHS Digital until April 2017.
- Better Care Fund planning for 2017/18 will need to incorporate plans for achieving health and social care integration by 2020 and future initiatives, e.g. devolution, will need to be factored into those plans.

**Communications**

- Regular progress updates reported into governance boards (e.g. Health and Wellbeing Board, Greater Peterborough Area Executive Partnership).
- Communication in line with programme and project plans.

**Appendix 1 – Health & Social Care Programme Activities update**

As previously shared with partners across the system, the below diagram outlines the current agreed health and social care programme structure and key local priority initiatives:




Alignment with the new STP governance structure, where appropriate, continues to ensure a consistent approach across the system. Below is an update on progress against the Peterborough Health and Social Care programme work streams:

**Data and Digital Enablers:** Governance and consent recommendations on a common approach have been approved**.** The immediate focus continues to be development of practical data sharing solutions to support multi-disciplinary working, including risk stratification/case finding proof of concept pilot. Work is being aligned to the STP Digital Delivery Group and the Local Digital Roadmap 2020.

**Child Health:** This incorporates the 0-25 re-design, CAMHS re-design and 0-19 Health and Wellbeing Service re-design projects. Start and finish group planning is underway for CAMHS and 0-19 Health and Wellbeing Service and governance has been established. 0-25 Transition re-design current offer and data analysis now completed. Further work is being finalised to develop the future operating model. Agreement is in place from the Healthcare Executive to bring together the STP and Joint Commissioning Unit.

**Integrated Adult Community Services:** Roll out criteria for Trailblazer neighbourhood team sites has been agreed. Planned timescales for scaled up implementation of the MDT Case Management model is April 2017. An initial proof of concept pilot for case finding is being supported via the Data Sharing work. A Multi-specialty Community Provider (MCP) bid was submitted to NHSE on 23rd December 2016 and an MCP steering group has been established. A workshop was held on the 15th February to develop an initial proof of concept pathway for respiratory.

**Point of Access (Front Door):** Alignment of the PCC Adult Social Care Front Door with health, including integration discussions with GP Network. A detailed model is now in development and further benefits analysis is being undertaken. The LGA Digital Transformation Fund awarded £40k to support the development of a Local Information Platform (LIP) (previously referred to as the Information Hub), which will support the consistency, quality and accuracy of information.

**Admission Avoidance:** Whole system plan has been developed; incorporates DTOCs, A&E and winter planning. Mapping of intermediate care provision being undertaken to inform effective commissioning approach. 24/7 Mental Health crisis response service live in Peterborough.

**Discharge:** Agreement for 7 Day Services to be overseen by A&E Delivery Board as this previously sat with the Systems Resilience Group (SRG). Draft interim bed review completed. DTOC Workshop held on 10th January by NHSE, NHSI and ADASS and recommendations being implemented. DTOC Sub-group has been established, reporting into the A&E Delivery Board, and is meeting bi-weekly.



**Prevention and Early Intervention:** PCC is undertaking further work to refine the Home Services Delivery Model to ensure integrated and strengthened intermediate care tier provision. A single Head of Service has been appointed across PCC's Care and Repair, Assistive Technology, Therapy Services and Reablement teams. PCC and CPFT are working closely to ensure integration is achieved across system-wide intermediate care provision. There is a continued focus on the expansion and embedding of Assistive Technology across social care and health.

**Community VCS:** Procurement options are being explored for the Wellbeing Network and Social Prescribing pilots. Community Serve project is underway to build community resilience and 'meet and eat' social dining sessions are running regularly across all three pilot areas (Can-Do area, Westwood & Ravensthorpe and the Ortons). Community hubs have been established and area coordinators are in place. A volunteer time-bank pilot is being explored.

**Ageing Healthily:** Key objectives for this work include:

- Falls Prevention: District level leads group is looking at further development to support local implementation of the joint falls pathway.
- Mental Health and Dementia: Final draft of Cambridgeshire and Peterborough Dementia Strategic Plan completed by Public Health.
- Continence and UTIs: further development of gaps and priorities is being undertaken.

**Market Capacity (not VCS):** Care Home Educators have now been recruited by the CCG and further work to develop joint working with care homes is a priority. PCC is exploring joint commissioning opportunities to ensure efficiencies on an ongoing basis.

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**Health & Wellbeing Strategy – Performance Indicator Assignment & Improvement Trajectory Methodology**

Each Health & Wellbeing Strategy section performance report includes a quarterly update from the section lead on current and on-going activities, future plans and milestones, risks and key considerations. In addition to this, a number of key performance indicators have been chosen for each section in order that progress can be objectively monitored against national performance in relation to both observed numbers (e.g. number of people dying from all cardiovascular diseases) and statistical significance in comparison to England (e.g. directly age-standardised mortality rates, which take in to account differences in demographics between populations, such as disproportionately high percentages of older or younger people compared to England).

For each performance indicator, an appropriate partnership Board has been asked to agree both the appropriateness of the indicator and a three year improvement trajectory, encompassing the period from the start of Health & Wellbeing Strategy in 2016 through to March 2019. The process for the assignment of these performance indicators and improvement trajectories is noted below:

