Cambridgeshire and Peterborough health system Blueprint

2014/15 to 2018/19

Appendices

20th June 2014

Contents

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

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

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

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

Where are we now?

In 2004 the Wanless reviews[1] used various scenarios to examine future health trends and the factors that would influence the long term resource needs of the NHS. The review provides evidence of a "win- win": if people have a high level of engagement in their health better health outcomes are associated with a less expensive health system.

Preventing ill health involves many actions, some of which are under the control of health services and some are not. The interaction of these factors can be complex, but estimates from studies on major disease states such as coronary heart disease show that approximately half the interventions that reduce ill health occur in the health system[2] . So maximising the prevention of illness is a strategic goal for the CCG. To deliver this the CCG will work with partners in the local Health and Wellbeing Boards who have responsibility for health promotion and some of the wide determinants of health such as housing and transport. The CCG also recognises that through its contracts with providers it contributes significantly to the local employment opportunities, and that socio-economic conditions themselves are powerful wider determinants of health.

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

[1] Wanless, D (2004) Securing Good Health for the whole population. HSMO: Norwich.
[2] http://www.nice.org.uk/niceMedia/documents/CHD_Briefing_nov_04.pdf

Figure A1-1

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

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

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

Where we would like to get to

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

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

Top level outcomes that we will use to measure change

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

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

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

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

Key actions to get there

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

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

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

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

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

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

A1.2 Strategic Goal (2) Keeping people safe

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

Where we are now

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

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

Where we would like to get to

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

Top level outcomes that we will use to measure change

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

Key actions to get there

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

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

Where we are now

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

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

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

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

Where we would like to get to

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

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

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

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

Top level outcomes that we will use to measure change

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

Key actions to get there

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

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

Where we are now

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

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

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

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

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

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

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

Where we would like to get to

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

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

Top level outcomes that we will use to measure change

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

Key actions to get there

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

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

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

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

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

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

Where we are now

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

Where we would like to get to

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

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

[5] http://www.sduhealth.org.uk/documents/publications/2014%20strategy%20and%20modulesNewFolder/Strategy_FINAL_Jan2014.pdf

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

Top level outcomes that we will use to measure change

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

Key actions to get there

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

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

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

There is wide agreement that integrated, person centred care is important[6]. Achieving this goal keeps the people central to all that we do and also enables efficient design of the health system.

Where we are now

Currently a multidisciplinary approach to care in the community is being piloted across the CCG, and the CCG is realistic in our expectation about the time that this approach will take to show any changes. At present the CCG has no indicators that provide a system overview on integrated and seamless patient centred services. A methodology to measure this has been proposed by the Department of Health[7]. There is also anecdotal evidence from clinical colleagues on the impact of people in our system because of sub-optimal integration.

[6] http://www.kingsfund.org.uk/sites/files/kf/integrated-care-patients-populations-paper-nuffield-trust-kings-fund-january-2012.pdf
[7] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212896/Interim-Integration-Measures-for-Patient-Experience.pdf

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

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

Where we would like to get to

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

Key actions to get there

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

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

Top level outcomes that we will use to measure change

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

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

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

[8] Draft version is available at: http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/CCG/Priority%20Older%20Peoples%20Programme/Older%20Peoples%20Programme%20-%20Outcomes%20Framework%20Mark%201%20-%20Jan%202014.pdf

Where we are now

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

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

Where we would like to get to

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

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

To reach this we will need improved data collection and analysis systems across the whole system, especially in the areas of community care data and integrated data across providers. We need to develop mechanisms to collect and act on the information that this will provide. An ongoing programme of targeted need assessment work, such as the needs assessment that underpinned the Older Peoples and Adult Services procurement[9], will help to separate demand from need and highlight areas for increased access to services.

Key actions to get there

The following actions will help us reach this goal:

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

Top level outcomes that we will use to measure change

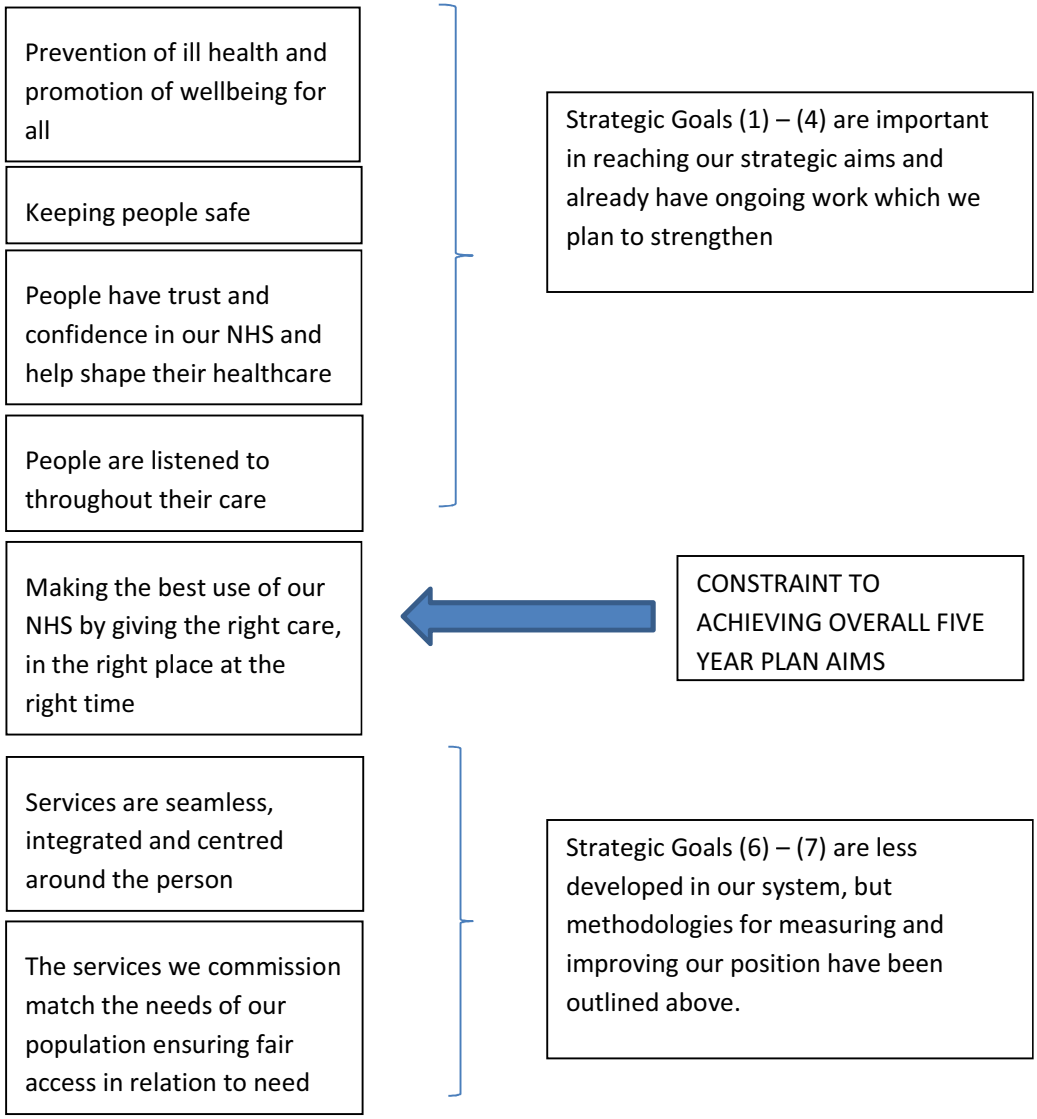
[9] http://www.cambridgeshireinsight.org.uk/currentreports/older-people-including-dementia

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

A1.8 Our strategic goals: summary and overview

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

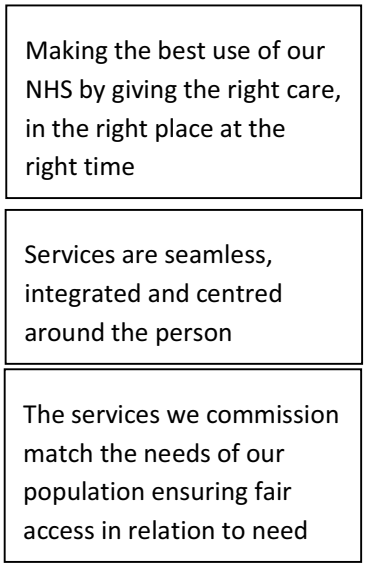
Figure A1-2



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

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

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



Appendix 2: Health outcomes

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

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

Current position

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

Areas where we can improve

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

Ambition for improvement

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

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

Next actions:

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

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

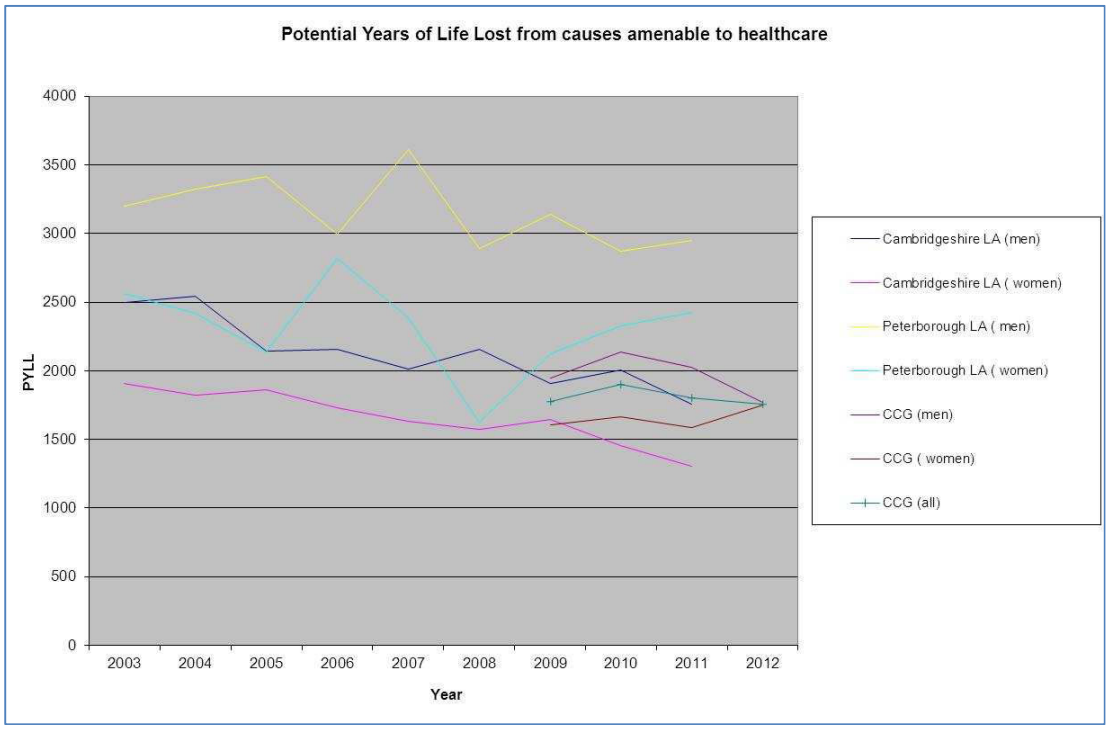
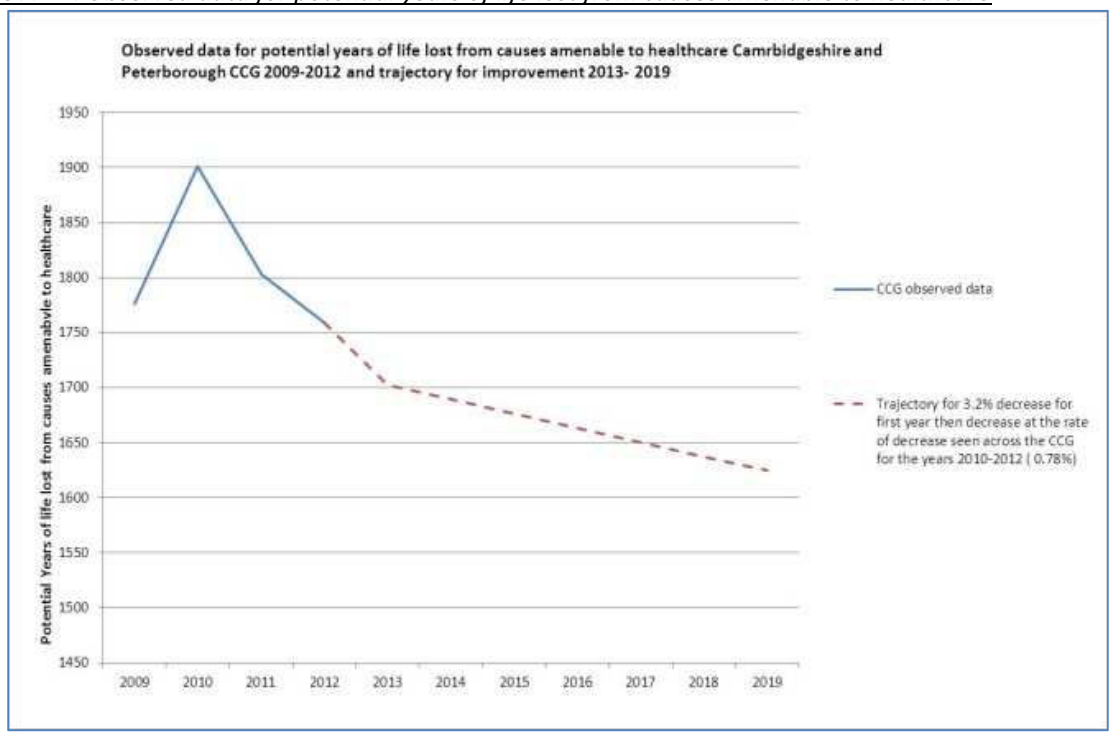


Figure A2-2: Observed data for potential years of life lost from causes amenable to healthcare



Ambition 2: Improving outcomes for people - Improving the health related quality of life of people with one or more long-term as measured by EQ 5D on the GP patient survey

Current position

This indicator is derived from the GP patient survey, which asks 5 questions about mobility, self-care, usual activities, pain and discomfort and anxiety/ depression that make up part of the EQ5D. The CCG is in the second best quintile with Cambridgeshire LA in the top quintile and Peterborough LA in the middle quintile.

Areas where we can improve

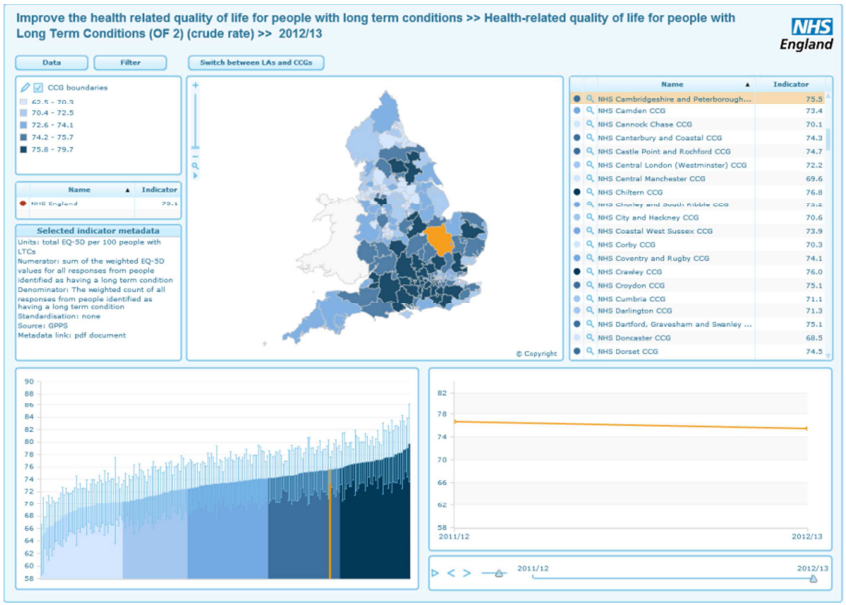
Experience of using this indicator to measure health and wellbeing at a population level is limited.
The natural history of change over time for this indicator is unclear: as people get older their EQ 5D may deteriorate anyway for reasons unrelated to healthcare -so this makes assessing areas for improvement challenging. There are only two years of data so it is not possible to assess how much change is feasible in the best performing areas of the country. As most health service contacts are outside of acute hospitals, improvements in this indicator are likely to come from community based interventions.

