Appendix 3

Cambridgeshire and Peterborough health system Blueprint

2014/15 to 2018/19

Working draft for discussion

30th May 2014

Version control

14 May 2014	Additional sections from PwC blueprint integrated	Fi Head
14 May 2014	Notes on who is providing which content added	Fi Head
19 May 2014	PwC chart on current health system added	Fi Head
19 May 2014	PwC chart on activity changes and financial impact added- need to list and record assumptions and clarify time period	Fi Head
21 May 2014	Strategic aims and goals moved to appendix	Fi Head
21 May 2014	IM&T strategy information added	Fi Head
21 May 2014	PwC information on why C&P were chosen added	Fi Head
22 May 2014	Section on approach written and added (2.4)	C Boaden
22 May 2014	Section on stakeholders written and added	C Boaden
22 May 2014	Section on risk written and added - further work required to complete this	C Boaden
22 May 2014	Formatting (header/ footer/ page numbering/ contents/ orientation etc)	C Boaden
22 May 2014	Placeholder under enablers for Quality Strategy	Fi Head
22 May 2014	Better Care Fund text added from Nigel Smith	Fi Head
22 May 2014	HEE section on workforce from Lucy Dennis	Fi Head
22 May 2014	Placeholder on primary care section + forward process actioned	Fi Head
22 May 2014	Financial gap section restructured and placeholder in	Fi Head
23 May 2014	CGG tables added to Appendix 5	C Boaden
23 May 2014	Formatting (header/ footer/ page numbering/ contents/ orientation etc)	C Boaden
23 May 2014	Tables from NW Associates anonymised and added to 5.4	C Boaden
23 May 2014	Appendix 6 replaced with new version from IOT	C Boaden
23 May 2014	Appendix 8 replaced with new versions from IOT	C Boaden
23 May 2014	Risks tables added and reviewed	C Boaden
28 May 2014	Formatting to emphasise key messages	C Boaden
28 May 2014	Tables/ graphics redrawn in IM&T section	C Boaden
28 May 2014	Graphic in section 4.2 revised – now clearer	C Boaden
28 May 2014	Section 3.3 reformatted/ source made clearer	C Boaden
28 May 2014	Reformatted graph in section 4.2 – source made clearer	C Boaden
28 May 2014	Stakeholder descriptions revised (section 4.3)	C Boaden
28 May 2014	Summary added – section 2	C Boaden
28 May 2014	Description of CCG/ LCGs/ providers added and graphic improved	C Boaden
28 May 2014	Addition to document purpose section	Fi Head
28 May 2014	CDG design principles clarified and added	Fi Head
28 May 2014	Method of working section written	Fi Head
28 May 2014	Top lines from Neal Wilson work added to description of current service and link to OPP	Fi Head
28 May 2014	Financial scenario section re-worked and merged with provider assumption table; conclusions outlined; data from Harper on Emergency Bed Days added	Fi Head
28 May 2014	Further edits to CDG section	Fi Head
28 May 2014	Edits to transformational work section	Fi Head
28 May 2014	Changes to bullet list of conclusions – section 8	Fi Head
29 May 2014	Changes to financial gap section 5.3	Fi Head
29 May 2014	Re-work section 7 on CDG work to date	Fi Head
29 May 2014	Revised finance information added from Wanda (appendix 9)	Fi Head
29 May 2014	Section 5.4 on primary care written and added (using information from Karen Key)	C Boaden
29 May 2014	Section 9.1 on quality written and added (using information from Paula South)	C Boaden
29 May 2014	Section 8, conclusions, changed from bullet points to text	C Boaden
29 May 2014	Governance timelines added – new appendix 1 (all other appendices now need renumbering)	C Boaden
29 May 2014	Check through and edits	C Boaden/ F Head
29 May 2014	IT section edited	F Head
30 May 2014	Formatting – figures and appendix references corrected throughout document	C Boaden
30 May 2014	Text reviewed (IT section/ CCG finance section/ OPP section)	C Boaden

Information to add to next version

More details on Care Design Group timelines	
Parity of esteem	
Health inequalities	
Mapping back to outcomes	
Comms information to inform strategic goals	

Contents

1. Document purpose

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

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

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

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

2. Summary

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

- The Cambridgeshire and Peterborough health system is not financially sustainable and faces a gap of at least £250 m by 2018/19
- The population of Cambridgeshire and Peterborough is increasing and there will be a greater proportion of older people in 5 years time
- Demand for mental health services continues to increase
- There are significant levels of deprivation and inequality that need to be addressed
- People are living longer and health outcomes are generally good but there are significant differences in people's health
- Our health system has multiple stakeholders

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

We have focused our work in the following key areas:

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

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

Governance and resourcing requirements for delivery need to be determined and agreed to enable the blueprint process to move into phase 2 and beyond and this document describes our current thinking in these key areas, as well as the other enablers (IM&T, workforce) that are crucial to the successful delivery of the changes being developed.

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

3. Introduction

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

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

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

NHS England, Monitor and NHS Trust Development Authority undertook an exercise to identify those health systems which were particularly challenged as a whole, and were most likely to benefit from intensive support in order to develop plans which would improve outcomes for the public and patients whilst developing a financially sustainable future across the health economy.

These were are the health systems that were at most risk of failing if the plans submitted did not identify future service configurations that were achievable and could resolve the major local challenges. In particular, the exercise focused on the level of financial challenge within the health system, and how aligned provider and commissioner plans were.

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

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

What factors make the Cambridgeshire and Peterborough health system unusual?

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

- Hinchingbrooke Health Care NHS Trust: The first NHS trust to be operated by a private partner, Circle

- Peterborough and Stamford Hospitals NHS Foundation Trust: Current supported by a contingency planning team to find a system-wide solution to the Trust's financial challenges
- Cambridge University Hospitals NHS Foundation Trust: A national centre for specialist treatment, and one of five academic health science centres in the UK
- Papworth NHS Foundation Trust: The UK's largest specialist cardiothoracic hospital

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

Method of joint working

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

1. A Joint Strategic Planning Stakeholder Group has met since December 2013. This is chaired by the CCG Director of Commissioning and has on its membership Directors from across the Health and Social Care system and Healthwatch. On 7th May the group held a "system summit" which considered the different plans from the organisations in the system.

   Outputs from this work include agreement on the demographic projections and the risk log. The system summit realised that there were differences in growth assumptions across the system and as a result the CCG commissioned further work to illustrate these differences. This is shown in section 5.3.

2. PwC were appointed by NHS England to work across Cambridgeshire and Peterborough. They commenced this role on 3rd April 2014 and their work has been overseen by a local steering group chaired by the Director of the NHS England Norfolk, Suffolk and Cambridgeshire Area Team. This process has produced an overview of healthcare, and a system-wide estimate of the financial challenge. PwC have facilitated two "Care Design Groups" that have taken a clinically focussed approach to identify changes that could improve outcomes and the financial sustainability of the health system. Their estimation of the financial impact of these changes is shown as figure 23.

3. The Cambridgeshire and Peterborough Chief Executives Group are working to agree the governance and delivery arrangements for this strategic planning work. A concordat on joint working is in the process of being signed off by the organisations in the system. Proposals on a delivery structure and resourcing for the next phase of this process will be considered by the Chief Executives Group on 27th June 2014.

3.2 Approach

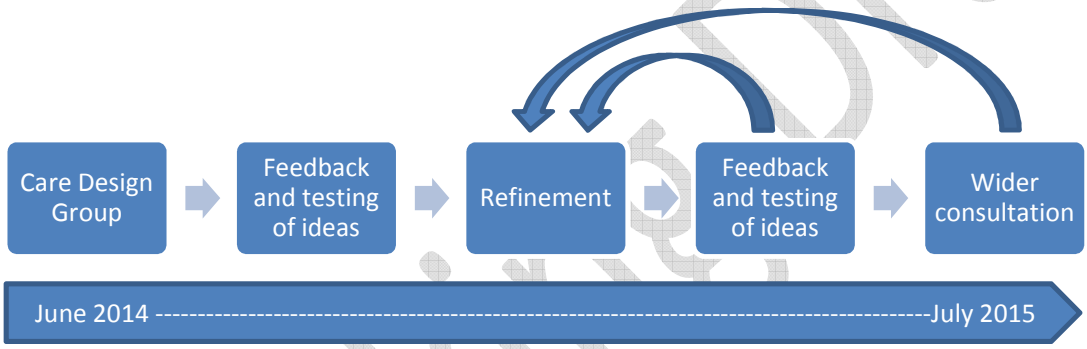
The starting point of this plan has been an understanding of the health needs of the Cambridgeshire and Peterborough population. Information about this is presented in appendix 1. The ambitions for improving health outcomes have been analysed and are presented in appendix 2.

The need to improve health outcomes whilst maintaining a financially sustainable system is not new to the Cambridgeshire and Peterborough health system. This plan outlines the transformational interventions that are ongoing already, notably the CCG's Older Peoples and Adult Community Services Procurement, and how these are expected to impact on the system.

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

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

Figure 1: Care Design Group process



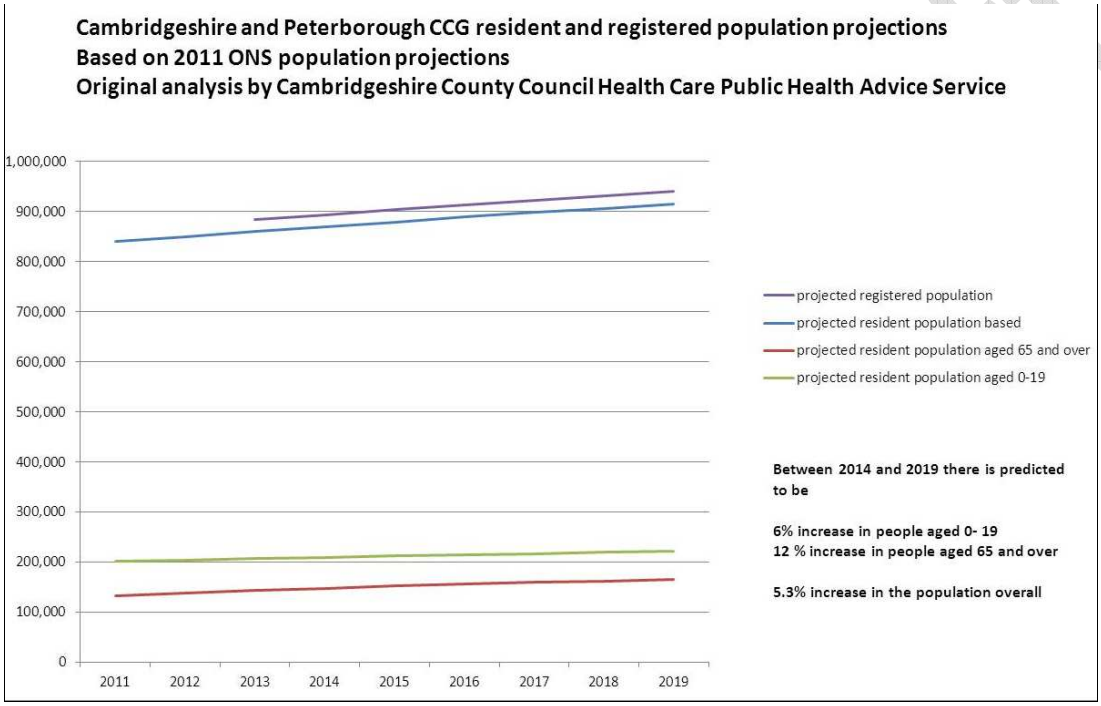
It is recognised, however, that £80m, is significantly short of the £250m shortfall and other approaches to identify options for change are likely to need to be considered.

3.3 Cambridgeshire and Peterborough: our population

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

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

Figure 2: Resident and registered population projections 2011 to 2019



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

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

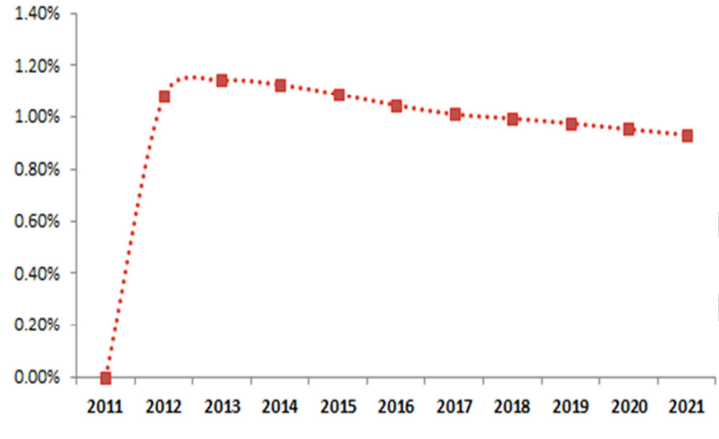
Figure 3: Cambridge & Peterborough: Area and population overview

Population projections (2011 – 2021)

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

Source: PwC

Figure 4: Population growth, 2011 – 2021



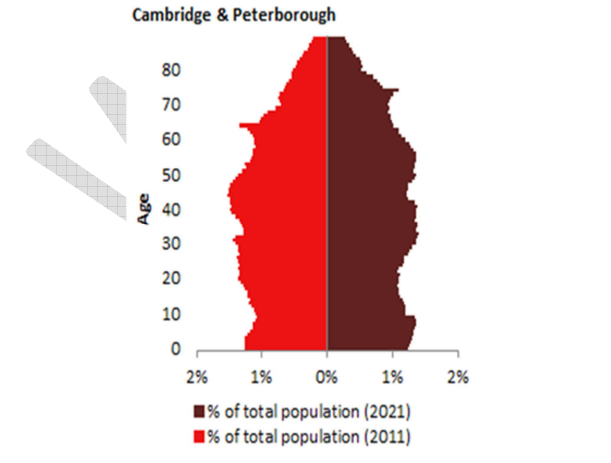
Source: PwC (information from Office of National Statistics (ONS) Sub-national population projections, Interim 2011-based)

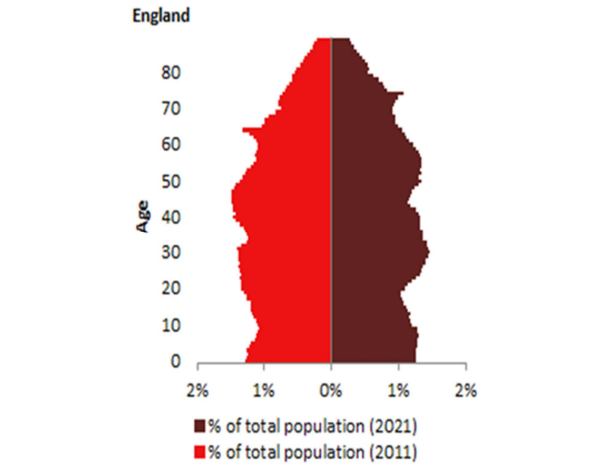
Figure 5: Population age distribution (2011 – 2021)