**Figure 1: Health & Wellbeing Strategy Performance Indicator Assignment/Improvement Trajectory Methodology Flowchart**

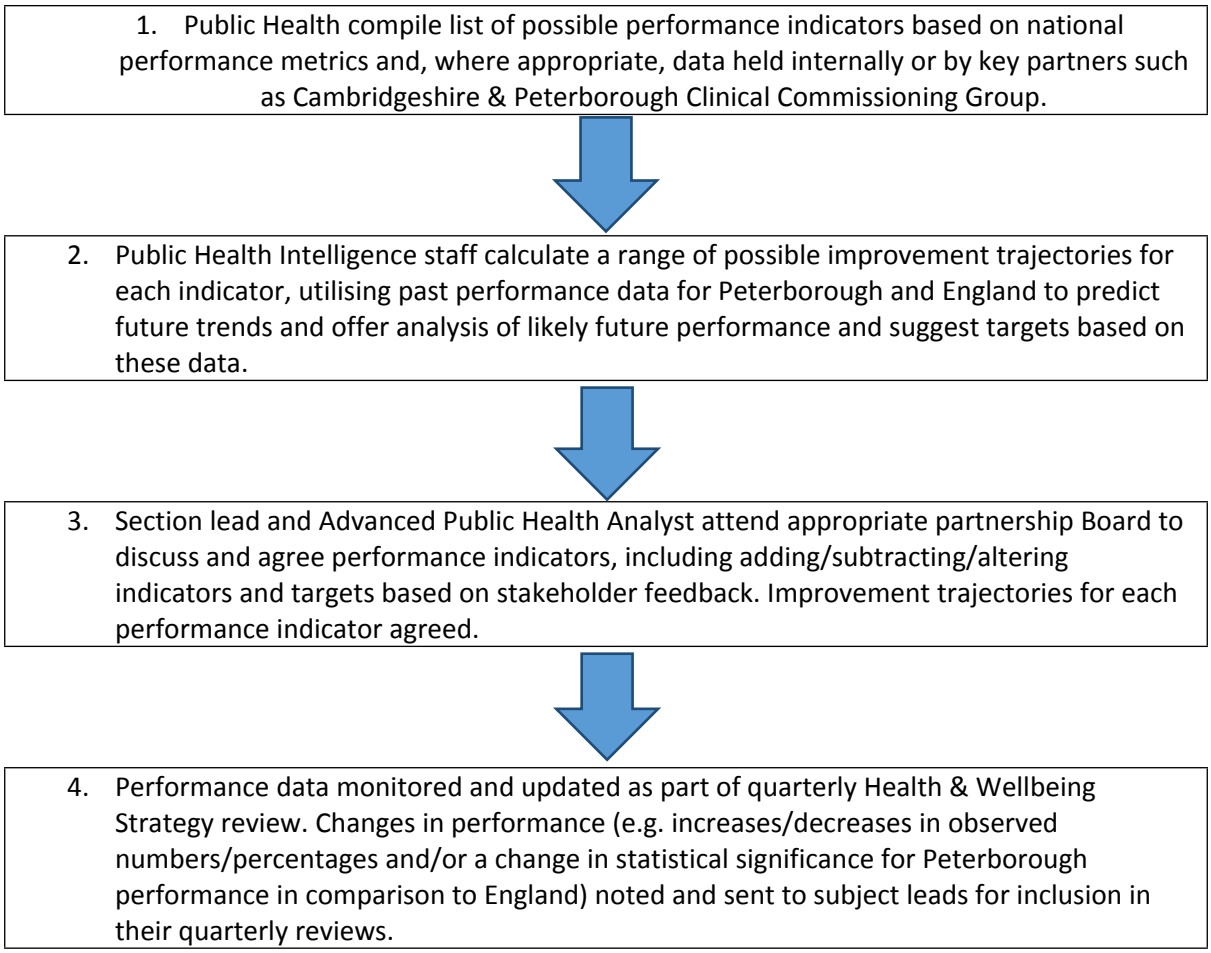
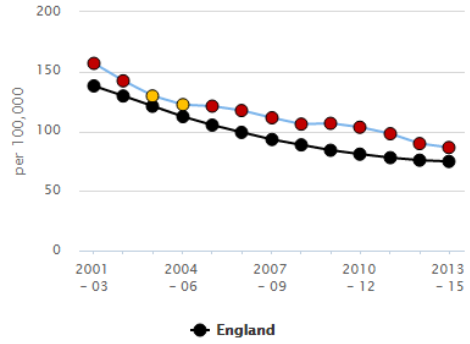


**Figure 2: Long Term Conditions & Premature Mortality Performance Matrix**

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Agreed Target |
|---|---|---|---|---|---|---|---|---|
| 3.1 | Under 75 mortality rate from all cardiovascular diseases - Persons (directly standardised rate per 100,000) | Decreasing - getter better | Statistically significantly worse than England | 2013-15 | 349 | 86.3 | 74.6 | Reduction in DSR of 0.5% per year |
| 3.2 | Under 75 mortality rate from all cardiovascular diseases - Males (directly standardised rate per 100,000) | Decreasing - getter better | Statistically similar to England | 2013-15 | 230 | 116.6 | 104.7 | Reduction in DSR of 1.0% per year |
| 3.3 | Under 75 mortality rate from all cardiovascular diseases - Females (directly standardised rate per 100,000) | Decreasing - getter better | Statistically significantly worse than England | 2013-15 | 119 | 57.7 | 46.2 | Continue recent trend of reduction in DSR of 2.45/100,000 per year |
| 3.4 | Inequalities between electoral wards in emergency CVD hospital admissions (disparity in directly standardised rate per 100,000) | Increasing - getting worse | Disparity between most deprived 20% and least deprived 80% has increased between 2013/14 and 2014/15 | 2014-15 | N/A | 305.8 | N/A | Reduction in DSR of most deprived 20% of Peterborough electoral wards of 2.0% per year |
| 3.5 | Recorded Diabetes (proportion, %) | Increasing - getting worse | Statistically similar to England | 2014-15 | 9,740 | 6.5% | 6.4% | Match or exceed England trend |
| 3.6a | The rate of hospital admissions for stroke (directly standardised rate per 100,000) | Decreasing - getter better | Rate has reduced, national benchmark unavailable | 2014-15 | 369 | 250.7 | N/A | Reduction in DSR of 1.0% per year |
| 3.6b | The rate of hospital admissions for heart failure (directly standardised rate per 100,000) | Decreasing - getter better | Rate has reduced, national benchmark unavailable | 2014-15 | 335 | 235.2 | N/A | Reduction in DSR of 1.0% per year |
| 3.7 | Outcomes for a wider range of long term conditions will be defined following completion of the long term conditions needs assessment | - | To be decided upon completion of relevant Joint Strategic Needs Assessment | N/A | N/A | N/A | N/A | - |

The table above provides an example of chosen Health & Wellbeing Strategy indicators, in this case for the 'Long Term Conditions & Premature Mortality' section of the strategy, For each indicator, the 'Peterborough Trend' column shows the recent trend in terms of Peterborough performance, whereas 'Current Status' shows statistical significance in comparison to England and 'Agreed Target' refers to the improvement trajectory option chosen by the relevant partnership Board - for this section of the strategy, the Greater Peterborough Executive Partnership Board that met on 09/12/2016 - after the aforementioned discussion. A specific example of the improvement trajectory process is noted below.