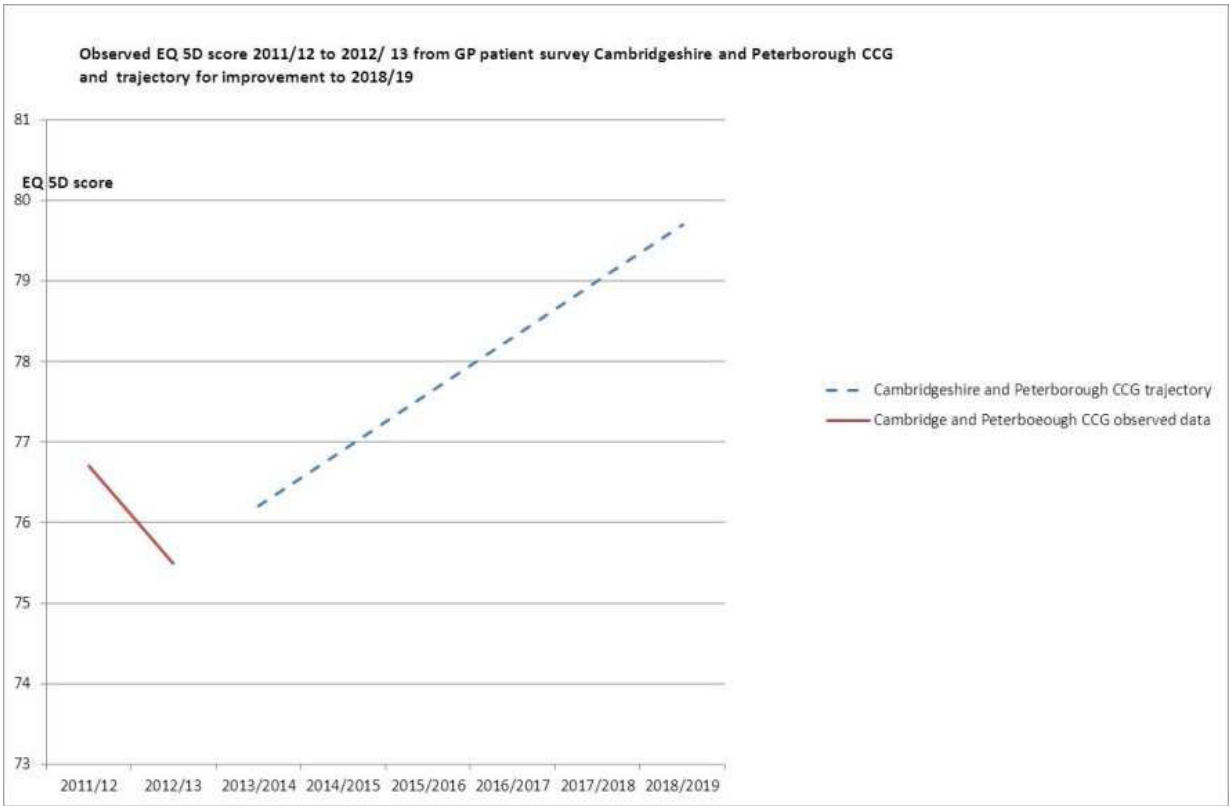
Ambition for improvement

The trajectory has been chosen recognising that the currently best performing CCG is NHS Surrey with a score of 80. Cambridgeshire and Peterborough aims to improve to this position over the next 5 years

Next actions

Next actions are to consider the GP patient survey results at GP practice level and see where areas for improvement might be. This will suggest actions that integrate into other areas of the strategy, e.g. if scores are high on depression/ anxiety or mobility or pain. The indicator appears in the Older People's and Adult Service Procurement outcome specification.





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

Current position:

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

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

Areas where we can improve

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

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

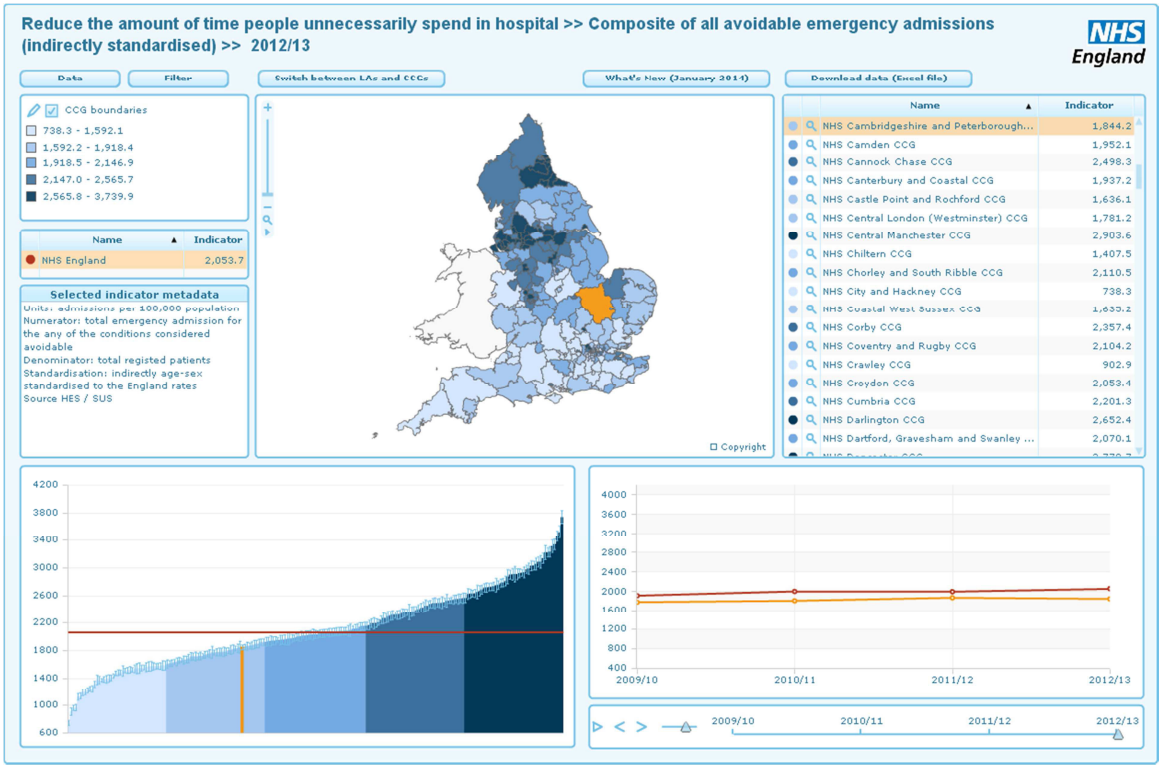
Together, these areas account for almost 80% of the 2013/14 admissions in this category to date.

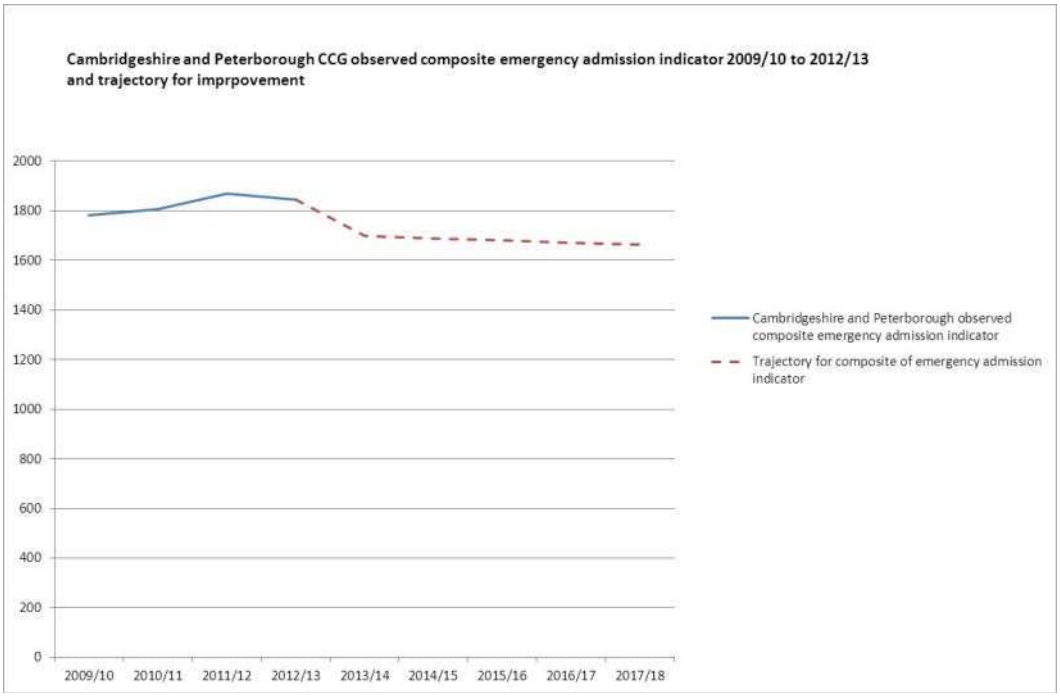
Ambition for improvement

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

Next actions:

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





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

Current position

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

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

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

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

Ambition for improvement

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

Next actions

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

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

Current position

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

Areas where we can improve

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

Ambition for improvement

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

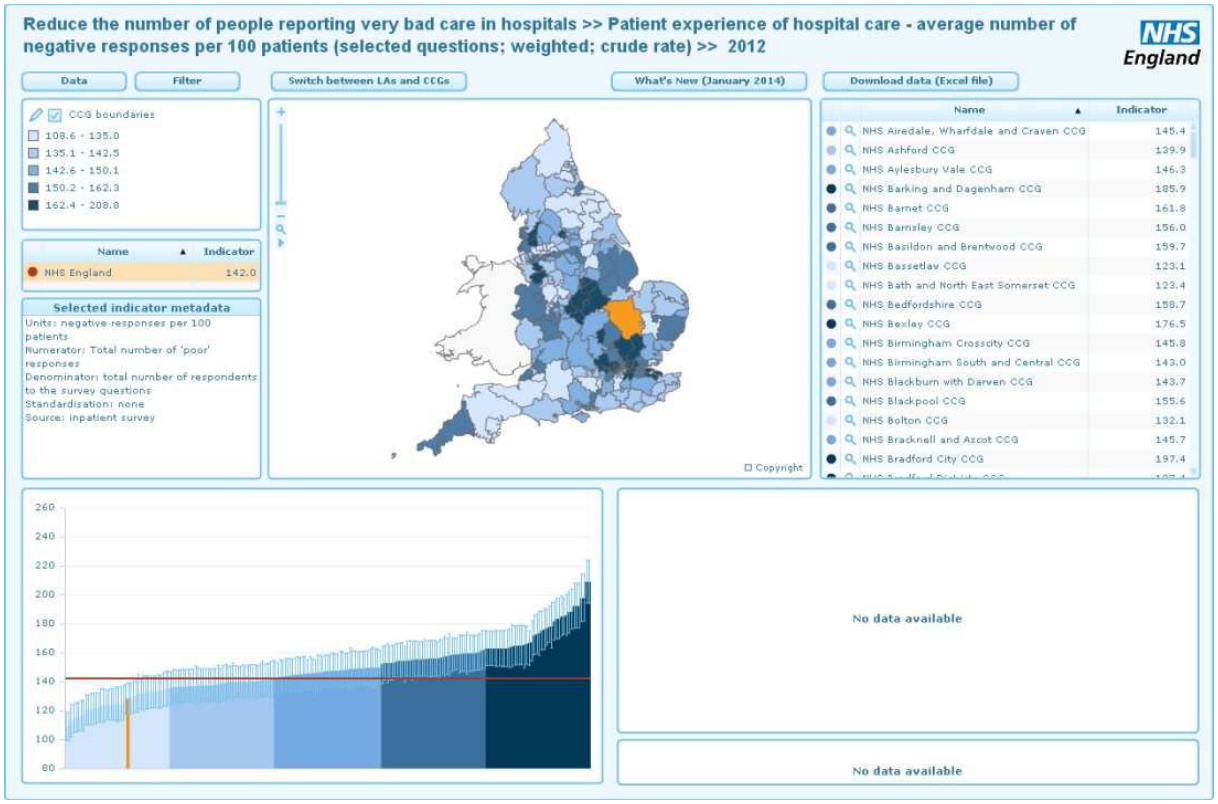
Next Actions

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

With a view to increasing the amount of people reporting a positive experience of hospital care, we will work with its healthcare colleagues to demonstrate leadership and organisational commitment and assist them to understand patient experience with a view to improving services and co-designing improvements and will:
-dedicate resources to capture, understand and use patient experience, through storytelling and numerical data consistently frame patient experience as an integral part of the quality framework, alongside clinical effectiveness and safety focus on areas of poor performance and assist in developing actions for improvement.