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

Source: PwC

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





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

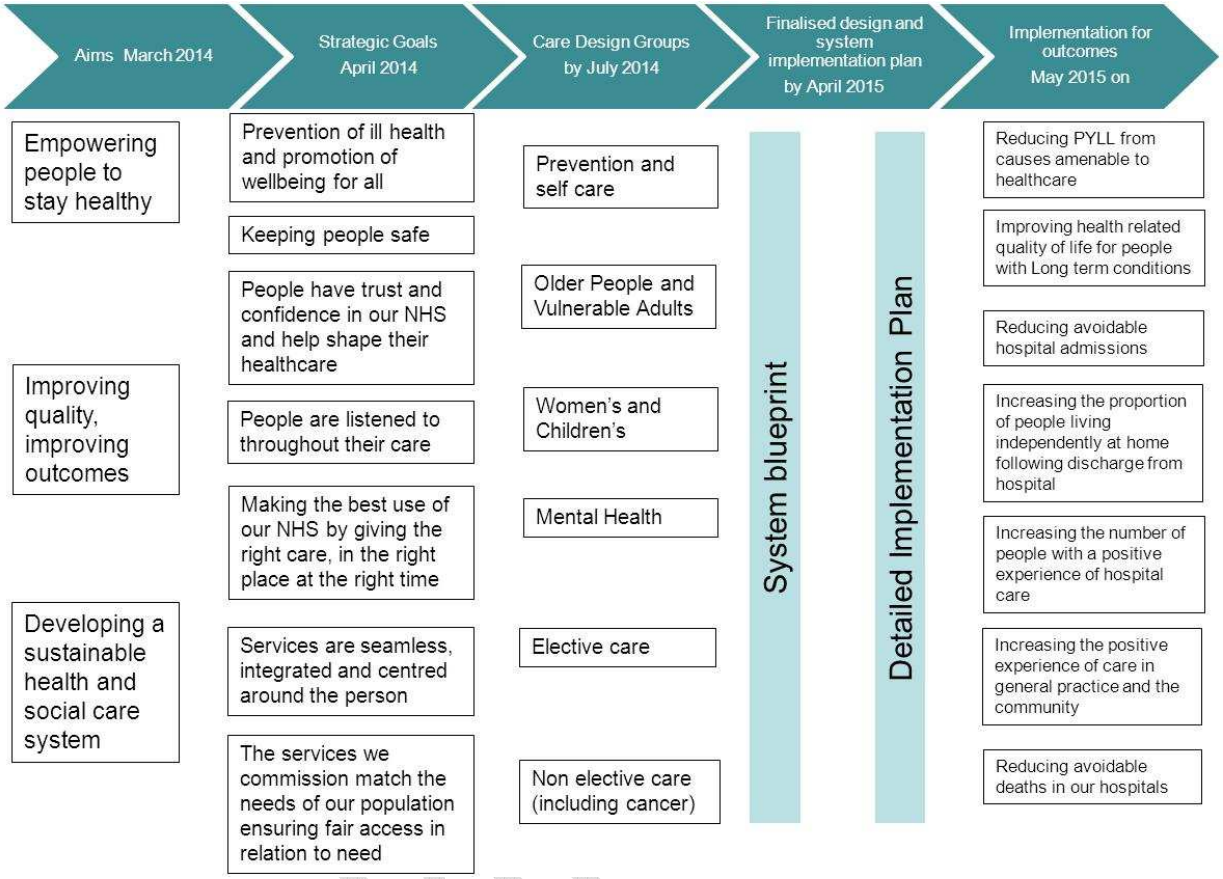
3.4 System strategic aims and goals

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

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

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

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



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

4. Cambridgeshire and Peterborough health system Context

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

4.1 Cambridgeshire and Peterborough: the health of our people

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

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

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

4.1.1 Cambridgeshire

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

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

Figure 9: Health profiles – Cambridgeshire

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	15751	2.5	20.3	83.7		0.0
	2 Proportion of children in poverty	14360	13.4	21.1	45.9		6.2
	3 Statutory homelessness	600	2.4	2.3	9.7		0.0
	4 GCSE achieved (5A*-C inc. Eng & Maths)	3380	57.5	59.0	31.9		81.0
	5 Violent crime	5756	9.3	13.6	32.7		4.2
	6 Long term unemployment	1827	4.5	9.5	31.3		1.2
Children's and young people's health	7 Smoking in pregnancy ‡	970	13.7	13.3	30.0		2.9
	8 Starting breast feeding ‡	5889	81.9	74.8	41.8		96.0
	9 Obese Children (Year 6) ‡	876	16.3	19.2	28.5		10.3
	10 Alcohol-specific hospital stays (under 18)	61	48.8	61.8	154.9		12.5
	11 Teenage pregnancy (under 18) ‡	269	24.8	34.0	58.5		11.7
Adults' health and lifestyle	12 Adults smoking	n/a	19.5	20.0	29.4		8.2
	13 Increasing and higher risk drinking	n/a	23.9	22.3	25.1		15.7
	14 Healthy eating adults	n/a	32.4	28.7	19.3		47.8
	15 Physically active adults	n/a	60.3	56.0	43.8		68.5
	16 Obese adults ‡	n/a	20.9	24.2	30.7		13.9
Disease and poor health	17 Incidence of malignant melanoma	124	19.6	14.5	28.8		3.2
	18 Hospital stays for self-harm	1386	228.3	207.9	542.4		51.2
	19 Hospital stays for alcohol related harm ‡	13550	1829	1895	3276		910
	20 Drug misuse	2172	5.3	8.6	26.3		0.8
	21 People diagnosed with diabetes	26519	5.1	5.8	8.4		3.4
	22 New cases of tuberculosis	35	5.7	15.4	137.0		0.0
	23 Acute sexually transmitted infections	3677	591	804	3210		162
	24 Hip fracture in 65s and over	600	426	457	621		327
Life expectancy and causes of death	25 Excess winter deaths ‡	217	14.3	19.1	35.3		-0.4
	26 Life expectancy – male	n/a	80.6	78.9	73.8		83.0
	27 Life expectancy – female	n/a	84.5	82.9	79.3		86.4
	28 Infant deaths	26	3.5	4.3	8.0		1.1
	29 Smoking related deaths	772	164	201	356		122
	30 Early deaths: heart disease and stroke	330	48.8	60.9	113.3		29.2
	31 Early deaths: cancer	637	94.5	108.1	153.2		77.7
	32 Road injuries and deaths	353	57.5	41.9	125.1		13.1

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

4.1.2 Peterborough

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

- Over the last 10 years, all-cause mortality rates have fallen. The early death rate from heart disease and stroke has fallen, but is worse than the England average.
- In Year 6, 19.2% of children are classified as obese. Levels of teenage pregnancy, GCSE attainment and smoking in pregnancy are worse than the England average. The level of alcohol-specific hospital stays among those under 18 is better than the England average.

- The estimated level of adult smoking is worse than the England average. Rates of road injuries and deaths and hospital stays for alcohol related harm are worse than the England average.

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

Figure 10: Health profiles – Peterborough

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	62988	34.1	20.3	83.7		0.0
	2 Proportion of children in poverty	9470	23.5	21.1	45.9		6.2
	3 Statutory homelessness	267	3.7	2.3	9.7		0.0
	4 GCSE achieved (5A*-C inc. Eng & Maths)	1097	49.3	59.0	31.9		81.0
	5 Violent crime	3403	19.6	13.6	32.7		4.2
	6 Long term unemployment	1398	11.6	9.5	31.3		1.2
Children's and young people's health	7 Smoking in pregnancy ‡	476	16.8	13.3	30.0		2.9
	8 Starting breast feeding ‡	2109	74.5	74.8	41.8		96.0
	9 Obese Children (Year 6) ‡	391	19.2	19.2	28.5		10.3
	10 Alcohol-specific hospital stays (under 18)	14	35.5	61.8	154.9		12.5
	11 Teenage pregnancy (under 18) ‡	153	44.5	34.0	58.5		11.7
Adults' health and lifestyle	12 Adults smoking	n/a	23.7	20.0	29.4		8.2
	13 Increasing and higher risk drinking	n/a	21.0	22.3	25.1		15.7
	14 Healthy eating adults	n/a	28.0	28.7	19.3		47.8
	15 Physically active adults	n/a	56.6	56.0	43.8		68.5
	16 Obese adults ‡	n/a	24.9	24.2	30.7		13.9
Disease and poor health	17 Incidence of malignant melanoma	26	16.2	14.5	28.8		3.2
	18 Hospital stays for self-harm	551	297.4	207.9	542.4		51.2
	19 Hospital stays for alcohol related harm ‡	4310	2302	1895	3276		910
	20 Drug misuse	1445	12.0	8.6	26.3		0.8
	21 People diagnosed with diabetes	8413	5.9	5.8	8.4		3.4
	22 New cases of tuberculosis	45	25.9	15.4	137.0		0.0
	23 Acute sexually transmitted infections	1463	793	804	3210		162
	24 Hip fracture in 65s and over	180	538	457	621		327
Life expectancy and causes of death	25 Excess winter deaths ‡	98	22.3	19.1	35.3		-0.4
	26 Life expectancy – male	n/a	77.7	78.9	73.8		83.0
	27 Life expectancy – female	n/a	82.6	82.9	79.3		86.4
	28 Infant deaths	13	4.3	4.3	8.0		1.1
	29 Smoking related deaths	238	208	201	356		122
	30 Early deaths: heart disease and stroke	133	77.7	60.9	113.3		29.2
	31 Early deaths: cancer	179	106.1	108.1	153.2		77.7
	32 Road injuries and deaths	90	49.3	41.9	125.1		13.1

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

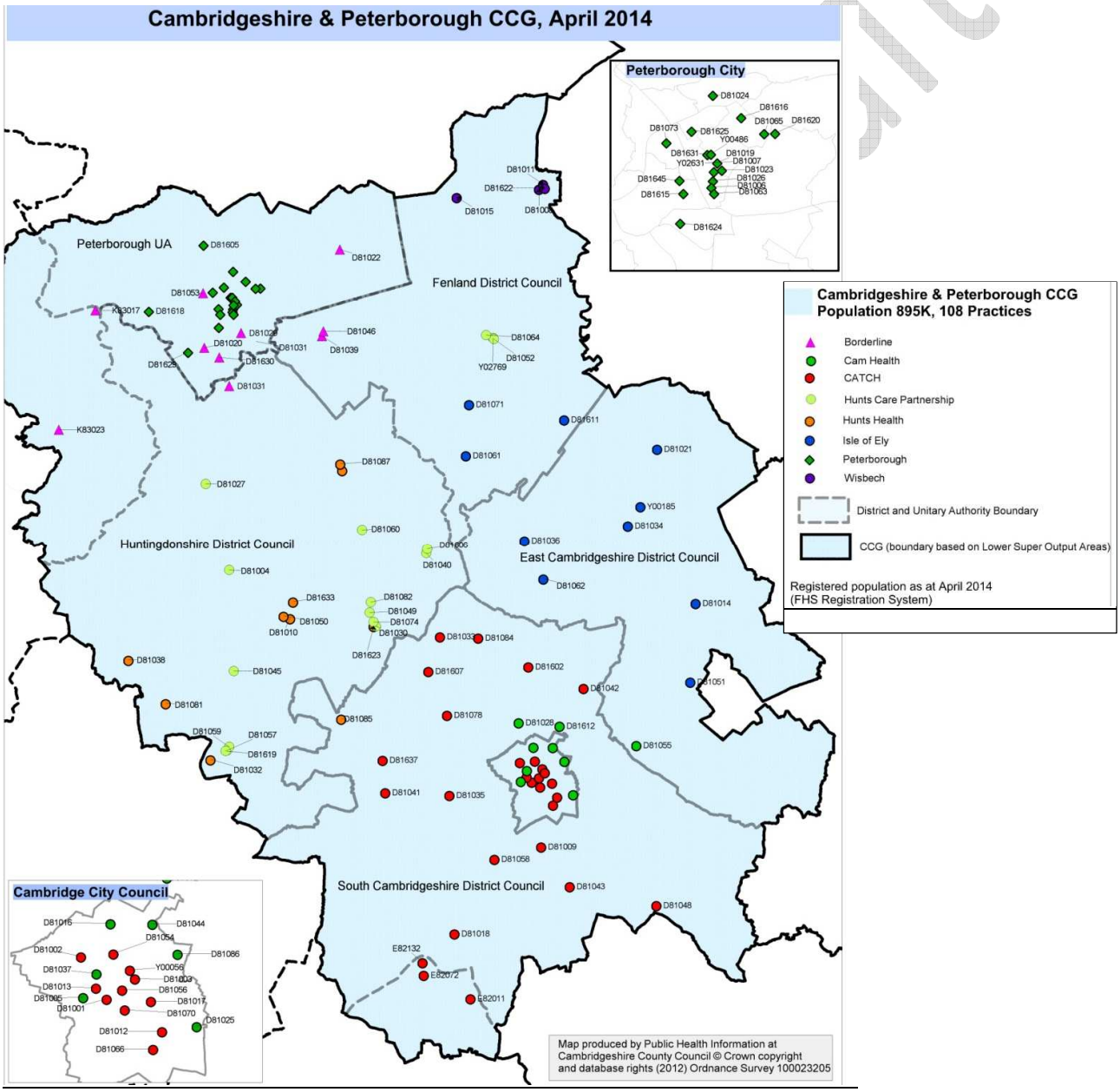
Appendix 3 provides further context around the health needs of our population, the health outcomes we want to deliver, our current position, areas where we can improve, our ambitions for improvement and next steps.

4.2 The health system across Cambridgeshire and Peterborough

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

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

Figure 11: Cambridgeshire and Peterborough CCG



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

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

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

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

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

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

4.3 Summary of services by setting of care

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

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

- Overall, the CCG and Area Team commissioned less acute care than the national average in 2013/14. The difference between the activity across Cambridgeshire and Peterborough and national comparators indicates that there were fewer elective spells, excess bed days, and first and follow-up attendances than the national average. This was partly balanced by more outpatient procedures than expected. This effect was also seen in general at LCG level.

- The CCG buys more episodes of care in hospital for patients 65 years and older than might be expected for the size of the population aged 65 and over. One possible explanation for this is that people aged 65 and over in the CCG may receive some services in acute care whereas, in other health systems, these services are delivered in another setting. Section 6.1.1 outlines the role of the Older People's and Adult Community Services Procurement in enabling care for the over 65 year old population to take place in the best possible health setting for them.

Figure 12: Summary of services by setting of care

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

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

4.4 Stakeholders in the Cambridgeshire and Peterborough health system

Stakeholder management is integral to the successful development and delivery of the System Blueprint. A stakeholder management strategy has been developed for Phase 1 of the work. As part of this, stakeholders have been categorized in groups and methods of engagement have been determined for each group as follows.

Stakeholder Group A Stakeholders for whom a significant proportion of business is to commission or deliver healthcare in the system
• *CCG Governing Body* • *Contracted NHS provider Trusts* • *Directors of Social Care, Cambridgeshire and Peterborough* • *Local Commissioning Group (LCG) Chairs and Local Chief Officers in Cambridgeshire and Peterborough* • *CCG Strategic Action Team*

Stakeholder Group B Organisations who have a section of their business interested in commissioning or delivering healthcare in the system
• *Healthwatch organisations: Cambridgeshire, Peterborough, Northamptonshire and Hertfordshire* • *CCG member practices: Cambridgeshire and Peterborough* • *Cambridgeshire County Council* • *Peterborough City Council* • *Hertfordshire County Council* • *Northamptonshire County Council* • *Health and Wellbeing Boards: Cambridgeshire, Peterborough, Northamptonshire and Hertfordshire* • *CCG Patient Reference Group* • *Health Overview and Scrutiny Committees: Cambridgeshire, Peterborough, Northamptonshire and Hertfordshire* • *Local Medical Committee (LMC)* • *CCG staff* • *Health Education England*

Stakeholder Group C People who do not have a job to commission or deliver healthcare but are still a vital part of our local health system
• *Our residents in Cambridgeshire and Peterborough* • *People who use local health services and their carers* • *Patient Forums and Patient participation groups (PPGs)* • *Independent and salaried contractors: GPs, dentists, pharmacists* • *Optometrists* • *Private and voluntary providers* • *Other Local Professional Committees* • *Media* • *Interest groups* • *Voluntary, community and third sector organisations* • *Charitable organisations* • *District Councils*

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

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

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

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

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

In Cambridgeshire the population is forecast to increase by 11% between 2011 and 2021 (65,400 people in total) with most of the increase in Cambridge City and South Cambridgeshire. In Peterborough, the population is forecast to increase by 13% between 2011 and 2021 (23,450 people in total). In Cambridgeshire and Peterborough the population aged 75 years and over is set to increase by 33% between 2011 and 2021 (20,000 people).

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

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

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

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

- People are living longer but there are significant health inequalities

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

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

- Demand for mental health services continues to increase

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

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

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

An analysis of these for Cambridgeshire and Peterborough is shown as Appendix 2. This appendix also show trajectories for improvement for these top level outcomes.