**Figure 3: Health & Wellbeing Strategy indicator 3.1 – Under 75 mortality rate from all cardiovascular diseases (Persons) – Peterborough, directly standardised rate per 100,000**




Recent trend: –

| Period | | Count | Value | Lower CI | Upper CI | East of England | England |
|---|---|---|---|---|---|---|---|
| 2001 - 03 | ● | 519 | 156.9 | 143.6 | 171.0 | 118.1 | 138.0 |
| 2002 - 04 | ● | 475 | 142.2 | 129.6 | 155.7 | 111.1 | 129.5 |
| 2003 - 05 | ● | 439 | 129.5 | 117.6 | 142.3 | 104.2 | 120.9 |
| 2004 - 06 | ● | 420 | 122.3 | 110.8 | 134.7 | 97.6 | 112.3 |
| 2005 - 07 | ● | 421 | 121.0 | 109.6 | 133.3 | 90.7 | 105.1 |
| 2006 - 08 | ● | 411 | 117.3 | 106.2 | 129.4 | 85.3 | 99.0 |
| 2007 - 09 | ● | 397 | 111.3 | 100.5 | 122.9 | 80.2 | 93.1 |
| 2008 - 10 | ● | 386 | 106.0 | 95.5 | 117.2 | 77.8 | 88.6 |
| 2009 - 11 | ● | 397 | 106.6 | 96.2 | 117.8 | 74.6 | 84.0 |
| 2010 - 12 | ● | 389 | 103.3 | 93.2 | 114.3 | 72.3 | 80.8 |
| 2011 - 13 | ● | 375 | 97.9 | 88.1 | 108.5 | 69.6 | 77.8 |
| 2012 - 14 | ● | 352 | 89.6 | 80.4 | 99.6 | 67.4 | 75.7 |
| 2013 - 15 | ● | 349 | 86.3 | 77.4 | 96.0 | 66.4 | 74.6 |

*Source: Public Health England (based on ONS source data)*

Source: Public Health Outcomes Framework, URL: http://www.phoutcomes.info/public-health-outcomes-framework#page/4/gid/1000044/pat/6/par/E12000006/ati/102/are/E06000031/iid/40401/age/163/sex/4

A reduction in under 75 mortality from all cardiovascular diseases is a central tenet of Peterborough City Council's 2016-19 Health & Wellbeing Strategy. The above data show that Peterborough has had a statistically significantly worse rate of under 75 mortality from all cardiovascular diseases for every three year pooled period since 2004-06, although the directly standardised rate per 100,000 has fallen in each of the last four three year pooled periods.

At the time that this indicator was agreed as appropriate for inclusion in the 2016-19 Health & Wellbeing Strategy, the most recently available data were for 2012-14. The below three improvement trajectory options were discussed:

1: Continue recent reduction in directly standardised rate of 6.85/100,000 per year

| Actual | | | Predicted | | Target | | |
|---|---|---|---|---|---|---|---|
| 2010-12 | 2011-13 | 2012-14 | 2013-15 | 2014-16 | 2015-17 | 2016-18 | 2017-19 |
| 103.3 | 97.9 | 89.6 | 82.8 | 75.9 | 69.1 | 62.2 | 55.4 |

2: Reduction in directly standardised rate per 100,000 of 1.0% per year

| Actual | | | Predicted | | Target | | |
|---|---|---|---|---|---|---|---|
| 2010-12 | 2011-13 | 2012-14 | 2013-15 | 2014-16 | 2015-17 | 2016-18 | 2017-19 |
| 103.3 | 97.9 | 89.6 | 82.8 | 75.9 | 75.1 | 74.4 | 73.6 |

3: Reduction in directly standardised rate per 100,000 of 0.5% per year

| Actual | | | Predicted | | Target | | |
|---|---|---|---|---|---|---|---|
| 2010-12 | 2011-13 | 2012-14 | 2013-15 | 2014-16 | 2015-17 | 2016-18 | 2017-19 |
| 103.3 | 97.9 | 89.6 | 82.8 | 75.9 | 75.5 | 75.1 | 74.8 |

Predicted values for 2013-15 and 2014-16 are based on performance from the previous three periods for which data are available. In this instance, a continued reduction in directly standardised rate of 6.85/100,000 per year was considered unrealistic as it would result in a value of 55.4/100,000 by 2017-19 which is likely to be significantly lower than the England value. The Board elected to set the improvement trajectory target based on 'option 3' above; a reduction in directly standardised rate per 100,000 of 0.5% per year. Performance across the period 2010-12 – 2012-14 led to a

prediction Peterborough value of 75.9/100,000 by 2014-16, thus a target of 74.8/100,000 by 2017-19 has been adopted (although it should be noted that Peterborough performance was slightly worse than predicted for 2013-15, with a rate of 86.3/100,000 compared to a predicted 82.8/100,000). This results in the current status of the indicator in figure 2 of 'decreasing – getting better' but still 'statistically significantly worse than England'.

| HEALTH AND WELLBEING BOARD | | AGENDA ITEM No. 13 |
|---|---|---|
| **23 MARCH 2017** | | PUBLIC REPORT |
| Contact Officer(s): | Will Patten, Director of Transformation, Peterborough City Council | Tel. 07919 365883 |

**ADULT SOCIAL CARE, BETTER CARE FUND (BCF) UPDATE**

| RECOMMENDATIONS | |
|---|---|
| **FROM :** Will Patten, Director of Transformation, | **Deadline date :** N/A |
| The Health and Wellbeing Board are requested to note the update of BCF delivery and planning for BCF 2017/18 submission | |

**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 BCF Programme and planning approach for the BCF 2017/18 submission.

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. BCF 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 £12.6 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. It includes funding for the Disabled Facilities Grant, which supports housing adaptations. In April 2017, Peterborough will be required to submit a new, jointly agreed BCF Plan, covering a two year period.

3.1.2 The BCF 2016/17 plan was fully 'Approved' and written confirmation has been received by NHS England.

**3.2 GOVERNANCE:**

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

3.2.2 Following approval by this Board in March 2015, the Section 75 Agreement between PCC and CCG was in place by 1st April 2015 when BCF funding began. The Section 75 Agreement has been reviewed to reflect changes for 2016/17 and contractual changes have been legally executed.