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

- recognise the link between patient experience and staff well-being and develop plans for improving both (based on existing data collection on staff well-being within the 20114/15 quality dashboard)
- ensure patient experience forms an integral part of staff induction, development/training and appraisal raise awareness of and succeed in reaching all groups in the community, to understand and respond to their needs and reduce the differences, which exist in terms of access, experiences and outcome
- demonstrate that patients, families and carers' views make a difference to the commissioning of local health services



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

Current position

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

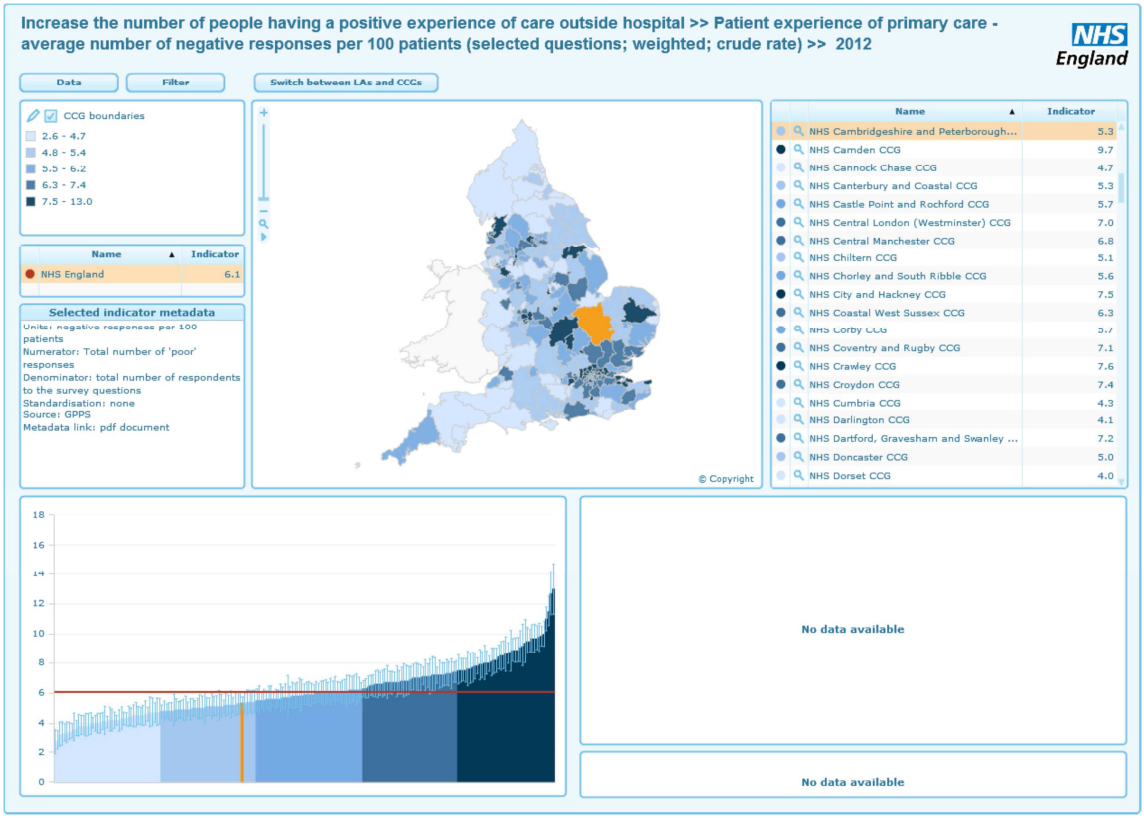
- "Overall, how would you describe your experience of your GP surgery?"
- "Overall, how would you describe your experience of Out of Hours GP services?

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

Areas where we can improve and ambitions for improvement:
The middle range of the best quintile has a score of 4.1, so we will aim to achieve this over 5 years

Next actions:

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



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

Current position

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

Areas where we can improve/ ambition for improvement

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

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

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

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

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

Appendix 3 : JSNA summary

JSNA Summaries: Cambridgeshire and Peterborough CCG
February 2014

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

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

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

Area	Key issues	Recommendations	Gaps	Links and other notes
Children and Young People	A good start to life has a positive impact throughout the life course Need is to identify and focus on vulnerable children	Work in a targeted way with more vulnerable families to: • promote parental mental and physical health • support good parenting skills • develop social and emotional skills • prevent violence and abuse		Cambridgeshire Children's and Young People's JSNA 2010 http://www.cambridgeshireinsight.org.uk/currentreports/children-and-young-people
	Peterborough has high rate of children 'in need' per 10,000 head of population of 0-17 year olds. In 2010 this was 547 per 10,000 population (in the highest 10% of LAs in England) Approximately 2.9% of the child population of Cambridgeshire were referred to social care in 2008/9 Referrals are highest in Wisbech, Huntingdon and Cambridge South and lowest in Sawston and Linton and Bassingbourn, and St Ives Localities. Most Cambs referrals for abuse/neglect	• Address some of the current challenges for safeguarding services • Recruitment, retention and work force stability • • Delivery of safeguarding training • • Engaging children and young people in effective consultation on service delivery• • Developing services for the families • Reducing accidents and intentional injuries to children and young people	The gap between the high rate of children in need in Peterborough and the low rate of children subject to a child protection plan warrants further investigation.	http://www.peterborough.gov.uk/health_and_social_care/joint_strategic_needs_assessmen/keeping_people_safe.aspx Children and Young People Safeguarding JSNA - Peterborough http://www.peterborough.gov.uk/pdf/HealthAndSocialCare-JSNA-ChildrenAndYoungPeopleSafeguarding.pdf Cambridgeshire Children's and Young Peoples JSNA http://www.cambridgeshireinsight.org.uk/currentreports/children-and-young-people

Area	Key issues	Recommendations	Gaps	Links and other notes
Children in poverty	Core priority for Peterborough.	Consider the following areas: • Information advice and guidance • Accommodation • New arrival families • Access • Employment opportunities • Services: staff skills • Education and training		Peterborough JSNA on Children and Young Peoples' outcomes: Child Poverty http://www.peterborough.gov.uk/pdf/HealthAndSocialCare-JSNA-ChildrenAndYoungPeopleChildPoverty.pdf
Older People	Significant growth in numbers over the next 20 years	• Prevent ill health and promotion of good health amongst older people. • Promote the message that stopping smoking, sensible alcohol consumption, healthy eating and physical activity have health benefits even at older ages.	Primary prevention needs consideration as well	
		• Reconfigure services to support older people to live in a community setting as long as possible, avoid admission to hospital/care homes, and return to a community setting after discharge from hospital. • Preventing hospital admissions and developing integrated care models • Case management by multi-disciplinary teams for 'frail' elderly people • Falls prevention • Increase awareness of mental health problems amongst those caring for older people; developing integrated services for mental health which facilitate early intervention and support older people and their carers in the community.	The evidence base as to what works in preventive services and admission avoidance to hospital or care homes for older people is still developing, so it is essential to evaluate initiatives and measure how well they are working. In future needs assessments, explicitly consider the needs of older people as in specific	

Area	Key issues	Recommendations	Gaps	Links and other notes
		• • Improve advice and support for carers of older people with mental health problems including cognitive impairment; • Improve commissioning processes to promote joint working across health, social care and voluntary organisations • Re-ablement services are now widely available and proven to be effective in helping older people regain their independence through assisting with re-learning everyday tasks.	groups e.g. among prisoners, Travellers. The development of reablement needs to continue, to benefit more people	
	The recent JSNA work for both older people and people with disabilities has identified that there is a requirement to further assess the needs of carers and how their caring role impacts on their own health and wellbeing, and how a multi-agency approach can be developed to best support them.	• Comply with the requirements of the national Carers' Strategy as identified by the Joint Carers' strategy for Cambridgeshire. .		Cambridgeshire JSNA on Older people including dementia http://www.cambridgeshireinsight.org.uk/currentreports/older-people-including-dementia
Physical activity	Participation in physical activity decreases with age Overall downward trend in rates of participation in sport locally, with the exception of Huntingdonshire and South Cambridgeshire. Sports participation in all age groups is relatively low in Fenland and is generally lowest in the more deprived areas in each district, with the exception of East Cambridgeshire. In Peterborough local data indicates that low levels of take-up correlate strongly with wards with high levels of deprivation. These areas also correlate to higher levels of childhood obesity as identified through the National Child Measurement Programme	• Incorporate into the Healthy City Plan, and delivered through the • Joint commissioning across partners to ensure best use of available resources. • Extend Carnegie Weight Management Clubs for year 2		Cambridgeshire JSNA on preventing ill health in adults of working age http://www.cambridgeshireinsight.org.uk/currentreports/jsna-prevention-ill-health-adults-working-age-2 Peterborough Obesity JSNA http://www.peterborough.gov.uk/pdf/HealthAndSocialCare-JSNA-Obesity.pdf

Area	Key issues	Recommendations	Gaps	Links and other notes
Obesity	Levels of adult obesity in Peterborough are higher than the East of England (EoE) average, but very close to the England average rate. Peterborough continues to have a higher level of childhood obesity than most other areas within the EoE. Nationally the prevalence of obesity among adults has increased over recent years. The estimated levels of obesity in Cambridgeshire (22.1%) are significantly lower than in England (24.2%). Fenland, with estimated obesity at 25.8%, is significantly higher than the county level (22.1%) but is not in comparison to the national levels (24.2%).	As above for physical activity	Interventions that focus on diet	Peterborough JSNA on Obesity http://www.peterborough.gov.uk/pdf/HealthAndSocialCare-JSNA-Obesity.pdf Cambridgeshire JSNA on preventing ill health in adults of working age http://www.cambridgeshireinsight.org.uk/currentreports/jsna-prevention-ill-health-adults-working-age-2
Alcohol	Increased risk drinking in Peterborough estimated to be lower than the regional average amongst some of the lowest in the country, with Peterborough ranked the 34th lowest local authority area for levels of hazardous drinking. The prevalence of binge drinking in Peterborough (19.7%) is similar to the national level (20.1%). Data from 2009 found that about 30% of men drank more than the recommended limit. Overall, Cambridgeshire as a county compares well to the national average on statistics for alcohol misuse and harm, but Cambridge City is above the national average for a number of indicators including hospital admissions specifically caused by alcohol, aspects of alcohol related crime, and binge drinking.	The priorities for action, include • Ensure effective performance monitoring of all services commissioned, and evaluated to • Assess quality and outcomes, in particular their impact in reducing alcohol-related hospital admissions. • Establish effective data collection • Review the capacity at each tier within the treatment • Develop work within hospital to support alcohol-specific interventions for individuals • Undertake work to establish a greater understanding of who and what contributes to admission to hospital under the category 'mental and behavioural disorders'. • Target particular geographical areas of need or high risk groups, including proactive screening	Alcohol actions in Cambridgeshire?	http://www.peterborough.gov.uk/pdf/HealthAndSocialCare-JSNA-Alcohol.pdf

Area	Key issues	Recommendations	Gaps	Links and other notes
		within primary care • Systematic Tier 1 provision of Identification on and Brief Advice (IBA) within a range • Consider how issues related to emerging trends of increased drinking at home could be best identified and addressed, instigate specific interventions for older men (and specific ethnic groups) to address their increased representation in hospital admissions. • Improve safety within the city centre and the night-time economy, planning the • Development of a more balanced night time economy. • • Address street drinking and its related anti-social behaviour through consistent use of the • Designed Public Places Order (DPPO) etc • Continue the robust management of licensees		
Diet	Less than half of all older people in Cambridgeshire are thought to consume a healthy diet and 20% of older people are thought to be obese. Significant numbers of the latter group are heavy drinkers. Peterborough:30% of adults consume five or more portions of fruit or vegetables every day (comparable to the national average There are no significant differences consumption of fruit and vegetables by adults across MSOAs in Peterborough.		Dietary habits in Cambs and recommendations for this	http://www.cambridgeshireinsight.org.uk/older-people-including-dementia/facts-figures-and-trends http://www.peterborough.gov.uk/health_and_social_care/joint_strategic_needs_assesmen/how_we_live_affects_our_health.aspx
Smoking	Peterborough:			Peterborough Health and Social Care JSNA

Area	Key issues	Recommendations	Gaps	Links and other notes
	calculated prevalence of current cigarette is 27% which is significantly higher than England (22.2%) In 3 MSOAs nearly 40% of adults smoke (Orton Longueville (38.9%), Paston (42.3%) and North Bretton (42.4%).) Cambridgeshire: Smoking prevalence estimated at 11.5 % * (less than the English average in) but 26.1 % in people in routine and manual occupations			http://www.peterborough.gov.uk/pdf/HealthAndSocialCare-JSNA-Smoking.pdf
				http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/101/page/0/par/E12000006/are/E07000008
Different population Groups		To consider the needs and outcomes for particularly vulnerable or marginalised populations in Cambridgeshire – including Gypsies and Travellers, homeless people, migrant workers, people with learning disabilities, people with mental health needs, people with physical/sensory impairments, when developing or changing services		Cambridgeshire summary JSNA http://www.cambridgeshireinsight.org.uk/cambridgeshire-joint-strategic-needs-assessment-jsna/jsnasummaryreport2013
Gypsies and Travellers	Gypsies and Travellers make up almost 1% of the population in Cambridgeshire representing the largest ethnic minority in the county. Gypsies and Travellers have • significantly poorer health status (in Peterborough only 55% reported no health problems) • more self-reported symptoms of ill-health than the rest of the population • reported health problems being between two	• better data collection and ethnic monitoring. • promotion of immunisations and screening. • Mental health specialist support services. • Male health specialist support services. • More support around complex health needs.	Investigation into infant and maternal mortality and prevalence of disabilities	Cambridgeshire JSNA on travellers 2010 http://www.cambridgeshireinsight.org.uk/currentreports/travellers Peterborough JSNA _ We are not all the same http://www.peterborough.gov.uk/health_and_social_care/joint_strategic_needs_assesmen/we_are_not_all_the_same.aspx More information on Peterborough travellers in

Area	Key issues	Recommendations	Gaps	Links and other notes
	and five times more prevalent. • Poor mental health is a particular concern Access issues • Low uptake of early intervention and prevention measures such as screening and immunisation • Adverse rates of lifestyle risk factors such as rates of smoking and obesity.	• Raising awareness of the Gypsy and Traveller community with professionals. • Training health champions from the Gypsy and Traveller community.		Facts and Figures JSNA http://www.peterborough.gov.uk/pdf/HealthAndSocialCare-JSNA-DemographicPopulation-FactsFiguresAndTrendsSection.pdf
Homeless people	Cambridge In 2010 the population of single homeless people and rough sleepers was estimated to be approximately 500. This group of people are approximately 7 t0 8 times more likely to be admitted to hospital and have a mean age at death of 44 years. Mental health issues and substance misuse are common. In addition around 600 families are classified as “statutory homeless" each year and there are a number of "hidden homeless people" who are unrecognised by services.	Multiagency working Service user involvement in service design Information sharing to enable integrated client records Develop services enabling prevention of homelessness and early intervention for the newly homeless to improve individual lives and to reduce overall homelessness. Support is particularly required at transition points such as leaving care, prison release and A&E/hospital discharge. In addition services should be co-ordinated, accessible and responsive to the needs of the homeless population. Develop a strategy to address the health needs of the homeless population in Cambridgeshire as part of a joint commissioning strategy Recognise that the issues identified in this JSNA are ongoing	Quantification of homelessness and its effects in Peterborough	Peterborough JSNA on social and environmental context contains information on employment, housing etc http://www.peterborough.gov.uk/pdf/HealthAndSocialCare-JSNA-SocialAndEnvironmentalContext.pdf Cambridgeshire JSNA on people who are homeless or at risk of homelessness http://www.cambridgeshireinsight.org.uk/currentreports/people-who-are-homeless-or-risk-homelessness

Area	Key issues	Recommendations	Gaps	Links and other notes
Different ethnic backgrounds and Migrant workers	Peterborough: • Proportionally more Pakistani people aged 0 – 15 years and more white British people aged 65+. • There has been a steady rise in the numbers of pupils with English as an Additional Language (EAL) from 14.7% (2003) to 19.4% (2007). • The ten most common languages are English, Punjabi, Urdu, Polish, Portuguese, Slovakian, Lithuanian, Guajarati, Czech and Chinese. • 83 different languages were recorded are spoken as first languages by students in Peterborough schools	Recommendations (Cambridgeshire JSNA) • Increase access to primary care health services with emphasis on health promotion and disease prevention. • Engage with employers and other stakeholders to establish networks for sharing information and good practice with the aim of promoting healthy work conditions • Improve access to language provision in terms of initial access to short term translation and interpretation facilities. • Improve the access and condition of appropriate housing in order to reduce migrant worker dependence on poor quality tied accommodation and Houses in Multiple Occupation (HMOs). • Improve organisations' adaptive capacity; ensuring that service providers are flexible enough to respond to the changing needs of the migrant population, a population that can be highly mobile and transient in nature. • Improve data collection to ensure more robust, timely and comprehensive data • Ownership needs to be multiagency.	Examine the needs of those who have no recourse to public funds or who are destitute in order to ascertain how these individuals and families may be best supported.	Peterborough demographic facts and figures page 17http://www.peterborough.gov.uk/pdf/HealthAndSocialCare-JSNA-DemographicPopulation-FactsFiguresAndTrendsSection.pdf Cambridgeshire Migrant workers JSNA http://www.cambridgeshireinsight.org.uk/currentreports/migrant-workers
People with learning disabilities	Cambridgeshire: As the population grows and ages, the number of people with disabilities is also expected to rise.	• Health checks for adults with learning disability are important to reduce inequalities in accessing healthcare. 75% of		Cambridgeshire JSNA on adults and children with physical and learning disabilities through the life course http://www.cambridgeshireinsight.org.uk/j