In summary theses are:

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

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

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

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

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

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

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

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

	Emergency Bed Days			Emergency Bed Days per 1000 Weighted Population		
	2012/13	2013/14	% change	2012/13	2013/14	% change
Locality Group:						
CATCH	75,946	77,886	3	477.45	473.16	-1
CamHealth	29,956	32,677	9	456.54	480.33	5
Hunts Care Partners	49,226	52,071	6	462.17	470.57	2
Hunts Health	26,362	26,333	0	462.03	444.33	-4
Isle of Ely	37,164	40,221	8	470.96	487.70	4
Wisbech	22,490	24,299	8	452.74	475.63	5
Borderline	39,706	42,499	7	433.06	438.60	1
Peterborough	50,591	53,197	5	429.80	410.74	-4
CCG overall:	331,441	349,183	5	455.74	457.93	0

Source: CCG Business Intelligence Team

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

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

Current inpatient activity

Age group	Urgent Care	Elective Care	Maternity & Paediatrics
0 - 4	4,181	1,507	1,683
5 - 19	3,456	3,816	408
20 - 39	6,702	10,088	7,643
40 - 59	8,221	22,874	323
60 - 74	8,227	27,722	-
75+	13,059	20,776	-

Current AE activity

Age group	Urgent Care
0 - 4	9,119
5 - 19	25,214
20 - 39	38,297
40 - 59	29,084
60 - 74	19,227
75+	17,971

Current outpatient activity

Age group	Elective Care	Maternity & Paediatrics
0 - 4	22,224	-
5 - 19	70,879	852
20 - 39	155,776	12,323
40 - 59	182,680	636
60 - 74	183,015	-
75+	118,485	1

Future inpatient activity (2021)

Age group	Urgent Care	Elective Care	Maternity & Paediatrics
0 - 4	4,648	1,675	1,871
5 - 19	3,889	4,294	459
20 - 39	6,890	10,371	7,858
40 - 59	8,849	24,621	348
60 - 74	9,656	32,537	-
75+	17,448	27,759	-

Future AE activity (2021)

Age group	Urgent Care
0 - 4	10,138
5 - 19	28,374
20 - 39	39,372
40 - 59	31,306
60 - 74	22,566
75+	24,011

Future outpatient activity (2021)

Age group	Elective Care	Maternity & Paediatrics
0 - 4	24,708	-
5 - 19	79,763	959
20 - 39	160,148	12,669
40 - 59	196,634	685
60 - 74	214,802	-
75+	158,308	1

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

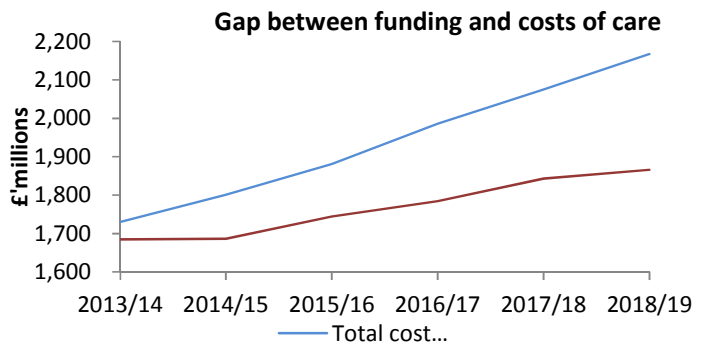
With these facts in mind PwC have modelled three financial scenarios for the whole of the Cambridgeshire and Peterborough health system for 2014-2019. The assumptions underlying this modelling are shown in appendix 4. All of these models include mental health and community care. They also include the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

Scenario 1: The "base case" scenario

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

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

Year	Health care gap £'m *(total income less total cost)*
2013/14	(46,043)
2014/15	(114,256)
2015/16	(136,199)
2016/17	(201,223)
2017/18	(231,912)
2018/19	(301,793)



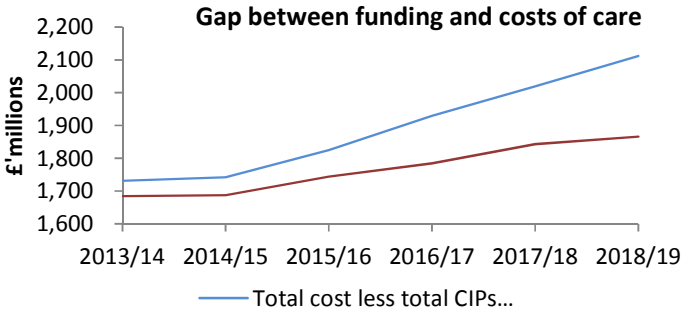
Source: PwC

Scenario 2: "Cost Improvement Plans achieved"

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

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

Year	Health care gap £'m *(total income less total cost)*
2013/14	(46,043)
2014/15	(55,610)
2015/16	(80,338)
2016/17	(145,362)
2017/18	(176,051)
2018/19	(245,932)



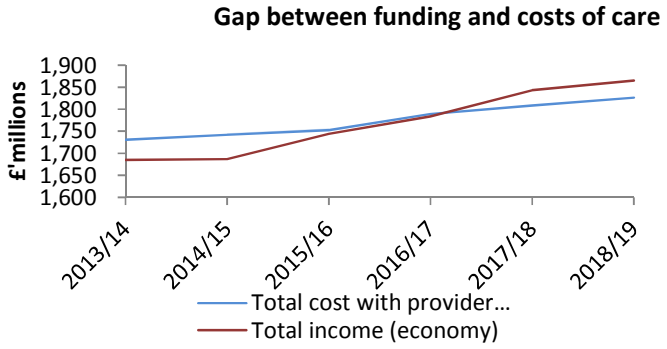
Source: PwC

Scenario 3: "Year on year efficiency savings"

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

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

Year	Health care gap £'m *(total income less total cost)*
2013/14	(46,043)
2014/15	(55,480)
2015/16	(8,083)
2016/17	(4,912)
2017/18	34,819
2018/19	39,084



Source: PwC

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

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

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

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

Achieving this alignment will involve a several approaches:

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

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

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

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

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

5.4 The challenges facing primary care across Cambridgeshire and Peterborough

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

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

Challenges facing General Practice nationally include:

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

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

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

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

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

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

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

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

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

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

6.1 The commissioner context: ongoing transformational programmes in the CCG

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

6.1.1 Older People and Adult Community Services (OPACS) procurement

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

- An innovative Framework for improving outcomes which goes beyond traditional organisational boundaries
- A new contracting approach which combines a capitated budget with Payment By Outcomes to enable a population approach to service delivery, align incentives in a better way than current funding mechanisms allow, in a way which is consistent with the CCG's long term financial plan
- A 5 + 2 year contract term to enable investment and transformation
- A Lead Provider responsible for the whole pathway, providing leadership and operational coordination

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

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

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

Case for Change

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

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

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

Critical Success Factors

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

- improve patient experience and service quality for patients and their carers through care organised around the patient
- deliver services which are sensitive to local health and service need, as defined in the Local Requirements
- move beyond traditional organisational and professional boundaries, so front-line staff can work effectively and flexibly together to deliver seamless care
- support older people to maintain their independence and reduce avoidable emergency admissions, re-admissions and extended stays in acute hospitals (including delayed transfers of care)
- deliver an organisational solution for older people's care which can demonstrate strong leadership, sound governance, resilience, and the confidence of commissioners and provider partners
- demonstrate credible approach to engaging patients and representative groups in design and delivery of services
- provide a sustainable financial model (see Financial Principles below)

Financial Principles

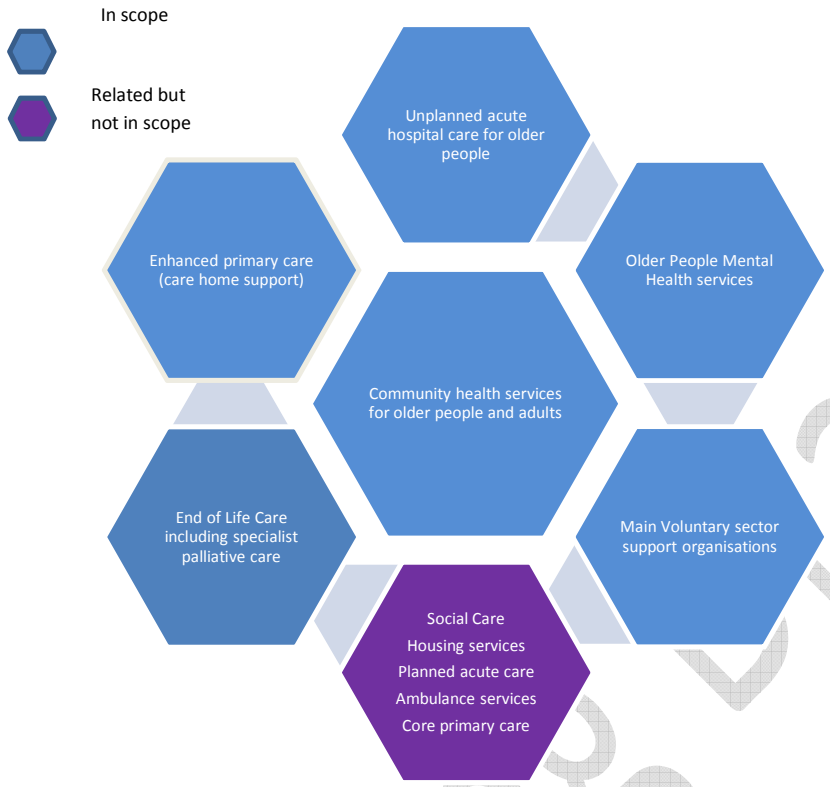
The CCG has agreed the following financial principles which have been used to develop the financial framework and to evaluate solutions:

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

Services to be Provided

The core scope of services is acute unplanned hospital care for older people (65 and over), older people's mental health services and older people and adult community services. The entire range of services relevant to the care of older people is shown in Figure 20: Service range. The underlying principle is to create an integrated care pathway between all of these services including the Services which are the subject matter of this Procurement.

Figure 20: Service range



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

Whilst the full range of social care and funding is not in the scope of the procurement, the CCG is working closely with Local Authority partners on the procurement and wider Older People Programme. Cambridgeshire County Council, Peterborough City Council and District Council representatives have been integrally involved in steering the programme and also in the detailed dialogue and evaluation associated with the procurement. There is a strong alignment and synergy between the OPACS work and the aims of the Better Care Fund which will enable and support it.

Outcomes Framework

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

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

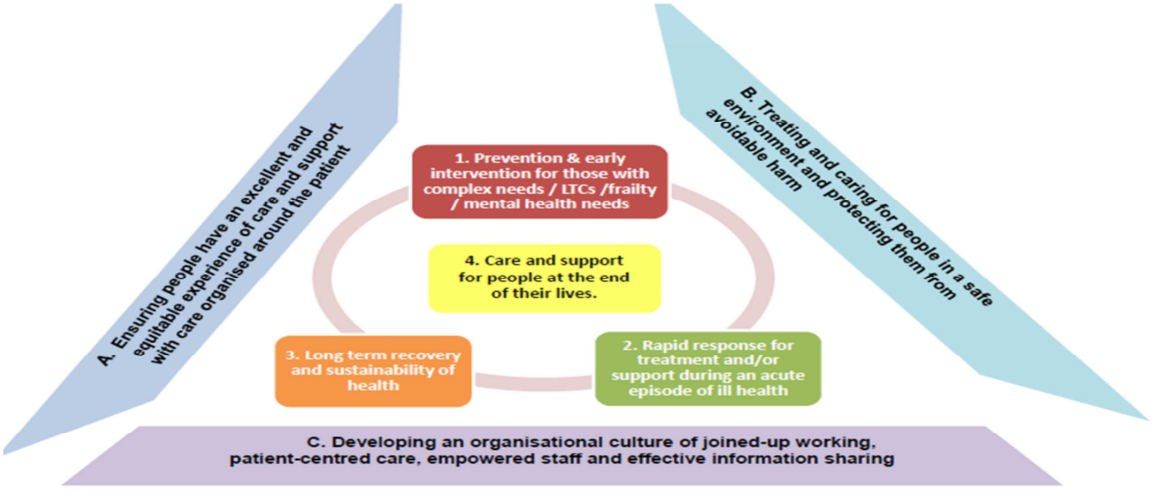
value of the Contract will be paid on achievement of the Outcomes Framework Indicators, which are designed as markers of a high quality, improved service which is financially sustainable.

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

Outcomes Framework Structure

The Outcomes Framework covers seven outcome domains as shown below.

Figure 21: Outcomes Framework Domains



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

Summary

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

6.1.2 Enhancing Integration and Joint Commissioning through the Better Care Fund

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

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

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

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

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

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

Design principles for the Care Design Group process

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

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

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

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

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

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

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

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

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

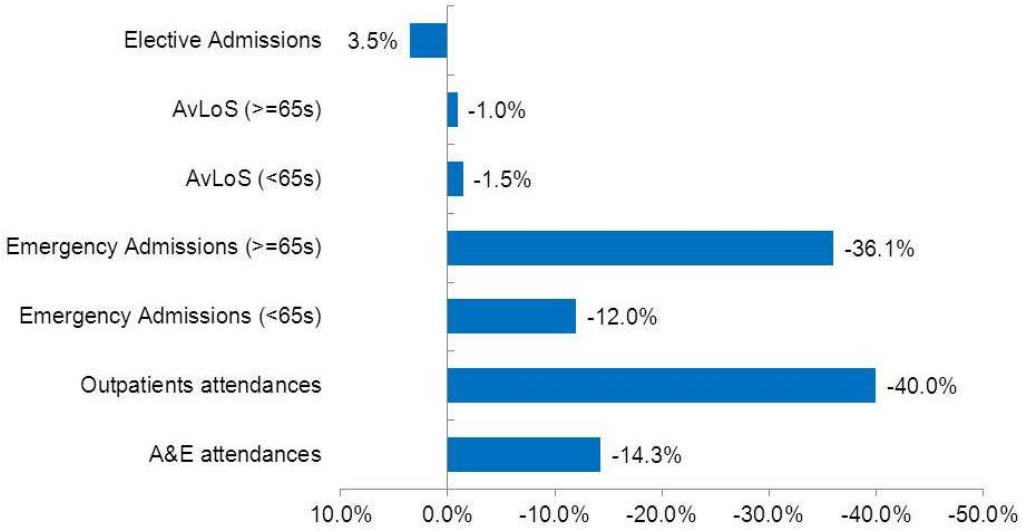
The possible interventions that came out of the Elective and Non- Elective Care Design Group process have been assessed by PwC.

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

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

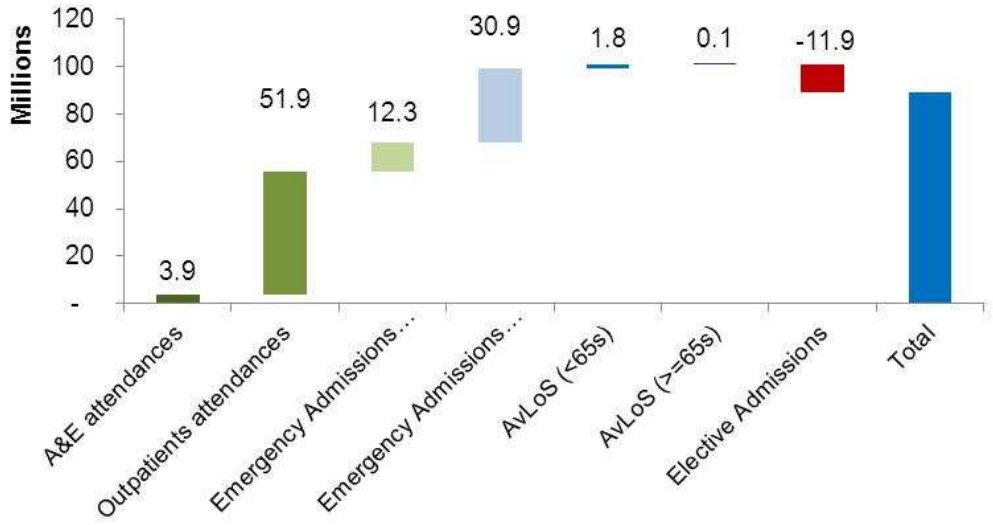
- Deliver health services differently i.e. transform areas of the health system
- Reduce the demand for healthcare

Figure 22: Impact on activity



Source: PwC

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



Source: PwC

8. Conclusions from planning work to date

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

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

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

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

9. Enablers for Change

9.1 Quality Strategy for Cambridgeshire and Peterborough

The System Blueprint articulates the imperative for fundamental change and service redesign across the Cambridgeshire and Peterborough system. Any period of change affords an opportunity to innovate and do things better, and the system-wide "Quality Promise" shown here embeds quality improvement as central to the changes in the health system.

In essence the Quality Promise will be an explicit driver for change and continuous improvement in service delivery and the custodian of positive patient experiences.

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

The Quality Promise Statements

Cambridgeshire and Peterborough System will:

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

9.2 Cambridge and Peterborough Workforce

Baseline

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

Between 2000 and 2010 the local workforce in Cambridgeshire and Peterborough grew by 60%. This is faster than the workforce growth across the other counties in the East of England (EoE).

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

All of which were above the respective average growth rates for EoE. After the 10-year growth, in 2010 staff numbers per population in the area were above EoE average and above the average for England.

Projections

Following a review of the 2013/14 workforce plans it is evident that the system is facing significant efficiency savings gap; workforce capacity gap estimated at 5.6% p.a. over the next 5 years.

The workforce plans demonstrate that overall establishment levels are forecast to reduce in the next 5 years by 4%; with the most significant reductions taking place in Community and Mental Health sectors (11%) and by 1.5% in acute care.

Figure 24: Establishment by profession 2013-2018

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

Figure 25: Establishment plan by sector: 2013-2018

Sector	Organisation	Estab FTE March 2013	Estab FTE March 2018	FTE Change	% Change	EoE average
Acute	Org 1	8194	7895	-299	-4%	
	Org 2	1505	1452	-52	-3%	
	Org 3	1644	1802	158	10%	
	Org 4	3511	3531	20	1%	
Acute Total		**14854**	**14680**	**-174**	**-1%**	**-2%**
Community	Org 5	2664	2254	-411	-15%	
Community Total		**2664**	**2254**	**-411**	**-15%**	**-11%**
Mental Health	Org 6	2250	2004	-246	-11%	
Mental Health Total		**2250**	**2004**	**-246**	**-11%**	**-11%**

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

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

Skill Mix

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

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

National Workforce Priorities

HEEoE invests up to £67m each year into the workforce within Cambridge and Peterborough, a significant amount of this is aligned to contracts with Education Providers. As 70% of the healthcare workforce in 2020 are currently employed in the NHS in the East of England, consideration should be given to the education and development needs of this workforce to enable them to continue to deliver high quality care and support the implementation of new models of care delivery.

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

- Explore the impact of National Quality Board Safe Staffing guidance on nursing and midwifery workforce planning requirements
- Maintain midwifery training numbers at a sufficient level to meet service demand
- Continue to deliver “Call to Action for Health Visiting” in order to achieve sufficient health visitor by April 2015, ensuring a smooth transition of health visitors to Local Government from April 2015
- Commission Improving Access to Psychological Therapies (IAPT) Training places at a sufficient levels and numbers to meet service demand and commissioning intentions across all aspects of the IAPT programme to 2015
- In collaboration with East Anglia Ambulance Trust, support the delivery of up to 550 paramedics through two strands; degree and technician training route
- Increase Mental Health awareness across all front line staff
- Recruit, retain and develop staff based on the NHS Constitution Values
- Increase GPs in training by 50% by 2016

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

Local Workforce Priorities

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

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

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

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

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

Primary Care

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

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

9.3 Information management and technology

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

Strategic context for information management and technology

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

Current position:

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

Areas where we can improve IT across the health system:

The following have been identified as areas for improvement:

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

The CCG, together with NHS England, GP practices, acute and community providers have a number of active programmes to allow patients and carers to manage and share data on their own care. These include the provision of Summary Care Records, Electronic Prescription Service, patient access to selected electronic services within GP practices (e.g., ordering repeat prescriptions, booking appointments, patient record access, etc). Completion statistics are reported to the respective national leads. The CCG is also working with providers to encourage them to enable their clinical systems to allow greater patient and carer involvement.