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 Greater Peterborough Executive Partnership Commissioning Board. 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 The BCF Q3 NHS England reporting template has been issued and the submission deadline is 3rd March 2017.

**3.4 BCF PLANNING SUBMISSION 2017/18**

3.4.1 At the time of writing, BCF guidance and funding allocations for 2017/18 and beyond have not yet been published. They were expected on 18th November, but have been delayed. Currently we do not have an anticipated date for publication.

3.4.2 From information released to date, key changes expected are:

- The policy framework and guidance will be wider in scope that purely BCF and will incorporate the wider integration agenda.
- The plan will cover a period of 2 years: 2017/18 and 2018/19.
- It is anticipated that a new BCF settlement will also see additional funding allocated to local authorities.
- The national conditions will be reduced to three: plans must be jointly agreed; maintenance of Adult Social Care and a requirement to invest in NHS-commissioned out of hospital services. However, areas will likely still be required to discuss their approach to meeting previous national conditions.

3.1.3 Since the agreement of 2016/17 BCF plans, the local system has collectively signed up to the Sustainability and Transformation Plan (STP) and new STP governance arrangements have been established. Over the same period there has been a significant increase in joint working between local public sector organisations in Peterborough and Cambridgeshire through the development of proposals for local devolution. These developments offer an opportunity to review the local approach to BCF plans to reduce the risk of duplication and improve the chance of success. The following proposals are presented for discussion by the Health and Wellbeing Board:

- **Greater alignment of BCF activity with the STP and local authority transformation plans.** In its first two years, the BCF has maintained a separate project structure for many of its transformation projects. Given the fact that many BCF performance targets are dependent on activity across the STP Delivery Boards, further alignment is necessary. It is proposed that the BCF should shift to commissioning activity either from the HCE/ STP or local authority transformation programmes as appropriate, to reduce duplication and ensure that all partners can be engaged with the correct pieces of work. The BCF plan would describe activity to be commissioned, and responsibility for implementation would be passed to the most appropriate group. It would include specific targets in relation to performance indicators for BCF-commissioned activity as well as clarity on the primary governance.
- **Greater alignment of Peterborough and Cambridgeshire BCF Plans.** BCF transformation activity has always been aligned to some extent between Cambridgeshire and Peterborough. As most health and social care service transformation activity is now system wide, it is proposed that there should be further alignment of the two plans. Separate BCF budgets would still be maintained in line with statutory requirements, and each Health and Wellbeing Board would still be responsible for agreeing plans.
- **A single commissioning Board for Peterborough and Cambridgeshire.** At present there are two separate boards in Cambridgeshire and Peterborough overseeing BCF activity – the Cambridgeshire BCF Delivery Board and Greater Peterborough Executive Partnership Commissioning Board. To support more effective joint commissioning it is proposed that these are replaced by a single board across Cambridgeshire and

Peterborough. This would support a more joined up approach to planning and allow a more coordinated approach between the two areas and enable streamlined reporting into the two Health and Wellbeing Boards.

## 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 to ensure clear and standardised reporting mechanisms.

## 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 £12.6m BCF.

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

## 6. BACKGROUND DOCUMENTS

i) BCF Quarterly Data Collection Template Q3 15-16 Peterborough (final)
ii) BCF Quarterly Data Collection Template Q4 15-16 Peterborough (final)
iii) BCF Quarterly Data Collection Template Q1 16-17 Peterborough (final)
iv) BCF Quarterly Data Collection Template Q2 16-17 Peterborough (final)

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| HEALTH AND WELLBEING BOARD | | AGENDA ITEM No. 14 |
|---|---|---|
| **23 MARCH 2017** | | PUBLIC REPORT |
| Contact Officer(s): | Aidan Fallon, Senior Communications and Engagement Manager | Tel. |

## CAMBRIDGESHIRE & PETERBOROUGH SUSTAINABILITY AND TRANSFORMATION PLAN (STP) UPDATE REPORT

| RECOMMENDATIONS | |
|---|---|
| **FROM:** Cambridgeshire & Peterborough Health & Care Executive (Report produced by the System Delivery Unit) | **Deadline date:** n/a |
| The Health and Wellbeing Board is asked to note this update report. | |

### 1. ORIGIN OF REPORT

1.1 This report is submitted to the Board from the System Delivery Unit of the Cambridgeshire & Peterborough STP.

### 2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to update the Health & Wellbeing Board on progress relating to the Cambridgeshire & Peterborough Sustainability and Transformation Plan (STP).

## 3. BACKGROUND

3.1 Cambridgeshire and Peterborough's five-year Sustainability and Transformation Plan (STP) to improve local health and wellbeing was published in November 2016.

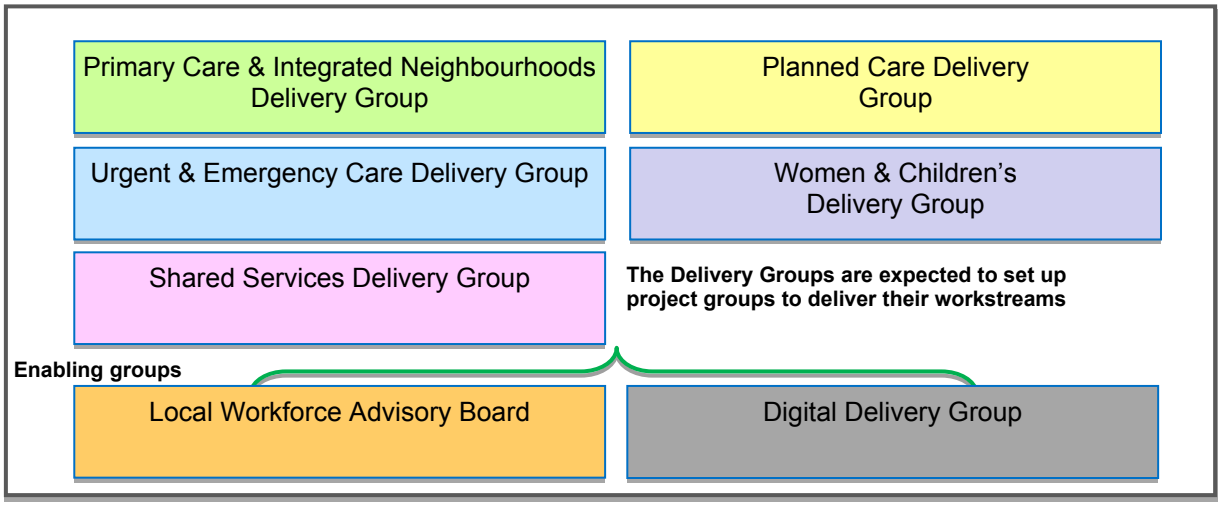
3.2 Led by local clinicians, the STP has been developed by all local NHS organisations and local government officers, as well as through discussions with our staff and patients. It aims to provide solutions to the county's challenges to deliver the best possible care to keep the population fit for the future and take joint responsibility for improving health and wellbeing.