Area	Key issues	Recommendations	Gaps	Links and other notes
	Leading to an increased proportion of people with a learning disability aged over 55 so that parents caring for them are likely to have died or become frail. Social care requirements for people with learning disability in England are expected to increase by 14%, up to 2030. The number of children with disabilities is predicted to increase. The number of children with statements of special educational needs has increased in Cambridgeshire. People with learning disability in England are more likely to go into hospital for conditions that could have been treated in the community. People with learning disabilities in Cambridgeshire reported certain shortcomings in the provision of health care services, in 2007. This included: a lack of easy read information; poor attitudes from some health staff towards people with learning disabilities and their carers; insufficient care available whilst person with learning disability is in hospital; inadequate hospital facilities, including access and delays in referrals. Local surveys identified that people with autism have unmet needs, such as difficulties with identification and diagnosis, and lack of training amongst staff concerning people with autism with whom they came into contact In 2011-12, most cases of alleged abuse were for adults with learning disability, with most abuse occurring in the adults' own homes. There was an increase in safeguarding referrals for adults with learning disability, compared with the previous year, which is thought to reflect good practice in	eligible adults received a health check, in Cambridgeshire, in 2012 • Identifying adults with a learning disability on information recorded during a hospital admission is important to ensure reasonable adjustments are made. This is happening less often in Cambridgeshire, than the England average for psychiatric admissions. • Better sharing of information on people with a learning disability across agencies would allow us to assess the best place for care		oint-strategic-needs-assessment/current-jsna-reports/physical-disabilities-and-learning

Area	Key issues	Recommendations	Gaps	Links and other notes
	the community.			
People with mental health needs	The prevalence of mental ill health among the working age population is high in Cambridge City because of the demography, new growth, higher levels of crime, alcohol related harm and suicide. Fenland also has a high prevalence of mental ill health due to the association between mental ill health and its determinants with deprivation. Suicide rates are high in Fenland. Homeless, Travellers and prison populations have high levels of mental ill health. Migrant workers and black and minority ethnic communities are also vulnerable and may have barriers to accessing mental health services.	• Apply the comprehensive evidence base of what works to promote mental health and wellbeing in communities • Strengthen and extend partnership working to promote mental health and wellbeing, and provide responsive services by: Obtaining views of local stakeholders on all changes to mental health services to ensure they are patient-centred and socially inclusive. • Working with GP Commissioning Clusters to ensure equitable provision and targeting of mental health services based on needs assessments that identify the areas and populations at greatest need. • Review availability of counselling services for groups where evidence shows greatest benefit to include: • Applying learning and experience from the 14-19s IAPT pilot to implement a 'transition' service for primary care mental health • Ensure seamless service for those who do not meet criteria for the IAPT or secondary care services but can benefit from provision of 'talking therapies	There is a perceived need for more counselling services especially for those whose needs fell between the criteria for IAPT and secondary care. People making the transitioning into or out of adult mental health services need to be catered for. Young adults (17-22 years old) may find current local service models unattractive and people with young onset dementia often have very different needs to older people with dementia. There is robust evidence for interventions that have the largest impact on improving mental health and wellbeing for the general	Cambridgeshire JSNA mental health in adults of working age http://www.cambridgeshireinsight.org.uk/currentreports/mental-health-adults-working-age

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

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

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

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

Appendix 4: Assumptions underlying the PwC finanical projections

Source: PwC

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

Population growth rates: (percentages)

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

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

Population growth rates: (absolute numbers, in thousands)

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

Cost inflation rates:

	2015	2016	2017	2018	2019
Cost inflation	2.60%	2.90%	4.40%	3.40%	3.30%

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

Inflation rates:

	2015	2016	2017	2018	2019
Inflation	2.1%	2.00%	2.00%	2.00%	2.00%

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

Provider efficiency rates (assuming leakage does not fall):

	2015	2016	2017	2018	2019
Provider efficiency	4%	4.5%	4%	4%	4%

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

Appendix 5: Care Design Group Outputs

Elective 1: Primary Care Referral Protocols

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

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

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

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

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

Elective 4: Single provider for specific elective services

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

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

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

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

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

Urgent 2: Single Point of Access for Professionals

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

Urgent 3: Front end A&E model

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

Delivery requirements	More effective "gatekeeping" to prevent inappropriate A&E attendances. Consideration of the long term model of urgent care provision, including reconfiguration of the current services, for example, the co-location of GP and minor injury units at the same site as A&E departments.

Urgent 4: Discharge planning, including early supported discharge to ensure that patients do not stay in hospital for longer than they need to.

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

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

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

Summary of the idea / option	The closure of an A&E with the Local Health Economy may be possible following reconfiguration of services and investment in certain areas to support the new model. Efficiencies could be achieved from the closure of any A&E through improved economies and also utilising "out of hospital" urgent care facilities. This would likely entail: • Usage of 24/7 rotas; • Required consultants to be available 24/7; and Efficiencies would arise through savings on middle grade doctors, nursing staff, diagnostics and facility costs through economies of scale.
Issues addressed	A perceived view that urgent care services are dispersed over too many sites in the LHE. Low activity at some urgent care sites.
Clinical outcomes	Emergency services will be concentrated on a smaller number of sites, allowing for greater specialism and experience. May address challenges in recruiting emergency care clinicians.
Financial outcomes	Economies of scale will reduce the cost of delivering urgent care. Patients will be seen at an appropriate site (better use of urgent care centres).
Challenges and risks	Increased pressure on other sites (including A&E and other urgent care services) which may worsen quality of care and increase financial pressure. Public and political acceptance of a proposal of this nature.
Additional information or analysis required	Detailed modelling of the impact of the regrading of various sites across the LHE, to understand the impact it may have both within and outside the LHE.
Interdependencies	Urgent 3: Front end A&E model.

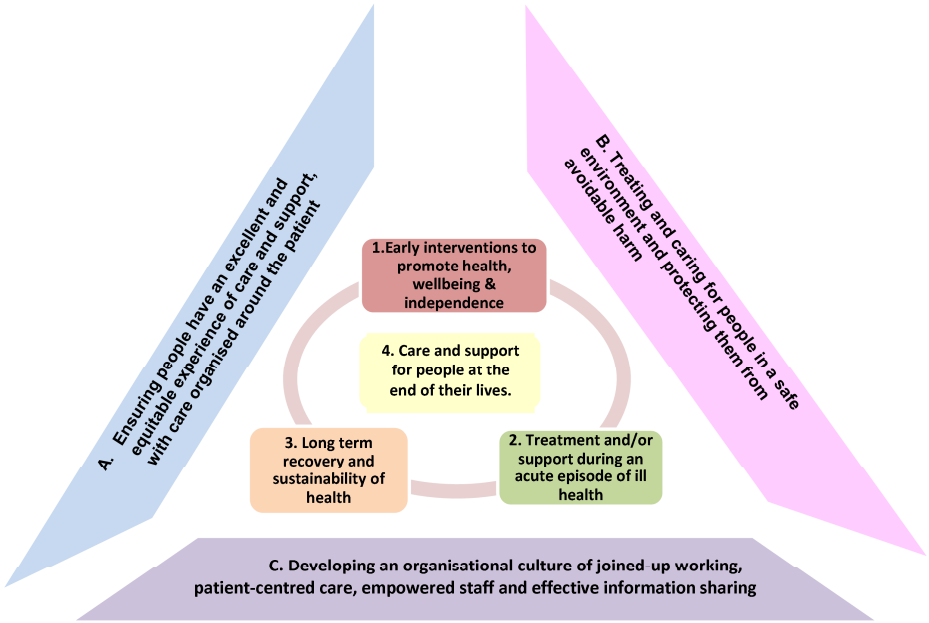
Delivery requirements	Significant consultation process would be required if this is determined to be a viable option. Detailed modelling to understand the impact on other services, sites and LHEs. Improved "gatekeepers" to A&E will be required to minimise pressure on other sites, accompanied by strong patient education.

Urgent 6: Closer links between GPs and the ambulance service

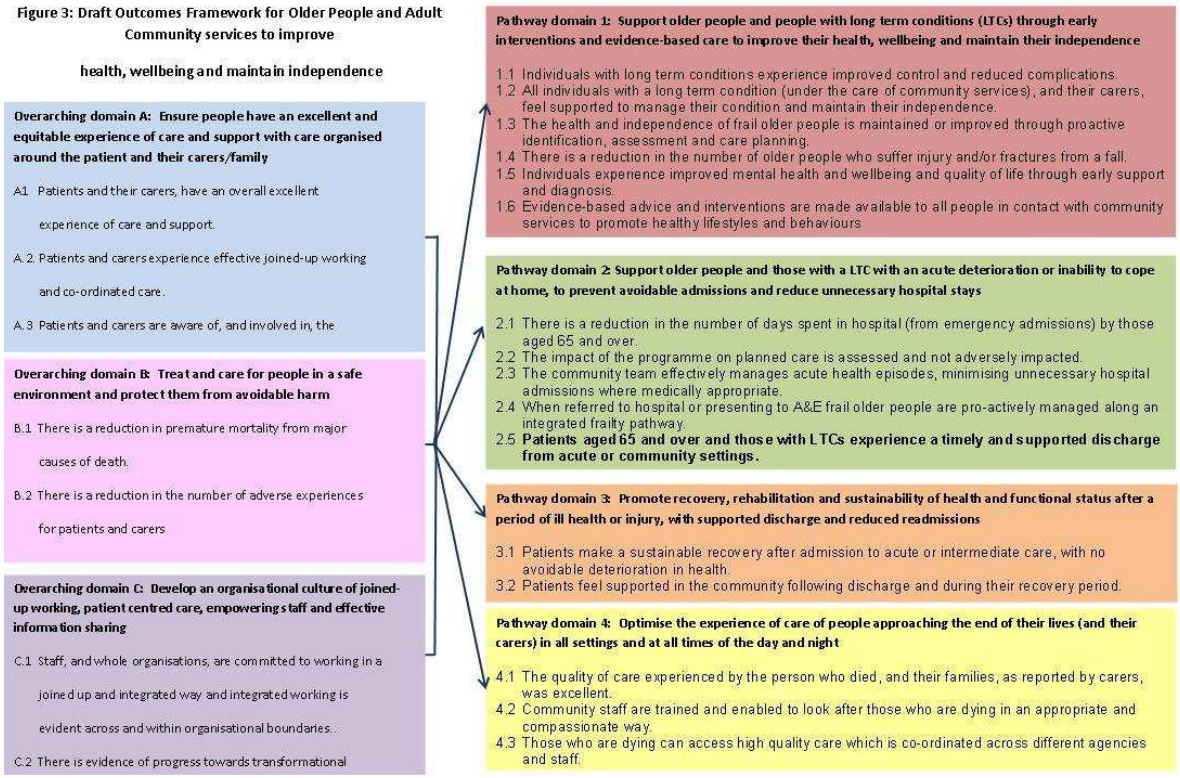
Summary of the idea / option	A scheme in South Warwickshire has GPs undertaking shifts with the ambulance service. GPs attend emergencies instead of ambulance crews, reducing the number of ambulance call outs and also the number of conveyances to hospital.
Issues addressed	The number of ambulance attendances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

Appendix 6: Summaries of proposed further CDG areas

OLDER PEOPLE PROGRAMME	
Summary of the idea / option	The CCG wants to achieve the overall ambitions of improving outcomes and improving patients' experiences of older people services. Our vision is for older people's services to be organised around the needs of the patient, not around organisational structures. The objective is to make sure older patients have the right support to stay healthy, to maintain their independence and to receive care in their home or local community whenever possible with hospitalisation as a last resort. To do this, our aim is to improve the way services are organised and the way they work together to provide a seamless pathway for older people. To achieve our vision, we are tendering a contract for Integrated Older People's services and Adult Community Services using a 5 year outcomes-based contract. http://www.cambridgeshireandpeterboroughccg.nhs.uk/older-peoples-programme.htm
Issues addressed by this idea / option	The case for change includes: • Substantial growth in the numbers and proportion of older people • minimal financial growth in the health sector, alongside reductions in funding for Local Authorities • shortcomings in current service provision, which result in poor patient experience and clinical outcomes for patients. The critical success factors for the programme are: a. Improve patient experience and service quality for older people and their carers through care organised around the patient b. Deliver services which are sensitive to local health and service need, as defined in local outcome specifications c. Move beyond traditional organisational and professional boundaries, so front-line staff can work effectively and flexibly together to deliver seamless care d. Supporting older people to maintain their independence, and reducing avoidable emergency admissions, re-admissions and extended stays in acute hospitals (including delayed transfers of care) e. Deliver an organisational solution for the older people's care which can demonstrate strong leadership, sound governance, resilience, and the confidence of commissioners and provider partners f. Demonstrate credible approach to engaging patients and representative groups in design and delivery of services g. Provide a sustainable financial model (see financial principles below)

OLDER PEOPLE PROGRAMME	
Clinical outcomes	Our approach is based on improving outcomes for patients (both clinical outcomes and patient experience outcomes). For this purpose we have developed an Older Peoples Outcomes Framework. The Framework is composed of outcomes built around the patient pathway (domains 1-4 in the diagram): 1. Prevention and early intervention 2. Rapid response 3. Long term recovery 4. Care and support for people at the end of their lives There are an additional three overarching domains (A-C) which include patient experience, patient safety, and organisational culture. 