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

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

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

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

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

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

PROGRAMME VISION:
Integrated technologies supporting Integrated Care across Cambridgeshire and Peterborough

PROGRAMME AIM:

- To ensure safe and effective technologies are available for people to be proactively supported to maintain their health, wellbeing and independence for as long as possible, and support care in their home and local communities wherever possible
- For technologies to be used in an integrated way, with systems supporting services organised around the patient

- To ensure that introduction of systems meet local needs, adhere to national requirements and are implemented based on best practice
- To ensure systems provide value in support of good and efficient care with measurable outcomes
- To enable introduction of systems that support identification of the most appropriate services and clinical pathways for the patient
- To support availability of essential clinical information in unscheduled care settings to aid clinical decision making and inform patient care.
- To facilitate exploitation of joint procurement options for introduction of common technologies across service providers
- Supporting QIPP initiatives across all LCGs

The headline outcomes milestones and projects are shown below.

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

Improved and timely access to clinical information across health and social care service boundaries

Standardisation of information recording, reporting and sharing

Improved business intelligence through standardised reporting

Common electronic clinical records supporting integrated care

Figure 27: Key Projects - Milestones

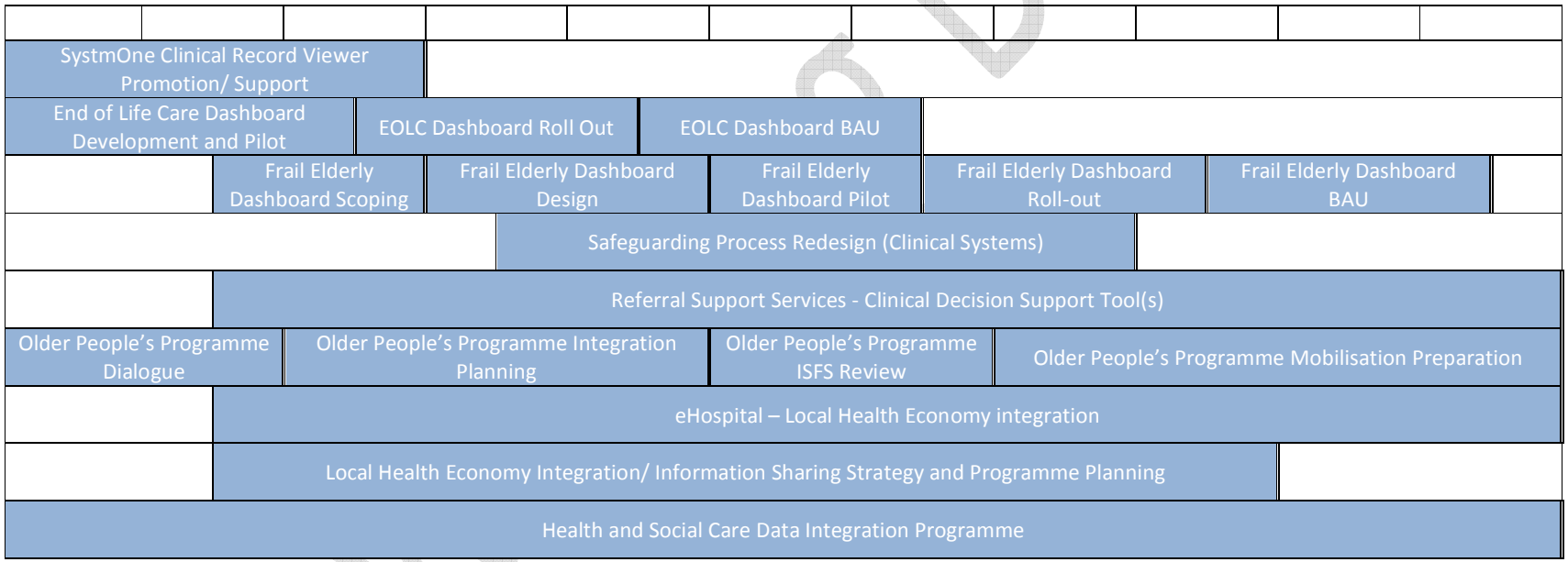


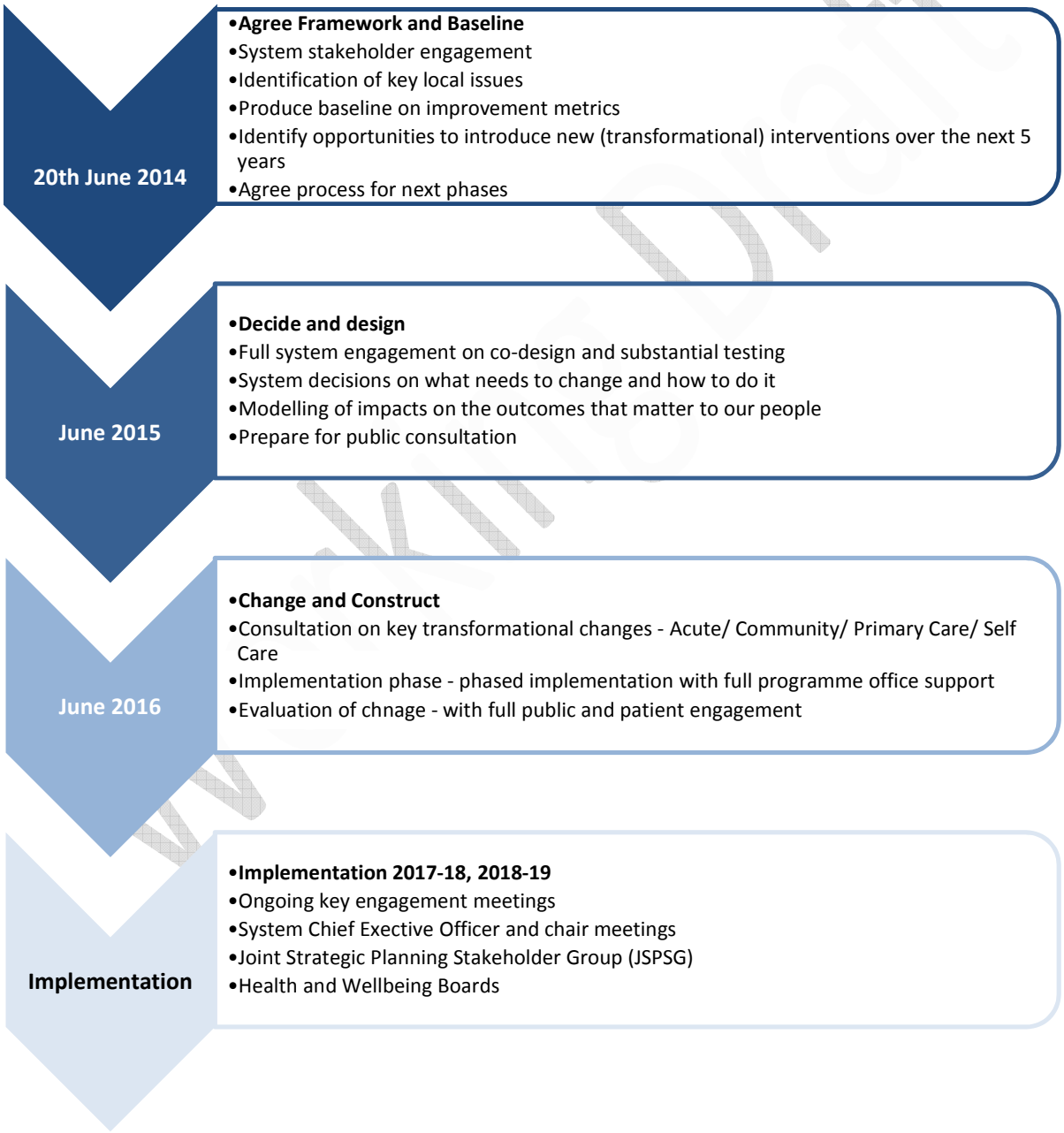
Figure 28: Projects descriptions

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

10.Forward process for the Cambridgeshire and Peterborough System Blueprint

The Cambridgeshire and Peterborough Chief Executives Group are working to agree the governance and delivery arrangements for this strategic planning work. A concordat on joint working is in the process of being signed off by the organisations in the system. Proposals on a delivery structure and resourcing for the next phase of this process will be considered by the Chief Executives Group on 27th June 2014.

Figure 29: Phases of work



11.Risks

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

Figure 30: Risks to Blueprint Production

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

Figure 31: Risks to Blueprint Delivery

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

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

Appendices

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[2] 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[3] . 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 al"l 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.

[2] Wanless, D (2004) Securing Good Health for the whole population . HSMO: Norwich.
[3] 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 [4] 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.

[4] 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

As mentioned above, 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 reducing 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 the Potential Years ofLlife 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, then 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

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

CCG INPUT TO BE ADDED

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.

A1.5 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.[5]
- 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 Peoples 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 health system efficienct.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"[6] 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.

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

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

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

- 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[7]. 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[8]. There is also anecdotal evidence from clinical colleagues on the impact of people in our system because of sub-optimal integration.

The process of designing the Older Peoples 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.[9]

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

[7] http://www.kingsfund.org.uk/sites/files/kf/integrated-care-patients-populations-paper-nuffield-trust-kings-fund-january-2012.pdf
[8] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212896/Interim-Integration-Measures-for-Patient-Experience.pdf
[9] 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

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.

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[10], 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

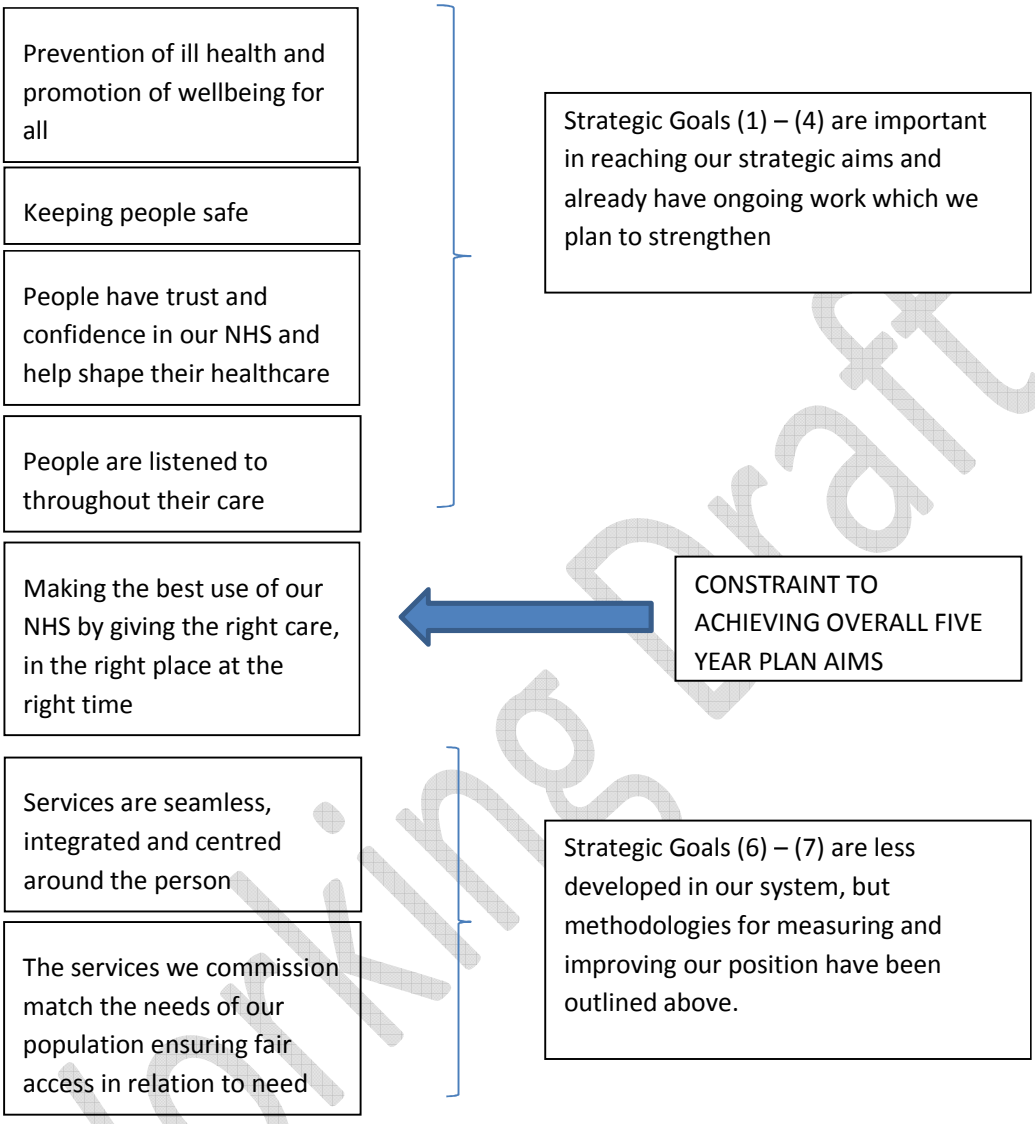
- Ambition 1: Improving outcomes for people: Securing additional years of life for our local population with treatable conditions as measured by potential years of life lost (PYLL) from causes amenable to healthcare

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

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



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

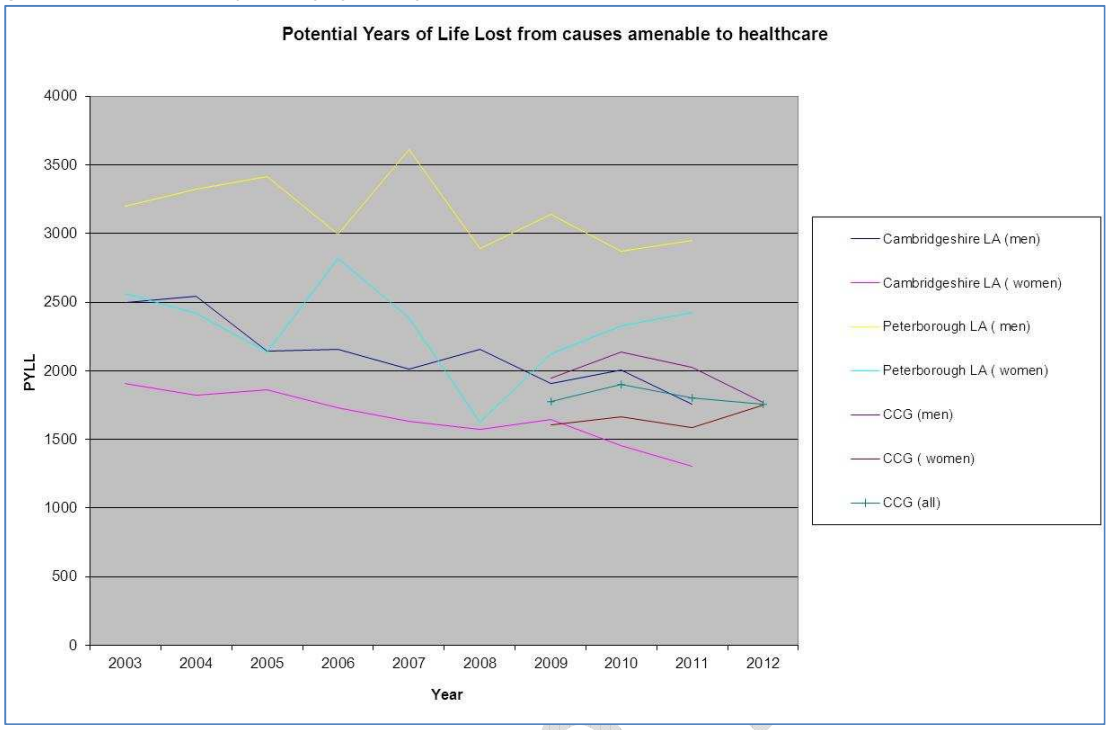
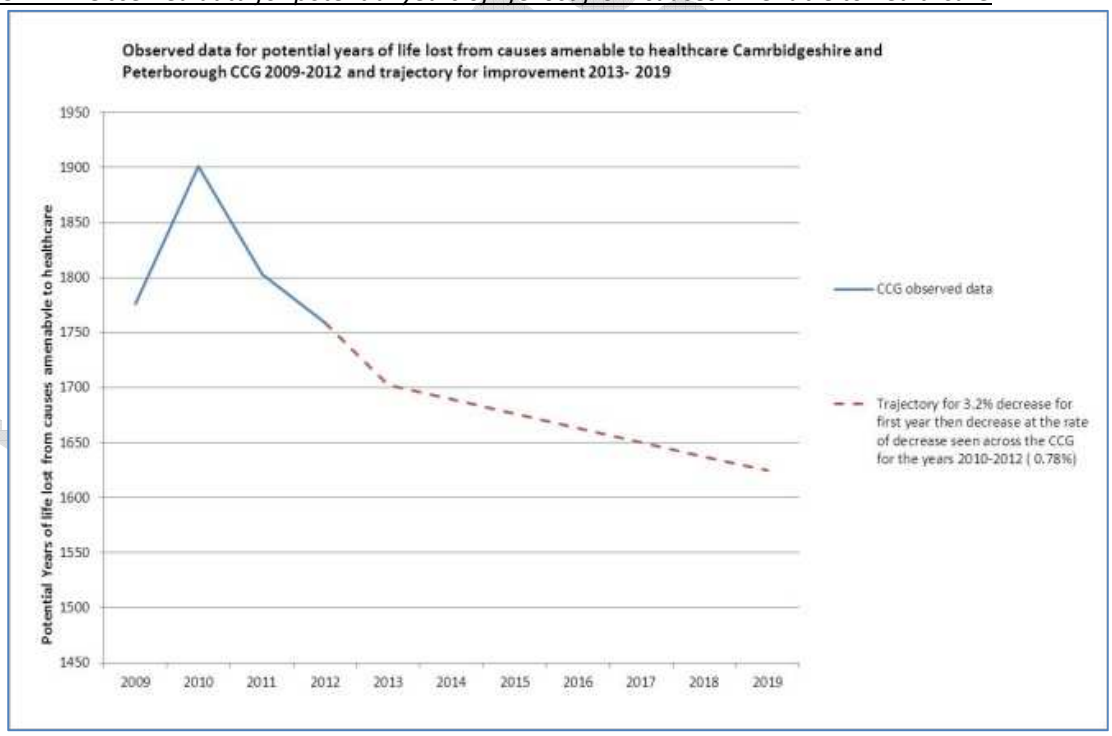