3.3 It addresses the system-wide financial challenge of £504m over the next four years. It also estimates the need to invest £43m to improve services over these four years, which increases the total system-wide financial challenge to £547m.

3.4 Through discussion with our staff, patients, carers, and partners we have identified four priorities for change as part of our *Fit for the Future* (STP) programme, and developed a 10-point plan to deliver these priorities, as illustrated at Annex 1.

3.5 We have also developed a delivery governance structure to ensure effective implementation of the STP and this is illustrated at Annex 2. At its core are seven Delivery Groups, each one responsible to Accountable Officers who are Chief Executive Officers from across the health and social care system.

**Fit for the Future (STP) Delivery Groups**




The Delivery Groups cover clinical services, workforce and support services and are designed to encourage system-wide working and to allow for patient-led care to be at the forefront of everything we do. Membership includes clinicians from organisations across the system and we are currently ensuring that each Delivery Group has patient and public representation (See section 5 below). Project groups have been established within each Delivery Group to take forward specific aspects of work and, again, these groups include clinical membership and will all have patient and public representation.

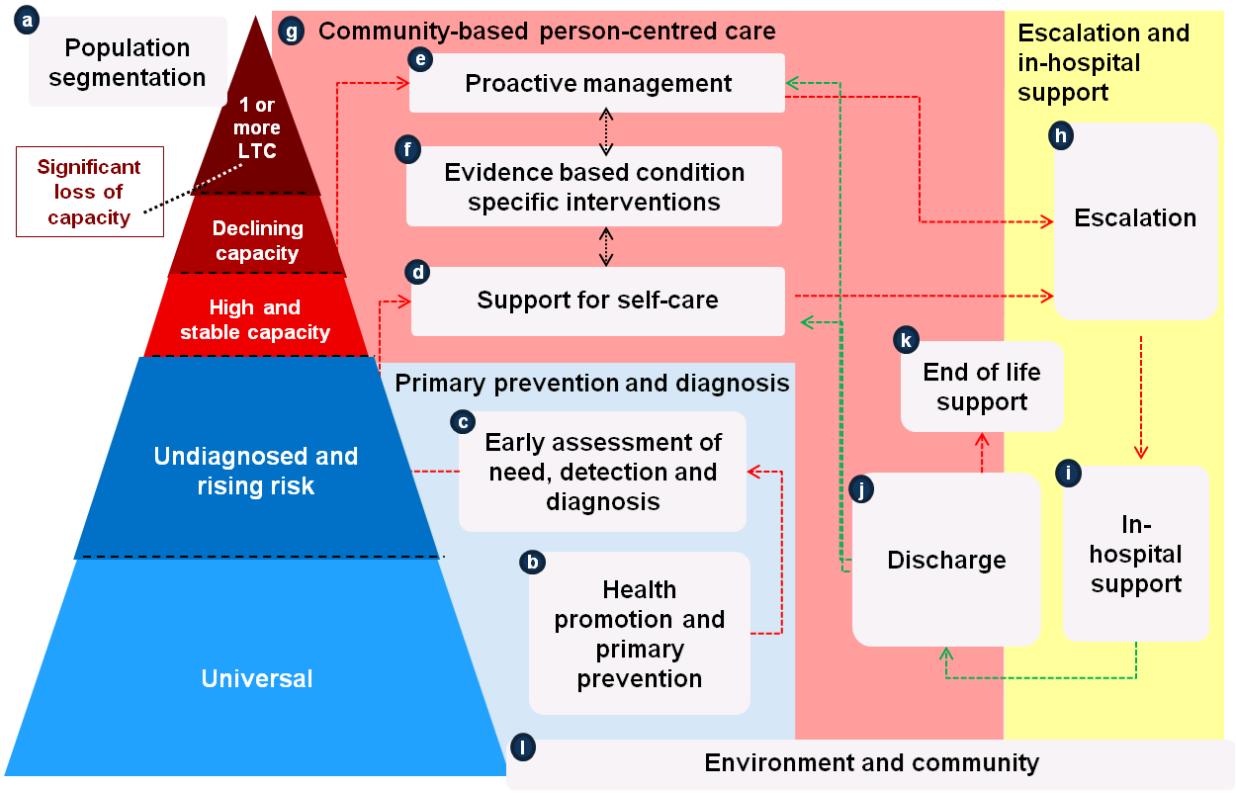
## 4.0 KEY ISSUES

4.1 This section summarises the focus for early implementation across the seven Delivery Groups within *Fit for the Future*.

### 4.2 Primary Care and Integrated Neighbourhoods

4.2.1 The purpose of this Delivery Group is to implement integrated health and care neighbourhood teams providing proactive care stratified by different levels of need, as determined by people's medical and psychosocial conditions, and as illustrated in the diagram below. We have brought together previously disparate work on healthy ageing,

long-term conditions management, and mental health for the first time in this delivery programme.