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



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

OLDER PEOPLE PROGRAMME	
Financial outcomes -	The financial outcome will be to provide a sustainable financial model with the following financial principles: • Aligning improved patient outcomes with financial incentives • Sharing financial gain and risk across the commissioner – provider system • Delivering recurrent financial balance in a sustainable way • Creating the conditions for investment and delivering a return on investment
Challenges and risks	The challenge is achieve the overall ambitions of improving outcomes and improving patients' experiences of older people services whilst also meeting the programme's critical success factors. The overall risk is that we do not achieve our vision and our critical success factors. The programme has a comprehensive risk register including risks around: • Clinical ownership • Communications and engagement generally • Contracting and legal risks • Finance and achieving the financial outcomes above • High dependency areas including the future of PSHFT and older people's mental health • Social service integration, funding and use of the better care fund • The procurement • The timeline • Mobilisation including estates, IM&T and workforce
Interdependencies with other proposed or existing programmes	The future of providers in the Cambridgeshire and Peterborough CCG footprint Developments around the Better Care Fund and other functional / contractual integration with Local Government services
Delivery requirements -	The programme will bring about many changes in our way of working and delivery including the use of a capitated budget, an outcomes based longer-term contract, workforce changes, estates changes and information technology changes

OLDER PEOPLE PROGRAMME	
Impact on health inequalities	We are carrying out an 'Equalities Impact Assessment' (EIA). The EIA contains an outline of the means by which the CCG has gathered evidence in relation to groups with protected characteristics and patients who may face inequalities. The inequalities could be in regard to either access to, or outcomes from the proposals. The EIA also contains a description of the positive and negative impacts in respect of those groups and patients arising from the proposals. It will include consideration of how the CCG's proposals, in relation to the reconfiguration of services for older people, could be amended to improve the experience of people with protected characteristics or those patients who may face inequalities. Using the EIA as a tool, we need to ensure the new services offer equitable access and outcomes to all, hence decreasing health inequalities. The EIA can be found at: http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/CCG/Have%20your%20say/Equality%20Impact%20Assessment%20-%20final.pdf

Mental Health

MENTAL HEALTH	
Summary of the idea / option	1. A further programme of mental health service transformation to reflect the latest evidence base and thinking on the "recovery" model for mental health. 2. Greater partnership working with local authority commissioners, housing providers, the voluntary sector, community services and primary care 3. Greater use of the potential of technology such as apps to support patients in the community. 4. Improved information provision/ information sharing processes with appropriate governance in place 5. Integrated physical/mental health approach to patient care
Issues addressed by this idea / option	1. Consensus amongst service users and carers that community based care is usually the preferred option over acute ward admission, provided risks can be managed and sufficient community support is available. 2. More patients could be supported in the community if "non-medical" issues such as housing and employment were addressed. 4. The requirement to continue to deliver annual cost improvements and also the level of QIPP savings from mental health set out in the CCG's five year plan. 5. Greater coordination between health and local authority commissioners (both social care and housing) will be critical to the success of any transformed service model designed to support more patients to remain in the community. This is a particular challenge for the CCG because we will need to work closely with a range of local authorities across Cambridgeshire and Peterborough. 6. Delivery of key national guidance such as Closing the Gap and Crisis Care Concordat. 7. Duplication of services will be reduced by integrated physical/mental health care
Clinical outcomes	1. We routinely measure both clinical and non-clinical outcomes for people with mental health problems, reflecting the importance of non-clinical measures in terms of most patients' overall quality of life and recovery. 2. The clinical outcomes we anticipate include measurable improvements in patient reported levels of health and wellbeing, both in terms of mental and physical health. 3. The non-clinical outcomes we anticipate include a range of social inclusion measures around work, employment, social contact etc. 4. Patients receive integrated care.

MENTAL HEALTH	
Financial outcomes -	Delivery of 4% annual cost improvement plus the QIPP savings requirements attached to mental health in the 5 year plan. Therefore it is essential that the CCG's 5 year plan is clear as to:- • the level of financial savings required from mental health services; • any additional investment planned to meet population and acuity growth; • the investment plan for IAPT services in order to meet national access targets;
Challenges and risks	Our main challenges arise from:- 1. Our relatively low investment in mental health, making further savings extremely challenging; 2. The rapid growth in the local population, especially of older people; 3. Meeting the national requirement for IAPT access targets from the current MH budget will necessitate redeployment of resources away from areas of greatest clinical priority e.g. services for patients with severe/complex MH needs; 4. The reliance on local authority commissioners for community support services and suitable housing solutions; 5. Resources will need to be redeployed from secondary to primary care to enable primary care to manage an increasing number of patients, 6. The level of innovation and redesign has been very good and there is lack of clarity as to what else can be done to deliver savings, other than by decommissioning essential core services for vulnerable patients with significant mental health needs. 7. The recent focus of "parity of esteem" between physical and mental health has highlighted the strong link – i.e. good mental health improves physical health outcomes. This focus has highlighted the fact that under investment in mental health may actually increase costs across the local system. 8. National guidance sets service requirements and minimum standards which are not all deliverable within the existing mental health services budget e.g. Crisis Care Concordat
Additional information or analysis required	1. We still lack robust information on the cost of each of the pathways that we commission and the patient outcomes that they deliver. Preparation for "care pathways and pricing" (formerly PBR) will help address this but progress is slow and hampered by poor data quality. This is a longstanding problem for mental health services nationally. A number of initiatives to improve information provision and financial transparency are ongoing. 2. Evidence of innovative cost effective service models elsewhere which could be implemented locally.

MENTAL HEALTH	
Interdependencies with other proposed or existing programmes	1. Enhanced mental health input into physical health services - both hospital and community based - would improve patient experience, clinical and quality of life outcomes, and lead to significant savings (as evidenced by liaison psychiatry and IAPT for people with long term conditions). 2. OPAC-the integrator and their approach after the 18 month subcontract could vastly alter the delivery of all mental health services 3. Children's services redesign-a decision to commission an integrated model could impact on the proposed redesign 4. Better Care Fund –the bids proposed form part of the proposed service model, if these are not successful this will result in reduced service delivery.
Delivery requirements -	Our redesign/transformation plans will require further radical changes in workforce, skills and methods of working, information technology use, and support for primary care, etc. We are currently developing a service redesign process with the following key stages:- • A programme of service user engagement during the next 2-3 months - to gather key messages about priorities and what they seek most from the mental health services that they access; • Meetings with each Local Commissioning Group to gather local GP feedback on the main priorities for their patients and how services might be designed differently; • Parallel meetings with the local voluntary sector to gather views on the current challenges and their potential role in future solutions; • Ongoing meetings between GP commissioners, local authority colleagues and senior CPFT clinicians - to explore potential new service models that reflect the feedback received from service users and other key stakeholders; • An extensive programme of stakeholder engagement, likely to include a formal public consultation to gather feedback about the redesign proposals that will have been developed by that time; • Local commissioner review of the feedback received from this engagement, consideration of recommended changes to the original proposals and presentation of revised proposals to the CCG Governing Body and appropriate local authority decision making meetings for approval; • Regular briefings for local Health Committees (formerly Scrutiny Committees); Additional commissioning time may be required.

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

Women and Children

WOMEN AND CHILDREN	
Summary of the idea / option	The Children Programme Board is taking forward a number of projects in order to address locally identified issues. A major part of this work will focus around the comprehensive review of maternity, children and young peoples health services which is due to start in June 2014. It is likely that the result of this review will be a comprehensive redesign of these services which will be aligned with the Principles of the East of England Strategic Clinical Network which are: 1. Child and Family Focused- we will ensure the voices of children, young people and their families are heard throughout the health care systems and their needs drive planning and delivery in collaborative with clinical expertise 2. Health Promotion – we will prioritise investment ad resources to improve the health and wellbeing of our children and young people 3. Transformation – we will invite children, young people and families to be active participants in the review and future design of services 4. Settings- we will offer children, young people and families services in settings where they feel welcome, comfortable, safe and cause as little disruption to family life as possible 5. Information and Communication – we will share the best information and intelligence between professionals and with children, young people and their families to allow the best possible healthcare 6. Evidence based and Sustainable – we will commission and deliver services to consistent standards, informed by best practice and available evidence. All children and young people will have equitable access to services to meet their needs
Issues addressed by this idea / option	The following emerging priorities have been identified by both Cambridgeshire and Peterborough JSNA's and the East of England Strategic Clinical Network 1. Promote good health- reducing risks (smoking, obesity) 2. Identify high risk pregnancies/women with complex conditions 3. Promote good holistic health (Healthy Child Programme) 4. Early recognition of ill health 5. Safeguarding children and young people 6. Prevention and early detection of illness in Primary care, effective, safe, efficient and appropriate emergency and urgent care 7. Effective, efficient and best practice management of Long Term Conditions 8. Early engagement integral to service design and pathway delivery 9. Integrated pathways of complex care include transitional elements LTC – asthma, diabetes, epilepsy and cancer, CAMHS, SEND and Palliative Care

WOMEN AND CHILDREN	
	10. Maternal mental health assessments included in Maternity Pathway 11. Services are seamless integrated and centred around the patient Services offered by providers match population health need and ensure enough provision where there is increased deprivation
Clinical outcomes	1. Reduction in the incidence of infant mortality including still births 2. Reduction in the incidence of child and young person mortality 3. Reduction in Child and Young Person unplanned hospital attendance 4. To improve engagement of women, children and young people – experience of maternity and children's services 5. To promote an effective transition for children into adulthood 6. To improve the mental health and wellbeing of women and children
Financial outcomes -	There will be some medium term savings to be gained from admissions avoidance for common conditions such as Asthma, Diabetes and Epilepsy which will be better managed in the community. Longer term savings will be gained from reductions in unplanned hospital admissions for children and young people, reductions in health conditions relating to smoking and obesity, a reduction in accidents and injuries in children and young people and improvements in maternal health and wellbeing.
Challenges and risks	Challenges: 1. Development of sustainable and high quality services 2. Ensuring services maintain Child, Young person and family focus 3. Addressing Inequalities in provision 4. 23.7% estimated local population growth in 0-19 year olds over next 5 years 5. Poor Outcomes Risks: 6. Workforce- difficulties in recruitment , increases in costs, reductions in establishment across all areas of expertise 7. Training 8. Finances
Additional information or analysis required	Further information needs will be identified as part of the overall programme development. Population data and other information is being collated to support the re-design of services across the whole area. Following the launch event for the Women and Children's Programme held on June 6th and 7th Three very clearly defined work streams have been identified 1. Children and Young People with Acute Care Needs 2. Children and Young People with Long Term Care Needs 3. Maternity and Newborn

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

Prevention

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

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

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

Atrial Fibrillation - detecting, and effective management of	
Summary of the idea / option	Reduce the prevalence of undetected atrial fibrillation (AF) in the population and increase the proportion of those with AF who are effectively anticoagulated. Untreated AF confers a high risk of stroke which can be significantly reduced through anticoagulation 1. Support GPs in detecting and treating AF, e.g. through the use of GRASP-AF audit 2. Work with public health colleagues to improve public understanding of AF and anticoagulation
Issues addressed by this idea / option	Highest cause of PYLL and known driver of local inequalities Particular potential impact on men and more deprived groups Increasing contribution of stroke to CVD morbidity and mortality and morbidity through stroke
Clinical outcomes	PYLL reduction of 28.22 per 100,000 if all AF detected and treated appropriately (estimated 8423 patients in CCG not anticoagulated and at risk) Reduced incidence of stroke in the C&P population Reduction in deaths from stroke Reduction in long term morbidity in stroke survivors
Financial outcomes -	Reduced admissions rates for stroke Reduced spend on rehabilitation
Challenges and risks	Anticoagulation seen as difficult, inconvenient and risky Potential for increase in pathological bleeding Identifying unknown AF cases Effective engagement with primary care
Additional information or analysis required	Current use of GRASP-AF Prescribing advice re novel oral anticoagulants (NovACs) Service availability and constraints re INR monitoring throughput
Interdependencies with other proposed or existing programmes	Older People's Programme CHD Programme - CCG Commissioning priority (workstream 3) Health & Wellbeing Boards Academic work programmes ongoing re this issue locally and nationally (EAHSN)
Delivery requirements -	Engagement work needed to promote GRASP_AF and communicate benefits IT pathways for data flows for monitoring GRASP-AF / other metrics Investment in INR monitoring and / or prescribing budgets
Impact on health inequalities	Potential to increase health inequalities as mobile more able to access monitoring for warfarin unless services carefully designed

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

Cancer pathways	
Summary of the idea / option	Important cause of local PYLL 1. Develop alternative pathways for investigation of symptoms not meeting 2WW criteria 2. Improve GP access for cancer diagnostics (e.g. colonoscopy) 3. Support uptake of cancer decision support tools in routine consultations
Issues addressed by this idea / option	Improving early diagnosis of cancer Improving pick-up rates of cancers that present in non-classical ways Better gatekeeping for secondary care services
Clinical outcomes	These are difficult to quantify individually due to lack of PYLL data related to these interventions. As a bundle of measures, improving early detection and treatment of cancer is estimated to prevent 28.9 PYLL per 100,000
Financial outcomes -	Potential for reduction in emergency diagnoses of cancers; early diagnosis may reduce treatment costs
Challenges and risks	Overloading diagnostic services Poor value for money in new pathways (potential for high numbers of non-cancer referrals)
Additional information or analysis required	Current GP pathways for possible cancer outside 2WW Local service availability and capacity for direct GP referrals
Interdependencies with other proposed or existing programmes	Older People's Programme End of Life Care programme RSS programme
Delivery requirements -	May require significant expansion of diagnostic service capacity IT systems supporting decision tools
Impact on health inequalities	Potential to increase health inequalities if worried well are most able to access new services. Mitigate this by ensuring that new access pathways are available through non traditional routes to maximise access for all, including the most disadvantaged

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

Appendix 7: Reducing potential years of life lost

Background

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

Metrics

The CCG Indicator 1.1 "Potential Years of Life Lost from causes amendable to healthcare" records, for each person who dies aged less than 75, the number of years of life lost and standardises this so that comparisons can be made across populations with different age structures[11].

Current situation

PYLL Data for Cambridgeshire and Peterborough CCG

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

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

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

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

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

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

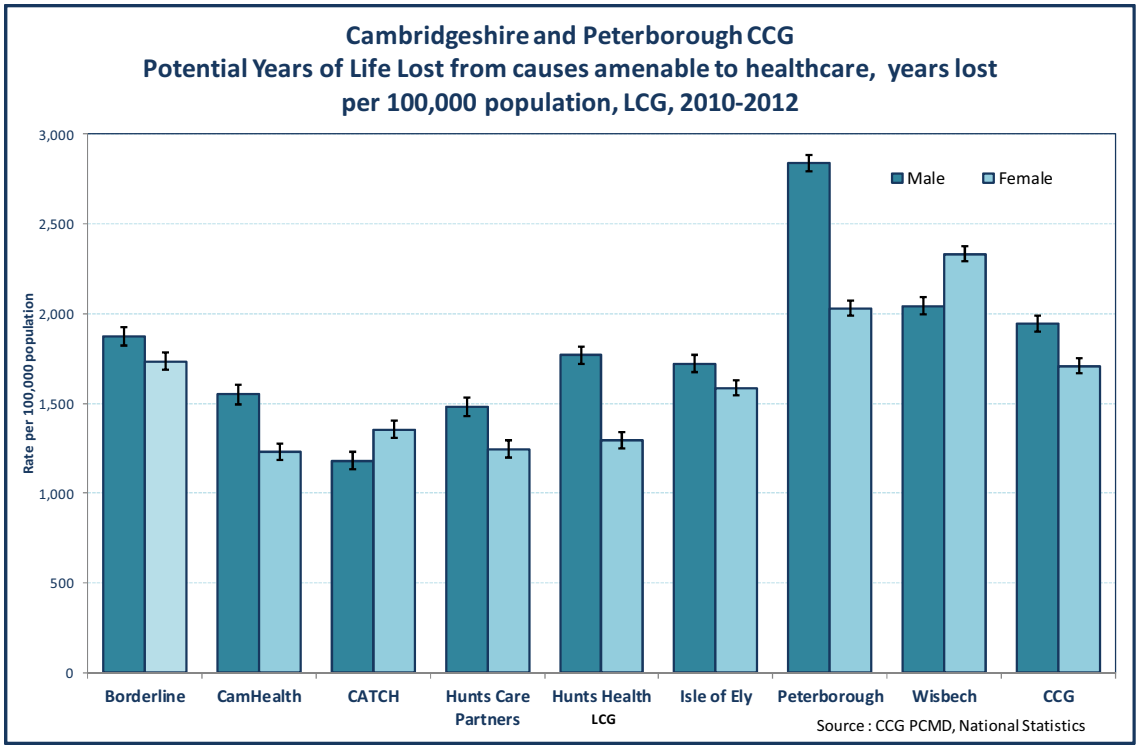


Figure A7-1: Potential Years of Life Lost (PYLL), rate per 100,000 population, by sex and LCG, 2010 - 2012

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

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

Compared with national data the CCG benchmarks well overall for PYLL (lowest quintile)[13], but there is evidence of inequality by geography and by gender[14].