Figure A2-2: Observed data for potential years of life lost from causes amenable to healthcare



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

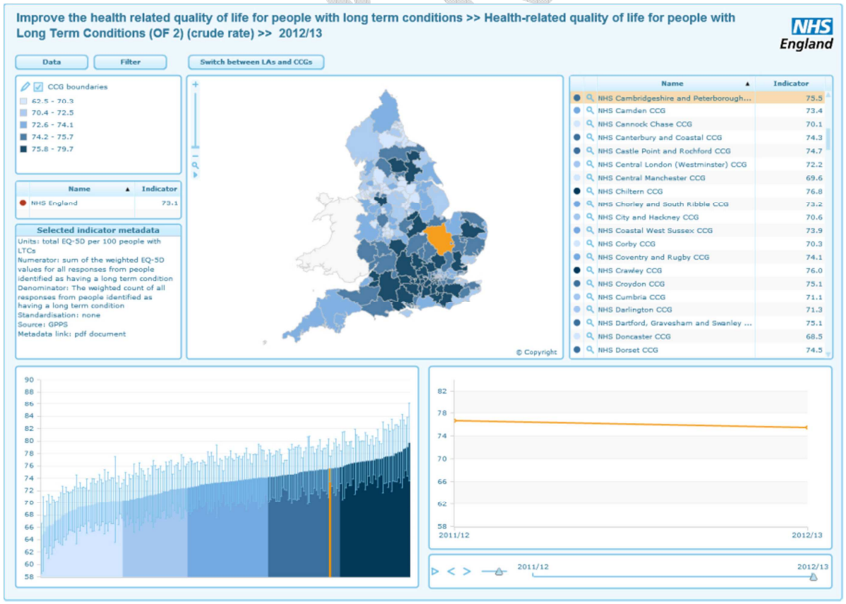
Experience of using this indicator to measure health and wellbeing at a population level is limited. The natural history of change over time for this indicator is unclear: as people get older their EQ 5D may deteriorate anyway for reasons unrelated to healthcare -so this makes assessing areas for improvement 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.

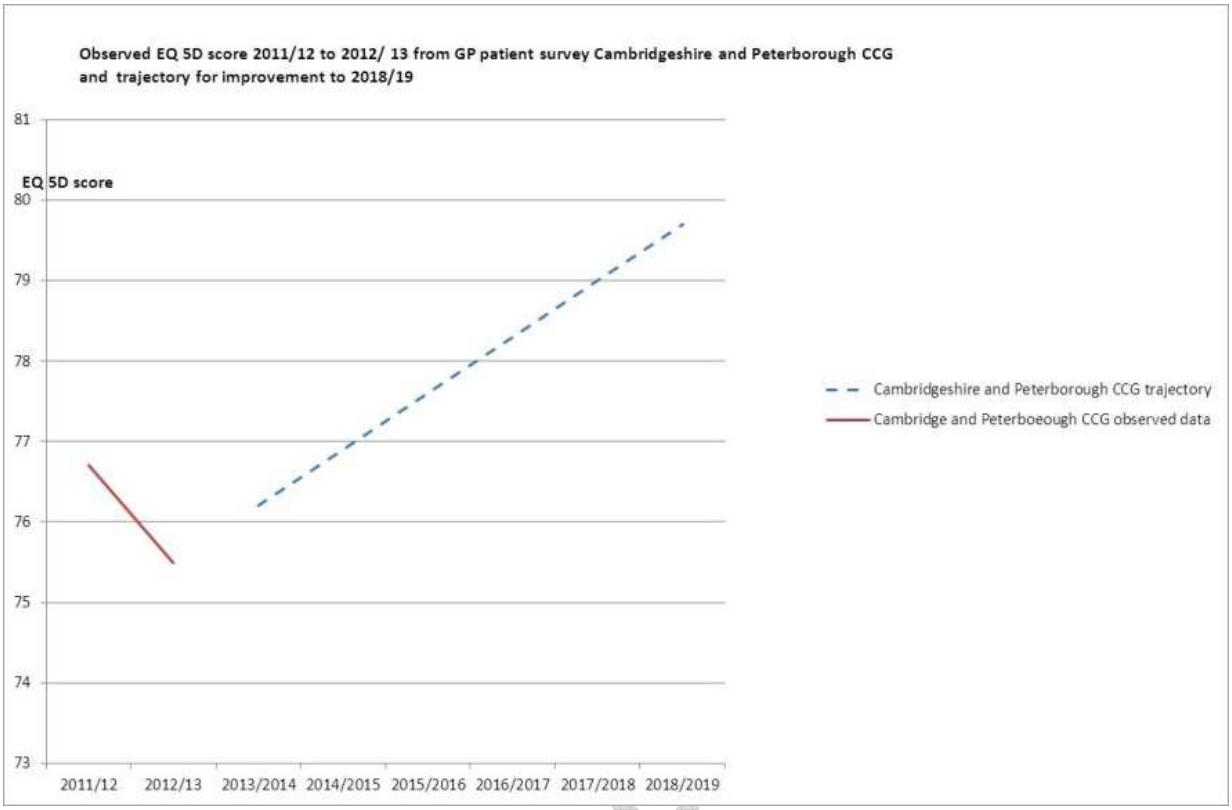
Ambition for improvement

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, eg - 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	Peterboro' relative position	Peterboro' 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

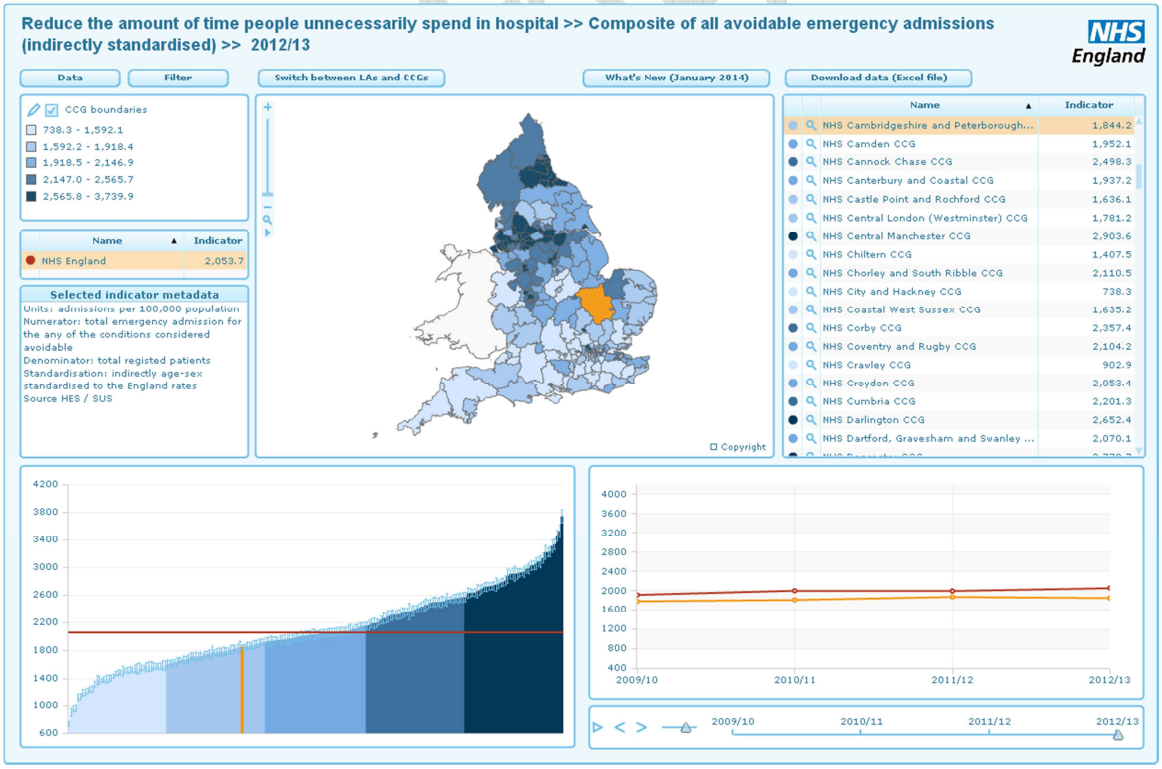
Together, these areas account for almost 80% of the 2013/14 admissions in this category to date.

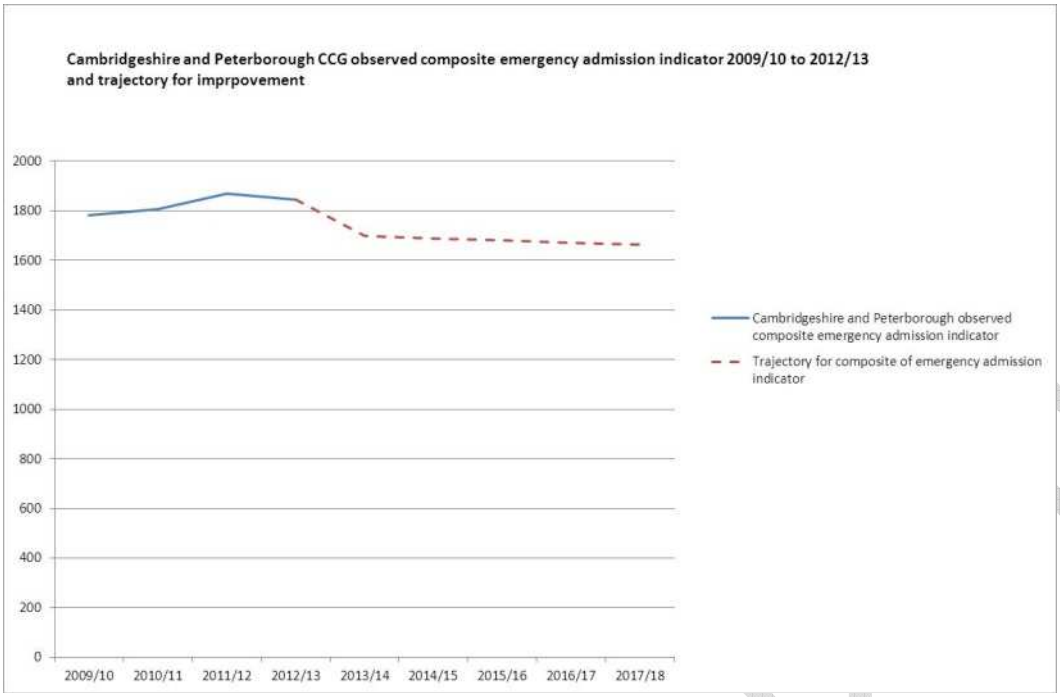
Ambition for improvement

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

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

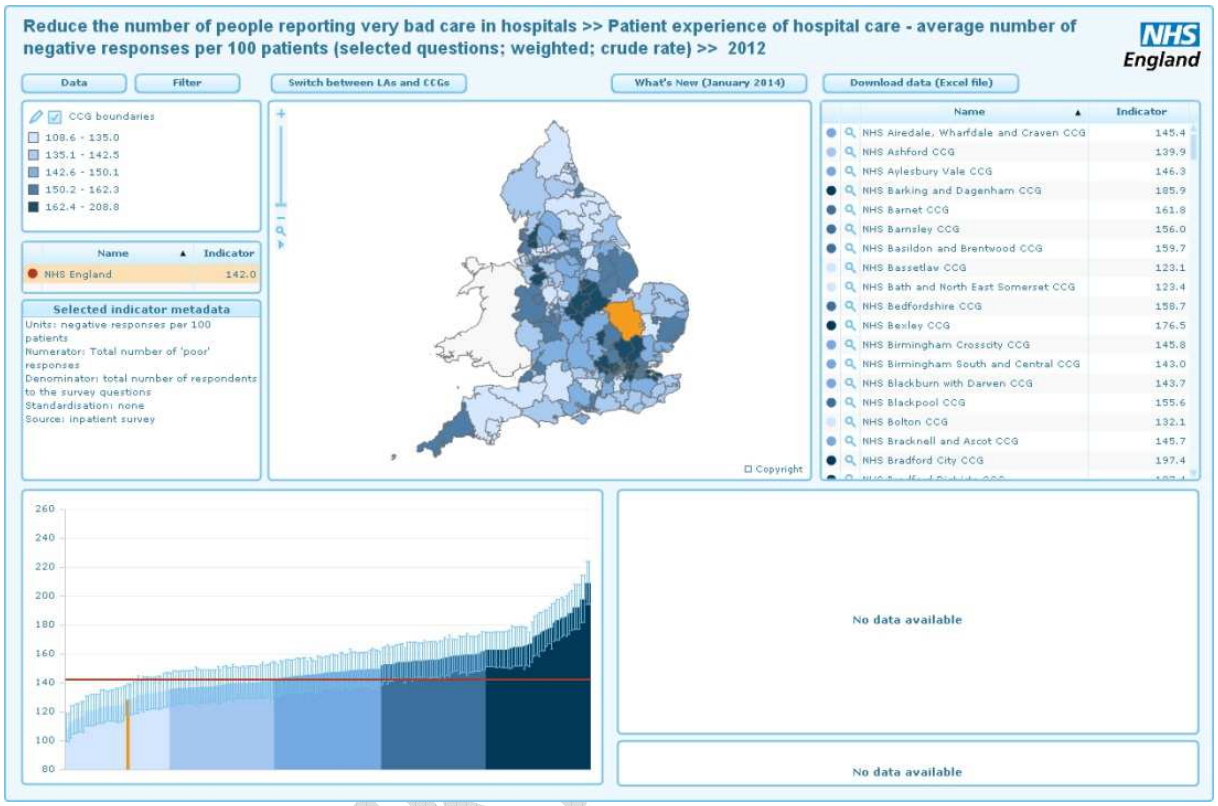
Next Actions

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:

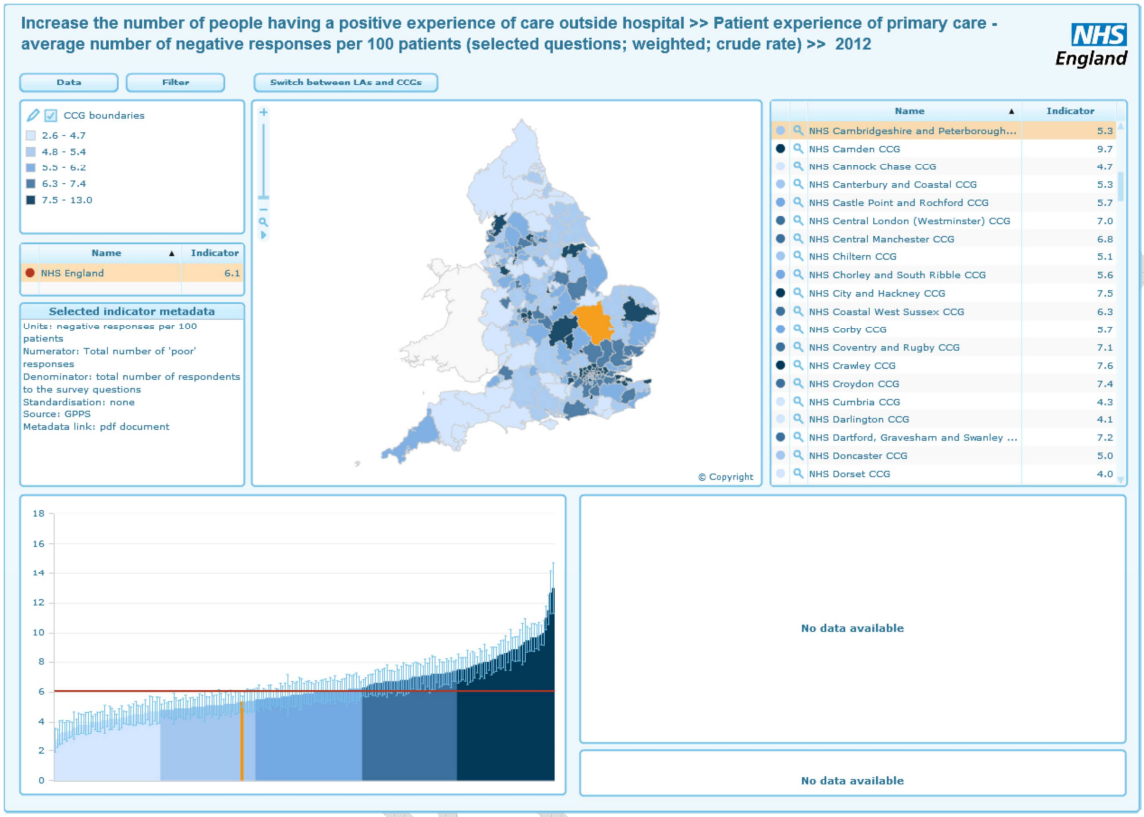
- "Overall, how would you describe your experience of your GP surgery?"
- "Overall, how would you describe your experience of Out of Hours GP services?