4.2.2 Early implementation work is underway in a number of areas, including:

'*Social Prescribing'*: This is where a healthcare professional can refer people to a link worker to co-design a non-clinical 'social' prescription. For example, an older single man experiencing loneliness and depression could receive a social prescription to an organisation such as Men's Sheds Association (see http://menssheds.org.uk/what-is-a-mens-shed/);

- Stroke prevention: Improving atrial fibrillation identification and management to reduce the risk of Stroke and manage Cardio vascular disease;
- Community Diabetes: Establishing a transformational community based diabetes model bringing care out of the acute setting and providing a holistic local offering to diabetic patients;
- Proactive Case Management: The identification and management of a wider cohort of at-risk patients than are currently cared for to maintain people in the Community; and
- Community Respiratory services: The development of community respiratory clinics run by Community Respiratory Consultant and follow-up clinics run by dedicated community respiratory nurse.

## 4.3 Urgent and Emergency Care

4.3.1 This Delivery Group is seeking to manage demand for urgent and emergency care services which have seen significant increases over recent years resulting in clinical and financial challenges for the system. The increase in demand in Cambridgeshire & Peterborough is driven mainly by population growth and, in particular, by growth in the older frail population, as well as a lack of community based services to support vulnerable people.

4.3.2 The focus for early implementation is:

- Extended Joint Emergency Team (JET): The Health & Care Executive (see diagram at Annex 2) has agreed to provide additional investment to recurrently fund an expansion of and enhancement to the current JET service to enable it to care for an increased cohort of vulnerable patients. This increased funding will be used mainly to recruit additional staffing;

- Stroke Early Supported Discharge (ESD): Funding has been approved by the HCE to allow the commissioning of an Integrated Community Neurorehabilitation and Early Supported Discharge Service. This will combine therapy and associated staff to support all patients on the neuro and stroke pathways ensuring equity of provision and economies of scale. The service will provide both intensive stroke discharge support for six weeks and home based neuro rehabilitation; and

- Mental Health Crisis First Response Service: Funding to continue the urgent & emergency mental health liaison services has been agreed by the HCE. The First Response Service provides a comprehensive crisis assessment pathway, covering all ages, and providing a genuine alternative to A&E. The current service has demonstrated that it can improve patient care and safety, as well as reduce A&E attendance, therefore providing savings for the urgent and emergency care system.

4.4 **Planned Care**

4.4.1 The focus for Planned Care is to define, design and implement shorter, faster, better and more cost effective pathways of care for patients needing planned (or sometimes known as 'elective') care. This involves looking at every stage of the patient 'journey' from GP referral, outpatient appointment, procedure to follow up, ensuring that we are making the most effective use of clinical and financial resources.

4.5 **Women and Children**

4.5.1 The Women, Children and Maternity Services STP Delivery Group is leading seven projects over the next five years to improve services and outcomes for women and children.

4.5.2 Early implementation work across these projects includes:

- Maternity network developments**:** The initial focus is on developing a networked model of maternity care across Cambridgeshire and Peterborough to ensure consistent, high quality care and outcomes. Developing a community perinatal mental health service (see below), reviewing clinical protocols for inutero transfers and focussing on services for unwell, new born babies are also initial priorities for this work programme;

- Perinatal mental health: A priority is to develop a business case to establish a specialist community perinatal mental health service. Whilst there are pockets of expertise in our localities, there is currently no dedicated community service and the benefits for mothers and babies of introducing an evidence-based service would be significant;

- Urgent care: An early priority for this group is to identify new pathways of care for conditions that are currently seen in A&E, for example, minor illnesses and accidents, which could be treated closer to home if appropriate services were available. More joined up and integrated pathways across community and hospital services would ensure safe and sustainable services are provided at the right time, in the right place, by the right practitioner;

- Specific disease pathways: Developing proactive asthma and continence pathways and care models is the focus of this work stream, with the aim of developing community based clinics and improving the tools and information available to children and families.

This would enable children and young people with asthma to be treated closer to home where appropriate, reducing A&E attendances, whilst community continence clinics will enable more routine cases, currently seen in hospital outpatient clinics, to be seen in the community with earlier, more proactive intervention;

- Mental health support for children: This work programme is seeking to transform emotional health and wellbeing services for children and young people, with an initial focus on the introduction of a Crisis Assessment Team for children and adolescents with mental health issues. We will also be seeking to implement, locally, the national I-Thrive framework; an integrated, person centred and needs led approach to delivering mental health services for children, young people and their families;

- 0-19 universal services: Developing an integrated Healthy Child Programme for 0 – 19 year olds which meets the needs of children and young people and their families is central to this work programme. Our aim is to improve access to services and ensure equity of service provision across Cambridgeshire and Peterborough to ensure our children and young people are supported to have the very best start in life; and

- Specialist disability services: The focus of this group is to improve pathways for children who have a disability to ensure care and services are co-ordinated and that we are able to achieve positive outcomes for young people with disabilities supporting them to become independent adults.

**4.6 Shared Services**

4.6.1 This Delivery Group is focussed on ensuring that we optimise the use of our resources, assets and potential. This includes, for example, making best use of NHS buildings and land, sharing 'back office' functions such as Human Resources, and streamlining our procurement and purchasing processes.

4.6.2 Key projects for early implementation include:

- Merger of Hinchingbrooke Healthcare NHS Trust and Peterborough & Stamford Hospitals NHS Foundation Trust to enable shared service savings;

- Exploring back office consolidation across primary care at scale;

- Implementing a single approach to procurement; and

- Development and sign off of a strategic estate plans, (including potential for primary care co-location, including other public services)

**4.7Workforce**

4.7.1 Our new models of care will have significant implications for our workforce. In order to maximise the impact of the care models, the Local Workforce Advisory Board is working closely with clinical leads to ensure that workforce requirements can be met. Care models must take into account current workforce capacity and capability, and consider the change required to develop a workforce which is capable, competent, motivated, and supported to provide the best care for the population in the future.

4.7.2 Key projects for early implementation include:

- Development of a system wide Workforce Investment Plan, with a commitment to investment priorities in relation to Apprenticeships (via LEVY), Pre-Registration, Continued Professional Development (CPD) and wider workforce transformation; and

- Linking to the supply improvement programme and design a tailored programme for primary care, linking to case load management trailblazers.

### 4.8 Digital Delivery

4.8.1 This Delivery Group is concerned with how best we can meet the opportunities and challenges of providing healthcare in a digital world by making best use of technology to support care, for example, tele-medicine, tele-monitoring, remote monitoring and paper free care delivery.