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

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

In 2012, PYLL for the Cambridgeshire Local Authority was in the lowest quintile (and similar to the England average), whereas Peterborough LA was in the central quintile for PYLL[15]. Analysis by gender at CCG level shows that for 2009 to 2011, PYLL for men were significantly greater than for women in the same period. This difference was not seen in 2012. The main causes of premature (age under 75) deaths for the CCG for 2009-2012 were cancers and cardiovascular disease.

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

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

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

Data from the Public Health Intelligence team[17] and published literature[18][19] has been used to calculate the total number of deaths in Cambridgeshire and Peterborough in people aged under 75 that are caused by each risk factor using a measure called the 'population attributable risk' (PAR).

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

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

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

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

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

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

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

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

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

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

Areas for intervention

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

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

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

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

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

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

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

Table 4: areas selected for PYLL intervention analysis

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

Evidence-based interventions: brief overview

Area 1: Prevention and health promotion

General

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

Health checks

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

Smoking cessation

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

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

Alcohol

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

Local situation:

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

Physical activity

Cost-effective interventions:

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

Local situation:

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

Area 2: Cardiovascular disease

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

<u>Stroke prevention</u>

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

through stroke risk assessment (such as the 'CHADS-VASC' score) and risk of bleeding score (such as the 'HAS-BLED')
    - Consider implementation of GRASP-AF across whole CCG to enable quality monitoring of AF management and reduce stroke risk at population level – the CCG currently has no data on AF anticoagulation prescribing rates

Improving management of stroke and transient ischemic attack (TIA)

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

Reducing mortality from CHD

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

Area 3 – Cancers

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

    - Improving uptake of bowel cancer screening in men in Peterborough
    - Improving GP access to diagnostic colonoscopy / flexible sigmoidoscopy

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

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

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

Area 4 – Maternal and neonatal

High smoking in pregnancy rates in Peterborough exceed national targets. For England as a whole, the most recent figures[21] indicate that 12.9% of mothers are current smokers at the time of delivery compared to 18% of new mothers in Peterborough. Infant mortality in smokers is known to be up to twice the rate of that in non-smokers and ex-smokers. Avoidance of infant deaths has potential for large impact on PYLL as well as the PYLL benefits from the mother's health gains.

Possible intervention:

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

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

Recommendations

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

Category	Interventions	Area of impact	PYLL prevented (per 100,000)	Notes
1	Maternal smoking cessation via SmokeFree Champion midwife in Peterborough hospital	• CHD • Cancers • Infant mortality • Stillbirths and low birth weight • Inequalities	Not yet established	Infant mortality in smokers around twice that of non-smokers
1	The CCG CHD Programme: • Increasing uptake of cardiac rehabilitation • Improving detection and management of high cardiovascular risk • Smoking cessation • Health checks	• CHD	Difficult to estimate as bundle of interventions addressing known priority areas for PYLL 10.45 for cardiac rehab (MI and heart failure)	Include PYLL as a metric within this Programme
1	Increase prescription of anti-thrombotics by supporting GPs to identify patients with AF and increase anticoagulation prescribing rates through use of GRASP-AF audit tool	• Mortality from stroke	28.22	Estimated total of 8423 patients in CCG with diagnosed and undiagnosed AF not on warfarin.
1	Extend provision of Early Supported Discharge schemes following a stroke (from 20 to 40%)	• Mortality from stroke	2.57	CCG data for 2013 gives a ESD rate of 4.5%, far below the 20% indicative threshold given in the NHS England data
1	Increase proportion of patients with TIA treated within 24 hours (from 71 to 100%)	• Mortality from stroke	2.57	CCG data for 2013 shows 76.8% treated within 24 hours. This is estimated to be a cost-saving measure

2	Improving Bowel Cancer screening uptake in men in Peterborough	• Cancers • Inequality (gender and geography)	Unknown	28.9 per 100,000 estimated PYLL benefit from combined cancer strategy interventions
2	Improving GP access to colonoscopy	• Cancers • Inequality (gender and geography)	Unknown	
2	Other early diagnosis of cancer initiatives – alternative referral pathways, reduced thresholds for accessing diagnostic tests in primary care, computerised decision support tools	• Cancers • Inequality (gender and geography)	Unknown	
2	Ensure that all patients transferred to a cardiac centre within 72 hours following nSTEMI (assumes increase from 92 to 100%)	• CHD	0.92	Local data need clarification
2	Optimise/reconfigure acute stroke services to ensure 24/7 access to specialist care (incl. thrombolysis) and acute stroke units along the lines of the London model of centralised hyper-acute stroke services	• Mortality from stroke • Potentially inequality	TBC	Local data need clarification
2	Bystander CPR – increase proportion of NHS staff trained in CPR	• Acute CHD mortality	5.5 (for whole population training, not just NHS staff)	Local training levels unknown; PYLL benefit not clear if training restricted; training whole population may not be feasible
2	Implementation of NICE guidelines on Acute Kidney Injury		Unclear – NHSE revised estimates	
3	Greater provision of angioplasty following STEMI and reduced door to balloon times (increase rate of reperfusion from 70% to 100%)	• Acute CHD mortality		Papworth's door to balloon time is 5 minutes lower than the national average and performs very well in other statistics to national averages. Unlikely that PYLL gains would provide a good return on investment.

Recommended actions

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

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

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

*Using calculations in Appendix 1

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

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

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

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

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

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

SECTION 1

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

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

Methodology

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

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

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

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

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

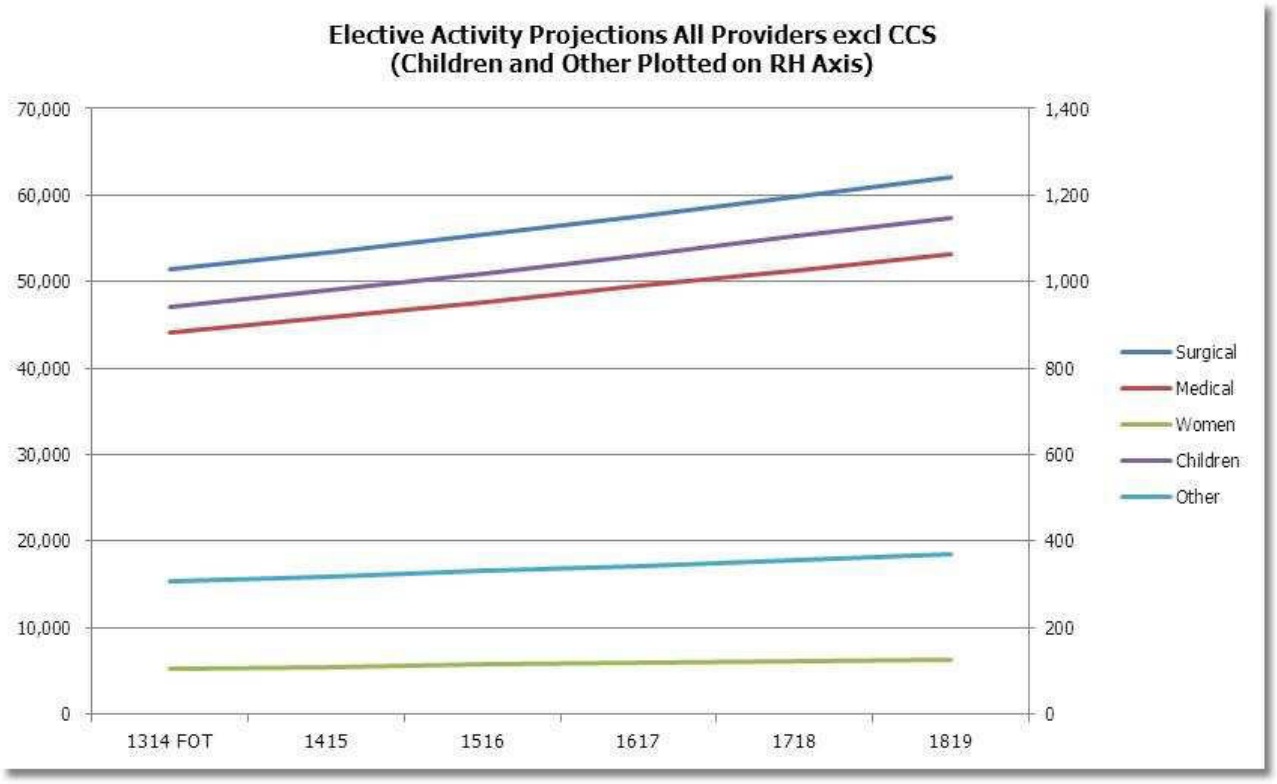
- CUHFT: Cambridge City, South Cambridgeshire and East Cambridgeshire
- Hinchingbrooke: Huntingdonshire
- PSHFT: Peterborough
- QEHKL: Fenland
- Papworth: Cambridgeshire
- CCS: Cambridgeshire
- Others: Cambridgeshire

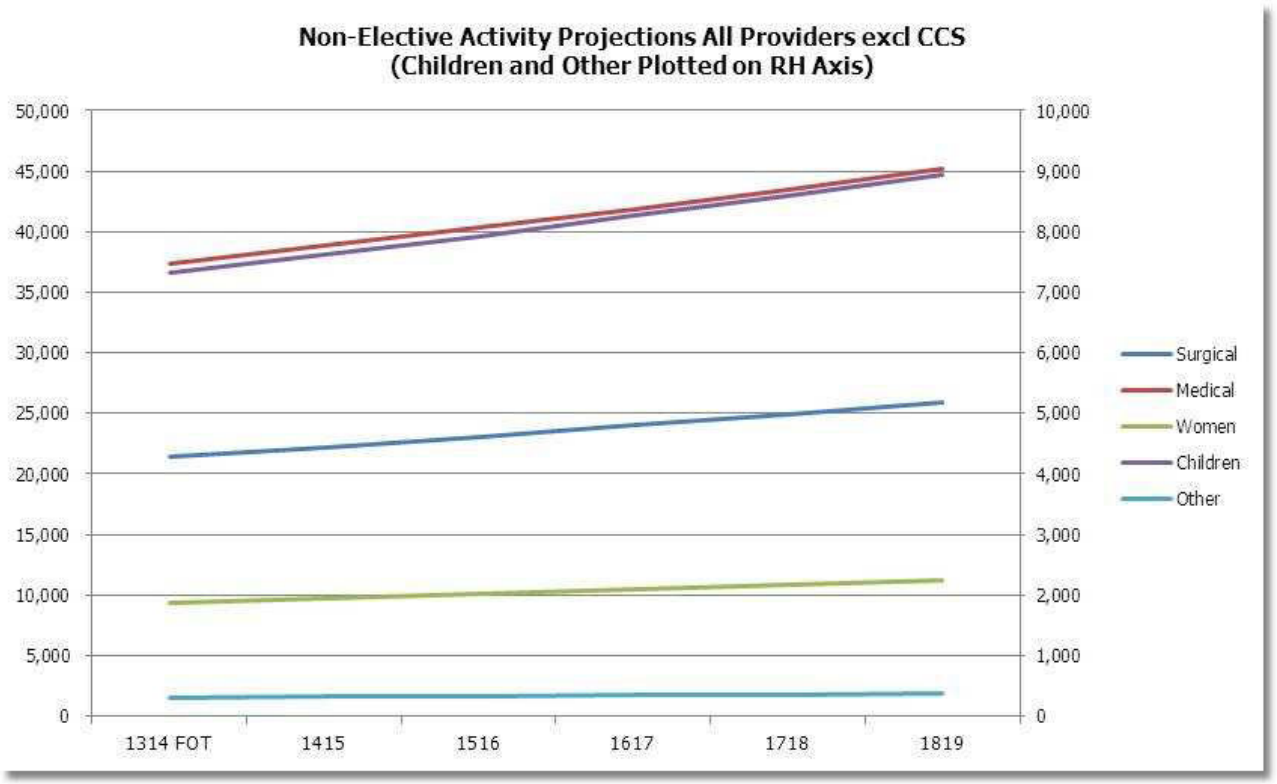
Older People's projections were based on age band projections from the Cambridgeshire CC Research Group

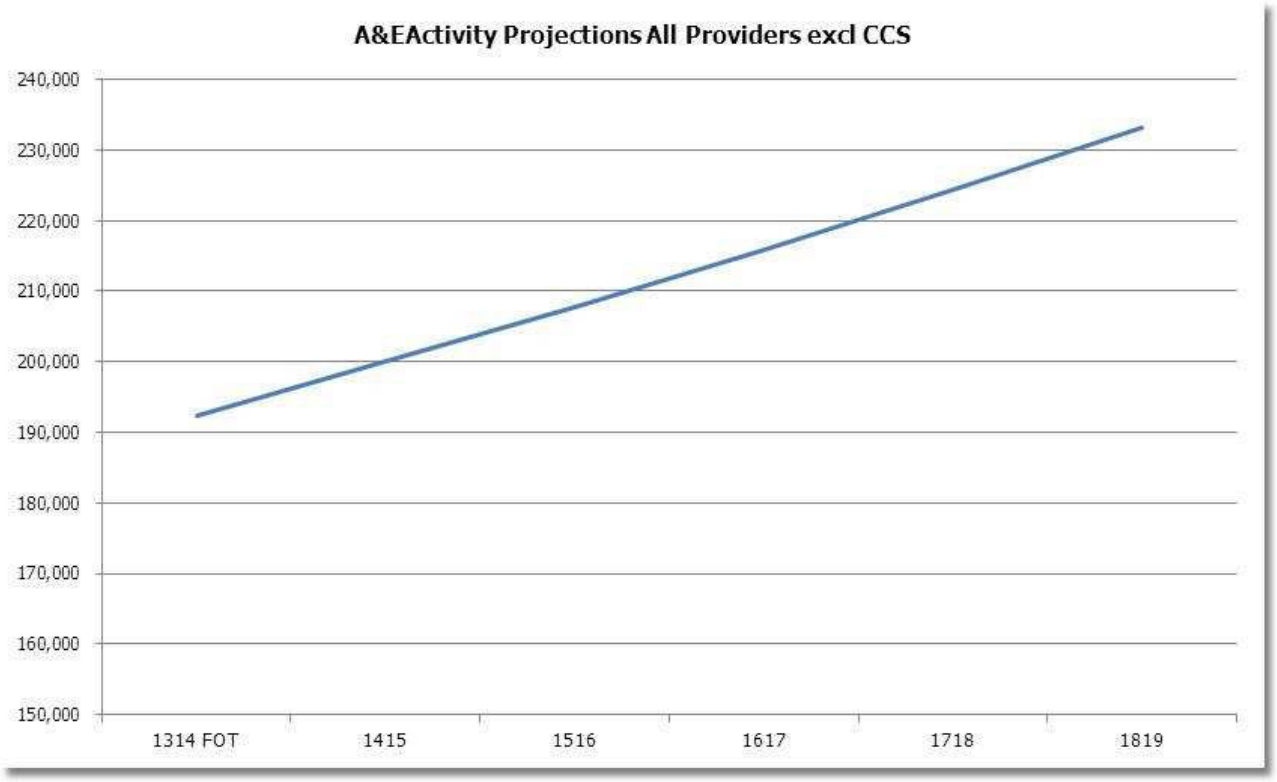
Information from CCS and CPFT has not been included because of data availability.