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 CAPCCG 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, eg 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

Future Actions for consideration by the Quality Directorate in monitoring and reducing avoidable deaths

Include the following in the Quality dashboard (form NHS Outcomes framework)

- Deaths involving VTE
- Incidence of medication errors causing severe harm or death
- Admission of full term babies to neonatal care
- Incidence of harm to children due to failure to monitor

Accuracy of clinical coding is essential to get good data to identify cases to review and analyse. We will consider undertaking a themed review of clinical coding by providers, including validation of their coding processes and outcomes. Introduce KPIs e.g. review of all emergency admissions within 24 hours by a consultant; more consultant presence in ward areas with no other clinical commitments when they are on call; more MDT reviews. Embed definitions and review processes of new national 'avoidable deaths' when they become available.

Appendix 3 : JSNA summary

JSNA Summaries: Cambridgeshire and Peterborough CCG
February 2014

Notes:
This document is a working draft
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_assesmen/keeping_people_safe.aspx Children and Young People Safeguarding JSNA - Peterborough http://www.peterborough.gov.uk/pdf/HealthAndSocialCare-JSNA-ChildrenAndYoungPeopleSafeguarding.pdf Cambridgeshire Childrens 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 followiing 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 • Increae awareness of mental health problems amongst those caring for older people; developing integrated services for mental health which facilitate early intervention and support older	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	

Area	Key issues	Recommendations	Gaps	Links and other notes
		people and their carers in the community. • • 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.	the needs of older people as in specific groups eg 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	• 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
	wit h high levels of deprivation. These areas also correlate to higher levels of childhood obesity as identified through the National Child Measurement Programme			
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 34thth 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	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	Alcohol actions in Cambridgeshire?	http://www.peterborough.gov.uk/pdf/HealthAndSocialCare-JSNA-Alcohol.pdf

Area	Key issues	Recommendations	Gaps	Links and other notes
	indicators including hospital admissions specifically caused by alcohol, aspects of alcohol related crime, and binge drinking.	• 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 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		Dietary habits in Cambs and recommendations	http://www.cambridgeshireinsight.org.uk/older-people-including-dementia/facts-figures-and-trends

Area	Key issues	Recommendations	Gaps	Links and other notes
	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.		for this	http://www.peterborough.gov.uk/health_and_social_care/joint_strategic_needs_assesmen/how_we_live_affects_our_health.aspx
Smoking	Peterborough: calculated prevalence of current cigarette is 27% which is significantly higher than England (22.2%) and the region.. Peterborough has a si 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			Peterborough Health and Social Care JSNA 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	Gypsies and Travellers make up almost 1% of	• better data collection and ethnic	Investigation into	Cambridgeshire JSNA on travellers 2010

Area	Key issues	Recommendations	Gaps	Links and other notes
Travellers	the population in Cambridgeshire representing the largest ethnic minority in the county. Gypsies and Travellers have • significantly poorer health status (in Peterborough on ly 55% reported no health problems) • more self-reported symptoms of ill-health than the rest of the population • reported health problems being between two 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.	monitoring. • promotion of immunisations and screening. • Mental health specialist support services. • Male health specialist support services. • More support around complex health needs. • Raising awareness of the Gypsy and Traveller community with professionals. • Training health champions from the Gypsy and Traveller community.	infant and maternal mortality and prevalence of disabilities	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_assessmen/we_are_not_all_the_same.aspx More information on Peterborough travellers in 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,	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
		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		
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	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

Area	Key issues	Recommendations	Gaps	Links and other notes
		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.		
People with learning disabilities	Cambridgeshire: As the population grows and ages, the number of people with disabilities is also expected to rise. 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	• Health checks for adults with learning disability are important to reduce inequalities in accessing healthcare. 75% of 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		Cambridgeshire JSNA on adults and children with physical and learning disabilities through the lifecourse http://www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/physical-disabilities-and-learning

Area	Key issues	Recommendations	Gaps	Links and other notes
	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 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	• 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	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	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
	barriers to accessing mental health services.	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 the 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	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 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:

	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

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: CDG 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.

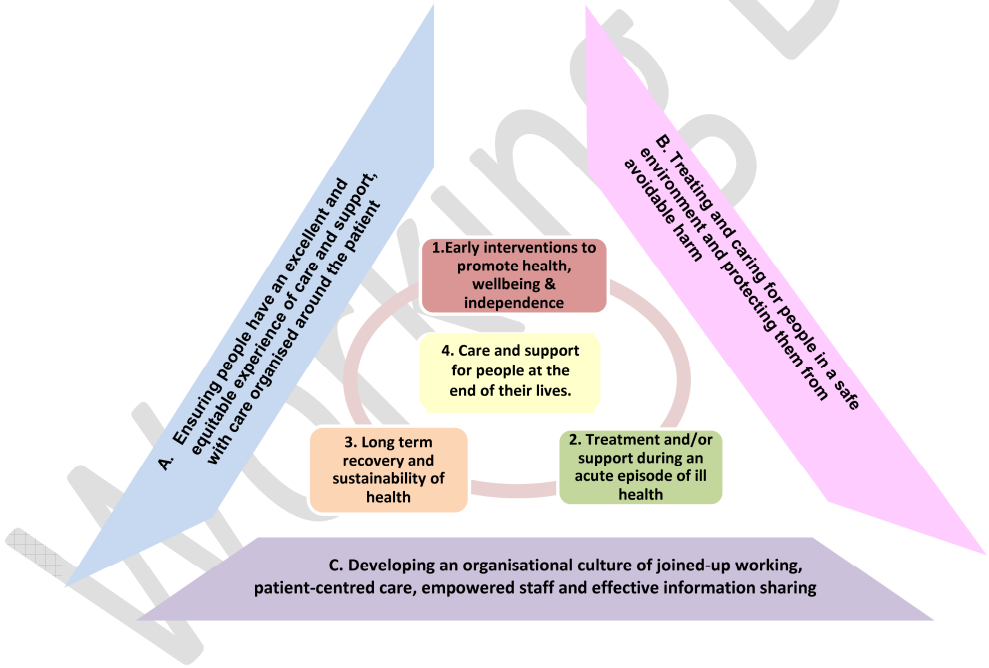
Delivery requirements	Significant consultation process would be required if this is determined to be a viable option. Detailed modelling to understand the impact on other services, sites and LHEs. Improved "gatekeepers" to A&E will be required to minimise pressure on other sites, accompanied by strong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

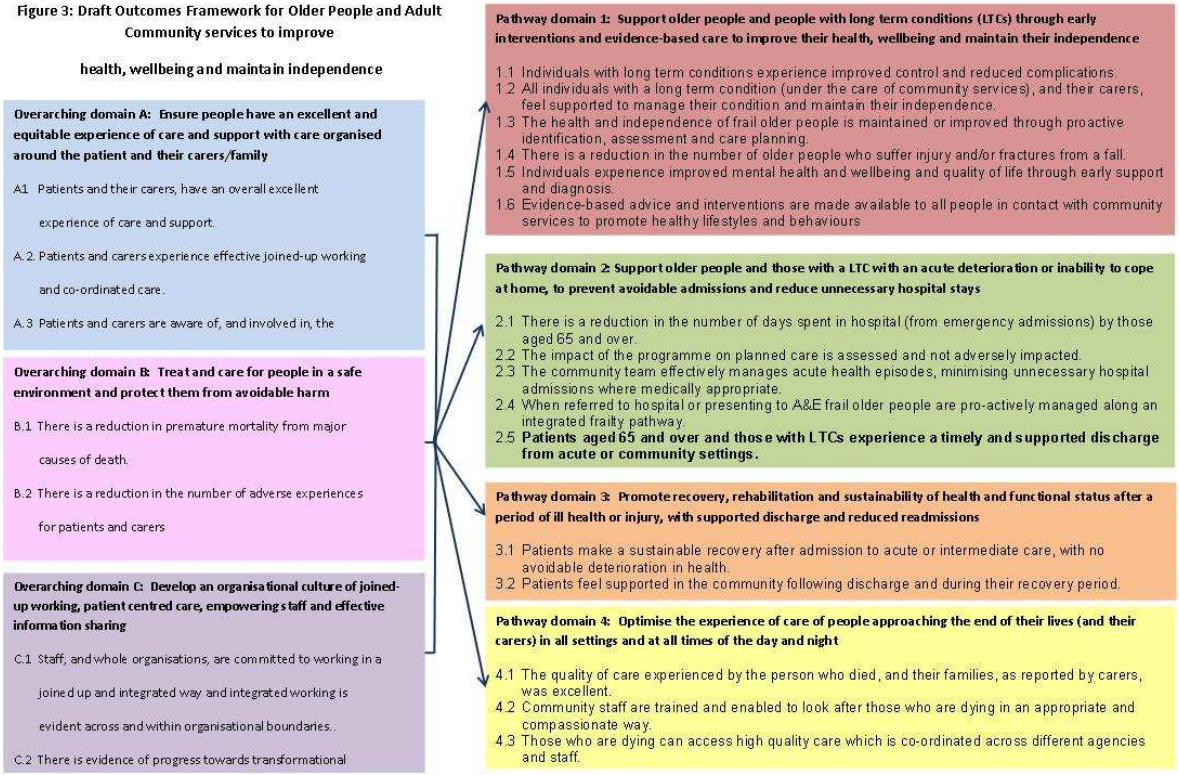
Urgent 6: Closer links between GPs and the ambulance service

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.
	 **Figure 3: Draft Outcomes Framework for Older People and Adult Community services to improve** **health, wellbeing and maintain independence** **Overarching domain A: Ensure people have an excellent and equitable experience of care and support with care organised around the patient and their carers/family** A1 Patients and their carers, have an overall excellent experience of care and support. A.2. Patients and carers experience effective joined-up working and co-ordinated care. A.3 Patients and carers are aware of, and involved in, the **Overarching domain B: Treat and care for people in a safe environment and protect them from avoidable harm** B.1 There is a reduction in premature mortality from major causes of death. B.2 There is a reduction in the number of adverse experiences for patients and carers **Overarching domain C: Develop an organisational culture of joined-up working, patient centred care, empowering staff and effective information sharing** C.1 Staff, and whole organisations, are committed to working in a joined up and integrated way and integrated working is evident across and within organisational boundaries. C.2 There is evidence of progress towards transformational **Pathway domain 1: Support older people and people with long term conditions (LTCs) through early interventions and evidence-based care to improve their health, wellbeing and maintain their independence** 1.1 Individuals with long term conditions experience improved control and reduced complications. 1.2 All individuals with a long term condition (under the care of community services), and their carers, feel supported to manage their condition and maintain their independence. 1.3 The health and independence of frail older people is maintained or improved through proactive identification, assessment and care planning. 1.4 There is a reduction in the number of older people who suffer injury and/or fractures from a fall. 1.5 Individuals experience improved mental health and wellbeing and quality of life through early support and diagnosis. 1.6 Evidence-based advice and interventions are made available to all people in contact with community services to promote healthy lifestyles and behaviours **Pathway domain 2: Support older people and those with a LTC with an acute deterioration or inability to cope at home, to prevent avoidable admissions and reduce unnecessary hospital stays** 2.1 There is a reduction in the number of days spent in hospital (from emergency admissions) by those aged 65 and over. 2.2 The impact of the programme on planned care is assessed and not adversely impacted. 2.3 The community team effectively manages acute health episodes, minimising unnecessary hospital admissions where medically appropriate. 2.4 When referred to hospital or presenting to A&E frail older people are pro-actively managed along an integrated frailty pathway. 2.5 **Patients aged 65 and over and those with LTCs experience a timely and supported discharge from acute or community settings.** **Pathway domain 3: Promote recovery, rehabilitation and sustainability of health and functional status after a period of ill health or injury, with supported discharge and reduced readmissions** 3.1 Patients make a sustainable recovery after admission to acute or intermediate care, with no avoidable deterioration in health. 3.2 Patients feel supported in the community following discharge and during their recovery period. **Pathway domain 4: Optimise the experience of care of people approaching the end of their lives (and their carers) in all settings and at all times of the day and night** 4.1 The quality of care experienced by the person who died, and their families, as reported by carers, was excellent. 4.2 Community staff are trained and enabled to look after those who are dying in an appropriate and compassionate way. 4.3 Those who are dying can access high quality care which is co-ordinated across different agencies and staff. http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/CCG/Have%20your%20say/Outcomes%20Framework%20Mark%202%20-%20final.pdf

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, 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

WOMEN AND CHILDREN	
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 10. Maternal mental health assessments included in Maternity Pathway 11. Services are seamless integrated and centred around the patient 12. 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 well being.

WOMEN AND CHILDREN	
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.
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 (eg 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 eg 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, eg 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'[11]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[12].

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)[13]

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

[11] 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

[12]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

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

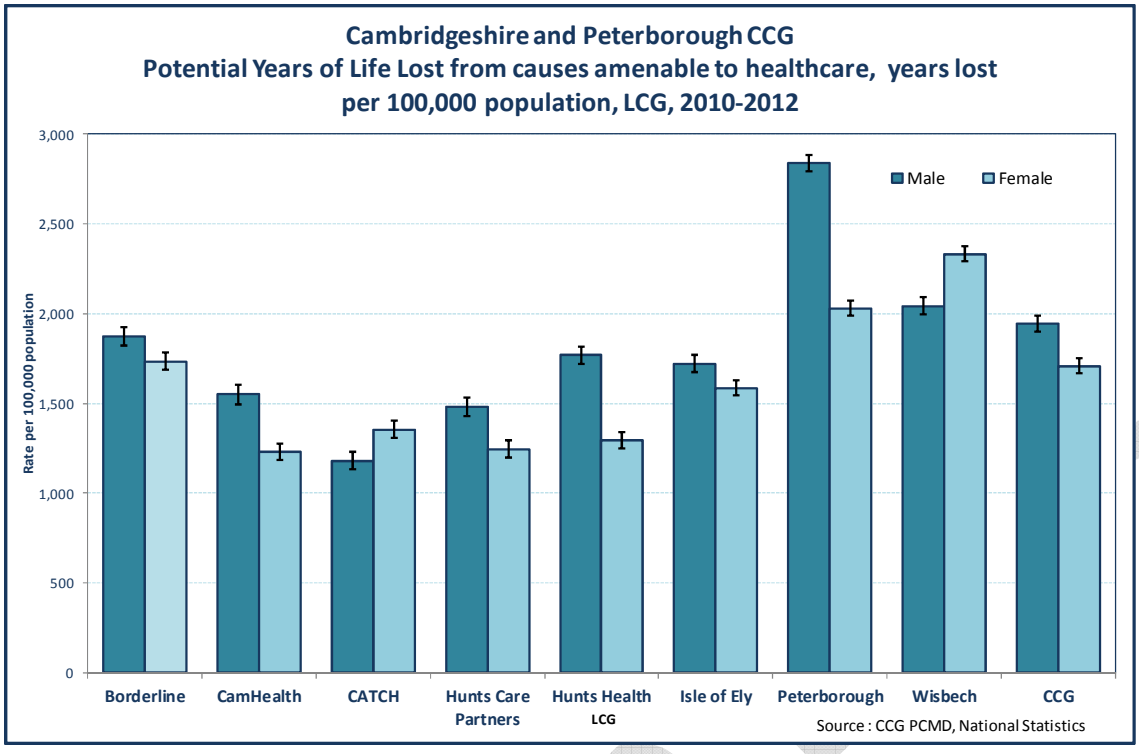


Figure A7-1: Potential Years of Life Lost (PYLL), rate per 100,000 population, by sex and LCG, 2010 - 2012

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)[14], but there is evidence of inequality by geography and by gender[15].