4.8.2 A key component of this work is the Cambridgeshire & Peterborough Local Digital Roadmap (LDR) which was published in January 2017 and which supports the delivery of the STP given the central role of digital technology.

## 5.0 ENSURING EFFECTIVE PATIENT & PUBLIC INVOLVEMENT IN STP IMPLEMENTATION

5.1 We are committed to ensuring that we effectively involve patients, service users and the public at every stage of STP implementation.

5.2 Early patient and public involvement work in STP implementation includes:

- Ensuring that there is patient, service user or voluntary sector representation on every Fit for the Future Delivery Group and live Improvement Area Group;
- Working with Healthwatch who can advise on effective involvement and, in particular, facilitate access to specific and seldom heard groups; and
- When a Delivery Group/Improvement Area reaches a stage where PPI activity is required, ensuring that there is access to the extensive existing 'pools' of patients, service users and third/voluntary sector organisations who can be involved.

5.3 We recognise that we need to engage more widely than we have traditionally done and reach audiences that have not been heard to date. We will do this in a variety of ways, including:

- Exploiting the potential of social media to establish an on-going two-way dialogue with audiences that we would not routinely access e.g. teenagers and women aged between 30- 50;
- Use the facilitative input of organisations and groups that understand how to engage effectively with seldom heard groups e.g. Healthwatch and mental health charities;
- Promote the Fit for the Future website as the central point of contact with up-to-date information on activity and progress;
- Advertise opportunities for people to be involved;
- Develop practical support to individuals involved in the STP programme; and
- Develop opportunities for individuals and groups to improve their involvement skills e.g. quality events, conference or guides.

## 6. IMPLICATIONS AND CHALLENGES

6.1 If the NHS Trusts and CCG meet their savings and efficiency plans, and all aspects of the STP are delivered, this will achieve the savings and efficiency target and produce a small NHS surplus by 2020/21.

6.2 Due to the high levels of acute hospital activity, and resulting deteriorating financial position in our system, we are looking at ways to accelerate the pace of change and focus early investment on the areas that will have greatest impact on reducing hospital activity levels.