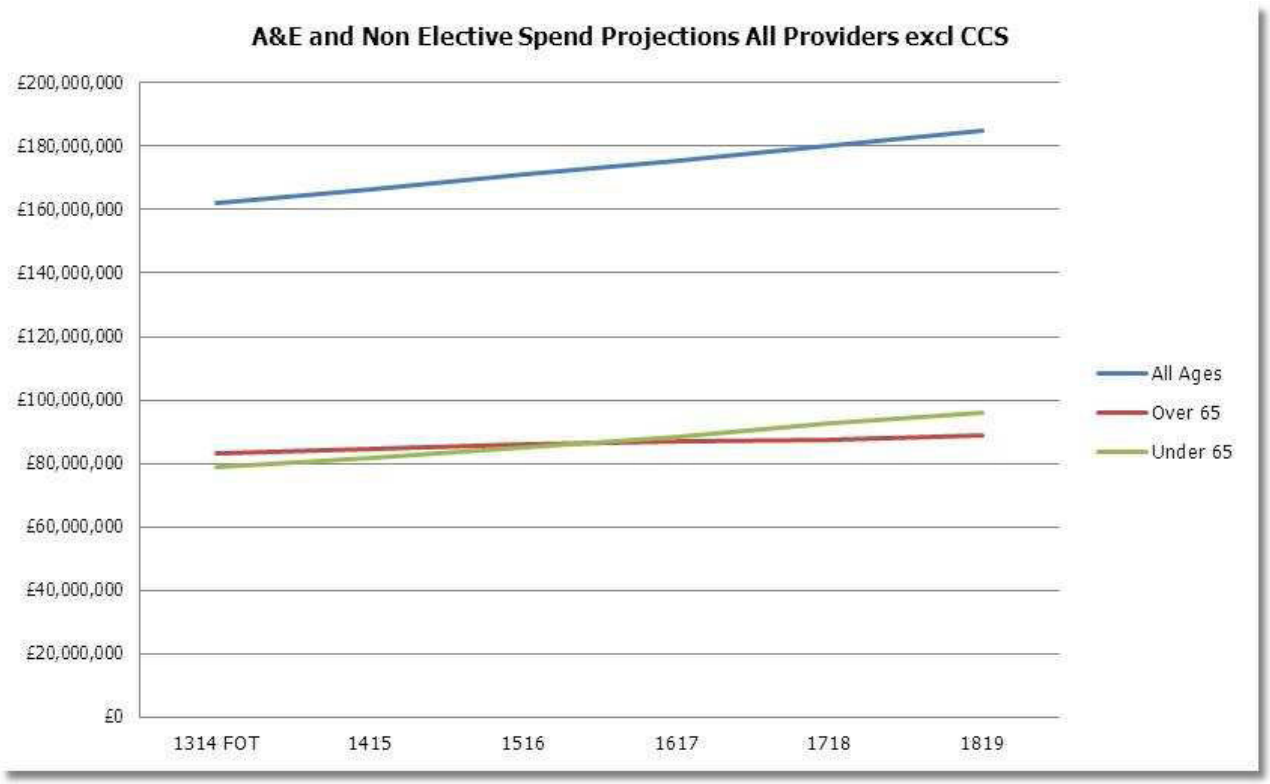
Results of the current model

These are presented graphically below:


Elective Activity Projections All Providers excl CCS
(Children and Other Plotted on RH Axis)
70,000
60,000
50,000
40,000
30,000
20,000
10,000
0
1,400
1,200
1,000
800
600
400
200
0
1314 FOT
1415
1516
1617
1718
1819
Surgical
Medical
Women
Children
Other


Non-Elective Activity Projections All Providers excl CCS
(Children and Other Plotted on RH Axis)
50,000
45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
10,000
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
1314 FOT
1415
1516
1617
1718
1819
Surgical
Medical
Women
Children
Other


A&EActivity Projections All Providers excl CCS
240,000
230,000
220,000
210,000
200,000
190,000
180,000
170,000
160,000
150,000
1314 FOT
1415
1516
1617
1718
1819


A&E and Non Elective Spend Projections All Providers excl CCS
£200,000,000
£180,000,000
£160,000,000
£140,000,000
£120,000,000
£100,000,000
£80,000,000
£60,000,000
£40,000,000
£20,000,000
£0
1314 FOT
1415
1516
1617
1718
1819
All Ages
Over 65
Under 65

Comments on the model outputs so far:

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

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

SECTION 2

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

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

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

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

1. Smoking

1.1 Previous smoking prevalence – national data

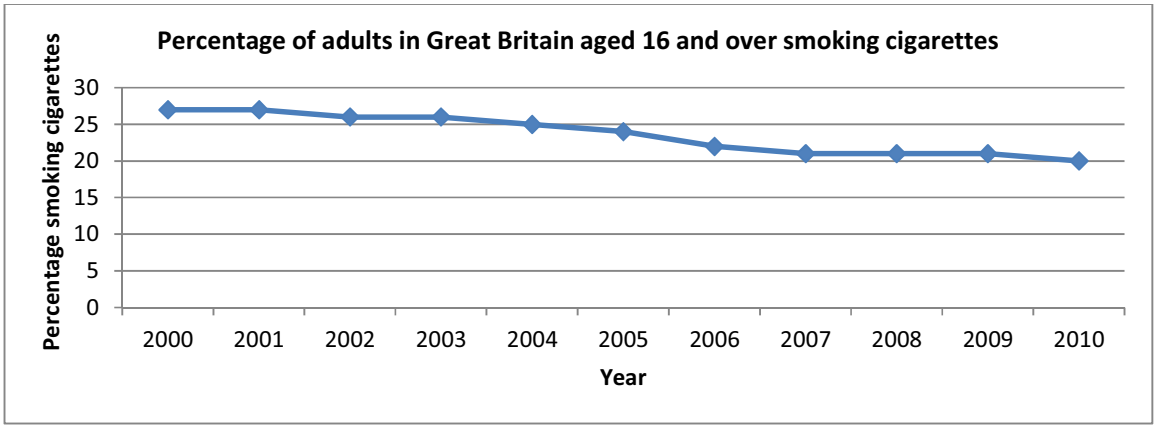


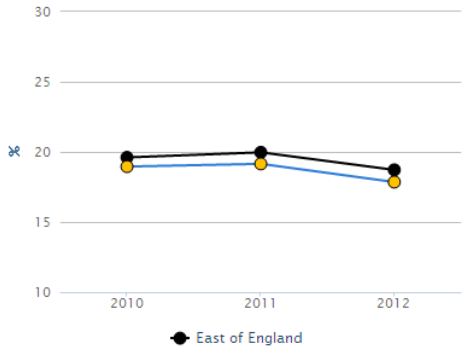
Figure 1: Smoking prevalence data from the General Lifestyle Survey, Office of National Statistics
http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-226919

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

1.1.1 **Previous smoking prevalence – local data**

The data in figure 2 show the proportion of people aged 18+ who are self-reported smokers in Cambridgeshire and Peterborough between 2010 and 2012[22]. The proportion of adults who smoke appeared to decrease between 2010 and 2012 (Cambridgeshire: 19.0% in 2010, 17.9% in 2012. Peterborough: 25.2% in 2010, 21.1% in 2012), however this was not statistically significant.

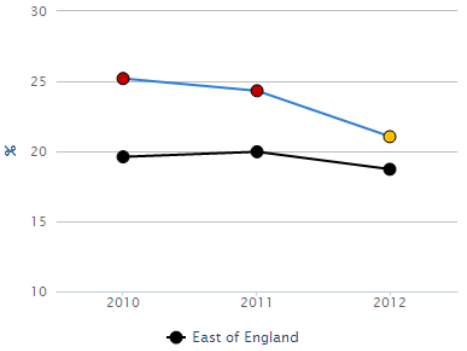
2.14 - Smoking Prevalence Cambridgeshire — Proportion - %



Period	Sig	Value	Lower CI	Upper CI	East of England	England
2010		19.0	17.4	20.6	19.6	20.8
2011		19.2	17.3	21.0	20.0	20.2
2012		17.9	15.8	19.9	18.7	19.5

Source: Integrated Household Survey. Analysed by Department of Health and published by Public Health England.

2.14 - Smoking Prevalence Peterborough — Proportion - %



Period	Sig	Value	Lower CI	Upper CI	East of England	England
2010		25.2	23.0	27.4	19.6	20.8
2011		24.3	22.0	26.7	20.0	20.2
2012		21.1	18.7	23.4	18.7	19.5

Source: Integrated Household Survey. Analysed by Department of Health and published by Public Health England.

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

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

1.2 Future smoking prevalence

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

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

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

2. Cholesterol

2.1 Current/previous cholesterol levels

The mean blood cholesterol level for men aged 16 and over in England in 2008 was 5.2mmol/l and for women 5.4mmol/l[24]. Table 1 shows that the prevalence of high cholesterol levels (>5mmol/l total cholesterol) in England decreased from 66% in 2003 to 61% in 2008.

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

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

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

Source:
Joint Health Surveys Unit (2009) Health Survey for England 2008. The Information Centre: Leeds, and previous editions.

Table 1: The prevalence of high cholesterol levels in England[24]

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

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

2.2 Future cholesterol levels

A recent conference abstract[25] states that average cholesterol levels in the UK could be expected to fall by 0.1mmol/l by 2030. We therefore estimate that average cholesterol levels may have reduced by 0.05mmol/l by 2019. This would result in a mean blood cholesterol of 5.15mmol/l for men and 5.35 for women, a reduction in the risk factor prevalence of approximately 1% for both sexes.

3. Obesity

3.1.1 Local obesity prevalence

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

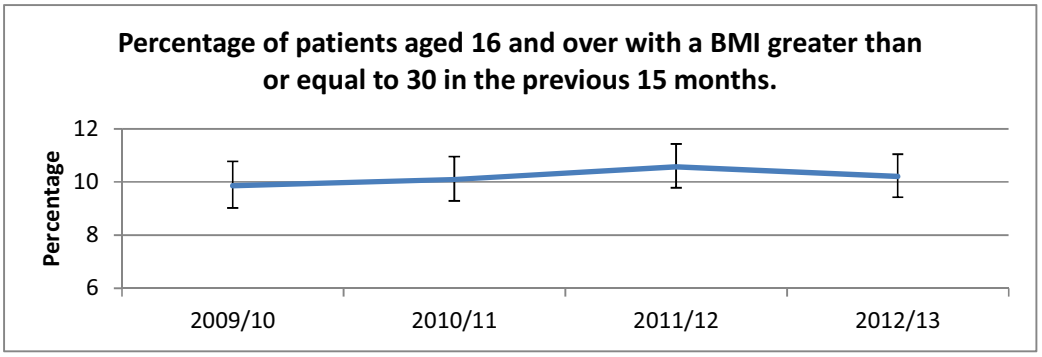


Figure 3: Percentage of patients aged 16 and over with a BMI greater than or equal to 30 in the previous 15 months (Data from QOF) in C&P CCG [26] [27]

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

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

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

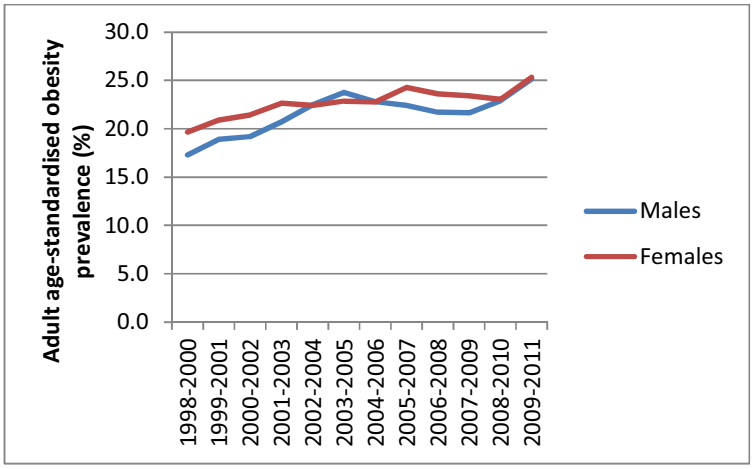


Figure 4: Adult (aged 16+ years) age standardised obesity prevalence (%) in the East of England
Source: Health Survey for England (HSE). Obesity in adults is defined as a BMI greater than or equal to 30kg/m^2

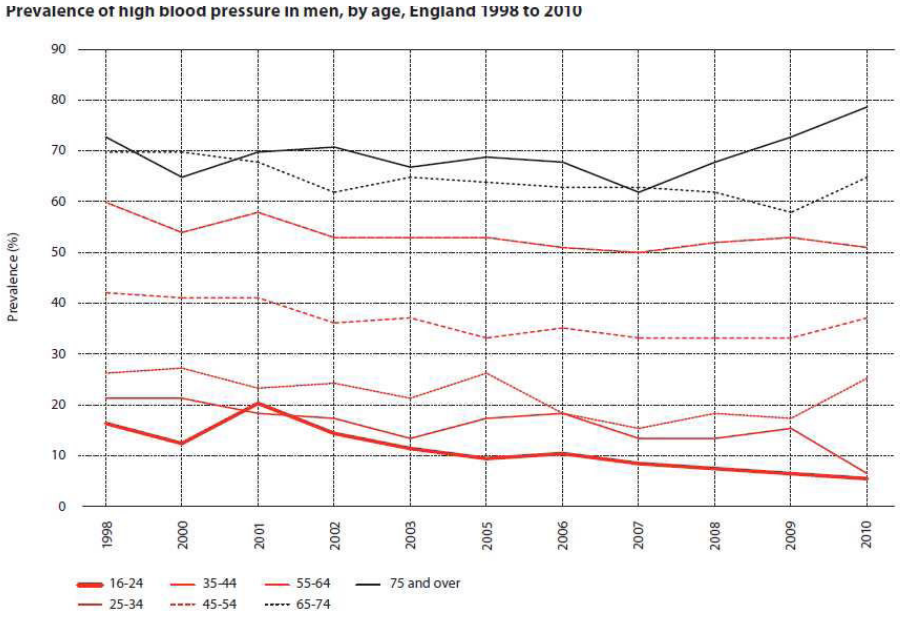
3.2 Future obesity prevalence

A 2007 report by the UK Government's Foresight Programme[28] suggested that approximately 40% of males and 35% of females aged 21-60 would be obese or morbidly obese by 2019. This is based on an assumption that the proportion of adults who are obese/morbidly obese in 2011 would be approximately 30% (compared to 25% in Figure 4). Therefore we can estimate that the prevalence of obesity in the C&PCCG area will be approximately 30-35% in 2019.