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

[15] 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[16]. 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)[17]. 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[18] and published literature[19][20] 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:

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

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

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

[19] 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.

[20] 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[21] 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):

[21] 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[22] 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

[22] 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, eg 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, eg 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:

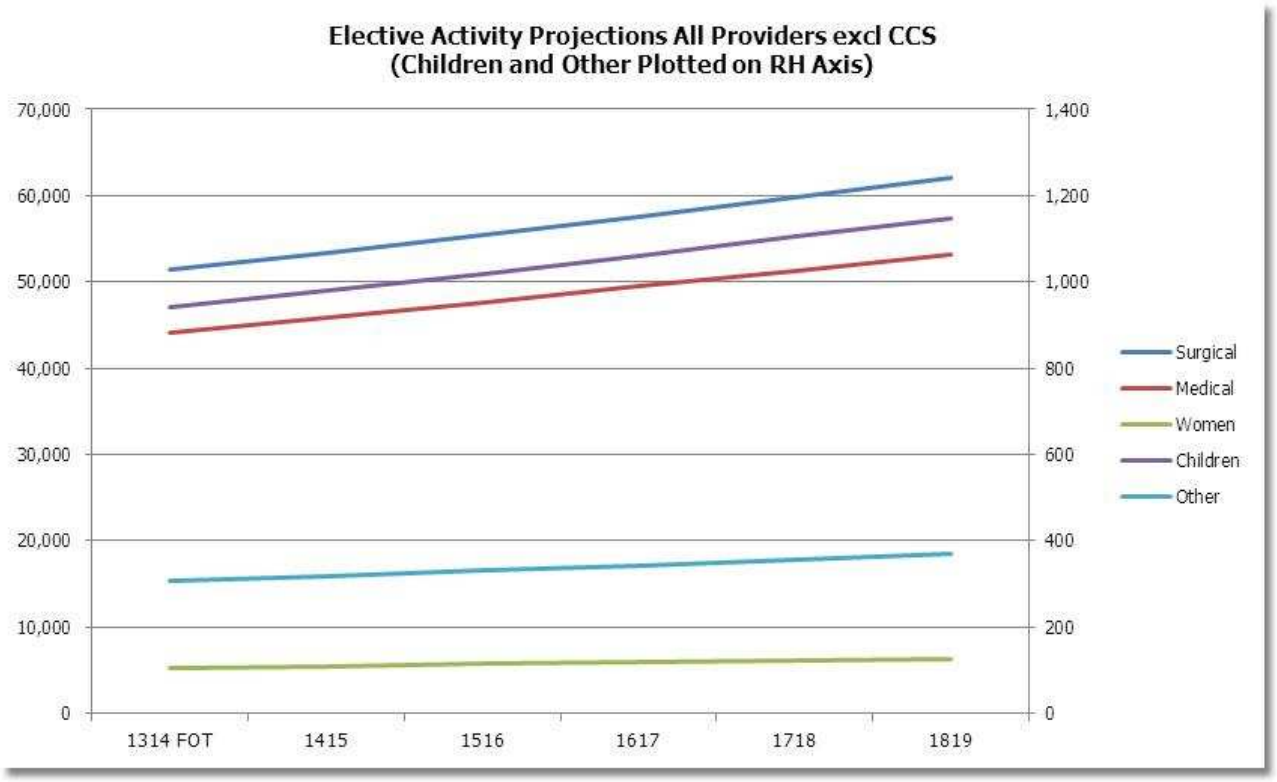
- CUHFT: Cambridge City, South Cambridgeshire and East Cambridgeshire
- Hinchingbrooke: Huntingdonshire
- PSHFT: Peterborough
- QEHKL: Fenland
- Papworth: Cambridgeshire
- CCS: Cambridgeshire
- Others: Cambridgeshire

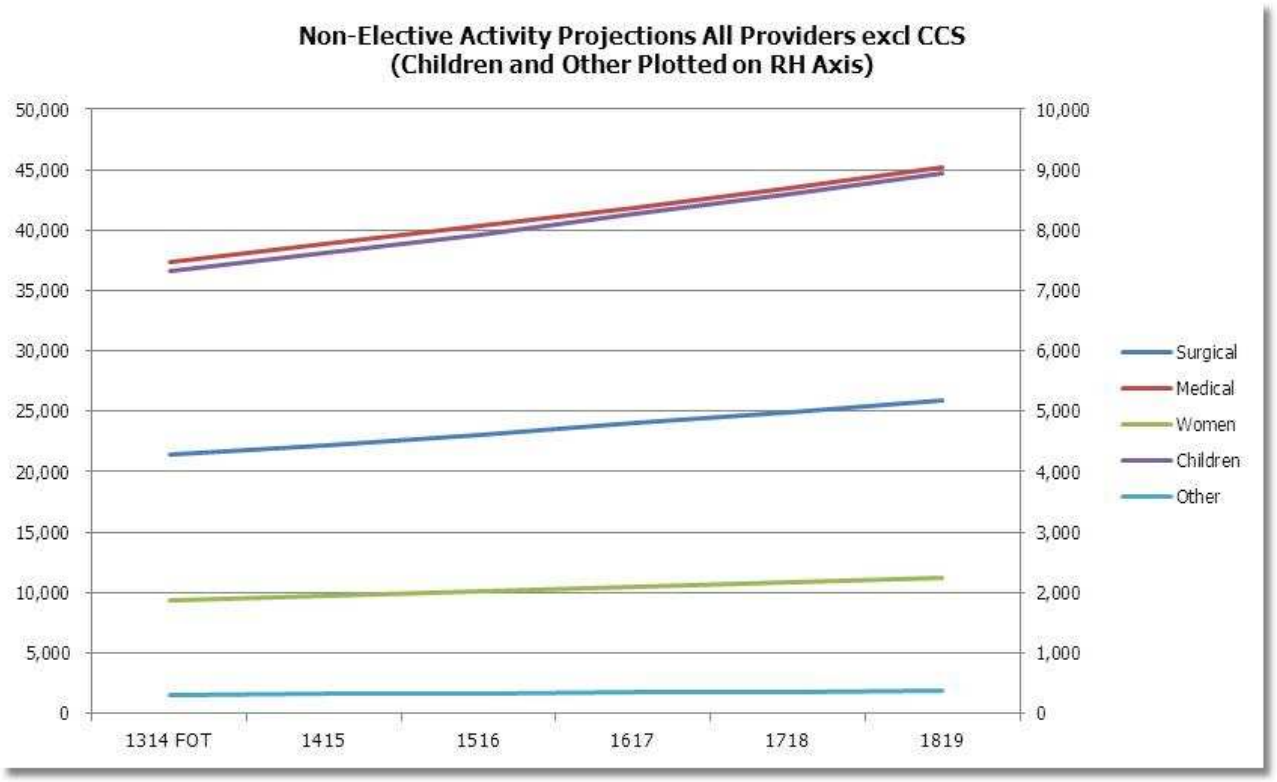
Older People's projections were based on age band projections from the Cambridgeshire CC Research Group

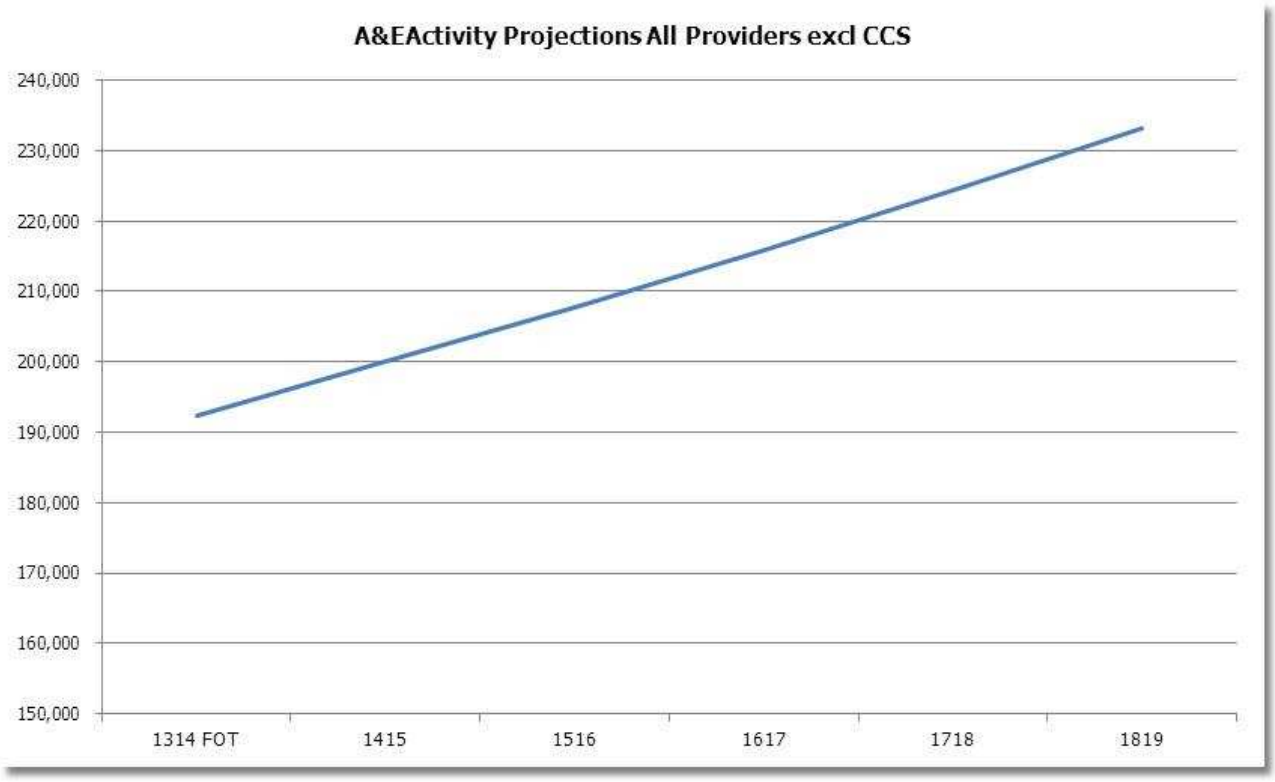
Information from CCS and CPFT has not been included because of data availability.

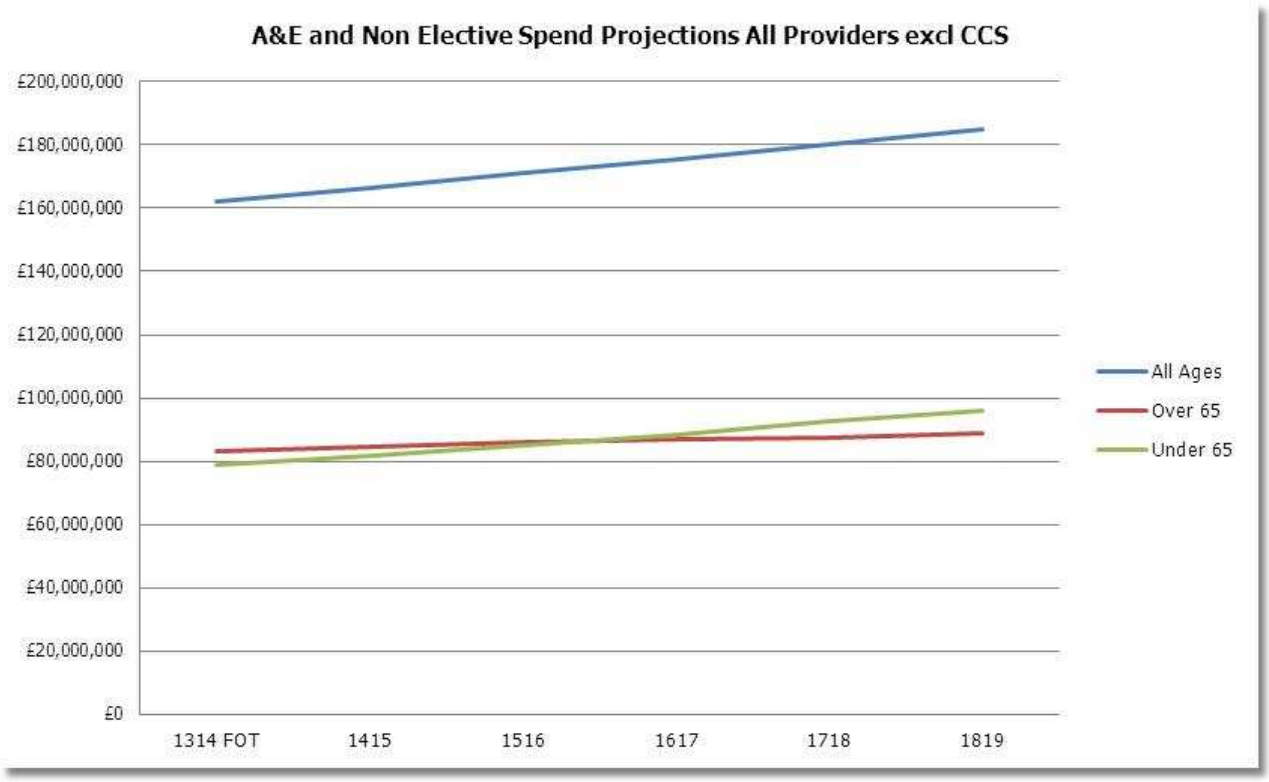
Results of the current model

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

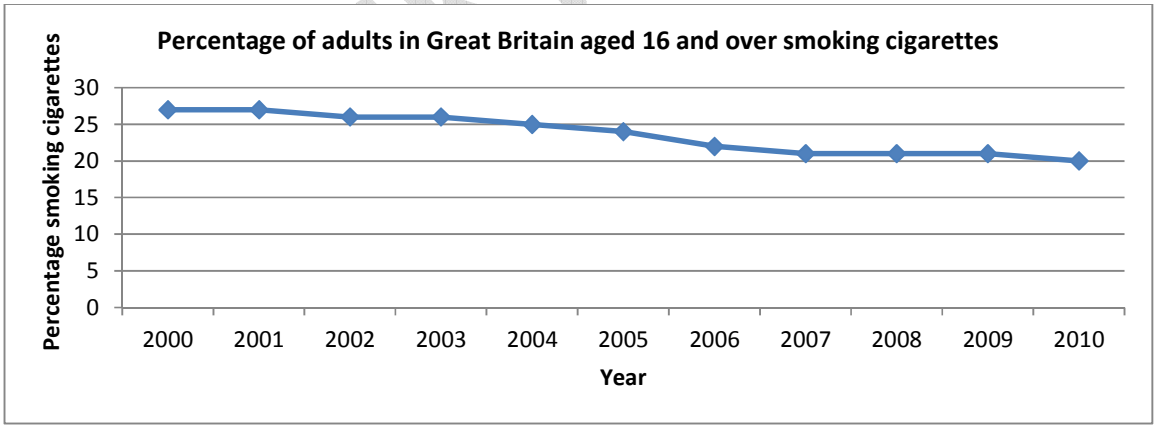


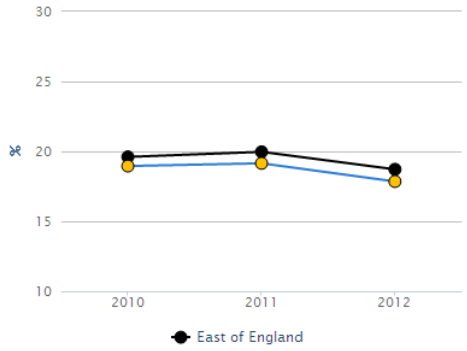
Figure 1: Smoking prevalence data from the General Lifestyle Survey, Office of National Statistics
http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-226919

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[23]. 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.

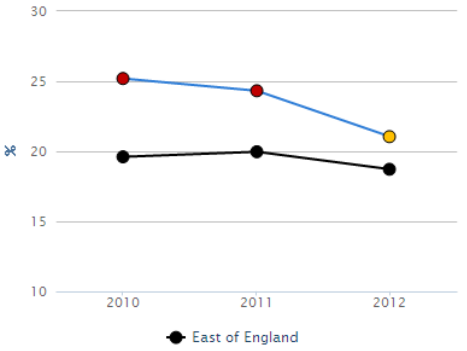
2.14 - Smoking Prevalence Cambridgeshire — Proportion - %



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)[24]. 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

[23] 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+.

[24] 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[25]. 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[25]

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

[25] 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[26] 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).

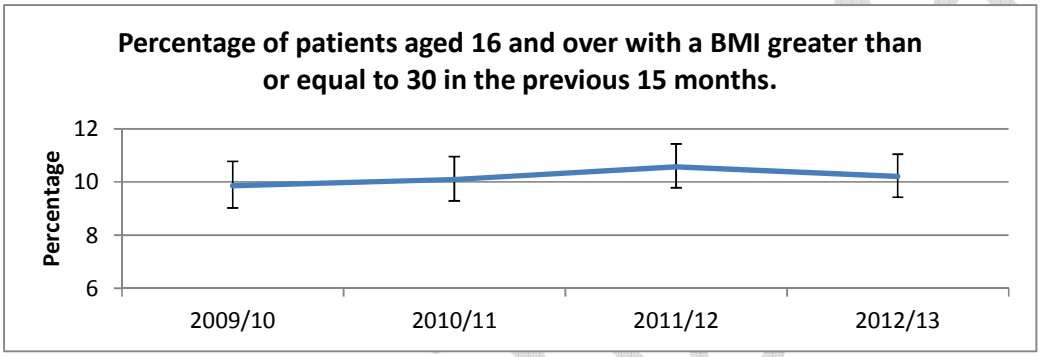


Figure 3: Percentage of patients aged 16 and over with a BMI greater than or equal to 30 in the previous 15 months (Data from QOF) in C&P CCG [27] [28]

[26] *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))*

[27] 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.