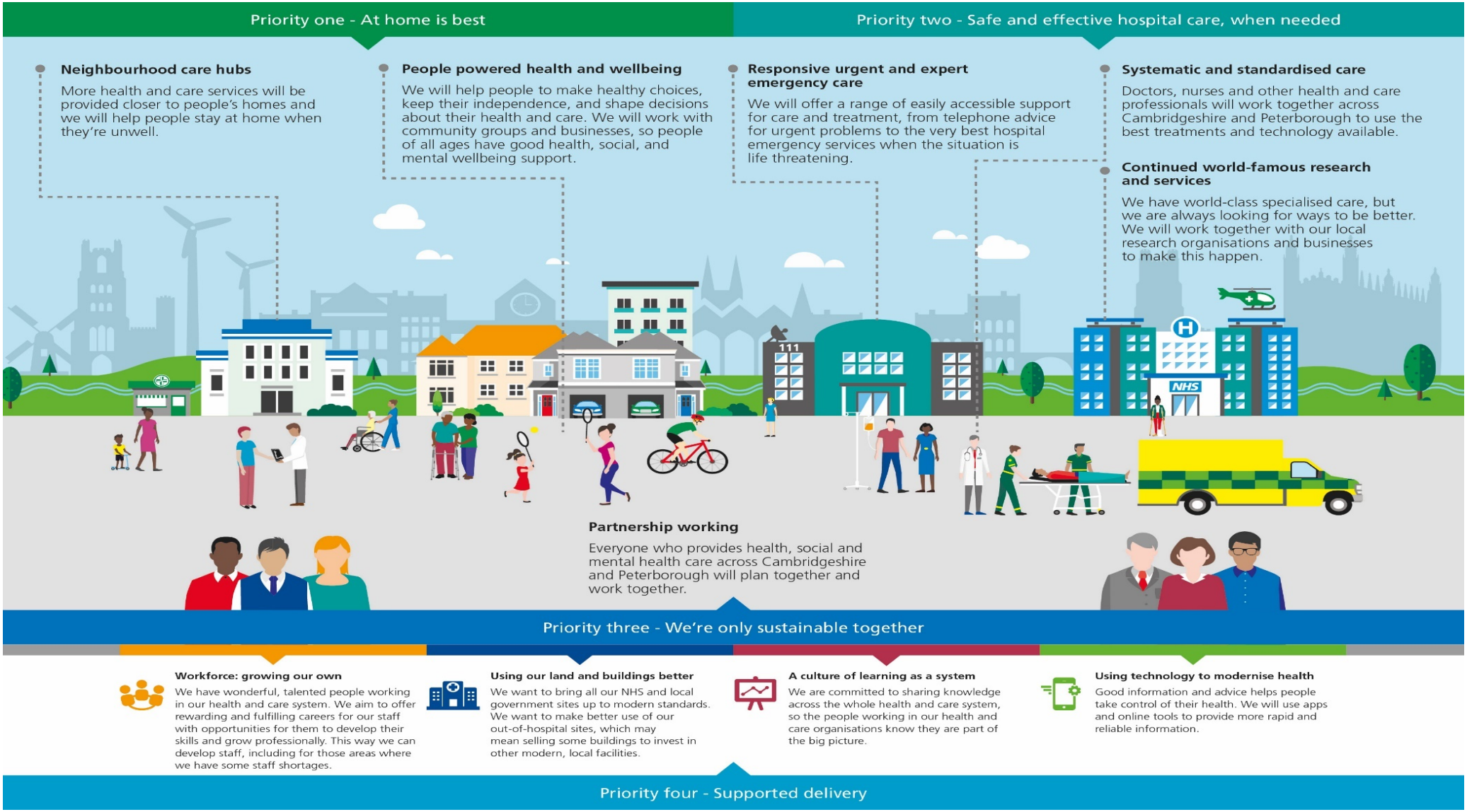
## 7.0 RECOMMENDATION

7.1 The Health & Wellbeing Board is asked to note this update report.

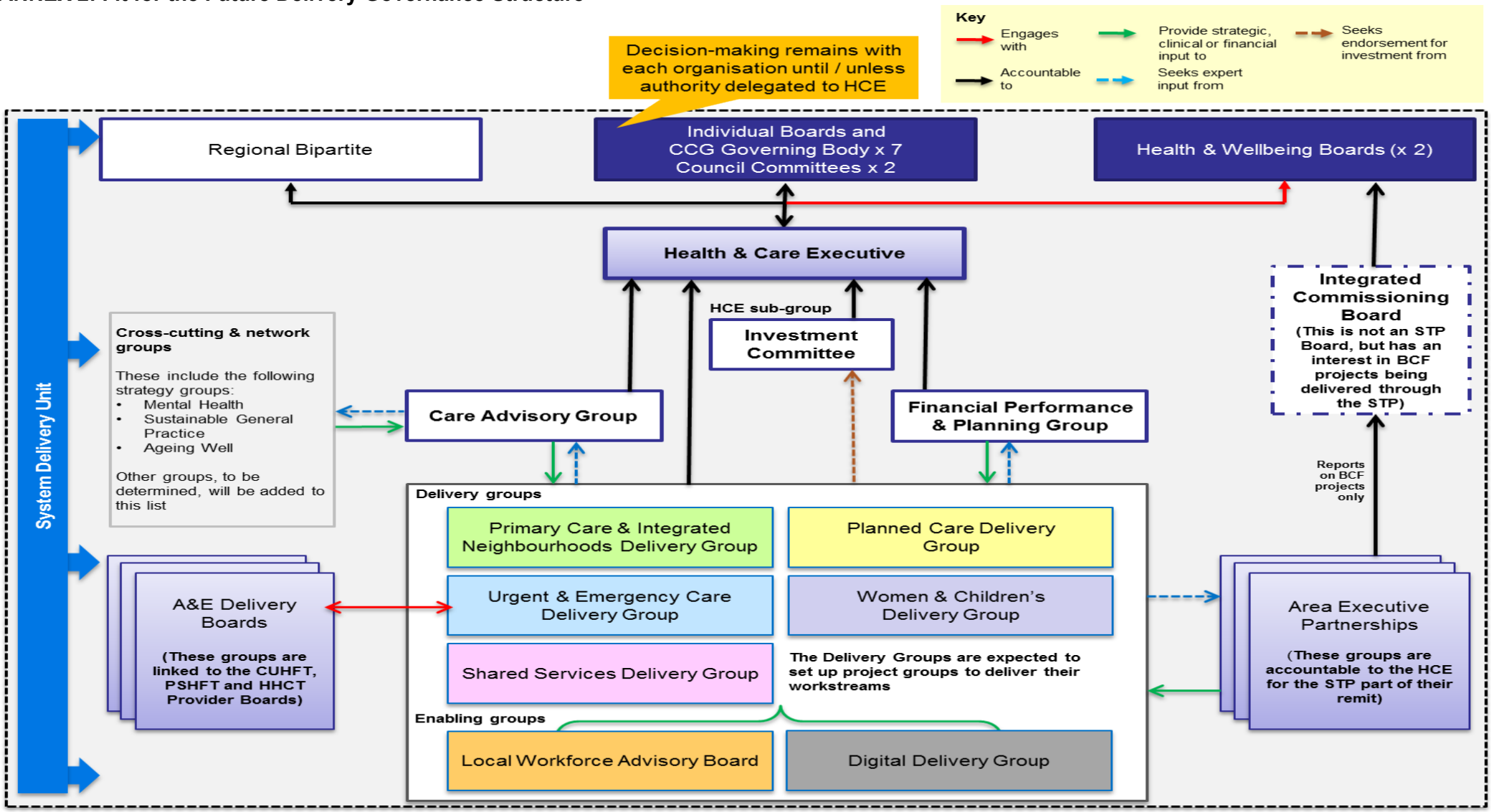
## 8.0 SOURCE DOCUMENTS

| Source Documents | Location |
|---|---|
| • Cambridgeshire and Peterborough Sustainability and Transformation Plan<br>• Sustainability and Transformation Plan summary document<br>• Frequently Asked Questions | All available at www.fitforfuture.org.uk/what-were-doing/publications/ |
| • Cambridgeshire and Peterborough Local Digital Roadmap | http://dev.speed.agency/fitforfuture/wp-content/uploads/2017/01/0064-PH-STP-DRM-Public.pdf |

## ANNEX 1: Cambridgeshire & Peterborough Fit for the Future Priorities



## ANNEX 2: Fit for the Future Delivery Governance Structure



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Updated on: 15 MARCH 2017

**HEALTH AND WELLBEING BOARD**
**DRAFT AGENDA PLAN 2017/2018**

| MEETING DATE | ITEM | CONTACT OFFICER |
|---|---|---|
| **Monday 12 June 2017** | Annual Health and Wellbeing Strategy Performance Report<br>VAWG Needs Assessment<br><br>**For information**:<br>Better Care Fund Update<br>Sustainable Transformation Programme Update<br>Quarterly Health & Wellbeing Strategy Performance Update | Dr Robin / Ryan O'Neill<br>Helen Gregg<br><br><br>Will Patten<br>Scott Haldine (Scott.Haldane@cpft.nhs.uk)<br>Dr Robin |
| **Monday 11 September 2017** | Adults and Childrens Local Safeguarding Board Annual Reports 2016/17<br><br><br>**For Information**:<br>Better Care Fund Update<br>Sustainable Transformation Programme Update<br>Quarterly Health & Wellbeing Strategy Performance Update | Jo Procter<br><br><br><br>Will Patten<br>Scott Haldine, (Scott.Haldane@cpft.nhs.uk)<br>Dr Robin |
| **Monday 4 December 2017** | <br><br><br>**For Information**:<br>Better Care Fund Update<br>Sustainable Transformation Programme Update<br>Quarterly Health & Wellbeing Strategy Performance Update | <br><br><br><br>Will Patten<br>Scott Haldine, (Scott.Haldane@cpft.nhs.uk)<br>Dr Robin |
| **Monday 19 March 2018** | <br><br><br>**For Information**:<br>Better Care Fund Update<br>Sustainable Transformation Programme Update<br>Quarterly Health & Wellbeing Strategy Performance Update | <br><br><br><br>Will Patten<br>Scott Haldine, (Scott.Haldane@cpft.nhs.uk)<br>Dr Robin |

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