4. Hypertension

a. 1 National data

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



[28] https://www.gov.uk/government/publications/reducing-obesity-future-choices

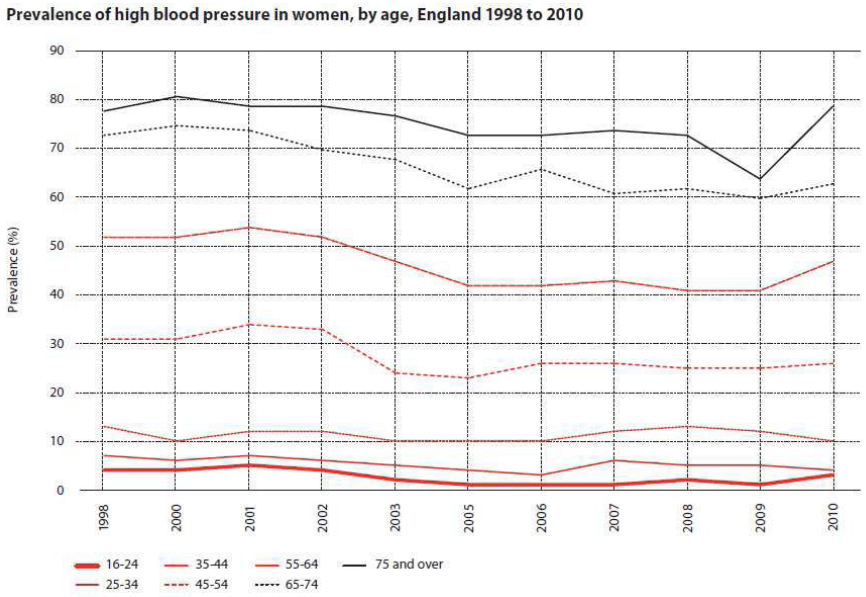


Figure 5: Prevalence of high blood pressure in England, 1998-2010[29]

4.1.2 Local data

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

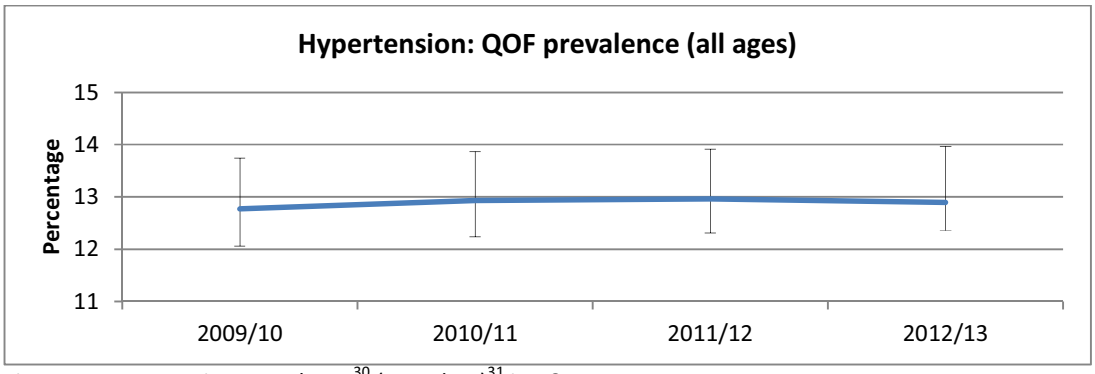


Figure 6: Hypertension prevalence[30] (QOF data)[31] in C&P CCG

4.2 Future prevalence

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

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

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

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

Future prevalence

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

Method

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

Limitations:

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

Assumptions:

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

Results

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

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

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

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

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

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

Conclusions

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

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

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

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

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

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

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

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

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

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

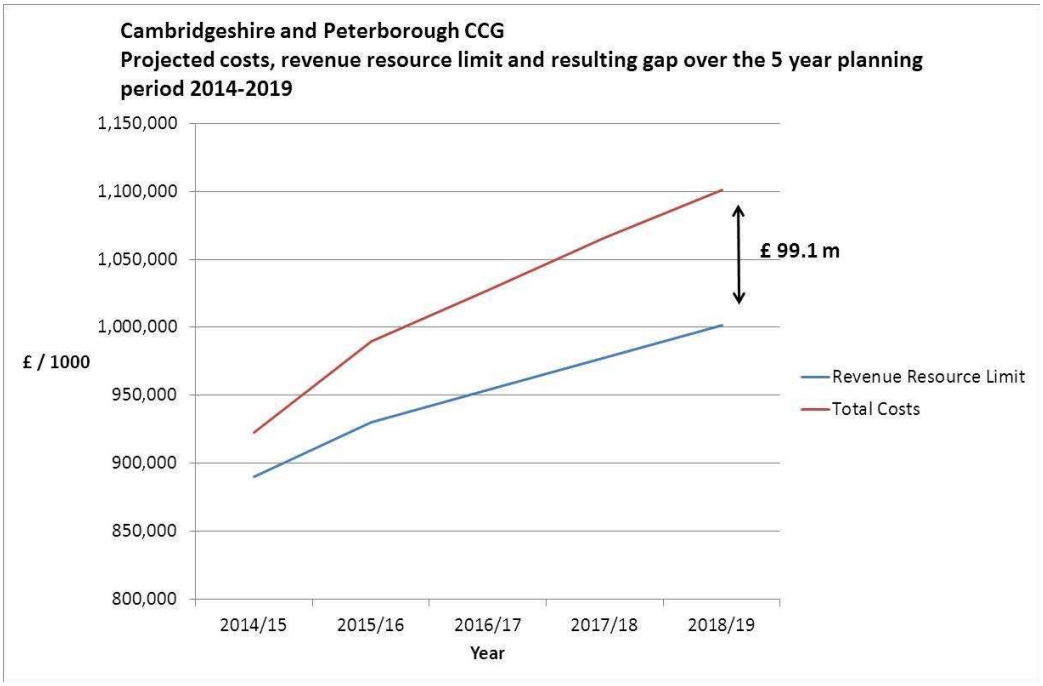
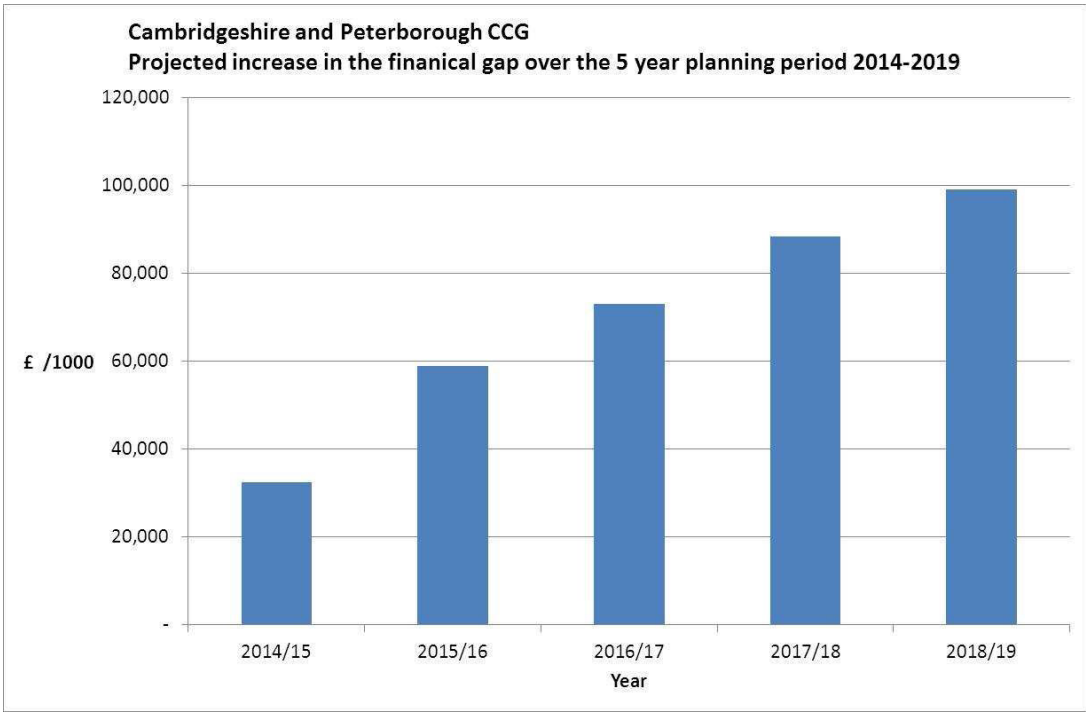


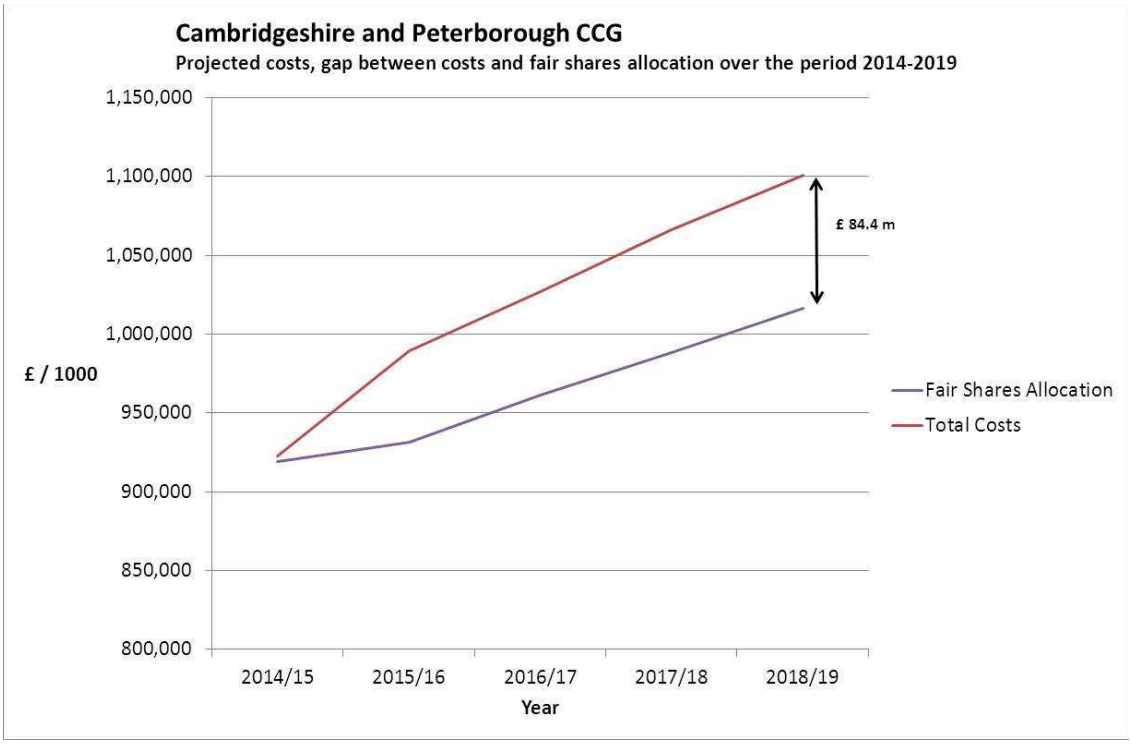
Figure A9-2 below shows the increase in the financial gap over the 5 year period.

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



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

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



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

Figure A9-5

CAMBRIDGESHIRE AND PETERBOROUGH FIVE YEAR FINANCIAL PLAN - BASE CASE

18-Jun-14	2013/14			2014/15			2015/16			2016/17			2017/18			2018/19		
	Rec	Non Rec	Total	Rec	Non Rec	Total	Rec	Non Rec	Total	Rec	Non Rec	Total	Rec	Non Rec	Total	Rec	Non Rec	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Planned Resources																		
Recurrent resource	853,942	0	853,942	849,204		849,204	875,134		875,134	911,672		911,672	935,102		935,102	958,760		958,760
Uplift			0	24,604		24,604	21,681		21,681	23,430		23,430	23,658		23,658	24,161		24,161
In year adjustments	(4,738)	7,638	2,900	(1,155)		(1,155)			0			0			0			0
Anticipated adjs Hinch specialsit		2,481	2,481	2,481		2,481			0			0			0			0
Return of prior year surplus / (deficit)		2,659	2,659		(4,874)	(4,874)			0		9,306	9,306		9,633	9,633		9,873	9,873
Running Cost	20,800		20,800	20,943		20,943	18,889		18,889	18,889		18,889	18,889		18,889	18,889		18,889
Better Care Fund (ITF)			0			0	14,857		14,857			0			0			0
Total Resources	**870,004**	**12,778**	**882,782**	**896,077**	**(4,874)**	**891,203**	**930,561**	**0**	**930,561**	**953,991**	**9,306**	**963,297**	**977,649**	**9,633**	**987,282**	**1,001,810**	**9,873**	**1,011,683**
Planned Expenditure (13/14 is FOT)																		
Bought forward recurrent spend	858,914	6,631	865,545	858,914		858,914	859,588		859,588	895,262		895,262	921,666		921,666	946,061		946,061
Running Costs	20,800	(2,197)	18,603	20,800		20,800	18,889		18,889	18,889		18,889	18,889		18,889	18,889		18,889
Inflation / deflation			0	(9,345)		(9,345)	(12,232)		(12,232)	(3,975)		(3,975)	(4,073)		(4,073)	(9,058)		(9,058)
Population growth 1.5%			0	11,623		11,623	12,608		12,608	12,817		12,817	13,142		13,142	13,336		13,336
Other growth			0	12,306	3,400	15,706	19,179		19,179	25,049		25,049	25,689		25,689	26,070		26,070
Primary care			0	4,115		4,115			0			0			0			0
Re-stating Contingency			0		4,444	4,444		4,653	4,653		4,770	4,770		4,888	4,888		5,009	5,009
Marginal rate and re-admiss reserve			0		8,442	8,442		8,442	8,442		8,822	8,822		9,219	9,219		9,634	9,634
Better care fund			0			0	36,323		36,323			0			0			0
1% non rec CCG requirement			0		8,904	8,904		9,306	9,306		9,540	9,540		9,776	9,776		10,018	10,018
1.5% transition to 2015/16		3,508	3,508			0			0			0			0			0
Total spend before QIPP	**879,714**	**7,942**	**887,656**	**898,413**	**25,190**	**923,603**	**934,355**	**22,401**	**956,756**	**948,043**	**23,132**	**971,176**	**975,314**	**23,884**	**999,198**	**995,298**	**24,661**	**1,019,959**
Planned QIPP Savings			0	(23,282)	(9,118)	(32,400)	(24,856)	(10,644)	(35,500)	(12,258)	(5,254)	(17,512)	(15,252)	(6,537)	(21,788)	(12,875)	(5,518)	(18,393)
Total Spend after QIPP	**879,714**	**7,942**	**887,656**	**875,131**	**16,072**	**891,203**	**909,499**	**11,757**	**921,256**	**935,785**	**17,879**	**953,664**	**960,062**	**17,347**	**977,409**	**982,423**	**19,143**	**1,001,566**
Surplus / (deficit)	**(9,710)**	**4,836**	**(4,874)**	**20,946**	**(20,946)**	**(0)**	**21,062**	**(11,757)**	**9,305**	**18,206**	**(8,573)**	**9,633**	**17,587**	**(7,715)**	**9,873**	**19,387**	**(9,270)**	**10,117**

Appendix 10: Strategic Planning Concordat

Cambridgeshire & Peterborough Local Health and Care Economy

Strategic Planning Concordat

Our commitments

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

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

Our values

We will:

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

Practical actions

To this end we commit to these actions:

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

We acknowledge that this may result in the following:

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

Parties to this concordat

Health care Providers:

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

Commissioning organisations:

- CCG
- NHS England

Local Authorities:

- Cambridgeshire County Council
- Peterborough City Council

Health care regulators:

- Monitor
- Trust Development Authority