[28] 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,-

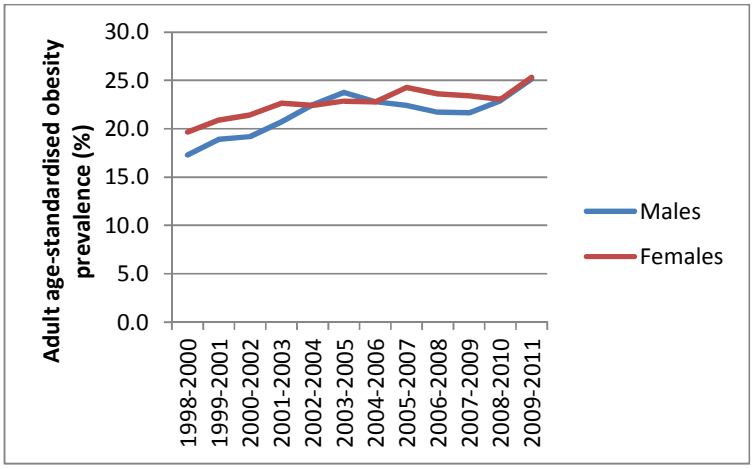


Figure 4: Adult (aged 16+ years) age standardised obesity prevalence (%) in the East of England
Source: Health Survey for England (HSE). Obesity in adults is defined as a BMI greater than or equal to 30kg/m^2

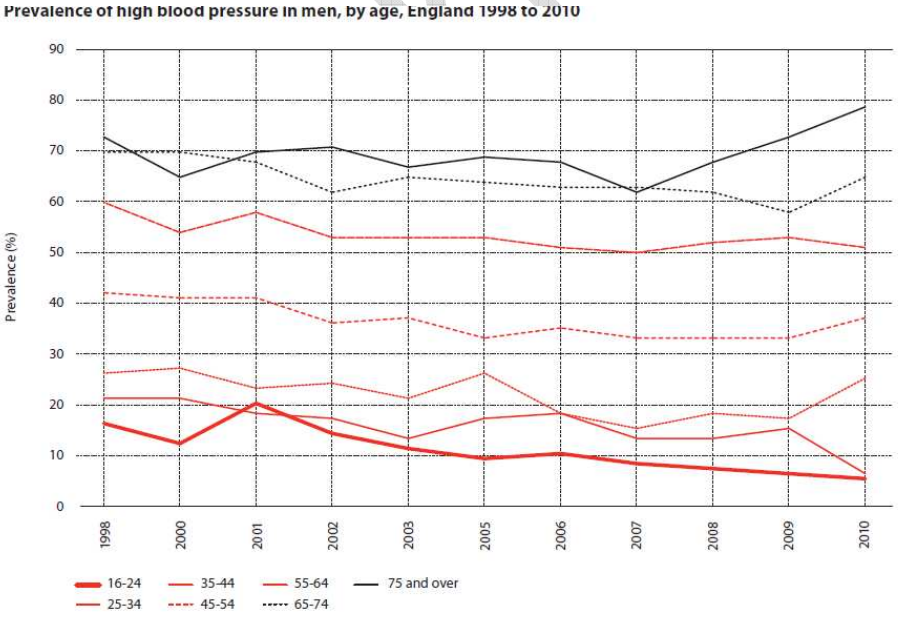
3.2 Future obesity prevalence

A 2007 report by the UK Government's Foresight Programme[29] 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.



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

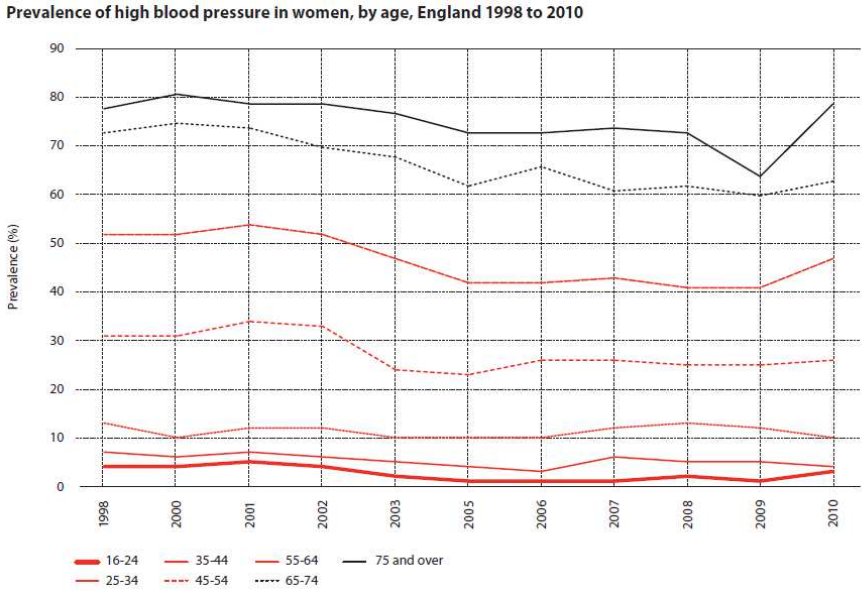


Figure 5: Prevalence of high blood pressure in England, 1998-2010[30]

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.

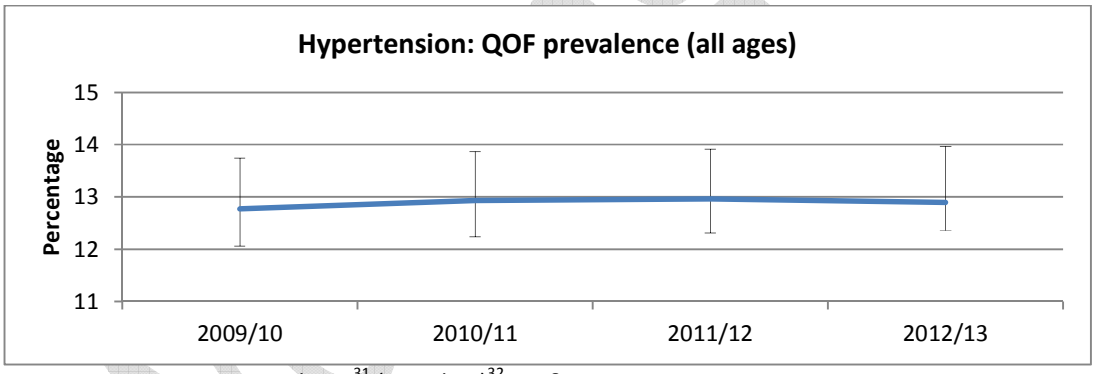


Figure 6: Hypertension prevalence[31] (QOF data)[32] in C&P CCG

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.

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

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

[32] 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.

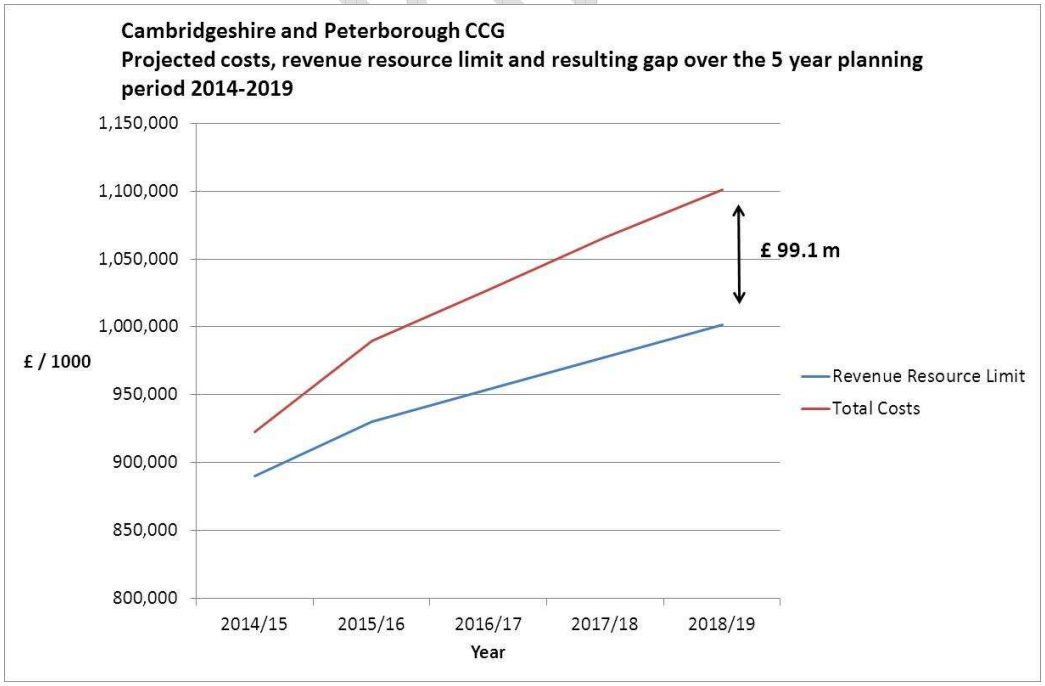
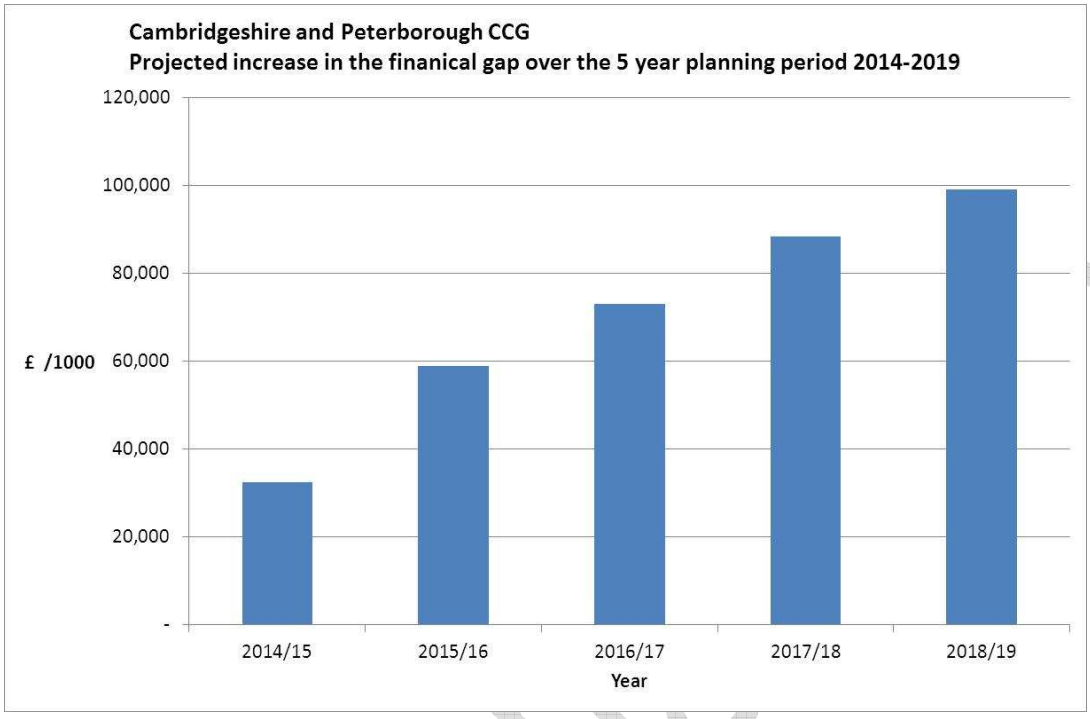


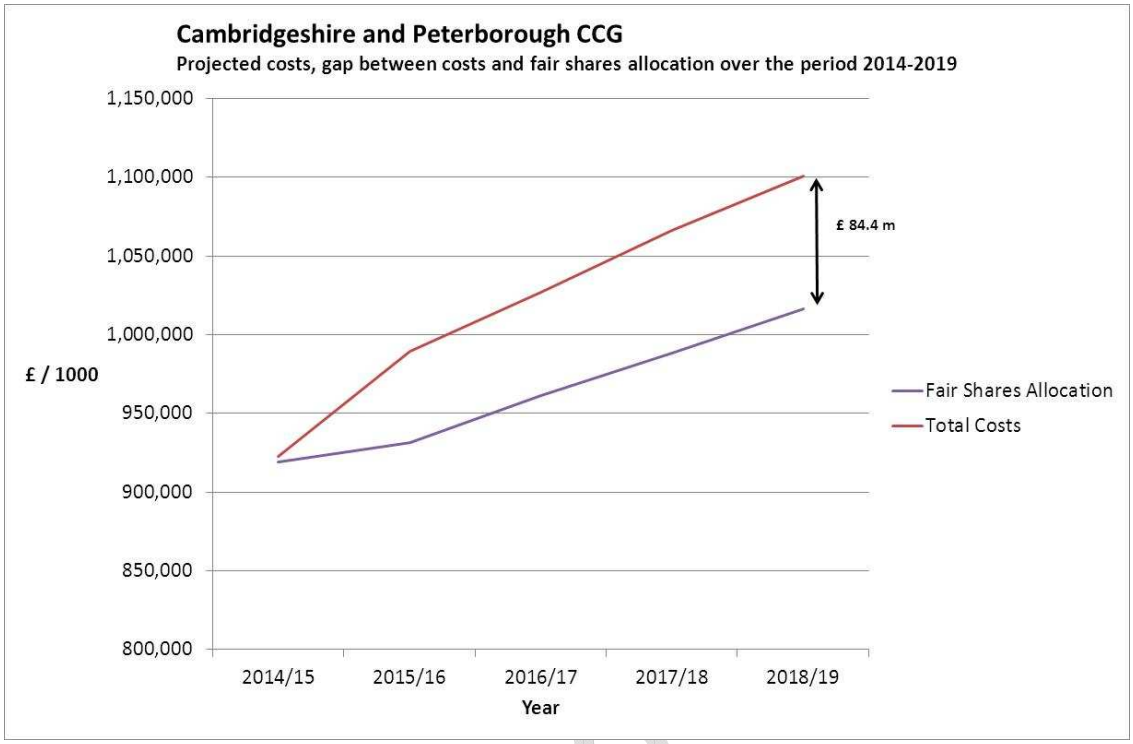
Figure A9-2 below shows the increase in the financial gap over the 5 year period.

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

29-May-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		(5,998)	(5,998)			0		9,306	9,306		9,633	9,633		9,872	9,872
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**	**(5,998)**	**890,079**	**930,561**	**0**	**930,561**	**953,991**	**9,306**	**963,297**	**977,649**	**9,633**	**987,282**	**1,001,810**	**9,872**	**1,011,682**
Planned Expenditure (13/14 is FOT)																		
Bought forward recurrent spend	858,914	6,631	865,545	858,914		858,914	855,118		855,118	890,278		890,278	914,054		914,054	937,952		937,952
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)	(12,233)		(12,233)	(7,342)		(7,342)	(7,449)		(7,449)	(12,602)		(12,602)
Population growth 1.5%			0	11,623		11,623	13,011		13,011	12,971		12,971	13,243		13,243	13,510		13,510
Other growth			0	11,182	3,400	14,582	20,198		20,198	24,924		24,924	27,038		27,038	26,744		26,744
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		8,780	8,780		9,175	9,175		9,588	9,588		10,019	10,019
Better care fund			0		0	0	39,033		39,033			0			0			0
1% non rec CCG requirement			0		8,904	8,904		9,306	9,306		9,679	9,679		9,922	9,922		10,167	10,167
1.5% transition to 2015/16		3,508	3,508		0	0			0			0			0			0
Total spend before QIPP	**879,714**	**7,942**	**887,656**	**897,289**	**25,190**	**922,479**	**934,017**	**22,738**	**956,756**	**939,721**	**23,625**	**963,345**	**965,775**	**24,398**	**990,173**	**984,493**	**25,195**	**1,009,689**
Planned QIPP Savings			0	(23,282)	(9,118)	(32,400)	(24,850)	(10,650)	(35,500)	(6,777)	(2,904)	(9,681)	(8,934)	(3,829)	(12,763)	(5,683)	(2,436)	(8,119)
Total Spend after QIPP	**879,714**	**7,942**	**887,656**	**874,007**	**16,072**	**890,079**	**909,167**	**12,088**	**921,256**	**932,943**	**20,721**	**953,664**	**956,841**	**20,569**	**977,410**	**978,810**	**22,760**	**1,001,570**
Surplus / (deficit)	**(9,710)**	**4,836**	**(4,874)**	**22,070**	**(22,070)**	**(0)**	**21,394**	**(12,088)**	**9,305**	**21,048**	**(11,415)**	**9,633**	**20,808**	**(10,936)**	**9,872**	**23,000**	**(12,888)**	**10,112**